Medical Deception: Overview and Updates

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Disclosures

- Independent of my work as as professor at the University of Alabama, I provide paid consultation services surrounding issues of medical deception.
- My choice to speak on medical deception, as well as the content of my talk, may be biased by this interest. I have worked to avoid this.

Unlearning Objectives

- It is illogical, unhelpful and dangerous to think of genuine illness and feigned illness as mutually exclusive
- Medical deception is not the rare and severe psychiatric problem that DSM tells us it is
- Think dimensionally, not categorically
- Consciousness, automaticity, and intentionality are complicated and require thoughtful assessment for each patient
- We must understand provider roles in enabling medical deception and encourage preventive practices

Who Encounters Medical Deception?

- Routinely
  - Consultation-Liaison Psychiatry
    - Difficult patient consultation
  - Forensic Psychiatrists
    - Investigating malingering or factitious disorder
    - Investigating medical child abuse
- Inadvertently
  - Child Psychiatry
    - Exaggerated psychiatric or medical complaints by parents
  - Adult Psychiatry
    - Excessive medical or psychiatric complaints in themselves or their children

Who Enacts Medical Deception?

- Adults, regarding their own physical or mental health
  - Factitious disorder, malingering, illness anxiety d.o.
- Caregivers of a dependent child, elder, or developmentally disabled adult.
  - Factitious disorder imposed on another
  - Illness anxiety by proxy, malingering by proxy
- Children and adolescents regarding their own physical or mental health
  - In these cases the respective contributions of the parent and child are often unclear

Types of Medical Deception

- Medical conditions
  - Chronic illnesses
  - Physical Disability
  - Recurrent cute illness episodes
- Psychiatric conditions
  - Neuropsychological deficits
  - Psychosis, acute suicide risk, bipolar disorder
  - Developmental disability
- Anything that a professional has to authenticate

Brief History

- Early Theories and Nosology
  - Hysteria –Sydenham, 1697
  - Briquet's Disease – 1859
  - Studies on Hysteria – Freud and Breuer 1895
  - Ganser Syndrome - 1898
  - Psychoanalysis and the ascendency of dissociation
- DSM – The Modern Era
  - Three notable trends

Cramer, P. (2019). What Has Happened to Hysteria?. The Journal of Nervous and Mental Disease, 207(9), 705–706. doi: 10.1097/NMD.0000000000000850.

DSM Notable Trends

Edition	Hysteria	Hypochondriasis	Somatization		Malingering	Factitious
DSM-I 1950	Conversion		Psychoneurosis with Somatic Symptoms			
DSM-II 1968	Hysterical Neuroses	Hypochondria	Briquet's			
DSM-III 1980 - R 1987	Conversion	Hypochondriasis	Somat'n	Psych Factors Affecting Phys Cond.	Malingering	Factitious DO
DSM-IV 1994 -TR 2000	Conversion	Hypochondriasis	Somat'n	Psych Factors Affecting Phys Cond.	Malingering	Factitious DO (proxy?)
DSM-5 2013	Conversion	Illness Anxiety DO	Somatic Symptom DO	Psych Factors Affecting Phys Cond.	Malingering	FDIOS FDIOA

Brief History

Three Major Trends

- From unreal to real illnesses
  - Early recognition of the connection between stress/trauma and illness
  - Process referred to as somatization
  - Poorly defined mechanisms
  - Genuine objectively verifiable disease
    - Asthma, peptic ulcers,

"DISORDERS DUE TO DISTURBANCE OF INNERVATION **OR OF PSYCHIC CONTROL**"

DSM Notable Trends

Edition	Hysteria	Hypochondriasis	Somatization		Malingering	Factitious
DSM-I 1950	Conversion		Psychoneurosis with Somatic Symptoms			
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Brief History

"Psychosomatic" Medicine

- Theory and research on the cascade of hormonal and neurotransmitter responses to stress unifies mind and body for a subset of illnesses.
  - Type A coronary prone personality
  - Biopsychosocial models of pain
  - HPA / SAM
  - Psycho-neuro-immunology
- Explains the psychological role in the etiology of disorders as medically genuine (biologically based).
- Patients are "reclaimed" as "legitimate" medical patients

