ICD-11 DIAGNOSTIC GUIDELINES
Mood Disorders

Note: This document contains a pre-publication version of the ICD-11 diagnostic guidelines for Mood Disorders. There may be further edits to these guidelines prior to their publication.

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MOOD DISORDERS

Mood Disorders refers to a superordinate grouping of Depressive Disorders and Bipolar Disorders. Mood disorders are defined according to particular types of Mood Episodes and their pattern over time. The primary types of Mood Episodes are:

Depressive Episode
Manic Episode
Mixed Episode
Hypomanic Episode

Mood Episodes are not independently diagnosable entities, and therefore do not have their own diagnostic codes. Rather, Mood Episodes are the components of Bipolar or Related Disorders and Depressive Disorders.

The sections that follow first describe the characteristics of Mood Episodes. This is followed by diagnostic guidelines for Mood Disorders.

Bipolar or Related Disorders include the following:

6A60 Bipolar Type I Disorder
6A61 Bipolar Type II Disorder
6A62 Cyclothymic Disorder
6A6Y Other Specified Bipolar or Related Disorders

Depressive Disorders include the following:

6A70 Single Episode Depressive Disorder
6A71 Recurrent Depressive Disorder
6A72 Dysthymic Disorder
6A7Y Other Specified Depressive Disorders

6A73 Mixed Depressive and Anxiety Disorder is also included in the section on Depressive Disorders, although it also shares features with Anxiety or Fear-Related Disorders.

Diagnostic guidelines are also provided in GA34.41 Premenstrual Dysphoric Disorder in the section on Depressive Disorders. Premenstrual Dysphoric Disorder is classified in the grouping of Premenstrual Disturbances in the ICD-11 chapter on Diseases of the Genitourinary System, but is cross-listed here for reference.

The following category for Mood Disorders that do not fit the descriptions for any of the above categories is also provided:

6A8Y Other Specified Mood Disorders

Mood Episode Descriptions

Depressive Episode

Essential (Required) Features:

- The concurrent presence of at least five of the following characteristic symptoms occurring most of the day, nearly every day during a period lasting at least 2 weeks. At least one symptom from the Affective cluster must be present. Assessment of the presence or absence of symptoms should be made relative to typical functioning of the individual.

  Affective cluster:

  - Depressed mood as reported by the individual (e.g., feeling down, sad) or as observed (e.g., tearful, defeated appearance). In children and adolescents depressed mood can manifest as irritability.
  - Markedly diminished interest or pleasure in activities, especially those normally found to be enjoyable to the individual. The latter may include a reduction in sexual desire.

  Cognitive-behavioural cluster:

  - Reduced ability to concentrate and sustain attention to tasks, or marked indecisiveness.
  - Beliefs of low self-worth or excessive and inappropriate guilt that may be manifestly delusional. This item should not be considered present if guilt or self-reproach is exclusively about being depressed.
  - Hopelessness about the future.
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation (with or without a specific plan), or evidence of attempted suicide.

  Neurovegetative cluster:

  - Significantly disrupted sleep (delayed sleep onset, increased frequency of waking during the night, or early morning awakening) or excessive sleep.
  - Significant change in appetite (diminished or increased) or significant weight change (gain or loss).
  - Psychomotor agitation or retardation (observable by others, not merely subjective feelings of restlessness or being slowed down).
  - Reduced energy, fatigue, or marked tiredness following the expenditure of only a minimum of effort.

- The symptoms are not better accounted for by bereavement.
- The symptoms are not a manifestation of another medical condition (e.g., a brain tumour) and are not due to the effect of a substance or medication on the central nervous system (e.g., benzodiazepines), including withdrawal effects (e.g., from stimulants).
- The clinical presentation does not fulfil the definitional requirements for a Mixed Episode or Schizoaffective Disorder.

- The mood disturbance results in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features:

- In some individuals, the affective component of a Depressive Episode may be primarily experienced and expressed as irritability, or as an absence of emotional experience (e.g., 'emptiness'). These variants in the expression of the affective component can be considered as meeting the depressed mood requirement for a Depressive Episode if they represent a significant change from the individual's typical functioning.
- In some individuals, particularly those experiencing a Severe Depressive Episode, there may be reluctance to describe certain experiences (e.g., psychotic symptoms) or inability to do so in detail (e.g., due to psychomotor agitation or retardation). In such cases, observations made by the clinician or reported by a collateral informant are important in determining diagnostic status and severity of the episode.
- Depressive Episodes may be associated with increased consumption of alcohol or other substances, exacerbation of pre-existing psychological symptoms (e.g., phobic or obsessional symptoms), or somatic preoccupations.

Boundary with Normality (Threshold):

- Some depression of mood is a normal reaction to severe adverse life events and problems (e.g., divorce, job loss), and is common in the community. A Depressive Episode is differentiated from this common experience by the severity, range, and duration of symptoms. If the diagnostic requirements for a Depressive Episode listed above are met, a Depressive Episode should still be considered present, even if there are identifiable life events that appear to have triggered the episode.
- A Depressive Episode should not be considered to be present if the individual is exhibiting normal grief symptoms, including some level of depressive symptoms, and the individual has experienced the death of a loved one within the past 6 months, or longer if a more extended period of bereavement is consistent with the normative response for grieving within the individual's religious and cultural context. Individuals with no history of Depressive Episodes may experience depressive symptoms during bereavement, but this does not appear to indicate an increased risk of subsequently developing a Mood Disorder. However, a Depressive Episode can be superimposed on normal grief. The presence of a Depressive Episode during a period of bereavement is suggested by persistence of constant depressive symptoms a month or more following the loss (i.e., there are no periods of positive mood or enjoyment of activities), severe depressive symptoms such as extreme beliefs of low self-worth and guilt not related to the lost loved one, presence of psychotic symptoms, suicidal ideation, or psychomotor retardation. A prior history of Depressive Disorder or Bipolar Disorder is important to consider in making this distinction.

Developmental Presentations:

- Depressive Episode is relatively rare in childhood and occurs with similar frequency among boys and girls. After puberty, rates increase significantly and girls are

approximately twice as likely as boys to experience a Depressive Episode.

- All of the characteristic features of Depressive Episode can be observed in children and adolescents. As in adults, symptoms of Depressive Episode should represent a change from prior functioning. Assessment of Depressive Episode in younger children in particular is likely to rely on the report of other informants (e.g., parents) regarding signs and symptoms and the extent to which these represent a change from prior functioning.
- *Affective cluster:* In young children, depressed mood may present as somatic complaints (e.g., headaches, stomachaches), whining, increased separation anxiety, or excessive crying. Depressed mood may sometimes present in children and adolescents as pervasive irritability. However, the presence of irritability is not in and of itself indicative of a Depressive Episode and may indicate the presence of another Mental, Behavioural or Neurodevelopmental Disorder or be a normal reaction to frustration.
- *Cognitive-behavioural cluster:* As noted, reduced ability to concentrate or sustain attention may manifest as a decline in academic performance, increased time needed to complete school assignments, or an inability to complete assignments. These symptoms of Depressive Episode must be differentiated from problems with attention and concentration in Attention Deficit Hyperactivity Disorder that are not temporally tied to changes in mood or energy.
- *Neurovegetative cluster:* Hypersomnia and hyperphagia are more common symptoms of a Depressive Episode in adolescents than in adults. Appetite disturbance in children and adolescents may manifest in failure to gain weight as expected for age and development rather than as weight loss.
- Similar to adults, children and adolescents experiencing a Depressive Episode are at increased risk for suicidality. In younger children, suicidality may manifest in passive statements (e.g., 'I don't want to be here anymore') or as themes of death during play, whereas adolescents may make more direct statements regarding their desire to die.
- Self-injurious behaviours that are not explicitly suicidal in terms of lethality or expressed intent may also occur in Depressive Episode in young children and adolescents. Examples include head banging or scratching in young children and cutting or burning in adolescents. If unaddressed, these types of behaviours tend to increase in frequency and intensity over time among children and adolescents with Depressive Disorders.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Mixed Episode:*** Depressive symptoms in a Mixed Episode may be qualitatively similar to those of Depressive Episode, but in Mixed Episode several prominent depressive symptoms occur simultaneously or alternate rapidly with several prominent manic symptoms such as irritability, racing or crowded thoughts, increased talkativeness, or increased activity.
- ***Boundary with Attention Deficit Hyperactivity Disorder:*** Problems with attention and concentration in Attention Deficit Hyperactivity Disorder are persistent over time (i.e., are not episodic) and are not temporally tied to changes in mood or energy. However, Mood Disorders and Attention Deficit Hyperactivity Disorder can co-occur, and both diagnoses may be assigned if the full diagnostic requirements for each are met.
- ***Boundary with Prolonged Grief Disorder:*** Prolonged Grief Disorder is a persistent and pervasive grief response following the death of a partner, parent, child, or other person close to the bereaved that persists for an abnormally long period of time following the loss (e.g., at least 6 months) and is characterized by longing for the deceased or

persistent preoccupation with the deceased accompanied by intense emotional pain (e.g., sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to experience positive mood, emotional numbness, difficulty in engaging with social or other activities). Some common symptoms of Prolonged Grief Disorder are similar to those observed in a Depressive Episode (e.g., sadness, loss of interest in activities, social withdrawal, feelings of guilt, suicidal ideation). However, Prolonged Grief Disorder is differentiated from Depressive Episode because symptoms are circumscribed and specifically focused on the loss of the loved one, whereas depressive thoughts and emotional reactions typically encompass multiple areas of life. Further, other common symptoms of Prolonged Grief Disorder (e.g., difficulty accepting the loss, difficulty trusting others, feeling bitter or angry about the loss, feeling as though a part of the individual has died) are not characteristic of a Depressive Episode. The timing of the onset of the symptoms in relation to the loss and whether there is a prior history of a Depressive Disorder or a Bipolar Disorder are important to consider in making this distinction.

- ***Boundary with Dementia:*** Older adults experiencing a Depressive Episode may present with memory difficulties and other cognitive symptoms, which can be severe, and it is important to distinguish these symptoms from Dementia. Dementia is an acquired chronic condition characterized by significant cognitive impairment or decline from a previous level of cognitive functioning in two or more cognitive domains (e.g., memory, attention, executive function, language, social cognition, psychomotor speed, visuoperceptual or visuospatial abilities) that is sufficiently severe to interfere with performance or independence in activities of daily living. If memory difficulties and other cognitive symptoms in older adults occur exclusively in the context of Depressive Episode, a diagnosis of Dementia is generally not appropriate. However, a Depressive Episode can be superimposed on Dementia (e.g., when memory difficulties and other cognitive symptoms substantially predate the onset of the Depressive Episode). The timing and rate of onset of the memory difficulties and other cognitive symptoms in relation to other depressive symptoms are important to consider in making this distinction.

Severity and psychotic symptoms qualifiers:

The severity of all current Depressive Episodes should be rated based on the number and severity of the symptoms, as well as the impact that the mood disturbance has on the individual's functioning.

In addition, Moderate and Severe Depressive Episodes are described as 'without Psychotic Symptoms' (i.e., delusions or hallucinations) or 'with Psychotic Symptoms'. By definition, Mild Depressive Episodes do not include psychotic symptoms.

Delusions during Moderate or Severe Depressive Episodes are commonly persecutory or self-referential (e.g., being pursued by authorities because of imaginary crimes). In addition, delusions of guilt (e.g., falsely blaming oneself for wrongdoings), poverty (e.g., of being bankrupt) and impending disaster (perceived to have been brought on by the individual), as well as somatic (e.g., of having contracted some serious disease) or nihilistic delusions (e.g., believing body organs do not exist) are known to occur. Delusions related to experiences of influence, passivity or control (e.g., the experience

that thoughts or actions are not generated by the person, are being placed in one's mind or withdrawn from one's mind by others, or that thoughts are being broadcast to others) can also occur, but less commonly than in Schizophrenia and Schizoaffective Disorder. Auditory hallucinations (e.g., derogatory or accusatory voices that berate the patient for supposed weaknesses or sins) are more common than visual (e.g., visions of death or destruction) or olfactory hallucinations (e.g., the smell of rotting flesh).

Psychotic symptoms are often subtle, and the boundary between psychotic symptoms and persistent depressive ruminations or sustained preoccupations is not always clear. Psychotic symptoms may vary in intensity over the course of a Depressive Episode or even over the course of the day. Psychotic symptoms may be intentionally concealed by individuals experiencing a Depressive Episode.

- Mild Depressive Episode:
    - None of the symptoms of a Depressive Episode should be present to an intense degree.
    - The individual is usually distressed by the symptoms and has some difficulty in continuing to function in one or more domains (personal, family, social, educational, occupational, or other important domains).
    - There are no delusions or hallucinations during the episode.

- Moderate Depressive Episode without Psychotic Symptoms:
    - Several symptoms of a Depressive Episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall.
    - The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).
    - There are no delusions or hallucinations during the episode.

- Moderate Depressive Episode with Psychotic Symptoms:
    - Several symptoms of a Depressive Episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall.
    - The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).
    - There are delusions or hallucinations during the episode.

- Severe Depressive Episode without Psychotic Symptoms:
    - Many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree.
    - The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).
    - There are no delusions or hallucinations during the episode.

- Severe Depressive Episode with Psychotic Symptoms:
    - Many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree.
    - The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).
    - There are delusions or hallucinations during the episode.

