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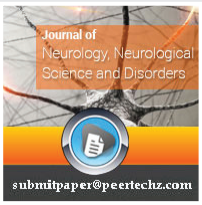

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Research Article

Development of the Clinical Interview for Bipolar Disorder (CIBD) – Rational and experts' panel evaluation

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Abstract

Bipolar Disorder (BD) is underdiagnosed, and the average time gap between the onset and diagnosis due to poor screening is 7 years. This study aims to describe the development of the semi-structured Clinical Interview for Bipolar Disorder (CIBD) for diagnosing bipolar spectrum disorders and assessing the impact of psychological interventions, using a mixed method approach of clinician and interviewee ratings, with a recovery approach.

Methods: CIBD was based on DSM-5 and developed by a multidisciplinary team. Firstly, a research review on BD assessment was conducted, and published guidelines from international BD experts were incorporated into the interview. Secondly, an expert panel formed by 9 psychiatrists, 8 psychologists, a nurse, and a neuropsychologist with expertise in BD was asked to assess it for clarity, pertinence, and completeness.

Results: CIBD structure and sections were rated with high scores (range: 0-80) regarding usefulness (78.63), clarity (74.53), and completeness (77.63). The expert panel gave suggestions to clarify, add and change some instructions in the introduction, suicide risk scale for BD, and the empowerment scale, and an index was also added to help navigate the interview.

Conclusion: CIBD is an acceptable and comprehensive tool for assessing BD and related disorders contributing to a recovery perspective and might be useful for tracing intervention improvements. Experts highlight the CIBD's unique contributions, including the suicidality scale encompassing BD-specific risk factors, BD specifiers, and the assessment of clients' empowerment. Overall, the CIBD seems to be a promising innovative instrument for diagnosing and assessing BD.

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Introduction

Bipolar Disorder (BD) causes unusual shifts in mood, energy, activity levels, and the ability to carry out daily tasks (National Institute of Mental Health, 2018). The recurrence of manic/hypomanic and depressive episodes and even the inter-episodic refractory symptoms have far-reaching consequences influencing various aspects of daily life, such as work productivity, interpersonal connections, and overall quality of life [1,2]. Considered the second leading cause of disability-adjusted life-years, BD is particularly burdensome due to its early onset and chronicity across the lifespan, displaying no marked variation by sex [3-5]. Furthermore, BD exhibits one of the most elevated suicide rates within the domain of mental disorders, surpassing even those witnessed in cases of major depression. The incidence of suicide in BD is approximately twice as high as that recorded in major depression, and the mortality rate associated with BD ranks second only to schizophrenia, as demonstrated by Monson, et al. [6]. Consequently, BD is associated with a reduced life expectancy, and the Global Burden of Disease (GBD) study from 2019, reveals that a staggering 40 million individuals struggled with bipolar disorder [7]. Additionally, insights from the World Mental Health survey indicate that the bipolar spectrum was estimated to affect 4% - 6% of the adult population [8].

Initially, BD was conceptualized as a binary concept, comprising BD type I and BD type II, until multiple authors contributed to a return to Kraepelinian theory, proposing the existence of a broader Bipolar Spectrum (BS). The BS would encompass not only the traditional manifestations of bipolar disorders but also milder variations, such as mood disorders that do not fully satisfy the current diagnostic criteria outlined in the International Classification of Diseases (ICD-11) and the revised 5th edition of the DSM (DSM-5-TR), constituting a wider group under Bipolar and Related Disorders [9]. Evidence shows that even in subsyndromal or subthreshold presentations, BD can potentially cause adverse social and functional outcomes [10]. Furthermore, it is likely that the high rates of comorbidity with alcohol abuse and substance abuse/dependence, as well as with anxiety disorders, maximize the negative consequences of BD [11-13]. Therefore, the identification of patients with BS disorders accurately and early on is extremely relevant at clinical, social, and economic levels.

Assessment challenges and recovery in bipolar disorder

BD has been historically recognized as a challenging condition to diagnose among psychiatric disorders [14]. This group of disorders is particularly difficult to identify during its initial stages, even in the prototypical cases, and especially in patients that begin with depressive episodes (pseudo-unipolar), as only 20% of patients experiencing a depressive episode receive an accurate diagnosis of BD within the first year of seeking treatment [13,14]. Consequently, BD is frequently underdiagnosed, and poor screening leads to a delay of 5-10 tears between illness onset and diagnosis [15,16]. Additionally, a substantial percentage of subthreshold BD is still frequently diagnosed as unipolar major depression [8,17,18].

