

Fabricated Illness: Working within the Family System to Find a Pathway to Health

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The term medically unexplained symptoms refers to a clinical presentation where the child's symptoms and impairment cannot be explained by any known organic pathology, and may include conversion disorders, somatoform pain disorders, factitious disorder, and factitious disorder by proxy. In this case study, we present our treatment of a 9-year-old girl with a 2-year history of medically unexplained abdominal cramping and vaginal discharge. During the 9 months that we worked with this family, we were never able to clarify in our own minds the source of the child's symptoms—that is, who was responsible for their induction or who was the instigator or maintainer of the exaggerated symptoms. Nor did we come to fully understand the function of the symptoms in the family system. Our case report does not answer either of these questions. Instead, we describe how we worked with the family despite the ongoing ambiguities as to why the symptoms were occurring and who was inducing them. The functional outcome was disappearance of symptoms, return to full school attendance, and improved parenting behavior.

Keywords: Fabricated Illness; Dynamic Maturational Model; Attachment; Medically Unexplained Symptoms; Induced Illness by Proxy

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In pediatric practice, a child with fabricated or induced illness¹ by proxy is one who presents with medically unexplained symptoms, whose parent or parents falsify illness in the child by exaggerating, fabricating, or producing symptoms, and who present the child for care while disclaiming knowledge of the cause of the problem (Bass & Jones, 2009; Royal College of Paediatrics and Child Health, 2009). In older children and adolescents, fabricated illness may be induced by the child herself (Edwards & Butler, 1987; Gilarski & Graham, 1995; Kazak, Westervelt, Bracikowski, & Hassler, 1988; Libow, 2000, 2002; Peebles, Sabella, Franco, & Goldfarb, 2005). The medical profession has conceptualized fabricated illness by proxy as a severe form of child abuse because of the serious risk of physical, emotional, and educational harm for children and the risk of death in up to 25% of presentations (Bools, Neale, & Meadow, 1992; Jureidini & Donald, 2001; McGuire & Feldman, 1989; Royal College of Paediatrics and Child Health, 2009). Our clinical experience suggests, however, that fabricated illness is better conceptualized along a broad spec-

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¹Fabricated or induced illness is also known as factitious disorder (American Psychiatric, 2000), factitious disorder by proxy (American Psychiatric, 2000) factitious illness by proxy (Adshead & Bluglass, 2001), fabricated or induced illness by carers (Royal College of Paediatrics and Child Health, 2009), or in the past as Munchausen by proxy (Meadow, 1977).

trum that ranges from exaggerated reporting of symptoms by very anxious parents to the actual production of symptoms, with varying degrees of risk. In our hospital-based practice, when we have been able to establish a therapeutic relationship with the parents, we and the parents have had the opportunity to collaboratively explore the story of symptom onset, parental family-of-origin stories, and parental emotional functioning. We have subsequently been able to piece together a formulation of the multiple interacting factors that affected the family and that contributed to the child presenting with fabricated or medically unexplained illness (Kozłowska, 2007b; Kozłowska, Foley, & Crittenden, 2006; Kozłowska et al., 2008).

Our theoretical position with regard to fabricated illness is more open than the position typically documented in the literature, where fabricated illness is immediately conceptualized as a rare form of child abuse perpetrated by a parent, usually the mother (Bass, 2009; Jureidini & Donald, 2001; Royal College of Paediatrics and Child Health, 2009). We take the perspective that when parents have been exposed to significant loss and trauma that remain unresolved, their behavior is likely to be motivated by trauma-related triggers in situations where the parents feel threatened or perceive their children to be threatened. Emotional triggers may include images of threatening events that are actually happening at the moment or that are being recalled from the past (Damasio, 2010a). These triggers function to activate threat-related emotional states, action plans (dispositional representations), and styles of mental processing (Damasio, 2010a), which are not always accessible to conscious reflection, but may nevertheless motivate current behavior (Crittenden, 2006a, 2008; Damasio, 2010b; Kozłowska, 2007b, 2010a,b; Kozłowska et al., 2006).

Our model provides a more open frame of reference and allows for a non-blaming, “curious” therapeutic stance, which facilitates a collaborative approach where the family and therapeutic team work together to untangle and understand the process of how the family arrived at their current position, and to identify what factors trigger and perpetuate the family’s pattern of functioning. We maintain an empathic stance toward children and their families, and put aside feelings of anger, blame, disbelief, frustration, disdain, and anxiety, which commonly make it difficult for professionals to engage with these families (Freeland & Foley, 1992). This is not to say that we are able to work with all families; some are, indeed, incapable of engaging in this process of assessment and therapeutic intervention, in which case, referrals to child protection services are required (Griffith, 1988; von Hahn et al., 2001). Nevertheless, our theoretical stance allows us to work productively with a subset of families (and a far broader one than is currently described in the literature).

In working with children who have presented with induced or fabricated illness, we use a pragmatic clinical approach² (Holmes, 2009) that, under the broader umbrella of systems thinking, utilizes ideas and practices from diverse theoretical models—family therapy models, cognitive-behavioral theories, narrative therapy, art therapy, sensorimotor approaches, rehabilitation medicine—to address issues on different system levels (Capra, 1997). We have found ourselves also drawing heavily from the dynamic-maturational model of attachment (DMM) (Crittenden, 2006a,b, 2008; Kozłowska, 2007b, 2010b; Kozłowska & Hanney, 2002; Kozłowska et al., 2006), which proved to be a central element in understanding the case presented below. More generally, in work with this patient population, our therapeutic team flexibly and pragmatically chooses assessments and interventions that enable us to understand the emotional functioning of individuals within the family, along with manner in which the family functions as a whole. By engaging the family and by exploring possible precipitating and perpetuating factors with the family, we

²In this approach clinical models are an amalgam of ideas and practices derived from a number of theoretical models, pragmatically selected and adapted to conducting clinical work with specific clinical populations (Holmes, 2009).

hope to achieve both lasting therapeutic change and the best possible outcomes for children with induced or fabricated illness.

