

The NIMH Life Chart Manual™ for Recurrent Affective Illness:

The LCM™

**Clinician Retrospective
(LCM-C/R)**

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PRINCIPLES OF CONSTRUCTING A RETROSPECTIVE LIFE CHART

Formal life charting is an effective and valuable tool for the longitudinal retrospective and prospective assessment of affective disorders. The process of retrospective life-charting can progress in several stages, at the onset providing clinician and patient with a first visual overview of a patient's prior course of illness while also potentially signaling the beginning of a joint endeavor to construct a very detailed retrospective life chart incorporating data collected from many different sources.

A brief "rough" life chart represents a useful entity in itself and can uncover several important aspects of a patient's course of illness. Since the life chart essentially incorporates all aspects of the patient's previous psychiatric history, it should from the very beginning form an integral part of the current assessment.

Start by sketching a rough outline of the major prior episodes, hospitalizations, and medications during your first contact with the patient. Even a two-minute telephone interview or brief consultation can produce important graphable life chart data. Continue to life chart during your first meeting with the patient by expanding on the first draft (or, if this is your first contact with the patient, to begin the process of life charting); this graphic illustration of the development of the patient's past course of illness can provide both clinician and patient with a critical advantage when assessing past treatment responses and mapping out current and future interventions. Proceed to generate a more detailed life chart in subsequent sessions with the patient as more records are being collected. It is useful to conceptualize life-charting as an open-ended process; additional retrospective information is continuously added and integrated into the already existing chart while the collection and graphing of prospective data can simultaneously be instituted using life charting criteria as described in the prospective life chart manuals for the patient (LCM-S/P) and the clinician (LCM-C/P).

Guidelines

The following guidelines and principles of life charting apply more fully to the construction of a detailed life chart but are also relevant for a briefer version.

When you are using the life-charting process as part of the initial history taking, you may have to take the patient's mood state into consideration when gathering the information if the patient is in an illness episode. While a depressive or hypo/manic mood state may obscure some elements of the history, we have found that it is nonetheless advisable and useful to begin to develop the life chart in the first visit. Keep in mind that the life chart will be reviewed and modified a number of times as more data are collected, and that final revisions will be made when the patient is in a balanced mood state. For the more detailed life chart, attempt to set up an interview time when the patient is in a reasonably **balanced mood state**; this will facilitate the gathering of reliable and detailed information over a life-span.

A broad brush life-chart will certainly take much less time and has great utility by itself if time is limited; for a detailed life chart, however, a relaxed and unhurried atmosphere will be more conducive to the process and will reassure the patient that you are firmly invested in this endeavor. Making the life chart an ongoing part of the therapeutic process in multiple sessions will also help avoid a too pressured approach on a first visit.

It is important from the onset to let the patient know that this is **not a test of any kind** but a joint and collaborative effort with a shared goal, namely to learn as much as possible about the patient's prior course of illness in the service of helping to get her/him better. Explaining the rationale for a life chart to the patient (briefly, that knowing more about prior medications, number of episodes, frequency or increase in cycling, past treatment responses, stress sensitivity, etc. can have a significant impact on the choice of current and future treatment regimes) helps the patient better to appreciate the importance of the task at hand and fosters a

sense of partnership that can enhance future treatment acceptance and compliance. Let the patient know in a caring and direct manner that you are aware that you are going to ask her/him many questions, some of which may concern very difficult or painful times in her/his life. Use this process to develop a **therapeutic relationship** on the basis of shared details of life and illness evolution. Life-charting the structure and details of the illness, gaining knowledge of and insight into the disorder, and developing with each patient an early warning system of symptoms derived from the life-charting process is useful and an effective therapeutic approach in itself and can be of unique value to the patient and to you in the management of her/his illness.

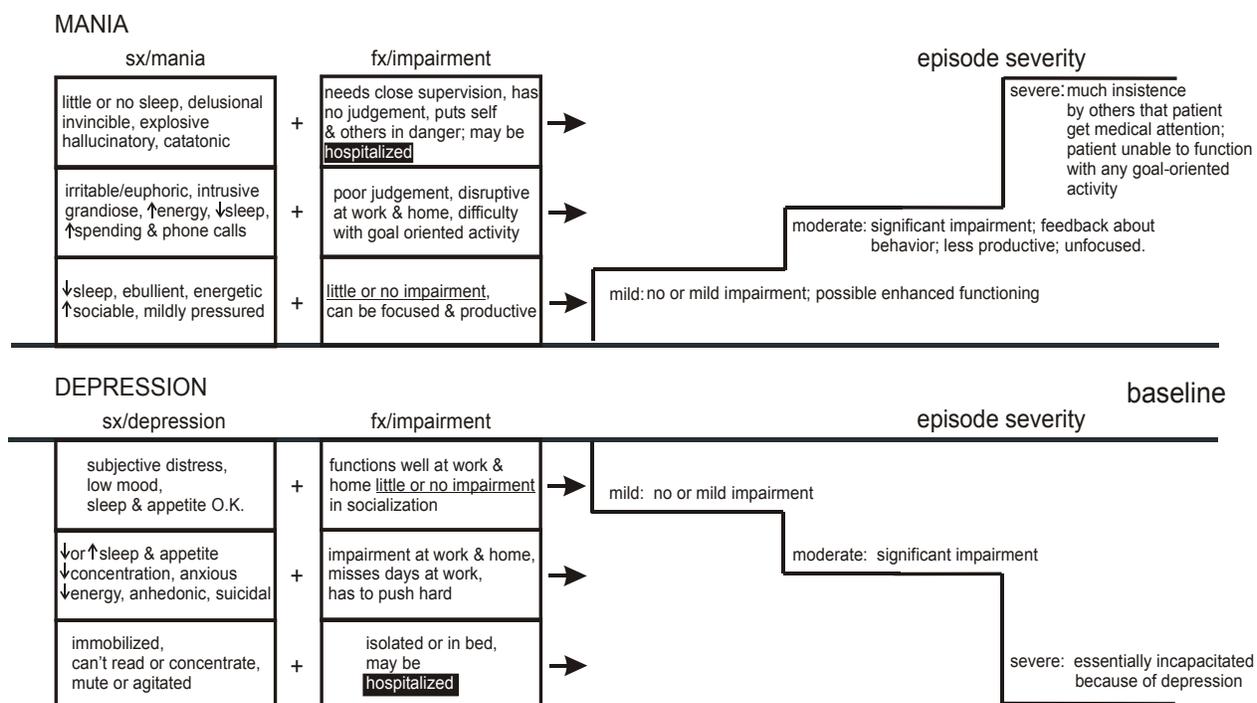
A. The Brief Life Chart

Whether you construct a brief or detailed life chart, in both instances it is important to familiarize yourself with the life chart methodology, i.e., how to assess and chart episodes, record medications and possible hospitalizations, inquire after life events etc. For a brief life chart you will primarily rely on the patient's recollections of this information and there will be limitations in the extent and verification of data via records and other sources.

