

# Novel Cases: Malingering by Animal Proxy

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Malingering to obtain medications of abuse is well documented in the general medical setting. However, we have found no cases previously reported of such malingering in a veterinary setting. We report five cases submitted by veterinarians in which clients (pet owners) are strongly suspected or confirmed to have been engaging in malingering to obtain controlled medications for their personal use. Cases bear a striking resemblance to malingering in the general medical setting for drugs to abuse. We propose that veterinarians, like their medical counterparts, are potential targets of malingering by their clients for drugs of abuse. Because of their familiarity with this condition, psychiatrists may have a role in training veterinarians to recognize malingering on the part of their human clients. In addition, psychiatrists may benefit from familiarizing themselves with novel forms of malingering, such as are presented in this case series.

*J Am Acad Psychiatry Law* 30:520–4, 2002

Malingering to obtain medications for purposes of drug abuse is well documented in the general medical setting.<sup>1,2</sup> However, we know of no cases previously reported of such malingering in a veterinary setting.

A diagnosis of malingering is considered when a patient is suspected of intentionally producing false or grossly exaggerated physical or psychological symptoms. The deception is motivated by external incentives such as avoiding work, obtaining financial compensation, evading prosecution, or obtaining drugs.<sup>3</sup>

In a veterinary setting, malingering takes on a different twist. Instead of misrepresenting illness in themselves, clients (pet owners) report false symptoms in their pets to veterinarians.

External incentive must be identified when considering a diagnosis of malingering.<sup>4</sup> External incentive for a client in the veterinary setting may be overlooked. In the following cases, veterinarians

suspected abuse of veterinary medications by the client (pet owner) as the external incentive driving malingering behavior. Abuse of veterinary drugs by humans is well documented. Anabolic steroids, sympathomimetic agents,<sup>5</sup> muscle relaxants,<sup>6</sup> and anesthetics<sup>7,8</sup> used for veterinary purposes have been reported to be abused by humans.

There are reports of persons obtaining veterinary medications for abuse by burglary of veterinary clinics,<sup>9</sup> from mail-order catalogs,<sup>6</sup> and on the black market.<sup>5</sup> There are also reports of veterinary staff taking veterinary drugs for personal use.<sup>7</sup> However, we have found no previous reports of malingering by a pet owner to obtain a veterinary drug intended for abuse. We now report on five novel cases of malingering in a veterinary setting.

## Methods

Permission was obtained from the listserv manager to distribute a questionnaire to approximately 650 veterinarians belonging to an e-mail listserv.<sup>10</sup> Veterinarians belonging to the listserv were primarily from the United States, Canada, Australia, and the United Kingdom. They were asked whether they had ever suspected or confirmed that a client had taken a drug prescribed for a pet and whether this had changed their prescribing practices. Results of the questionnaire are published elsewhere.<sup>11</sup> For the pur-

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pose of identifying cases, veterinarians were asked to submit case reports in which a client was suspected or confirmed to have taken the pet's medication for personal use. Thirty-five veterinarians submitted one or more case reports. The authors selected five cases that best illustrated malingering behavior by clients who were attempting to obtain veterinary medication for personal use. Cases are told in the first person as submitted by participating veterinarians.

### Case Series

#### *Case 1: Benzodiazepine*

Setting: Veterinary clinic in United States, early 1990s. A female client in her late twenties, who had visited the clinic several times sporadically, came to my clinic describing symptoms in her dog consistent with the diagnosis of noise phobia. She reported that symptoms occurred during thunderstorms and described the dog as acting frantically. Results of a physical examination of the dog at this time were normal, but this is not unusual in noise phobia, in which a diagnosis is usually made by the client's description of pet behavior. The client specifically requested that I prescribe Tranxene, a benzodiazepine, stating she had read that this medication would be useful to treat her pet's condition. When I searched the behavioral texts, Tranxene was noted as one of the first-line treatments for noise phobia, and I felt comfortable prescribing it in an oral dose of 7.5 mg, as needed at the first sign of storms.

The client called me at the office approximately two weeks later, reporting that Tranxene had been beneficial for her pet during several storms, but she went on to relate that during a recent storm, the pet had "jumped up on the kitchen counter and spilled the medications down the sink." She requested that I call in a refill prescription for the pet because of this mishap.

I contacted the pharmacy to determine when the last prescription had been filled. The pharmacist thought it his duty to warn me ("be careful, Doc") that the client had recently filled several prescriptions for benzodiazepines, including Tranxene, prescribed by medical doctors. I became wary and decided that I was in a difficult situation. However, with this information, I decided not to refill the medication for the client, because of a suspicion that the client might be taking the drug I had prescribed for her pet. I called the client back and told her that the symptoms she described in her dog were probably not noise

phobia and suggested that we would discuss treatment the next time she brought the pet into clinic. The client never returned to clinic.

