25 For Clinicians: A Guide to the Clinical Interview of Patients with Mood Disorders

Essential Concepts

- Here is Ghaemi's rule: *Psychopharmacology is first and foremost diagnosis; after diagnosis, treatment follows.* Thus the clinical interview revolves around getting data to make a diagnosis and then discussing the rationale for treatment based on the diagnosis.
- Always seek to obtain history from family members or friends. Do not rely on the patient's self-report. Other clinicians are also often a biased source of information.
- Once depression is identified, shift the interview to obtaining history on the *course* of illness.
- Spend as much time as possible on examining possible past mania or hypomania.
- Assess secondary causes, but do not overinterpret psychosocial factors as being causative.
- After the mania aspect of the interview, the next largest amount of time should be spent on detailed treatment history, especially concomitant medication use and duration of treatment trials.
- Tell the patient the diagnosis, why it is made, and why others are not made.
- Once the diagnosis is made, the treatment recommendations should follow simply.

It is my experience that the clinical process of assessing depression and mania is not sufficiently appreciated by many clinicians. In this chapter I will walk readers through how I

TABLE 25.1. Seven Steps in the Diagnostic Interview of Patients with Mood Disorders

1. Identify a current major depressive episode (5 minutes).
2. Assess the course of depressive illness (5 minutes).
3. Spend the bulk of the interview assessing past mania or hypomania (10–15 minutes).
4. Examine causes of secondary depression (5 minutes).
5. Obtain past treatment history (5–15 minutes).
6. Discuss the rationale for the diagnosis (5 minutes).
7. Discuss treatment options (5–10 minutes).

Note: Suggested times will vary based on complexity of a patient's history. In a newly diagnosed patient, no time is needed for past treatment history, and more time can be spent on course of illness, secondary triggers, and discussion of diagnostic rationale. In a patient with extensive past treatment, the other sections might be somewhat briefer to allow for more extensive examination of past treatment history.

approach the clinical interview in patients with mood disorders. Table 25.1 summarizes the steps I take in the clinical interview. Please refer to Appendix B for a complete clinical evaluation form I use in my practice.

BEFORE THE INTERVIEW: ASK FOR FAMILY AND FRIENDS TO BE PRESENT

Usually, when I go to the waiting room to find my patient, someone else is there, a family member or a friend. About half the time, that other person remains seated. Most psychiatrists do not invite that person to join the interview. I always do. Not only that, I inform my patients before their first interview that they should seek to bring a family member or friend along with them. This is for two reasons: First, family members and friends can corroborate the history or, in the case of mania, actually provide accurate history, whereas patients, owing to lack of insight, often invalidly deny the presence of manic episodes in their personal history. Second, when discussing treatment options, the presence of others in the office improves the likelihood that the treatment plan will be understood and implemented; frequently, patients are depressed and cannot clearly understand the complex treatment options being described—family members can hear and repeat what was said later to the patient. Further, if family members are not present, the patient will later have to explain what I said to them; it is

better for the family to hear what I have to say directly from me rather than secondhand.

If there are concerns about certain confidential topics (which usually do not have a direct impact on the diagnostic interview anyway), family can be asked to leave the room for a few minutes in the middle of the interview and then be invited to return toward the end, where I provide my diagnostic impressions and treatment recommendations.

TIP

Avoid interviewing patients alone. Ask for a family member or a friend to be present at the first diagnostic interview.

BEGIN BY ASKING ABOUT DEPRESSION

Usually, the presenting complaint is depression. As the psychotherapeutic saying goes, it is best to meet patients where they are, so I usually start with the noncontroversial and straightforward determination of the presence of clinical depression.

