Yale Conferences & Events

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Parallel Sessions

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**Session 3B.2: Malingering as Embodied Critique by Marcus Byrd and Austin Bryan**

Speaker: Welcome back. You are welcome to send technical questions to the host in the chat panel. If you would like to submit a question, please do so in the Q&A panel.   
  
Speaker: Hello everyone. Welcome to the last section of our 2022 conference. We have live closed captions available. You can view them by selecting “Show captions” on your menu. Each section will be about 35 minutes. The first section will have one presenter and the second has two presenters. Please space yourselves for COVID practices. We would love to hear from you in the feedback form.   
  
Take space and make space. Use "I" rather than using generalizations. Avoid instances of distress or violence. I am excited for our next presentations.   
  
Fabian Fernandez: I am a white Latino man with a purple hoodie on and my nails are painted white. This is from my dissertation entitled, ‘Where the Safety Net becomes the Carceral Net’. I want to talk about the policing of healthcare. I am going to share my screen. I am having some technical issues. Give me a moment. The slides weren't moving.   
  
I hope you can see that. I want to start by asking how we bring abolitionist to.   
  
My work explores this logic, and it is rooted as an abolitionist organizer. Let's take a moment to breathe here. I recognize that psychiatric emergencies can be emotional. This is by my experience navigating and supporting loved ones experiences. I want to honor your experiences. It features some scenes of involuntary holds, chemical restraints and there are content warnings.

If it makes sense to skip over these ethnographic [stories], each slide has large text and warnings. I don’t share these stories to sensationalize violence. I share these to critique the logic that is happening while providers think about how to deal with patients.

I focus on the emergency department, and they have to go through the ED to be screened for COVID in order to be admitted. Psychiatrists have been hired to evaluate holds while folks are waiting for admission.   
  
These changes have expanded the tools to all patients in the ED. I argue that effective responses to conflict and restraints are interpreted as mobilizing holds and restraints to manage these patients. The event of deinstitutionalization did not abolish surveillance or punishment but has distributed them. I argue the limitation of psychiatric holds has brought the work of medicine and the law closer together.   
  
As campaigns call for divestment of these states, we have to be vigilant in the ways it is being used not only in ED but also in society at large.

From the 1960s to the 80's it described the deinstitutionalizing process where people were released from these hospitals to community treatment centers. It allowed the release of people with developmental disabilities and mental illness, they still required measures for seclusion for their own good or for society.

It can be successful, but it doesn’t mean the end of psychiatric oppression. I believe that Black studies and disability studies have a lot to learn from each other. Saidiya Hartman writes about the enduring studies of slavery.

Emancipation is confused for abolition of slavery. Slavery was deinstitutionalized. The conditions of forced labor and anti-Black forms of violence highlight the need for abolition.

Oppression is furthered through the responsibility of freedom. Those emancipated encountered the responsibility with little enjoyment. They argued people had rights to take care of themselves in a disintegrating safety net and growing carceral net.   
  
Liberation can serve as legitimation just as emancipation rehabilitated. It turned psychiatry to a legitimate science.   
  
I review here 5150 psychiatric holds. There are 3 justifications to place patients on a hold: Grave Disability and danger to others and danger to self. I reviewed a doctor who summarized the challenges. It's a pretty large quote. I want to quote it in full.

[Transcriber’s Summary:

We're worried about the risks of leaving; we'll call in our colleagues with 5150s. They might not be appropriate with the law, but they do so, because they know there's language that's not actionable by the sheriffs. If I don't have a 5150, they won't hold the patient. There's what's right for the patient and there’s also defensiveness by the physician.

So that is a situation where maybe physicians are not acting in the best interest of the patient but acting more in the best interest of themselves and their license. “What do we do? What do we do?” And if you're not sure, you pull the 5150 because that'll get you everything and then you can pare it down depending on what your evaluation shows.” ]  
  
That's the doctor’s way of thinking. This comment highlights the ways that psychiatric holds are not natural categories, but are shaped by emotional responses, labor conditions, fears of liability, demands from security, and the broader social context. I don’t want to exceptionalize any of these holds by arguing that there are illegitimate.   
  
I want to argue we can take the opportunity to take the logical holds together. I'm happy to share some of my thoughts in the Q&A. As signposting, here are the three takeaways.

[Reading: Key Points]

Rather than viewing how they're distinct, we can view how they're similar.   
  