#### *Case 2: Anabolic Steroid*

Setting: Veterinary Clinic in Canada, 1986. A male client, unknown to me, arrived at my clinic unaccompanied by an animal and reported concern about his extremely thin dog. He wondered if I could prescribe any medication that would "make my dog gain weight." He had not mentioned any specific drug at this point.

I had no suspicion of his motives and asked him a few general questions about his dog. He described a middle-aged German Shepherd dog that was severely underweight and was not eating well. I suggested to him that if his dog was as he said, it should be seen by a veterinarian before any course of action was taken. After several suggestions of this nature by me, he became somewhat impatient and told me that another veterinarian had suggested that his dog should be prescribed Winstrol tablets (anabolic steroid). Still unsuspecting, I told him his dog should be examined, and that it was very unlikely that it had any condition that would be helped by Winstrol. At this point, about five minutes after his arrival, the gentlemen gave a sigh of exasperation and left my clinic, never to return.

Later, on discussion with my employees, it became clear that this person's story was almost certainly fabricated. He was known to one staff member as a bodybuilder with an unsavory reputation. It was rather embarrassing to me that his stocky build and complexion affected by acne had not raised some suspicion of anabolic steroid use while I was conversing with him. On the other hand, I was pleased that by applying basic medical principles, I had thwarted his scheme, albeit naively. In hindsight, the frustration he expressed left me with the disquieting thought that he had probably had success with his method in the past at other veterinary clinics.

#### *Case 3: Thyroid Supplement*

Setting: Veterinary Clinic in Canada, 1995. A past female employee of my clinic had a dog with hypothyroidism, which I was treating with levothyroxine. I treated her pet while she was employed for three months, and she remained a client afterward for six months. On several occasions, she asked for additional refills of a prescription that should have lasted much longer. I was surprised to find out that she was

also a client at another veterinary clinic in town, receiving thyroid medication for her pet there as well.

I went back to my records to determine whether medication from the inventory was missing during her employment term with me. Unfortunately, the records did not give me the specific information for which I was looking, since thyroid medication is not a controlled substance. I advised the client that I would no longer see her (and her pet). I explained it was in the best interest of her pet to stay with one veterinarian. She was believed to be consuming levothyroxine in an effort to lose weight. Coincidentally, she did lose approximately 25 pounds body weight in a few months.

*Case 4: Opiate*

Setting: Veterinary Clinic in United States, mid 1980s. A male professional in his early thirties, from a family that had been clients for years, called the clinic describing a “cough” in the family dog. I had examined the pet at yearly intervals, and the cough had started subsequent to an annual examination during which no cardiopulmonary signs were noted. The client was fairly detailed in his description, enough that I was convinced it was not a cardiac cough or anything that needed a thorough work-up in office. He called during heavy pine pollen season that can cause a cough in dogs. I seem to remember he requested Hycodan (hydrocodone) or codeine, but I suggested that we use Torbutrol (butorphanol), as it was indicated for treatment of cough and was less constipating and longer acting than the other agents. I prescribed a 7- to 10-day oral course of 5 mg of Torbutrol to be administered every eight hours.

After several months of refills, the dog continued to cough, by the client’s report. I became concerned that the cough might be due to something besides allergies. One day when he called for a refill, I learned that the dog was not living with him. I wondered how he could describe a cough’s timing and characteristics if he was not there with the dog. That was when I became suspicious and called his mother, with whom the dog was actually living. I was surprised his mother had not brought in the pet for this lingering cough. I voiced my concern that the pet needed a thorough work-up rather than continued antitussives. His mother got very quiet and said, “The dog isn’t coughing.” I replied, “I didn’t think so.” The mother then thanked me for calling and asked me not to refill the medication. Her lack of

surprise and calm understanding spoke volumes, which led me to believe that her son was seeking drugs, and she was aware of the problem. The client never called and never came to the clinic at any subsequent time.

*Case 5: Antidepressant*

Setting: Veterinary Clinic in Canada, 1994. A new client, a young female in her late twenties, brought her dog to the clinic and specifically asked that I prescribe amitriptyline for her dog. She said her dog “went crazy at home, destroyed the place,” and was “extremely nervous all the time.” I examined the dog and could find nothing wrong; however, that’s not unusual for behavioral problems. The owner related that a previous veterinarian (she had “just moved”) had prescribed amitriptyline for her dog in the past and that it had worked well. I asked for the name of the previous veterinarian for collateral information, but the client was unable to provide the veterinarian’s name. Although the owner seemed far more anxious and agitated than the dog, I agreed to treat her pet, and the provisional diagnosis was separation anxiety disorder. I prescribed oral amitriptyline at 30 mg for administration every 12 hours for 21 days.

