symptoms of ADHD, such as rapid speech, racing thoughts, distractibility, and less need for sleep, overlap with the symptoms of hypomania. The double counting of symptoms toward both ADHD and bipolar II disorder can be avoided if the clinician clarifies whether the symptoms represent a distinct episode and if the noticeable increase over baseline required for the diagnosis of bipolar II disorder is present.

**Personality disorders.** The same convention as applies for ADHD also applies when evaluating an individual for a personality disorder such as borderline personality disorder, since mood lability and impulsivity are common in both personality disorders and bipolar II disorder. Symptoms must represent a distinct episode, and the noticeable increase over baseline required for the diagnosis of bipolar II disorder must be present. A diagnosis of a personality disorder should not be made during an untreated mood episode unless the lifetime history supports the presence of a personality disorder.

**Other bipolar disorders.** Diagnosis of bipolar II disorder should be differentiated from bipolar I disorder by carefully considering whether there have been any past episodes of mania and from other specified and unspecified bipolar and related disorders by confirming the presence of fully syndromal hypomania and depression.

**Comorbidity**

Bipolar II disorder is more often than not associated with one or more co-occurring mental disorders, with anxiety disorders being the most common. Approximately 60% of individuals with bipolar II disorder have three or more co-occurring mental disorders; 75% have an anxiety disorder; and 37% have a substance use disorder. Children and adolescents with bipolar II disorder have a higher rate of co-occurring anxiety disorders compared with those with bipolar I disorder, and the anxiety disorder most often predates the bipolar disorder. Anxiety and substance use disorders occur in individuals with bipolar II disorder at a higher rate than in the general population. Approximately 14% of individuals with bipolar II disorder have at least one lifetime eating disorder, with binge-eating disorder being more common than bulimia nervosa and anorexia nervosa.

These commonly co-occurring disorders do not seem to follow a course of illness that is truly independent from that of the bipolar disorder, but rather have strong associations with mood states. For example, anxiety and eating disorders tend to associate most with depressive symptoms, and substance use disorders are moderately associated with manic symptoms.

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**Cyclothymic Disorder**

**Diagnostic Criteria**

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<thead>
<tr>
<th>Diagnostic Criteria</th>
<th>301.13 (F34.0)</th>
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<tbody>
<tr>
<td><strong>A.</strong> For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.</td>
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<td><strong>B.</strong> During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.</td>
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<tr>
<td><strong>C.</strong> Criteria for a major depressive, manic, or hypomanic episode have never been met.</td>
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<tr>
<td><strong>D.</strong> The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.</td>
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<tr>
<td><strong>E.</strong> The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).</td>
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</tbody>
</table>
F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With anxious distress (see p. 149)

**Diagnostic Features**

The essential feature of cyclothymic disorder is a chronic, fluctuating mood disturbance involving numerous periods of hypomanic symptoms and periods of depressive symptoms that are distinct from each other (Criterion A). The hypomanic symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a hypomanic episode, and the depressive symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a major depressive episode. During the initial 2-year period (1 year for children or adolescents), the symptoms must be persistent (present more days than not), and any symptom-free intervals last no longer than 2 months (Criterion B). The diagnosis of cyclothymic disorder is made only if the criteria for a major depressive, manic, or hypomanic episode have never been met (Criterion C).

If an individual with cyclothymic disorder subsequently (i.e., after the initial 2 years in adults or 1 year in children or adolescents) experiences a major depressive, manic, or hypomanic episode, the diagnosis changes to major depressive disorder, bipolar I disorder, or other specified or unspecified bipolar and related disorder ( subclassified as hypomanic episode without prior major depressive episode), respectively, and the cyclothymic disorder diagnosis is dropped.