Research also suggests that around 75% of individuals with BD also experience another disorder throughout their lives [13]. Differential diagnosis in BD is particularly challenging because a patient can present a variety of symptoms simultaneously, with a maniac and depressive symptoms (during a mixed episode, for example), and having a history of substance abuse, it becomes hard to disentangle what comes first and establish which is the primary and secondary condition. In this context, BD can be divided into primary and secondary types, which can have several meanings: chronological, where one precedes the other, or related to causality, where the secondary disturbance cause is associated with the primary one, for instance, if BD emerged due to another medical condition (e,g., brain injury, metabolic or endocrine disturbances).

Another diagnostic challenge arises in the presence of manic episodes with psychotic symptoms, especially if these are incongruent with mood. Their occurrence can make the differential diagnosis with other psychotic disorders more complex, namely with schizoaffective disorder, which is often unrecognized leading to BD being misdiagnosed instead in the absence of appropriate differential questioning [14,19,20]. A comprehensive plan of previous treatment, psychiatric and family history, and the symptoms' course are essential to avoid an incorrect diagnosis. Research sustains that an accurate diagnosis of BD in its early stages could help avert the long-term damaging effects of misdiagnosis [12]. Besides, research mentions there are identifiable risk factors that influence the course of bipolar disorder, some of them possibly modifiable, underlining the importance of early diagnosis and tools for a valid diagnosis [21].

Semi-structured clinical interviews are still the most reliable instruments for diagnosis and can be crucial to detect the subthreshold symptoms of the bipolar spectrum that frequently go unseen [15,22,23]. At the same time, several efforts have been made to detect BD at earlier stages, and according to a recent systematic review on this topic [24], the *Bipolar Prodrome Symptom Scale* (BPSS) is the most frequently used semi-structured interview for early BD detection.

Neto, et al. [25] mentioned that the most frequently used semi-structured interviews to diagnose BD are the Structured Clinical Interview for DSM [26] and the Composite International Diagnostic Interview (CIDI) [27]. The first is based on DSM-5 criteria, and the second also integrates the ICD-11 criteria. Both instruments define diagnoses from a perspective based strictly on the number of symptoms required for the categorical definition established in the classifications for each diagnostic category.

These instruments are used for the diagnosis of several mental disorders and their severity; however, they do not cover functionality, interference of mood episodes, or the specificities of the risk of suicide for bipolar, namely the additional risk of episodes with mixed characteristics, or the risk of mania/depressive episodes with psychotic characteristics. Furthermore, they have not incorporated the changing paradigm of treatment outcomes in mental disorders, which more and more has turned to a recovery perspective instead of

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the classic medical model where improvement was solely based on reducing symptomatology, hospitalization, and medication compliance. Recovery in mental health means having a better sense of living, even though you might have some clinical symptomatology [28]. This concept has become increasingly important, being seen as a goal of mental health care programs [29] and recovery is now seen as a personal journey of coping with mental illness, which involves a series of subjective experiences, thus being based on the persons' empowerment and perception of competence to deal with their difficulties [30]. Taking this into consideration and the significant impact that BD has on various aspects of daily life, a recovery approach is particularly relevant, and it should emphasize the importance of managing acute episodes, preventing relapses, and improving inter-episodic residual symptoms to enhance global functioning [31].

To the best of our knowledge, there is currently a lack of semi-structured interviews that include inquiries into Personal Recovery (PR), empowerment, and functionality. This significant gap in comprehensive assessment methods for the bipolar spectrum indicates the need for further research and development in this field. Chirio-Espitalier and collaborators [29], who thoroughly investigated personal recovery assessment measures in BD, stressed how underdeveloped this field is in the BS, in contrast with schizophrenia. The authors mention that only self-report measures for PR were found in their systematic review, mentioning some studies with qualitative open interviews on the topic, which cannot be reproduced for clinical purposes.

Hence, our research team had two main aims with this study, firstly to describe the development of the Clinical Interview for Bipolar Disorder (CIBD), which incorporates a recovery-based approach to bipolar-related symptoms and allows bipolar and related disorders diagnoses according to DSM-5-TR. Secondly, to submit CIBD to an expert panel to evaluate its clarity, usefulness, and validity.

Methods

This interview emerged from a broader research project that aimed to improve the assessment of people on the BS, diagnose bipolar and related disorders, and measure their improvements after undergoing a psychological intervention (ref: SFRH/BD/130116/2017). The decision to develop a new instrument emerged from the realization that even though some semi-structured clinical interviews could assess the diagnosis of the more prevalent types of BD (i.e., Type I and Type II), no single instrument could assess other less common bipolar-related disorders and specifiers.

