"Two cases of romance scams in the mental health clinic"

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Background

- Historically, intimate relationships were facilitated by friends or family who could vouch for the identity of each partner. Today, American romance is online, as of 2021, 30% of American men and women acknowledged using a dating site or app service in their lifetime.[1]
- "Catfishing" (a type of financial scam) is becoming an increasingly common problem today. Perpetrators use false identities to deceive and manipulate unsuspecting individuals to obtain money or personal information.[2]
- The American public was estimated to have lost 1.3 billion dollars in financial scams in 2021, an almost 15-fold increase from 87 million dollars in 2017, four years previous. The median financial loss for victims of romance scams was $2,400, with losses for those aged 70 years and older reaching a median loss of $9,000.[3]
- In a 2013 study conducted in an inpatient psychiatric setting of patients with severe mental illness, 70% of the 122 adults were identified as having experienced "financial victimization" over the previous 28 days.[4]
- We currently lack estimates for the prevalence of financial scams or "catfishing" in the outpatient psychiatric clinic as neither studies currently published are not generalizable to our patients in the clinic. The 1.3 billion dollars in losses reported by the FTC for the American public have been estimated as only a tiny fraction of the actual fraud committed (Less than 3 %). Victims are often embarrassed or unwilling to admit they have been exploited. [5]
- The impact of these scams can be devastating, both financially and emotionally. Victims of catfishing scams often experience symptoms such as anxiety, depression, and difficulty trusting others.[6]
- In these case reports, we will examine two instances of catfishing within the outpatient psychiatric clinic. The case will be analyzed regarding victim risk factors, the impact on the victim, and the steps taken to resolve the situation. In addition, this report aims to provide information and education on the tactics used in these types of scams and to raise awareness of the potential consequences for our patients.

Case #1

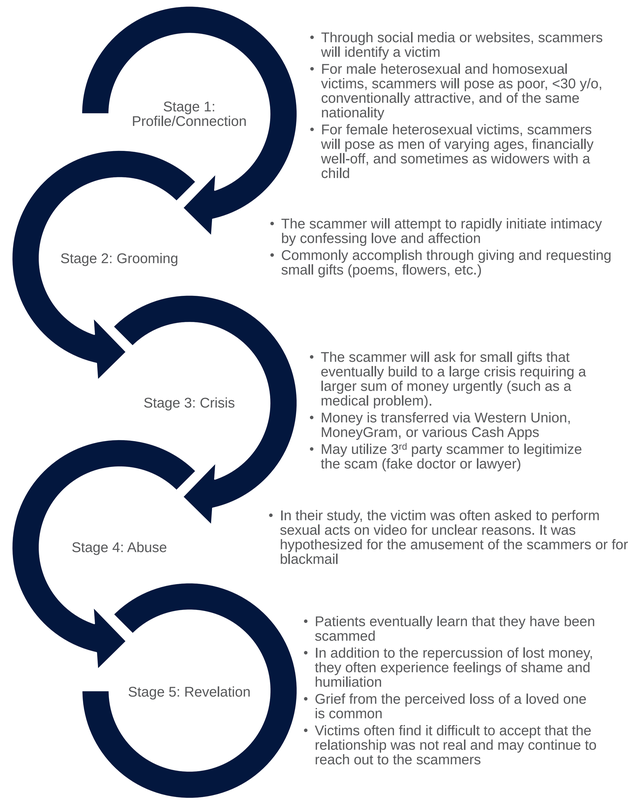
Patient A (P-A) is a 48-year-old heterosexual, single, never married, white male factory worker followed in a community hospital outpatient psychiatry clinic every 2-3 months for treatment of a *persistent depressive disorder*. He has no children and lives with a roommate, works full-time, and denies any significant religious or social engagement. During a routine follow-up appointment, P-A endorsed having a long-term, long-distance girlfriend not previously mentioned. He reported communicating predominately by text and was unwilling to report when he had last seen her in person. He denied sending her any money and reported feeling supported by his girlfriend. The provider expressed concerns about "catfishing" with education about possible warning signs. At each subsequent visit (q2-3 months), P-A was asked about his girlfriend. He gradually revealed more information about the relationship, including that he had sent her ~500 dollars and other gifts when she "needed it," and eventually shared a picture of his "girlfriend" (a casually dressed woman in her 20-30s). P-A remained resistant to the provider's concerns. At his 8th appointment, he reported having concerns that she might be trying to scam him and was worried about catfishing. P-A's concerns were explored and the patient was asked to reflect upon his relationship (Motivational Interviewing techniques). At his next appointment (approximately 18 months after the provider's initial concerns were raised), the patient reported that he had discontinued speaking with his "ex-girlfriend" due to his concerns about catfishing that had been raised at multiple previous visits. He had been unable to convince his girlfriend to visit him and had continued to ask him for money. He endorsed feeling lonely and down. The provider validated the difficult decisions the patient had taken to protect himself and began exploring options for activities and social engagement to address the patient's feelings of loss and isolation.