THE REFERRAL

Lucy³ was an 8-year-old girl who lived with her parents and brothers on a farm. She was referred to our psychiatric consultation-liaison team by a pediatrician, who had come to the conclusion that Lucy's symptoms were medically unexplained. Lucy had reported a 2-year history of vaginal discharge—12 months of creamy discharge, followed by 8 months of blood-stained discharge, followed by 4 months of clear, watery discharge—and a 10-month history of recurring skin eruptions. She had been fully investigated by multiple pediatricians and all possible organic causes had been ruled out.⁴

ASSESSMENT, ENGAGEMENT, AND INTERVENTION

Our work with Lucy and her family occurred over a period of 9 months and involved (1) a family assessment; (2) a case conference with professionals; (3) a follow-up meeting with Mr. and Mrs. Irving that addressed the family's medical questions and enabled us to develop an agreed plan for moving forward; (4) a 3-month period in which the family was given the task of documenting the presentation of the symptoms, with contact being maintained by regular telephone calls; (5) a rehabilitation admission; and (6) a 6-month period of telephone follow-up.

The Family Assessment Interview

The family assessment was conducted by the therapeutic team: a child psychiatrist, a senior social worker, a clinical psychologist, and a child psychiatry fellow (Kozłowska, English, & Savage, in press). Completion of a genogram (see Figure 1) with the family revealed a complex history—domestic violence, mental illness, substance abuse, and a history of loss (miscarriages and deaths)—on both sides of the family. Mrs. Irving's parents had divorced when she was 7 years old because her father had been violent to her mother when intoxicated. The mother remarried 3 years later. Mrs. Irving had no contact with her biological father from the time of the divorce for many years—until her sister's suicide 9 years before our assessment. On the medical side, Mrs. Irving's mother had been diagnosed with schizophrenia and depression, and had been treated with diethylstilbestrol (DES). This powerful synthetic estrogen, which was given to many pregnant women in the mistaken belief that it would reduce both the risk of miscarriage and the complications of pregnancy, was removed from the market in 1971, after it was found to act as a transplacental carcinogen in humans (Titus-Ernstoff et al., 2008).⁵ Much more recently, action groups had raised concerns about ongoing effects in third-generation women (Mesner, 2009; Vowes, 2009). Because of her own experiences of miscarriage, as well as her family history of precocious puberty and endometriosis, Mrs. Irving had been in contact with those groups in an effort to obtain further information about the generational effects of DES. Mrs. Irving also had a history of postnatal depressions.

³Lucy is a pseudonym. The family gave us permission to write up their story in de-identified form. We have done this in a way that adequately camouflages the family without changing the essential dynamics.

⁴See Appendix 1 in Supplemental material on the Wiley library web site for a summary of investigations.

⁵See Appendix 2 in Supplemental material on the Wiley library web site for a summary of Information About Diethylstilbestrol (DES).

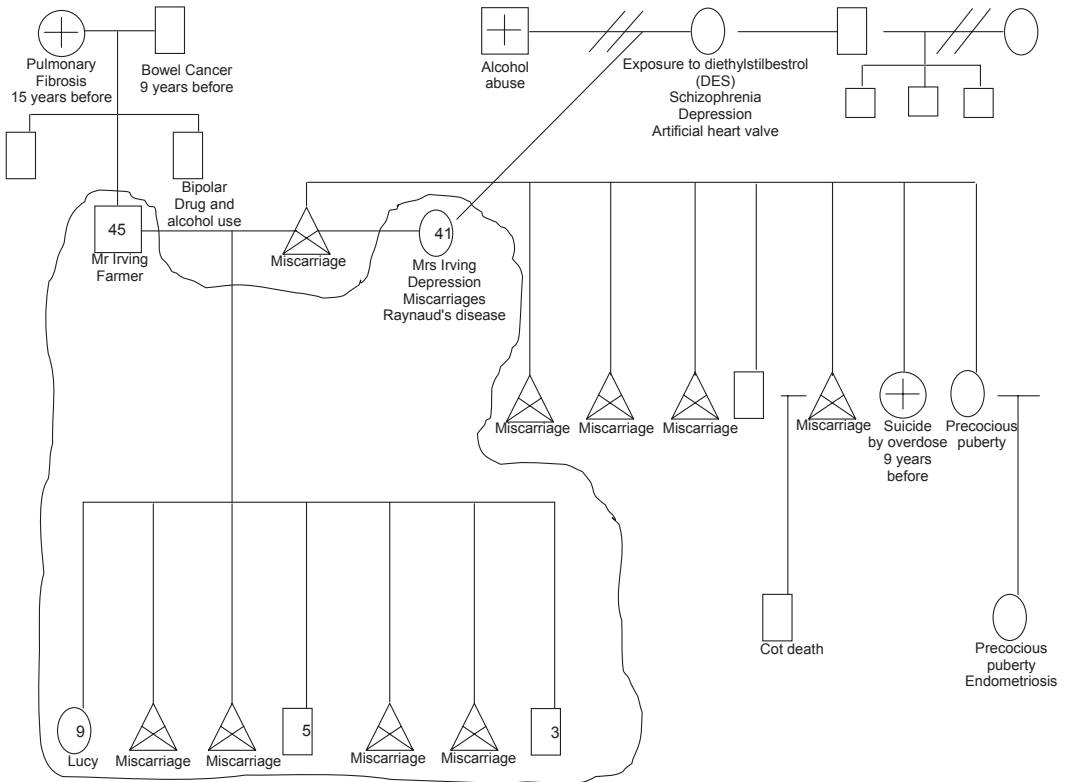


FIGURE 1. Genogram.

Lucy’s medical history and concurrent life events from a family perspective

The process of taking Lucy’s medical history⁶ was used to ascertain the temporal order of events, their relationship with life events and the family’s understanding of what had occurred. This task was difficult to achieve because the family—Mr. Irving in particular—were angry that the medical doctors had failed yet again to clarify what was wrong. In addition, Mr. Irving was resentful at being “dragged” to a hospital interview about what he regarded to be “women’s business.” Successful collection of the history, as seen from the family perspective, required that the interviewer keep the family on task, contain parental outbursts of anger and anxiety, and engage Mr. Irving, who sat with his face turned away as often as was possible.

The medical history given by the family did not differ significantly from the medical record and is reported in terms of a time line.