Manic Episode

Essential (Required) Features:

- Both of the following features occurring concurrently and persisting for most of the day, nearly every day, during a period of at least 1 week, unless shortened by a treatment intervention.
    - An extreme mood state characterized by euphoria, irritability, or expansiveness that represents a significant change from the individual's typical mood. Individuals commonly exhibit rapid changes among different mood states (i.e., mood lability).
    - Increased activity or a subjective experience of increased energy that represents a significant change from the individual's typical level.
- Several of the following symptoms, representing a significant change from the individual's usual behaviour or subjective state:
    - Increased talkativeness or pressured speech (a feeling of internal pressure to be more talkative).
    - Flight of ideas or experience of rapid or racing thoughts (e.g., thoughts flow rapidly and, in some cases, illogically from one idea to the next; the person reports that her thoughts are rapid or even racing and has difficulty remaining on topic).
    - Increased self-esteem or grandiosity (e.g., the individual believes that he can accomplish tasks well beyond his skill level, or that he is about to become famous). In psychotic presentations of mania, this may be manifested as grandiose delusions.
    - Decreased need for sleep (e.g., the person reports being able to function with only 2 or 3 hours of sleep), as distinct from Insomnia, in which an individual wants to sleep but cannot.
    - Distractibility (e.g., the person cannot stay on task, because attention is drawn to irrelevant or minor environmental stimuli, such as being overly distracted by outside noise during a conversation).
    - Impulsive reckless behaviour (e.g., the individual impulsively pursues pleasurable activities without regard to their potential for negative consequences, or impulsively makes major decisions in the absence of adequate planning).
    - An increase in sexual drive, sociability, or goal-directed activity.
- The symptoms are not a manifestation of another medical condition (e.g., a brain tumour) and are not due to the effect of a substance or medication on the central nervous system (e.g., cocaine, amphetamines), including withdrawal effects.

- The clinical presentation does not fulfil the definitional requirements for a Mixed Episode or Schizoaffective Disorder.
- The mood disturbance results in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning, requires intensive treatment (e.g., hospitalization) to prevent harm to self or others, or is accompanied by delusions or hallucinations.

Additional Clinical Features:

- Manic Episodes may or may not include psychotic symptoms. A wide variety of psychotic symptoms may occur in mania; among the most common are grandiose delusions (e.g., being chosen by God, having special powers or abilities), persecutory delusions, and self-referential delusions (e.g., being conspired against because of one's special identity or abilities). Delusions related to experiences of influence, passivity or control (e.g., the experience that thoughts or actions are not generated by the person, are being placed in one's mind or withdrawn from one's mind by others, or that thoughts are being broadcast to others) may also occur. Hallucinations are less frequent and commonly accompany delusions of persecution or reference. They are usually auditory (e.g., adulatory voices), and less commonly visual (e.g., visions of deities), somatic, or tactile.
- Some patients may exhibit symptoms or impairment in functioning that is sufficiently severe as to require immediate intervention (e.g., treatment with mood-stabilizing medications). As a result, their symptoms may not meet the full duration requirement of a Manic Episode. Episodes that meet the full symptom requirements but last for less than 1 week because they are shortened by a treatment intervention should still be considered Manic Episodes.
- A manic syndrome arising during antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy, transcranial magnetic stimulation) should be considered a Manic Episode if the syndrome persists after the treatment is discontinued and the full diagnostic requirements of a Manic Episode are met after the direct physiological effects of the treatment are likely to have receded.

Boundary with Normality (Threshold):

- Periods of euphoric or irritable mood that are entirely contextually appropriate (e.g., euphoria after winning a lottery) should not be considered as meeting the mood component of the diagnostic requirements for a Manic Episode.

Developmental Presentations:

- Manic Episode is rare in childhood and adolescence. It is normal for children to display over-excitement, exuberance, or silliness in contexts such as special occasions, celebrations, or some types of play. Manic Episode should only be considered when these behaviours are episodic and recurrent (or characterized by rapid onset if a first episode), are inappropriate for the context in which they arise, are in excess of what might be expected given the person's age or developmental level, represent a distinct change from previous functioning, and are associated with significant impairment in personal, family, social, educational, or other important areas of functioning.

- When a Manic Episode occurs in children or adolescents, all of the characteristic features can be observed. The reports of other informants (e.g., parents) are particularly important in the case of children in evaluating the nature of symptoms and the extent to which they represent a change from previous functioning. The extreme mood state characteristic of Manic Episode may manifest as extreme irritability in children and adolescents. Younger children may exhibit excessive or severe tantrums or increased physical aggression (e.g., throwing things, or hitting).
- In children and adolescents, increased distractibility may manifest as a decline in academic performance, increased time needed to complete school assignments, or inability to complete assignments.
- Increased self-esteem or grandiosity associated with a Manic Episode should be differentiated from children's normal tendency to overestimate their abilities and believe that they have special talents. Grandiose beliefs that are held with clear evidence to the contrary or acted on in such a way that they place the child in danger are more suggestive of Manic Episode. Examples of manifestations of grandiosity include magical or unrealistic ideas (e.g., thinking they can fly) in younger children or overestimation of abilities or talents based on current functioning (e.g., believing they should coach their high school sports team) in adolescents.
- Specific manifestations of increased goal-directed activities associated with Manic Episode may differ across ages. For example, a younger child might build elaborate projects with blocks, while an adolescent might disassemble electronics or appliances.
- As in adults, children and adolescents may engage in impulsive reckless behaviours during a Manic Episode, but these are likely to present differently in children and adolescents based on behavioural repertoire and access to specific activities. For example, a child may exhibit risky play, disregarding possible injury (e.g., running into a busy street, climbing a tall tree, trying to fly), whereas for adolescents, analogous behaviour may include driving fast, spending excessively, or engaging in risky sexual behaviour.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Hypomanic Episode:*** The symptoms of Manic Episodes may be qualitatively similar to those of Hypomanic Episodes, but, unlike in a Hypomanic Episode, the mood disturbance is sufficiently severe to result in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning or to require intensive treatment (e.g., hospitalization) to prevent harm to self or others, or is accompanied by delusions or hallucinations.
- ***Boundary with Mixed Episode:*** Manic symptoms in a Mixed Episode may be qualitatively similar to those of Manic Episode, but in Mixed Episode several prominent manic symptoms occur simultaneously or alternate rapidly with several prominent depressive symptoms such as dysphoric mood, expressed beliefs of worthlessness, hopelessness, or suicidal ideation.
- ***Boundary with Attention Deficit Hyperactivity Disorder:*** Many features of Manic Episode such as increased activity, rapid speech and over-talkativeness, distractibility, and impulsivity can be observed in individuals with Attention Deficit Hyperactivity Disorder. Differentiating between these disorders can be particularly challenging among children and adolescents. However, in Attention Deficit Hyperactivity Disorder, symptoms have their onset before the age of 12, are persistent over time (i.e., are not

episodic), and are not temporally tied to changes in mood or energy (e.g., are not accompanied by intense mood elevation). However, rates of Attention Deficit Hyperactivity Disorder are substantially elevated as compared to the general population among children and adolescents diagnosed with Bipolar Disorders, and both diagnoses may be assigned if the full diagnostic requirements for each are met.

Mixed Episode

Essential (Required) Features:

- The presence of several prominent manic and several prominent depressive symptoms consistent with those observed in Manic Episodes and Depressive Episodes, which either occur simultaneously or alternate very rapidly (from day to day or within the same day). Symptoms must include an altered mood state consistent with a Manic and/or Depressive Episode (i.e., depressed, dysphoric, euphoric or expansive mood), and be present most of the day, nearly every day, during a period of at least 2 weeks, unless shortened by a treatment intervention.
- When manic symptoms predominate in a Mixed Episode, common depressive (contrapolar) symptoms are dysphoric mood, expressed beliefs of worthlessness, hopelessness, and suicidal ideation.
- When depressive symptoms predominate in a Mixed Episode, common manic (contrapolar) symptoms are irritability, racing or crowded thoughts, increased talkativeness, and increased activity.
- When depressive and manic symptoms alternate rapidly during a Mixed Episode, such fluctuations may be observed in mood (e.g., between euphoria and sadness or dysphoria), emotional reactivity (e.g., between flat affect and intense or exaggerated reactiveness to emotional stimuli), drive (e.g., alternating periods of increased and decreased activity, verbal expression, sexual desire, or appetite), and cognitive functioning (e.g., periods of activation and inhibition or slowing of thoughts, attention and memory).
- The symptoms are not a manifestation of another medical condition (e.g., a brain tumour) and are not due to the effect of a substance or medication on the central nervous system (e.g., benzodiazepines), including withdrawal effects (e.g., from cocaine).
- The clinical presentation does not fulfil the diagnostic requirements for Schizoaffective Disorder.
- The mood disturbance results in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning or is accompanied by delusions or hallucinations.

Additional Clinical Features:

- Delusions and hallucinations characteristic of both Depressive and Manic Episodes (see above) can occur in Mixed Episodes.
- A mixed syndrome arising during antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy, transcranial magnetic stimulation) should be considered a Mixed Episode if the syndrome persists after the treatment is discontinued

and the full diagnostic requirements of a Mixed Episode are met after the direct physiological effects of the treatment are likely to have receded.

Developmental Presentations:

- There is limited research regarding Mixed Episodes in children and adolescents; however, there is some evidence to suggest that adolescents with Bipolar Disorders may be more likely than adults with Bipolar Disorders to experience Mixed Episodes.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Manic Episode:*** Manic symptoms in a Mixed Episode may be qualitatively similar to those of Manic Episode, but in Mixed Episode several prominent manic symptoms occur simultaneously or alternate rapidly with several depressive symptoms such as dysphoric mood, expressed beliefs of worthlessness, hopelessness, or suicidal ideation.
- ***Boundary with Depressive Episode:*** Depressive symptoms in a Mixed Episode may be qualitatively similar to those of Depressive Episode, but in Mixed Episode several prominent depressive symptoms occur simultaneously or alternate rapidly with several prominent manic symptoms such as irritability, racing or crowded thoughts, increased talkativeness, or increased activity.
- ***Boundary with Hypomanic Episode:*** Manic symptoms in a Mixed Episode may be qualitatively similar to those of Hypomanic Episode, but, unlike in a Hypomanic Episode, the mood disturbance in Mixed Episode is sufficiently severe to result in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning or to require intensive treatment (e.g., hospitalization) to prevent harm to self or others, or is accompanied by delusions or hallucinations. Moreover, in Mixed Episode several prominent manic symptoms occur simultaneously or alternate rapidly with several prominent depressive symptoms such as dysphoric mood, expressed beliefs of worthlessness, hopelessness, or suicidal ideation, which are not characteristic of Hypomanic Episode.

Hypomanic Episode

Essential (Required) Features:

- Both of the following symptoms occurring concurrently and persisting for most of the day, nearly every day, for at least several days:
    - Persistent elevation of mood or increased irritability that represents a significant change from the individual's usual range of moods (e.g., the change would be apparent to people who know the individual well). This does not include periods of elevated or irritable mood that are contextually appropriate (e.g., elevated mood after graduating from school or related to falling in love). Rapid shifts among different mood states commonly occur (i.e., mood lability).
    - Increased activity or a subjective experience of increased energy that represents a significant change from the individual's typical level.

- In addition, several of the following symptoms, representing a significant change from the individual's usual behaviour (e.g., the change would be apparent to others who know the individual well) or subjective state.
    - Increased talkativeness or pressured speech (a feeling of internal pressure to be more talkative).
    - Flight of ideas or experience of rapid or racing thoughts (e.g., thoughts flow rapidly from one idea to the next; the person reports that her thoughts are rapid or even racing and has difficulty remaining on a topic).
    - Increased self-esteem or grandiosity (e.g., individual is more self-confident than usual)
    - Decreased need for sleep (e.g., the person reports needing less sleep than usual and still feels well-rested). This differs from Insomnia, in which an individual wants to sleep but cannot.
    - Distractibility (e.g., the person has difficulty staying on task, because attention is drawn to irrelevant or minor environmental stimuli, such as being overly distracted by outside noise during a conversation).
    - Impulsive reckless behaviour (e.g., the individual pursues pleasurable activities with little regard to their potential for negative consequences, or makes decisions in the absence of adequate planning.)
    - An increase in sexual drive, sociability or goal-directed activity.
- The symptoms are not a manifestation of another medical condition (e.g., a brain tumour) and are not due to the effect of a substance or medication on the central nervous system (e.g., cocaine, amphetamines), including withdrawal effects (e.g., from stimulants).
- The clinical presentation does not fulfil the definitional requirements for a Mixed Episode.
- The mood disturbance is not sufficiently severe as to cause marked impairment in occupational functioning or in usual social activities or relationships with others and is not accompanied by delusions or hallucinations.

Additional Clinical Features:

- A hypomanic syndrome arising during antidepressant treatment (medication, electroconvulsive therapy, light therapy, transcranial magnetic stimulation) should be considered a Hypomanic Episode if the syndrome persists after the treatment is discontinued and the full diagnostic requirements of a Hypomanic Episode are met after the direct physiological effects of the treatment are likely to have receded.

Boundary with Normality (Threshold):

- Hypomanic Episodes are often difficult to distinguish from normal periods of elevated mood, for example related to positive life events, particularly given that Hypomanic episodes are not associated with significant functional impairment. In order to be considered a Hypomanic episode, the symptoms must represent a significant and noticeable change from the individual's typical mood and behaviour.
- The occurrence of one or more Hypomanic Episodes in the absence of a history of other types of Mood Episodes (i.e., Manic, Depressive, or Mixed Episodes) is not a sufficient basis for a diagnosis of a Mood Disorder.

