Juvenile-Onset Bipolar Disorder: Discussion, Diagnosis and Treatment Considerations

Presented by:

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“The ability to learn faster than your competitors may be the only sustainable competitive advantage.”
— Arie de Geus
Juvenile-Onset Bipolar Disorder: Under-diagnosed, Under-treated, Under Discussion

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Consulting Child Psychiatrist
Diablo Behavioral Healthcare
&
William J. Shryer, D.C.S.W, L.C.S.W.
Clinical Director
Diablo Behavioral Healthcare
Danville, CA
Bipolar Definitions & Subtypes

- Hypomanic episode: same as manic, without severity or duration criteria
- Mixed episode: criteria for both manic and depressive episodes met within a 1-week period
- Bipolar I: At least 1 manic or mixed episode
- Bipolar II: 1 or more episodes of both major depression and hypomania, without manic or mixed episodes
- Cyclothymia:
  - 1 year of hypomanic and depressive symptoms
  - Clinically significant distress or impaired functioning
  - No more than 2 consecutive months without symptoms

How often do Bipolar Spectrum Disorders occur in youths?

- Lifetime prevalence of 1-2% in adults for Bipolar I
- Less common in children
  - 0.4% to 1.2% prevalence for any bipolar (Lewinsohn, Klein, & Seeley, 1995), with more BP II and cyclothymia
  - Incidence appears much greater after puberty
  - BP II, Cyclothymia, and BP NOS may be five times as common as BP I in juveniles
  - 20-30% of “depressed” youth → Bipolar Disorder
- Very discrepant rates identified by different research groups, let alone clinicians
Features of Juvenile-Onset BPD

- The disorder is very difficult to diagnose. It is characterized by:
  - Chronic course, rapid cycling, psychosis
  - Mixed symptom presentation; irritability > euphoria
  - Poor interpersonal and academic and functioning
  - High suicide risk
  - Frequent comorbidity with disruptive behavior disorders, anxiety, and substance abuse
  - Increased health services utilization
  - Unpredictable response to mood stabilizers


How Common Is It?

- Typical phenotype (DSM-IV) (bipolar-I and bipolar-II) = 1%-2% of community adolescents, peak onset 15-19 years (mean 18)

- Many children referred to clinics (6%) present with a broader phenotype:
  - Clear but brief adult-like episodes, lasting several hours to days
  - Chronic mood lability, mood swings, affective storms
  - Rapid cycling, mixed symptoms, mild psychosis
  - Excessive anger, temper tantrums and oppositional/aggressive responses in situations that elicit frustration
  - Depressions with quick onsets and offsets
  - Poor interepisode recovery
  - Sleep continuity disturbances
  - Executive function deficits
  - ADHD-like symptoms plus bipolar family history
  - Functional impairment
Bipolar NOS (DSM-IV)

• Manic symptoms that don’t fit into any of the previous diagnostic categories
• Some ways to earn a residual diagnosis
  - Manic or hypomanic sx of insufficient duration (including very rapid cycling)
  - Repeated hypomania without a depressive episode
  - Manic symptoms, but insufficient number co-occurring

BP NOS still a serious threat

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Proband diagnostic group (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bipolar</td>
</tr>
<tr>
<td>Received treatment</td>
<td>55.6_a</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>44.4_a</td>
</tr>
<tr>
<td>Social impairment</td>
<td>66.7</td>
</tr>
<tr>
<td>Family impairment</td>
<td>55.6</td>
</tr>
<tr>
<td>School impairment</td>
<td>83.3_a</td>
</tr>
</tbody>
</table>

Note. Percentages within the same row with different subscripts differ at p<.05
Improving Differential Dx

- Look for symptoms more specific to bipolar
- Careful family history
- Look for evidence of cycling

J Clin Child & Adol Psychol

What’s the Diagnosis?

- 8 year old male
- Trouble concentrating in school, high motor activity
- Explosively violent
  - Slams doors until they break
  - Cut cat with scissors
  - Chased mom with knife, cursing at her
  - Threatened to kill siblings in sleep
  - Expresses remorse later
Increase in diagnosis of BD in youth

Figure. National trends in visits with a diagnosis of bipolar disorder as a percentage of total office-based visits by youth (aged 0-19 years) and adults (aged = 20 years).

Moreno et al., 2007

Why is Pediatric Bipolar Disorder Suddenly So Common in the U.S.?

• Forty-fold increase in childhood BP diagnoses in past 10 years

• May be due to:
  - Lack of DSM-IV diagnostic criteria
  - Disagreement on BP-NOS, not BP I and II
  - Lower clinician threshold for calling activated behaviors as mania in US and India
  - Higher threshold for same in UK, Europe
  - Diagnostic “fad”
  - Previous under-diagnosis
  - Decrease in age at onset of bipolar disorder
  - Genetic anticipation
  - Aggressive marketing of mood stabilizer/antipsychotic drugs
  - Disagreement on prominence of ADHD versus bipolar symptoms
Rage Attacks

“It comes on so quickly; faster than a knee-jerk reaction. It’s like electricity shoots through me. It’s like being struck by lightning. I feel rage and hurt, and need to strike back. It becomes primal - infantile.”

“I would throw things, smash a couple of frogs between rocks. I was raging all the time-everyday, multiple times a day, verbally abusive, nasty, negative, but very careful not to show it to the outside world.”

A 10-year Old Girl’s Description of Bipolar Disorder

“When I feel happy, I get real bouncy... I’m hopping all over the place, and my mind seems to be focused on one thing for a short time. Sometimes, I don’t necessarily feel bouncy, just kind of light and airy, like a butterfly. I sort of flit and float from place to place, physically and in my mind.

When I feel depressed, I’m like...dead. I just sit there lifelessly, and my body just sort of flops around, like a Beanie Baby. Also, my mind just sort of drifts away and wonders aimlessly into space.”

Birmaher, 2004
Clinical Manifestations

- **Elation / Euphoria**
  - Laughs w/o reason
  - Laughs and jumps around while telling of school failure
- **Grandiosity**
  - Steals b/c rules “do not apply” (vs. ignoring rules [Conduct D/O])
  - Believes s/he is failing school b/c teacher is “stupid”
  - Special abilities, intelligence, strength
  - Grandiosity unreliable as a symptom in young kids
- **Hypersexuality**
  - Inappropriate kissing, touching (self & others), sexual talk at young age
  - Fascination w/ body parts
  - Sexually provocative and/or promiscuous behavior

School Dysfunction

- Poor/failing grades
- Distractible (lack of motivation/interest)
- Harass teachers (oppositional / grandiose)
- Unrealistic career/recreational strivings
- Frequent fights or explosive outbursts
- Inability to concentrate (racing thoughts)
- Frequent changes in activities and subjects
Family Dysfunction

- Isolates in room and/or explosive outbursts
- Insomnia (racing thoughts, nightmares, emotional intensity)
- Excessive withdrawal from family activities
- Argumentative and oppositional
- Multiple activities started but not finished
- Phone and credit card charges

Classic Bipolar I

Distinct episodes of marked mania and depression (variable interepisode interval – may be shorter in children)

Days

Mania

Depression
The Modal Child Presentation
(Ultra-rapid? And Comorbid ADHD)

Days

Mania

Comorbid Hyperactivity

Depression

Juvenile-onset Bipolar Disorder

Cycling Pattern
24 Hours

Ultra-Ultra Rapid Cycles of Mood and Energy
Longitudinal Course: Youth vs. Adults
(Judd et al., 2002; Birmaher & Axelson, 2003)

- No Significant Mood Symptoms: Youth 44%, Adults 53%
- MDD: Youth 11%, Adults 9%
- Manic: Youth 4.5%, Adults 2%
- Mixed: Youth 2.9%, Adults 1%
- Subthreshold Symptoms: Youth 26.8%, Adults 23%

Comorbidity and Differential Diagnosis in Children
Diagnostic Conundrum

How do we separate the core symptoms that distinguish juvenile-onset BPD from those of other more commonly diagnosed disorders of childhood, when they share so many of the same symptoms?

- Bipolar Disorder
- Anxiety Disorders
- Obsessive-compulsive
- Disruptive Disorders
  - Oppositional defiant
  - Attention-deficit
- Separation

Dangers of Misdiagnosis

- Potential for negative influence on course and outcome
- Long latency before appropriate treatment is initiated
- Treatment with medications that induce behavioral and/or affective adverse effects
- Arrest in the development of adaptive social relationships
- Family strife
**Controversy in Diagnosing Children**

- Serious diagnosis
- Life-long label and treatment
- Many children don’t fit the adult prototype (“Cade’s Disease”)
  - Do these kids really have bipolar?
  - Is there a different pediatric subtype?
  - Are we misdiagnosing?