- After Lucy’s seventh birthday, Mrs. Irving had noticed a frequent, creamy discharge on Lucy’s underwear. A childhood clinic nurse reassured Mrs. Irving that prepubertal girls often experienced some vaginal discharge.

⁶In addition to asking the family about the family history, we also accessed the hospital medical file, and—with parental consent—phoned all medical practitioners who had treated Lucy, and asked them for copies of correspondence. Had the family not given us consent to contact other professionals involved in Lucy’s care, this would have increased our concern about Lucy’s safety and wellbeing, and we may have resorted to other information exchange options available to us under the umbrella of Child Protection Policies and legislation.

- At 7 years and 4 months, Lucy reported suddenly “feeling wet” and showed blood-stained underwear to her mother. The family doctor said this reflected pubertal-type activity. Mr. Irving began to buy free-range chickens because he was worried the “early pubertal activity” could be caused by sex hormones fed to chickens.
- At 7 years and 6 months of age, Lucy contracted pneumonia. She had 3 weeks home from school and was treated by the family doctor with antibiotics and steroids.
- Subsequent “bursts” of vaginal bleeding involved Lucy running to the toilet, with the bleeding “exploding” into the toilet and “covering the whole bowl.” Lucy stopped attending school because of the extent of the “leakage” and was formally homeschooled by her mother. She was investigated medically by multiple specialists and had six hospital admissions. Lucy also developed additional symptoms: weight gain; severe headaches that involved a “banging” sensation on Lucy’s forehead; bruise-like skin eruptions in the upper arms and the epigastric region of the upper abdomen; and a variety of other nonspecific symptoms such as fatigue, dizziness, and “pins and needles”.
- When Lucy turned eight, Mrs. Irving began to consult alternative practitioners. One naturopath suggested Lucy was “psychosomatic” and was experiencing “phantom period pain.” The second suggested “leaky gut syndrome” and prescribed liquid vitamins and a healthy diet. “Leaky gut syndrome” was said to be caused by an “unspecified autoimmune condition, which enabled toxins and parasites to invade the body,” a condition which is not acknowledged by the medical profession.
- Our assessment took place when Lucy was 8 years and 3 months old. At that time Lucy’s symptoms consisted of a “leakage of clear fluid” that was only occasionally blood stained. Episodes were reported to occur daily and consisted of “big gushes” that soaked Lucy’s pads, her clothing, or mattress and sheets. Other symptoms included “linear-looking” episodic skin eruptions, headaches, and weight gain.

The family’s presentation at the interview

Mr. and Mrs. Irving articulated their frustration and anger that doctors had failed to clarify what was wrong with Lucy. Both parents raised a large number of medical questions with our team and Mr. Irving suggested a search for an international specialist, who would provide the family with an answer. During the moments when her parents became animated, Lucy sat quietly observing the scene with an odd, wide smile and an odd look in her eye. Her younger brothers played quietly with the toys in the room. While describing Lucy’s skin eruptions, Mrs. Irving pointed out every discoloration, dimple, and unevenness that could be identified on Lucy’s skin, asking whether these were normal or whether they could be a dermatological manifestation of Lucy’s problem.

The family’s dilemma as articulated in the family session, and a way forward

At the completion of the assessment, we summarized the family’s dilemma. We concurred with Lucy’s parents that they were at a difficult decision point: (1) either they could accept the medical opinion that there was no organic pathology, or (2) they could continue to seek more and more medical opinions, and to see more and more doctors. We articulated that both options put the parents in a difficult position. The first—accepting there was no organic cause—was anxiety provoking because the doctors could be wrong, and Mr. and Mrs. Irving had a responsibility to make sure that Lucy received adequate medical care. Failure to provide medical care could be seen as neglect. The second—seeing more and more doctors—was “tricky” because it could result in a large number of medical investigations and interventions that could potentially cause significant side effects or even result in significant harm to Lucy. Thus, too much medical care, especially if it was not needed, could be seen as a form of iatrogenic abuse. We offered our assistance in helping the family struggle with the above dilemma.

We offered to call a medical case conference to clarify Mr. and Mrs. Irving's medical questions. We then documented Mr. and Mrs. Irving's questions carefully and obtained consent to contact the school and all professionals involved. Our reason for not conducting the case conference with the family present was that we needed the health professionals to be able to articulate their points of view without constraint, so that we could assess the medical data objectively. We were concerned that this type of discussion would trigger a variety of intense affects expressed by the medical staff— anxiety, frustration, anger, disbelief—which, if expressed in the presence of the family, could have undercut our future engagement with the family (Epstein et al., 2006; Freeland & Foley, 1992).

The Case Conference: The Professionals' Point of View

We met with or talked to the key professionals involved—the general pediatrician, pediatric gynecologist, pediatric urologist, pharmacist, family doctor, and school principal—to clarify their opinions, to gather together all the relevant evidence, and to obtain answers to both our own questions and those posed by the family (see Text Box 1). Interestingly, staff at Lucy's school, her family doctor, and those involved in hospital admissions had not witnessed any "leakage episodes."

Second Family Appointment: Feedback after the Medical Case Conference

First we met with the parents to discuss the answers to the parents' medical questions (see Text Box 1). Disappointed by the answers, Mr. and Mrs. Irving demanded that we organize another medical opinion. We expressed our willingness to comply, but insisted that this approach would prove fruitful only if the expert was provided with more data than previous doctors had had access to. We said that in all difficult-to-diagnose medical conditions, doctors required specific observational information, which allowed them to make a diagnosis. In Lucy's case the efforts to gather this information in hospital had not been successful—the nurses and doctors had not been able to observe the "gushy leaks" for themselves—consequently, the family would have to collect this information at home using video technology and sample collection. We were firm that we could not organize another opinion until the family had collected the needed data. We emphasized that since the "gushy leaks" were happening very frequently, we did not see that this data gathering would pose any particular problem.

Lucy then joined the session. The idea of collecting data was introduced to her using the externalizing intervention of "playing detective to catch the sneaky bleed" (White, 1984, 1986). One of our team members (S. F.) was designated as the contact person, who would keep in weekly telephone contact with Mrs. Irving. The key aim of this telephone intervention was to maintain an intense level of communication with the family, thereby helping both to promote rapport with the family and to minimize the likelihood that the family would obtain a referral to see yet another professional.