Developmental Presentations:

- As in adults, Hypomanic Episode in children and adolescents are similar to, but less severe than, Manic Episode and may present for a shorter period of time. The information in the section on *Developmental Presentations* for Manic Episode, above, is therefore also applicable to Hypomanic Episode.
- Hypomanic Episode may be difficult to distinguish from developmentally normative behaviours in children and adolescents (e.g., changes in sleep or irritability during adolescence). Factors to consider include the episodicity and a marked, co-occurring, change in cognitions (e.g., racing thoughts) or behaviours (e.g., increased activity level).
- Increased irritability in younger children may be manifest as excessive or more severe tantrums or increased physical aggression (e.g., throwing things, or hitting).

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Manic Episode:*** The symptoms of Hypomanic Episodes may be qualitatively similar to those of Manic Episodes, but the mood disturbance is not sufficiently severe to result in marked impairment in personal, family, social, educational, occupational, or other important areas of functioning or to require intensive treatment (e.g., hospitalization) to prevent harm to self or others, and is not accompanied by delusions or hallucinations.
- ***Boundary with Mixed Episode:*** Manic symptoms in a Mixed Episode may be qualitatively similar to those of Hypomanic Episode, but, unlike in a Hypomanic Episode, the mood disturbance in Mixed Episode is sufficiently severe to result in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning or to require intensive treatment (e.g., hospitalization) to prevent harm to self or others, or is accompanied by delusions or hallucinations. Moreover, in Mixed Episode several prominent manic symptoms occur simultaneously or alternate rapidly with several prominent depressive symptoms such as dysphoric mood, expressed beliefs of worthlessness, hopelessness, or suicidal ideation, which are not characteristic of Hypomanic Episode.
- ***Boundary with Attention Deficit Hyperactivity Disorder:*** Many features of Hypomanic Episode such as increased activity, rapid speech and over-talkativeness, distractibility, and impulsivity can be observed in individuals with Attention Deficit Hyperactivity Disorder. Differentiating between these disorders can be particularly challenging among children and adolescents. However, in Attention Deficit Hyperactivity Disorder, symptoms have their onset before the age of 12, are persistent over time (i.e., are not episodic), and are not temporally tied to changes in mood or energy (e.g., are not accompanied by mood elevation). However, rates of Attention Deficit Hyperactivity Disorder are substantially elevated as compared to the general population among children and adolescents diagnosed with Bipolar Disorders, and both diagnoses may be assigned if the full diagnostic requirements for each are met.

Mood Disorder Descriptions

BIPOLAR AND RELATED DISORDERS:

Bipolar and Related Disorders are episodic mood disorders defined by the occurrence of Manic, Mixed or Hypomanic Episodes or symptoms. These typically alternate over the course of these disorders with Depressive Episodes or periods of depressive symptoms.

Because the symptoms of Bipolar Type I Disorder and Bipolar Type II Disorder are substantially similar apart from the occurrence of Manic or Mixed Episodes in Bipolar Type I Disorder and Hypomanic Episodes in Bipolar Type II Disorder, following a separate listing of the *Essential Features* for each of these disorders, the other guideline sections (e.g., *Additional Clinical Features*, *Boundaries with Other Disorders and Conditions*) are provided for both disorders together.

6A60 Bipolar Type I Disorder

Essential Features:

- A history of at least one Manic or Mixed Episode (see above Essential Features for Mood Episodes). Although a single Manic or Mixed Episode is sufficient for a diagnosis of Bipolar Type I Disorder, the typical course of the disorder is characterized by recurrent Depressive and Manic or Mixed Episodes. Although some episodes may be Hypomanic, there must be a history of at least one Manic or Mixed Episode.

Type of current Mood Episode, psychotic symptoms, severity of current Depressive Episodes, and remission qualifiers:

The type of current Mood Episode, the presence or absence of psychotic symptoms, the severity of current Depressive Episodes, and the degree of remission should be described in Bipolar Type I Disorder. (See descriptions of psychotic symptoms and Depressive Episode Severity in Mood Episode descriptions above.) Available categories are as follows:

6A60.0	Bipolar Type I Disorder, Current Episode Manic, without psychotic symptoms
6A60.1	Bipolar Type I Disorder, Current Episode Manic, with psychotic symptoms
6A60.2	Bipolar Type I Disorder, Current Episode Hypomanic
6A60.3	Bipolar Type I Disorder, Current Episode Depressive, Mild
6A60.4	Bipolar Type I Disorder, Current Episode Depressive, Moderate, without psychotic symptoms
6A60.5	Bipolar Type I Disorder, Current Episode Depressive, Moderate, with psychotic symptoms
6A60.6	Bipolar Type I Disorder, Current Episode Depressive, Severe, without psychotic symptoms
6A60.7	Bipolar Type I Disorder, Current Episode Depressive, Severe, with psychotic symptoms
6A60.8	Bipolar Type I Disorder, Current Episode Depressive, Unspecified Severity

6A60.9	Bipolar Type I Disorder, Current Episode Mixed, without psychotic symptoms
6A60.A	Bipolar Type I Disorder, Current Episode Mixed, with psychotic symptoms
6A60.B	Bipolar Type I Disorder, currently in partial remission, most recent episode Manic or Hypomanic
6A60.C	Bipolar Type I Disorder, currently in partial remission, most recent episode Depressive
6A60.D	Bipolar Type I Disorder, currently in partial remission, most recent episode Mixed
6A60.E	Bipolar Type I Disorder, currently in partial remission, most recent episode unspecified
6A60.F	Bipolar Type I Disorder, currently in full remission

6A60.0 Bipolar Type I Disorder, Current Episode Manic, without psychotic symptoms

- All diagnostic requirements for a Manic Episode (see page __) are currently met.
- There are no delusions or hallucinations during the current Manic Episode.

Note: If the individual has experienced Manic or Mixed Episodes in the past, a duration of 1 week is not required in order to diagnose a current episode if all other diagnostic requirements are met.

6A60.1 Bipolar Type I Disorder, Current Episode Manic, with psychotic symptoms

- All diagnostic requirements for a Manic Episode (see page __) are currently met.
- There are delusions or hallucinations during the current Manic Episode.

Note: If the individual has experienced Manic or Mixed Episodes in the past, a duration of 1 week is not required in order to diagnose a current episode if all other diagnostic requirements are met.

6A60.2 Bipolar Type I Disorder, Current Episode Hypomanic

- All diagnostic requirements for a Hypomanic Episode (see page __) are currently met.

6A60.3 Bipolar Type I Disorder, Current Episode Depressive, Mild

- All diagnostic requirements for a Mild Depressive Episode (see page __) are currently met.

6A60.4 Bipolar Type I Disorder, Current Episode Depressive, Moderate, without psychotic symptoms

- All diagnostic requirements for a Moderate Depressive Episode (see page __) are currently met.

- There are no delusions or hallucinations during the current Depressive Episode.

6A60.5 Bipolar Type I Disorder, Current Episode Depressive, Moderate, with psychotic symptoms

- All diagnostic requirements for a Moderate Depressive Episode (see page __) are currently met.
- There are delusions or hallucinations during the current Depressive Episode.

6A60.6 Bipolar Type I Disorder, Current Episode Depressive, Severe, without psychotic symptoms

- All diagnostic requirements for a Severe Depressive Episode (see page __) are currently met.
- There are no delusions or hallucinations during the current Depressive Episode.

6A60.7 Bipolar Type I Disorder, Current Episode Depressive, Severe, with psychotic symptoms

- All diagnostic requirements for a Severe Depressive Episode (see page __) are currently met.
- There are delusions or hallucinations during the current Depressive Episode.

6A60.8 Bipolar Type I Disorder, Current Episode Depressive, Unspecified Severity

- All diagnostic requirements for a Depressive Episode (see page __) are currently met.
- There is insufficient information to determine the severity of the current Depressive Episode.

6A60.9 Bipolar Type I Disorder, Current Episode Mixed, without psychotic symptoms

- All diagnostic requirements for a Mixed Episode (see page __) are currently met.
- There are no delusions or hallucinations during the current Mixed Episode.

Note: If the individual has experienced Manic or Mixed Episodes in the past, a duration of 2 weeks is not required in order to diagnose a current episode if all other diagnostic requirements are met.

6A60.A Bipolar Type I Disorder, Current Episode Mixed, with psychotic symptoms

- All diagnostic requirements for a Mixed Episode (see page __) are currently met.
- There are delusions or hallucinations during the current Mixed Episode.

Note: If the individual has experienced Manic or Mixed Episodes in the past, a duration of 2 weeks is not required in order to diagnose a current episode if all other diagnostic requirements are met.

6A60.B Bipolar Type I Disorder, currently in partial remission, most recent episode Manic or Hypomanic

- The most recent Mood Episode was a Manic or Hypomanic Episode (see page __).
- The full diagnostic requirements for a Manic or Hypomanic Episode are no longer met, but some significant manic or hypomanic symptoms remain. (Note that in some cases, residual mood symptoms may be of opposite polarity to the symptoms of the most recent episode.)

6A60.C Bipolar Type I Disorder, currently in partial remission, most recent episode Depressive

- The most recent Mood Episode was a Depressive Episode (see page __).
- The full diagnostic requirements for a Depressive Episode are no longer met, but some significant depressive symptoms remain. (Note that in some cases, residual mood symptoms may be of opposite polarity to the symptoms of the most recent episode.)

6A60.D Bipolar Type I Disorder, currently in partial remission, most recent episode Mixed

- The most recent Mood Episode was a Mixed Episode (see page __).
- The full diagnostic requirements for a Mixed Episode are no longer met, but some significant mood symptoms remain.

6A60.E Bipolar Type I Disorder, currently in partial remission, most recent episode unspecified

- The full diagnostic requirements for a Mood Episode are no longer met, but some significant mood symptoms remain.
- There is insufficient information to determine the nature of the most recent mood episode.

6A60.F Bipolar Type I Disorder, currently in full remission

- There are currently no longer any significant mood symptoms.

Course Features:

- Although the onset of a first Manic, Hypomanic, or Depressive Episode most often occurs during the late teen years, onset of Bipolar Type I Disorder can occur at any time through the life cycle, including in older adulthood. Late-onset mood symptoms may be

more likely to be caused by the effects of medications or substances or other medical conditions.
- The majority of individuals who experience a single Manic Episode will go on to develop recurrent Mood Episodes. More than half of Manic Episodes will be immediately followed by a Depressive Episode.
- The risk of recurrence of Mood Episodes in Bipolar Type I Disorder increases with the number of prior Mood Episodes.
- Individuals with Bipolar Type I Disorder are at increased lifetime risk of suicidality.

Gender-Related Features:

- Prevalence rates for Bipolar Type I Disorder are similar between men and women with a tendency for men to exhibit earlier onset of symptoms.
- Manic Episodes occur more commonly in men and are typically more severe and impairing. In contrast, women are more likely to experience Depressive Episodes, Mixed Episodes, and rapid cycling.
- Disorders Due to Substance Use often co-occur with Bipolar Type I Disorder among men, whereas women are more likely to experience comorbid medical conditions including migraines, obesity, and thyroid disease as well as co-occurring mental disorders including Anxiety or Fear-Related Disorders and Eating Disorders.

6A61 Bipolar Type II Disorder

Essential Features:

- A history of at least one Hypomanic Episode *and* at least one Depressive Episode (see above Essential Features for Mood Episodes). The typical course of the disorder is characterized by recurrent Depressive and Hypomanic Episodes.
- There is no history of Manic or Mixed Episodes.

Type of current Mood Episode, severity and psychotic symptoms in current Depressive Episodes, and remission qualifiers:

The type of current Mood Episode, the severity and presence or absence of psychotic symptoms in current Depressive Episodes, and the degree of remission should be described in Bipolar Type II Disorder. (See descriptions of psychotic symptoms and Depressive Episode Severity in Mood Episode descriptions above.) Available categories are as follows:

6A61.0	Bipolar Type II Disorder, Current Episode Hypomanic
6A61.1	Bipolar Type II Disorder, Current Depressive Episode, Mild
6A61.2	Bipolar Type II Disorder, Current Depressive Episode, Moderate, without psychotic symptoms
6A61.3	Bipolar Type II Disorder, Current Depressive Episode, Moderate, with psychotic symptoms
6A61.4	Bipolar Type II Disorder, Current Depressive Episode, Severe, without psychotic symptoms

6A61.5	Bipolar Type II Disorder, Current Depressive Episode, Severe, with psychotic symptoms
6A61.6	Bipolar Type II Disorder, Current Depressive Episode, Unspecified Severity
6A61.7	Bipolar Type II Disorder, currently in partial remission, most recent episode Hypomanic
6A61.8	Bipolar Type II Disorder, currently in partial remission, most recent episode Depressive
6A61.9	Bipolar Type II Disorder, currently in partial remission, most recent episode unspecified
6A61.A	Bipolar Type II Disorder, currently in full remission

6A61.0 Bipolar Type II Disorder, Current Episode Hypomanic

- All diagnostic requirements for a Hypomanic Episode (see page __) are currently met.

6A61.1 Bipolar Type II Disorder, Current Episode Depressive, Mild

- All diagnostic requirements for a Mild Depressive Episode (see page __) are currently met.