1. Start with the most recent episode or hospitalization and graph the episode or hospitalization on the life chart according to **the life-charting schema illustrated below where episode severity is based on functional impairment arising from mood dysregulation.**

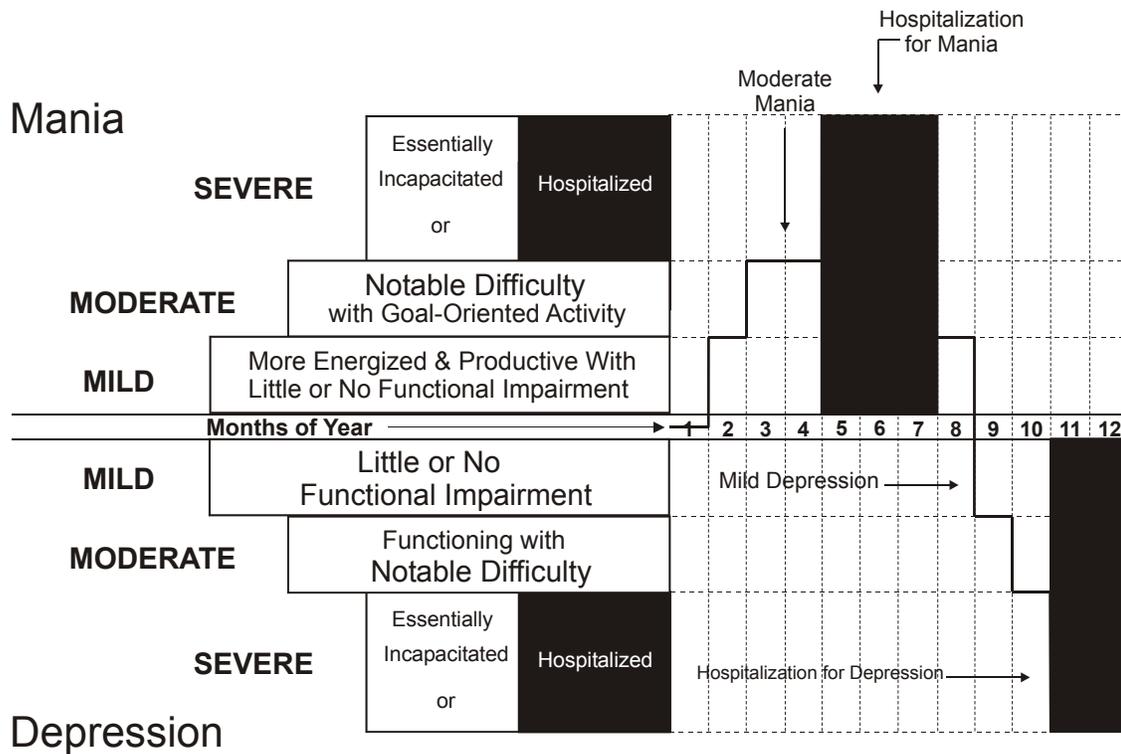
Summary Schema

Retrospective Life Charting Of Severity Levels: Symptoms And Definitions



Please Note: *Functional impairment due to other medical illnesses such as the flu, a broken leg, arthritis, heart disease etc. are not factored into rating episode severity.*

This page gives you a partial view of the retrospective life chart form indicating the three retrospective levels of episode severity based on mood associated functional impairment. Episode severity has been precoded in the left margin of the life chart form. Blackening the episode denotes that the patient was hospitalized during this period for mania or severe depression and can also serve as an additional reference point for other hospitalizations the patient may have had. Hospitalizations, once entered on the life chart, help provide anchor points for episodes that may have occurred and been treated on an outpatient basis.



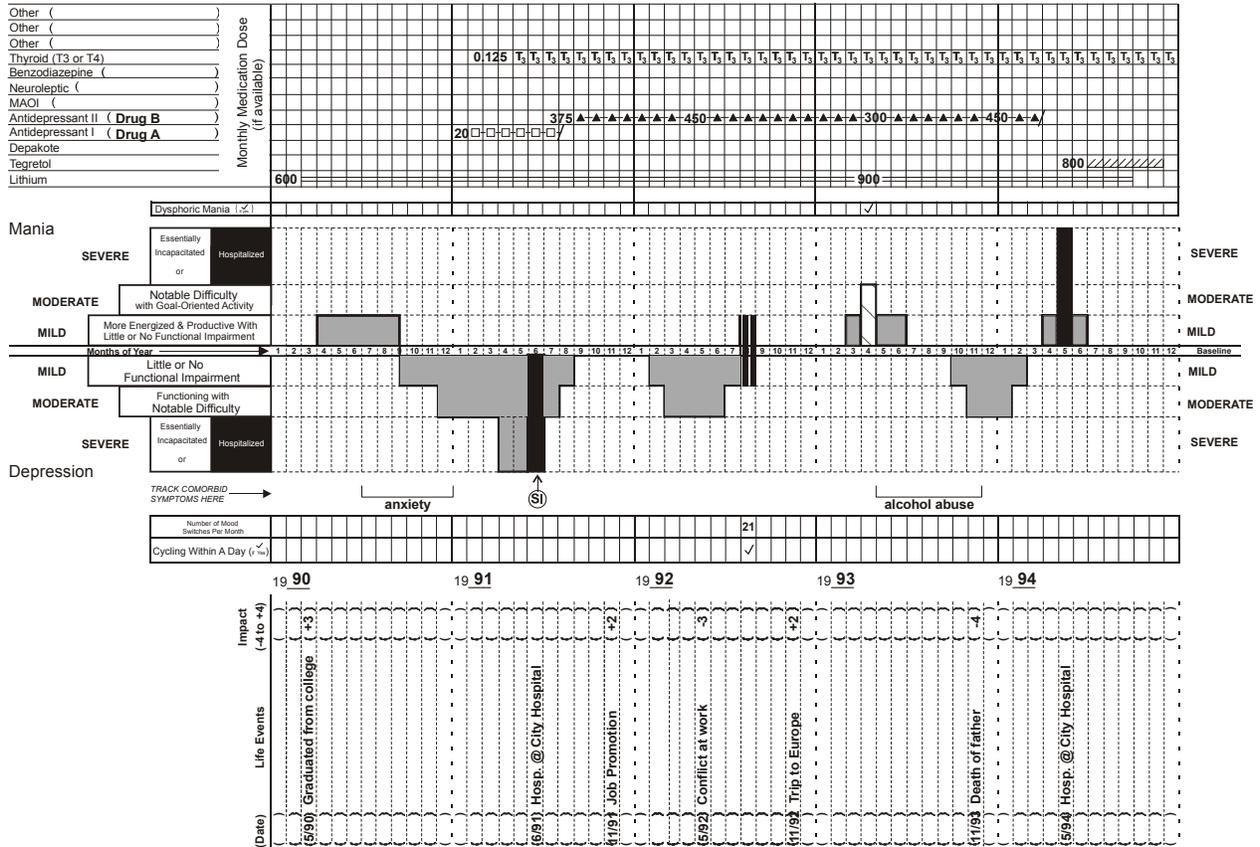
record the medications for these and subsequent episodes whenever possible. For a brief initial life chart, medication doses can be plotted as recalled (to be later confirmed with other available records). If specific drug names and doses are not available, the class of medication and approximate length of trial can often be obtained via the patient's memory. (We have added a medication list at the end of the manual, which you could show to the patient to see whether this provides any memory trigger for medications they may have been on in the past).