Case #2

Patient B (P-B) is a 76-year-old retired, heterosexual, single, divorced white male veteran followed long-term in the veteran's affairs (VA) outpatient psychiatry clinic every 2-3 months for treatment of *recurrent major depression with co-morbid mild cognitive impairment (MCI).* P-B lives alone in an apartment, estranged from his children, with ongoing support primarily from VA social work and the mental health clinic. He was initially brought to the VA in 2018 by his family with concern for repeated problems with his finances, housing, and inability to pay bills. P-B sold his camper to financially assist a "woman" whom he has met online. P-B reported his intention to sell everything to move to Michigan to live with his girlfriend. The patient and family agreed to a financial fiduciary at the VA recommendation who would coordinate the patient's bills and provide him with a spending allowance based on his expenses each month. A the time of this report, the patient continues to intermittently endorse having a "girlfriend" who he reports will be coming to live with him soon. The patient has shared pictures of his "girlfriend" which show a woman in her 20-30s in a state of undress. The patient frequently endorses loneliness and reports enjoying texting his girlfriend so he has someone to speak with. The patient expresses frustration with his spending allowance as he reports needing more money so that he could bring his girlfriend to live with him. While his provider has repeatedly discussed concerns about catfishing and financial scams, the patient remains resistant to the idea. Interventions with the patient have been aimed at addressing loneliness (adult day care, regular visits), addressing depression and MCI with psychotherapy and pharmaceutical treatment, and utilizing motivational interviewing techniques to examine his situation and his relationships with the goal of patient-oriented change.

Figure 1

According to the 2015 article "Anatomy of the Online Dating Romance Scam" by Monica T Whitty, catfishing and related romance scams follow a generalized plan[7]:



Teaching Points & Implications for Practice

- "Catfishing" (a type of financial scam) is becoming an increasingly common problem today. Perpetrators use false identities to deceive and manipulate unsuspecting individuals to obtain money or personal information.
- No current evidence-based screening or intervention tool exists to identify or address catfishing victims.
- Motivational interviewing techniques can be used to motivate change and ameliorate ambivalence.
- Victims of catfishing often experience feelings of shame, humiliation, and grief (e.g., loss of a loved one) and may find it difficult to accept the relationship was not real and continue to reach out to the scammer.
- Future research should be aimed at developing screening tools used to identify potential victims, in addition to evidence-based interventions designed to help reduce the instance of catfishing in vulnerable populations.
- Psychiatrists and mental health practitioners are well-positioned to both help with the implementation of screenings and interventions; as well as to aid in long-term treatment needs (e.g., grief and depression) after victims have been identified.
- We speculate that the rise of easy accessibility to artificial intelligent native language processing tools (ChatGPT, Bard, etc.) will make it easier for perpetrators to scam many different victims at once regardless of the native language of the scammer or victim

Discussion

The two cases presented here demonstrate several elements common to financial scams and catfishing such as "loneliness" and lack of significant social and emotional support. While some evidence would suggest women are more frequent targets of "catfishing," each of the cases fits the typical male heterosexual pattern (Figure 1, Stage 1). P-A and P-B demonstrated significant ambivalence throughout their treatment course, as neither one of the patients presented with concerns about their relationships and it is uncertain how long the scams would have continued without intervention.