CIBD rationale and development

We developed our interview following the steps and structure of the Clinical Interview for Psychotic Disorder [32], a comprehensive assessment tool for psychotic disorders, which has already shown good preliminary psychometric properties and high inter-rater reliability [33]. Since this interview was developed at the same research institute, it covered common concerns using a recovery approach beyond clinical symptoms (towards psychotic symptoms). Even though this interview allowed for the differential diagnosis of mood and affective disorder, its focus regarding functionality and interference of symptoms was towards psychosis, hence the need for a new instrument that could do the same for bipolar-related symptoms.

Given the challenge of distinguishing between hypomanic and manic symptoms in the assessment of Bipolar Disorder (BD), a deliberate endeavor was made to incorporate supplementary questions that aid in this differentiation while also considering the relevant psychosocial factors, such as the individual's capacity to manage symptoms and the extent to which they disrupt daily functioning, not only during mood episodes but also throughout everyday life (ensuring a way to assess personal recovery). To achieve these goals, a multidisciplinary team was assembled, comprising psychologists and psychiatrists with expertise in mood and psychotic disorders assessment and clinical intervention. The team's extensive experience developing and validating assessment tools, including diagnostic interviews for severe mental illnesses and other psychiatric populations, significantly contributed to the conceptualization of the Clinical Interview for Bipolar Disorder (CIBD).

After acknowledging there was a need for an instrument that could assess all the described dimensions of the BS and that would take into consideration the practitioners' and the client's perspective, there was a first phase where state-of-the-art was investigated and the international guidelines from the leading mental health authorities on the field of bipolar and related disorders were consulted (CANMAT[1] and ISBD[2], Yatham, et al. 2018; AREDOC[3], Parker, et al. 2020) [34,35]. Consequently, a second phase of the development of the questions to assess the diagnostic criteria, taking into consideration the DSM-5 APA's pocket guide for diagnostic exams [36], as well as suggested wordings from the AREDOC's task force and other international guidelines. As an example, for the DSM-5 criteria for manic and hypomanic episodes on DSM-5 "*inflated self-esteem or grandiosity*" the task force proposed "*grandiosity in overrating capabilities (e.g. feeling capable of achieving great things; feeling one with the world and seeing in a new light; increased creativity)*", thus, examples to capture these rephrasing to assess these criteria were added.

Given the high prevalence of suicidal behavior in people with BD, with a risk of dying by suicide 30 times higher [37] than in the general population, there was an effort to include a detailed suicide risk assessment, which considered the specificities of the risk factors associated with BD. Thus, a section to assess suicide risk was added to this interview, taking into account

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[1]CANMAT – Canadian Network for Mood and Anxiety Treatments

[2]ISBD – International Society for Bipolar Disorders

[3]AREDOC – Assessment, Revision and Evaluation of DSM and Other Operational Criteria

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specific BD risk factors such as the fact that suicidal ideation and suicide attempts in BD are significantly higher in people with predominant depressive polarity, depressive mixed episodes, and rapid cycling of mood episodes, seasonal patterns and early age of onset [38,39]. Additionally, CIBD questions about the existence of current suicidal intents, family history of suicide, as well as access to means, and previous suicidality [38], providing a proximal and distal suicidality risk score that should orient the clinicians' intervention.

In line with the diagnostic convergence of DSM 5 and ICD-11 and content-related aspects concerning the diagnosis of BD (Reed, et al. 2019), we added a table at the end of the interview with a list of the diagnoses and respective codes from ICD-11, which the interviewer should be able to use and code from the information on the interview, as long as they assess the last experienced mood episode and its severity.

The items' final version and wording of CIBD involved a discussion between the authors and a group of independent experts in BD, which were external to the research team. This collaborative effort culminated in CIBD's initial draft in September 2020. This was presented to people diagnosed with BD to comment regarding the clarity of the questions and understanding of the overall interview, and suggestions were applied when appropriate. After the improvement of CIBD and several drafts, an agreed draft version was submitted to an additional expert panel for blind evaluation to assess relevance, clarity, and pertinence and to seek further suggestions and improvements (procedure and panel description below).

Changes from CIPD to CIBD

With the authors ' permission and consent, we used a structure similar to CIPD and adapted the relevant sections (for further details, see Martins, et al. 2015 [32]). The retained elements include the interview's general structure and questions according to the order of the diagnostic criteria of DSM-5 and its semi-structured way of questioning, as well as the sections aimed at collecting the interviewee's view of their symptoms. Questions were added for the diagnosis of BS that were not in focus on CIPD (e.g., cyclothymic disorder, other specified bipolar and related disorders). The section introduction was kept mainly the same, with adjustments having been made to focus on current symptoms related to bipolar mood variation. Additions to the initial clinical data section were made to include the beginning of bipolar symptoms and questions about a family history of bipolar and mood disorders.