**Pediatric Bipolar Comorbidity**

- Comorbidity is the rule more than the exception (70% - 90%)
- ADHD: 70-90% in childhood, 30%-40% in adolescents
- Conduct or Oppositional Defiant Disorder: 30%-76%
- Substance Use Disorders (mainly adolescents): 40%
- Anxiety Disorders: 36%

Kafantaris et al., 2001; Geller et al., 2000; Biederman et al 1999
Bipolar Versus ADHD

- Bipolar:
  - Cardinal manic symptoms
  - Cyclic course
  - Poor attention, distractible, impulsive when manic or mixed
  - Rapid cycling moods, psychosis
  - Family history of BP
  - Depressive states
  - Cycle acceleration on Ritalin

- ADHD:
  - Constant problems with distractibility, attention, organization regardless of mood state
  - Age at onset younger
  - Typically not seriously depressed
  - Improved concentration and reduced impulsiveness on Ritalin


Mania or ADHD?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>ADHD</th>
<th>Bipolar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elated/Euphoric</td>
<td>Can get silly—transitory, rarely impairing</td>
<td>Outrageous behavior</td>
</tr>
<tr>
<td>Grandiosity</td>
<td>Can brag—usually trying to boost self-esteem</td>
<td>Truly believes at the time in outlandish ideas</td>
</tr>
<tr>
<td>Need for Sleep</td>
<td>Some have never needed much sleep; medications can interfere with sleep</td>
<td>Sleeps 2+ hours less than usual, fully rested</td>
</tr>
</tbody>
</table>
Mania or ADHD? (Cont.)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>ADHD</th>
<th>Bipolar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racing thoughts</td>
<td>*Especially if low IQ or has LD, can be</td>
<td><em>During mood can be tough to follow, causes interference</em></td>
</tr>
<tr>
<td></td>
<td>difficult to follow</td>
<td></td>
</tr>
<tr>
<td>↑ Goal directed</td>
<td>*Hyperactivity is chronic and unfocused</td>
<td><em>Engage in elaborate schemes &amp; surges of activity</em></td>
</tr>
<tr>
<td>activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressured Speech</td>
<td><em>Chronic motor mouth</em></td>
<td><em>Episodes where loud, hard to interrupt, intrusive</em></td>
</tr>
</tbody>
</table>

BPD vs ADHD: Symptoms that Differ

*Geller et al. (2002)*

<table>
<thead>
<tr>
<th>Symptom</th>
<th>EOBD</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elated Mood</td>
<td>89%</td>
<td>13%</td>
</tr>
<tr>
<td>Grandiosity</td>
<td>86%</td>
<td>5%</td>
</tr>
<tr>
<td>↓ Sleep</td>
<td>40%</td>
<td>6%</td>
</tr>
<tr>
<td>Flight of ideas</td>
<td>71%</td>
<td>10%</td>
</tr>
<tr>
<td>Hypersexuality</td>
<td>43%</td>
<td>6%</td>
</tr>
<tr>
<td>Suicidality</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>60%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Note that the “ADHD” group excludes any with mood disorder*
BPD vs ADHD:
Symptoms that Overlap

Geller et al. (2002)

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>EOBD</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritability</td>
<td>98%</td>
<td>72%</td>
</tr>
<tr>
<td>↑ Speech</td>
<td>97%</td>
<td>81%</td>
</tr>
<tr>
<td>Distractability</td>
<td>93%</td>
<td>96%</td>
</tr>
<tr>
<td>↑ Energy (cf. change in energy)</td>
<td>100%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Because not making “episodic” distinction

Note that the “ADHD” group excludes any with mood disorder

GRAPES

• Grandiosity – especially unstable self-esteem
• Racing thoughts
• Activity – episodes of goal-directed activity
• Pressured speech
• Elated, expansive, euphoric mood
• Sleep – Decreased need (getting less, and does not miss it)

Note that this saves some of the best for last!
Predictors of Bipolar Disorder in Depressed Youth

• MDD with
  • Psychosis
  • Rapid onsets and offsets
  • Antidepressant-induced mania/hypomania/rapid cycling
  • Family history of bipolar disorder

Bipolar versus OCD

• Racing thoughts versus intrusive thoughts
• Increased, goal-directed activity versus compulsive behavior
• Function of behavior: to satisfy a reward-driven reward state or alleviate anxiety?
• OCD kids generally do not have elation, giddiness, hypersexuality, decreased need for sleep
Bipolar Versus “Being a Normal Teenager”

Healthy Teen:
- Common to see increases in risk taking, mood instability, family conflict
- Excitement appropriate to context (e.g., Christmas, Senior prom)
- Has “bad days” but functioning generally stable
- “Grandiosity” appropriate to context
- Occasional has a mood disorder symptom without meeting duration or severity requirements
- Occasionally stays up too late, wakes up late, or has problems sleeping

Bipolar Teen:
- Same three factors but to greater degree and associated with school or social impairment
- Excitement/elation inappropriate to context
- Sudden deterioration in functioning
- Inappropriate grandiosity (e.g., “No one knows more than I do”) or delusional or hallucinating
- Clusters of manic or depressed symptoms that cycle together
- Up most of the night for several nights in a row, sleeps most of the day

Assessments

- Kiddie Schedule for Affective Disorders and Schizophrenia (2-4 hours!)
- Questionnaire measures: CBCL (look for attention, severe aggression, mood instability)
- Parent-rated Young Mania Rating Scale (http://www.healthyplace.com/communities/bipolar/pymrs.asp)
Assessments

- School history (distractibility, inattention, mood-dependent performance shifts)
- Academic functioning and attendance shifts
- Receptive and expressive language difficulties
- Social interactions and peer relationships
- Psycho-educational & psychological testing
- Special Education referral (ED, LD)
- Human Services Agency involvement (past or current CPS, Family Preservation, etc.)

Other Strategies Not Ready for Clinical Use vis Bipolar

- fMRI and other imaging techniques
  - Expensive
  - Findings not specific to bipolar disorder
- Neuropsychological batteries
  - Again, findings not specific, or not validated against clinically meaningful comparison groups yet
- MMPI-A or Personality Inventory for Children
  - Conceptually promising, but not validated yet
Genetics

- Family history
  - Concordance rate for BD in monozygotic twins is 57%
  - Dizygotic twins rate = 14%
  - Unipolar rates: Monozygotic twins = 40%; Dizygotic twins = 11%
  - Family pedigrees of BD children have high rates of unipolar depression, substance and alcohol abuse, ADHD

Children of Bipolar Parents

- Increased risk
  - 2.7 times more likely to have any mental health dx
    - Depression, anxiety, substance abuse, adhd...
  - 4 times more likely to have a mood disorder
  - 5.4% of children w/ BP parent already met criteria for bipolar disorder (vs. 0% for non-bipolar parent)

LaPalme, Hodgins, & LaRoche, 1997
Genetic “Iceberg”

Recognized (Bipolar I, II)

Spectrum (missed bipolar I & II; Cyclothymia, NOS)

Unimpaired (low loading, high functioning family members, “hyperthymic”)

Neurobiology

• Smaller amygdala volumes

• Amygdala hyperactivation plus ventrolateral and dorsolateral prefrontal cortical hypoactivation when viewing fearful faces
## FDA-Approved Bipolar Disorder Treatments in Adults

<table>
<thead>
<tr>
<th>Agents</th>
<th>Manic</th>
<th>Mixed</th>
<th>Maintenance</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ATYPICALS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aripiprazole (Abilify®)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>–</td>
</tr>
<tr>
<td>Olanzapine (Zypraxa®)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>–</td>
</tr>
<tr>
<td>Quetiapine (SEROQUEL®)</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>+</td>
</tr>
<tr>
<td>Risperidone (Risperdal®)</td>
<td>+</td>
<td>+</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Ziprasidone (Geodon®)</td>
<td>+</td>
<td>+</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbamazepine ER (Equetro™)</td>
<td>+</td>
<td>+</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Divalproex DR (Depakote®)</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Divalproex ER (Depakote® ER)</td>
<td>+</td>
<td>+</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Lamotrigine (Lamictal®)</td>
<td>–</td>
<td>–</td>
<td>+</td>
<td>–</td>
</tr>
<tr>
<td>Lithium (Lithobid®, Eskalith®)</td>
<td>+</td>
<td>–</td>
<td>+</td>
<td>–</td>
</tr>
<tr>
<td>Olanzapine/fluoxetine (Symbyax ®)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>+</td>
</tr>
</tbody>
</table>

### Number of Current Medications

![Bar chart showing 85% of people on 2+ medications](chart.png)

*85% on 2+ meds*

*CABF Online Survey (2002, May)*
Pediatric BPD-I, Manic, Mixed, without Psychosis

Stage 1: Monotherapy with Mood Stabilizer or Atypical Antipsychotic
(Li, VAL, CBZ, OLZ, QUE, RISP)

Stage 2: Switch Monotherapy Agent

Stage 3: Switch Monotherapy Agent

Stage 4: Combination treatment

Stage 5: Alternate Monotherapy (OXC, ZIP, ARI)

Stage 6: ECT (adolescents) or Clozapine

Why Treat Bipolar Patients With Adjunctive Psychotherapy?