The Subsequent Three Months: "Playing the Detective or Coinvestigator"

The second author (S. F.) made weekly telephone calls to Mrs. Irving and also maintained contact using e-mail. The latter allowed Mr. and Mrs. Irving to write down questions at times when S. F. was not available. This weekly contact facilitated the emergence of a therapeutic relationship between Mrs. Irving and S. F., one in which Mrs. Irving experienced S. F. as being empathic and curious. This rapport allowed for an ongoing conversation about Mrs. Irving's anxiety for Lucy, about her ideas as to where else she could go for help, and about the various diagnoses that had

been offered by alternate health practitioners. S. F. used these discussions to applaud Mrs. Irving's commitment to Lucy, to acknowledge the difficulties of trying to make sense of differing opinions offered by different health professionals, and to refocus Mrs. Irving on the task of collecting the needed medical evidence. The weekly contact also provided new information about family functioning. Specifically, frequent interruptions by the children made it clear that Mrs. Irving was struggling to establish appropriate boundaries with all three of her children. When it became clear that the family was struggling with the collection of evidence, S. F. introduced the idea of an observational admission under our psychological medicine team, which was readily accepted by both parents.

Preadmission Interview with Lucy and Her Mother

The preadmission interview was set up to clarify the structure and goals of the 2-week admission. Lucy was to follow a daily timetabled program—hospital school, physiotherapy, individual therapy, and art therapy—to help us assess Lucy's educational, physical, and psychological functioning in the hospital setting. Mrs. Irving would be required to absent herself from the ward during the day program, returning at 5 p.m. For the first two nights, she was to sleep at Lucy's bedside, but would subsequently be required to remove herself to the parent's room on the ward (the family home was a 3-hour drive away). Mr. Irving was to stay home, run the farm—so as to maintain the family income—and look after Lucy's two brothers. He and the boys were to visit on the weekend so that the entire family could practice a variety of family-based homework tasks set by the team. Other goals of admission included the following:

- To gather a sample of the “gushy vaginal leaks.” To this end, Lucy was to carry specialized “urine collector” pads⁷ in her school bag. If she had a leakage episode, she was to report it to the nursing staff and hand in her pad. The pad was then to be immediately aspirated to yield a sample for analysis. If Lucy reported “leakage” episodes, but failed to notify staff and to provide the pad, we would treat the episode as if it had not happened.
- A School-Aged Assessment of Attachment (SAA) was planned with Lucy, to further add to the information about her emotional and psychological functioning (Crittenden, Kozłowska, & Landini, 2010; Farnfield, Hautamaki, Nørbech, & Nicola, 2010).
- Frequent appointments with Mrs. Irving were booked in to conduct an Adult Attachment Interview (AAI), to assess her emotional and psychological functioning (Crittenden, 2006a; Farnfield et al., 2010), and to discuss issues that arose from the AAI or from Lucy's admission.

Lucy and her mother arrived at the preadmission appointment bearing a specimen jar containing clear fluid, wet pads weighing 1.35 kg,⁸ and a DVD of a “leakage episode.” Lucy also showed us one of her erupting skin lesions on her right arm. Our dermatologist pronounced the lesion to be caused by trauma, most likely a form of dermatitis artefacta that is a skin lesion induced by Lucy herself. Formal analysis of the fluid sample revealed it consisted of tap water⁹ contaminated by a small amount of urine. The DVD of the “gushy

⁷These are specialized pads used for the collection of urine in infants and young children. They allow the urine to be aspirated from the collection chamber inside the pad.

⁸Had the pad contained this much fluid from Lucy's body she should have been severely ill (dehydrated) and requiring urgent medical care.

⁹A body-derived fluid would have included electrolytes, protein, and squamous cells.

leaks” demonstrated Lucy urinating into the toilet in spurts. On the following day, in a telephone call with S. F., Mrs. Irving reported that Lucy had confessed that the sample she had provided was water.

The Inpatient Admission: New Information Gathered

Observational information about Lucy

Lucy was observed in a number of therapeutic settings: on the ward by nursing staff; in group physiotherapy; in individual therapy sessions with the third author (B. S.); and in the Hospital School. A clear pattern of behavior emerged across the range of settings.

- Lucy was always immaculately dressed, often in a pseudo-mature and “precocious” style of outfit. She frequently spent time in the morning fussing about her outfit and appearance—for example, choosing accessories for her silver dress.
- All of Lucy’s interactions with staff and other patients were driven by what Lucy wanted or needed.
- Lucy was frequently bossy and rude with her mother. For example, she swore at her mother, and when her mother was late for a visit she yelled loudly and angrily, “Where have you been?” Mrs. Irving failed to punish Lucy’s rude behavior and acted as if it was normal for a child to behave in that way.
- Lucy displayed separation anxiety, somatic anxiety, and oppositional behavior. When separated from her mother she became agitated and whiney, and repeatedly asked the nursing staff to phone her mother. She also complained of somatic symptoms—headaches, stomach aches, a sore throat, sore legs and limping, pain, fatigue, and dizziness—when anxious or when she did not want to follow adult directions. The somatic complaints would fade-out if they were ignored.
- Lucy was observed to be domineering toward, and derogatory of, other children, even those who were much older than she. She repeatedly told another patient that she was a “loser” and “a failure.”
- Lucy was very distractible, had a short attention span, required firm limit setting and the repetition of instructions to keep her in line and focused on the task at hand.
- Lucy’s interactions with us were characterized by recurrent displays of anger—expressed either directly or passively—which were subsequently disarmed by Lucy through the use of her smile. For example, during one morning ward round, Lucy hit the psychiatrist (K. K.) in the face several times with a soft toy and then smiled sweetly so as to disarm her aggression. Later that day she played a game of charades with her psychologist (B. S.) where she acted out the death of the psychiatrist. During other therapy sessions, Lucy objected to the therapist writing notes and would alternate between trying to read them, demanding that she stop writing notes, and attempting to snatch the paper out of the therapist’s hands. When the therapist tried to engage her with a variety of exploratory tasks, Lucy would smile at the therapist with her “fixed smile” and would simultaneously refuse to cooperate.
- During the whole admission there were no incidents of “gushing leaks,” and at no time did Lucy offer the nursing staff a pad specimen.