6A61.2 Bipolar Type II Disorder, Current Episode Depressive, Moderate, without psychotic symptoms

- All diagnostic requirements for a Moderate Depressive Episode (see page __) are currently met.
- There are no delusions or hallucinations during the current Depressive Episode.

6A61.3 Bipolar Type II Disorder, Current Episode Depressive, Moderate, with psychotic symptoms

- All diagnostic requirements for a Moderate Depressive Episode (see page __) are currently met.
- There are delusions or hallucinations during the current Depressive Episode.

6A61.4 Bipolar Type II Disorder, Current Episode Depressive, Severe, without psychotic symptoms

- All diagnostic requirements for a Severe Depressive Episode (see page __) are currently met.
- There are no delusions or hallucinations during the current Depressive Episode.

6A61.5 Bipolar Type II Disorder, Current Episode Depressive, Severe, with psychotic symptoms

- All diagnostic requirements for a Severe Depressive Episode (see page __) are currently met.
- There are delusions or hallucinations during the current Depressive Episode.

6A61.6 Bipolar Type II Disorder, Current Depressive Episode, Unspecified Severity

- All diagnostic requirements for a Depressive Episode (see page __) are currently met.
- There is insufficient information to determine the severity of the current Depressive Episode.

6A61.7 Bipolar Type II Disorder, currently in partial remission, most recent episode Hypomanic

- The most recent Mood Episode was a Hypomanic Episode (see page __).
- The full diagnostic requirements for a Hypomanic Episode are no longer met, but some significant hypomanic symptoms remain. (Note that in some cases, residual mood symptoms may be of opposite polarity to the symptoms of the most recent episode.)

6A61.8 Bipolar Type II Disorder, currently in partial remission, most recent episode Depressive

- The most recent Mood Episode was a Depressive Episode (see page __).
- The full diagnostic requirements for a Depressive Episode are no longer met, but some significant depressive symptoms remain. (Note that in some cases, residual mood symptoms may be of opposite polarity to the symptoms of the most recent episode.)

6A61.9 Bipolar Type II Disorder, currently in partial remission, most recent episode unspecified

- The full diagnostic requirements for a Mood Episode are no longer met, but some significant mood symptoms remain.
- There is insufficient information to determine the nature of the most recent mood episode.

7A61.A Bipolar Type II Disorder, currently in full remission

- There are currently no longer any significant mood symptoms.

Course Features:

- Bipolar Type II Disorder has its onset most often during the mid-twenties; however, onset during late adolescence and throughout early and mid-adulthood may also occur. Initial onset of Bipolar Type II Disorder in older adults is rare.

- While onset typically begins following a single Depressive Episode, some individuals experience several Depressive Episodes before occurrence of a Hypomanic Episode.
- The presence of chronic and gradually worsening experiences of affective lability or mood swings, particularly during adolescence and early adulthood, has been associated with an increased risk of developing Bipolar Type II Disorder.
- Up to 15% of individuals with Bipolar Type II Disorder will subsequently develop a Manic Episode resulting in a change of diagnosis to Bipolar Type I Disorder.
- Spontaneous intra-episode shifts from a Depressive Episode to Hypomanic Episode are not uncommon.
- Risk of recurrence increases with each subsequent Mood Episode.

Gender-Related Features:

- Women are more likely to experience Hypomanic Episodes, Mixed Episodes, and rapid cycling. The time of greatest risk for a Hypomanic Episode is during the early postpartum period following childbirth. A qualifier of 'Current Episode Perinatal' should be assigned under these circumstances. Approximately half of those who experience postpartum hypomanic symptoms will later develop a Depressive Disorder. Differentiating between normal experiences of mood and sleep disturbances typically associated with caring for a newborn and symptoms of Bipolar Type II disorder is challenging.

Symptomatic and Course Presentation Qualifiers for Mood Episodes in Bipolar Type I and Bipolar Type II Disorders:

Additional qualifiers may be applied to describe a current mood episode in the context of Bipolar Type I Disorder (Depressive, Manic, Mixed or Hypomanic Episodes) and Bipolar Type II Disorder (Depressive or Hypomanic Episodes). These qualifiers indicate other important features of the clinical presentation or of the course, onset, and pattern of Mood Episodes. These qualifiers are not mutually exclusive, and as many may be added as apply. (Note that these same qualifiers, with the exception of Rapid Cycling, may also be applied to current Depressive Episodes in the context of Depressive Disorders. The qualifier Rapid Cycling is specific to Bipolar Type I and Bipolar Type II Disorders.)

Available qualifiers are as follows:

with prominent anxiety symptoms (6A80.0)

- This qualifier can be applied if, in the context of a current Depressive, Manic, Mixed, or Hypomanic Episode, prominent and clinically significant anxiety symptoms (e.g., feeling nervous, anxious or on edge, not being able to control worrying thoughts, fear that something awful will happen, having trouble relaxing, muscle tension, autonomic symptoms) have been present for most of the time during the episode. If there have been panic attacks during the current Depressive or Mixed Episode, these should be recorded separately (see 'with panic attacks' qualifier). This qualifier may be used whether or not the diagnostic requirements for an Anxiety or Fear-Related Disorder are also met, in which case the Anxiety or Fear-Related Disorder should also be diagnosed.

with panic attacks (6A80.1)

- This qualifier can be applied if, in the context of a current Episode, there have been panic attacks during the past month that occur specifically in response to depressive ruminations or other anxiety-provoking cognitions. If panic attacks occur exclusively in response to such thoughts, the 'with panic attacks' qualifier should be used rather than an additional co-occurring diagnosis of Panic Disorder. If some panic attacks over the course of the Depressive or Mixed Episode have been unexpected and not exclusively in response to depressive or anxiety-provoking thoughts and the full diagnostic requirements for Panic Disorder are met, a separate diagnosis of Panic Disorder should be assigned.

current Depressive Episode persistent (6A80.2)

- This qualifier can be applied if the diagnostic requirements for Depressive Episode are currently met and have been met continuously for at least the past 2 years.

current Depressive Episode with melancholia (6A80.3)

- This qualifier can be applied if, in the context of a current Depressive Episode, several of the following symptoms have been present during the worst period of the current episode:
    - Loss of interest or pleasure in most activities that are normally enjoyable to the individual (i.e., pervasive anhedonia).
    - Lack of emotional reactivity to normally pleasurable stimuli or circumstances (i.e., mood does not lift even transiently with exposure).
    - Terminal insomnia (i.e., waking in the morning 2 hours or more before the usual time).
    - Depressive symptoms are worse in the morning.
    - Marked psychomotor retardation or agitation.
    - Marked loss of appetite or loss of weight.

with seasonal pattern (6A80.4)

- This qualifier can be applied to Bipolar Type I or Bipolar Type II Disorder if there has been a regular seasonal pattern of onset and remission of at least one type of episode (i.e., Depressive, Manic, Mixed, or Hypomanic Episodes). The other types of Mood Episodes may not follow this pattern.
- A substantial majority of the relevant Mood Episodes should correspond with the seasonal pattern.
- A seasonal pattern should be differentiated from an episode that is coincidental with a particular season but predominantly related to a psychological stressor that regularly occurs at that time of the year (e.g., seasonal unemployment).

with rapid cycling (6A80.5)

- This qualifier can be applied if the Bipolar Type I or Bipolar Type II Disorder is characterized by a high frequency of Mood Episodes (at least four) over the past 12 months. There may be a switch from one polarity of mood to the other, or the Mood Episodes may be demarcated by a period of remission.
- In individuals with a high frequency of Mood Episodes, some may have a shorter duration than those usually observed in Bipolar Type I or Bipolar Type II Disorder. In particular, depressive periods may only last several days. However, if depressive and manic symptoms alternate very rapidly (i.e., from day to day or within the same day), a Mixed Episode should be diagnosed rather than rapid cycling.

In the context of Bipolar Type I or Bipolar Type II Disorder, Mood Episodes that occur during pregnancy or commencing within about 6 weeks after delivery (referred to as the puerperium) can be identified using one of the following two additional diagnostic codes, depending on whether delusions, hallucinations, or other psychotic symptoms are present. These diagnoses should be assigned in addition to the relevant Bipolar Disorder diagnosis.

Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms (6E20)

- This additional diagnostic code should be used for Mood Episodes that arise during pregnancy or commencing within about 6 weeks after delivery that do not include delusions, hallucinations, or other psychotic symptoms. This designation should not be used to describe mild and transient depressive symptoms that do not meet the diagnostic requirements for a depressive episode, which may occur soon after delivery (so-called postpartum blues).

Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms (6E21)

- This additional diagnostic code should be used for Mood Episodes that arise during pregnancy or commencing within about 6 weeks after delivery that include delusions, hallucinations, or other psychotic symptoms. This designation should not be used to describe mild and transient depressive symptoms that do not meet the diagnostic requirements for a depressive episode, which may occur soon after delivery (so-called postpartum blues).

Note: For the following sections, see also material under Depressive Episode (p. _), Manic Episode (p. _), Mixed Episode (p. _) and Hypomanic Episode (p. _). Material on Additional Clinical Features, Boundary with Normality (Threshold), Developmental Presentations, and Boundary with Other Disorders and Conditions (Differential Diagnosis) that relates specifically to the Mood Episodes is contained in these sections, whereas material focusing on Bipolar Type I Disorder and Bipolar Type II Disorder overall appears below.

Additional Clinical Features for Bipolar Type I Disorder and Bipolar Type II Disorder:

- In combination with a history of one or more Depressive Episodes, a Mixed, Manic or Hypomanic Episode arising during antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy, transcranial magnetic stimulation) is grounds for a diagnosis of Bipolar Type I or Bipolar Type II Disorder if the syndrome persists after the treatment is discontinued and the full diagnostic requirements of the Mood Episode are met after the direct physiological effects of the treatment are likely to have receded.
- Inter-episode periods may be characterized by complete remission of symptoms or by the presence of residual hypomanic, manic, mixed, or depressive symptoms, in which case the 'partial remission' qualifier should be applied.
- Suicide risk is significantly higher among individuals diagnosed with Bipolar Type I and Bipolar Type II Disorder than among the general population, particularly during Depressive or Mixed Episodes and among individuals with rapid cycling.
- Recurrent panic attacks in Bipolar Type I Disorder and Bipolar Type II Disorder may be indicative of greater severity, poorer response to treatment, and greater risk for suicide.
- Family history is an important factor to consider because heritability of Bipolar Disorders is the highest of all mental disorders.
- When individuals with Bipolar Type II Disorder seek clinical services, they almost invariably do so during Depressive Episodes. Given that individuals experiencing a Hypomanic Episode often have a subjective experience of improved functioning (e.g., greater productivity and creativity at work), they rarely seek clinical care during such episodes. Thus, Hypomanic Episodes usually must be assessed retrospectively in individuals presenting with depressive symptoms.
- Individuals initially diagnosed with Bipolar Type II Disorder are at high risk of experiencing a Manic or Mixed Episode during their lifetime. If this occurs, the diagnosis should be changed to Bipolar Type I Disorder.
- Patients diagnosed with Bipolar Type I Disorder and Bipolar Type II Disorder are at elevated risk for developing a variety of medical conditions affecting the cardiovascular system (e.g., hypertension) and metabolism (e.g., hyperglycemia), some of which may be due to the effects of the chronic use of medications used to treat Bipolar Disorders.
- Individuals with Bipolar Type I or Bipolar Type II Disorder exhibit high rates of co-occurring Mental, Behavioural or Neurodevelopmental Disorders, most commonly Anxiety or Fear-Related Disorders and Disorders Due to Substance Use.

Boundary with Normality (Threshold) for Bipolar Type I Disorder and Bipolar Type II Disorder:

- The presence or history of Hypomanic Episodes in the absence of a history of at least one Depressive Episode is not a sufficient basis for a presumptive diagnosis of Bipolar Type II Disorder.

Culture-Related Features for Bipolar Type I Disorder and Bipolar Type II Disorder:

- Studies indicate that the prevalence of Bipolar or Related Disorders varies across cultural, ethnic, and migrant groups, partly as a function of social stress. Symptom

expression may also vary and be shaped by common cultural idioms, cultural histories or personal histories that are prominent in identity formation and expressed as grandiose ideas or beliefs. For example, grandiosity may be expressed in culturally specific ways such that a Muslim individual experiencing a Manic Episode may believe he is Muhammad, whereas a Christian individual may believe he is Jesus. Individuals from the person's cultural group may be helpful in distinguishing normative expressions of belief or ritual from manic or psychotic experiences and behaviours.

- In some cultural contexts, mood changes are more readily expressed in the form of bodily symptoms (e.g., pain, fatigue, weakness) rather than directly reported as psychological symptoms.
- Some types of symptoms may be considered more shameful or severe according to cultural norms, leading to reporting biases. For example, some cultures may emphasize shame more than guilt, whereas in others suicidal behaviour and thinking may be prohibited. In some cultural groups, features such as sadness and lack of productivity may be perceived as signs of personal weakness and therefore under-reported.
- The cultural salience of depressive symptoms may vary across social groups as a result of varying cultural 'scripts' for the disorder which make specific types of symptoms more prominent, for example: psychological (e.g., sadness, emotional numbness, rumination), moral (e.g., guilt, worthlessness), social/interpersonal (e.g., lack of productivity, conflictive relationships), hedonic (e.g., decreased pleasure), spiritual (e.g., dreams of dead relatives), or somatic symptoms (e.g., insomnia, pain, fatigue, dizziness).