This is the first case. Kurt was an unhoused veteran and was unable to change his colostomy bag because of his accident. He wasn't unable to get far enough away from the hospital when discharged. He yelled out for his wheelchair. Security was waiting for the doctor to give approval. They held his wheelchair, an extension of his body, hostage.   
  
Kurt was waiting for 3 days in the hospital to get long term care. I overhear [someone] speaking, saying the patient preferred to be on the street and use the hospital to clean his bag. He was admitted but then left AMA. The patient said he can't care for himself. Street nursing is not meeting his needs. The doctor explained he was trying to separate concerns with the ER. The doctor said the patient has the autonomy to make poor decision. He wasn't on a hold or under the influence. He had emotional outbursts around care.   
  
He was put under psychiatric care. A nurse said they had the capacity but just wanted to stay in the hospital. Security asked if they wanted to be restrained. Kurt took the medicine.   
  
I was able to interview Kurt. He said he usually doesn't get restrained. "What do you think what happens when you fight me? I fight back." They put me on a medical hold. “I'm going to sue them”! He said he'd rather be medicated than locked up. "What's the difference between here and jail?" He got in another fight with his nurse and left AMA.   
  
Grave Disability can be understood as a condition when, “as a result of a mental disorder, they're unable to provide basic personal needs”. Kurt is an unusual case because of refusing treatment. It shouldn't be evidence of Grave Disability. The doctor tried to use that to break the cycle, by bridging them to long term care. The attending incorrectly attempted to put Kurt on a hold. He might not have been placed on hold, but he got chemically strained until he got placed in a nursing facility.   
  
I want to reflect on what Gilmore says. In her work, she says the same community subject to organized abandonment and exposed to tools of state violence. Kurt cursed off the bed side staff; the doctor was worried about the long-term admission and financial risk to change his colostomy bag.   
  
There's tension between the nurse’s abandonment and doctor’s violence. The tension and experienced by Kurt who feels abandoned on the street.

Social programs are gutted for more coercive forms of control. We see this in California who turn to tools of psychiatry. In 2022, California passed CARE Court which focuses on unhoused people and getting them off the street instead of funding housing. The state doesn’t increase forms of support but increase tools of confinement.   
  
Paul was found unconscious on the streets. The medical team assessed him, and he requested food, but they were worried by GI bleeding. He threatened to punch the nurse, so they fed him, but he vomited. He had elevated level of potassium which were associated with life threatening [conditions]. Medical wanted to stabilize him but he was not interested, and he began yelling that he wanted to leave.  
  
The nurse and doctor decided to hold the door closed and call sheriffs for backup. They said to me, “This is what I'm there for.” I'm there for observation. Because it escalated, I wanted to see what the medical team would do. I felt guilty because I didn't calm him down. I was torn when the nurse held the door shut.   
  
The sheriff led the charge. The patient demanded to call 911. They responded, "we are 911." They were going to administer medication. The patient yelled for help. They put restraints on his arms and feet. They injected him with medication and put him in a psych room. The resident said it was important to treat them for potassium levels. They hooked him up without consent.   
  
They continued to work on his body without consent. A few nights later, I talked to a psychiatric about staff drawing blood without consent. With 5150, you need a legal hearing. Given the critical condition, they're able to draw labs. The psychiatric shrugged. They said I could call ethics to confirm.  
  
We can see the interplay with psychiatry and internal medicine. Psychiatry serves to keep patients in the hospital. Emergency serves to circumvent limitations.

I want to talk about affect and agitation. These authors invite us to examine ways of feeling fear, and anger to incarceration as common-sense solutions. Strong emotions allow for dismantling privatization of things like social welfare and should also work to build up forms of policing. They critique this as a controlled approach to safety.   
  
Both of these situations, affects shape psychiatric holds. Paul was angered at attempts to hold in the hospital which became the reason why they should hold him. They justify the patient hostage.   
  
We see the psychiatric danger expands to the carceral logic. In 2016, No New Jail activists shut down to create a behavioral health justice center.

This is the last case. Loranne was an unhoused white woman. She was refusing to leave the hospital and it was noted that she was manipulative. She was evaluated and was told she was ready to be discharged.   
  
There's a clear protocol. If they're refusing, they're violating rules and is an arrestable defence. The Sherriff attempted to explain she was discharged. She put her gown down, threatening them.   
  
The sheriff was fed up and attempted to arrest her. The psychiatric communicated was that she was placing the patient on a psychiatric hold. They restrained her to the bed. She got exactly what she wanted, to stay in the hospital. They asked if she was violent or not. If she was not, they could check restraints every 2 hours. Violent would be every 15 minutes.   
  