Observational information about Mrs. Irving

Mrs. Irving was anxious about Lucy and had difficulty complying with the strict visiting times. She became better at maintaining these boundaries during the course of the admission. She used her free time to read the *1-2-3 Magic* parenting book lent to her by the second author (S. F.) (Phelan, 2003), an intervention prompted by S.F. having heard the children screaming during the preceding telephone intervention. As the admission

progressed, Mrs. Irving became increasingly uneasy that Lucy's vaginal symptoms had again ceased on admission to hospital, and became preoccupied trying to explain this discrepancy in her own mind.

Information from the school-aged assessment of attachment

The SAA¹⁰ with Lucy confirmed our clinical impression that she used a coercive self-protective strategy (Type C3-4 moving to Type C5-6) (see Figure 2 and Text Box 2) (Crittenden, 1999, 2006a; Crittenden et al., 2010; Farnfield et al., 2010). This means that Lucy used a range of coercive behaviors as a means of obtaining comfort and protection from her parents because these functioned better than other signals to elicit care, reassurance, and protection. Lucy's strategy involved a focus on the self, a pointed dismissal of others and their feelings, the use of sexualized images to shock others (specifically the interviewer at the time of the interview), and the use of disarming behavior (Lucy's smug smile, babyish speech, cute coy looks) both to disarm adult anger and to deceive others as to the underlying affect that was motivating her behavior. Like older individuals using Type C5-6 self-protective strategy, Lucy also gave the appearance of needing rescue from dangerous circumstances (e.g., her leakage episodes) that were, in fact, self-induced. Lucy's use of provocations which had a sexual flavor—the seductive component of the Type C5-6 strategy—was very unusual in a child so young and was very disconcerting for the interviewer. Lucy's coercive strategy was advanced for her age: it involved not only feigned helplessness (illness) and disarming behaviors (Type C3-4)—as is commonly seen in young school-aged children—but also the active use of psychological deception (Type C5-6). Lucy did not display her anger openly. Instead it was hidden and controlled—she covered it with her fixed smile—but anger nevertheless continued to motivate her behavior.

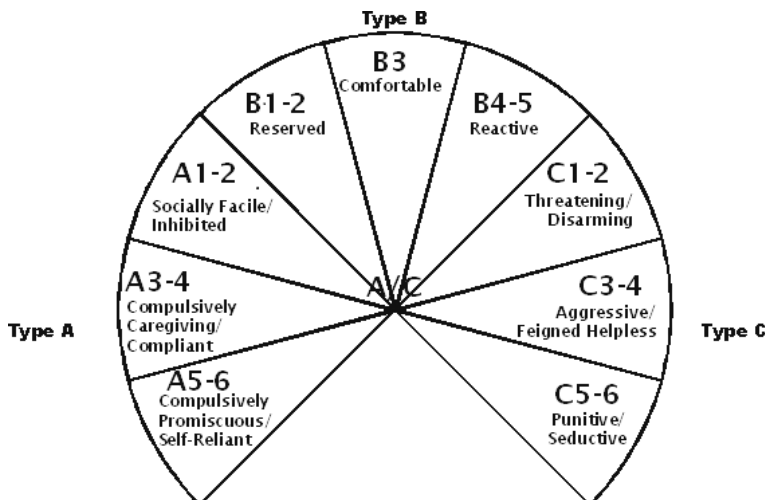


FIGURE 2. The Dynamic Maturational Model (DMM) of patterns of attachment in the late school-aged years and adolescence (Figure provided courtesy of Patricia Crittenden).

¹⁰A more detailed account of the information elicited through the SAA is available in Appendix 3 in Supplemental material on the Wiley library web site.

Information emerging from Mrs. Irving's AAI

In our first individual session with Mrs. Irving, the first author (K. K.) administered the AAI¹¹ (see Figure 2 and Text Box 2). The process of giving the AAI served two key functions: it helped us understand Mrs. Irving's emotional and psychological functioning and it deepened Mrs. Irving's sense of being understood: "you know more about me now than most people in my whole life."

The AAI suggested that, in relation to her own attachment figures, Mrs. Irving had organized using a Type A3-4 self-protective strategy (see Figure 2). The compulsive caregiving component of Mrs. Irving's strategy (Type A3) refers to a pattern of organization where the child comforts, amuses, or cheers up a withdrawn or neglectful caregiver, so as to maximize the amount of comfort and protection that they can obtain from the caregiver. By adulthood, compulsive caregivers feel safest and most comfortable when caring for the needs of other people, even to the exclusion of their own needs (Crittenden & Landini, 2010). The compulsive performance component (Type A4)¹² refers to a pattern where the child focuses on doing the "right thing," so as to comply with the caregivers' wishes and expectations, because by these means, they ensure the caregivers' love and approval (Crittenden, 2004; Crittenden & Landini, 2010). Compulsive compliant children (Type A4) tend to be vigilant and over-responsive to any suggestion of demands from their (hostile) caregivers, thereby decreasing the likelihood that the caregivers will become angry or abusive (Crittenden, 1999, 2004; Crittenden & Landini, 2010). Psychologically, all the Type A strategies consist of taking others' perspectives, foreseeing their demands, and, without reference to one's own desires or feelings, meeting those demands (Crittenden, 1999; Crittenden & Landini, 2010).

Mrs. Irving's AAI also had linguistic markers of unresolved loss and trauma in relation to her father's violence, past sexual abuse, her sister's suicide, and the punitive expectations of her religious family and the priests from the Catholic Church. Most of the time Mrs. Irving pushed information about these events out of mind (dismissed unresolved loss or trauma), but intermittently, images and memories would intrude into her mind, and she spoke of them as if they were happening in the here and now (preoccupied unresolved trauma).

