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A Commentary on Existential Psychopharmacologic Clinical Practice: Advocating a Humanistic Approach to the "Med Check"

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A patient must feel heard before she will listen. If a clinician does not first listen carefully to a patient's story, pharmacotherapy is reduced to a random target shoot, ineffective and even dangerous. Psychotherapy training teaches clinicians how to listen, among other things, and, unfolding over an hour, has valuable effects.

Psychopharmacotherapy, by contrast, often is shoehorned into a 15-minute session, called a "med check," inhibiting the therapeutic alliance and frustrating both patients and clinicians. That brief clinical contact is intended to include a symptom review, discussion of medication effects, update of relevant medication conditions and treatments, review of significant current life events and stressors, and completion of administrative forms and prescriptions. Rarely is there time for adequate documentation without typing during the session, a distracting practice encouraged by burgeoning caseloads and widespread adoption of electronic medical records.

In this article, our main claim is that the success of clinical psychopharmacotherapy requires adoption of a psychotherapeutic stance. We have previously described in detail the process and components of both initial evaluation and follow-up visits in psychopharmacotherapy practice.[1] We describe "existential psychopharmacology," based on the existential tradition in psychiatry,[2] emphasizing that a human-to-human connection must be established for successful medication treatment.

Empathy precedes and potentiates prescription.

DEFINING "MED CHECKS"

Pharmacotherapy is typically delivered in the brief appointment called a "med check," a follow-up visit after initial diagnostic assessment. The clinician "checks" a list of symptoms, "checks" medications and their side effects, and may change medications and/or doses. Typically, the procedure is scheduled for 15 minutes, an interval chosen for scheduling efficiency and reimbursement targets. For some patients, more time is needed, while others may be adequately served with a brief contact. Nonprescribing mental health professionals rightly disparage the 15-minute "med check" as a rapid-fire superficial accounting of symptoms and side effects.[3,4]

The common practice of eliciting "target symptoms" and assigning specific medications to address these symptoms rather than a broader diagnosis has been criticized. It often is not appreciated that this symptom-oriented approach to pharmacotherapy contradicts the Hippocratic approach to medicine, which emphasized treating diseases, not symptoms.[5] The job of the physician, in the Hippocratic tradition, is to identify diseases that underlie symptoms, not simply to treat the latter. Contemporary pharmacotherapy, being symptom-focused, is non-Hippocratic. In many cases, the target symptoms misdirect the clinician, who might consequently prescribe an ineffective treatment.[1] We propose that empathic listening and alliance-building, combined with informed and systematic inquiry into symptoms, is a powerful approach for responding to patients in a way that appreciates their complexity and individuality. This approach supplements but does not replace a careful diagnostic assessment. Both a systematic approach to diagnosis and more attention to empathic alliance-building are needed.

THE INITIAL ENCOUNTER: SUPPORTING ALLIANCE AND ADHERENCE THROUGH LISTENING

Developing an alliance during the initial appointment increases the likelihood of a second appointment.[5] About one half of patients fail to continue with psychopharmacotherapy,[6] whether in anxiety and depression[7] or schizophrenia.[8] Failing to return, or prematurely discontinuing medications, ensures failure of treatment. An alliance is strengthened by attending to the patient's perspective and concerns. That requires the kind of careful listening that is a challenge to maintain in today's busy clinical settings.

Nonadherence is in part a consequence of the limited efficacy of psychiatric medications, a disappointing fact that underlines the importance of maximizing treatment alliance. In this way, psychopharmacotherapy is not different from other chronic medical diseases, often characterized by similar medication effect sizes. Treatment benefit requires that a patient take medications and come to appointments. Research into enhancing treatment alliance and adherence, not only into finding more efficacious medications, deserves greater attention.[9–12] We believe that an existential listening-based approach has significant value in increasing adherence.

One simple way to begin a listening-based med check is to offer open-ended, nondirective statements or questions (like "How's it going?" or "I suppose things aren't going so well") and then hold your tongue to see how the patient reacts to those comments, avoiding the common practice of starting with specific and targeted questioning.[4] Specific questions may fail to elicit the most pertinent information, or even put some patients on the defensive. Patients often spontaneously provide valuable data regarding their symptoms if one listens as they tell their stories. After initial spontaneous reports, follow-up questioning can draw out necessary further details and clarifications.