Regarding the time frame, CIBD also follows the same approach, allowing the interviewer to select the time frame that better suits the goal of the interview (e.g., lifetime for diagnosis; last week for monitoring change/evaluation of interventions). CIBD was also developed to support and be used throughout the therapeutic process (identifying targets for intervention, assessing change, evaluating the efficacy of interventions), assessing the client's perception of their mood and bipolar symptoms interference. At the end of each main section [e.g. major depressive episode (MDE), hypomanic episode (HE), manic episode (ME), cyclothymia], participants are also asked to evaluate from zero to five (0 = Cause no difficulties; 5 = Lots of difficulties), how their mood symptoms cause interference in the different areas of their lives (family, romantic relationship, work/school, social relationships, finances, and daily routine). After each group of mood symptoms and preserving the same recovery-based approach, patients are queried about their perceived empowerment towards mood symptoms (scale adapted from CIPD). The interviewees are asked to place themselves on a scale from 1 to 5, considering their perceived sense of empowerment towards the mood symptoms they were questioned about (Figure 1).

This scale is presented even if the person does not have any active symptomatology, changing the wording to – *how capable/hopeful would you feel towards your depressive symptoms, if they resurged now/ how do you think you would be able to cope?* The clinician is then prompted to independently evaluate the symptoms' severity and interference, using a scale from 0 (Minimal severity | No interference at all) to 5 (Maximal Severity | Major interference – see online resource 1 for the complete table).

CIBD also comprises an altered version of the CIPD's suicide risk assessment. This assessment was modified to include bipolar-specific risk factors, as recent literature suggested (e.g., mixed episodes and rapid cycling as additional risk factors, voices of command with suicide incitement; Dome, et al. 2019 [38]). Moreover, a section to assess the specifiers of bipolar and related disorders was added, which, as far as we know, was not explored by any other interviews for BD (e.g., with anxious distress; mixed features; melancholic features, etc.), allowing for a better characterization of the current/most recent episode, and of the recurrence and seasonality of symptoms. Similarly to CIPD, a final table summarises the interview's output, providing a quantitative assessment of the interference and severity of the symptoms (patient-rated and clinician-rated) and distal and proximal suicide risk score and total, as well as a total score for the empowerment scale regarding mood and bipolar symptoms.

Furthermore, a mood chart was designed and included in the interview (online resource 2) to illustrate the illness's course and assist in the diagnosis. This chart displays the pattern, sequence, and duration of mood episodes and bipolar symptoms, favoring the detection of repetitive episodes patterns, which is deemed helpful in monitoring and preventing future ones.

CIBD final structure

CIBD opens with a section of instructions for the interviewer, followed by a page to collect sociodemographic and clinical data, which is followed by an introduction to the interviewee (where the goals and process of the interview are explained). The interview consists of three consecutive modules (that should be applied through the order they appear because only if the first module does not reach a diagnosis should the interviewer continue to the next). The first module assesses the presence/absence of MDE, HE and ME and if they are in partial or complete remission. There is also a section to evaluate suicide risk after MDE. Cyclothymia disorder (CD) is assessed if none of the episodes is present, but there are interferent mood symptoms. If there is a clear diagnosis of bipolar I, II, or CD,

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Figure 1: Measuring empowerment regarding mood symptoms.

Perceived Empowerment Assessment Scale regarding affective bipolar symptoms

Instruction: Please select the option that best describes how you think you can manage and how confident you are about your symptom's improvement, selecting the number from 1 to 5 that best describes your experience, using the following scale.

1	2	3	4	5
I feel incapable/There's nothing I can do/ Without hope.				I feel definitely capable/ I have tried things/ I am certain I will improve.