General Themes

• Increase adherence to drug regimens
• Understand vulnerability to future episodes
• Enhance social and occupational functioning
• Heighten capacity to manage stressors in social-occupational milieu
• Increase protective effects of family
• Decrease denial and encourage acceptance of disorder
• Lower trauma associated with disorder
Family-Focused Treatment (FFT) of Bipolar Disorder

- 21 outpatient sessions over 9 months
- Assessment of patient and family
- Psychoeducation about bipolar disorder (*symptoms, early recognition, etiology, treatment, self-management*)
- Communication enhancement training (*behavioral rehearsal of effective speaking and listening strategies*)
- Problem-solving skills training


Is Psychosocial Treatment Effective in Improving the Course of Bipolar Disorder?

Results of Randomized Clinical Trials
The Systematic Treatment Enhancement Program for Bipolar Disorder: A Multi-Center Study of Effectiveness and Treatment Dissemination (NIMH Grant MH80001)

- NIMH-Funded, 15 sites, 30 therapists
- 293 patients with acute bipolar depression
- Randomly assigned to intensive therapy (30 sessions of FFT, interpersonal therapy, cognitive-behavioral therapy) or a brief psychoeducation control (“collaborative care”)
- Primary outcome: time to recovery from depression
Proportion Meeting
Effectiveness and Efficacy Criteria:
Mood Stabilizers with and without Antidepressants

No significant differences, All p>.23

<table>
<thead>
<tr>
<th></th>
<th>MS+AD</th>
<th>MS+PLA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Recovery</td>
<td>24%</td>
<td>27%</td>
</tr>
<tr>
<td>Effectiveness Response Rate</td>
<td>32%</td>
<td>38%</td>
</tr>
<tr>
<td>At Least Transient Remission</td>
<td>41%</td>
<td>49%</td>
</tr>
</tbody>
</table>

>50% SUM-D reduction at week 6

Sachs et al., 2007, NEJM

The STEP-BD Multisite Program (15 sites, N=293)
(Miklowitz et al., 2007; Arch Gen Psychiatry)

χ²(3) = 8.02, p = 0.046

Hazard Ratios (vs CC)
- CBT: 1.34, p = .12
- FFT: 1.87, p = .013
- IPSRT: 1.48, p = .045
FFT versus Brief Psychoeducation (Enhanced Care) for Bipolar Adolescents Undergoing Pharmacotherapy

<table>
<thead>
<tr>
<th>Time after Randomization, wks</th>
<th>Psychiatric Status Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 24 48 72 96</td>
<td>3 2.5 2 2.5 2</td>
</tr>
</tbody>
</table>

Treatment x time interaction, $F [1, 5014] = 9.15, P = 0.0025$

Miklowitz et al., *Arch Gen Psychiatry*, 2008

Psychoeducational Strategies
Psychoeducation About Bipolar Disorder: General Principles

• Identify the patient as the “expert” on his or her illness, an “active collaborator” in treatment
• Explain the concept of a syndrome and the relationship among the various symptoms the patient is experiencing
• Discuss the causes of the disorder from a non-blaming stance
• Discuss elements of treatment that are likely to bring about change
• Instill optimism about the future course of the illness
• Address the patient’s emotional reactions to the educational material

The Therapeutic Stance in Psychoeducation

• Be warm, approachable, genuine, accepting, and self-disclosing
• Use a Socratic rather than an overly didactic style
• Deal with affective reactions, including the patient’s frustration about the illness and its treatments
• Avoid technical jargon
• Use appropriate pacing
### Handout # 2

#### Symptoms of Mania
- Elated mood
- Decreased need for sleep
- Increased energy and activity
- Increased sexual thoughts
- Talking fast
- Loss of self-control
- Irritability!
- Easily distracted, Racing Thoughts, Lots of ideas
- Being overconfident or unrealistic

#### Symptoms of Depression
- Low mood or sadness
- Tearfulness
- Sleeping too much or too little
- Low self-esteem
- Trouble concentrating
- Increase or Decrease in Appetite (Crave Sweets or Carbohydrates)
- Loss of interest in activities/boredom

Some people also:
- feel really tired or low in energy
- wish they weren’t alive
- feel worthless or guilty
- talk or move slowly
- lack of thoughts
Handout # 3

Recent Life Events

Things that have stressed you out lately:

_________________  __________________
_________________  __________________
_________________  __________________
_________________  __________________
_________________  __________________
_________________  __________________
_________________  __________________

STRESS Thermometer

STOP!

Calm Down

Relax

The things you did to help you feel better:

_________________  __________________
_________________  __________________
_________________  __________________
_________________  __________________
_________________  __________________

Handout # 4

Factors Affecting Health Problems

Genes

Daily Events

Possible Outcomes

Good  Okay  Poor
Risk and Protective Factors

Risk Factors For Mood Problems
- Drug / alcohol abuse
- Poor sleeping habits
- Irregular daily routines
- Stressful life events
- Family conflict or distress
- Conflict in interpersonal situations

Protective Factors
- Staying consistent with medications
- Learning as much as possible about the disorder
- Keeping regular sleep/wake routines
- Family education and supportive involvement
- Keeping environment low key and predictable
- Avoiding alcohol and street drugs
- Developing relapse prevention plans
- Participating in ongoing psychotherapy
- Mutual support groups
- Keeping a mood chart

Managing Stress: The 3-Minute Breathing Space

- Sit in comfortable chair with your back upright
- Close eyes or stare at an object. For 60 seconds, be aware of noises in the room – acknowledge each sensation, thought, or feeling, whether pleasant or unpleasant
- For 60 seconds, focus on in-breath and out-breath; if attention shifts, gently escort yourself back to your breathing
- For 60 seconds, shift your attention to your entire body – notice posture and sensations in different parts of the body as you breathe in and out
- Slowly open your eyes and come back in contact with the room

Source: Segal, Williams, & Teasdale, 2001; Mindfulness-based cognitive therapy for depression. NY: Guilford
Daily monitoring of mood symptoms

- Encourage the child or teen patient to keep a regular mood chart

- Explain that this is one of the things the kid can do in addition to taking medications to gain more control of the illness

- At the beginning of each session, examine the role of environmental stressors, drug nonadherence, and alcohol / drug use

---

**HOW I FEEL**

Week of Mar 3

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super-Hyper</td>
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<td></td>
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<tr>
<td>Energized</td>
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<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Balanced</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Down</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I woke up at: 7 7 6 6 6 8 11
I went to bed at: 10 11 10:30 10:30 12 12 10

Examples of:

- **Super-Hyper**: Feel good about myself, Talk faster, Like being high, Lots of ideas, Need less sleep
- **Down**: Suicidal, Don’t want to go to school, Short-tempered, Stop eating or eat more, Want to be alone, Want to live in a bubble
- **Angry**: Pissed off, Hate everyone, Irritable, Snap easily
Promoting good sleep hygiene

*Enlist the help of parents so the patient can:*

- Establish a regular bedtime and wake time
- Avoid caffeine and other stimulants
- Avoid alcohol, illicit drugs, or activating over-the-counter medications
- Exercise early in the day, not right before bed
- Avoid working in bedroom
- Avoid highly stimulating activities before bedtime
- Anticipate stressors that could destabilise daily routines; develop a management plan

Relapse-Prevention Contracting

- Develop plans when patient is euthymic, rather than during a crisis interval
- Empower the patient: frame this as “a way to maintain control over your life even when your mood starts to change”
- Identify other “agents of the plan” (relatives, friends, and clinicians)
- Explain that there is a “brief window of opportunity” in which early intervention may prevent hospitalization
Elements of an Early Response Plan for Escalating Mania

- Contact the physician and get an emergency medical appointment
- Examine what to do if a clinician cannot be reached
- If appropriate, have a small supply of antipsychotic medication available
- Be aware of hospital resources and admission procedures
- Familiarize parents with 24-hour on-call services or suicide hotlines

Elements of an Early Response Plan for Escalating Mania (Cont’d)

- Keep environment structured and low in stimulation
- Stay away from alcohol and drugs
- Keep consistent sleep/wake cycles
- Learn to trust the judgment of significant others
Elements of an Early Response
Plan for Escalating Mania (Cont’d)

• Bring someone you trust with you when you go out at night
• Get help managing money, give up car keys
• Avoid making major life decisions (use 2-person rule, 48-hour rule: “if it’s a good idea now, it’ll be a good idea then”)\(^1\)

The Mania Prevention Contract

• List prodromal signs
• List circumstances in which, historically, these have been most likely to occur
• What can parents do?
• What can the child do?
• The psychiatrist? Therapist?
• Have all emergency contact info in one place
Medications and Compliance

• Only 35% of BD kids take all of their prescribed medications

Promoting Adherence to a Mood Stabilizer Regimen

• People with bipolar disorder are more likely to commit to a mood stabilizer regimen if
  - They receive information from mental health professionals about the disorder and how the medications will help
  - They are approached with compassion and with acknowledgement that taking medications doesn’t change one’s identity
  - It is their own decision and not one foisted on them by others
  - Dosages can be adjusted or other medications substituted to control side effects
Effective Ways to Inquire About Medication Adherence

• Ask the patient
  - Do you have any difficulty taking all your prescribed medication?
  - Do you ever try to cope on your own without the medication?
  - Many people miss taking their medications from time to time; how has it been for you?

