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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An Attribution Problem

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I have often lectured to students about the 4 basic needs found in most human beings: food, water, sex, and . . . explanations. When situations occur in our lives, we seek ways to understand them. Sometimes our explanations are evidence-based and valid. Sometimes they are superstitious or spiritual or just plain wrong.

The model of cognitive therapy focuses on the meanings people apply to events and situations that lead to distress. Many of these meanings take the form of "attributions" or explanations. When a patient consults a doctor, he or she will invariably have an explanation for the symptoms presented. The patient will seek, then may or may not accept, the physician's attribution for the problem.

A young woman consulted me after presenting a variety of complaints to several primary care physicians. Ms. A was 28 years old, recently married to a man she had known for 5 years, and held a stable job in commercial real estate. Two years ago, she had a series of bladder infections and was treated with an antibiotic. She "reacted" to this drug with episodes of hot sweaty palms, diarrhea, and chest pains. These episodes were followed in 1 week by a "weird feeling" in her head. She returned to her physician, who acknowledged that this could have been drug-related, and the doctor discontinued the drug. The episodes went away.

The symptoms returned 1 year ago, with diarrhea, dizziness, and a similar weird feeling, this time in the context of being a bridesmaid at a good friend's wedding. She consulted a "Doc-in-the-box" who examined her, ordered laboratory tests, and found "nothing wrong."

In the past several weeks, the symptoms have returned. "I was hoping they would go away," she told me, "but instead they seem more frequent now, and they are prohibiting my daily activities." She found that she preferentially was staying at home and had recently refused to travel for her job.

CLINICAL PRESENTATION

Ms. A consulted me, upon referral from the third primary care physician she had recently seen. Her history was mostly unrevealing: no family history of similar symptoms, the middle child in a family of 5 children, academic success in high school and college, and a long-standing relationship with a man she loved and recently had married. No alcohol or drug abuse. "I shouldn't have any stress," she said. "I have a nice home, a good man, and a good job." She also had a life-long love of outdoor activity.

Most recently, her episodically recurring symptoms included diarrhea, palpitations, sweating, chest pains, and a burning sensation throughout her body. My diagnostic impressions included panic disorder and generalized anxiety. We contracted for a course of brief cognitive therapy.

PSYCHOTHERAPY

At the end of our initial session, I explained the cognitive model to her: Anxiety could be understood as the end product of the meanings

(attributions) she attached to situations and events. By identifying her beliefs and considering alternative explanations, she could overcome the anxiety episodes she had been experiencing. The initial "reaction to an antibiotic" she had experienced may in fact have had nothing to do with the drug.

Ms. A returned in a week for her second session. She reported 3 separate instances of anxiety symptom occurrence. In each case, she had acknowledged the situation, identified her automatic thoughts, and found satisfactory alternative explanations that obviated her anxiety. She felt "empowered." We discussed the value of the technique of shift of set. When something was happening to her, she could imagine that it was happening instead to a friend and focus on the advice she might offer to her friend.

We separated events that were "controllable" from those that were "uncontrollable." She could do something about the former, but had to find a way to accept the latter. We discussed the concepts of "participant" and "observer" and illustrated how she could shift from one vantage point to the other. We set our next appointment for 2 weeks later.

In our third session, Ms. A reported no anxiety episodes over the previous 2 weeks. She had handled a routine visit to her gynecologist so differently from the past that her doctor commented on it. She had "stopped saying the things to myself that brought on anxiety." Her husband also noted a remarkable difference and asked: "What has this therapist taught you?"

I described a variety of situations to her and asked her to think them through aloud. She did so flawlessly. "I know I will have times when I need to make a conscious decision to take an alternative path," she said. We discussed the content of our short therapy interaction and focused on what she had learned and how it had helped. Future sessions would be available, if she had a need for them.

I contacted her in 6 months and again 1 year later and was told that she was doing well. Events occur in people's lives, and they naturally make attributions to explain them. Some of these explanations lead to distress. When they are taught that these attributions may not always be correct and that they can find alternatives, some people quickly become masters of their own destiny. Anxiety is the loser, and the patient is the big winner. ◆