b. Next turn to the onset of the illness and record the first illness episode on the life chart. Proceed from there sequentially to the current time trying to place subsequent episodes and any treatments received as best as possible. (Even if patients cannot always place episodes accurately in time, they do generally remember whether they had a severe episode or hospitalization and around what year. For the basic life chart don't be overly concerned about exact dates at this point or whether you are capturing all episodes. You and the patient are sketching a rough outline of the patient's illness in an effort to elucidate some of the major episodes, any changes in episode pattern, previous hospitalizations, and medications.

4. Life events form an integral part of a life chart; however, for the basic, first version generally only note the ones that might have preceded the early episodes, the episodes during the last year, and the ones that come spontaneously to the patient's mind (often because they had a temporal or causative relationship to an episode), e.g. a death in the family, marriage, a move, etc.; thorough investigation of the presence and role of psychosocial stressors in the patient's longitudinal course of illness constitutes an important part of the more extensive life-charting interview.

While a detailed life chart covers the patient's entire life, the basic version primarily covers time ill, i.e., from the first illness episode to the current time. A basic and rapidly constructed life chart (here constructed on the Self-Version identical to the Clinician Retrospective Form) might look like this:

NIMH-TM Self Ratings (RETROSPECTIVE): SAMPLE RATINGS
 Patient Name My Chart Years 1990 - 1994
 PLEASE PRINT



(As you can see, the life chart method also provides for medication legends that will be printed out in the computerized version of the life chart. It is fine for the hand drawn version to simply draw lines through each medication row for the medication that you have entered in the margin. Be sure to indicate the dose at the start of a medication (if known) or any dose change that may have occurred over time).

B. The Detailed Life Chart

In research centers and other clinical settings patient information often is first gathered through structured screening interviews and prior treatment and hospital records to assess the patient's appropriateness for inclusion in certain studies and protocols. The life-charting interview can be scheduled subsequent to the acceptance into the study and provides the clinician/investigator with the benefit of having some data at hand prior to the first life-charting meeting with the patient.

1. Episodes and Hospitalizations

a. In preparation for the construction of a detailed life chart begin with the rough outline above and continue by reviewing any available information. If hospital records were obtained as part of the screening or history taking process, **graph the hospitalizations** on the life chart using life charting criteria, note the exact admission and discharge dates in the life event section, record any **medications and treatments** received while hospitalized in the medication section of the form and be sure to specify medication doses and duration as noted in the available records. Carefully read any past outpatient **progress notes and treatment summaries** from physicians, therapists, clinics, or day programs and make some notes for yourself as to possible **previous episodes** and **symptomatology** to be used in the construction of the life chart. This will give you increased awareness of the patient's history and will facilitate the interview process since you will be able to ask some informed questions and at times prompt the patient's memory. Only record on the life chart right now what you are reasonably sure of, i.e. hospitalizations, some demographic data, and some events/dates. If you sketched an initial life chart as part of your first assessment, compare the information and where possible, either verify the data or note the differences for yourself for further investigation. All this provides a framework for the collaborative effort with the patient. However, records can contain erroneous or conflicting information, and it is important whenever possible to clarify and validate any data you have entered on the life chart during your meetings with the patient and with family and/or friends during later sessions.

b. Episode Description

When you begin the life-charting interview with the patient start with the **assessment and cataloguing of past episodes**. Establish a symptom checklist with the patient and categorize the episodes as mild, moderate, and severe by evaluating the level of functional impairment arising from the mood and vegetative symptoms.

This classification of episodes should integrate clinically accepted and validated mood and functional impairment criteria but should also reflect a patient's idiosyncratic symptomatology to assess not only the more generally recognized manifestations of this illness but also to capture the subtleties and variations that can present an aspect of this disorder. **Sample key words for mood and vegetative symptoms and associated levels of functional impairment are displayed in the following two lists for mania and depression.**