The former is better so the nurse had more time for other patients. We can see, emotions and labour structures shape the category that's violent or not. It follows them to different hospitals and holds. That gets worked into aggregate data. It highlights the ways how they rub up against each other.   
  
This is not the first time this has happened. Hansen writes an experience where she held a patient in the hospital with the hopes of avoiding arrest. [Abolitionists] write about how healthcare workers participate work as "soft police" and argue for the end of policing. Care should not be caged or coerced whether it is in jail or a hospital. Coercive modalities further reinforce oppression. Involutory commitment must not be a part of the legal system.

When people call for treatment and not punishment San Francisco proposed to expand the authority of others to put people on 5150. The author of this legislation. Mental health needs to be met with compassion. The majority of mental health holds were done by police in San Francisco. Rather than restricting the ability to place people on holds from police they authorized to expand the ability to place others on hold.   
  
It feeds a system to hold people captive. Earlier this year San Francisco held a hearing that did a proposal for long term mental health facility. They argue they don't have enough beds. In light of this I want to think how abolitionist might help us moving forward. They write about a vision of a world where mental healthcare isn't coercive. I want to share the quote.   
  
We see peers walking with each other through suffering. We see transformative justice helping us resist change and embrace against harm and abuse. Our distress is a response to cycles of suffering. We see ourselves spending time with loving people and in loving spaces. We see us no longer vilifying people.   
  
We see us taking actual care of each other and not imprisoning each other and saying it is care. How might this framework approach these three cases? Kurt said he wanted an apartment, a dog and someone to change his colostomy bag. Paul said he wanted to communicate the severity of the condition. For Lorrane we might could meet her expressed needs.   
  
In this article, abolitionists envision a world where we can ensure we can care for one another. I hope this talk equips us with some tools to get there. By being critical of the overlapping logic and we can dismantle course of care and align ourselves with the work of abolition. Thank you.   
  
Speaker: Thank you so much. We have time for a question or two before the next session. I didn't see any questions. You can raise your hand or unmute yourself. I have a question/comment. I appreciate your talk. A lot of the work that needs to be done happens outside the hospital systems.   
  
The hospital systems have a militant approach and something I noticed as a psychiatry resident is the disproportionate care that people get between the medical ED and the psychiatric ED and medically or chemically restraining patients. I was wondering if you could speak to either of those things.   
  
Fabian Fernandez: There is so much here around the ways that ED doctors and psychiatrists disagree on medication. ED doctors want things that are on/off, and psychiatrists know it can mess up patients. What forms of restraints are used, and abandoning care and they are sedated in rooms and don't have access to measure CO2. People can have suffocated if they are sedated in the ED. There are questions of neglect that happen with psychiatric patients.   
  
I know that sometimes emotional responses might mask underlying medical concerns. An abolitionist approach can meet people where they are at and can work with folks to get at what is happening and what they need in that moment to feel safe and grounded. To your comment I think abolitionist is happening in all sorts of institutions and how carceral happens in education.   
  
It is starting to happen in healthcare. There is a group that is going to talk about interrupting this issue and they do work in healthcare spaces and abolish these things. Please check those out.   
  
Speaker: If there aren't anymore questions, thank you so much and we will go to our last presentation. This is Marcus and Austin get started.   
  
Marcus Byrd: I am a third-year psych resident.   
  
Austin Bryan: I am a fifth year PhD candidate in the Department of Anthropology.   
  
Marcus Byrd: This is a working paper we turned into a presentation, so we invite feedback at the end of the talk. This leaves many in the US without stable housing, a reliable income and food. In one department in Illinois malingering is a frequent topic for overworked doctors.   
  
Austin Bryan: They find that going hungry may be read as an embodied critique.   
  
[Reading quote on screen.]   
  
Using a biopolitical framework, the body is individually and collectively experienced as socially experienced and is subject to regulation by larger political processes. These frame our understanding of malingering to obtain housing and avoid poverty.   
  
This perspective approaches the embody experience of those suspected of malingering and what does it reveal about the logic of care in the US.   
  
The concept of malingering is a service user who fakes an illness to obtain resources. It is the practice of a problem with patients that must be protected and managed to preserve resources in hospitals and society. Malingering has a militarized connotation, and it is how it is understood in social understandings. Considerable resources have gone into understanding malingering and a political economy has developed with the advent of screening methods.   
  