We placed follow-up telephone calls, but we could not reach the owner. However, she was back on our doorstep about 10 days later looking for a refill (the prescription should have lasted about three weeks). At this point, it was clear that the medication was being misused. I refused to refill the amitriptyline and suggested we try something different, acepromazine (a sedating phenothiazine). Admittedly, it was an excuse, because I thought something was wrong. The client was not receptive to this idea and said that she would “think about it.” We never saw her in the clinic again. I strongly suspect she had taken the drugs and that there was nothing wrong with her dog.

**Discussion**

We propose that the human behavior described by veterinarians in these cases constitutes a form of malingering. According to Cunnien,<sup>4</sup> an atypical presentation of physical or psychological symptoms in the presence of external incentive should trigger consideration of malingering. In each case, atypical factors were noted by veterinarians, alerting them to the possibility of deception on the part of their clients. External incentives for clients were identified in each

case, and veterinarians were confronted not only with falsely reported physical symptoms but also with psychological symptoms such as separation anxiety and noise phobia. The animal was a passive participant in each client's scheme to deceive veterinarians. Thus, we assert that the cases represent a novel form of malingering: by animal proxy.

The similarities between the actions that characterize malingering to obtain medications for the purpose of drug abuse in the medical<sup>1,2,4,12</sup> and veterinary settings are striking. Clients requested specific medications and failed to follow up in the clinic after veterinarians ceased to prescribe the requested medicines (removal of external incentive). Clients asked for early refills and participated in "doctor shopping."<sup>12</sup> To our knowledge, Case 1 (benzodiazepine) represents the first report in which both a medical doctor and veterinarian were involved in "doctor shopping" on the part of the same client. Atypical factors were also common, signifying that clients had left clues to their deception that might be detected by veterinarians.

Because the client's external incentive, suspected in each case, was to obtain controlled medication for personal use, it is important to point out that doses of medications included in this case series all overlapped with doses used in humans. Although pets usually weigh much less than humans, pharmacokinetics in animals also differ (e.g., more efficient hepatic metabolism). Higher doses of medication are often required per pound of animal body weight compared with humans. For example, the dose of Tranxene for a large dog is 22.5 mg per day.<sup>13</sup> The corresponding dose for anxiety in humans is 7.5 mg orally three times daily or 15 mg orally each night, as a single dose.<sup>14</sup> Therefore, it is evident that veterinary clients may be exposed to controlled substances at dosages that could lead to dependence. Despite recognition of the potential for abuse of veterinary medications by clients,<sup>10</sup> veterinarians may not have the formal training in substance abuse that could aid them in identification of at-risk clients. Some individuals have proposed incorporating substance abuse education into the formal curriculum of veterinary schools.<sup>15</sup> Psychiatrists, especially those with additional training in addiction or malingering, may have a future role in providing substance abuse education to veterinarians.

For psychiatrists, it may be useful to examine similarities between cases of malingering by animal

proxy and previously reported cases of a similar condition known to occur in the medical setting, factitious disorder by proxy (Munchausen syndrome by proxy). In both conditions, the actual patient plays a passive role, serving merely as a conduit through which a caretaker may achieve his or her objective. In factitious disorder by proxy, the patient is usually a preschool child<sup>3</sup> whose limited verbal skills allow a caretaker to take a dominant role during interaction with medical professionals. A pet, similar to an infant, is unsophisticated and without verbal skills and thus is at risk for use in malingering by proxy. Pets involved in malingering by animal proxy could be subject to unnecessary suffering (unnecessary blood tests, invasive testing, harmful treatments) as a result of their caretakers' actions, not unlike children involved in cases of factitious disorder by proxy.<sup>16</sup>

Distinguishing factors between these conditions include the motivation for the caretakers' behavior. In each case of malingering by animal proxy, the external incentive was readily apparent to veterinarians. By definition, external incentive is absent in cases of factitious disorder by proxy, in which the caretaker's behavior is presumed to be motivated by psychological benefits of assuming the sick role by proxy.<sup>3</sup> An important gender difference exists between caretakers in each condition. Whereas a preponderance of factitious disorder by proxy cases have involved female caretakers,<sup>3</sup> no overt gender predominance exists in caretakers who engage in malingering by animal proxy.<sup>10</sup> Methods that caretakers used to deceive clinicians also differed. In factitious disorder by proxy, caretakers reported false symptoms to physicians and deliberately induced symptoms of illness in children.<sup>3</sup> For example, a caretaker might administer ipecac to a child to simulate gastrointestinal illness. By contrast, in no cases of malingering by animal proxy did caretakers actively induce symptoms in animals, at least to the knowledge of veterinarians. Deceit came only in the form of false reports to veterinarians.