Encouraging Medication Adherence

• Develop cues for pill storage and use
• Examine the role of medications in the kid’s family relationships
• Examine subtle or overt pressures from family members to discontinue medications
• Clarify the “symbolic significance” of taking medications (e.g., loss of creativity, giving up of emotions)\(^1\)
• Encourage “grieving over the lost healthy self”\(^2\)

---

Working with the Treating Psychiatrist

• Establish roles in case early on

• Have regular dialogue about treatment progress, new symptoms, side effects

• Encourage kid/family to have ongoing discussion with physician about medication choices, side effects

• Develop coordinated relapse prevention plan

Working with Parents

• Always develop an alliance with relatives as part of the treatment plan

• Educate them about the nature, course, etiology, and treatment of bipolar illness

• Encourage a common understanding of the recent episode and its precipitants

• Examine assumptions often held by relatives that disruptive symptoms are really under the kid’s control

• Coach the child and relatives on communication and problem-solving skills
Reasonable Accommodations in the School Setting

- Help teachers distinguish bipolar disorder from other psychiatric disorders
- Develop plan to manage behavioral problems
- Allow later starts to the day
- Allow more frequent breaks, time outs, school counseling visits
- Have “escape hatches” during periods of escalation (e.g., in-school counseling)
- Excused absences for medical appointments
- Individualized educational plans
- Reducing overstimulation in classroom
- Parent as advocate

Summary - I

- Good treatment starts with a good diagnosis
- Optimal pharmacotherapy is essential
- Psychosocial treatment should be a key component of the outpatient plan
Summary - II

• Key elements of psychoeducation:
  - Building a strong alliance with the child and parents
  - Providing self-management tools
  - Removing barriers to treatment adherence
  - Developing relapse prevention plans
  - Enhancing skills for communicating and solving problems

Questions?

A list of resources can be found at www.behaviorquest.com.
Prejudicial Treatment of Children and Families with Bipolar Disorder
by Tracy Anglada

Have you read the papers or watched the news lately? If so, then you’ve heard the latest buzz, namely that the diagnosis of bipolar disorder has greatly increased in the childhood population. This increase was not news to parents and advocacy groups who have fought long and hard to finally get a correct diagnosis and treatment for their children over this past decade. According to the Center for Disease Control, parent reporting of serious emotional and behavioral difficulties has remained at a constant 5% in the under 18 population for the past five years. Since parent report is one of the first indicators that doctors examine, it does not appear that the recent increase in diagnosis is related to a shocking rise in the illness itself, rather a rise in recognition of the illness. A pitiful lack of recognition of the illness in children in previous decades has caused what appears to be a shocking increase of 40 fold. This increase has become the banner statistic for the media to declare over diagnosis and misdiagnosis without regard for all the facts. The current rates put bipolar disorder in children at approximately 1% of the population which is not a shocking statistic and indicates that the rates will increase yet more as children continue to be identified and properly treated. Childhood rates would be expected to reach over half of the conservative adult rate of 4% since more than half of onset occurs prior to age 20. Considering this, the headlines could have just as easily read, “Bipolar Disorder in Children Still Gravely Under Treated!”

So why is there a huge backlash against the diagnosis? Why hasn’t there been a large scale congratulations regarding the progress made by doctors and researchers in identifying the illness in the childhood population? Surely if it had been cancer the headlines would have been different! The current climate is one that is bred by prejudice. Parents are at the heart of the organizations who have been advocating for more research, clearer diagnostic standards, brain scans and medication safety testing. Parents have the most vested interests in outcome. Yet, when the debate starts to rage, parents are accused of looking for a quick fix, not wanting to deal with their children and seeking out the diagnosis as if it were a status symbol. Casual newspaper readers now feel justified in critiquing every child and family with this diagnosis. These accusations are no less demeaning than saying that a depressed adult is defective in moral character or that poor parenting causes autism. In this debate, it is the parents left hurting and the children left suffering. While medical advancements and refinements in the diagnosis are welcome, the attack from many media sources is harmful and encourages stigma. This current treatment of the topic has robbed parents of the one thing they need the most on this journey: support!

For those who want to make a difference for children who may have bipolar disorder or who may have a different yet severe psychiatric illness, then support their parents, support research and support advocacy organizations. In this way you can point parents in the right direction while helping them understand the complexities of the bipolar diagnosis. You can help ease the burden and erase the stigma associated with bipolar disorder and other psychiatric illnesses in children. By learning the real facts surrounding issues versus the sensational headlines and by refusing to participate in the prejudicial and uneducated condemnation of this diagnosis, you can help make a difference.
Professional Resources

Diagnostic Assessment Protocol
For Juvenile-onset Bipolar Disorder

The Challenge:

While there is continuing debate over the validity of the diagnosis of mania in children, a number of systematic clinical investigations and family/genetic studies have begun to shed light on the presentation and naturalistic course of pediatric bipolar (PBD), suggesting a developmentally different presentation in young children as compared to its adult form (Carlson, 1984; Faedda et al., 1995; Wozniak and Biederman, 1997; Geller et al., 1998; Papalos and Papalos, 1999; Biederman et al., 2000; Egeland et al., 2000). Adult-onset and juvenile-onset forms of bipolar disorder have certain similar features and comorbitides in common, but in the juvenile form of the disorder, the frequent overlap of symptoms with other disorders far more commonly diagnosed in childhood has had a confounding affect on clinical diagnostic practice for years (Papalos, 2002).

The development of specific diagnostic criteria that more closely resemble the actual presentation of symptoms and behaviors in childhood, as well as clinical tools to assist clinicians in the rapid and reliable assessment of children at risk, are important tasks for clinical research in the upcoming years. Additionally, genetic studies will benefit from the development of well validated, and rapid screening instruments for the large-scale ascertainment of affected sibling pairs that will be required to generate meaningful conclusions when candidate gene and genome wide searches are undertaken in this population. Toward that end, the Juvenile Bipolar Research Foundation has sponsored the development of a comprehensive and integrated set of diagnostic tools. The Child Bipolar Parent Questionnaire (CBQ) (Papalos and Papalos, 2002) is the foundation of this assessment package.

The Development of The Child Bipolar Parent Questionnaire Version 2.0 (CBQ)

The Child Bipolar Parent Questionnaire Version 2.0 (CBQ), a 65 item questionnaire rated on a Likert-type scale for frequency of occurrence, was developed by Dr. Demitri Papalos to serve as a rapid screening inventory of common behavioral symptoms and temperamental features associated with pediatric bipolar disorder. The CBQ measures, in a standardized format, the behavioral problems of children ages 5-17, as reported by their parents or parent surrogates.

The first version of the CBQ, an 85-item checklist, was constructed based on the model proposed by Depue et al. (1981) who derived a dimensional approach to defining bipolar disorder in adults. 70 of the original 85 items were keyed to symptoms drawn from DSM-IV diagnostic categories for separation anxiety disorder, generalized anxiety disorder, phobias, obsessive compulsive disorder, oppositional defiant disorder, conduct disorder, attention-deficit disorder, major depression and bipolar disorder. The checklist was administered to parents of a large clinical sample of children with a DSM-IV diagnosis of bipolar disorder. The most common positively endorsed items were rank ordered according to frequency of occurrence, and of these, the 65 highest ranked symptoms and behaviors were included in the CBQ Version 2.0. This initial research, suggesting a Core Phenotype for pediatric bipolar disorder involving dimensions of anxiety, attention deficit, and aggressive behavior, became the basis for the Core Diagnostic Criteria developed for a series of studies sponsored by The Juvenile Bipolar Research Foundation, and became the basis for several newly developed diagnostic companion interviews of the CBQ.
The Core Diagnostic Assessment Package – Child Bipolar Questionnaire (CBQ), Jeanne/Jeffrey Questionnaire for Children, and Child Bipolar Screening Interview (CBSI)

The Core Diagnostic Assessment package was designed for use in clinical and research settings to screen for bipolar disorder in children from both parent and child report. The package includes two easy-to-use self-administered questionnaires – one for parents and one for children – and a follow-up interview to be administered by a clinician or researcher. The Core Diagnostic Assessment package is available in hard copy or online version with downloadable data and summary report features.

Parent Self-administered Questionnaire – The Child Bipolar Questionnaire. The CBQ is a parent-report questionnaire designed for initial screening purposes. The questionnaire is suitable for use by clinicians and by research studies. The CBQ is available in paper-and-pencil and online versions. Items are rated “1-Never or hardly ever,” “2-Sometimes,” “3-Often,” or “4-Very often or almost constantly.” The questionnaire takes approximately 10 minutes to complete. The CBQ has 10 subscales, each of which may be scored separately. Three scores may be derived from CBQ responses: a total score, derived from the number of items scored >1; a severity score, derived from the number of items scored >2; and a Core Criteria score, derived from a subset of 33 items keyed to Core Diagnostic Criteria.