One of the theories that emerges in the literature is the idea that this is a cost to society and there are specific tools. We will note our methodology and get into the ethnographic cases as we analyze them. To read the experiences of malingering patients we must assemble a text to be read. In addition to reviewing this literature it is observing while providing care while he worked with 10 patients who were regarded as malingering.

It was to subjugate this to the [Inaudible.] gaze. We both generated some notes and based on these conversations and began to code them for themes. The three primary themes that emerged were housing, unemployment, and hunger. From these themes two sorts are theories emerged. Care of housing and food security as income. Starting with care as housing they lack housing. They found that among patients’ 66% of those were unhoused. This related to patterns that emerged and they were staying at shelters or couldn't access the housing they secured.

A man with numerous medical conditions, when attempts were made to discharge him, he said he was going to attempt suicide and lived in homeless housing. He got kicked out because of a dispute.   
  
Another patient had HIV and used cocaine. He was admitted for suicidality. He lost his keys, and his landlord was away. There was a malingerer presentation before discharging.   
  
A patient who arrived from Wisconsin who lacked housing, asked an officer for assistance, and brought to the hospital. Patients who malinger will just ask to be admitted. They'll negotiate which institution to be placed.   
  
A white woman in her 30s with history of substance use said she was suicidal and wanted to be admitted. When she was, she asked for the institution name.   
  
Austin Bryan: This is an intense conflict with the preferred government mentality in a classic scene of biopolitical. There's internal governance and transformed into subjects. Technology of governance take hold of life not to repress it but to develop it and manage it.   
  
There was a transformation to sovereignty. The psychiatric institution to recast the malingerer with respect to chronically homeless, which is a reason that contributes to decision for discharge.   
  
With a critique of the neoliberal concept of homelessness, they offer the concern with the limit resources of municipalities. The invention of chronic homelessness deemphasizes compliance. It's a move that's unexpected and despised.   
  
An anthropologist said it's often misapplied. There are racial inequities, and it's details the biopolitical stance to build the world for white people. They use Black bodies for labour or disposable. It can be extended to class and race.   
  
Krause writes it's equivalent for banks to not give loans. It's not clear if the violence is led by the state. It's the case for the psychiatric malingerer who is turned away form the harsh necro politicized society.   
  
The next theme is food security as income. Unemployment is a common experience of a malinger patient that's unhoused. For example, a Black man with common ED visits. The chart reviewed he had similar visits in a nearby hospital. Sometimes he was discharged or went to psychiatric.   
  
I asked the attending and was told I should tell the patient to get a job. One concept that emerges in the expert discourse in malinger is the frequent flyer. A high number of ED visits in a short time. They note that in the evaluation. 33% of patients that were malingerers were frequent flyers.   
  
Another case of a 50-year-old Black man with many medical conditions, was brought in by police. He was seen numerous times by psychiatry. Most recently, the service drew attention to having a psychiatric disorder but was a danger to staff. It was suspect of malinger.   
  
Literature was seeing food as secondary gain. There was another suicidal patient who was sleeping in his car. He went to a restaurant and didn't have enough many to pay the bill. He left without paying. It's easily overlooked. There are limited food options in the hospital like crackers, juice, or water. Sometimes they're delivered meal trays in the ER.   
  
How much a patient consumes, is sometimes cited as secondary gain and a sign of malingering and supports further discharge.   
  
Austin Bryan: The concepts of those unhoused, shows the cycle of homelessness. Sociologists describe a sign of misdemeanor. They'll enter jails for shelter or food. Right to food is rooted in international rights law to protect humans from malnutrition. The United States doesn't have a public right to food.   
  
Income is a key factor to reduced hunger and mental health. Labor power must be exchanged to live. A researcher traces necro capitalism from the 1600s to 21st century. Premature death was something calculable or profitable and a framework for how life and death drives the economy.   
  
Another researcher shows the moral economically of hunger is replaced by food security. Corporate management of food forms the biopolitical strategies.   
  
Marcus Byrd: In conclusion, when read as a text, the malingerer's experience can be the embodiment of two theories. Housing and food security. The hungrier they are, can be conceptualized as discontent.   
  
The malingerer's experiences reject some regimes of truth like the expectation of government and the state's failure of provisions is outside of psychiatry. They're told to take what's not there, which embodies the critique of human rights to have housing and food into commodities.   
  
The experiences show the contradiction. The state is invested in the biopolitical cultivation and disposability. The epidemiology should be questioned. Malingering can be thought of a social structure and different from other disorders. They're flawed as people who work in forensic contexts.   
  