At one level, one simply identifies major depression to get beyond it. In other words, it often is relatively easy to know that a patient has a current major depression—it may take only 5 minutes to quickly review current neurovegetative symptoms—but this is not the end of the evaluation, only the beginning. This is so because, as discussed in Chapter 1, depression is not a diagnosis but only a constellation of signs and symptoms. Diagnoses are bipolar depression, or secondary depression, or unipolar depression—with unipolar depression signifying that the bipolar and secondary diagnoses have been ruled out. Thus, as soon as a major depressive episode is identified, especially currently, the clinician should stop talking about depression and shift the focus to identifying past mania or hypomania and assessing possible secondary causes (mainly medical).

It is irrelevant, for instance, to spend much time assessing how depressed the patient is, whether he or she is hopeless or helpless, whether his or her symptoms are atypical or typical, and so on. All these features are important perhaps prognostically and therapeutically, but they are unimportant diagnostically. They do not differentially diagnose bipolar as opposed to secondary or unipolar depression.

KEY POINT

After you have identified a current major depression, change the subject to the depressive course of illness or past mania. Detailed evaluation of current major depressive symptoms is not diagnostically valuable.

Obviously, an assessment of concurrent psychotic symptoms can be diagnostically and therapeutically relevant, and an evaluation of suicidality is clinically necessary; but soon after identifying depression, the clinician should shift the focus to the more onerous task of looking for past mania or hypomania and the course of illness.

QUICKLY MOVE TO ASSESSING THE COURSE OF DEPRESSIVE ILLNESS

I emphasize something that is rarely done: *Evaluate the course of the depressive illness.* The reader will recall that the course of depression, unlike the details of current depressive symptoms, *can* differentiate between bipolar and unipolar conditions, as well as help to identify secondary depression. Too often clinicians simply say, "The patient has depression," as if this is enough to make a diagnosis. They have no idea when the depressive episodes began, how many there have been, how long they have lasted, precipitating factors, interepisode symptoms, and so on.

So here is what is diagnostically important: *age of onset, number of episodes, duration of major depressive episodes, and interepisode status.* Ask patients how far back they can remember depression for the first time, refreshing their memory as to the definition of a major depressive episode (daily depressed mood or anhedonia with multiple neurovegetative symptoms, day in and day out, most of the day, nearly every day, for weeks on end, or more).

Then ask how long their depressive episodes have lasted in the past. Here patients usually throw up their hands and claim ignorance. I usually say, "I could make it up, but your guess is better than mine." Patients need to know that this is important; force them to think about it. Usually they can give an average duration; it need not be precise—if they are especially exasperated, give them options: more than a month, less than

a month, about 6 months, over a year. These are the time frames that are diagnostically relevant because unipolar depression lasts 6 months to a year or longer, whereas bipolar depression is shorter, usually 3 to 6 months or less. Also, ideally assess the durations in untreated periods to understand the natural unmedicated history, if a patient has been nonresponsive to medications, then treated periods also reflect the natural history of the illness.

Then ask how many episodes the patient has had: "How many times in your life have you felt very depressed like that?" Usually, if currently depressed, patients overestimate their past depression: "Forever" is the common desperate answer. "Really?" I reply, "All your life, every day, day in and day out, without every having one day of being different, forever?" Usually they back off at that point. "So how many times?" "I don't know, you know, doc." Again one can offer multiple-choice answers: "Just once? A few times? More than 5 times? More than 10 or 20 times?" Sometimes it is obvious in the history that the patient has had many episodes, more than 10 or 20; in this case, the exact number matters little. What does matter diagnostically is that if a patient has one or two or three episodes, this is common in unipolar depression and uncommon in bipolar disorder. Many episodes are more common in bipolar illness, especially if they are brief (less than 3 months in duration).

Finally, once you have identified the ballpark number of episodes, determine if there are periods of wellness between episodes. This is usually not difficult; either patients will claim that they are always depressed, which may reflect interepisode dysthymia or subclinical depression, or they have periods of euthymia, which they or their family can clearly describe: "Were there ever times when you were not depressed and were your normal self or normal like everyone else in your mood energy for weeks or months on end or longer?". If such periods are present, then past mania can be more easily assessed compared to that enthymic baseline.