P-B's case demonstrates some of the steps that can be taken to protect individuals who have demonstrated disruptions to their insight and judgment which do not apply in the case of P-A who has preserved insight and judgment. While (at the time of this publication) P-B continues to send small gifts to various "girlfriends" out of his weekly spending allowance, the fiduciary control of his money has maintained him in his home and supplied him with food and necessities since 2018 without the frequent destabilizations and homelessness he had experienced prior due to repeat financial scams. P-B's losses are certainly measured in the tens of thousands of dollars, in excess of the average median loss reported in the background of this report. P-A has been hesitant to share the full amount he had sent to his "girlfriend" over the course of their ~3-year relationship, never disclosing to us more than "$500 and frequent small gifts." Financial stressors have been frequently reported by P-A (including initiating bankruptcy proceedings while under our care) and we speculate that he has likely been sending more than he has disclosed or the gifts he had been sending were likely outside his means. A discussion of the ethical concerns surrounding fiduciary control of P-B's finances is warranted and pertinent to his case but beyond the scope of this report.

The American public is increasingly exposed to stories about romance scams with T.V. shows like "Catfish" and the stories of Manti Te'o and others.[9] While numerous investigators have begun exploring the characteristics of both victims and perpetrators over the last 15 years (which may prove to be helpful for screening purposes) there is currently a lack of research about effective ways to address and treat this growing problem. In general, our best guidance at this time is counseling patients to be cautious of unsolicited conversations/texts, requests for personal information, and pressure to act quickly. Unfortunately, scammers will frequently utilize third parties to legitimatize their claims (doctors and lawyers). Individuals should be wary of individuals who are reluctant to meet in person or who refuse to video chat.[9, 10]

In the two cases described above, we used principles of motivational interviewing to help guide patients to recognize areas of concern & motivate self-directed change as our patients' ambivalence to our concerns limited our ability to reduce risk and harm to the patient. Lacking evidence for proven treatment options, motivational interviewing has been used in many other areas of psychiatric practice when patients lack insight into a physician-identified problem.[11] If the current trends continue, we suspect these types of scams will more of a problem as technology continues to change. We (and others) speculate that the recent rise of artificially intelligent native language processing tools such as ChatGPT, Bard, and others will make it easier for perpetrators to scam many different victims at once as early reports suggest that many individuals or having difficulty recognizing they're speaking with nonhuman intelligence.[12]

We do not have good estimates about the prevalence of financial scams in our outpatient clinics or other general outpatient psychiatric clinics, though the national numbers would suggest that Americans, regardless of mental health status or impairments to insight/judgment, are being victimized. We speculate that we are missing many other cases of catfishing and financial scams occurring in our clinics as studies looking at the severely mentally ill and cognitively impaired (a subset of our patient population)[4,8] would suggest that psychiatric patients are vulnerable to these scams.

Finally, we suspect that it will be difficult to identify patients who are currently being victimized because of a lack of patient insight into the scams at early stages (Figure 1, Stage 1-4), patient reluctance to engage with clinicians about all romantic relationships, patient embarrassment and humiliation once the scam is discovered, and the difficulty many patients have in accepting that their relationships were a scam (Figure 1, Stage 5). Following the revelation of the scam, patients are often grieving the perceived loss of a loved one alone (without the support that is naturally provided by their community with a death of a loved one) and are embarrassed to reveal they were duped. Each of these patients was able to discuss the risks of financial scams during our visits but was resistant to engaging with the topic as it pertained to them, likely because it represented a threat to their emotional and social well-being.[7]

Areas for future research should be aimed at screening tools for recognizing and identifying potential victims and evidence-based interventions. Our role as psychiatrists and mental health practitioners will not stop with identification and interventions as many of the victims struggle with grief and depression as a result of the scams, symptoms that we are well-versed and prepared to treat in our current practices.[10]

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