

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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Brief Encounter

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Finding a place for a psychiatrist in the oncology clinic seems justified because patients diagnosed with cancer are confronted with making some major life adjustments. Frequently, the difficulties faced lead to depressed and anxious moods or anger and sufficient dysfunction to meet psychiatric criteria for an adjustment disorder.^{1,2} Less often, the diagnosis and its consequences precipitate major depression or generalized anxiety in the patient with cancer.

The time allotted to the oncologist, as well as an ample agenda for the visit and minimal training in evaluating emotional states, supports the value of having a mental health professional on the patient's team. Thirty months ago, I was invited to join oncologist Dr. Frank Brescia on morning clinic rounds at the Hollings Cancer Center in Charleston, S.C., 1 day per week. It was his expressed belief that I would complement his efforts and enhance patient care resources.

PSYCHO-ONCOLOGY SESSION

I reported to the clinic that first Thursday morning, with little idea about what I might be asked to do. The oncologist greeted me with a capsule history of his first patient and a brief summary of what he expected to accomplish with the visit. We entered the room together, accompanied (as would happen with each subsequent female patient) by a nurse.

I was introduced to the patient and her friend with a joke, stressing that my presence was "routine" and not specifically occasioned by "this" patient. Dr. Brescia directed the inquiry and then did a physical examination of areas relevant to the presenting problem. My role at this point was one of observation (i.e., listening and no comments). As the visit concluded, the oncologist summarized his findings, commented on the patient's course, ordered relevant laboratory tests, scheduled diagnostic procedures, noted planned chemotherapy appointments, and arranged the return visit. Since most of the patients in this supportive care clinic had already discussed with Dr. Brescia that cure of their cancer was an unlikely prospect, his focus was typically on pain control, sleep problems, fatigue, appetite, and activity. Fifteen to 20 minutes after we had entered the room together that first morning, Dr. Brescia had completed his visit, and he and the nurse departed. I remained alone (with the patient and her friend), without a specific agenda for my interaction with the patient and with an unstated time allotment for the visit.

That first day, I asked the patient (who was preparing to leave) whether she might remain so that I could ask her a few questions. She agreed. I asked if she had discussed her cancer and treatment with her husband, and then, with her 12-year-old son. She began to cry, then acknowledged that her husband was "having more difficulty with her cancer" than she was. Her son, she said, "probably knew," but she had not talked with him directly. We spoke for 10 minutes. She left, thanking me for talking with her, and expressed the hope that I would be available when she returned in 2 weeks. I assured her that I would.

When I emerged from the clinic room, Dr. Brescia dramatically stopped his chart documentation and asked me, "What did you learn, and is there anything we need to do?" This question has followed each visit over the past 2¹/₂ years.

DISCUSSION

Over the years, my portion of the oncology visit has ranged from 10 to 30 minutes. I am aware that a "prolonged" brief visit will deprive me of precious time with the oncologist immediately following the session, as he must go on to his next patient. The initially unstructured encounter has assumed different forms over time. I ask about the patient's understanding of his or her disease and its treatment. I inquire about the patient's concept of supportive (palliative) care. I make a rapid assessment for the presence of major depression, generalized anxiety, or organic mental dysfunction, if my observations suggest these disorders might be present.

I make a brief exploration of the patient's and family's adjustment to the cancer when relevant. I inquire about any current or past psychiatric treatment and always ask if there are any questions the oncologist or I might be able to answer. So, there are components of engagement, assessment, psychoeducation, and brief cognitive restructuring.

When I meet with the oncologist after the visit, I make any relevant recommendations (e.g., start a trial of an antidepressant drug, add an anti-anxiety drug, consider a referral for brief psychotherapy or to my study for brief cognitive therapy to aid in adjustment to cancer).²

What has been the impact of my presence at these cancer clinic visits? I have developed a repertoire of ways to quickly engage an often anxious oncology patient who may not have anticipated my questions, or even my presence. My evaluation and recommendations complement those of the oncologist, leading to a rapport that stresses acceptance and collaborative effort between us. When present for the same patient's successive clinic visits,

I am greeted warmly by the patient and expected to play an active role in the clinic visit.

My participation has led to a significant number of referrals for brief psychotherapy and the detection of significant depression in a number of patients. There has been an unanticipated and gratifying reaction among other oncologists in the clinic whom I have met. It can be summarized as, "Where can I get one of those?" (meaning me!). Three oncologists have referred patients to my study, and 2 others have asked a series of excellent questions about psychiatric aspects of their patients' care, as have a large number of oncology nurses.

Dr. Brescia and I have "modeled" our collaboration for an increasing group of oncology fellows, psychiatry fellows, and student nurses. We have proposed a Psycho-Oncology Fellowship Program for the Medical University of South Carolina. I have learned more oncology in the past 30 months than in the 30 years that preceded them.

The following final questions are relevant to the process of brief psychotherapy. Does my cognitive orientation influence the focus of my questions to the patient? I am sure that it does. My comments typically seek to emphasize some control in a situation where the patient often feels painfully little self-efficacy. Last, but not least, in doing psychotherapy, what constitutes brief therapy? Once I thought that psychotherapy needed years to make an impact, then months, and then weeks. Now, I have learned that an alert and patient therapist can sometimes help a patient in a period of 10 or 15 minutes. Brief therapy, indeed.

Acknowledgment: The opportunity to work alongside Dr. Frank Brescia, a superb physician and teacher, has been unparalleled in my medical career. I am grateful to him as well as to Dr. Marilyn Laken, who introduced us.

REFERENCES

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