SPEND THE BULK OF THE INTERVIEW ASSESSING PAST MANIA OR HYPOMANIA

In the typical interview, it might have taken 5 minutes to establish that the patient has a current major depressive episode. Another 5 to 10 minutes should establish the depressive course of illness. Next, one should take as much time as needed (up to 15 minutes or more) to examine the ins and outs of possible past mania or hypomania. Unfortunately, this part of the interview, the most important clinical aspect diagnostically and therapeutically, is often conducted with only a single question or hurriedly. The clinician should take his or her time and come at the question slowly and in a roundabout fashion so as to avoid patients' natural defensiveness about the stigma of bipolar disorder.

I usually begin with an open-ended question, especially if I have established a period of normal or euthymic mood in the past in the assessment of the course of depressive illness: "Did you ever feel the opposite of depressed, where you were not sad and down and depressed, but you also weren't just your normal self?" With equivocal responses, I might get more specific: "Did you ever have times where you were more energetic than normal compared with when you were not depressed or more energetic than most people around you, so that you were doing lots of things or not sleeping much and not feeling tired?" Or perhaps: "Did you ever have periods where you were angry and irritable but not depressed and full of energy, doing lots of things?"

If a somewhat positive response is elicited, or if the patient comes to the appointment with possible past mania as a clinical question, I ask an open-ended question of the patient so as not to direct the patient toward manic criteria but seeking to get his or her own words about it: "Tell me about how you felt and how you behaved, or what people told you about how you were, during that time (when you felt hyper or more energetic than usual or when you or your doctor or others said you might be manic or hypomanic)?"

Then, importantly, *I write down what the patient says verbatim*. It is very important to do this. Bipolar disorder is such a controversial topic, with patients getting different opinions from different doctors, that it is important to avoid miscommunication by letting the patients speak for themselves. Consider if I write: "The patient had elevated mood, with decreased need for sleeping, flight of ideas, distractibility, and increased goal-directed activity for 5 days." The patient may disagree and go to another clinician, who is skeptical about the bipolar diagnosis, and that clinician simply may disbelieve my interpretation of what the patient had said. But no one could deny mania if I write: "The patient stated that he would feel 'hyped up and like I could do anything; I was a tyrant, felt I was smarter than everyone else, like there was nothing I couldn't do; I didn't need to sleep for days on end, yet I was full of energy; I was giddy at times; my thoughts

were all over the place; I couldn't keep up with them; I would wake up in the middle of the night and clean the house five times over; then the next day I would paint the house inside and outside, even though it was perfectly fine; and a week later I would do it again with a different paint color.'"

TIP

Write down the patient's description of manic symptoms verbatim. Let patients speak for themselves. Since clinicians tend to disbelieve each other's descriptions of mania, avoid translating patients' descriptions into clinical lingo.

Once a manic or hypomanic episode is identified, the diagnostic process is over: The diagnosis of bipolar disorder has been made. If mania or hypomania cannot be identified, the interview is still not over; then the absence of mania/hypomania needs to be confirmed by third parties. This is done most efficiently if family or friends are present at the interview; if they are not present, the clinician should call, or ask the family to call, to quickly review mania criteria over the phone. Sometimes I make this phone call during the patient interview, sometimes later.

EXAMINE CAUSES OF SECONDARY DEPRESSION

These causes are most often medical, although they also can be psychosocial. It is important to distinguish between a trigger and a cause. A *trigger* is the final event that leads to the episode, but it is not the sole or even the main *cause* of the episode. This is similar to what Aristotle called the *efficient cause*. Sometimes there is a certain trigger, sometimes another trigger, and sometimes no trigger. Don't focus on triggers. Although they may be somewhat relevant later, especially in psychotherapy, they are diagnostically irrelevant.

