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.

Dr Schuyler is in the private practice of adult psychiatry, specializing in adaptation to illness. He is author of the paperback book *Cognitive Therapy: A Practical Guide* (W.W. Norton & Company, 2003). In addition, he worked in an outpatient oncology office from September 1997 to February 2009 helping cancer patients adjust to their disease.

Dr Schuyler can be contacted at deans915@comcast.net.

doi:10.4088/PCC.09f00854

MD Psychotherapist

Dean Schuyler, MD

I have made the argument multiple times for providing a psychiatrist to aid in the adjustment of patients diagnosed with cancer. Especially in this cost-conscious time, one rejoinder I receive is, "Why a psychiatrist? Counseling can be accomplished quite adequately by a psychologist or social worker. Why, cognitive therapists are as often psychologists or social workers as they are psychiatrists!" And the rejoinder is apt.

Depending on your description of the job for the mental health practitioner in the oncology setting, any effective psychotherapist can potentially aid a patient's adjustment. However, questions may arise that relate to the patient's illness. Often, I find that my training in medicine can help me answer these questions. An evaluation that focuses on the patient's diagnosis may point the way to a useful treatment approach. That is the standard strategy for a physician.

I recall telling the oncologist who provided my introduction to cancer in 2000, "All of your patients must be depressed." I learned quickly (and have shared with you) that the most common mental health diagnosis in the patient with cancer is an adjustment disorder, not major depressive disorder.

On those occasions when the clinician is confronted with major depressive disorder, does having antidepressant medication on hand help? I believe that it does, and one of my contributions to the oncology practice in which I previously consulted was to request samples of several antidepressant medications for the practice's pharmacy.

Mr A was referred to me for evaluation by his oncologist during my consultation time in that office. His problem and its treatment, I believe, illustrate the benefit of my medical training.

CASE PRESENTATION

The oncologist asked this 60-year-old, married, father of 3 grown children to "come an hour early" for his oncology appointment so that the psychiatrist would get a chance to talk with him. Mr A was healthy for most of his life until 1 year before we met, when pain in his chest and shoulder led to a workup and diagnosis of multiple myeloma. He had retired to Charleston, SC, 2 years earlier, after a successful 30-year career as an engineer.

Treatment consisted of radiation, followed by the prescription of lenalidomide and dexamethasone and then a stem cell transplant. Mr A felt that now, 3 months later, he was not doing well. This was manifest by constant aches and pains, no "get up and go," poor sleep, low energy, moodiness, no appetite, and a 25-lb weight loss, accompanying constant fatigue.

Believing that the patient was suffering from major depressive disorder, his internist had prescribed mirtazapine, 15 mg/d for 5 days, then 30 mg/d for 10 days. There was no prior history of depression. Diagnostically, Mr A met *DSM-IV* criteria for a diagnosis of major depressive disorder, and mirtazapine was a reasonable choice for treatment. I suggested

that he continue the medication at 30 mg/d for another 3 weeks. I would contact him again at that time, and if there was no response to treatment, I would increase the dose to 45 mg/d.

PSYCHIATRIC TREATMENT

A telephone call to Mr A revealed no major change, and I suggested increasing the antidepressant dose. We met again 1 week later, and his condition was unchanged. I gave him a schedule for tapering and discontinuing mirtazapine. Our third visit came 2 weeks later when I started a trial of escitalopram 10 mg. Mr A felt discouraged but expressed the thought that "recovery from the transplant might take up to a year." He promised to work diligently at the twice-weekly physical rehabilitation that had been prescribed for him.

When we met again 1 month later, Mr A reported that he was "feeling a lot better." He was going to rehabilitation 5 days a week, had started daily walks, and reported that his mood, concentration, and memory were all much improved. It was at this point that our cognitive therapy work began, 6 months after his transplant.

We examined first Mr A's standards for judging his recovery. He had expected a full and rapid return to his condition prior to diagnosis. We discussed the place for exercise and what he could reasonably expect. Then we focused on his definition of, and his plans for, his retirement. Mr A wanted to find an opportunity to function as a consultant in his new home state.

Our fifth visit came 2 months later. He had continued vigorous physical therapy and had continued to notice positive changes in function. He was aware of a dramatic increase in motivation. Mr A said that looking back, he had expected too much, too fast. He was now working as a consultant 5 to 10 hours each week. He had regained the weight he had lost. We reviewed his functioning and his concerns, and I told him that I believed that he had recovered from depression. I recommended 6 months to 1 year of continued antidepressant medication.

We met 2 months later. Mr A noted that others he had spoken to who had suffered from a similar problem and had been given a stem cell transplant told him that it "takes at least a year to recover." He was walking daily, sleeping well, had good energy, and felt "back to normal."

Our seventh and final meeting came 2 months later, now 1 year after his stem cell transplant. We revisited the notion of reasonable expectations, as well as his plan for this stage of his life. He attributed his recovery from depression "largely to the antidepressant medication." He noted that having the opportunity to talk out his thoughts with a therapist really promoted his recovery and adjustment.

In retrospect, Mr A's major depressive disorder occurred in the context of recovering from multiple myeloma and a stem cell transplant but likely could have occurred in a variety of contexts. The syndrome responded to treatment with an antidepressant drug, but clear benefit had also resulted from a course of cognitive therapy. ◆