Health Anxiety of Parents (AKA FII) - treatability ??

Sue Foley (Senior Social Worker)
Kasia Kozlowska (Child and Adolescent Psychiatrist)
Blanche Savage (Clinical Psychologist)
The Department of Psychological Medicine, The Children’s Hospital at Westmead
Contact:: sue.foley@health.nsw.gov.au
Presenter: Sue Foley
B.Soc.Stud, M.A., M.S.W., M.Ed. Ed.D Candidate UTS (Sydney)

• Senior Social Worker, and Co-ordinator of Child and Adolescent Psychological Telemedicine Outreach Service, The Department of Psychological Medicine, The Children’s Hospital at Westmead, NSW Australia.

• Children’s Court Clinician, The Sydney Children’s Hospital Network (SCHN).

• Clinical Social Worker (Private practice)

• Member ISPCAN Council
About the authors

- We are all members of multi-disciplinary psychiatric consult liaison teams at the Children’s Hospital at Westmead – a tertiary referral service for complex medical and psychiatric and child protection presentations of children and families.
- The hospital also has a Child Protection Unit with specialist and experienced staff. Sue has worked in that unit and also in the Department of Community Services with experience in these kinds of presentations since 1985.
About the authors

• A small but constant number of referrals each year are made for assessment and consideration, where there are concerns that physical symptoms may be being exaggerated or even induced.

• Examples include:
  – Epilepsy, reported urine retention, pain, nocturnal fits, breathing problems secondary to arnold chiari malformation, vaginal bleeding, abdominal pain, infection, allergy.

• In the literature the presentations are sometimes referred to as Munchausen’s syndrome by proxy, factitious illness by proxy etc.
The Abstract

• This presentation will describe the dilemmas for mental health, paediatric and child protection agencies in deciding what interventions are needed or more importantly may be effective.

• The condition known as FII (Fabricated or Induced Illness) is frightening for clinicians because of the risk of significant harm or even death.

• The dilemma is further accentuated because understanding motivation and potential for change requires time and analysis of the family system, attachment issues and the meaning of the symptoms.
Abstract continued..

- Where the behaviour includes symptom induction or significant fabrication, the risk of harm needs serious elucidation.
- The presentation will provide information and case studies about current therapy and case management practices being used by the authors.
- The dilemmas continue and will be discussed.
The dilemma with these cases

- In the literature, the condition is understood as parents deliberately creating or exaggerating symptoms in children to meet the parents’ own emotional or care or financial needs.
- Usually understood in black and white terms – and nearly always conceptualised as a form of child abuse.
- Child protection and psychiatry systems believe parents have to admit to abuse before can be treated…but clinically this is not a very useful approach.
A different way of thinking about these cases

Risk cannot be ignored

- Somatising symptoms that get a lot of attention
- Exaggeration of symptoms by anxious parents
- Deliberate creation of symptoms

Risk cannot be ignored
Falling on a continuum

- Abdominal or limb pain
- Alleged fitting or epilepsy
- Pain and nocturnal fits
- Breathing problems secondary to Chiari malformation
- Urine Retention
- Vaginal bleeding
- Over-dosing children on salt and insulin

Risk
A different way of thinking about these cases...

- Usually anxiety and unresolved loss in the parental history are part of the dynamic. Parents become hypervigilant to medical symptoms.
- Parents can genuinely believe their children are ill and want them to be safe and cared for.
If possible .. Hear from a Mum
- Donna

One of her children died, one was brain damaged and twins were at serious risk because of in hospital harm
Working in the grey areas in a mental health setting

- Different from a forensic approach, we work to understand and work with the system.
- How did the family come to be organised the way it is?
- What are their motivations?
- Taking a curious stance as joint investigators.
- Allows us to engage with the family in a non-blaming and non-punitive way. (But sometimes we are still green monsters)
Working in the grey areas in a mental health setting

• Our focus:
• Safety – may need behavioural monitoring and will need working with the context and system – medical, educational and perhaps even courts
• A pragmatic focus on the child’s functioning; on the parental interactions and on the family’s overall functioning and explore what obstacles are getting in the way of improved functioning, which helps us to avoid blaming.
• The work is slow – even after recognition (which can take 18 months), most cases take six months to two years to reach adequate resolution.
• There is rarely total admission or insight.
Complexity: multiple lenses are needed to develop understanding

- Multi-systemic family therapy
- Legal and safety lenses
- Dynamic Maturation Model of Attachment
- Trauma, grief and loss frameworks
- Cognitive behavioural approaches
- Parenting programs
- Narrative approaches
Systems issues

- Looking at interactions:
  - In the family (usually an over functioning and an under functioning parent)
  - Between the family and health professionals (dismiss and exaggerate – both parties)
  - Between different health professionals (threatened or overly engaged)
  - Between different agencies (distrust or polarisation: CS, hospital, doctors, school etc)
Principles we use

- Good communication
- Transparency
- Clear roles
- Recognising and addressing dilemmas
- Recognising symptoms of threat and trauma (hyper-arousal and hypersensitivity)
- Advocating for the child and family
Noticing and managing the anxiety all around

• Containment: family, other professionals, the therapist(s)! (never work alone!)
• Understanding and leaning into anxiety in the system (as opposed to avoiding)
  – Giving the parent a therapist in our team
• Working to understand the parents’ “anxious” / trauma / attachment story
Managing risk and child protection

• When and how to get child protection services involved?
• NB early age is problematic for safety.
• How dangerous is the situation?
• What role do you need CP services to play?
• Managing polarisation
• Need ongoing assessment of risk factors and protective factors
Strategies to gain understanding

• What are the benefits and disadvantages of illness in this family?
• Ask: How does the illness help the parents?
• Collect the data with the help of parents and sometimes the child
• There may need to be separation to help with assessing and identifying reality of medical situation
Examples of interventions

• Must attend school
• Anxiety (always) and mood (sometimes) management
• Limit the number of professionals directly involved but have good indirect supports
• Work on safe and effective connections and attachments within families and with the child’s system.
• Challenging function limitations is essential
References and resources

Resources

- http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60177-8/fulltext