Brief History

Three Major Trends

- Filling in the blanks for psychogenesis
- The developing recognition of intentional medical deception

DSM Notable Trends

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Brief History

Three Major Trends

- Filling in the blanks for psychogenesis
- The developing recognition of intentional medical deception
  - Medical deception was regarded as psychologically uninteresting.
  - "secondary gain"
  - Up until DSM-5 FD was it's own segregated category

Brief History

Three Major Trends

- Filling in the blanks for psychogenesis
- The developing recognition of intentional medical deception
- The persistence of the psychodynamic default

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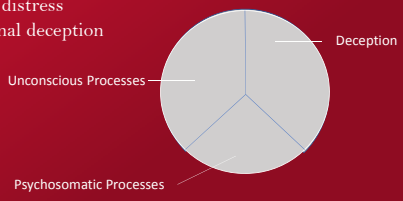
Where do we stand now?

- The connection between psychological factors and illness might be:
  - A yet to be discovered "real" disease with a biological mechanism (gut bacteria)
  - The unconscious and unintentional production of physical distress
  - Intentional deception



Is it real, or is it in your head?

Genuine — Exaggerated — Psychological

One implication of thinking this way is that life-threatening illnesses may be prevented or cured by faking them

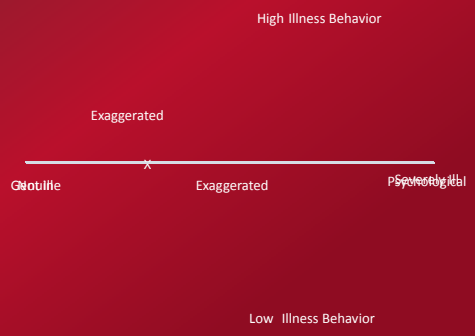
This gets less hilarious when you realize that this can be the source of serious medical error

- Firing patients
- Departures from standards of care
- Mistaking mental health problems as evidence of fakery

DSM-5 Tells Us What Not to Do

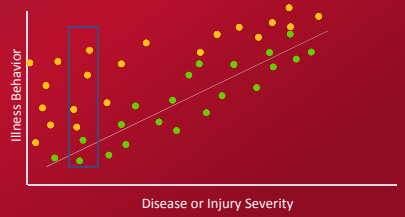
- Avoid either-or thinking
  - Verified disease does nor disqualify somatic symptom and related dos
- Avoid pejorative, dismissive labels
  - Hypochondria -> Illness Anxiety Disorder
  - "Unexplained" is a euphemism for "not real"
- Avoid diagnosis by exclusion
  - But this calls for affirmative criteria

Is it real, or is it in your head?

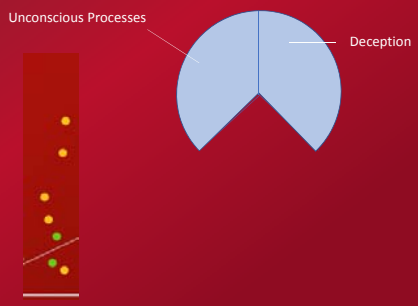


Illness Behavior

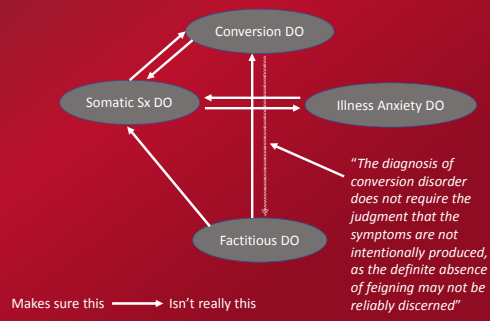
- Illness behavior is abnormal behavioral, social, and psychological responses to real or imagined disease or injury



Accounting for Illness Behavior



Deferential Diagnoses?



"The diagnosis of conversion disorder does not require the judgment that the symptoms are not intentionally produced, as the definite absence of feigning may not be reliably discerned"

Makes sure this → Isn't really this

DSM For Dummies

"Assume that the excessive illness behavior is a product of still-mysterious unconscious forces that somehow cause the experience of physical symptoms that are unrelated to known patterns of biological functioning; unless, of course, you accidentally catch the patient faking, but you are certainly under no obligation to actively look into that possibility".