Component	Guiding descriptions	DS	HS	MS	CSV	Global
Perceived ability to cope	I do not feel capable of dealing with it at all	1	1	1	1	1
	I feel I am barely capable of dealing with it	2	2	2	2	2
	I feel I am moderately capable of dealing with it	3	3	3	3	3
	I feel I am quite capable of dealing with it	4	4	4	4	4
	I feel I am definitely capable of dealing with it	5	5	5	5	5
Perceived control & Ideas to improve*	I feel that none of the aspects of these difficulties are dependent on me (there is nothing I can do. I have no ideas to improve).	1	1	1	1	1
	I feel that the aspects of these difficulties are not only dependent on me (there are few I can do. I have ideas but I do not think I could act on them).	2	2	2	2	2
	I feel that some aspects of these difficulties are dependent on me (there is something I can do. I have ideas that I intend to try in the future)	3	3	3	3	3
	I feel that some aspects of these difficulties are dependent on me (there are several things I can do. I have ideas that I intend to try soon)	4	4	4	4	4
	I am certain that some aspects of these difficulties are dependent on me (there are several things I can do. I have already acted on my ideas)	5	5	5	5	5
Hope	I do not have any hope that improvement is possible.	1	1	1	1	1
	I have little hope that improvement is possible.	2	2	2	2	2
	I have some hope that improvement is possible.	3	3	3	3	3
	I am quite hopeful that improvement is possible.	4	4	4	4	4
	I am certain that improvement is possible.	5	5	5	5	5

*The ideas to improve do not have to agree with mental health professionals' therapeutic plans (e.g., taking medication, going to appointments), these are ideas the patient considers to be useful.

DS: Depressive Symptoms; HS: Hypomanic symptoms; MS: Mania Symptoms; CSV: Cyclothymic Symptoms Variation.

the interview ends there; if it is not clear, then the questioning should proceed. The interview also investigates if the mood symptoms initiated after a medical condition or after taking/ abstaining from any substance, offering instruction to skip to module 2 when that happens, which covers BD diagnoses related to a medical condition or substance/drug-induced. Finally, there is module 3, which explores other specified and unspecified bipolar and related disorders.

After the three modules, the interviewer is provided with summary tables that can be filled in afterward, organized by diagnosis, with clear instructions to reach each possible diagnosis. Additionally, there is the empowerment scale that is presented after each mood episode (Figure 1) and a separate and optional section to assess the specifiers of the Bipolar and Related Disorders, and the aforementioned mood chart (also optional). CIBD also allows the differential diagnosis of substance-use-related disorders, given its high comorbidity (with a section to assess substance and related disorders for alcohol and stimulants, according to DSM-5-TR table of diagnoses associated with substance class; APA, 2022; p. 546 [40]).

Given the potential overlap observed with psychotic symptoms, we recognized the importance of enabling a differential diagnosis between BS and psychosis. Consequently, we have furnished an attachment based on CIPD, containing a decision tree to accomplish this task (refer to Martins et al., 2015 for further details [32]).

Finally, due to recent changes in some bipolar and related disorders, the interview was updated to include the most recent nomenclature of DSM-5-TR diagnoses and ICD-10-CM [8] and a table is provided at the end of the interview to attribute it correctly.

Diagnosis included in CIBD

The interview provides the name and code from DSM-5-

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TR, and when "xx" is reported in a code, it indicates that the ICD-10-CM code depends on the applicable subtype, specifier, or class of substance. In module one, it is possible to diagnose the following: (F.31.xx) Bipolar I Disorder; (F31.81) Bipolar II Disorder, and (F34.0) Cyclothymic Disorder. In module two, the following diagnoses are assessed: (F06.33-34) Bipolar and Related Disorder Due to Another Medical (where it is asked to include the name of the medical condition (e.g., *F06.33 bipolar disorder due to hyperthyroidism, with manic features*); F10/13-16/.14/24/94 Substance/Medication-Induced Bipolar and Related Disorder, and differential diagnosis with (F10.xx) Alcohol Use Disorder; and (F14/15.xx) Stimulant-Related Disorders. Lastly, if none of the previous diagnoses applies, module 3 assesses (F31.89) Other Specified Bipolar and Related Disorders, (F31.9) Unspecified Bipolar and Related Disorders and (F39) Unspecified Mood Disorder [added after revision of the first draft due to DSM-5-TR changes].

Expert panel evaluation

Participants: A group of 19 mental health professionals with clinical experience in BD and the application of semi-structured interviews was accepted to take part in an expert panel tasked with conducting a comprehensive critical evaluation of CIBD. Nine were psychiatrists (47.4%), eight were psychologists (42.1%), and two were other mental health professionals (a nurse and a neuropsychologist; 11.5%). The panel's mean of years of experience was 12.26 (*SD* = 8.28), varying between a minimum of 5 to a maximum of 39 years of experience, with a median of 10 years.

Procedures: This study was submitted and approved by the Faculty of Psychology and Educational Sciences Ethics Committee (Reference Number: 06/12/13/5.11). Participants gave written informed consent and data confidentiality was explained and guaranteed through anonymised submission of assessments. Moreover, clear instructions about the General Data Protection Regulation (GDPR) following the European Regulations (EU) 2016/679 of the European Parliament and Council (17.04.2016) were provided and followed.

