Arbitrary Inference

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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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I am a cognitive therapist. Although I acknowledge that problems in later life typically have their origins in early life, I do not believe that the origin needs to be identified in order for change to occur. Making the patient aware of his or her thinking may provide a shorter and surer route to change. Furthermore, we each make cognitive errors all of the time. As I describe these errors, you will become aware (if you are not already) of them in yourself as well as in your patients.

The cognitive error of *polarization* describes our tendency to think in terms of black or white, all or nothing, perfect or flawed. There is no middle ground, no gray, and no partial success for people when they think this way. *Personalization* is the error in which the individual places himself or herself in the center of his or her every thought. There is no sensitivity to the effect of an event on another individual. In the extreme, personalization represents the thinking of the narcissistic individual. *Overgeneralization* is the expectation that, once an event has occurred, it will be forever repeated. There is no novelty—never anything new. Finally, *arbitrary inference* involves jumping to a conclusion not warranted by the data observed.

An anxious medical student once told me on the first day of a month-long elective in medicine that he was scared that he would fail the examination at the elective's end; this was an illustration of an arbitrary inference. He thought that he might have to repeat the elective and could fail it again. Then, he would be asked to leave medical school, and his father would be furious with him.

So, we all do it at one time or another. When our patients are distressed, they often seek to attribute their concern to a physical cause. At times, they are correct. At times, however, they are not correct. Some of the attributions are spurious and may lead to further inferences built on this false foundation. This skewed thinking is one way that the medically ill may add emotional distress to the symptom incurred from the physical problem.

CASE PRESENTATION

I was asked to see Dr A, an older Veterans Administration (VA) inpatient who was presenting a management problem to the hospital staff. He was a 75-year-old former internist, married to his wife of 40 years, with 4 adult children. He ran a medical office practice in Maryland for over 30 years. He graduated from medical school in 1973 and completed an internship in 1974 and a medical residency in 1977. When he retired from the practice of medicine, he and his wife moved to Charleston, South Carolina.

A bout of hematuria signaled the presence of bladder cancer 4 years ago. Dr A was treated with surgery followed by regular BCG (bacille Calmette-Guérin) injections. He was followed with cystoscopies every 3 months. Dr A did well until he developed widespread bone pain and was admitted to the VA hospital in Charleston. X-rays and a computerized axial tomography scan documented the bone lesions, thought to be metastases from his original bladder cancer.

PSYCHOTHERAPY

As a doctor, medical inferencing formed the basis of how Dr A diagnosed his patients. When Dr A developed a medical problem, he applied this principle to himself. As he focused more and more on his own explanations for his symptoms and complaints, Dr A found the medical care he was receiving to be substandard. He complained about his medical care.

Lying in bed, with only occasional contact with the hospital staff, there was ample time for Dr A to think. Some of his productions were useful, but many of them only served to generate anxiety and concern. Dr A saw himself in the final stage of life,

with little hope of survival. He developed signs and symptoms of depression. He slept poorly, had little appetite, and had lost a significant amount of weight. He had very little energy and was often tired. His usually competent memory began to fail. He was angry, sad, and worried most of the time.

Dr A's treatment team decided to start a dose of methylphenidate 5 mg twice daily to treat his depression. When I met Dr A, I emphasized that seeking an explanation for symptoms was a common approach that patients take to illness. When the patient is also a physician, arbitrary inferences related to explaining problems are an all too common finding. The result is often that the patient "creates" things to worry about in addition to his or her physiologically based symptoms. One can easily "think oneself" into a depressed state. In point of fact, Dr A's bone lesions might not be related to bladder cancer at all. Rather, they may indicate a separate condition (multiple myeloma), with a different prognosis and avenue of treatment. I urged Dr A to suspend the inferencing process and allow himself to "be a patient, not a doctor."

Dr A acknowledged that some of his distress might have been self-perpetuated. We spoke about how difficult it was to switch from the role of healer to that of one "being healed." I tried to clearly communicate that, while what he was doing was by no means unique to him, it was complicating the problem rather than aiding the treatment.

I recommended to the medical staff that a special effort be made to make Dr A aware of his treatment team's thinking about his illness. Furthermore, the treatment team might profit from listening to his speculations about the potential causes of his problems. Methylphenidate might quickly help his depressive symptoms, and quieting his active mind of arbitrary inferences might lead to greater comfort and less anxiety and depression.

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