Boundaries with Other Disorders and Conditions (Differential Diagnosis) for Bipolar Type I Disorder and Bipolar Type II Disorder:

- ***Boundary with Cyclothymic Disorder:*** In Cyclothymic Disorder, the number, severity and/or duration of depressive symptoms have never met the threshold required for a Depressive Episode and there is no evidence of a history of Mixed or Manic Episodes.
- ***Boundary with Attention Deficit Hyperactivity Disorder:*** Although a Manic, Hypomanic, or Mixed Episode may include symptoms characteristic of Attention Deficit Hyperactivity Disorder such as distractibility, hyperactivity, and impulsivity, Bipolar Type I and Bipolar Type II Disorder are differentiated from Attention Deficit Hyperactivity Disorder by their episodic nature and the accompanying elevated, euphoric or irritable mood. However, Attention Deficit Hyperactivity Disorder and Bipolar Type I and Bipolar Type II Disorder can co-occur. When they do, Attention Deficit Hyperactivity Disorder symptoms tend to worsen during Hypomanic, Manic, or Mixed Episodes.
- ***Boundary with Schizophrenia and Other Primary Psychotic Disorders:*** The presentation is not better accounted for by a diagnosis of Schizophrenia or another Primary Psychotic Disorder. Individuals with both Bipolar Type I Disorder and Bipolar Type II Disorder can exhibit psychotic symptoms during Depressive Episodes, and individuals with Bipolar Type I Disorder can exhibit psychotic symptoms during Manic or Mixed Episodes, but these symptoms occur only during Mood Episodes. Conversely, individuals with a diagnosis of Schizophrenia or other Primary Psychotic Disorder may experience significant depressive or manic symptoms during psychotic episodes. In such cases, if the symptoms do not meet the diagnostic requirements for a Depressive, Manic, or Mixed Episode, their presence and severity in the context of a psychotic disorder diagnosis can be denoted by applying qualifier scales from 'Symptomatic Manifestations

of Primary Psychotic Disorders', i.e., 'with depressive symptoms in primary psychotic disorders (See page __)' or 'with manic symptoms in primary psychotic disorders (See page __).',If all diagnostic requirements for both a Depressive, Manic, or Mixed Episode and Schizophrenia are met concurrently or within a few days of each other and other diagnostic requirements are met, the diagnosis of Schizoaffective Disorder should be assigned rather than Bipolar Type I or Bipolar Type II Disorder. A Hypomanic Episode superimposed on Schizophrenia does not qualify for a diagnosis of Schizoaffective Disorder. However, a diagnosis of Bipolar Type I or Bipolar Type II Disorder can co-occur with a diagnosis of Schizophrenia or other Primary Psychotic Disorder, and both diagnoses may be assigned if the full diagnostic requirements for both disorders are met and psychotic symptoms are present outside of Mood Episodes.

- ***Boundary with Anxiety or Fear-Related Disorders:*** Symptoms of anxiety, including panic attacks, are common in Bipolar Type I and Bipolar Type II Disorder, and in some individuals may be a prominent aspect of the clinical presentation. In such cases, the qualifier 'with prominent anxiety symptoms' should be applied to the diagnosis for non-panic anxiety symptoms. If the anxiety symptoms meet the diagnostic requirements for an Anxiety or Fear-Related Disorder, the appropriate diagnosis from the Anxiety or Fear-Related Disorders grouping should also be assigned. For panic attacks, if these occur entirely in the context of anxiety associated with Depressive, Hypomanic, Manic, or Mixed Episodes in Bipolar Type I and Bipolar Type II Disorder, they are appropriately designated using the 'with panic attacks' qualifier. However, if panic attacks also occur outside of symptomatic Mood Episodes and other diagnostic requirements are met, a separate diagnosis of Panic Disorder should be considered. Both qualifiers may be assigned if warranted.
- ***Boundary with Personality Disorder:*** Individuals with a Personality Disorder may exhibit impulsivity or mood instability, but Personality Disorder does not include Depressive, Hypomanic, Manic, or Mixed Episodes. However, co-occurrence of Personality Disorder and Bipolar Type I and Bipolar Type II Disorder is relatively common. Symptoms of Personality Disorder should be assessed outside the context of a Mood Episode to avoid conflating symptoms of a Mood Episode with personality traits, but both diagnoses may be assigned if the diagnostic requirements for both diagnoses are fulfilled.
- ***Boundary with Oppositional Defiant Disorder:*** It is common, particularly among children and adolescents, for patterns of noncompliance and symptoms of irritability/anger to arise as part of a Mood Disorder. For example, noncompliance may be a result of depressive symptoms (e.g., diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). During Hypomanic or Manic episodes, individuals are less likely to follow rules and comply with directions. Oppositional Defiant Disorder often co-occurs with Mood Disorders, and irritability/anger can be a common symptom across these disorders. When the behaviour problems occur primarily in the context of Hypomanic, Manic, Depressive, or Mixed Episodes, a separate diagnosis of Oppositional Defiant Disorder should not be assigned. However, both diagnoses may be given if the full diagnostic requirements for both disorders are met and the behaviour problems associated with Oppositional Defiant Disorder are observed outside the occurrence of a Mood Episode. The Oppositional Defiant Disorder qualifier 'with chronic irritability-anger' may be used if appropriate.
- ***Boundary with Substance-induced Mood Disorder:*** A Depressive, Hypomanic, Manic, or Mixed syndrome due to the effect of a substance or medication other than

antidepressant medication on the central nervous system (e.g., cocaine, amphetamines), including withdrawal effects, should be diagnosed as Substance-Induced Mood Disorder rather than Bipolar Type I or Bipolar Type II Disorder. The presence of continuing mood disturbance should be assessed once the physiological effects of the relevant substance subside.

- ***Boundary with other Mental Disorders:*** Irritability is a symptom that is also observed in other disorders (e.g., Depressive Disorders, Generalized Anxiety Disorder). In order to attribute this symptom to a Manic, Hypomanic, or Mixed Episode, the clinician should establish the episodicity of the symptom and its co-occurrence with other symptoms consistent with a Manic, Hypomanic, or Mixed Episode.
- ***Boundary with Secondary Mood Syndrome:*** A Depressive, Hypomanic, Manic, or Mixed syndrome that is a manifestation of another medical condition should be diagnosed as Secondary Mood Syndrome rather than Bipolar Type I or Bipolar Type II Disorder.

6A62 Cyclothymic Disorder

Essential Features:

- Mood instability over an extended period of time (i.e., 2 years or more) characterized by numerous hypomanic and depressive periods. (In children and adolescents depressed mood can manifest as pervasive irritability.) Hypomanic periods may or may not have been sufficiently severe or prolonged to meet the diagnostic requirements for a Hypomanic Episode.
- Mood symptoms are present for more days than not. While brief symptom-free intervals are consistent with the diagnosis, there have never been any prolonged symptom-free periods (e.g., lasting 2 months or more) since the onset of the disorder.
- There is no history of Manic or Mixed Episodes.
- During the first 2 years of the disorder, there has never been a 2-week period during which the number and duration of symptoms were sufficient to meet the diagnostic requirements for a Depressive Episode.
- The symptoms are not a manifestation of another medical condition (e.g., hyperthyroidism) and are not due to the effect of a substance or medication on the central nervous system (e.g., stimulants), including withdrawal effects.
- The symptoms result in significant distress about experiencing persistent mood instability or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features:

- In children, it may be appropriate to assign the diagnosis of Cyclothymic Disorder after a somewhat briefer period of initial symptoms (e.g., 1 year).
- Individuals initially diagnosed with Cyclothymic Disorder are at high risk for developing Bipolar Type I or Bipolar Type II Disorder during their lifetime.
- Individuals with Cyclothymic Disorder do not typically exhibit psychotic symptoms.

Boundary with Normality (Threshold):

- Cyclothymic Disorder is distinguished from normal variations in mood by a history of distress or difficulty functioning due to repeated occurrences of mood disturbance.

Course Features

- The course of Cyclothymic Disorder is often gradual and persistent. Onset of Cyclothymic Disorder commonly occurs during adolescence or early adulthood and may be difficult to differentiate from normal mood instability associated with hormonal changes that accompany puberty.

Developmental Presentations:

- Onset of Cyclothymic Disorder in children typically occurs before the age of 10. Symptoms of irritability (particularly during periods of low mood) and sleep disturbance are often the prominent clinical features and reasons for consultation.
- Cyclothymic Disorder is underdiagnosed in children and adolescents despite evidence for greater prevalence of this disorder in this age group as compared to Bipolar Type I and Type II Disorders. However, the most common trajectory in children and adolescents is symptom remission; only a minority will maintain the diagnosis into adulthood or be at high risk for developing Bipolar Type I or Bipolar Type II Disorder.
- Co-occurrence with other Mental, Behavioural or Neurodevelopmental Disorders is common in children and adolescents with Cyclothymic Disorder, particularly with Attention Deficit Hyperactivity Disorder.

Culture-Related Features:

- There is little information available about cultural influences on Cyclothymic Disorder. The information on Culture-Related Features for Bipolar Type I Disorder and Bipolar Type II Disorder (p. _) may be relevant.

Gender-Related Features:

- There are no known differences in prevalence rates between genders for Cyclothymic Disorder.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Single Episode Depressive Disorder and Recurrent Depressive Disorder:*** During the first 2 years of the disorder, depressive periods in Cyclothymic Disorder should not be sufficient to meet the diagnostic requirements for a Depressive Episode. Outside of this 2-year period, there may be instances in which the symptoms are severe enough to constitute a Depressive Episode. In such cases, if there is no history of Hypomanic Episodes, Single Episode Depressive Disorder or Recurrent Depressive Disorder may be diagnosed along with Cyclothymic Disorder.
- ***Boundary with Bipolar Type I Disorder:*** If the number and severity of symptoms reaches the diagnostic threshold for a Manic Episode or a Mixed Episode in the context

of an ongoing Cyclothymic Disorder, the diagnosis should be changed to Bipolar Type I Disorder.

- ***Boundary with Bipolar Type II Disorder:*** If the number and severity of symptoms reaches the diagnostic threshold for Single Episode Depressive Disorder or Recurrent Depressive Disorder in the context of an ongoing Cyclothymic Disorder and the individual has a history of Hypomanic Episodes but no history of Manic or Mixed Episodes, the diagnosis should be changed to Bipolar Type II disorder.
- ***Boundary with Attention Deficit Hyperactivity Disorder:*** Although hypomanic symptoms overlap with symptoms of Attention Deficit Hyperactivity Disorder such as distractibility, hyperactivity, and impulsivity, Hypomanic Episodes are differentiated from Attention Deficit Hyperactivity Disorder by their episodic nature and the accompanying elevated, euphoric or irritable mood. Attention Deficit Hyperactivity Disorder and Cyclothymic Disorder can co-occur and, when this occurs, Attention Deficit Hyperactivity Disorder symptoms tend to worsen during Hypomanic Episodes.
- ***Boundary with Oppositional Defiant Disorder:*** It is common, particularly among children and adolescents, for patterns of noncompliance and symptoms of irritability/anger to arise as part of a Mood Disorder. For example, noncompliance may be a result of depressive symptoms (e.g., diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). Individuals may be less likely to follow rules and comply with directions when experiencing hypomanic symptoms. In contrast, individuals with Oppositional Defiant Disorder do not exhibit the episodicity characteristic of Cyclothymic Disorder. However, Oppositional Defiant Disorder often co-occurs with Mood Disorders, and irritability/anger can be a common symptom across these disorders. When the behaviour problems occur primarily in the context of mood disturbance, a separate diagnosis of Oppositional Defiant Disorder should not be assigned. However, both diagnoses may be given if the full diagnostic requirements for both disorders are met and the behaviour problems associated with Oppositional Defiant Disorder are observed outside of periods of mood disturbance. The Oppositional Defiant Disorder qualifier 'with chronic irritability-anger' may be used if appropriate.
- ***Boundary with Personality Disorder:*** Individuals with Personality Disorder may exhibit impulsivity or mood instability, but Cyclothymic Disorder does not include persistent problems in self-functioning and interpersonal dysfunction that characterize Personality Disorder. Personality Disorder should be assessed outside the context of a Mood Episode to avoid conflating symptoms of a Mood Episode with personality traits, but both diagnoses may be assigned if the diagnostic requirements for both diagnoses are fulfilled.
- ***Boundary with Secondary Mood Syndrome:*** Chronic mood instability that is a manifestation of another medical condition should be diagnosed as Secondary Mood Syndrome rather than Cyclothymic Disorder.
- ***Boundary with Substance-induced Mood Disorder:*** Chronic mood instability due to the effects of a substance or medication on the central nervous system (e.g., benzodiazepines), including withdrawal effects (e.g., from stimulants), should be diagnosed as Substance-Induced Mood Disorder rather than Cyclothymic Disorder.

6A6Y Other Specified Bipolar or Related Disorders

Essential (Required) Features:

- The presentation is characterized by manic or hypomanic symptoms (with or without depressive symptoms) that share primary clinical features with other Bipolar and Related Disorders (e.g., persistent elevation of mood).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the Bipolar or Related Disorders grouping.
- The symptoms are not better accounted for by another Mental, Behavioural or Neurodevelopmental Disorder (e.g., Schizoaffective Disorder; a Disorder Due to Addictive Behaviours; a Personality Disorder).
- The symptoms and behaviours are not a manifestation of another medical condition and are not due to the effects of a substance or medication (e.g., alcohol, cocaine) on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

DEPRESSIVE DISORDERS:

Depressive Disorders are characterized by depressive mood (e.g., sad, irritable, empty) or loss of pleasure accompanied by other cognitive, behavioural, or neurovegetative symptoms that significantly affect the individual's ability to function. A Depressive Disorder should not be diagnosed in individuals who have ever experienced a Manic, Mixed or Hypomanic Episode, which would indicate the presence of a Bipolar Disorder.