Sample Key Words for Levels of DEPRESSION and Associated Functional Impairment

Types of Mood & Vegetative Symptoms	Severity Level	Functional Impairment
subjective distress mild sad mood not sharp, sluggish "a bit off" mild disinterest sleep and appetite o.k.	MILD	<ul style="list-style-type: none"> • minimal or no impairment • continue to function well at work, school, and home
depressed mood hopeless lack of interest tearful anxious irritable decreased concentration decreased energy decreased self-esteem feelings of guilt, self-reproach unable to enjoy things suicidal ideation sleep disturbance appetite disturbance physically slowed down decreased sexual interest/activity agitated angry socially withdrawn isolates at home	MODERATE	<ul style="list-style-type: none"> • some extra effort needed to function • occasionally missing days from work or school • noticeable impairment at work, school, or home • much extra effort needed to function • very significant impairment at work, school, or home • missing many days from work or school • barely scraping by
immobilized lack of self care poor eating poor fluid intake unable to dress long speech delays, or mute very agitated, pacing very suicidal cannot think or remember false beliefs (delusions) sensory distortions (hallucinations)	SEVERE	<ul style="list-style-type: none"> • not working • not in school • not functioning at home • cannot carry out any routine activities • incapacitated at home OR • Hospitalized

Sample Key Words for Levels of MANIA and Associated Functional Impairment

Types of Mood & Vegetative Symptoms	Severity Level	Functional Impairment
<p>increased energy increased activity more social enthusiastic, exuberant irritable talkative feel more productive</p>	<p>MILD</p>	<ul style="list-style-type: none"> • minimal or no impairment • continue to function well at work, school, and home • functioning may even improve in some areas
<p>euphoric irritable intrusive hypertalkative disruptive insistent overinvolved decreased need for sleep increased energy pressured flight of ideas very distractible increased spending speeding uncomfortably driven increased sexual interest/activity promiscuous grandiose may be reckless</p>	<p>MODERATE</p>	<ul style="list-style-type: none"> • difficulty with goal-oriented activity • feel productive but may not be (e.g., starting many projects without finishing) • get in trouble with work, school, family • others comment about behavior • can't focus • others angry/frustrated with you • poor judgement • great difficulty with goal oriented activities
<p>need little or no sleep feel out of control explosive feel all powerful invincible angry potentially violent excessive energy extremely driven reckless see or hear things not there</p>	<p>SEVERE</p>	<ul style="list-style-type: none"> • close supervision needed • asked to leave work or school • unable to function with any goal-oriented activity • bizarre behavior or decisions • family and friends insist that you get help • in trouble with the law • Hospitalized

Begin with the patient's **worst** episode of depression and ask for the mood and vegetative symptoms experienced during the episode. Assess the resulting functional impairment and categorize the episode at the appropriate level of episode severity based on the functional impairment. For many patients their worst episode will fall into the severe range but for others their worst episode of depression may only meet criteria for a moderate level of severity according to the degree of their functional incapacitation. A hospitalized episode automatically is rated as severe (and will be shaded in on the life chart).

If the patient's worst episode falls into the severe range, proceed to inquire about symptomatology at the next, less extreme level of depression, evaluate the concomitant functional impairment and place this stage of depression at the appropriate level of episode severity based on the functional impairment arising from the mood dysregulation. If this represents the patient's **moderate level of depression**, continue the cataloguing of episodes by getting symptom and impairment information for the **mild** depressive episode.

For the bipolar patient continue the assessment by exploring symptomatology and functional impairment for their **hypo/manic** episodes and proceed to get information for their mild, moderate, and severe manic episodes in the same step-wise fashion as above as illustrated in the life chart schema on page five of this manual.

c. When you have developed such a mood and functional impairment schema for each patient for their depressive and manic episodes **extrapolate typical signal symptoms for each level of depression and/or hypo/mania** and use these as keys to facilitate the process of retrospective assessment (e.g. decreased sleep or over involvement in projects is typical for this patient when (s) he is hypomanic, or a decrease in concentration may be a characteristic marker of a mild depressive episode for another patient) and write them down for the patient to keep and use as an early warning system for an impending mood change.

d. Return to the past year on the life chart and graph the nearest or most recent episode according to the patient's symptom and impairment schema. Continue to delineate the course of illness for the entire year in detail by recording all depressive and/or manic episodes using life-charting criteria. Enter all medications for the last year and any life events that might have occurred during this time.

e. Now turn to the onset of the illness and assess and graph the first episode that is clearly remembered and/or documented. Proceed from here to delineate the subsequent course of illness up to the current time using all the components of the life chart methodology as described in this outline.

Be sure to inquire about symptoms of depression, separation anxiety, or any other psychiatric difficulties including elated or highly productive periods, or periods of substance or alcohol abuse that may have preceded the first more clearly remembered and/or recorded mood episode. School attendance, grades, ability to form friendships, participation in after-school activities, truancy, etc. are effective ways to probe for a possibly earlier onset of the illness than had been assumed.

f. Episode Pattern

Some patients demonstrate a **seasonal component** in their course of illness; the more common seasonal presentation would be for hypo/manic episodes to occur during spring and summertime with depressions more typical in fall or winter. However, for some patients the pattern might be reversed.

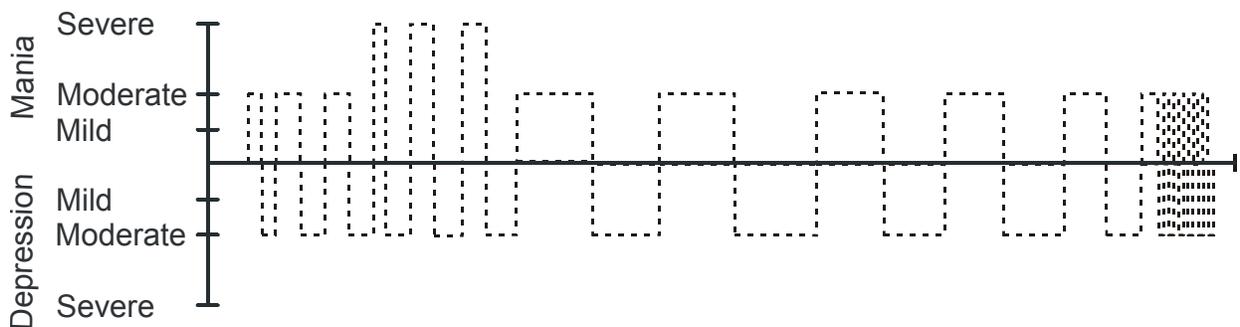
Some patients have a fairly stable **rhythmic** pattern to their illness with episodes having a tendency to occur at similar yearly, monthly, or weekly intervals independent of the seasons of the year. This can be a useful pathway to pursue by working forward and backward from an established episode to the same time of the previous or subsequent year or month. If holidays are typical times for the patient to experience a mood shift,

use this as one of the markers over time to inquire about other episodes that may have occurred in another year during this time period.