Child Self-administered Questionnaire – The Jeffrey/Jeannie Questionnaire for Children. The child-report version of the CBQ is also for use by clinicians and research studies as an initial screening instrument. It was developed based on a model used by Martinez and Richters, 1993, in a community violence project. Keyed to CBQ items, the questions describe symptoms and behaviors experienced by another child, Jeffrey or Jeannie. Each item is illustrated with pictures designed to allow a child to endorse a symptom or behavior without the use of words. The scale was developed for use with children under 12 years old. It takes 15 minutes for a child to complete. The child responds by choosing a rating on an illustrated Likert-type scale that best matches the degree and frequency with which he/she has had the experience described. The scale is scored in the same manner as the CBQ. The Jeffrey/Jeannie includes many of the subjective symptoms of bipolar disorder and major depression that parents may not observe, including psychotic features. An online, interactive version of the Jeffrey/Jeannie is in development.

Clinician Administered Interview – The Child Bipolar Screening Interview (CBSI)
The CBSI is a clinician- or researcher-administered interview. Developed as a follow-up to the CBQ and Jeffrey/Jeannie, it was designed to collect more detailed information about mood disturbance and accompanying mood-related symptoms from parents whose children were high-scorers on the self-administered questionnaires. The CBSI grew from the perceived need for an instrument covering all of the research criteria proposed for alternative phenotypes to DSM-IV (Narrow and Broad as well as Core phenotypes). The CBSI does not require specific episode duration or a specific type of mood episode to make a diagnosis. Rather, it gathers enough information about type and quality of mood states, periodicity and frequency of mood symptoms, clustering of symptoms, cycling, and occurrence across multiple settings, as well as other features associated with pediatric bipolar disorder, to diagnose using several different criteria sets, making it useful to studies interested in the comparative value of different phenotypes. It also provides information indicative of potential comorbidity, although insufficient to make DSM-IV diagnoses. The CBSI is simple to administer. Most of the items are rated on a Likert-type scale for severity, frequency, or duration of occurrence, in an effort to avoid the necessity of lengthy, descriptive responses from parents already overburdened with the demands of family life. This feature and the fact that the goal of the interview is to collect information without applying rule-outs based on previously accepted definitions of an episode, make the CBSI appropriate for administration by non-psychiatically trained personnel. An online version of the CBSI has been.
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<td>1 2 3 4</td>
<td>8) has night terrors and/or nightmares</td>
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<tr>
<td>1 2 3 4</td>
<td>9) wets bed</td>
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<tr>
<td>1 2 3 4</td>
<td>10) craves sweet-tasting foods</td>
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<tr>
<td>1 2 3 4</td>
<td>11) is easily distracted by extraneous stimuli</td>
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<tr>
<td>1 2 3 4</td>
<td>12) is easily distracted during repetitive chores &amp; lessons</td>
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<tr>
<td>1 2 3 4</td>
<td>13) demonstrates inability to concentrate at school</td>
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<tr>
<td>1 2 3 4</td>
<td>14) attempts to avoid homework assignments</td>
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<tr>
<td>1 2 3 4</td>
<td>15) able to focus intently on subjects of interest and yet at times is easily distractible</td>
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<tr>
<td>1 2 3 4</td>
<td>16) has poor handwriting</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>17) has difficulty organizing tasks</td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>18) has difficulty making transitions</td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>19) has difficulty estimating time</td>
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<tr>
<td>1 2 3 4</td>
<td>20) has auditory processing or short-term memory deficit</td>
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<tr>
<td>1 2 3 4</td>
<td>21) is extremely sensitive to textures of clothes, labels, and tightness of fit of socks or shoes</td>
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<tr>
<td>1 2 3 4</td>
<td>22) exhibits extreme sensitivity to sound and noise</td>
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<tr>
<td>1 2 3 4</td>
<td>23) complains of body temperature extremes or feeling hot despite neutral ambient temperature</td>
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<tr>
<td>1 2 3 4</td>
<td>24) is easily excitable</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1 2 3 4</td>
<td>25) has periods of high, frenetic energy and motor activation</td>
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<tr>
<td>1 2 3 4</td>
<td>26) has many ideas at once</td>
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<tr>
<td>1 2 3 4</td>
<td>27) interrupts or intrudes on others</td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>28) has periods of excessive and rapid speech</td>
<td></td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>29) has exaggerated ideas about self or abilities</td>
<td></td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>30) tells tall tales; embellishes or exaggerates</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>31) displays abrupt, rapid mood swings</td>
<td></td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>32) has irritable mood states</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>33) has elated or silly, goofy, giddy mood states</td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>34) displays precocious sexual curiosity</td>
<td></td>
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<tr>
<td>1 2 3 4</td>
<td>35) exhibits inappropriate sexual behaviors, e.g. openly touches self or others' private parts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 2 3 4</td>
<td>36) takes excessive risks</td>
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</table>
developed with the ability to record interviewer notes and tentative diagnoses as well as client/subject data.

Psychometrics
Cronbach [alpha] coefficients were calculated to evaluate the internal consistency of the CBQ subscales and total score. The alpha estimate for the CBQ total score was 0.936 (95%CI 0.932 – 0.940). The corresponding alpha coefficient estimate among the 33 CBQ items forming the CBQ Core Criteria was very close to the alpha coefficient for the entire CBQ scale: 0.924 (95%CI 0.920 – 0.929). Of note, the alpha coefficient estimated among the 11 CBQ factors was substantially smaller (as expected), with alpha and its 95% CI estimated as 0.838 (95%CI 0.830 – 0.846).

In the test-retest procedure, parents of 108 subjects were asked to repeat the CBQ assessments of their children/adolescents within 7 days of the initial assessment. The concordance coefficient estimate for the CBQ total score was 0.819 (95%CI 0.757 – 0.881). The concordance coefficient for the CBQ core subscale score 0.786 (95%CI 0.714 – 0.858), and the concordance coefficients for the 11 CBQ factors ranged from 0.683 (Factor 7 [anergia/depression]) to 0.831 (Factor 4 [low threshold for arousal]).

After further validation in a larger sample, the CBQ V. 2.0 may provide a useful screening instrument that can be used by pediatricians, and mental health practitioners, as well as by family genetic and offspring studies. We want to assess the ability of this instrument to satisfy three prerequisites for use in such clinical and research settings: (1) identification of core symptom categories related to bipolar disorder (2) use with children and young adolescents, and (3) ability to distinguish between affected and well siblings and control subjects with attention-deficit disorder with hyperactivity.
CHILD BIPOLAR QUESTIONNAIRE - Version 2.0©
http://www.jibrf.org/cbq/index.html

(65 Item Behavioral and Symptom Checklist)
Demitri Papulos, M.D.

Gender of Child   Age (Yrs.)   (Mos.)   Date of Birth   /   /   
Completed by:  Mother   Father   Other   
Address (optional):

Email Address:

Name of person filling out form (optional):

Instructions:

My child has and/or had the following symptoms and/or behaviors. You may have noticed a behavior as far back as early childhood or you may have observed it more recently. In either case, estimate how frequently the behavior has occurred since you first noticed it. Circle a number in the “Frequency” column using the following key, to represent the frequency of occurrence:

<table>
<thead>
<tr>
<th>Never or hardly ever</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very often or almost constantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FREQUENCY</th>
<th>SYMPTOM/BEHAVIOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4</td>
<td>1) displays excessive distress when separated from family</td>
</tr>
<tr>
<td>1 2 3 4</td>
<td>2) exhibits excessive anxiety or worry</td>
</tr>
<tr>
<td>1 2 3 4</td>
<td>3) has difficulty arising in the AM</td>
</tr>
<tr>
<td>1 2 3 4</td>
<td>4) is hyperactive and easily excited in the PM</td>
</tr>
<tr>
<td>1 2 3 4</td>
<td>5) has difficulty settling at night</td>
</tr>
<tr>
<td>1 2 3 4</td>
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<tr>
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<tr>
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<td>feels easily humiliated or shamed</td>
</tr>
<tr>
<td>43)</td>
<td>fidgets with hands or feet</td>
</tr>
<tr>
<td>44)</td>
<td>is intolerant of delays</td>
</tr>
<tr>
<td>45)</td>
<td>relentlessly pursues own needs and is demanding of others</td>
</tr>
<tr>
<td>46)</td>
<td>is willful and refuses to be subordinated by others</td>
</tr>
<tr>
<td>47)</td>
<td>argues with adults</td>
</tr>
<tr>
<td>48)</td>
<td>is bossy towards others</td>
</tr>
<tr>
<td>49)</td>
<td>defies or refuses to comply with rules</td>
</tr>
<tr>
<td>50)</td>
<td>blames others for his/her mistakes</td>
</tr>
<tr>
<td>51)</td>
<td>is easily angered in response to limit setting</td>
</tr>
<tr>
<td>52)</td>
<td>lies to avoid consequences of his/her actions</td>
</tr>
<tr>
<td>53)</td>
<td>has protracted, explosive temper tantrums</td>
</tr>
<tr>
<td>54)</td>
<td>has difficulty maintaining friendships</td>
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<td>61)</td>
<td>is fascinated with gore, blood, or violent imagery</td>
</tr>
<tr>
<td>62)</td>
<td>has acknowledged experiencing auditory and/or visual hallucinations</td>
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<td>hoards or avidly seeks to collect objects or food</td>
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<td>64)</td>
<td>has concern with dirt, germs, or contamination</td>
</tr>
<tr>
<td>65)</td>
<td>is very intuitive and/or very creative</td>
</tr>
</tbody>
</table>
The JEFFREY/JEANNIE Illustrated interview
for 5-12 year old children linked to the Child Bipolar Questionnaire
See http://www.jbrf.org/interview/index.html for full illustrated interview and automated scoring program