Consequences of the DSM Approach

- Factitious Disorder and Malingering will only be diagnosed when physical (not psychological) evidence is available to prove active deception.
- Physical evidence is only available for the most audacious instances of medical deception
- The consequence is FD and Malingering will falsely appear to be:
  - Severe (untreatable)
  - Rare (not worth bothering about)
  - Categorically distinct from the other somatic symptom disorders.

Consequences of the DSM Approach

- Undermines both the empirical and clinical search for (non-psychoanalytic) motivational explanations for excessive illness behavior
- Leads us to overlook mild to moderate cases of medical deception that are expressed as subjective symptoms, such as weakness, fatigue, dyspepsia, and pain.
- All of these things severely adversely impact our understanding of Factitious Disorder and Malingering.
  - Specifically our ability to prevent it!

The Sick Role

- Talcott Parsons, 1951
- Described the compelling social contract that is activated among an identified sick person and those within their social orbit.
- Expectations for the sick person
  - Try to get better
- Expectations of other
  - Support, both instrumental and emotional
  - Forbearance
  - Kindness

The Sick Role

- Think of the sick role the social scaffolding for adaptive illness behavior
  - Facilitates adaptive illness behavior
  - Requires occupants of the sick role to relinquish it as soon as possible.
  - Punishes those who give sick people a hard time
- It is no exaggeration to say this is one of the most *powerful* human social norms.
- Medical deception cannot be fully understood without reference to this social contract.

My Bottom Line

I believe that the construction of the DSM and our individual reluctance to see and act upon consciously motivated excessive illness behavior reflects the powerful norm of not accusing people of faking illness.

We wait until we have undeniable evidence of faking, get angry, and fire our deceptive patients.

They go to the next nearest hospital and repeat the process.

This helps no one

Excessive Illness Behavior

Predisposing Factors

- A genuine chronic illness or physical disability
  - Sick role enactment is more believable
- Strong psychological needs for approval and belonging
  - Insecure attachment
  - Borderline personality functioning
- Barriers to the usual routes to social support
  - Poor social skills
  - Powerlessness
  - Poverty
- These are all problems the sick role is good at solving

Precipitating Factors

- Acute illness
  - Adventitious learning about the powerful reinforcing treatment one receives when sick.
- Threat of interpersonal rejection or criticism
- Being genuinely but irrationally worried about being sick
  - The power to make the medical system provide the reassurance for which one is desperate
- An acute predicament
  - The urgent need to get out of something
  - The need to secure money from a lawsuit

Perpetuating Factors

- The need to maintain the rouse in order to avoid be caught breaking the sick role contract.
- An addiction-like compulsion to experience the rewards of the sick role
- The powerfully felt expectation of others to honor claims to the sick role
  - "Go big or go home"
- Structural aspects of the healthcare system
  - EMRs
  - Discoordinated care
  - Procedure based income streams

Assessment

- Two Step Process
  - Affirmatively establish the presence of excessive illness behavior
    - This really can't be done while ignoring the medical evidence of disease / injury.
    - Exclusion
  - Arrive at a functional assessment of the psychological mechanisms that caused and maintain the excessive illness behavior

Indicators of Excessive Illness Behavior

- Negative test results
- Failure of reliable treatments
- Voiced suspicions
- Unobserved signs
- A bias towards "more"
- Inappropriate influence
  - Giving an inaccurate hx
  - Misrepresenting the work of other providers
  - Controlling access to previous records
  - Insisting on tests or treatments

Hamilton's Sign

Good Doctor	Good Person
Makes/Keeps patients well	Makes/Keeps people happy
Verifies / Questions	Trusts / Accepts
Follows standards of care	Makes exceptions
Sets limits	Acquiesces

If a provider finds themself having to decide between being a good doctor and a good person, there is a strong chance that the patient/family is engaged in some type of medical deception.