The cyclothymic disorder diagnosis is not made if the pattern of mood swings is better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders (Criterion D), in which case the mood symptoms are considered associated features of the psychotic disorder. The mood disturbance must also not be attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism) (Criterion E). Although some individuals may function particularly well during some of the periods of hypomania, over the prolonged course of the disorder, there must be clinically significant distress or impairment in social, occupational, or other important areas of functioning as a result of the mood disturbance (Criterion F). The impairment may develop as a result of prolonged periods of cyclical, often unpredictable mood changes (e.g., the individual may be regarded as temperamental, moody, unpredictable, inconsistent, or unreliable).

**Prevalence**

The lifetime prevalence of cyclothymic disorder is approximately 0.4%–1%. Prevalence in mood disorders clinics may range from 3% to 5%. In the general population, cyclothymic disorder is apparently equally common in males and females. In clinical settings, females with cyclothymic disorder may be more likely to present for treatment than males.

**Development and Course**

Cyclothymic disorder usually begins in adolescence or early adult life and is sometimes considered to reflect a temperamental predisposition to other disorders in this chapter. Cyclothymic disorder usually has an insidious onset and a persistent course. There is a 15%–50% risk that an individual with cyclothymic disorder will subsequently develop bipolar I disorder or bipolar II disorder. Onset of persistent, fluctuating hypomanic and depressive symptoms late in adult life needs to be clearly differentiated from bipolar and
related disorder due to another medical condition and depressive disorder due to another medical condition (e.g., multiple sclerosis) before the cyclothymic disorder diagnosis is assigned. Among children with cyclothymic disorder, the mean age at onset of symptoms is 6.5 years of age.

**Risk and Prognostic Factors**

**Genetic and physiological.** Major depressive disorder, bipolar I disorder, and bipolar II disorder are more common among first-degree biological relatives of individuals with cyclothymic disorder than in the general population. There may also be an increased familial risk of substance-related disorders. Cyclothymic disorder may be more common in the first-degree biological relatives of individuals with bipolar I disorder than in the general population.

**Differential Diagnosis**

**Bipolar and related disorder due to another medical condition and depressive disorder due to another medical condition.** The diagnosis of bipolar and related disorder due to another medical condition or depressive disorder due to another medical condition is made when the mood disturbance is judged to be attributable to the physiological effect of a specific, usually chronic medical condition (e.g., hyperthyroidism). This determination is based on the history, physical examination, or laboratory findings. If it is judged that the hypomanic and depressive symptoms are not the physiological consequence of the medical condition, then the primary mental disorder (i.e., cyclothymic disorder) and the medical condition are coded. For example, this would be the case if the mood symptoms are considered to be the psychological (not the physiological) consequence of having a chronic medical condition, or if there is no etiological relationship between the hypomanic and depressive symptoms and the medical condition.

**Substance/medication-induced bipolar and related disorder and substance/medication-induced depressive disorder.** Substance/medication-induced bipolar and related disorder and substance/medication-induced depressive disorder are distinguished from cyclothymic disorder by the judgment that a substance/medication (especially stimulants) is etiologically related to the mood disturbance. The frequent mood swings in these disorders that are suggestive of cyclothymic disorder usually resolve following cessation of substance/medication use.

**Bipolar I disorder, with rapid cycling, and bipolar II disorder, with rapid cycling.** Both disorders may resemble cyclothymic disorder by virtue of the frequent marked shifts in mood. By definition, in cyclothymic disorder the criteria for a major depressive, manic, or hypomanic episode has never been met, whereas the bipolar I disorder and bipolar II disorder specifier “with rapid cycling” requires that full mood episodes be present.

**Borderline personality disorder.** Borderline personality disorder is associated with marked shifts in mood that may suggest cyclothymic disorder. If the criteria are met for both disorders, both borderline personality disorder and cyclothymic disorder may be diagnosed.

**Comorbidity**

Substance-related disorders and sleep disorders (i.e., difficulties in initiating and maintaining sleep) may be present in individuals with cyclothymic disorder. Most children with cyclothymic disorder treated in outpatient psychiatric settings have comorbid mental conditions; they are more likely than other pediatric patients with mental disorders to have comorbid attention-deficit/hyperactivity disorder.