Malingering can be reconceptualized around other psychiatric disorders. While psychiatric identifies some malingering as adaptive, the experiences of malingerers suggest it might always be adaptive in an effort to cope with failures.   
  
That's the end of our formal talk. We're happy to take any questions or feedback.   
  
Austin Bryan: Thank you.   
  
Speaker: Thank you. Reminding people, you can submit questions, unmute yourself or raise your hand.   
  
Speaker: The question I have, what are some of the practical next steps for mental health providers working in EDs? We're constrained with the responsibility of the hospital and systemic problems.   
  
Marcus Byrd: I think part of the goal for the paper is to describe and theorize what's going on without a clear goal. There's a separation between those ideas. Theory and practice, depending on where you work. I'm not an anthropologist. I'm a psychiatrist. I'm thinking about practice.   
  
Anthropologists think about if they can explain. By fleshing out the theory, we can come up with practical solutions.   
  
Austin Bryan: I agree. Right now, we're trying to locate what are these experiences when take seriously, telling us? A bit about the failures of the states or failures of private care. We need to more rigorously dig into the ethnographic details to pull that out. We have some other artifacts. There was originally a slide we had, to include a list of ways to identify malingerers that are locally conceptualized attendings and residents who have their own strategies. I think those type of artifacts of knowledge protection help reveal. There's a simultaneous theory being presented around how the institution sees the malingerer and how they experience it.   
  
I wanted to add Fabian's ethnographic details were also a direction we are headed in methodologically where you had so much incredible details. I am curious to hear from you on the methods you can point us to when we work in these restricted spaces.   
  
I think another way to think about it is we make subjects of people. We call them patients. It is interesting to turn the lens on ourselves. What would that be or what would it look like? That is happening when you read into the experience further. They are coming in and requesting psychiatric admission for basic needs. That is another way to conceptualize this.   
  
Speaker: Thank you.   
  
Fabian Fernandez: I wanted to ask you -- it was a beautiful talk. You better publish this because I want to cite it. There is the embody critique that you talk about. I am curious if it is ever spoken about. Do they say, “fuck this commodified housing and food system?” Does it ever come to the forefront?   
  
Speaker: I have seen one patient who said Chicago has the worst social services and they get more care and the things I need, and he was angry and upset with me. I haven't seen too many folks in that regard but affect comes into it. They are angry and upset and they feel desperate. They are pleading to come to the hospital, so I think those nuances is a way for these ideas to come out and we pathologize as antisocial and uncooperative.   
  
I think there are a lot of parallels between our talks so back at you.   
  
Speaker: I am right here. I am currently a fellow in Nashville right now. At the hospital I am at they have a program with the frequent flyers, and it is FF, but it is called familiar faces. Instead of ten different teams and there is a concern for malingering and there is this person again. The FF team is providers instead of getting one of 15 teams there is coordination of care.   
  
I don't know if you had heard of that as being ways to cope with malingering.   
  
Speaker: I don't think Northwestern has anything quite like that. It had more robust social services it would pay for and broader services that were gutted. That is one consideration. I think we always think of practical solutions of everything. I learn something and then I want to practice it. Those sorts of avenues are good for short to midterm idea to get people off the street.   
  
What do you do right now to help with houselessness? What are we going to do? We are forced to look at practical solutions. I support all those things. I think looking at neoliberalism I think they should be providing basic needs and thinking about how to get organized within the psychiatric space. We could get together and lobbying for work to get governing institutions to implement these things.   
  
Speaker: As an anthropologist looking at this a lot of the focus of literature and research on malingering and preserving budgets of privatized hospitals. You have the focus of the inquiry and figure out the most efficient way to save cost by detecting frequent fliers aren't able to receive this expensive packing of care.   
  
To underscore what Marcus was saying is reemphasizing the moment we are in is crisis. It is a crisis if one person is not housed and reframing some of this in terms of how the malingering is presenting crisis and this is unacceptable for their social life. Thank you for the question.   
  
Speaker: All good thoughts. Thank you.   
  
Speaker: It is an interesting hybrid concept. We have about five more minutes if anyone wants to ask a question, or we can give you five minutes back.   
  
Speaker: We appreciate the opportunity to talk with you. Thanks so much for all of this.   
  
Speaker: Thank you so much.   
  
Speaker: We have a break until 5 and then there is the closing session. Thanks to our presenters and I hope everyone has a great evening.   
  
[End of session.]