The AAI helped us understand that as a child, Mrs. Irving had inhibited the expression of her own feelings of distress, fear, and anger, and had organized her own behavior so that it: (1) did not attract unwanted attention (the anger of her father), (2) maximized her experience of emotional closeness with her mother (by listening to her mother's problems and preempting her demands); and (3) maximized her sense of love and acceptance from her stepfather (by being very careful to do the right thing and to thus comply with his expectations)—a mixed Compulsive Compliant, Compulsive Caregiving, and Compulsive Performing strategy. As an adult, Mrs. Irving dismissed negative affective and episodic information (inhibition of negative affect and episodic information) to avoid reflecting about her own unmet emotional needs for comfort. This habitual dismissal allowed her to idealize her childhood relationship with her mother and stepfather, and to avoid the emotional pain that would accompany more balanced reflections.

We thought that unresolved loss and trauma events continued to have a here-and-now effect on Mrs. Irving's feeling states and behavior. It was likely that trauma-associated feeling states—distress, anxiety, anger, pain—triggered by current events, functioned to motivate Mrs. Irving's current behavior, without Mrs. Irving being aware of the

¹¹A more detailed account of the information elicited through the AAI is available in Appendix 4 in Supplemental material on the Wiley library web site.

¹²The minus sign in (Type A4⁻) refers to a milder form of compulsive compliance (Type A4).

connection. This lack of awareness put Mrs. Irving at risk of engaging in self-protective behaviors which were poorly matched with the danger at hand.

The Inpatient Admission: Case Formulation

We used all the above-described information to formulate a hypothesis concerning the evolution of Lucy's medical presentation. It seemed to us that Lucy's original symptom—a vaginal discharge often seen in prepubertal girls—occurred at a time when Mrs. Irving was extremely stressed in the context of struggling with multiple practical and emotional demands:

- (1) The needs of her children: 6-year-old Lucy, a 3-year-old toddler, and a baby.
- (2) Her feelings of grief with regard to her sister's death (still unresolved according to AAI discourse analysis).
- (3) The grief associated with her third and fourth miscarriages, which appear to have functioned as reminders of DES exposure, and to have raised Mrs. Irving's anxiety about the effects of DES in third-generation females. This anxiety had led her to search the Internet for information and to make contact with DES-ACTION.
- (4) Her own depressive illness, which typically increases levels of anxiety and makes rumination about past negative events more likely.

We hypothesized that Mrs. Irving had had to manage these responsibilities and life events on her own. She was married to an emotionally distant husband whose key preoccupation was to support the family financially, and who spent large amounts of time out of the home, attending to the farm. Second, she was adept at caregiving for others—a key component of the Type A3 self-protective strategy—but less able to identify and elicit help with regard to her own feelings, needs, and predicaments.

Data from the AAI led us to hypothesize that the vaginal discharge that Lucy reported to Mrs. Irving had triggered not just ordinary responses of concern, but feeling states that were intensified and ultimately connected to unresolved loss and trauma. Mrs. Irving had probably experienced intense feelings of fear—in particular, that Lucy could die from her bleeding or that the bleeding resulted from a DES-associated illness that was potentially disabling or even life threatening. Mrs. Irving's strategy of dismissing intense, unresolved feeling states meant that she was unable to keep them in mind, reflect upon them, connect them to past traumas rather than to the present, and recognize that she was misinterpreting the actual danger level of Lucy's vaginal discharge. From a practical perspective, the consequence was that Mrs. Irving unintentionally reinforced Lucy's symptoms by hyperattending to any somatic complaint that Lucy reported. Mrs. Irving remained preoccupied with Lucy's symptoms and was unable to accept the medical feedback that nothing organic could be found, because these reassurances failed to address her inner feeling states of fear, distress, and anxiety. In her communications with health professionals, Mrs. Irving highlighted and exaggerated her descriptions of Lucy's symptoms. These exaggerations functioned to underline the seriousness of the situation, to ensure that help was obtained for her daughter, and to assure herself that she was fulfilling her responsibility to look after her child. But what Mrs. Irving's actions actually reflected was the continuing failure of the medical system to address her unresolved feelings that were triggered by Lucy's symptoms and distress.

Lucy must have discovered—not necessarily in a conscious way—that her “vaginal” symptom elicited significant attention and caregiving from her mother, that it distracted her mother from her own depression, and that it diverted some of the mother's attention away from the younger children. It is probable that this attention from Mrs. Irving to both Lucy and the symptom itself—taking the form of both questions about

the symptom and repeated examinations of Lucy's body—not only functioned to maintain the original symptom, but also facilitated the emergence of new symptoms. A large number of Lucy's symptoms reflected normal body sensations (fatigue, dizziness, pins and needles) that, if attended to, may have become a focus of conscious attention. Others, however, such as the skin eruptions, had clearly been self-induced, possibly suggested to Lucy by her mother's detailed examination of every dimple and discoloration of Lucy's skin.

It seemed to us that the interaction between Mrs. Irving's self-protective strategy (her tendency to be vigilant to the feelings and needs of others and to act as their caregiver) and that of Lucy (her focus on getting what she wanted and her use of deception and displays of exaggerated affect, in this case behaviors and evidence that communicated illness, to elicit comfort and protection) was important. In particular, these two strategies interacted to create a dynamic that allowed the factitious illness to be maintained over time. The absence of an involved spouse, who could have provided an alternative point of view, was also not helpful.

In summary, according to our reflections, it seemed likely that Lucy had reported real symptoms to her mother, but had subsequently elaborated these symptoms and that Mrs. Irving—as a good, compliant individual—had accepted her daughter's complaints and reports at face value. When speaking with doctors, Mrs. Irving had further exaggerated the symptoms to obtain help for her child. Interestingly, it was a discrepancy in the presentation of the symptoms—the sudden disappearance of Lucy's symptoms during each of the seven hospital admissions—that finally made Mrs. Irving uneasy and alerted her to the possibility that not all was as it seemed.