1. Jeffrey gets really cranky and angry at other people, even people he likes. How often do you feel like this? (CBQ 32)

2. Jeffrey has bursts of energy when he feels he can do a lot of things all at once without stopping? How often do you feel like this? (CBQ 25)

3. Jeffrey is feeling kind of silly and giddy, and all he can think of is doing funny things that make him laugh. When Jeffrey feels silly like this, he can’t stop laughing even if others tell him to stop. How often do you feel like this? (CBQ 33)

4. Jeffrey thinks that he is smarter and stronger than his friends or feels he is a very special and important person. How often do you feel like this? (CBQ 29)

5. Jeffrey gets so excited and has so many thoughts in his mind that he talks very fast and feels like he can’t stop. How often do you talk really fast and can’t stop? (CBQ 28)

6. Jeffrey does things other people think are scary, like climbing too high, jumping off high places, or running into the street without looking. How often do you do things like that? (CBQ 36)

7. Jeffrey likes to take off his clothes and show off his body to others. How often do you feel like doing this? (CBQ 34, 35)

8. Jeffrey is in the classroom, and is trying to hear what the teacher is saying, but he keeps thinking about other things or having daydreams, and when he tunes back in, he has missed part of the lesson. How often does this happen to you? (CBQ 13)

9. Jeffrey has many thoughts that come into his head all at once, and they come so fast, it feels like a bunch of bees buzzing in his mind. How often do you feel like this? (CBQ 26)

10. Jeffrey is tired, and doesn’t feel like doing much today, even with his friends. He just wants to be left alone. How often do you feel like this? (CBQ 38)

11. Jeffrey didn’t feel like eating at all today. He wasn’t feeling hungry in the morning, in the afternoon, or at night. How often have you not felt like eating for the whole day? (CBQ)

12. Jeffrey feels very bored and for some reason doesn’t have much interest in things he usually likes to do. Nothing seems like it would be fun. How often do you feel like this? (CBQ 37)

13. Jeff gets so bored that he just has to find something to do, even if it means bothering his mother or teasing his brother or sister. He buts in to what they’re doing so that he won’t be so bored. How often do you try to get things going like this when you’re bored? (CBQ 27)
14. Jeffrey can get really hungry, so hungry that he can’t stop himself from eating a humungous amount of sweet or sometimes salty foods at one time. How often do you eat a lot of sweet or salty food like this? (CBQ 10)

15. When Jeffrey feels bad about himself, he feels that his parents don’t love him. How often do you feel like nobody loves you? (CBQ 40)

16. When Jeff feels sad or bored, it feels like it’s hard to move or do very much. How often do you feel like this? (CBQ 38, 39)

17. When Jeff feels sad or bored, his thoughts slow down and he can’t think too well. How often do you feel like this? (CBQ)

18. When Jeff feels sad, he thinks about dying. He thinks about hurting or killing himself. How often do you think about things like that? (CBQ 58, 59, 60)

19. When Jeffrey tries to wake up in the morning, he can feel so tired that his body just doesn’t want to get moving, and when his mother tries to get him up, he just doesn’t want to move. How often do you feel like this in the morning? (CBQ 3)

20. After school, the way Jeffrey feels changes from being bored to cranky to really silly. When this happens, Jeffrey feels like he has a motor inside that’s revving up really fast. How often do you feel like this in the afternoon or at night? (CBQ 4, 31)

21. Jeffrey gets really scared at night when he is alone in his room. He thinks of bad things that could happen, like that someone could come in and get him or hurt his family or that there is a monster under his bed or in the closet. How often do you think about things like that? (CBQ 6, 8)

22. Jeffrey has a really scary dream, and he feels like he’s living in the dream. How often do you feel like this? (CBQ 8)

23. Jeff gets so angry that he can’t stop himself, and he worries that he might hurt someone. How often do you worry about this? (CBQ 55, 58, 59)

24. Jeff feels like other people are going to hurt him. How often do you feel like this? (CBQ 2)

25. Jeff gets really scared when he is apart from his mother and wants to stay really close to her. How often do you feel like this? (CBQ 1)

26. When Jeff walks into class, he feels like everyone is looking at him and he gets nervous. How often do you feel like this? (CBQ 2, 42)

27. Jeff feels like kids are saying mean things about him or making fun of him behind his back. How often do you feel like this? (CBQ 41)

28. Jeffrey thinks that other kids are ganging up on him to make things hard for him. How often do you think things like that? (CBQ)

29. When Jeff’s mom tells him that he can’t go somewhere that he wanted to go to, he can get really angry and upset. How often do you feel like this? (CBQ 46, 51)
30. There are times when Jeff wants something really badly, so much that he feels like he has to have it, no matter what he has to say or do to get it. How often do you feel like this? (CBQ 45)

31. When things don’t go right, and Jeff’s parents say no to something, or when they make him wait, Jeff gets really angry really fast and yells or curses. How often do you get angry and yell like this? (CBQ 44, 46, 51, 53, 57)

32. After Jeff gets angry and blows off steam at someone, he feels really bad inside. How often do you feel like this? (CBQ)

33. There are times when Jeffrey feels his body get really, really hot, and he gets so hot, he feels like taking off his clothes. Sometimes this happens at night and he wakes up sweating. How often do you feel like this? (CBQ 23)

34. Jeff hears a voice talking to him inside his mind. The voice sounds just like someone is speaking, but there’s no one around. How often does this happen to you? (CBQ 62)

35. At night, when he’s lying in bed, Jeff sees things that scare him, like bugs or ghosts or monsters. How often do you see scary things like that? (CBQ 62)

36. Jeff hears people talking about him on TV or on the radio. How often does this happen to you? (CBQ 62)

37. Jeffrey gets upset or angry and maybe a little scared when somebody asks him to stop what he’s doing and start something new. How often do you feel that way? (CBQ 18)

38. It’s very difficult for Jeffrey to get started on things, as if he’s stuck and can’t get going. How often do you feel like that when you have to get moving? (CBQ 18)

39. Jeffrey hates loud noises. They make him feel scared and angry. How often do you feel like that? (CBQ 22)

40. If Jeff’s clothes or shoes don’t fit just right or if they feel funny, he can’t get comfortable when he feels this way. How often do you feel like that? (CBQ 21)
The Core Phenotype

Core Diagnostic Criteria

The instruments in the Core Diagnostic Assessment package, although useful from several diagnostic perspectives, are particularly informed by the criteria for the Core phenotype of juvenile-onset bipolar disorder. The Core Diagnostic Criteria were developed by Dr. Demitri Papalos in response to the need for an alternative to DSM-IV that included not only a categorical definition of mania but also the specific dimensions of impairment clinically observed to be prominent in children with bipolar disorder. The Core phenotype places the DSM-IV manic or mixed episode in a broader framework of specific functional impairments directly related to the regulation of affect, drive, attention, arousal, and circadian rhythm, linked to defined neurobehavioral systems, and reflecting a neurobiological model informed by recent research. (Kalin & Shelton, 2000; Dolan 2002; LeDoux, 2000; Drevets, 1998; Blumberg et al. 2002; Papalos & Papalos, 2000; Xu et al., 2004). The Core phenotype, with its inclusion of aggression, executive function deficits, and anxiety as diagnostic criteria, is an effort to provide a heuristic for pediatric bipolar disorder with both clinical and neurobiological underpinnings that has the additional advantage of lending a more parsimonious approach to diagnosis and treatment: the symptoms of children who are commonly being diagnosed today with three or four disorders are seen as different dimensions of the same condition.

