

EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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Transition to Private Practice

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If you are a regular reader of this section of the journal, you know that I am a cognitive therapist. You are aware, as well, that I have applied this present-oriented model to aid the adjustment of patients diagnosed with cancer.^{1,2} My initial work in this area was accomplished at the Hollings Cancer Center of the Medical University of South Carolina, working alongside an enlightened oncologist.^{3,4}

In late 2007, the Institute of Medicine of the National Academies, Washington, D.C., published the results of a 2-year study that established guidelines mandating the provision of appropriate psychosocial services to all cancer patients and their families.⁵ For me, the next phase in pursuing this application of cognitive therapy (and satisfying the mandate) came in the form of an opportunity to work as a psychiatrist in an oncology private practice. M. Daud Nawabi, M.D., the head of this outpatient group practice in Charleston, S.C., was instrumental in providing this opportunity.

PRACTICE GUIDELINES

I believe that, in the next decade, every medical facility that treats people with severe illness will have a mental health clinician hired to aid patients' adjustment. Several features of my new job (begun in September 2007) have contributed to its success: (1) Having several examining rooms insures that a space will be available for the clinician to evaluate and deal with adjustment issues for however much time is required. (2) Being allowed to observe and be a party to the medical transaction enables the clinician to decide if his or her services are likely to be useful for the patient. (3) Being able to remain with the patient once the medical visit is over, and medical personnel have departed, facilitates the counseling venture that follows. (4) Permission to set up subsequent psychotherapy appointments in the same manner that future oncology and chemotherapy visits are scheduled helps integrate the clinician into the oncology practice.

THE CONSULTATIVE VISIT

Typically, the oncologist introduces the mental health clinician by name and profession at the outset of the visit. He or she may choose to add that the clinician's presence represents the standard of care of the practice and is not meant to prejudge that this particular patient is in need of mental health care. Once the medical purpose of the visit is achieved and the medical personnel depart, it is the clinician's initial task to *engage* the patient.

I have tended to do this by conveying how long I have worked in this capacity and how, in my view, my approach to the patient does not conform to most general expectations for a psychiatrist. Instead of asking about early life events and family background, I begin by inquiring about the symptoms that led to a diagnosis of cancer. My focus is on how the patient and the family system have adjusted to the diagnosis and treatment of the problem.

Along the way, I will ask the questions that allow for a DSM-IV diagnosis of major depressive disorder or generalized anxiety disorder. I will ask about, or already know, the various medications that the patient takes. I will include an assessment for the presence of psychosis or organicity, when appropriate.

I always find a way to teach and stress the importance of identifying and evaluating the meanings the patient attaches to significant illness-related events. I attempt to separate occurrences that are beyond the patient's control (e.g., the natural history of the disease) from decisions that are well within the patient's capability (e.g., what to do today). I have always decided to include in the interview significant others who accompany the patient, unless the patient requests that they leave.

These consultative visits generally last from 20 to 30 minutes. At their conclusion, I share with the patient my diagnostic opinion as well as a plan for future contact, if that seems indicated. After the visit, I then discuss this appraisal briefly with the patient's oncologist. In the past 6 months (6 hours per week), I have had 175 sessions with patients in this setting.

PSYCHOTHERAPY

I have seen 16 patients for more than 1 session and several for 5 or more sessions each. These brief cognitive therapies have considered a variety of issues: (1) dealing with loss of a family member; (2) planning a new life stage, considering the restrictions imposed by cancer and its treatment as well as new opportunities; (3) anticipating upcoming treatment events; (4) dealing with symptoms

and considering possible explanations for them; (5) establishing perspective when it has been lost; (6) examining the effect of cancer on one's self-view; (7) defining retirement and the inability to continue one's usual work; (8) separating the controllable from the uncontrollable; (9) focusing on the patient's choices and their consequences; (10) putting oneself first versus catering to the needs of others; (11) dealing with the impact of cancer and its treatment on one's spouse and children (especially young children); and (12) dealing with interpersonal (typically marital) problems exacerbated by the patient's diagnosis of cancer.

It is important to state that, so far, no one I have elected to speak with has refused to speak with me. The response to the presence of a psychiatrist has been uniformly positive. My name has been listed on the office door, with no distinction offered to differentiate my function from that of the oncologists. In subsequent articles, I will discuss the specifics of cognitive therapy to aid the adjustment of cancer patients seen in a private practice setting, offering case examples.

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