Unfortunately, most patients, and many clinicians, focus on the most recent psychosocial triggers as if they were absolute causes of episodes. This is a big mistake. The best way to think about this problem, in my opinion, is to recognize that the brain is a rationalizing machine. The classic split brain experiments in epilepsy show us how: In patients with intractable seizures requiring corpus callectomy (severing the

two hemispheres of the brain from each other), one creates a circumstance where the right hemisphere might note something and yet not be able to transfer that information to the left hemisphere, where verbal control is located. Since the left visual field is transmitted to the right hemisphere, researchers can place the right visual field behind a blindfold and show pictures in the left visual field, such as violent and anxiety-provoking images. The right hemisphere sees these pictures, and the patient feels scared and nervous. When asked why, the patient says: "Well, my neighbor had a car accident last week, and I was thinking about that" or "I was thinking about the recent war in the Middle East." In other words, the patient cannot verbalize why he or she suddenly feels anxious or scared, yet he or she comes up with an explanation, any explanation, as long as it is plausible, *even though it is wrong.* We do this all the time, so when patients say that there are depressed because of *x*, *y*, and *z* happening in their lives, they may be right, or they may be wrong. We cannot take those explanations as true at face value.

TIP

The brain is a rationalizing machine. As the clinician, do not accept at face value the patient's explanation for mood episodes, nor should you as a clinician simply ascribe mood episodes in a common-sense manner to apparent psychosocial factors.

True psychosocial causation, secondary depression owing to a psychosocial cause, should be relatively obvious and should be placed in the context of a nonrecurrent course of illness: The patient may have one episode after a horrible psychosocial trauma or maybe two episodes after two horrible psychosocial traumas, but most people, fortunately, do not have many isolated psychosocial traumas (or if they are the victim of recurrent abuse, they usually experience prominent posttraumatic symptoms rather than simply major depressive episodes alternating with euthymia). If recurrent major depressive episodes occur, the psychosocial factors should be seen as triggers, not causes.

The same is the case with medical factors. One might have no past depression, then have a stroke, and then experience a major depressive episode. This is poststroke depression. Most individuals do not experience repeated strokes (since

most persons get treated) followed by depressive episodes after every stroke. On the other hand, mild hypothyroidism may be a factor in contributing to recurrent depressive episodes.

KEY POINT

Unless a secondary factor is a clear and indisputable cause, preferably of a single, isolated episode with no recurrent course, view secondary factors as contributors but not as causes. In general, focus on the description of the syndrome rather than an explanation of causes. Be humble about etiology: We know far less than we think.

The role of substance abuse should be seen in this way too. If I've never had mania, take cocaine for the first time in my life, and then have a manic episode, one can call that condition cocaine-induced mania. However, if I have experienced many manic episodes and many periods of cocaine use, it would seem difficult to demonstrate a one-to-one correlation so as to justify the diagnosis of mood disorder secondary to cocaine use. Often the situation is the reverse: Cocaine use frequently occurs in those settings as the result, rather than the cause, of manic episodes.

OBTAIN PAST TREATMENT HISTORY

This step is often conducted quite superficially: "The patient has taken venlaxine, sertraline, fluoxetine, paroxetine, lithium, and olanzapine." This description tells me nothing. It is important to get some detail with each medication taken. I ask patients to provide this history in written form and bring that information to the interview; otherwise, much interview time can be lost in fleshing out the medication history. Even when an initial written version is provided, it is important to confirm and extend the written history provided by the patient because usually such history is only partially complete.

As shown in Table 25.2, the relevant factors needed are not only the names of the medications but also the durations of treatment, doses if available, and concomitant medications used. For each medication, one should assess efficacy and side effects and the reason for discontinuation.

TABLE 25.2. Medication History Chart

Past Medication Trials

Name	*Duration (Weeks)*	*Main Dose (mg/day)*	*Benefit*	*Side Effects*	*Reason Stopped*	*Other Agents in Same Trial*

Clinicians may be rolling their eyes, knowing that most patients cannot provide this information, especially in complex cases with decades of prior treatment. Yet again, my view is that any history is better than no history, and I feel that most of the fault lies with clinicians who do not take the time to bother eliciting this history rather than with patients who, understandably, will not recall many details.