For patients who have an **irregular or chaotic** course of illness the task is more difficult. However, the use of hospital records, clinic and physician notes, personal diaries, calendars etc. will assist in the construction of a life chart with as high a degree of accuracy as possible. Functional impairment with concomitant difficulties at work or in social situations becomes an especially important marker for remembering episodes. Life events (see later section), related to or independent of episodes, can help form an important outline for the course of illness and assume a key role particularly in the irregular presentation of this illness.

Often it is only possible to get **approximate dates** for some episodes and especially for **periods of rapid cycling** a patient may have experienced in the past. The life chart methodology employs **dotted lines** as the legend to signify that these episodes took place but precise onset/offset dates for the individual cycles are not available.

Example



g. Graph the episodes during your meetings with the patient using life-charting criteria. It is very effective and educational to jointly see the emerging prior course of illness; it helps trigger memory and facilitates comparison between episodes as to their level of severity in a more consistent and uniform fashion. If you need to "tidy up" the life chart to be as accurate as possible with the graphing of information, do so afterwards and go over it again during your next meeting with the patient.

Although it is useful to work broadly within some framework of **chronologic progression**, it is important for the patient to know that the life charting process allows for great **flexibility**, which easily permits to move back and forth in time. In fact, in some instances it is essential to do so when you are elucidating any kind of seasonal or rhythmic pattern to a patient's prior episodes of illness, when you are recording significant recurrent anniversaries or events (e.g. "each year on the anniversary of my husband's death I get depressed" or "every August we would rent a cabin in the woods" etc.), or when you are exploring mood changes around seasonal holidays. If you feel that you and the patient are "stuck" in some area that you are working on, return to this period again at a later time. Encourage the patient to obtain more information from family and friends, to bring in diaries, yearbooks, calendars, notebooks, school report cards and work evaluations (which can assist in uncovering fluctuations in the patient's ability to function effectively), in short, anything that can help in the delineation of the prior course of illness. More facts and details are always welcome and can be added to the life chart at any time.

2. Medications

a. Medications represent a critical element of the life chart with very important implications for future treatments but accurate information about them is often quite difficult to obtain. **Physician and hospital records** are indispensable in this process. Computer printouts from **pharmacies** can be very useful; additionally, ask patients to "raid" their medicine cabinets for **old medicine bottles** (and encourage them afterwards to discard old medications), and record the information on the medication section of the life chart.

Try to get start and stop dates of the medications; the start dates are usually more easily remembered since they often coincide with the onset or severity increase of an episode. If you cannot be sure about either the start or stop date place a question mark at the beginning and/or end of the medication legend to signify uncertainty regarding the specific date. Even if a patient cannot recall the precise name of a medication it is still very important to note the **class of medication**, which patients tend to remember fairly well (i.e. "I was on an antidepressant medication" or "I was on a tricyclic" or "I was on a medication where I couldn't have some foods like aged cheese etc."). **Reciting names of the more commonly used medications** can trigger memory (see sample list at the end of this manual). Some of the major mood stabilizers such as lithium, carbamazepine (tegretol), or valproate (depakote) seem to be remembered a little easier, possibly because they don't get changed around as frequently as adjunct medications; if maintenance medications are discontinued, it is often harder to determine when this happens, but generally patients at least remember whether they were on them for only a few months or for longer periods of time. Wherever possible get **doses of medications** to ascertain whether a patient had an adequate trial.

b. Be non-threatening and non-judgmental when inquiring about **medication compliance**. ("How frequently do you think you may have forgotten to take your medication in an average week?" might be a good way of approaching the subject). A patient might withhold the fact that there were several times in the past when (s) he discontinued her/his medications because (s) he feels you might react critically. This information could be crucial in the determination of future medication choices; you may assume the patient had a full therapeutic trial of a certain medication when in fact (s) he did not, or it might uncover some contributing factors in the patient's refractoriness to treatment.

The life-charting method provides for **medication legends** that will be printed out as such with the medication name in the computerized version of the life chart. It is fine for the hand drawn version to simply draw lines through each medication row for the medication that you have entered in the margin at the time point the

medication was started. Be sure to indicate the dose at the start of a medication (if known) or any dose change that may have occurred over time.

Record the medications as accurately as possible together with the patient; look closely at the interface of medications and a possible cycle acceleration as a result of the introduction of an antidepressant medication; for some patients it might mark the switch to bipolarity. Search for partial response or loss of efficacy of a medication; this is often something patients will remember spontaneously or when asked. Reiterating to the patient that knowledge of previous medication response patterns can have a significant impact on future treatment interventions reinforces the importance of the life-charting interview and again helps the patient understand why you are such a stickler for detailed information.

3. Life events constitute an important part of the detailed life chart. They form the basic outline for the patient's psychosocial history and can provide an essential framework for inquiring about illness episodes and medications. Furthermore, assessing the **severity of a negative impact** of life events promotes a more systematic investigation of the role of stressors in the longitudinal course of affective disorders as well as estimation of stress reactivity and specificity in the individual patient or group as a whole.

To ensure that a minimum of events is inquired after in a more uniform and consistent fashion, we suggest the use of a **life event checklist** (see below), taken from validated life event inventories in the literature and others that we have added. The life events on the checklist are arranged somewhat sequentially according to the approximate degree of upset, stress (even positive events), and distress they may cause the average person. They cover major areas of life, are mostly undesirable and of a significant magnitude (indicated by generally higher ranking scores on the Paykel life event list) such that they are more likely to be implicated in the precipitation of a mood change, primarily clinical depression. The semi-structured interview format of the life

chart employed in the elucidation of life events is useful to and reciprocal with the process of episode investigation.