Juvenile-onset Bipolar Disorder: Core Diagnostic Criteria

Must meet Criteria A-D for diagnosis

A. Episodic and abrupt transitions in mood states accompanied by rapid alternations in levels of arousal, emotional excitability, sensory sensitivity, and motor activity. Variable mood states are characterized by the following features: manic/hypomanic (mirthful, silly, goofy giddy, elated, euphoric, overly-optimistic, self-aggrandizing, grandiose); depressed (withdrawn, bored/anhedonic, irritable, sad, dysphoric, or overly pessimistic, self-critical). Episodes are defined by DSM-IV symptom criteria but not by DSM-IV duration criteria; manic/hypomanic or mixed episode required for diagnosis:

1. **Manic or hypomanic episodes** are associated with elated/euphoric (silly-goofy-giddy), or angry/irritable mood states, and 3 of the following symptoms and behaviors (4 if irritable mood only): more talkative than usual, pressured speech; flight of ideas; subjective experience of thoughts racing; distractibility; diminished need for sleep; increase in goal directed activity; heightened interest, enjoyment, and enthusiasm for usual activities; excessive involvement in pleasurable activities that have a high potential for painful consequences; overestimation of resources and capacities; over-valuation of self and others; more argumentative than usual; overbearing, bossy, in pursuit of personal needs or agenda. CBQ (11,12,25,26,28,29,30,36)²

2. **Depressive episodes** are associated with dysphoric/sad/irritable or anxious/fearful mood states with loss of interest and pleasure in previously enjoyed activities often resulting in expressions of boredom and excessive stimulus seeking behaviors; in addition to depressed mood or anhedonia, 4 or more of the following symptoms are present: decreased sense of self-esteem; slowed speech; paucity of thought; increased need for sleep or disrupted sleep; loss or increase in appetite; decrease or loss of energy; difficulty sustaining attention; diminished ability to concentrate or indecisiveness; psychomotor retardation; loss of initiative and motivation; under-estimation of resources and capacities; devaluation of self and others; negative interpretation of events and misattribution of other’s behaviors; recurrent thoughts of death, recurrent suicidal ideation. CBQ (37-42,60)

3. **Mixed episodes** are associated with overlapping features of the primary mood states (manic/hypomanic, angry, depressed, anxious) accompanied by other associated
symptoms of manic/hypomanic and depressive mood states. The presentation may include irritability, agitation, insomnia, appetite dysregulation, poor control over aggressive impulses, in addition to course modifiers such as aggression directed against self or others (e.g. suicidal thinking or attempts, aggressive displays, rages) or psychotic features. Mixed Episodes may be due to the direct effect of exposure to antidepressants, stimulant medication, electroconvulsive or light therapy, or other medical treatments (e.g. corticosteroids, sympathomimetic agents). CBQ (11, 12, 25, 26, 28, 29, 30, 36, 37-42, 60)

B. Poor modulation of drives (aggressive, sexual, appetitive, acquisitive) resulting in behaviors that are excessive for age and/or context. This regulatory disturbance is associated with excessive aggressive/light-based behaviors (critical, sarcastic, demanding, oppositional, overbearing "bossy", easily enraged, prone to violent outbursts), and/or self-directed aggression (headbanging, skin-picking, cutting, suicide), as well as, premature and intense sexual feelings and behaviors (precocious curiosity about sex and premature expression of sexual impulses, as well as inappropriate public displays), appetite dysregulation (excessive craving for carbohydrates and sweets, binge eating, purging, and anorexia), and poor control over acquisitive impulses (relentless pursuit of needs, buying excessively and hoarding). CBQ (10,34,35,46-49,51,53,55-60,63)

Episodic and abrupt transitions in mood states and poor modulation of drive are currently present most days and have been present for at least the past 12 months without any symptom free periods exceeding 2 months in duration, and cause functional impairment in 1 or more settings (e.g., significant behavioral problems at home but not necessarily in the school setting).

C. Four (or more) of the following disturbances have been present during the same 12-month period:

1. Excessive anger and oppositional/aggressive responses to situation that elicit frustration. Compared to his/her peers, the child exhibits difficulties in the postponement of immediate gratification, when parents set limits. In particular, when answered "no" to expressed wishes, when having to wait his/her turn, or when there are changes in planned activities or routines, this deficit results in maladaptive responses, such as seeming not to listen (purposeful), the display of disruptive, intrusive, and overbearing behaviors, or, in the extreme, temper tantrums and aggressive attacks, often followed by sullen withdrawal and expressions of remorse. CBQ (18,27,51)

2. Poor self-esteem regulation. At times is overly-optimistic, defiant arrogant, filled with bravado, and prone to self-aggrandizement, exaggeration of abilities, and has feelings of omnipotence, or, alternatively, is overly- pessimistic, self-critical, and overly sensitive to criticism or rejection, often responding to criticism with intense feelings of humiliation and shame. The child often expresses feelings of insecurity, worthlessness, and is capable of rapid and intense idealization and/or devaluation of self and others. CSQ (29,30,40-42)

3. Sleep/wake cycle disturbances; at least one of the following: 1) Sleep discontinuity (initial insomnia, middle insomnia, early morning awakening, hypersomnia) 2) Sleep arousal disorders (sleep inertia, night-terrors and nightmares - often containing images of gore and mutilation, and themes of pursuit, bodily threat and parental abandonment, sleep-walking, confusional arousals, bruxism and enuresis); 3) Sleep/wake reversals (a tendency toward periodic lengthening or shortening of sleep duration, often dependent on circadian and circannual changes in light/dark and temperature cycles, as well as, the availability of regular social zeitgebers). CBQ (3,5-9)

4. Low threshold for anxiety. A tendency to react with excessive anxiety and fearfulness in response to novel or stressful situations; transitions of context, loss, separation, or the anticipation of loss/separation from attachment objects, or loss of social status. Anxiety often arises from fear of harm to self in the form of anger, rejection, criticism, ostracism, or, alternatively, from the fear that he/she will harm others or self. This deficit can predispose to behavioral inhibition, or flight-based behaviors such as separation anxiety disorder, social phobias, and other anxiety disorders including panic-
disorder, obsessive compulsive disorder and post-traumatic stress syndrome. CBQ (1,2,64)
5. Disturbance in the capacity to habituate to sensory stimuli often when exposed to novel, repetitive or monotonous sensory stimulation. A tendency to over-react to environmental stimuli and to become over-aroused, easily excited, irritated, angry, anxious or fearful when exposed to novel sensory experiences, e.g., crowds, loud or unexpected sounds, (e.g., vacuum cleaners, ticking clocks, thunder and lightning), and dissonant sensations (e.g., shirt tags, fit of clothes or shoes, perceived foul odors). CBQ (21-24)
6. Executive Function Deficits; One or more of the following: Mental Inflexibility - Difficulty shifting cognitive set, planning ahead, planning strategically as seen in unrealistic estimates of energy resources and time requirements for the accomplishment of tasks (e.g. difficulty adjusting to changes in plans for the day such as planned trips and changes in venue), has difficulty giving up an idea or desire, no matter how unrealistic or unfeasible, has difficulty starting and completing school assignments without a great deal of prompting, often gets caught up on small details of an assignment and misses the larger picture. This executive dysfunction is often associated with working memory deficits, problems making transitions from one context to another, poor organizational skills, distractibility, excessive daydreaming, and performance deficits in school, particularly in the organization of thought for written expression. CBQ (17-20)
Emotional Inflexibility - Impulsive, acts before thinking. Over-reacts to small events, rapidly shifts emotional state, can demonstrate sudden anger, resentment, and/or rage for greater than 15 minutes that is unresponsive to reason, discussion, or soothing, can become progressively unrestrained or silly, and does not appear to gain pleasure from mastering a skill. CBQ (1,24,27,31,36,53)
Inflexibility of Motor Activity - The initiation of movement directed at the accomplishment of motor tasks is effortful (e.g., has difficulty starting activities in the morning, and requires help in initiating any activity), is often restless and fidgety. Handwriting is poor, and has trouble initiating and completing written assignments. CBQ (3,16,39,43)
7. A family history of recurrent mood disorder and/or alcoholism, as well as other bipolar spectrum disorders. A history of blitehal familial transmission is commonly observed.

D. Symptoms are not due to a general medical condition (e.g. hypothyroidism).

*CBQ refers to the Child Bipolar Questionnaire -- a 65-item screening inventory keyed to the Research Diagnostic Criteria.
Criteria A-D are required for diagnosis.

A. Episodic and abrupt transitions in mood states often accompanied by rapid alternations in levels of arousal, emotional excitability, sensory sensitivity, and motor activity.

☐ Episodic and abrupt transitions in mood states

Episodes are defined by DSM-IV symptom criteria but not by DSM-IV duration criteria. Check all that apply; at least one type must be selected:

1. Manic or Hypomanic Episodes
   ☐ 1. Inflated self-esteem or grandiosity
   ☐ 2. Decreased need for sleep
   ☐ 3. More talkative than usual or pressure to keep talking
   ☐ 4. Flight of ideas or subjective experience that thoughts are racing
   ☐ 5. Distractibility
   ☐ 6. Increase in goal-directed activity or psychomotor agitation.
   ☐ 7. Excessive involvement in pleasurable activities that have a high potential for painful consequences

2. A Depressive Episode
   ☐ 1. Depressed mood most of the day, nearly every day. Note: in children and adolescents, can be irritable mood.
   ☐ 2. Markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day
   ☐ 3. Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains
   ☐ 4. Insomnia or hypersomnia nearly every day
   ☐ 5. Psychomotor agitation or retardation nearly every day
   ☐ 6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day diminished ability to think or concentrate, or indecisiveness, nearly every day
   ☐ 7. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, a suicide attempt or a specific plan for committing suicide

☐ 3. A Mixed Episode

☐ B. Poor modulation of 1 or more drives (aggressive, sexual, appetitive, acquisitive)

Episodic and abrupt transitions in mood states and poor modulation of drive are currently present most days and have been present for at least the past 12 months without any symptom free periods exceeding 2 months in duration, and cause functional impairment in 1 or more settings (e.g., significant behavioral problems at home but not necessarily in the school setting).

C. Four (or more) of the following disturbances have been present during the same 12 month period.

☐ (1) Excessive anger and oppositional and aggressive responses to situation that elicit frustration.