Mental health professionals were recruited from three hospitals in the center of Portugal: Centro Hospitalar e Universitário de Coimbra (CHUC), Centro Hospitalar de Leiria (CHL), and Centro Hospitalar do Oeste (CHL) and from the associates of ADEB (Association for support of Depressive and Bipolar Patients), a non-profit social solidarity private association. In addition, it was asked that they could invite the panel to another renowned mental health professional that fit the inclusion criteria, recruiting them via email or telephone (snowball sampling), with their permission to be approached. The inclusion criteria were having more than five years of experience in mental health or research and assessment instruments and having professional expertise in psychology, psychiatry, neuropsychology, or nursing (in the mental health field). All the participants received an invitation to be part of the study via email with an integral copy of CIBD (and the attachment that is part of the interview) and a link created in the LimeSurvey platform, and an Excel spreadsheet to score the different illustrated sections of it. In this platform, the experts filled in anonymously their professional experience and were asked to update the spreadsheet sent to them (without identifiable information), with their assessments and comments about the interview.

The experts were asked to carefully analyze and evaluate the interview's structure in terms of three criteria: (a) usefulness, (b) clarity, and (c) completeness. They were also requested to evaluate the main sections' terms of three criteria: (a) relevance, (b) clarity, and (c) completeness. All questions were rated on a 5-point Likert scale from 1 (*not at all*) to 5 (*totally*). Participants were instructed to write suggestions or comments whenever they felt appropriate. For items scored 3 or below, experts were asked to correct or suggest modifications to the question/section.

Results

Quantitative data

The experts assessed the interview structure and sections with high scores (of a maximum of 80 points) regarding usefulness (78.63), clarity (74.53), and completeness (77.63), with no significant differences between mental health professionals. The results per section can be found in Table 1.

Qualitative data

The experts' panel gave suggestions to improve and make the interview clearer and easier to understand, and recommendations were grouped regarding content and structure, which can be seen in Table 2. Most experts (n = 10) mentioned the need to clarify the suicide risk scale's score and, if possible, to simplify and not have to do the score while asking. The suicide risk assessment was also mentioned as an important and necessary contribution (n = 4). This suggestion was accepted, and we moved the scoring and added information to clarify the ponderation of the scoring, and distal and proximal scoring, to the end of the interview.

The empowerment scale was also mentioned frequently as needing further clarification on its scoring, which was taken into consideration, resulting in added instructions and changing the wording of the initial instructions and how the score was registered.

There were a couple of suggestions to add questions for differential diagnosis, namely for borderline personality disorder, or additions of questions that were already included in CIBD's appendix, which were not included because we considered it was not in line (or were already covered) with the goals of the current interview (n = 4; for instance, the suggestion to assess other diagnoses and interference of alcohol abuse, or adding cannabis consumption to the interview). Some wording changes were not included because they were not supported by the DSM-5 criteria regarding alcohol and stimulant-related disorders (n = 3). The overall assessment and comments were very positive, highlighting as the most relevant contribution the bipolar-specific suicide risk scale (even though it required scoring clarification), the empowerment scale, the easy-to-use diagnostic tables, and the specifiers' assessment section.

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Table 1: Expert panel quantitative evaluation of the CIBD.

		Total sample (*N* = 19)	Psychologists (*n* = 8)	Psychiatrists (*n* = 9)	Other MH Professionals (*n* = 2)
	Highest possible score	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*
Structure and sections	80				
Usefulness		78.63 (2.09)	79.38 (0.74)	77.67 (2.69)	80.00 (0.00)
Clarity		74.53 (4.17)	73.50 (4.17)	74.78 (4.52)	77.50 (0.71)
Completeness		77.63 (1.83)	77.88 (1.73)	77.44 (2.07)	77.50 (0.71)
Major Depressive Episode	30				
Relevance		29.79 (0.63)	29.75 (0.71)	29.77 (0.67)	30.00 (0.00)
Clarity		27.63 (2.27)	26.38 (2.45)	28.33 (1.80)	29.50 (0.71)
Completeness		29.26 (1.05)	28.88 (1.13)	29.56 (1.01)	29.50 (0.71)
Hypomanic/Maniac Episode	25				
Relevance		24.89 (0.32)	24.88 (0.35)	24.89 (0.33)	25.00 (0.00)
Clarity		24.00 (1.25)	23.63 (1.51)	24.22 (1.09)	24.50 (0.71)
Completeness		24.79 (0.54)	24.75 (0.71)	24.89 (0.33)	24.50 (0.71)
Cyclothymic Disorder	5				
Relevance		5.00 (0.00)	5.00 (0.00)	5.00 (0.00)	5.00 (0.00)
Clarity		4.89 (0.32)	4.88 (0.35)	5.00 (0.00)	4.50 (0.71)
Completeness		4.83 (0.51)	4.75 (0.71)	5.00 (0.00)	4.50 (0.71)
Other Specified Bipolar and Related Disorder	20				
Relevance		20.00 (0.00)	20.00 (0.00)	20.00 (0.00)	20.00 (0.00)
Clarity		19.79 (0.54)	19.63 (0.74)	19.89 (0.33)	20.00 (0.00)
Completeness		19.79 (0.42)	19.88 (0.35)	19.67 (0.50)	20.00 (0.00)
Alcohol and Stimulant Related Disorders	35				
Relevance		35.00 (0.00)	35.00 (0.00)	35.00 (0.00)	35.00 (0.00)
Clarity		34.53 (0.84)	34.38 (1.06)	34.56 (0.73)	35.00 (0.00)
Completeness		34.74 (0.73)	34.50 (1.07)	34.89 (0.33)	35.00 (0.00)