LIFE EVENT CHECKLIST

1. **Death of spouse**
2. **Death** of close **family** member (including child)
3. Major **financial** difficulties
4. **Business failure** for self or important other
5. **Loss of job** for self or important other
6. **Divorce**
7. Marital **separation** due to discord
8. Serious **illness** of a child or close family member
9. **Unemployment** for at least one month
10. **Death** of close **friend**
11. **Demotion** for self or important other
12. Serious **personal illness** (hospitalized or at least one month off work)
13. **Lawsuit**
14. Increased **arguments** with **spouse**/life partner
15. Increased **arguments** with resident **family** member (not spouse); family problems
16. **Separation** from significant other (friend or relative)
17. **Retirement** of self or important other
18. **Change in residence**, major move
19. Close **friend** very **ill**
20. **Relationship problems** (not spouse)
21. **Holiday**
22. **Vacation** trip
23. **Pet** very **sick** or **dies**
24. **Anniversaries** of significant events
25. **Marriage**
26. **Car** or transportation **problems**
27. **Birth** of a child
28. **Change in work** conditions (for the worse); conflicts with boss or co-worker
29. Start **new type** of **work**
30. **Engagement**
31. **Accident** (i.e., car accident, injuries etc., to self and significant other person(s))
32. Job **promotion** for self or significant person (spouse, life partner, friend, or relative)

The interviewer, after establishing the occurrence and detailed circumstances of an event, may continue by asking the patient how much of the event was unanticipated, uncontrollable, undesirable, had potential to lower self-esteem or contained perceived long-term threat. The interviewer, based on all the information obtained, then makes a severity of negative impact rating on a five-point scale and records it in the life event section along with the life event itself. Use of such a rating scale is one approach to the estimation of severity of impact of life events, although others can be employed according to the needs of individual clinicians and investigators.

Negative Impact of Event Rating Scale

(Adapted from Paykel and Brown)

Consider the Event's: Desirability, Controllability, Unanticipatedness, Long-Term Threat, and Potential to Lower Self-Esteem in arriving at the impact rating. (You may also want to assess the positive impact an event may have had by marking it with a + sign and the level of positive impact)

0 = no impact

-1 = **mild** (negative) impact

+1 = **mild** (positive) impact

-2 = **moderate** (negative) impact

+2 = **moderate** (positive) impact

-3 = **marked** (negative) impact

+3 = **marked** (positive) impact

-4 = **severe** (negative) impact

+4 = **very positive** impact

a. Placement of the event

Carefully probe around as to the **placement of the event**: did it clearly precede the episode, confound or exacerbate the episode or take place subsequent to the episode. At times patients have the need to "explain" an episode by placing a stressful event prior to rather than during or following the episode but from both the clinical and research perspective it is important/helpful to establish the relationship of event and episode in each case as clearly as possible.

b. Life event inventory

In addition to the life event checklist, systematic life charting can include a comprehensive exploration of the presence and role of other psychosocial stressors in the longitudinal course of affective illness.

After establishing the presence (or absence) of any of the events on the checklist and any possible episodes connected with it, continue with exploring the last (most recent) episode and carefully probe for the placement of any psychosocial stressor linked to it. Mark the event on the life chart in the life events section (below the space allocated for depressive episodes); describe the event briefly and succinctly (possibly using some predetermined key words for later analysis of the life events section), note dates where available and assign an impact rating to it based on the above rating process. Then go back to the first episode and follow the same steps. Proceed in the same fashion for each episode already graphed on the life chart while also using this process to verify time placement of the episode and start and stop dates for any medications/treatments provided.

During this comprehensive exploration of life events inquire after more easily remembered dates such as school and college attendance, graduations, anniversaries, seasonal events, and traditional family celebrations.

Gather dates for births of siblings, moves, deaths or serious illnesses in the family of origin. Explore developmental milestones, personal illnesses, surgeries, head injuries or other accidents, personal social markers, e.g.. dating, engagement, marriage, separations, children, friendships, and other important relationships.

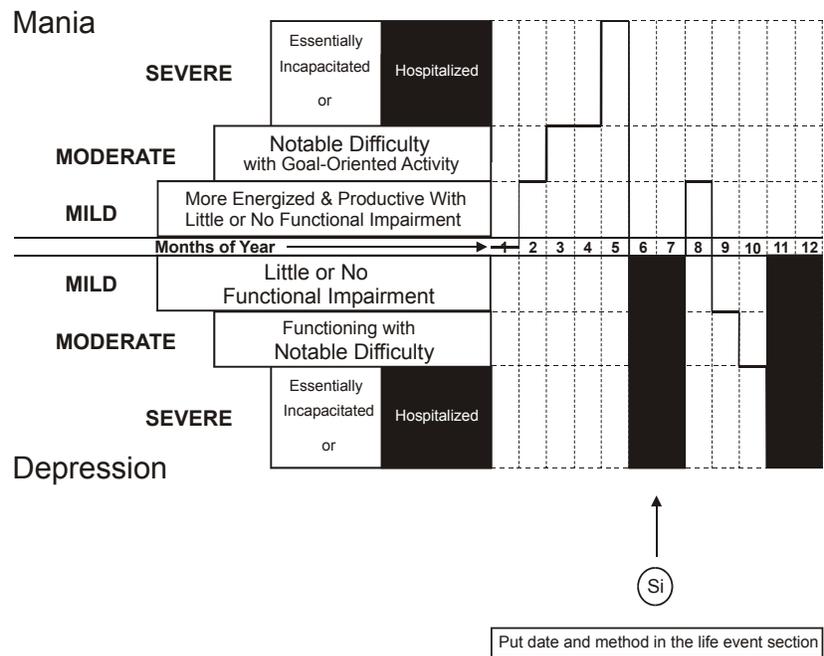
This may also be an appropriate time to inquire after a possible **history of abuse as a child, adolescent or adult**. These questions sometimes are not asked because the interviewer might feel that (s) he is intruding into an area that is too distressing for the patient to discuss. Thus a significant clinical aspect of a patient's life may