Because the presentation of Single Episode Depressive Disorder is the same as that of Recurrent Depressive Disorder apart from a history of prior Depressive Episodes, following a separate listing of the *Essential Features* for each of these disorders, the other guideline sections (e.g., *Additional Clinical Features, Boundaries with Other Disorders and Conditions*) are provided for both disorders together.

6A70 Single Episode Depressive Disorder

Essential (Required) Features:

- Presence or history of a single Depressive Episode (see above Essential Features).
- There is no history of Manic, Mixed, or Hypomanic Episodes, which would indicate the presence of a Bipolar Disorder.

Severity, Psychotic Symptoms, and Remission Qualifiers

The Depressive Episode in Single Episode Depressive Disorder should be classified according to the severity of the episode or the degree of remission. Moderate and Severe episodes should also be classified according to the presence or absence of psychotic symptoms. (See descriptions of episode severity and psychotic symptoms in Depressive Episodes above.) Available categories are as follows:

6A70.0	Single Episode Depressive Disorder, Mild
6A70.1	Single Episode Depressive Disorder, Moderate, without psychotic symptoms
6A70.2	Single Episode Depressive Disorder, Moderate, with psychotic symptoms
6A70.3	Single Episode Depressive Disorder, Severe, without psychotic symptoms
6A70.4	Single Episode Depressive Disorder, Severe, with psychotic symptoms
6A70.5	Single Episode Depressive Disorder, Unspecified Severity
6A70.6	Single Episode Depressive Disorder, currently in partial remission
6A70.7	Single Episode Depressive Disorder, currently in full remission

6A70.0 Single Episode Depressive Disorder, Mild

- All diagnostic requirements for a Mild Depressive Episode (see page __) are currently met.
- There are no delusions or hallucinations during the Depressive Episode.

6A70.1 Single Episode Depressive Disorder, Moderate, without psychotic symptoms

- All diagnostic requirements for a Moderate Depressive Episode (see page __) are currently met.
- There are no delusions or hallucinations during the Depressive Episode.

6A70.2 Single Episode Depressive Disorder, Moderate, with psychotic symptoms

- All diagnostic requirements for a Moderate Depressive Episode (see page __) are currently met.
- There are delusions or hallucinations during the Depressive Episode.

6A70.3 Single Episode Depressive Disorder, Severe, without psychotic symptoms

- All diagnostic requirements for a Severe Depressive Episode (see page __) are currently met.
- There are no delusions or hallucinations during the Depressive Episode.

6A70.4 Single Episode Depressive Disorder, Severe, with psychotic symptoms

- All diagnostic requirements for a Severe Depressive Episode (see page __) are currently met.
- There are delusions or hallucinations during the Depressive Episode.

6A70.5 Single Episode Depressive Disorder, Unspecified Severity

- All diagnostic requirements for a Depressive Episode (see page __) are currently met.
- There is insufficient information to determine the severity of the Depressive Episode.

6A70.6 Single Episode Depressive Disorder, currently in partial remission

- The full diagnostic requirements for a Depressive Episode (see page __) are no longer met, but some significant depressive symptoms remain.

6A70.7 Single Episode Depressive Disorder, currently in full remission

- There are currently no longer any significant depressive symptoms.

6A71 Recurrent Depressive Disorder

Essential (Required) Features:

- A history of at least two Depressive Episodes (see above Essential Features), which may include a current episode, separated by several months without significant mood disturbance.
- There is no history of Manic, Mixed, or Hypomanic Episodes, which would indicate the presence of a Bipolar Disorder.

Severity, Psychotic Symptoms, and Remission Qualifiers

The current Depressive Episode in the context of Recurrent Depressive Disorder should be classified according to the severity of the current episode or the degree of remission. Moderate and Severe current episodes should also be classified according to the presence or absence of psychotic symptoms. (See descriptions of episode severity and psychotic symptoms in Depressive Episodes above.) Available categories are as follows:

6A71.0	Recurrent Depressive Disorder, Current Episode Mild
6A71.1	Recurrent Depressive Disorder, Current Episode Moderate, without psychotic symptoms
6A71.2	Recurrent Depressive Disorder, Current Episode Moderate, with psychotic symptoms
6A71.3	Recurrent Depressive Disorder, Current Episode Severe, without psychotic symptoms
6A71.4	Recurrent Depressive Disorder, Current Episode Severe, with psychotic symptoms
6A71.5	Recurrent Depressive Disorder, Current Episode, Unspecified Severity
6A71.6	Recurrent Depressive Disorder, currently in partial remission
6A71.7	Recurrent Depressive Disorder, currently in full remission

6A71.0 Recurrent Depressive Disorder, Current Episode Mild

- All diagnostic requirements for a Mild Depressive Episode (see page __) are currently met.
- There are no delusions or hallucinations during the current Depressive Episode.

6A71.1 Recurrent Depressive Disorder, Current Episode Moderate, without psychotic symptoms

- All diagnostic requirements for a Moderate Depressive Episode (see page __) are currently met.
- There are no delusions or hallucinations during the current Depressive Episode.

6A71.2 Recurrent Depressive Disorder, Current Episode Moderate, with psychotic symptoms

- All diagnostic requirements for a Moderate Depressive Episode (see page __) are currently met.
- There are delusions or hallucinations during the current Depressive Episode.

6A71.3 Recurrent Depressive Disorder, Current Episode Severe, without psychotic symptoms

- All diagnostic requirements for a Severe Depressive Episode (see page __) are currently met.
- There are no delusions or hallucinations during the current Depressive Episode.

6A71.4 Recurrent Depressive Disorder, Current Episode Severe, with psychotic symptoms

- All diagnostic requirements for a Severe Depressive Episode (see page __) are currently met.
- There are delusions or hallucinations during the current Depressive Episode.

6A71.5 Recurrent Depressive Disorder, Current Episode, Unspecified Severity

- All diagnostic requirements for a Depressive Episode (see page __) are currently met.
- There is insufficient information to determine the severity of the current Depressive Episode.

6A71.6 Recurrent Depressive Disorder, currently in partial remission

- The full diagnostic requirements for a Depressive Episode (see page __) are no longer met, but some significant depressive symptoms remain.

6A71.7 Recurrent Depressive Disorder, currently in full remission

- There are currently no longer any significant depressive symptoms.

Symptomatic and Course Presentations for Mood Episodes in Single Episode and Recurrent Depressive Disorders

Additional qualifiers may be applied to describe the presentation and characteristics of a current Depressive Episode in the context of Single Episode Depressive Disorder or Recurrent Depressive Disorder. These qualifiers indicate other important features of the clinical presentation or of the course, onset, and pattern of Depressive Episodes. These qualifiers are not mutually exclusive, and as many may be added as apply. (Note that

these same qualifiers may also be applied to current Depressive Episodes in the context of Bipolar Type I Disorder or Bipolar Type II Disorder.)

Available qualifiers are as follows:

with prominent anxiety symptoms (6A80.0)

- This qualifier can be applied if, in the context of a current Depressive Episode, prominent and clinically significant anxiety symptoms (e.g., feeling nervous, anxious or on edge, not being able to control worrying thoughts, fear that something awful will happen, having trouble relaxing, muscle tension, autonomic symptoms) have been present for most of the time during the episode. If there have been panic attacks during the current Depressive Episode, these should be recorded separately (see below). When the diagnostic requirements for both a Depressive Episode and an Anxiety or Fear-Related Disorder are met, the Anxiety or Fear-Related Disorder should also be diagnosed.

with panic attacks (6A80.1)

- This qualifier can be applied if, in the context of a current Depressive Episode, there have been panic attacks during the past month that occur specifically in response to depressive ruminations or other anxiety-provoking cognitions. If panic attacks occur exclusively in response to such thoughts, the 'with panic attacks' qualifier should be used rather than an additional co-occurring diagnosis of Panic Disorder. If some panic attacks over the course of the Depressive Episode have been unexpected and not exclusively in response to depressive thoughts, a separate diagnosis of Panic Disorder should be assigned.

current Depressive Episode persistent (6A80.2)

- This qualifier can be applied if the diagnostic requirements for Depressive Episode are currently met and have been met continuously for at least the past 2 years.

current Depressive Episode with melancholia (6A80.3)

- This qualifier can be applied if, in the context of a current Depressive Episode, several of the following symptoms have been present during the worst period of the current episode:

    - Loss of interest or pleasure in most activities that are normally enjoyable to the individual (i.e., pervasive anhedonia).
    - Lack of emotional reactivity to normally pleasurable stimuli or circumstances (i.e., mood does not lift even transiently with exposure).
    - Terminal insomnia, i.e., waking in the morning 2 hours or more before the usual time.

- Depressive symptoms are worse in the morning.
- Marked psychomotor retardation or agitation.
- Marked loss of appetite or loss of weight.

with seasonal pattern (6A80.4)

- This qualifier can be applied to Recurrent Depressive Disorder if there has been a regular seasonal pattern of onset and remission of Depressive Episodes.
- A substantial majority of Depressive Episodes should correspond with the seasonal pattern.
- A seasonal pattern should be differentiated from an episode that is coincidental with a particular season but predominantly related to a psychological stressor that regularly occurs at that time of the year (e.g., seasonal unemployment).

In the context of Single Episode Depressive Disorder or Recurrent Depressive Disorder, Depressive Episodes that occur during pregnancy or commencing within about 6 weeks after delivery (referred to as the puerperium) can be identified using one of the following two additional diagnostic codes, depending on whether delusions, hallucinations, or other psychotic symptoms are present. These diagnoses should be assigned in addition to the relevant Depressive Disorder diagnosis.

6E20 Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms (6E20)

- This additional diagnostic code should be used for Mood Episodes that arise during pregnancy or commencing within about 6 weeks after delivery that do not include delusions, hallucinations, or other psychotic symptoms. This designation should not be used to describe mild and transient depressive symptoms that do not meet the diagnostic requirements for a depressive episode, which may occur soon after delivery (so-called postpartum blues).

6E21 Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms

- This additional diagnostic code should be used for Mood Episodes that arise during pregnancy or commencing within about 6 weeks after delivery that include delusions, hallucinations, or other psychotic symptoms. This designation should not be used to describe mild and transient depressive symptoms that do not meet the diagnostic requirements for a depressive episode, which may occur soon after delivery (so-called postpartum blues).

Note: For the following sections, see also material under Depressive Episode (p. _), Manic Episode (p. _), Mixed Episode (p. _) and Hypomanic Episode (p. _). Material on Additional Clinical Features, Boundary with Normality (Threshold), Developmental Presentations, and Boundary with Other Disorders and Conditions (Differential Diagnosis) that relates specifically to the Mood Episodes is contained in these sections, whereas material focusing

on Single Episode Depressive Disorder and Recurrent Depressive Disorder overall appears below.

Additional Clinical Features for Single Episode Depressive Disorder and Recurrent Depressive Disorder:

- Suicide risk is significantly higher among individuals diagnosed with Single Episode Depressive Disorder or Recurrent Depressive Disorder than among the general population.
- Recurrent panic attacks in Single Episode Depressive Disorder or Recurrent Depressive Disorder may be indicative of greater severity, poorer response to treatment, and greater risk for suicide.
- The presence of Dementia or Disorder of Intellectual Development does not rule out the diagnosis of Single Episode Depressive Disorder or Recurrent Depressive Disorder, but communication difficulties may make it necessary to rely more than usual on observations made by clinicians or knowledgeable collateral informants for making the diagnosis. Observable symptoms include psychomotor retardation, loss of appetite and weight, and sleep disturbance.
- There is a greater risk of Single Episode Depressive Disorder or Recurrent Depressive Disorder among individuals with a family history of Single Episode Depressive Disorder or Recurrent Depressive Disorder.
- Co-occurrence with other Mental, Behavioural or Neurodevelopmental Disorders is common, including Anxiety or Fear-Related Disorders, Bodily Distress Disorder, Obsessive-Compulsive or Related Disorders, Oppositional Defiant Disorder, Disorders Due to Substance Use, Eating Disorders, and Personality Disorder.

Course Features for Single Episode Depressive Disorder and Recurrent Depressive Disorder:

- The prevalence of Depressive Disorders significantly increases at puberty with the average age of onset occurring during the mid-20s.
- In the absence of intervention, Depressive Episodes typically last 3 to 4 months with nearly half of affected individuals experiencing symptom reduction within 3 months and the majority experiencing remission within 1 year. Remission and recurrence rates vary widely with most individuals experiencing an average of four Depressive Episodes over their lifetime, and approximately half experiencing a recurrence within the first 5 years. The risk of relapse increases with each subsequent Depressive episode.
- It is common for depressive symptoms to persist between discrete episodes (i.e., partial remission), with some individuals never experiencing a complete remission of symptoms. This presentation warrants closer attention, because symptom persistence has been associated with shorter time to relapse as well as co-occurrence of other Mental, Behavioural or Neurodevelopmental Disorders including Personality Disorder, Anxiety or Fear-Related Disorders, and Disorders Due to Substance Use.
- Lower rates of recovery are associated with longer duration and severity of symptoms and the presence of psychotic features.
- Individuals with Bipolar Disorders often present initially with a Depressive Episode. Vulnerability factors associated with transition from a Depressive Disorder to a Bipolar

disorder include earlier age at onset, a family history of Bipolar Disorders, and the presence of psychotic symptoms.