I find that patients who claim that they cannot remember details are often overconcerned with being exact. For instance, when I ask how long they took a certain drug, they become exasperated because they cannot remember if it was 2 months or 3.5 months or 4.25 months. Since they can't be precise, they will just say they don't remember. I then give them multiple-choice options: "Was it less than 1 month, more than 1 month, more than 1 year, more than 10 years?" Obviously, this forces them to say something, and we can get some valuable data, such as the idea that they took the drug somewhere between 1 and 6 months.

TIP

Detailed treatment history can be obtained from almost all patients. Use the multiple-choice method to get the relevant level of detail.

Hence, if, as is commonly the case, the patient is a vague historian on these details, I direct the history as a multiple-choice test: Dosing is the least important fact, especially with modern antidepressants, because most of them can be dosed easily to a therapeutic amount. Duration is much more important because no trial is therapeutic if it has lasted less than 1 month. I ask about more than 1 month or less than 1 month duration; if less, the trial was automatically not therapeutic, and usually it was stopped owing to side effects, about which I then inquire. If more than 1 month, I then get a sense if it was more than 6 months, more than 1 year, or longer still. However long it was used, I always ask about whether other medications were taken with it. Often patients can say that other medications were taken, but they do not remember which ones. It is just as important to know that they did *not* have monotherapy trials, especially with mood stabilizers in bipolar disorder, as it is to know the details of the other medications they received. I then ask whether they thought the medication trial was effective or not and whether they had side effects. People usually remember side effects more clearly than efficacy, although sometimes they can be clear when a drug was either definitely not effective or definitely extremely effective. It is still very useful clinically to see if one can elicit either extreme response, marked efficacy or marked inefficacy, or the absence of ever having such clear good or bad effects. Sometimes, if a patient has taken many drugs from the same class (such as ten different antidepressants), I will simplify the efficacy assessment by asking, "Was there any one of these that worked very well for you, that stands out as especially effective?" Also, if efficacy is reported, one should ask about whether the drug maintained its benefits if used long term (to assess tolerance or "poop out").

The assessment of concomitant medication use is especially important when assessing bipolar disorder or treatment-refractory depression (TRD). In the case of bipolar disorder, the relevant issue often is constant and chronic antidepressant use concomitantly with multiple failed mood stabilizer trials. The importance of the mood-destabilizing effect of the concomitant antidepressant in accounting for failure of mood stabilizers is discussed in Chapter 19. In the case of TRD, it is important to know if antidepressants are used together or singly or with other adjuncts so as to determine the extent of adequate combination therapy, especially since the Sequenced Treatment Alternatives to Relieve Depression (STAR-D) study identified somewhat more efficacy with combination therapy as opposed to switching antidepressants in TRD (see Chapter 12).

KEY POINT

The most important part of the treatment history, often ignored, is *concomitant medications.*

DISCUSS THE RATIONALE FOR THE DIAGNOSIS

Here I enact Osler's rule (see Chapter 5): *We treat diseases, not symptoms.* Thus the diagnosis, above all, is the most important fact that needs to emerge from the interview. If there is no diagnosis or a highly uncertain state in which no diagnosis can be made, then no treatment should be given (at least with medications, in most cases). If the diagnosis is made, the treatment options then follow clearly.

Many times clinicians jump at this point to discussion of treatment recommendations, skipping diagnosis altogether or addressing it only briefly. I am not sure why this is the case. Sometimes it probably has to do with time constraints; sometimes I think clinicians do not value diagnosis as important and rationalize their approach as simply treating symptoms anyway. The latter view goes against Osler's rule and a Hippocratic approach to psychopharmacology, however (see Chapter 5).