potentially be lost and might not be effectively addressed in future treatment interventions. Ask the patient up front in a direct and caring manner whether (s) he remembers ever having been abused verbally, physically, or sexually by anyone within the family or by others outside the family. If the patient does not seem to be ready for such inquiries during your first meeting, tell the patient that you can ask these questions at another time but do not omit them altogether. This clearly is not done to "talk the patient into something" but patients do remember that you asked them and if you do not approach the subject matter again, in addition to losing important information about the patient, you may also reinforce their own apprehension that this is indeed a forbidden topic. Mark the times, duration, and nature of the abuse on the life chart in the life event section. If the patient does not wish to have it recorded in a very specific form (e.g. sexually abused by father) state it in a more neutral way. If a patient does not want to have it entered on the life chart at all, respect this wish but integrate it in your own clinical assessment. Return to the life chart and carefully go over the patient's work history with her/him since this can provide both of you with very important data regarding the ability to function effectively at work, being able to hold jobs successfully and for long periods of time, or changing employment frequently or setting up multiple business ventures. Inquire after moves within a city or across the country and any concomitant social losses (neighbors, friends, relatives etc.); ask about financial difficulties/crises, role changes for the patient (e.g. retirement of self or spouse), or change in social status. Be aware of the patient's particular life circumstances and inquire about stressors likely to arise from and be relevant to their psychosocial environment (e.g. holding a job or working in the home, raising children as a single parent versus a two-parent household, living alone versus living with one's family of origin or significant others etc.). Each setting most likely includes common stress factors as well as some that might be very specific to that environment. It is additionally useful to consider each event within the contextual framework of the patient's life to fully understand the significance and impact of it for the patient, and to elucidate idiosyncratic vulnerability and sensitivity to certain psychosocial stressors (e.g. responses to loss, to interpersonal difficulties, to financial difficulties, to certain anniversaries etc.). This assists the patient in remembering similar, related, or additional events and facilitates inquiries regarding any mood changes related

to the event. Together with the patient graph any episodes derived from this process, define their temporal and/or possible causal relationship to the psychosocial stressor and continue to utilize this method for further treatment investigations. Again, continue to encourage the patient to bring in more information from family and friends and to have them join some of your meetings when they are able to do so.

c. Suicide attempts

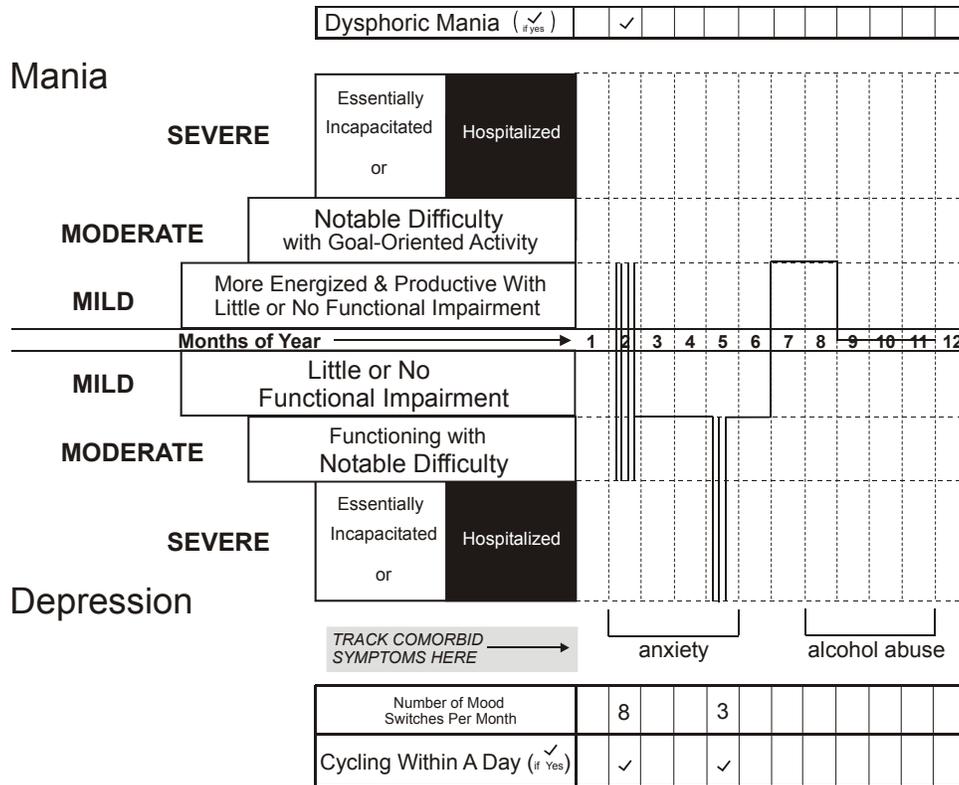
Suicide attempts constitute a very critical aspect of the patient's clinical history and need to be recorded on the life chart. Ask about them in a direct manner and try to get as much detailed information as possible from all sources; was the attempt part of an affective episode; what were the means used; was the patient hospitalized or taken to the emergency room as a result of it. Enter the occurrence of the attempt with date and method in the life event section and graph an arrow upward in the direction of the dateline pointing to the correct time period.



4. Additional psychiatric symptoms and/or disorders

a. Inquire openly and non-critically after any **history of substance abuse**. Clarify the types of substances used and ask for each category, i.e. alcohol, marijuana, steroids, hallucinogens (LSD, mushrooms), sedatives, opiates, amphetamines, cocaine, crack, PCP, ecstasy, and any other designer drugs. Also note periods of excessive or diminished caffeine intake since these might point to periods of depression or increased anxiety. Record the time periods as accurately as possible on the life chart, and try to establish as clearly as possible whether the onset of the use of substances preceded the emergence of the illness. Substance abuse represents an important factor in the patient's psychosocial history, may have masked an earlier illness onset, can impact on the course of illness through the intake of interfering or mood destabilizing substances, may affect the patient's environment, and might influence availability of social support. Record the times and substances used on the life chart and indicate duration of the substance abuse via an arrow from date of start to date of cessation in the "track comorbid symptoms here" row above the life events section. Any additional psychiatric symptoms are also noted in this "comorbid" row because of the high degree of comorbidity with mood disorders, which may have an impact on treatment response.

Recording of Comorbid Symptoms



b. Personality disorders are not formally recorded on the life chart graph since patients often are not privy to a possible axis II diagnosis. However, they are a part of the clinical evaluation and if a patient has been formally diagnosed with a personality disorder in the past it can be recorded in the life event section under "psychological assessments" with the date of the evaluation and the name of the physician. If the interviewing clinician has no reservation about informing the patient as to the presence of a diagnosed personality disorder, then it could be recorded as such with date of diagnosis in the life event section.

5. Family History

Family history is part of history taking but does not get per se recorded in detail on the life chart. However, family history as a component of the patient's psychosocial history can appear on the life chart in the form of a life stressor (e.g. father hospitalized for manic episode, or, paternal aunt commits suicide).