Culture-Related Features for Single Episode Depressive Disorder and Recurrent Depressive Disorder:

- The cultural salience of depressive symptoms may vary across social groups as a result of varying cultural 'scripts' for the disorder. For example, psychological (e.g., sadness, emotional numbness, rumination), moral (e.g., guilt, worthlessness), social/interpersonal (e.g., lack of productivity, conflictive relationships), hedonic (e.g., decreased pleasure), spiritual (e.g., dreams of dead relatives), or somatic symptoms (e.g., insomnia, pain, fatigue, dizziness) may systematically predominate.
- In some cultural contexts, mood changes are more readily expressed in the form of bodily symptoms (e.g., pain, fatigue, weakness) rather than directly reported as psychological symptoms.
- Some types of symptoms may be considered more shameful or severe according to cultural norms, leading to reporting biases. For example, some cultural groups may emphasize shame more than guilt, whereas in others suicidal behaviour and thinking may be prohibited or highly stigmatized, leading to reporting biases. Also, in some cultural groups, features such as sadness and lack of productivity may be perceived as signs of personal weakness and be under-reported.
- The perceived abnormality or acceptability of depressive symptoms may vary across cultures, affecting symptom detection and treatment acceptability. For example, some social groups or age cohorts may consider depressive symptoms to be normal reactions to adversity, depending on their tolerance of negative emotions or social withdrawal.
- Symptoms attributed to cultural concepts of distress may be evoked when querying about depressive symptomatology. Among Chinese, for example, symptoms of *shenjing shuairuo*, or weakness of the nervous system (e.g., weakness, headache, bodily aches, fatigue, feeling vexed, loss of face) may be commonly reported. Culturally related symptoms and idioms of distress may complicate detection of Depressive Disorders and assessment of severity, including whether psychotic symptoms are present. Examples include pain in heart, soul loss, aching heart, complaints related to "nerves", and heat inside the body. In some other cultures, a focus on a particular observable behaviour (e.g. "thinking too much") may be what is reported.

Gender-Related Features for Single Episode Depressive Disorder and Recurrent Depressive Disorder:

- Lifetime prevalence of Depressive Disorders is approximately twice as high for women. Gender differences in prevalence coincide with onset of puberty.
- Although women are more likely to attempt suicide, men are more likely to die by suicide by virtue of using more lethal methods.
- Women with a diagnosis of a Depressive Disorder are more likely to experience co-occurring Anxiety or Fear-Related Disorders, disturbances in appetite, and weight gain whereas it is more common for men to experience co-occurring alcohol and other Disorders Due to Substance Use, poor impulse control, and increased risk-taking behaviour.

Boundaries with Other Disorders and Conditions for Single Episode Depressive Disorder and Recurrent Depressive Disorder:

- ***Boundary with Dysthymic Disorder:*** Single Episode Depressive Disorder and Recurrent Depressive Disorder are differentiated from Dysthymic Disorder by the number of symptoms and the course of the disorder. Dysthymic Disorder is a chronic and persistent condition, and during the initial period of 2 years necessary to establish the diagnosis, the number and duration of symptoms are not sufficient to meet the diagnostic requirements for a Depressive Episode as required for a diagnosis of Single Episode Depressive Disorder or Recurrent Depressive Disorder. After this initial period, if the number and severity of symptoms reaches the diagnostic threshold for a Depressive Episode in the context of an ongoing Dysthymic Disorder, both Dysthymic Disorder and either Single Episode Depressive Disorder or Recurrent Depressive Disorder may be diagnosed. Unlike Dysthymic Disorder, Recurrent Depressive Disorder is episodic in nature. However, long periods of subthreshold depressive symptoms that occur following Depressive Episodes when there has not been an initial 2-year period of subthreshold symptoms are better diagnosed as Single Episode Depressive Disorder in partial remission or Recurrent Depressive Disorder in partial remission.
- ***Boundary with Mixed Depressive and Anxiety Disorder:*** Individuals who present with both depressive and anxiety symptoms more days than not for a period of 2 weeks or more, with neither set of symptoms, considered separately, being sufficiently severe, numerous, or lasting to justify a diagnosis of Single Episode Depressive Disorder or Recurrent Depressive Disorder or an Anxiety or Fear-Related Disorder may be diagnosed with Mixed Depressive and Anxiety Disorder.
- ***Boundary with Cyclothymic Disorder:*** Although in general, depressive periods in Cyclothymic Disorder are not sufficient to meet the diagnostic requirements for a Depressive Episode. There may be instances in which the symptoms are severe enough to constitute a Depressive Episode. In such cases, if there is no history of Hypomanic Episodes, Single Episode Depressive Disorder or Recurrent Depressive Disorder may be diagnosed, as appropriate, along with Cyclothymic Disorder.
- ***Boundary with Schizophrenia and Other Primary Psychotic Disorders:*** The presentation is not better accounted for by a diagnosis of Schizophrenia or another Primary Psychotic Disorder. Individuals with Single Episode Depressive Disorder or Recurrent Depressive Disorder can exhibit psychotic symptoms, but these occur only during Depressive Episodes. Conversely, individuals with a diagnosis of Schizophrenia or other Primary Psychotic Disorder may experience significant depressive symptoms during psychotic episodes. In such cases, if the depressive symptoms do not meet the diagnostic requirements for a Depressive Episode, the qualifier ‘with prominent depressive symptoms’ may be applied to the psychotic disorder diagnosis. If all diagnostic requirements for both a Depressive Episode and Schizophrenia are met concurrently or within a few days of each other, the diagnosis of Schizoaffective Disorder should be assigned rather than Single Episode Depressive Disorder or Recurrent Depressive Disorder. However, a diagnosis of Single Episode Depressive Disorder or Recurrent Depressive Disorder can co-occur with a diagnosis of Schizophrenia or other Primary Psychotic Disorder, and both diagnoses may be assigned if the full diagnostic requirements for both disorders are met and psychotic symptoms are present outside of Depressive Episodes.

- ***Boundary with Anxiety or Fear-Related Disorders:*** Symptoms of anxiety, including panic attacks, are common in Single Episode Depressive Disorder and Recurrent Depressive Disorder, and in some individuals may be a prominent aspect of the clinical presentation. In such cases, the qualifier 'with prominent anxiety symptoms' should be applied to the diagnosis for non-panic anxiety systems. If the anxiety symptoms meet the diagnostic requirements for an Anxiety or Fear-Related Disorder, the appropriate diagnosis from the Anxiety or Fear-Related Disorders grouping should also be assigned. For panic attacks, if these occur entirely in the context of anxiety associated with Depressive Episodes in Single Episode Depressive Disorder or Recurrent Depressive Disorder, they are appropriately designated using the 'with panic attacks' qualifier. However, if panic attacks also occur outside of symptomatic Mood Episodes and other diagnostic requirements are met, a separate diagnosis of Panic Disorder should be considered. Both qualifiers may be assigned if warranted.
- ***Boundary with Generalized Anxiety Disorder:*** Generalized Anxiety Disorder and Depressive Episodes in Single Episode Depressive Disorder or Recurrent Depressive Disorder can share several features such as somatic symptoms of anxiety, difficulty with concentration, sleep disruption, and feelings of dread associated with pessimistic thoughts. Single Episode Depressive Disorder or Recurrent Depressive Disorder are differentiated by the presence of low mood or loss of pleasure in previously enjoyable activities and other characteristic symptoms of a Depressive Episode (e.g., appetite changes, feelings of worthlessness, recurrent thoughts of death). In Generalized Anxiety Disorder, individuals are focused on potential negative outcomes that might occur in a variety of everyday aspects of life (e.g., family, finances, work) rather than thoughts of worthlessness or hopelessness. Rumination often occurs in the context of Single Episode Depressive Disorder or Recurrent Depressive Disorder but, unlike in Generalized Anxiety Disorder, is not usually accompanied by persistent worry and apprehension about various everyday aspects of life. Generalized Anxiety Disorder may co-occur with Single Episode Depressive Disorder or Recurrent Depressive Disorder, but should only be diagnosed if the diagnostic requirements for Generalized Anxiety Disorder were met prior to the onset of or following complete remission of a Depressive Episode.
- ***Boundary with Adjustment Disorder:*** Adjustment Disorder is characterized by a maladaptive reaction to identifiable psychosocial stressors, and can include depressive symptoms (e.g., rumination) but does not include a sufficient number and severity of symptoms to meet the requirements for a Depressive Episode. If the adjustment reaction meets the diagnostic requirements for Single Episode Depressive Disorder or Recurrent Depressive Disorder, even in the presence of identifiable psychosocial stressors, Single Episode Depressive Disorder or Recurrent Depressive Disorder should be diagnosed rather than Adjustment Disorder.
- ***Boundary with Oppositional Defiant Disorder:*** It is common, particularly in children and adolescents, for patterns of noncompliance and symptoms of irritability/anger to arise as part of a Mood Disorder. Specifically, noncompliance may result from a number of depressive symptoms (e.g., diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). Oppositional Defiant Disorder often co-occurs with Mood Disorders, and irritability/anger can be a common symptom across these disorders. When the behaviour problems occur primarily in the context of a Depressive Episode, a separate diagnosis of Oppositional Defiant Disorder should not be assigned. However, both diagnoses may be given if the full diagnostic requirements for both disorders are met and the behaviour problems

associated with Oppositional Defiant Disorder are observed outside the occurrence of Depressive Episodes.

- ***Boundary with Insomnia:*** Individuals experiencing Insomnia may also report depressed mood and may develop other depressive symptoms. However, the breadth and severity of symptoms are generally not sufficient to meet the diagnostic requirements for Single Episode Depressive Disorder or Recurrent Depressive Disorder.
- ***Boundary with Secondary Mood Syndrome:*** A depressive syndrome that is a manifestation of another medical condition (e.g., hypothyroidism) should be diagnosed as Secondary Mood Syndrome rather than Single Episode Depressive Disorder or Recurrent Depressive Disorder.
- ***Boundary with Substance-induced Mood Disorder:*** A depressive syndrome due to the effects of a substance or medication on the central nervous system (e.g., benzodiazepines), including withdrawal effects (e.g., from stimulants) should be diagnosed as Substance-Induced Mood Disorder rather than Single Episode Depressive Disorder or Recurrent Depressive Disorder. The presence of continuing mood disturbance should be assessed once the physiological effects of the relevant substance subside.

6A72 Dysthymic Disorder

Essential (Required) Features:

- Persistent depressed mood (i.e., lasting 2 years or more), for most of the day, for more days than not, as reported by the individual (e.g., feeling down, sad) or as observed (e.g., tearful, defeated appearance). In children and adolescents depressed mood can manifest as pervasive irritability.
- The depressed mood is accompanied by additional symptoms typically seen in a Depressive Episode, though these may be milder in form. Examples include:
    - Markedly diminished interest or pleasure in activities
    - Reduced concentration and attention or indecisiveness
    - Low self-worth or excessive or inappropriate guilt
    - Hopelessness about the future
    - Disturbed sleep or increased sleep
    - Diminished or increased appetite
    - Low energy or fatigue
- During the first 2 years of the disorder, there has never been a 2-week period during which the number and duration of symptoms were sufficient to meet the diagnostic requirements for a Depressive Episode.
- While brief symptom-free intervals during the period of persistent depressed mood are consistent with the diagnosis, there have never been any prolonged symptom-free periods (e.g., lasting 2 months or more) since the onset of the disorder.
- There is no history of Manic, Mixed, or Hypomanic Episodes, which would indicate the presence of a Bipolar or Related Disorder.
- The symptoms are not a manifestation of another medical condition (e.g., hypothyroidism) and are not due to the effect of a substance or medication on the central nervous system (e.g., benzodiazepines), including withdrawal effects (e.g., from stimulants).

- The symptoms result in significant distress about experiencing persistent depressive symptoms or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features:

- In children, it may be appropriate to assign the diagnosis of Dysthymic Disorder after a briefer period of initial symptoms (e.g., 1 year).
- Suicide risk is significantly higher among individuals diagnosed with Dysthymic Disorder than among the general population.
- There is a greater risk of Dysthymic Disorder among individuals with a family history of Mood Disorders.
- Co-occurrence with other mental disorders is common, including Anxiety or Fear-Related Disorders, Bodily Distress Disorder, Obsessive-Compulsive or Related Disorders, Oppositional Defiant Disorder, Disorders Due to Substance Use, Feeding or Eating Disorders, and Personality Disorder.

Boundary with Normality (Threshold):

- Some depressed mood is a normal reaction to severe adverse life events and problems, and is common in the community. Dysthymic Disorder is differentiated from this common experience by the severity, range, and duration of symptoms. Assessment of the presence or absence of signs or symptoms should be made relative to typical functioning of the individual.

Course Features:

- Dysthymic Disorder typically has a gradual onset beginning in childhood, adolescence, or early adulthood.
- The course of Dysthymic Disorder may fluctuate between dysthymia and symptoms of Single Episode Depressive Disorder or Recurrent Depressive Disorder.
- Early onset of Dysthymic Disorder is associated with increased likelihood of co-occurring Anxiety or Fear-Related Disorders, Personality Disorders, and Substance Use Disorders.
- In contrast to high rates of co-occurring Mental, Behavioural or Neurodevelopmental Disorders in young adults, Dysthymic Disorder in older adults typically occurs without co-occurrence.
- Greater symptom severity, higher levels of negative affectivity, poorer global functioning, and the presence of Anxiety or Fear-Related Disorders or Conduct-Dissocial Disorder have been associated with poorer long-term outcomes.