Hence, at this point in the interview, one should stop, ask the patient if there is anything else the clinician should know or has overlooked that is important, and then the rest of the time should be spent discussing the working diagnosis and then treatment recommendations. Since treatment relies completely on the diagnosis, at least in the Hippocratic approach, then a great deal of effort and time should be put into identifying the diagnosis, explaining the rationale for the working diagnosis chosen, reviewing the differential diagnosis, and explaining why other conditions are less likely and soliciting the patient's reactions and responses and input.

I am surprised at how frequently patients tell me that they received medications (often antidepressants) for lengthy periods of time (often years) without ever formally being told: "You have diagnosis X, and you do not have diagnoses Y and Z, and these are the reasons why."

It is important, respectful, and humane to state the diagnosis explicitly to the patient before discussing treatments in any way and further to elicit a two-way dialogue about the patient's feelings about the diagnosis.

KEY POINT

Make a diagnosis and be explicit about it, soliciting the patient's feedback and reaction. It is disrespectful of patients to avoid clear discussions of the working diagnosis and the rationale for it as opposed to other conditions.

The clinician should keep in mind, and the patient should be told, that working diagnoses are just that—working—so they are liable to change. In psychiatry, the course of the illness is the final arbiter of diagnosis: "Time will tell whether this diagnosis is right, or whether another one turns out to be the case," I tell my patients. Time will tell; both clinicians and patients need to be open-minded and revisit the diagnosis over time. A major mistake, often seen in public mental health settings, is that a diagnosis (often schizophrenia or "depression") is parroted over years, often from clinician to clinician, without ever being re-evaluated, even though the course of illness often clearly proves it wrong.

DISCUSS TREATMENT OPTIONS

Here I enact Holmes' rule (see Chapter 5): *All drugs are guilty until proven innocent.* Thus our presumption will be to avoid using medications and to look for evidence *to use them* rather than evidence *not to use them.* This means looking at evidence of efficacy *before* thinking about side effects.

This is the practical conclusion of the interview. The process at this point should be easy, if all the previous steps were taken with care. This is so because *the hardest part of psychopharmacology practice, in my view, is establishing the diagnosis; once the diagnosis is established, treatment choices should be simple.*

KEY POINT

Here is Ghaemi's rule: *Psychopharmacology is first and foremost, diagnosis; after diagnosis treatment follows.* In other words, the key to successful psychopharmacology practice is to get the diagnosis right. This is the hard part of psychopharmacology; treatment decisions are easy once the diagnosis is correct.

Here, after restating the diagnosis, the clinician should be able to turn to the scientific evidence base to offer treatment options. Invoking Holmes' rule, we first turn to evidence of efficacy to limit our universe of options. The patient is not allowed to choose from all the psychotropic drugs that exist, but only from the ones proven effective for his or her diagnosis. Thus, if the diagnosis is bipolar disorder type I, the options given are the four proven mood stabilizers (see Chapter 7); if the diagnosis is recurrent unipolar major depressive disorder, the options given are proven standard antidepressants. Within those proven treatments, the patient and clinician then can discuss side-effect risks and patient preferences.

It is key, though, to minimize polypharmacy and to maximize efficacy (i.e., to practice Hippocratic psychopharmacology), to always begin by limiting the initial medication options based on efficacy data and only then turn to side-effect concerns. If the approach is the reverse, as patients and many clinicians often do it, then patients end up on many inefficacious (although purportedly safer) drugs (i.e., gabapentin syndrome). As a result, the illness will continue to wreak havoc.

KEY POINT

Treatment decisions begin with efficacy, not safety.

HIPPOCRATIC PSYCHOPHARMACOLOGY

Putting it all together, the clinical interview aims primarily at getting the diagnosis right, which allows the implementation of Osler's rule—to identify a disease that can be treated. It then requires a conservative and efficacy-oriented approach to treatment, implementing Holmes' rule, which, with a correct diagnosis, leads the clinician toward that ultimate Hippocratic goal: *To cure sometimes, to heal often, and to console always.*