This approach to the psychopharmacotherapy visit is, in essence, similar to the approach to an existential or psychoanalytically oriented psychotherapy session. Patients are encouraged to speak their minds freely, and the therapist's job is to listen quietly or engage empathically in a way that facilitates this process.[5]

This "existential psychopharmacology" has 2 major benefits. First, clinical symptoms that are expressed within patients' spontaneous accounts are described in a more accurate and valid way than are those elicited by specific symptom-based questions.[10] Second, as patients tell their stories, and the psychopharmacotherapist listens,

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patients feel heard, understood, and connected with their clinicians. This makes it easier to discuss and address symptoms that are embarrassing or poorly articulated.

Existential psychopharmacology is not a passive approach. Following up a patient's spontaneous report with specific questions gathers useful data while also conveying interest and commitment to the patient. The pharmacotherapist asks interactive questions in order to clarify the definition and meaning of reported symptoms and to negotiate an appropriate treatment plan. The meaning of a symptom may turn out to be different from its initial appearance, and treatment options include a range of interventions that require the patient to understand and choose.

MAKING TREATMENT CHOICES

Patients have preferences; clinicians have evidence-based prescribing recommendations. Where the 2 circles of patient preference and clinician recommendations intersect is where negotiation is required in order to arrive at a treatment plan acceptable to both clinician and patient. This is a critical aspect of the concept of a jointly acceptable "treatment plan." Patients do not need to agree with all that clinicians may want, nor should clinicians accept all that patients prefer. Psychopharmacotherapy visits should end with an agreement, sometimes with an element of compromise when the patient's preferences constrain the clinician's treatment recommendations. The trade-off of compromise is fuller engagement of the patient in treatment planning.[4]

Treatment planning is often the final part of the med check visit. This is when the clinician may need to become more actively educative, explaining why some of the patient's preferences may run counter to their needs or interests despite other considerations that are also important. Too often, for example, treatment decisions are made by clinicians or by patients as though medication risks are the most significant consideration. This can lead to overprescribing of more innocuous but less effective treatments. At the other clinical extreme, very effective medications are sometimes prescribed in light of their efficacy without adequate attention to their serious risks, as for example may be the case with antipsychotics that have anti-insulin effects that cause or worsen diabetes and cardiovascular disease, as well as produce marked weight gain.[13]

As with all medical decisions, exclusively right and wrong answers are unlikely to exist. Instead, a spectrum of choices is available. These will range from the most conservative treatment approaches (no change in medications or a small dose adjustment) to the most aggressive treatment changes (multiple changes in major medications) or, often, one of the available middle options. Careful clinical listening promotes choices that are acceptable to both patient and clinician.

SIMILAR APPROACHES TO MEDICAL CARE TODAY

The discussion presented here is rooted in the existential psychiatry and psychotherapy literature, which dates back 100 years to Karl Jaspers, who introduced the concept of empathy into medicine.[14]

One modern approach that reflects values similar to those we have discussed is patient-centered care,[15,16] defined by the Institute of Medicine as "respecting and responding to patients' wants, needs and preferences, so that they can make choices in their care that best fit their individual circumstances."[17] Motivational Interviewing (MI)[18] also addresses some of the concerns raised in this article. MI, based in existential psychotherapy literature, is a directive approach that explores and resolves the patient's ambivalence about a certain behavior—in this context, taking medications for psychiatric symptoms. These modern approaches reflect values espoused by existential psychiatry, filtered through a more contemporary evidence-based approach. Existential approaches discussed here do not merely reflect "supportive" care.[19]

Supportive psychotherapy is based on the concept of focusing on strengthening the ego; it involves conscious efforts to help patients feel better and do better based on their strengths. Existential psychotherapy also does other things: focus on shared human experiences as opposed to disease orientation; put theories and interpretations aside in favor of experiencing the clinical phenomenon; focus on empathy as the primary mode of diagnosis and treatment; and rely on the interpersonal relationship as a 2-sided and equal experience, as opposed to "doctor" and "patient." Our focus is the use of alliance-building for the purpose of deeper diagnostic clarification, more accurate individualization of treatment, and improved adherence.

SUMMARY

In this article, we have described an approach incorporating some principles of what we call *existential psychopharmacology* and have detailed the core components of a quality follow-up visit. A listening-oriented approach to the first part of the visit, followed by specific questioning to clarify reported symptoms and elicit needed additional detail, enhances follow-up and adherence to medication treatment. Empathic listening also supports the development of a treatment plan based on shared decision-making, informed by psychoeducation to promote evidence-based decisions. The "med check," currently seen by some as a superficial clinical contact, can be of great value when empathic listening and evidence-based decision-making are joined with thoughtful prescribing and adequate time to do it, as in the rest of medicine.

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