The Inpatient Admission: Sharing the Formulation with Mrs. Irving

Mrs. Irving came to her second individual session with two concerns. First, she was mystified by the fact that Lucy's symptoms had ceased on admission to hospital. Second she had become aware—through her reading of the *1-2-3 Magic* parenting book, and her feelings of embarrassment when nursing staff had watched Lucy yelling at her—that Lucy's behavior was a significant problem. We validated Mrs. Irving's concerns about Lucy's behaviors by providing feedback about our own observations. We also suggested that Lucy seemed to become very anxious when separating from her mother. Mrs. Irving was able to use this feedback to further describe her own difficulties in managing Lucy and the other children at home. This was an important turning point in the therapy, because it allowed us to focus on Lucy's coercive behaviors and Mrs. Irving's responses, rather than the “vaginal dysfunction”.

In the third individual session, Mrs. Irving once again raised her mounting unease that it seemed “too coincidental” that Lucy's fluid loss had suddenly stopped, once again, on admission to hospital. We told Mrs. Irving that, like her, we could not explain why Lucy had experienced “vaginal” symptoms, but that we had generated a number of hypotheses, which we were happy to share with her:

- Lucy may have discovered by accident, through interactions with her mother with regard to her initial vaginal discharge, that her mother was anxious about, and very attentive to, issues having to do with the genital area. We said that this concern was understandable in view of Mrs. Irving's own sexual abuse as a child and her fear regarding the possible third-generation effects of DES. It was therefore possible that Lucy had continued to obtain care and comfort—either consciously or simply by repeating a known pattern of interaction—by focusing attention on her “vaginal” and other somatic symptoms.

- Lucy's symptoms had allowed her to avoid a variety of responsibilities and tasks such as going to school. We suggested that her experience while sick with pneumonia, when Lucy had been home with mother, may have suggested the benefits of being ill.
- Lucy's symptoms had allowed Lucy to spend more time with her mother. We pointed out that Lucy was an anxious child, who was jealous of the time her younger siblings spent with Mrs. Irving. Her symptoms allowed her to get more time and comfort from her mother, thus allowing her to triumph in competition with her brothers. This alternative, like the one above, may have been suggested to Lucy by her experience while sick with pneumonia.
- We pointed out that Mrs. Irving had had many recent life events to contend with and that she had been both stressed and severely depressed. We suggested that, although Lucy presented in a very "mature" way, she had actually experienced significant anxiety in the context of her mother being stressed. The symptoms could have functioned as a means of avoiding separation, which Lucy was unable to manage, and of staying close to her depressed and anxious mother.
- We discussed that children are very influenced by adults and that their behavior can be shaped by adult expectations. We pointed out that in the AAI Mrs. Irving had told the story of her going to confession as a child and making up sins because it was generally expected that she must have done something wrong and because she did not want to get into trouble. In the same way, it was possible that Lucy had reported symptoms because she felt it was expected of her. Similarly, she may have put water in the specimen jar and wet the pads with water because she knew she was expected to produce a sample.
- That all the medical doctors at the hospital were wrong and that Lucy's symptoms were the result of toxins arising from a parasite causing "leaky gut syndrome."

Mrs. Irving spent the fourth individual session and her free time at the hospital considering these hypotheses. Family homework for the weekend was as follows: Mr. and Mrs. Irving were not to mention the vaginal fluid at all, were to focus on predictable parenting, and were to organize a family outing. The key aim of this intervention was to help the family find different ways of being together that were unrelated to Lucy's symptoms. We also suggested that Mr. and Mrs. Irving discuss the possibility of Mrs. Irving leaving the hospital for a day—the following week—to visit Lucy's school and to re-enroll her in class for the coming school year.

In the fifth individual session with Mrs. Irving, she told us that the weekend had gone well, that the family had enjoyed themselves, and that there had been no episodes of "gushy leaks." She had discussed the school situation with her husband and had arranged to visit the school later in the week to organize enrollment. She also reported that she had read the entire *1-2-3 Magic* parenting book and was implementing the program with the children. She asked for more information about local courses. During the remainder of the session, Mrs. Irving confided how confused she and her husband felt, and how difficult it was to untangle discrepant medical opinions—in particular, the conflict between the diagnosis of "leaky gut syndrome" given by the naturopath versus the general medical consensus that there was no organic pathology. We suggested that possibly Mrs. Irving and her husband would never be able to know for sure what exactly had happened. We pointed out that Lucy now appeared to be well and that further visits to doctors were unlikely to provide the family with any useful answers.

The sixth, and final, individual session with Mrs. Irving took place at the end of the admission. Mrs. Irving reflected that she (and her husband) felt much less anxious following the 2-week admission and that during the previous few days she had decided to "let

go” of the anxiety that Lucy had something wrong with her. She had also decided to stop the medications prescribed by the naturopath. She said that the rehabilitation program had helped her realize that Lucy was no longer sick and was capable of normal functioning. We spent a large part of this session warning Mrs. Irving that it was possible that Lucy’s symptoms could be retriggered with stress or by her return home. The second author (S. F.) offered to maintain telephone and email contact for some months after the admission, so as to monitor how things were going.

Outcome of the Intervention

After discharge the third author (B. S.) rang Lucy’s school to establish a management plan for Lucy’s return, and the second author (S. F.) maintained telephone and email contact with Mrs. Irving over a 6-month period. Mrs. Irving attended the local *1-2-3 Magic* parenting program and the parents continued to implement the “weekly family outing” prescribed by the team. Mrs. Irving reported that Lucy loved the outings, had responded well to the *1-2-3 Magic* program, and that many of Lucy’s angry behaviors had settled. Lucy successfully reengaged at school, and began to bring home a string of awards. During the Christmas holidays the children spent considerable time at the beach with their father, and Mrs. Irving was able to have some breaks from the daily stress of parenting. Five months following her hospital admission, Lucy experienced one episode of stained vaginal discharge. Mrs. Irving interpreted this occurrence as a normal, prepubertal vaginal discharge and did not become anxious about it. There were no episodes of “gushy leaks,” and Lucy did not complain of any new somatic symptoms. When S. F. enquired how Mrs. Irving thought about Lucy’s now resolved vaginal symptoms, Mrs. Irving restated the explanation given to her by the naturopath, who had seen Lucy prior to our involvement. She said she believed that toxins arising from a parasite had been responsible for the unexplained bleeding. At the 18-month follow-up, Lucy was doing well and had joined the school debating team.