Upon literature review, we found only two previous reports of suspected malingering by proxy in the medical setting.<sup>17,18</sup> More cases may exist, particularly in the pediatric or geriatric settings in which caretakers often play a dominant role in the patients' interactions with medical professionals. The paucity of current cases reported in the literature could be due to several factors. First, malingering by proxy is not currently recognized in DSM-IV, and physicians

therefore may not be on the watch for this behavior. Second, the condition may be rare. Third, the condition may elude diagnosis. As Resnick<sup>19</sup> states, “No other syndrome [than malingering] is so easy to define but so difficult to diagnose.” This may be even more relevant to malingering by proxy, because of “the extensiveness of the investigation needed to make such a conclusion.”<sup>20</sup> Finally, the potential for an adverse outcome for the patient due to misdiagnosis might make physicians hesitant to diagnose malingering by proxy, even if strongly suspected.<sup>20</sup> We are planning further studies of malingering by proxy to characterize this condition, about which little is known currently. Until such time, psychiatrists and other physicians, particularly those who treat children or the elderly, should be aware of the possibility of malingering by proxy in their practices.

### Acknowledgments

The authors thank H. W. LeBourgeois Jr., DVM, for imparting his knowledge of clinical veterinary medicine and each veterinarian who contributed to the case series.

### References

1. Moldwin R: When renal colic is really malingering. *Postgrad Med* 82:49–52, 1987
2. Rubinstein JS: Abuse of antiparkinsonism drugs: feigning of extrapyramidal symptoms to obtain trihexyphenidyl. *JAMA* 239: 2365–6, 1978
3. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders* (ed 4). Washington, DC: American Psychiatric Association, 1998
4. Cunnien AJ: Psychiatric and medical syndromes associated with deception, in *Clinical Assessment of Malingering and Deception* (ed 2). Edited by Rogers R. New York: Guilford Press, 1997, p 45
5. Auge WK Jr, Auge SM: Naturalistic observation of athletic drug-use patterns. *Subst Use Misuse* 34:217–49, 1999
6. Luehr JG, Meyerle KA, Larson EW: Mail-order (veterinary) drug dependence [letter]. *JAMA* 263:657, 1990
7. Shomer RR: Misuse of ketamine. *J Am Vet Med Assoc* 200: 256–7, 1992
8. Spoerke DG, Hall AH, Grimes MJ, *et al*: Human overdose with the veterinary tranquilizer xylazine. *Am J Emerg Med* 4:222–4, 1986
9. Nolen SR: Sting ends ketamine theft ring. *J Am Vet Med Assoc News*, March 1, 2000. Available at <http://www.avma.org/onlnews/javma/mar00/s030100c.asp/> (site visited February 19, 2001)
10. LeBourgeois HW III, Foreman TA, Thompson JW Jr: *Survey on Client Misuse of Veterinary Drugs*. New Orleans: Tulane University School of Medicine, 2001
11. LeBourgeois HW III, Foreman TA, Thompson JW Jr: Drug-seeking in veterinary clinics: prescription for disaster. *Vet Tech* 22:461–5, 2001
12. Longo LP, Parran T, Johnson B, *et al*: Addiction. II: identification and management of the drug-seeking patient. *Am Fam Phys* 61: 2401–8, 2000
13. Overall KL: *Clinical Behavioral Medicine for Small Animals*. St. Louis: Mosby, 1997
14. Albers LJ, Hahn RK, Reist C: *Handbook of Psychiatric Drugs*. Laguna Hills, CA: Current Clinical Strategies Publishing, 2001
15. Raef TA: Workshop challenges veterinary community to address substance abuse. *J Am Vet Med Assoc* 207:290–1, 1995
16. Manthei DJ, Pierce RL, Rothbaum RJ, Manthei U, Keating JP: Munchausen’s syndrome by proxy: covert child abuse. *J Fam Violence* 3:131–40, 1988
17. Cassar JR, Hales ES, Longhurst JG, *et al*: Can disability benefits make children sicker [letter]? *J Am Acad Child Adolesc Psychiatry* 35:700–1, 1996
18. Roberts MD: Munchausen by proxy [letter]. *J Am Acad Child Adolesc Psychiatry* 36:578–9, 1997
19. Resnick PJ: The detection of malingered psychosis. *Psychiatr Clin North Am* 22:159–72, 1999
20. Roberts MD: Reply: Munchausen by proxy [letter]. *J Am Acad Child Adolesc Psychiatry* 36:1491–2, 1997