6. Conclusion

Throughout your meetings sketch in the information that the patient offers you but fill in omissions and verify information at times when the patient is not manic or depressed. Although the life-charting interview integrates many components of a thorough psychiatric assessment, you as the clinician might need to progress beyond that structure by being more interactive and focused on course of illness issues. Don't hesitate to ask questions when you need further clarification, or to follow up on a "hunch" when you sense that something needs to be explored in greater depth. This can actually facilitate the process and trigger further recollections. Be available to talk about some of the salient points arising in this process such as a vulnerability to certain stressors which might have preceded the onset of illness episodes since these may be key factors used in psychotherapy and adjunctive pharmacotherapies. Investigate in detail periods of cycle accelerations and a possible role antidepressants may have played in this. Clarify any period of medication discontinuation and loss of responsiveness to medications because this information can have an important impact on the choice of the next trial. Be empathic and reassuring when, in the process of life-charting the reality of her/his illness emerges in discernible form through the graphing of the episodes since it can be very difficult to see one's own illness so clearly delineated. This reality, however, may ultimately be helpful in establishing the foundation for compliance. Moreover, when patients see clearly defined episodes on the life chart that are a result of medication discontinuation, it may help them understand the medical nature of their disorder and the need for medication compliance.

It is useful to **review** the life chart in its entirety when the patient is in a balanced mood state and family and/or friends can join the meeting. Display the life chart where everyone can see it and go over it step by step. Don't hesitate to seek clarification on points of which you are not certain. Again inquire after interepisode functioning, verify severity of non-hospitalized episodes (especially hypo/mania), and confirm degree of incapacitation at home where appropriate, and how much assistance family and/or friends needed to provide. This process can be a very important educational and clinical experience for both patient and family. It points to the reality and complexity of this disorder and helps engage others in the understanding and management of this illness. Encourage family members, friends, and the patient to stay on the search for more information. Future additions and revisions are always possible and welcome and can only be of profit for the patient.

Common Psychotropic Medications

Listed by Generic Name (Brand Name)

MOOD STABILIZERS

Anticonvulsants

Acetazolamide	(Diamox)
Carbamazepine	(Tegretol)
Felbamate	(Felbatol)
Gabapentin	(Neurontin)
Lamotrigine	(Lamictal)
Levetiracetam	(Keppra)
Phenytoin	(Dilantin)
Topiramate	(Topamax)
Tiagabine	(Gabitril)
Valproic Acid	(Depakote, Valproate)
Zonisamide	(Zonegran)

Calcium Channel Blockers

Amlodipine	(Norvasc)
Diltiazem	(Cardizem)
Isradipine	(DynaCirc, Prescal)
Nifedipine	(Adalat, Procardia)
Nimodipine	(Nimotop)
Verapamil	(Calan, Isoptin)

Other

Lithium Carbonate	(Eskalith, Lithobid)
Lithium Citrate	(Cibalith-S)

ANTIDEPRESSANTS

SSRIs

Citalopram	(Celexa)
Fluoxetine	(Prozac)
Fluvoxamine	(Luvox)
Paroxetine	(Paxil)
Sertraline	(Zoloft)

SNRIs

Venlafaxine (Effexor)
Nefazodone (Serzone)
Trazodone (Desyrel)

Dopamine Related

Bupropion (Wellbutrin)
Pramipexole (Mirapex)

Cyclic Compounds

Amitriptyline (Amitid, Elavil)
Amoxapine (Asendin)
Clomipramine (Anafranil)
Desipramine (Norpramin, Pertofrane)
Doxepin (Adapin, Sinequan)
Imipramine (Tofranil, Janimine)
Maprotiline (Ludiomil)
Mirtazapine (Remeron)
Nortriptyline (Aventyl, Pamelor)
Protriptyline (Vivactil)
Trimipramine (Surmontil)

MAOIs

Isocarboxazid (Marplan)
Moclobemide (Not avail. In US)
Phenelzine (Nardil)
Selegiline (Eldepryl)
Tranylcypromine (Parnate)

NEUROLEPTICS

Chlorpromazine (Thorazine)
Chlorprothixene (Taractan)
Fluphenazine (Prolixin, Permitil)
Haloperidol (Haldol)
Loxapine (Loxitane, Daloxin)
Molindone (Moban)
Perphenazine (Trilafon)
Pimozide (Orap)
Prochlorperazine (Compazine)
Thioridazine (Mellaril)
Thiothixene (Navane)
Trifluoperazine (Stelazine)

Atypical Neuroleptics

Clozapine (Clozaril)
Olanzapine (Zyprexa)
Risperidone (Risperdal)
Ziprasidone (Geodon)

ANXIOLYTICS

Alprazolam (Xanax)
Chlorazepate (Tranxene)
Chlordiazepoxide (Librium)
Clonazepam (Klonopin)
Diazepam (Valium)
Flurazepam (Dalmane)
Lorazepam (Ativan)
Oxazepam (Serax)
Temazepam (Restoril)
Butalbital (Fiortal)
Mephobarbital (Mebaral)
Secobarbital (Seconal)
Buspirone (Buspar)
Zolpidem Tartrate (Ambien)

STIMULANTS

d-Amphetamine (Dexedrine)
Methylphenidate (Ritalin, Concerta)
Pemoline (Cylert)
Modafinil (Provigil)
Adderall amphetamine product

THYROID HORMONE

T-3 Liothyronine (Cytomel)
T-4 Levothyroxine (Synthroid)

SUPPLEMENTS

Ginkgo Biloba
Hypericum (St. John's Wort)
Melatonin
Piper Methysticum (Kava Kava)
S-adenosylmethionine (Sam-E)
ETHYL EPA (Laxdale)
EPA & DHA (Omega Brite)

ALCOHOL/SUBSTANCE ABUSE

Acamprosate (Campral)
Disulfiram (Antabuse)
Naltrexone (ReVia)
Buprenorphine (Temgesic, Buprenex)
Methadone (Dolophine, Methadose)

WEIGHT TREATMENTS

Megestrol Acetate (Megace)
Fenfluramine (Pondium)
Phentermine (Obermine, Phentrol)
Sibutramine (Meridia)

ANTIPARKINSONIAN

Atropine Sulfate (Atropine)
Benzotropine (Cogentin)
Trihexyphenidyl (Artane)
Amantadine (Symmetrel)
Carbidopa (Sinemet)
Procyclidine (Kemadrin)