The 7 Habits of Highly Effective Psychopharmacologists, Part 4

Developing and Implementing the Vision

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Issue: *Practitioners of psychopharmacology can become highly effective by developing the habit of becoming proactive rather than reactive to the forces that play upon their practices. Furthermore, being understood by patients can enhance outcomes, especially if patients realize that side effects may come first before therapeutic actions and that a treatment plan can be developed in which both the prescriber and the patient can win.*

This feature is the fourth and final in a series of articles adapting several habits of highly effective people[1] to the practice of psychopharmacology. The first article provided an overview of all 7 habits,[2] the second emphasized beginning with the end in mind,[3] and the third advised us to "sharpen our saw" through selective choices of continuing medical education programs.[4] Many of the principles pertaining to synergy as applied to the third habit of psychopharmacologists have been discussed in a previous BRAINSTORMS article.[5] Here we discuss the remaining 4 habits, all related to developing and implementing a vision about ourselves as practitioners of psychopharmacology. We will incorporate the perspectives of Sheehan[6] and Zajecka[7] from the May 2000 American Psychiatric Association meeting.

Many forces in psychopharmacology may lead practitioners to feel embattled, wondering how to react to one change after another. Thus, our practices are impacted by managed care, reduced fees, shorter appointments, fewer opportunities to provide psychotherapy, sicker patients, less access to inpatient services, and restrictions on the availability of medicines—all amid a veritable scientific revolution in the neurosciences that is generating a deluge of new treatment options. Although we cannot control *whether* these forces will be present (they are here to stay), we can decide *how* they will affect our practices.

BE PROACTIVE

Highly effective psychopharmacologists develop a vision of what they want to accomplish in their practices and then implement this vision by choosing to be responsible for their own practice behaviors, e.g., we can choose to be more efficient, but we cannot compromise our practice standards by writing prescriptions for patients we have not examined. Covey[1] describes this as taking the initiative to develop the mission of becoming *proactive* rather than *reactive*.

Becoming resourceful in areas where we can do something, such as continually developing better practice skills, will produce high-quality work. Making an initial diagnosis may be reacting to the patient's illness, but becoming proactive is to challenge that diagnosis when the patient is not responding well to treatment. Treating for unipolar depression while missing the diagnosis of bipolar disorder, for example, may lead to the use of aggressive combinations of antidepressants when mood stabilizers and atypical antipsychotics, with conservative use of antidepressants, may be called for instead.

Another proactive practice pattern is to manage the weight gain associ-

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ated with many psychotropic drugs by monitoring body mass index and controlling weight by adjusting drug selection, adding drugs, championing diets, and measuring fasting glucose when necessary. Other examples of becoming proactive are numerous, including obtaining thorough histories of prior undiagnosed episodes of illness and prior psychotropic drug treatments. The point is to develop these practices proactively, so they indeed become habits, and overcome our reactive approach to patient turmoil and changes in our field.

Understand, Then Be Understood

Highly effective psychopharmacologists also understand how to deal with outside forces in the context of the individual patient by clearly communicating directly to the patient about the diagnosis and treatment and then setting appropriate expectations after empathic listening.

Covey[1] states that it is not enough to understand the important issues; results are greatly enhanced if you are also understood by others. Patients are increasingly getting the bulk of their information (or misinformation) about their diagnoses and drug treatments from their pharmacist and media sources, e.g., the Internet. Our proactive role to enhance compliance and optimize outcomes is to educate, destigmatize, and reassure—and repeat this with every visit. Providing explicit written guidelines for medications covering how to start, switch, cross-titrate, taper, or take flexibly on an as-needed basis is one area in which highly effective psychopharmacologists can promote understanding in patients, their family members, and referral sources.

Put First Things First

The first thing that happens after a diagnosis is made and a treatment is prescribed is usually a side effect, not a therapeutic action. Highly effective psychopharmacologists set appropriate expectations about the onset of side effects and onset of therapeutic actions, about the time course of development of tolerance to side effects, and about the length of time for an adequate therapeutic trial. Many patients expect rapid therapeutic actions and also assume that acute side effects will persist as long as they continue to take the medication. It is also counterintuitive to many patients that adding yet another drug to one that is already causing side effects can actually lead to better overall tolerability.

Without setting realistic goals of treatment over the short run (putting first things first), Covey[1] explains that it is difficult to accomplish any long-term results. Putting first things first requires prioritizing the issues (e.g., long-term therapeutic actions vs. short-term side effects), setting realistic goals, and then accomplishing results with an opportunity-minded approach rather than a problem-minded approach. It then takes discipline to carry out the plan according to the set priorities without bailing out when predictable side effects start or expected delays in therapeutic action materialize.

Think Win/Win

Developing a participative treatment plan is a type of negotiation. In negotiating, Covey[1] advocates a balance between too much courage (being too forceful with a patient) and too much consideration (being too reticent). The idea is to develop a plan of action in which both the prescriber and the patient can win (win/win), recognizing that the psychopharmacologic treatment for many patients will be an iterative process of trial and error (several lose/lose scenarios before an eventual win/win). The best logical treatment imposed upon a reluctant patient may not work or be tolerated, creating a win for the prescriber but a loss for the patient. Worse, the patient is lost as an advocate in his or her own care. Following, albeit reluctantly, the irrational demands of a patient (patient wins, prescriber loses) will not work either. "I told you so" is only a Pyrrhic victory. The highly effective psychopharmacologist is always looking for ways to set up a win/win situation. If the patient refuses, deferring action until the next appointment when a win/win might be found may be the best option.

Summary

Adapting the 7 habits described by Covey[1] to clinical practice can lead to the development of a highly effective psychopharmacologist.

REFERENCES

1. Covey SR. The 7 Habits of Highly Effective People: Powerful Lessons in Personal Change. New York, NY: Simon & Schuster; 1990
2. Stahl SM. The 7 habits of highly effective psychopharmacologists: overview [Brainstorms]. J Clin Psychiatry 2000;61:242–243
3. Stahl SM. The 7 habits of highly effective psychopharmacologists, pt 2: begin with the end in mind [Brainstorms]. J Clin Psychiatry 2000; 61:327–328
4. Stahl SM. The 7 habits of highly effective psychopharmacologists, pt 3: sharpen the saw with selective choices of continuing medical education programs [Brainstorms]. J Clin Psychiatry 2000;61:401–402
5. Stahl SM. Are two antidepressant mechanisms better than one? [Brainstorms] J Clin Psychiatry 1997;58:339–340
6. Sheehan DV. Clinical pearls on how to become proactive, and how to understand, and then be understood. Presented at the 153rd annual meeting of the American Psychiatric Association; May 17, 2000; Chicago, Ill
7. Zajecka JM. Practical psychopharmacologists put first things first and think win/win. Presented at the 153rd annual meeting of the American Psychiatric Association; May 17, 2000; Chicago, Ill