☐ (2) Poor self-esteem regulation
(3) Sleep/wake cycle disturbances; at least one of the following:
   □ a. sleep discontinuity
   □ b. sleep arousal disorders
   □ c. sleep/wake reversals

(4) Low threshold for anxiety

(5) Disturbance in the capacity to habituate when exposed to novel, repetitive or monotonous sensory stimuli.

(6) Executive function deficits; at least one of the following:
   □ a. Mental inflexibility
   □ b. Emotional inflexibility
   □ c. Inflexibility of motor activity

(7) Family history

□ D. Symptoms are not due to a general medical condition.

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Child Bipolar Questionnaire-Dimensions of the Core Phenotype*

Subscale 1 – Mania (5 items required)

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
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<tbody>
<tr>
<td>24)</td>
<td>is easily excitable</td>
</tr>
<tr>
<td>25)</td>
<td>has periods of high, frenetic energy and motor activation</td>
</tr>
<tr>
<td>26)</td>
<td>has many ideas at once</td>
</tr>
<tr>
<td>27)</td>
<td>interrupts or intrudes on others</td>
</tr>
<tr>
<td>28)</td>
<td>has periods of excessive and rapid speech</td>
</tr>
<tr>
<td>31)</td>
<td>displays abrupt, rapid mood swings</td>
</tr>
<tr>
<td>32)</td>
<td>has irritable mood states</td>
</tr>
<tr>
<td>33)</td>
<td>has elated or silly, goofy, giddy mood states</td>
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</tbody>
</table>

Subscale 2 – Depression (4 items required)

<table>
<thead>
<tr>
<th>Item</th>
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</tr>
</thead>
<tbody>
<tr>
<td>37)</td>
<td>complains of being bored</td>
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<tr>
<td>38)</td>
<td>has periods of low energy and/or withdraws or isolates self</td>
</tr>
<tr>
<td>39)</td>
<td>has decreased initiative</td>
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<td>40)</td>
<td>experiences periods of self doubt and poor self-esteem</td>
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<td>42) feels easily humiliated or shamed</td>
<td></td>
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<tr>
<td>60) has made clear threats of suicide</td>
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**Subscale 3 - Poor Regulation of Aggressive Impulses (5 items)**

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<tr>
<td>53) has protracted, explosive temper tantrums</td>
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<tr>
<td>55) displays aggressive behavior towards others</td>
<td></td>
</tr>
<tr>
<td>56) has destroyed property intentionally</td>
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<tr>
<td>57) curses viciously, uses foul language in anger</td>
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</tr>
<tr>
<td>58) makes moderate threats to others or self</td>
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<tr>
<td>59) makes clear threats of violence to others or self</td>
<td></td>
</tr>
<tr>
<td>60) has made clear threats of suicide</td>
<td></td>
</tr>
<tr>
<td>61) is fascinated with gore, blood, or violent imagery</td>
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**Subscale 4 - Poor Regulation of Sexual Impulses (2 items required)**

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<tbody>
<tr>
<td>29) has exaggerated ideas about self or abilities</td>
<td></td>
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<tr>
<td>30) tells tall tales; embellishes or exaggerates</td>
<td></td>
</tr>
<tr>
<td>34) displays precocious sexual curiosity</td>
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<tr>
<td>35) exhibits inappropriate sexual behaviors, e.g. openly touches self or others' private parts</td>
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**Subscale 5 - Sleep/Wake Cycle Disturbances (3 items required)**

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<tbody>
<tr>
<td>3) has difficulty arising in the AM</td>
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<tr>
<td>4) is hyperactive and easily excited in the PM</td>
<td></td>
</tr>
<tr>
<td>5) has difficulty settling at night</td>
<td></td>
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<tr>
<td>6) has difficulty getting to sleep</td>
<td></td>
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<tr>
<td>7) sleeps fitfully and/or awakens in the middle of the night</td>
<td></td>
</tr>
<tr>
<td>8) has night terrors and/or nightmares</td>
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</table>
**Subscale 6 - Low Threshold for Arousal (3 items required)**

<table>
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<tbody>
<tr>
<td>21.</td>
<td>is extremely sensitive to textures of clothes, labels, and tightness of fit of socks or shoes</td>
</tr>
<tr>
<td>22.</td>
<td>exhibits extreme sensitivity to sound and noise</td>
</tr>
<tr>
<td>23.</td>
<td>complains of body temperature extremes or feeling hot despite neutral ambient temperature</td>
</tr>
<tr>
<td>2.</td>
<td>exhibits excessive anxiety or worry</td>
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<tr>
<td>64.</td>
<td>has concern with dirt, germs, or contamination</td>
</tr>
<tr>
<td>8.</td>
<td>has night terrors and/or nightmares</td>
</tr>
</tbody>
</table>

**Subscale 7 – Anergia (3 items required)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>has difficulty arising in the AM</td>
</tr>
<tr>
<td>38.</td>
<td>has periods of low energy and/or withdraws or isolates self</td>
</tr>
<tr>
<td>39.</td>
<td>has decreased initiative</td>
</tr>
<tr>
<td>37.</td>
<td>complains of being bored</td>
</tr>
<tr>
<td>14.</td>
<td>attempts to avoid homework assignments</td>
</tr>
</tbody>
</table>

**Subscale 8 - Poor Frustration Tolerance (6 items required)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44.</td>
<td>is intolerant of delays</td>
</tr>
<tr>
<td>45.</td>
<td>relentlessly pursues own needs and is demanding of others</td>
</tr>
<tr>
<td>46.</td>
<td>is willful and refuses to be subordinated by others</td>
</tr>
<tr>
<td>47.</td>
<td>argues with adults</td>
</tr>
<tr>
<td>48.</td>
<td>is bossy towards others</td>
</tr>
<tr>
<td>49.</td>
<td>defies or refuses to comply with rules</td>
</tr>
<tr>
<td>50.</td>
<td>blames others for his/her mistakes</td>
</tr>
<tr>
<td>51.</td>
<td>is easily angered in response to limit setting</td>
</tr>
<tr>
<td>52.</td>
<td>lies to avoid consequences of his/her actions</td>
</tr>
<tr>
<td>53.</td>
<td>has protracted, explosive temper tantrums</td>
</tr>
</tbody>
</table>

**Subscale 9 – Attention Deficits/Executive Functions (6 items)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>is easily distracted by extraneous stimuli</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>12)</td>
<td>is easily distracted during repetitive chores &amp; lessons</td>
</tr>
<tr>
<td>13)</td>
<td>demonstrates inability to concentrate at school</td>
</tr>
<tr>
<td>14)</td>
<td>attempts to avoid homework assignments</td>
</tr>
<tr>
<td>15)</td>
<td>able to focus intently on subjects of interest and yet at times is easily distractible</td>
</tr>
<tr>
<td>16)</td>
<td>has poor handwriting</td>
</tr>
<tr>
<td>17)</td>
<td>has difficulty organizing tasks</td>
</tr>
<tr>
<td>18)</td>
<td>has difficulty making transitions</td>
</tr>
<tr>
<td>19)</td>
<td>has difficulty estimating time</td>
</tr>
<tr>
<td>20)</td>
<td>has auditory processing or short-term memory deficit</td>
</tr>
</tbody>
</table>

**Subscale 10 - Fear of Harm to Self and Others***

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear might harm self</td>
</tr>
<tr>
<td>Fear might harm others</td>
</tr>
<tr>
<td>Fear harm might come to self</td>
</tr>
<tr>
<td>Fear harm will come to others</td>
</tr>
<tr>
<td>Fear will act on unwanted impulses (e.g., to stab a family member)</td>
</tr>
<tr>
<td>62) Has acknowledged experiencing auditory and/or visual hallucinations</td>
</tr>
<tr>
<td>59) makes clear threats of violence to others or self</td>
</tr>
<tr>
<td>60) has made clear threats of suicide</td>
</tr>
<tr>
<td>61) is fascinated with gore, blood, or violent imagery</td>
</tr>
</tbody>
</table>

*An additional factor emerged from a separate analysis of the data from the Yale Brown Obsessive-compulsive and the Overt Aggression scales. This factor described as Fear of Harm to Self and Others requires 2 or more of the italicized items from the YBOCS as well as 2 of the numbered items from the CBQ.

These dimensions of symptoms and behaviors are based on clinical observation of primary symptoms of the Core phenotype (Papolos et al, 2002) and are supported by factor analysis on a large sample of children (N=2795) whose parents reported on symptoms of bipolar disorder.

The algorithm for scoring of CBQ items to diagnose the Core Phenotype is as follows:

**Required for Diagnosis of Core Phenotype**

Subscale 1 and Subscale 3 or 4 plus 4 of 6 additional Subscales: 2, 5, 6, 7, 8, 9, 10.
References

For Publications and Poster Presentations that pertain to this assessment program please visit http://www.jbrf.org/jbrf_library/presentations.html

For the online versions of:

The Jeannie and Jeffrey Illustrated Interview
http://www.jbrf.org/interview/index.html

Automated scoring programs for both assessment instruments are available at the JBRF website and can be found by using the above links.

For further information about purchasing print versions contact Melissa@jbrf.org