Note. *M*: Mean; *SD*: Standard Deviation; *MH:* Mental Health

Table 2: Qualitative analysis summary of CIBD interview by the experts' panel.

	Accepted Suggestions			
Sections	*in terms of structure*	*n*	*in terms of content*	*n*
CIBD instructions and sociodemographic details	Add an index to help navigate the interview. Corrections to the text – typos, repeated words. Add more space to write comorbidities.	7	Add sections: interview duration, household, and source of information used. Change the text to improve clarity in instructions.	*8*
Clinical Details	More space for comorbidities Add starting and ending time	3	Add the source of information. Add an option to write other therapeutic interventions; Add space to write previous diagnoses.	3
Module 1 – Bipolar Disorder Type I/II and Cyclothymic				
MDD	Ask the reason for depressive symptomatology and assess if there is grief at the beginning instead of the end of the assessment of the depressive episode.	2	Ask the perceived reason for the depressive symptomatology and rephrase the first question. Add example.	4
BD Suicide Risk Scale	Change the scoring of the scale to the end. Improve structure and add space to write.	5	Clarify ponderation and scoring. Add a reminder to score sections that are assessed after this scale (e.g. mixed episodes, voices of control) at the end of the interview	7
Hipo/Maniac Episode	Correct numbering of questions. Correct typos/ repeated words. Clarify instructions.	6	Add examples to clarify symptoms.	4
Cyclothymic	No suggestions	-	Add questions to cyclothymia.	2
Module 2 – Bipolar Disorder and Related Disorders due to other medical condition				
Bipolar and related disorder due to another medical condition and Substance/medication-induced	Remove repeated questions. Correct numbering of questions.	3	Suggestions to change the term "medical condition" when questioning the interviewee to "health problem" for clarity. Add clarification for 3M/6M criteria in drug-induced BD.	2

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Module 3 – Other specified and Unspecified bipolar and related disorders				
Other specified bipolar and related disorders	No suggestions	-	No suggestions	-
An unspecified bipolar and related disorder	No suggestions	-	No suggestions	-
Other sections of the interview				
- Diagnosis tables Mood Episodes - Specifiers for Bipolar and Related Disorders Assessment Scale - Attachment – differential diagnosis with psychosis	Add information of pages to psychotic features in the episode specifier's assessment to facilitate characterizing all episodes in the same place. Typos corrected in attachment. Add notes in sections where the interviewee answers functionality. Move graph instructions to the top.	6	Add information on how to register a mixed features episode on the mood graph and an example – *added to the interview manual.* Add notes near the scoring by the clinician. Add instructions to navigate the interview.	8
Perceived empowerment towards symptoms Scale	Change the instruction - *mark with an x in the column* - to make a circle around the number and add the numbers to the columns (from 1 to 5) to make filling easier[4].	2	Improve the instructions on how it should be filled in and how to question the interviewee.	4

Note. n = number of suggestions.

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[4]Figure 1 already has this suggestion integrated, showing the numbers in the columns.

Assessment in bipolar spectrum research highlights the same difficulties discussed in literature dating back two decades ago [41,42]. These challenges underscore the difficulties in achieving accurate diagnoses and underline the importance of timely and precise identification of bipolar-related disorders, due to the significant consequences of misdiagnosis. In line with these considerations, there is a growing momentum to broaden the conceptualization of bipolarity as a spectrum, echoing earlier arguments by Angst and Cassano [21,43]. These authors reasoned that more differentiated research and treatment models for affective disorders as a spectrum could help reduce the under-recognition of bipolarity. This expanding viewpoint is supported by practitioners and researchers who emphasize the ongoing difficulties of diagnosis and inadequate treatment of BS disorders [42,44,45].

