

IATROGENIC ILLNESS

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Primary Disciplinary Field(s): Medicine, Psychology, Health Care Ethics

1. Core Definition

Iatrogenic illness refers to any adverse physical or psychological condition that is induced, precipitated, or aggravated by medical intervention, diagnostic procedures, or the physician's communication style. The term applies broadly, covering everything from complications arising from surgical error or drug side effects to psychological distress caused by incautious comments or misdiagnosis. Crucially, iatrogenic conditions are distinguished from natural disease progression; they are a direct consequence of the interaction between the patient and the healthcare system. In a clinical context, the physician's actions, whether intentional or accidental, therapeutic or diagnostic, become the originating factor for the patient's subsequent suffering or symptom manifestation. This phenomenon underscores the profound responsibility inherent in medical practice, where the power of suggestion and the authority of the diagnosis can shape a patient's subjective reality and physiological experience.

The concept emphasizes that the healing environment itself can sometimes become a source of harm. While many iatrogenic effects are physical (e.g., hospital-acquired infections or adverse reactions to medication), a significant subset involves psychological conditions, where the communication and examination process inadvertently suggest symptoms to susceptible patients. When addressing psychological disorders, such as neuroses or hysteria, the potential for iatrogenesis is particularly high, as the patient's **suggestibility** allows external inputs--even subtle ones from a medical authority--to be internalized and manifest as genuine symptoms. Understanding the sources of iatrogenesis is vital for promoting patient safety and improving the quality of patient-physician interaction across all medical specialties.

2. Etymology and Historical Development

The term **iatrogenic** is derived from the Greek words *iatros* (meaning "physician" or "healer") and *genesis* (meaning "origin" or "creation"). Thus, iatrogenic literally translates to "brought forth by the healer." While the recognition that medical treatments could cause harm is ancient, the formal articulation and study of iatrogenesis as a distinct clinical problem gained prominence in the early 20th century, particularly within the field of psychopathology. Early investigators recognized that the authoritative nature of medical scrutiny could inadvertently produce the very symptoms being sought, especially in conditions characterized by high suggestibility.

A foundational observation of iatrogenic symptoms in psychological disorders was made by Joseph Babinski (1908). Babinski's work focused on hysterical patients (now often categorized under

conversion reaction), demonstrating that specific signs or "stigmata" of hysteria--such as skin anesthesia, paralysis, or the sensation of a lump in the throat (*globus hystericus*)--could be induced merely by the doctor's persistent examination or expectation. His findings were crucial in linking the physician's diagnostic procedure directly to the creation of the illness itself. This historical recognition shifted the focus onto the physician's technique and communication as potential pathogenic factors.

3. Mechanisms of Iatrogenesis (Psychological Focus)

Psychological iatrogenesis often occurs through the mechanism of **suggestion**. In susceptible individuals, incautious comments made by a medical professional or excessively thorough examinations can plant the seed of a symptom or disease expectation. A therapist, for instance, may unwittingly produce or aggravate psychological symptoms through unguarded remarks about a patient's condition or prognosis. This is particularly frequent in patients exhibiting characteristics of hysteria or conversion reaction, disorders fundamentally defined by a high degree of psychological responsiveness to suggestion. The patient, seeking validation or meaning for their distress, warps and distorts the information received from the doctor through unconscious means to fit their existing neurotic needs, thereby generating or intensifying symptoms.

Furthermore, the authority figure of the physician can transform ambiguous physical sensations into concrete fears or illnesses. The process often involves a focus of anxiety; once a physician, even innocently, injects an element of doubt regarding the healthy status of a specific bodily function--such as cardiac function--the patient may direct all existing, diffuse anxiety onto that organ system. This creates a feedback loop where physical awareness leads to increased anxiety, which in turn leads to magnified physical symptoms, ultimately solidifying the iatrogenic illness.

4. The Role of Suggestibility (Pithiatism)

The study of psychological suggestibility in clinical settings was formalized by Babinski (1908). He pointed out that when doctors actively looked for classic signs of hysteria--such as specific areas of sensory loss or the complaint of **globus hystericus**--they often induced these very symptoms merely by the suggestive nature of the examination. The act of probing for a symptom implies its existence and possibility to the suggestible patient. Babinski coined the term **pithiatism** (from the Greek word for persuasion) to describe this specific form of conversion disorder where symptoms could be both caused and subsequently cured by persuasion or suggestion.

Pithiatism highlights the dual nature of medical influence: the same persuasive power used in diagnostic examinations, which can unintentionally generate symptoms, can also be employed therapeutically to remove them. This concept underscored the importance of careful communication and demonstrated that many supposedly organic stigmata of hysteria were, in fact,

functional and transient, responding directly to the physician's authoritative cues. Therefore, the physician's awareness of the power of suggestion is paramount to preventing iatrogenic harm in patients prone to conversion and hypochondriacal symptoms.

5. Examples in Clinical Practice

Iatrogenic illness is particularly frequent in the realm of cardiovascular difficulties, especially concerning functional heart murmurs. English and Finch (1964) observed that many individuals suffering from benign functional heart murmurs were subsequently informed of this fact by their physicians in a manner that led them to focus their underlying anxiety intensely upon their hearts. Once a physician introduces doubt about the patient's cardiac health, even if the finding is functionally irrelevant, the resulting preoccupation becomes deeply entrenched and difficult to eradicate. This preoccupation transforms a benign finding into a genuine, functional illness driven by health anxiety.

Another classic example involves misdiagnosis or over-solemn diagnosis. Bleuler (1930) illustrated this risk by describing a patient who developed a severe emotional breakdown--a neurosis or even psychosis--after a physician solemnly diagnosed "enlargement of the heart." The patient's fear and distress were so acute that they suffered a breakdown until subsequent examination (in this case, an X-ray photograph) provided relief by invalidating the initial frightening diagnosis. This scenario demonstrates how alarming, yet potentially inaccurate, information delivered by a medical professional can be instrumental in precipitating a severe mental health crisis in vulnerable individuals who may already be on the verge of a neurotic or psychotic condition.

6. Information Disclosure and Anxiety

The manner and amount of information disclosed to a patient are critical variables in determining the risk of psychological iatrogenesis. As Aldrich (1966) pointed out, providing **too much information** may paradoxically make a patient more apprehensive rather than less. This danger is amplified when the disclosed information includes serious possibilities (e.g., potential long-term complications or rare outcomes) and, most critically, when the physician provides these disturbing possibilities without simultaneously outlining immediate, concrete steps planned to mitigate the risk or address the concern.

When complex, serious, or uncertain information is delivered without a clear action plan, the patient is left in a state of anticipatory dread, allowing anxiety and fear to fill the informational void. The physician must carefully balance the ethical obligation for full disclosure with the psychological imperative to manage patient anxiety and prevent the transformation of theoretical risk into lived illness. Effective communication requires not only factual accuracy but also sensitivity to the patient's capacity to process stressful information and a focus on collaborative planning.

7. Further Reading

Iatrogenesis (Wikipedia entry)

Babinski, J. (1908). *Défense de la suggestion dans l'étude des phénomènes hystériques* (Pithiatism concept).

Bleuler, E. (1930). *Textbook of Psychiatry*. (Discussing iatrogenic origins of neuroses).

English, O. S., & Finch, S. M. (1964). *Introduction to Psychiatry*. (Discussing cardiac iatrogenic illnesses).

Aldrich, C. K. (1966). *An Introduction to Dynamic Psychiatry*. (Discussing information disclosure and apprehension).

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