Indicators of Excessive Illness Behavior

- These characteristics should be ignored
  - + Difficult patients / parents
    - + Critical, entitled, irritating
  - + Anxiety about diagnosis or treatment
  - + Multiple symptoms that come and go.
  - - The existence of a clearly verified diagnosis

Understanding the Mechanisms

- Inferences from functional relationship between "illness" exacerbations and threats in the environment.
- Reports of medical events that are objective but that are unobserved or unsubstantiated medically. (e.g., seizures, high fever)
- Catching the patient in lies, or inconsistencies
- Is the excessive illness behavior as much as the patient can get away with (factitious disorder) or as little as needed to get a benefit (malingering)

Understanding the Mechanisms

- Two Cautionary Notes
  - The mere existence of a benefit does not prove that the benefit motivated the illness behavior.
  - All really psychologically useful deceptions include self-deception.

Factitious DO or Malingering?

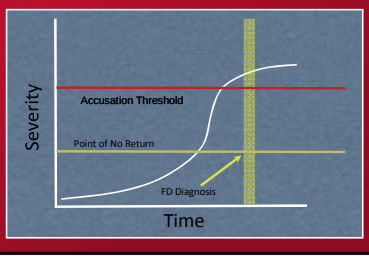
- I don't think this matters much
- Malingering is a poorly understood problem that elicits stereotypes that misguide assessment, treatment, and management
  - Overly simplistic belief that malingerers are
    - Greedy and shiftless
    - Drug seeking
    - Litigious opportunists
- There is not clear line between the psychological benefits that define factitious disorder and the instrumental/material benefits that define malingering
- Both types of benefits may coexist

Factitious DO or Malingering

- Malingering may be the only way powerless people can
  - Gain admission to a hospital to escape domestic abuse
  - Gain admission to a hospital to secure food for a child in a food insecure family
  - To obtain school excuses for a struggling student with undiagnosed ADHD.
  - Avoid work presentations for someone with disabling social anxiety
- Determining that someone is malingering should not be the end of your assessment, it should be the beginning of it.
  - The reasons for it may reflect modifiable psychological problems.

Snapshot Problem

1. 8 m.o. with diffuse complaints of fussiness GI pain
2. 2 y.o. w/ a G-tube and a hx of multiple endoscopies. Multiple hosps. Now with reports of bloody stool and a placement site infection.
3. 14 m.o. w/ a complex history chronic vomiting and diarrhea. Conventional symptomatic tx has not worked, tests negative.



A Case Example

EVIDENCE-BASED PRACTICE IN CHILD AND ADOLESCENT MENTAL HEALTH
https://doi.org/10.1080/23794925.2017.1389320

Routledge
Taylor & Francis Group

The Behavioral Treatment of Suspected Conversion Disorder in Children: Providing an Exit Strategy

Dane C. Hilton and James C. Hamilton

Department of Psychology, The University of Alabama, Tuscaloosa, AL, USA

We told him he had a brain injury, like a concussion
Develops some type of paroxysms while on vacation
We told him to recover we'd have to take away his screen time to rest his brain
They recur
We said we'd reintroduce it gradually as long as no more seizures occurred.
He is brought to UAB for a work up
He never had another seizure after the day we started that "treatment"
He starts to have suspicious seizures almost continually
Diagnosed with conversion after a negative VEEG and sent to us at UA

Prevention and Early Detection

- Be attentive to early signs of developing excessive illness behavior
- Intervene using "face-saving" stress and coping frameworks before patients have passed the point of no return.
- Encourage strict adherence to standards of care as a defense against inappropriate influence by the patient/family.

Prevention and Early Detection

- Practice differently
- Rediscover narrative medical notes
  - Document inconsistencies
  - Leave breadcrumbs
- Get notes from other providers and look for their breadcrumbs
- Warn vulnerable patients about the allure of the sick role
- Care more about why people are engaging in excessive illness behavior than catching them

Conclusions

- Much of what we think we know about the role of psychological factors in medically unexplained presentations is not empirically validated or clinically useful.
- Binary thinking about real vs. fake, conscious vs. unconscious, material vs. psychological benefits, is unhelpful.
- A multivariate/multidimension approach to understanding the nature and functional significance of excessive illness behavior is required.
- Prevention and early detection requires a dimensional developmental approach.