Developmental Presentations:

- In young children, Dysthymic Disorder may present as somatic complaints (e.g., headaches, stomachaches), whining, increased anxiety or fearfulness, or excessive crying.

- Adolescents with Dysthymic Disorder may demonstrate low self-esteem, and may be more reactive to negative (or perceived negative) feedback from others.
- Children and adolescents may present with pervasive irritability rather than depressed mood. However, the presence of irritability is not in and of itself indicative of Dysthymic Disorder and may indicate the presence of another Mental, Behavioural or Neurodevelopmental Disorder or be a normal reaction to frustration.
- In children and adolescents, reduced ability to concentrate or sustain attention may manifest as a decline in academic performance, increased time needed to complete school assignments, or an inability to complete assignments.

Culture-Related Features:

- There is little information available about cultural influences on Dysthymic Disorder. The information on Culture-Related Features for Single Episode Depressive Disorder and Recurrent Depressive Disorder (p. _) may be relevant.

Gender-Related Features:

- Although Dysthymic Disorder is more common among women in early life, there are no notable gender differences among older adults with late-onset Dysthymic Disorder.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Single Episode Depressive Disorder and Recurrent Depressive Disorder:*** Dysthymic Disorder is differentiated from Single Episode Depressive Disorder and Recurrent Depressive Disorder by the number of symptoms and the course of the disorder. Dysthymic Disorder is a chronic and persistent condition, and during the initial period of 2 years necessary to establish the diagnosis, the number and duration of symptoms are not sufficient to meet the diagnostic requirements for a Depressive Episode as required for a diagnosis of Single Episode Depressive Disorder or Recurrent Depressive Disorder. After this initial period, if the number and severity of symptoms reaches the diagnostic threshold for a Depressive Episode in the context of an ongoing Dysthymic Disorder, both Dysthymic Disorder and either Single Episode Depressive Disorder or Recurrent Depressive Disorder may be diagnosed. Unlike Dysthymic Disorder, Recurrent Depressive Disorder is episodic in nature. However, long periods of subthreshold depressive symptoms that occur following Depressive Episodes when there has not been an initial 2-year period of subthreshold symptoms are better diagnosed as Single Episode Depressive Disorder in partial remission or Recurrent Depressive Disorder in partial remission.
- ***Boundary with Bipolar and Related Disorders:*** Individuals with a pattern of depressive symptoms that resembles Dysthymic Disorder who have a history of Manic or Mixed Episodes should be diagnosed as Bipolar Type I Disorder. A pattern of chronic mood instability that is characterized by periods of both depressive symptomatology that is not sufficiently severe or prolonged to meet the diagnostic requirements for a Depressive Episode and periods of hypomanic symptomatology should be diagnosed as Cyclothymic Disorder.
- ***Boundary with Schizophrenia and Other Primary Psychotic Disorders:*** The symptoms are not better accounted for by Schizophrenia, Schizoaffective Disorder, or another

Primary Psychotic Disorder. Depressive symptoms are common in Psychotic Disorders, and these should only be diagnosed as Dysthymic Disorder if they persist for several years after the full remission of psychotic symptoms.

- ***Boundary with Generalized Anxiety Disorder:*** Generalized Anxiety Disorder and Dysthymic Disorder can share several features such as somatic symptoms of anxiety, difficulty with concentration, sleep disruption, and feelings of dread associated with pessimistic thoughts. Dysthymic Disorder is differentiated by the presence of low mood or loss of pleasure in previously enjoyable activities and other characteristic symptoms of Dysthymic Disorder (e.g., appetite changes, feelings of worthlessness, recurrent thoughts of death). In Generalized Anxiety Disorder, individuals are focused on potential negative outcomes that might occur in a variety of everyday aspects of life (e.g., family, finances, work) rather than thoughts of worthlessness or hopelessness. Rumination often occurs in the context of Dysthymic Disorder but, unlike in Generalized Anxiety Disorder, is not usually accompanied by persistent worry and apprehension about various everyday aspects of life. Generalized Anxiety Disorder may co-occur with Dysthymic Disorder, but should only be diagnosed if the diagnostic requirements for Generalized Anxiety Disorder were met prior to the onset of Dysthymic Disorder.
- ***Boundary with Oppositional Defiant Disorder:*** It is common, particularly in children and adolescents, for patterns of noncompliance and symptoms of irritability/anger to arise as part of mood disturbance. Specifically, noncompliance may result from a number of depressive symptoms (e.g., diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). When the behaviour problems occur primarily in the context of mood disturbance, a separate diagnosis of Oppositional Defiant Disorder should not be assigned.
- ***Boundary with Secondary Mood Syndrome:*** A chronic depressive syndrome that is a manifestation of another medical condition (e.g., hypothyroidism) should be diagnosed as Secondary Mood Syndrome rather than Dysthymic Disorder.
- ***Boundary with Substance-induced Mood Disorder:*** A chronic depressive syndrome due to the effect of a substance or medication on the central nervous system (e.g., benzodiazepines), including withdrawal effects (e.g., from stimulants), should be diagnosed as Substance-Induced Mood Disorder rather than Dysthymic Disorder.

6A73 Mixed Depressive and Anxiety Disorder

Essential (Required) Features:

- The presence of both depressive and anxiety symptoms for most of the time during a period of 2 weeks or more.
    - Depressive symptoms include depressed mood or markedly diminished interest or pleasure in activities.
    - There are multiple anxiety symptoms, which may include feeling nervous, anxious, or on edge, not being able to control worrying thoughts, fear that something awful will happen, having trouble relaxing, muscle tension, or sympathetic autonomic symptoms.
- Neither the depressive nor the anxiety symptoms, considered separately, are sufficiently severe, numerous, or lasting to meet the diagnostic requirements of another Depressive

Disorder or an Anxiety or Fear-Related Disorder. There is no history of Manic or Mixed Episodes, which would indicate the presence of a Bipolar Disorder.
- The symptoms are not a manifestation of another medical condition (e.g., hypothyroidism, hyperthyroidism) and are not due to the effect of a substance or medication on the central nervous system, including withdrawal effects (e.g., from alcohol, benzodiazepines).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features:

- Individuals with this mixture of comparatively mild symptoms of depression and anxiety are frequently seen in primary care, but many more cases exist among the population at large, which never come to clinical attention.

Boundary with Normality (Threshold):

- If worry is the only anxiety symptom (i.e., no sympathetic autonomic or other anxiety symptoms are present), a diagnosis of Mixed Depressive and Anxiety Disorder diagnosis is not appropriate.

Course Features:

- Epidemiological studies have yielded varying results regarding the course and onset of Mixed Depressive and Anxiety Disorder.
- While there is some evidence to suggest that approximately half of individuals with Mixed Depressive and Anxiety Disorder will experience remission of symptoms within 1 year of onset, those who do not remit are at increased risk of developing a Mental, Behavioural, Neurodevelopmental Disorder that meets full diagnostic requirements, typically for a Depressive Disorder or an Anxiety or Fear-Related Disorder.

Culture-Related Features:

- There is little information available about cultural influences on Mixed Depressive and Anxiety Disorder. The information on Culture-Related Features for Single Episode Depressive Disorder and Recurrent Depressive Disorder (p. _) and for Generalized Anxiety Disorder (p. _) may be relevant.

Gender-Related Features:

- It is unknown whether there are gender differences in prevalence rates of Mixed Depressive and Anxiety Disorder.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with other Depressive Disorders and Anxiety or Fear-Related Disorders:*** If the depressive symptoms or anxiety symptoms meet the diagnostic requirements for a

Depressive Episode or an Anxiety or Fear-Related Disorder, then the Depressive or Anxiety or Fear-Related Disorder should be diagnosed rather than Mixed Depressive and Anxiety Disorder. If appropriate, the 'with prominent anxiety symptoms' qualifier may be applied to Single Episode Depressive Disorder or Recurrent Depressive Disorder diagnoses.

- ***Boundary with Bipolar and Related Disorders:*** Mixed Depressive and Anxiety Disorder should not be diagnosed if there is a history of Manic or Mixed Episodes, which would indicate the presence of a Bipolar Disorder.
- ***Boundary with Adjustment Disorder:*** If the onset of the symptoms occurs in close association with significant life changes or stressful life events, a diagnosis of Adjustment Disorder is generally more appropriate than Mixed Depressive and Anxiety Disorder.

GA34.41 Premenstrual Dysphoric Disorder

Essential (Required) Features:

- During a majority of menstrual cycles within the past year, a pattern of mood, somatic, or cognitive symptoms is present that begins several days before the onset of menses, starts to improve within a few days after the onset of menses, and then becomes minimal or absent within approximately 1 week following the onset of menses. The temporal relationship of the symptoms and luteal and menstrual phases of the cycle should ideally be confirmed by a prospective symptom diary over at least two symptomatic menstrual cycles.
- The symptoms include:
    - At least one affective symptom such as mood lability, irritability, depressed mood, or anxiety, and
    - Additional somatic or cognitive symptom(s) such as lethargy, joint pain, overeating, hypersomnia, breast tenderness, swelling of extremities, concentration difficulties, or forgetfulness.
- The symptoms are not better accounted for by another mental disorder (e.g., a Mood Disorder, an Anxiety or Fear-Related Disorder).
- The symptoms are not a manifestation of another medical condition (e.g., endometriosis, polycystic ovary disease, adrenal system disorders and hyperprolactinemia) and are not due to the effect of a substance or medication on the central nervous system (e.g., hormone treatment, alcohol), including withdrawal effects (e.g., from stimulants).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Boundary with Normality (Threshold):

- Mild mood changes (e.g., increased emotional lability, irritability, subjective tension) that occur during late luteal or menstrual phase of the cycle for many women should not be labelled as Premenstrual Dysphoric Disorder. In contrast to Premenstrual Dysphoric Disorder, these symptoms are less intense and do not typically result in significant distress or impairment.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Premenstrual Tension Syndrome:*** Many women may experience cyclic emotional, physical, or behavioural symptoms that interfere with their lifestyles during the luteal phase of the menstrual cycle that are appropriately diagnosed and treated as Premenstrual Tension Syndrome. This is in contrast to Premenstrual Dysphoric Disorder, in which the symptoms are considerably more severe and cause significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- ***Boundary with Other Mental, Behavioural or Neurodevelopmental Disorders including Mood Disorders that are exacerbated premenstrually:*** Mood symptoms characteristic of Premenstrual Dysphoric Disorder including depressed mood, irritability, and anxiety can be present in other Mental, Behavioural or Neurodevelopmental Disorders (e.g., Depressive Disorders, Bipolar Disorders, Generalized Anxiety Disorder). Although symptoms of these disorders may be exacerbated during the late luteal and menstrual phases, Premenstrual Dysphoric Disorder is differentiated by the absence of symptoms 1 week post-menses. Because of the difficulty in accurate recall of the relationship between menstrual cycle and the course of symptoms, prospective mood ratings for two consecutive cycles should be considered.
- ***Boundary with Dysmenorrhea:*** Dysmenorrhea is characterized by cyclic pelvic pain or lower, umbilical, or suprapubic abdominal pain preceding or accompanying menstruation that interferes with daily activities. Unlike Premenstrual Dysphoric Disorder, the onset of Dysmenorrhea is coincident with the start of rather than prior to menses. Furthermore, mood symptoms are not typically associated with this condition.
- ***Boundary with the effects of hormones and their synthetic substitutes and antagonists:*** Use of hormone treatments, including for contraceptive purposes, may result in unwanted side effects that include mood, somatic, and cognitive symptoms. If symptoms do not persist after cessation of these medications beyond the period when their physiological effects should have subsided a diagnosis of Premenstrual Dysphoric Disorder should not be assigned.

6AZY Other Specified Depressive Disorders

Essential (Required) Features:

- The presentation is characterized by mood symptoms that share primary clinical features with other Depressive Disorders (e.g., depressed mood, decreased engagement in pleasurable activities, decreased energy levels, disruptions in sleep or eating).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the Depressive Disorders grouping.
- The symptoms are not better accounted for by another Mental, Behavioural or Neurodevelopmental Disorder (e.g., Schizophrenia or Other Primary Psychotic Disorder, an Anxiety or Fear-Related Disorder, a Disorder Specifically Associated with Stress).
- The symptoms and behaviours are not a manifestation of another medical condition and are not due to the effects of a substance or medication (e.g., alcohol, benzodiazepine) on the central nervous system, including withdrawal effects (e.g., from cocaine).

- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

6A8Y Other Specified Mood Disorders

Essential (Required) Features:

- The presentation is characterized by mood symptoms that cannot clearly be described as bipolar or depressive in nature (e.g., marked and persistent irritability in the absence of other clear manic or depressive symptoms).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the Mood Disorders grouping.
- The symptoms are not better accounted for by another Mental, Behavioural or Neurodevelopmental Disorder (e.g., Schizophrenia or Other Primary Psychotic Disorder, an Anxiety or Fear-Related Disorder, a Disorder Specifically Associated with Stress, Oppositional Defiant Disorder with chronic irritability-anger, Personality Disorder).
- The symptoms and behaviours are not a manifestation of another medical condition and are not due to the effects of a substance or medication (e.g., alcohol, benzodiazepine) on the central nervous system, including withdrawal effects (e.g., from cocaine).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.