CONCLUSION

While recognizing that children presenting with fabricated illness have potentially serious medium- to long-term adverse outcomes and are commonly referred for management to child protective services, the therapeutic team chose to take a more open position. We sought to engage the family by a process of trying to understand their concerns and the story of the presenting symptoms, to gather data that enabled us to assess the self-protective organization of both Lucy and her mother, and to understand the manner in which the family functioned as a whole.

Rather than giving our primary attention to the symptoms per se, our team flexibly and pragmatically chose interventions that simultaneously facilitated engagement, increased our understanding of family functioning, and encouraged a focus on active problem-solving tasks. In particular, we articulated the family’s options to them clearly and directly, we were empathic and informative about the options and their consequences, and established practical tasks for the family, ones that compelled them to engage in active problem solving and to take on a co-investigator role with regard to the symptoms. This intervention ensured that, in collaboration with the therapeutic team, the family shared responsibility for trying both to understand the problem and to find a solution for it—in lieu of their demanding further attention and further answers from health professionals. We utilized assessments of attachment—the SAA and the AAI—to obtain important information about self-protective functioning. Together with all the other data, information from these assessments of attachment

enabled us to formulate a hypothesis as to what may have happened in Lucy's family to allow for the onset and maintenance of her symptoms. We actively avoided denying, minimizing, dismissing, challenging, or pushing away any of the concerns expressed by the family. We also kept in frequent contact with the family—rather than trying to avoid contact—and used this ongoing contact to build a solid therapeutic alliance and to provide support with regard to family tasks.

Through this interpersonal process we were able to create a context in which the family—in particular, Mrs. Irving—felt respected and understood, and in which Mrs. Irving was able to step back, observe the functioning of her daughter from a distance, and consider various hypotheses about why the problem may have occurred. This process allowed for a diminution of Mrs. Irving's anxiety, which allowed her and her husband to relinquish their requests for further medical opinions and investigations, and to pursue alternate interventions that also served to improve functioning in the family system as a whole.

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Text Box 1.

Medical Questions Raised by Mr. and Mrs. Irving, with Answers

Question 1: Could Lucy's symptoms reflect the third-generation effects of DES, analogous to the increased risk of vaginal, cervical, and ovarian cancers in second-generation cohorts. How could this potential problem be monitored?

Answer: Lucy was prepubertal, and these tissues had not yet begun to develop. Since all investigations had been normal, the situation would be followed up by clinical reviews every 6 months. Further invasive testing would constitute a form of iatrogenic abuse. The next appointment with the referring pediatrician was scheduled.

Question 2: Could the symptoms be due to a lymphatic problem? Had this possibility been fully investigated?

Answer: Lucy had had various exploratory procedures, and no abnormal lymph vessels had been detected. Given the amount of reported fluid loss, the lymphatic vessels would be large and easily detected by these investigations.

Question 3: Had allergies been ruled out as a possible cause of the symptoms?

Answer: Lucy did not have any symptoms that reflected an allergic process.

Question 4: What did the skin changes (the recurring linear bruise-like skin eruptions) mean?

Answer: It was agreed that a dermatologist would be consulted.

Question 5: Could synthetic hormones—such as those given to chickens, but from other sources—be affecting Lucy, and how would that be reflected?

Answer: If synthetic hormones had affected Lucy, it would be reflected in the functioning of her adrenal-pituitary axis, and the functioning of this system had been carefully tested and was normal.

Question 6: The naturopath had suggested that Lucy's illness reflected "leaky gut syndrome" and had reported parasites in the blood when he had taken a sample blood drop. Had Lucy been tested for parasites in the blood?

Answer: On microscopic review by a microbiologist, the blood had shown no parasites.

Question 7: Who could provide another opinion?

Answer: Referral for yet another opinion would not yield any answers unless the family were able to provide further information about the problem. It was clear that with the data available, doctors were unable to identify any relevant medical problems.

Text Box 2.

Description of the SAA and AAI

The School-Aged Assessment of Attachment (SAA) and the Adult Attachment Interview (AAI) are validated, semi-structured interviews about childhood relationships and events (Farnfield et al., 2010; Hughes et al., 2000; Kozłowska & Williams, 2009; Rindal, 2000; Ringer & Crittenden, 2007; Seefeldt, 1997; Zachrisson, 2004). Both interviews are audio-taped and transcribed for linguistic analysis using the dynamic-maturational model of attachment and adaptation (Crittenden, 1995–2008, 2006a,b; Crittenden & Landini, 2010). The linguistic analysis involves consideration of the implicit aspects of speech (dysfluencies, tone, rhythm), temporal and affective biases, and discrepancies between memory systems (procedural, imaged, connotative, semantic, and episodic memory) (Crittenden, 2002; Crittenden & Landini, 2010; Crittenden et al., 2010; Schacter, 1996; Schacter & Tulving, 1994; Tulving, 1972, 1979, 1987). The analysis yields the speaker's attachment or self-protective strategy, a pattern description that identifies the manner in which the speaker organizes an interpersonal emotional response in the face of specific threats from caregivers or significant others or in the face of threats to progeny (Crittenden, 1999, 2006a,b; Kozłowska, 2007a,b; Kozłowska & Williams, 2009). The assessment also identifies unresolved losses or traumas—specific adverse events indicated by information-processing errors in the speaker's transcript, as evidenced via linguistic markers.

The SAA consists of cards whose themes address threats that school-age children frequently face or imagine facing. Emotional responses are elicited through the themes of separation and conflict. The interview protocol asks the responding children to make up a story about the child depicted on each card and then to recall a similar episode in their own lives.

The AAI consists of a series of questions—which are designed to probe different memory systems—about the speaker's childhood relationship with his or her parents. Other questions enquire about episodes of loss or trauma. Crittenden (Crittenden, 1999) modified the original AAI (George et al., 1986–1996) to include both a wider range of potentially threatening circumstances and probes for affect-based memory systems (imaged memory and connotative memory).

SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

Appendix S1. Summary of investigations and investigative procedures.

Appendix S2. Information about diethylstilbestrol (DES).

Appendix S3. Lucy's school-age assessment of attachment (SAA).

Appendix S4. Mrs. Irving's adult attachment interview (AAI).

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