The 7 Habits of Highly Effective Psychopharmacologists, Part 2

Begin With the End in Mind

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Issue: *Prior to prescribing a psychotropic drug, it is important to set explicit treatment goals by visualizing how the patient will look and function at the end of treatment, thus "beginning with the end in mind." By recognizing from the start where the finish line is, highly effective psychopharmacologists can incorporate simple, practical strategies to measure a patient's progress toward recovery through treatment.*

This feature is the second in a series of articles[1] on the 7 habits of highly effective clinical psychiatrists who practice psychopharmacology and have difficult patient management problems in their clinical practices; it is based on application of Steven Covey's highly acclaimed principles.[2]

Treatment in psychopharmacology can be conceptualized as a race. Thus, there is a starting line for treatment, progress toward the finish line along the way, and finally, crossing the finish line to end the race. One of the most important advances in the treatment of mood and anxiety disorders is our realization that the race is not a 4- to 8-week "sprint" but a multimonth to multiyear "marathon" to prevent relapses once the patient has responded to treatment.[3] With the recent developments of more efficacious treatments for mood and anxiety disorders, we can help our patients take another step toward the goal. Reaching the finish line has been redefined as maintaining remission with complete absence of symptoms.[4] Thus, the goal of treatment is being "well," not just "better than you were."

Although this goal seems reasonable and even laudable in principle, if it is difficult or time consuming, many clinicians will have difficulty putting it into practice. A practical tip for implementing this strategy, particularly in the treatment of affective and anxiety disorders, is to use simple graphics to map the route to the finish line. The following questions for your patient and the Figure should help.

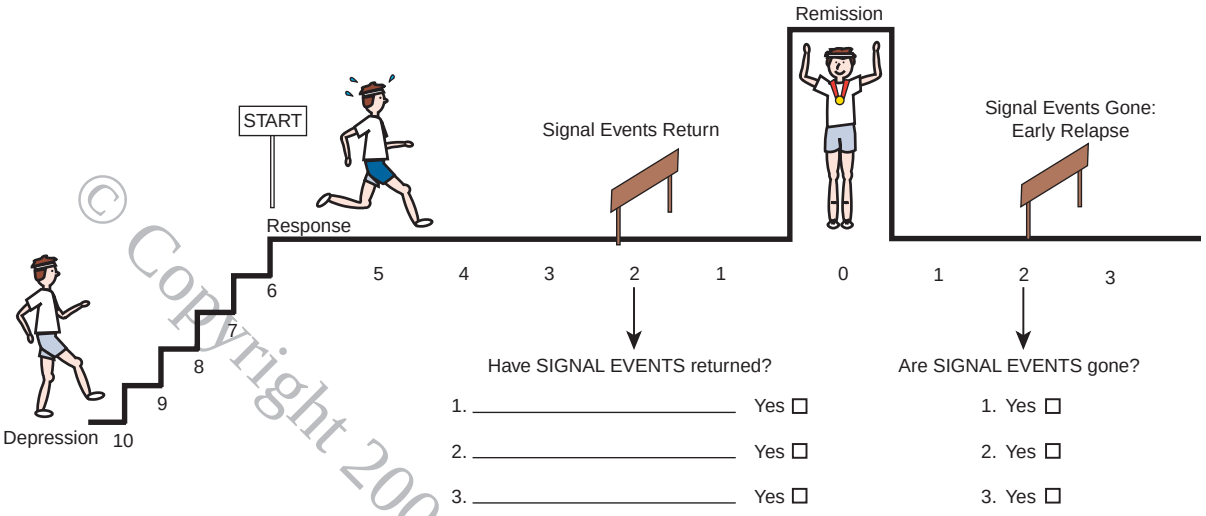
"On a 10-point scale of symptom severity, how did you do over the last week or two?"

The classical graphic for the course of depression can be readily constructed by answering: "Where is the finish line from here?" Thus, at the beginning of treatment, ask the patient to define the worst he or she can imagine in terms of symptom severity (e.g., suicidal), and define that as a 10. Next, ask where the patient is now, which defines current symptom severity on a 1 to 10 scale. Finally, ask whether they can recognize what normal would be, and define that as 0.

This approach allows a simple shorthand communication between psychopharmacologist and patient and is very simple to monitor, track, and discuss on follow-up visits. Furthermore, the patient's inability to define "normal" indicates a more complex case, perhaps inappropriate for this graphical approach.

"What are 3 signal events in your life that you do when you are well but not when you are depressed or anxious?"

Although a "pseudo-quantitative" 10-point scale can be quite helpful, it can be usefully complemented by asking patients to define 3 activities (signal events) that they are not doing now but generally do when well (e.g., prior to this episode of illness). Often the patient lacks insight and will have to go home and think about it, leaving the definition of these events for the second visit. It is usually advisable for the patient to consult family members,



friends, or coworkers for the answer, and one of them may need to accompany the patient to the next visit or be available by phone at the time of the second visit so that the signal events can be defined.

Examples of the types of signal events that are lost during a relapse of an affective or anxiety episode include working in the woodshop, making Sunday dinner for the entire family, keeping the car waxed and attractive, or calling and keeping contact with loved ones. Whatever they are, they are usually idiosyncratic for the patient and require some care in defining.

The benefit of defining signal events is not only that they signal progress in the "sprint to the end," usually the difference between response and recovery, but that signal events frequently are first to disappear when a patient is relapsing. Thus, monitoring these events over the long term can help the patient and family as well as the prescriber recognize the first signs of relapse prior to even more severe symptom recurrence.

Take-Home Points

- Treatment responses in psychopharmacology are often measured by how the patient is doing now compared with how the patient was doing at the beginning of treatment. However, "better than you were at the last visit" is now an outdated and inadequate goal of psychopharmacologic treatment.
- Highly effective psychopharmacologists measure treatment response by beginning with the end in mind, namely, comparing how the patient is doing now with the goal of wellness or a reasonable proximity to wellness.
- Simple and practical tools can be readily incorporated into the practice patterns of highly effective psychopharmacologists so that progress toward the finish line of treatment can be monitored easily and quickly.

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