The CIBD was developed to address the existing research gaps in this domain while adopting a recovery-based approach. Its acceptability was high by people with BD and experts involved in the study. The expert panel provided a very good overall rating of the interview, accentuating its necessity and practical utility. They consistently assigned high scores to all interview sections regarding usefulness, comprehensiveness, and clarity, with specific suggestions focusing on easing the clarity of instructions. Such high scores to the pertinence and completeness of the interview might even be questioned as to why they were so elevated. On reflection, we believe that it was because the interview was quite faithful to the diagnostic criteria known by the experts, with the additional contributions of international guidelines, which intended to make these criteria even clearer and more faithful to the clinical presentations of hypomanic and manic symptoms) [35,46]. Furthermore, there were more suggestions and requests for clarity in the sections that we developed from the start and in the navigation of the sections and the instrument's functionality, as should be expected for a new interview.

In response to the expert panel's valuable feedback, several significant modifications were incorporated into the interview. Significant adjustments included the addition of an index at the outset of the interview to facilitate navigation, providing illustrative examples within the interview manual to aid the completion of specific sections, and refining instructions for administering and filling the empowerment scale. The expert panel also supplied detailed commentaries on various interview sections, with particular attention given to enhancing the clarity of the questioning in the bipolar suicide risk assessment section. Thus, substantive revisions were undertaken to improve the understanding of this section by removing the scoring information from that part so that the focus during the interview would be on asking the questions. The scoring of proximal (current) and distal (lifetime history) risk factors was altered and sent to the end of the interview.

A limited number of suggestions made by the experts were not implemented as part of the interview revisions. For instance, proposals to add questions to facilitate a differential diagnosis of BPD and a section addressing cannabis dependence were not integrated into CIBD. The decision to exclude these suggestions was primarily driven by the complexity associated with diagnosing BPD. In cases where suspicions of BPD arise, we emphasize the utilization of a separate interview designed explicitly for assessing it (which is stated in the instructions of CIBD). Incorporating such an extensive addition into the interview was deemed impractical, as it would significantly increase the interview's complexity and length. Instead, we focused on psychosis differential diagnosis through CIBD attachment, an area we considered more necessary based on prior contributions and know-how of the research team [33,47,48]. Regarding cannabis use, even though it is frequently comorbid, it is not listed as one of the substances that might induce bipolar-like symptoms, so it was not deemed necessary to assess any further.

Even though only a few experts made that remark, one of the criticisms of the interview was that it could sometimes be dense and difficult to follow. In order to address this feedback, there was an effort to make the instruction less wordy and thus improve the overall fluidity of the interview. Additionally, some information was moved to the interview manual. Furthermore, it is our view that the perceived overwhelming nature of the interview can be mitigated through appropriate training in its administration.

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Limitations and future research

The assessment of this interview involved experts mainly within our professional network. Although some colleagues enlisted additional experts for the evaluation process, involving a more diverse range of individuals with varied backgrounds, ensuring a broader and more representative sample of experts would have been beneficial. There is also the possibility of a positive assessment bias since some of the expert panel knew the research team, even though we tried to mitigate that with an anonymous assessment. Additionally, having only two professionals from other mental health fields (other than psychologists and psychiatrists) calls for caution when looking at the means and standard deviation of their assessment.

To further validate the interview, our future research plans encompass a comprehensive study evaluating multiple aspects. This includes measuring inter-rater reliability to ascertain the consistency of results between different raters, assessing the interview's acceptability from the interviewees' perspective through qualitative interviews, and examining both convergent and divergent validity. Furthermore, we aim to evaluate the accuracy of CIBD and its predictive ability to detect changes, particularly following clinical interventions.

Conclusion

CIBD seems to be an acceptable and comprehensive interview to assess BD and related disorders, adding an important contribution to personal recovery in BD and measuring symptoms interference from the client's standpoint. This enhanced understanding of symptoms interference better informs the development and monitoring of intervention plans and their progress. Experts highlighted the CIBD's unique contributions, including the suicidality scale, BD specifiers, and clients' empowerment scale, which are not found in any other instrument. Overall, the CIBD seems to be a promising innovative instrument for diagnosing and assessing BD. Further investigation into its psychometric properties is warranted in forthcoming research endeavors.

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