

Teenage Boy With Multiple Pain Disorders

A case of mild factitious disorder by proxy

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History: Jason is a 14-year-old boy who presents with multiple pain disorders, dating to age 7. Medical history includes previous diagnoses of chronic Lyme disease, chronic migraine, fibromyalgia, chronic fatigue syndrome, and irritable bowel syndrome. Jason missed most of eighth grade this past year, but has done well with homebound education. Oddly, Jason's medical records do not corroborate his stated diagnoses.

Jason's mother (Ellen) and father accompany him to his first visit, and Ellen does almost all of the talking. His father is very quiet and defers to his wife. Jason has one older sibling, who still lives in the home while commuting to college.

Ellen appears very excited when telling us about Jason's various medications, doctors, and tests. Jason is on two antidepressants "for pain," an anticonvulsant, nonsteroidal anti-inflammatory drugs (NSAIDs), and muscle relaxants. He has physicians in three states, and averages two doctor visits a week.

On the surface, Ellen is very friendly and courteous. She tells us about an upcoming sleep study in which Jason will be participating, as she is convinced her son has a sleep disorder, "...but the doctors missed it on the first sleep study." Overall, she is very dissatisfied with his medical care. When we suggest that Jason see a psychotherapist, or have psychological testing, Ellen agrees, stating he will go, "as soon as he is finished with all his other tests."

There are a number of warning signs in this case that point to a factitious disorder: multiple diagnoses lacking solid medical evidence; multiple patient visits to a number of physicians in various locations; repeated medical tests; and a caretaker requesting more tests, doctors, and diagnoses. The mother's demeanor and affect are typical of parents in the mild factitious disorder by proxy (FDP) situation: very friendly, overly interested, excited and involved, and dissatisfied with the medical care.

The caretakers, usually the mother, often have personality disorders themselves, with narcissistic tendencies. If they are confronted, anger and splitting can ensue. Confrontation and honesty may work with healthy parents, but not with very psychiatrically ill parents.

Our goal is to gently nudge Jason and his family toward psychotherapy, and to minimize medications and tests. We want to ensure Jason is able to go successfully from freshman year of high school through his senior year. We eventually want to separate Jason from his mother with his departure for college. It takes a unified effort to help a child and family in this situation, and we must recruit others, particularly mental health professionals.

Diagnosis

This case represents mild FDP, as well as pediatric condition falsification (PCF).¹⁻⁶

Treatment

There are two treatment approaches that can be considered.

Approach 1: We establish a therapeutic relationship, and determine that Jason is not being poisoned or seriously harmed, other than psychologically, by the mother. Then, at a later date, we confront Jason's parents with our true thoughts.

Approach 2: We pursue a low key, nonconfrontational approach to both the parents and the child. Dialectical therapy, using acceptance, mindfulness, validation, and cognitive-behavioral techniques, among other tools, is currently our favored approach. After years of failure following confrontations with parents, I have used this laid-back "dialectical by proxy" approach with two young patients and their mothers, with reasonable success. One young woman currently is doing well in college, having physically separated from her parents. If our goal is to continue a therapeutic relationship, and ease the young person away from home, I believe that this approach may be best.

Long-term Follow-up

Over the 25 years I have been in practice, I have seen 10 patients with mild FDP/PCF. Five patients have been lost to follow-up (usually after we confronted the parent). Two patients have done well into their 20s, and are not considered to have a personality disorder. One young woman was diagnosed with borderline personality disorder, and has done poorly. Another young woman is doing well in college, and a 15-year-old has improved, and is attending high school part time. My impression is that, after the vitally important separation from parents, many victims may do well as adults, as long as they themselves do not have a personality disorder.

Discussion

The sample case represents a mild form of FDP, mild PCF, and possibly mild medical child abuse (MCA). FDP is primarily a psychiatric diagnosis that relates to the caregiver who exaggerates or completely fabricates the child's symptomatology. PCF relates more to the child/victim, who has had symptoms falsified. MCA relates to the healthcare providers, who may prescribe unnecessary and possibly harm-

ful treatments, including drugs. The MCA diagnosis recognizes the role of healthcare providers in the abuse of the child.

The incidence of FDP is not entirely known, but is considered to be relatively rare. The incidence has been quoted as ranging from 0.4 to 2 cases per 100,000 (among parents of children younger than 16 years of age). Boys and girls appear to be equally affected, and, typically, younger children are involved. However, with mild FDP presenting as headaches, we have witnessed most cases occurring in early adolescence. The incidence of the milder forms of these conditions is unknown.

The Participants

The three participants are the child/victim, the parent/perpetrator, and the healthcare team. The child (or adolescent) often is passive, deferring to the caretaker, who, regardless of the age of the patient, does almost all of the talking. Older children may collude with the parent. The adolescent often is dependent and immature, with separation anxiety.

The perpetrator parent, 90% of whom are the mothers, often is very attentive, knowledgeable, overly friendly, and comfortable in the medical setting. The vast majority of these parents have moderate to severe psychopathology, often some form of personality disorder. Some of the mothers display hypochondriacal traits, and occasionally have been involved in factitious disorders themselves. The caretakers that we have encountered with mild FDP are essentially “doctor addicts,” and are not actively inducing physical symptoms in the children. They seek various types of secondary gain, including sympathy, attention, and social interaction with the medical staff, and relief from their usual chores or work, and so on.

The role of the Internet has grown over the years. Parents can obtain a great deal of medical knowledge with-

out being part of a healthcare environment. Many of the perpetrators display a wealth of knowledge about the various conditions, although it tends to be superficial. Also, angry parents may use the Internet to post negative statements about healthcare providers.

The healthcare team is the third participant. Often, the primary provider is a subspecialist, eager to help with an unusual diagnosis. Healthcare providers have widely different levels of psychiatric acumen, and often ignore or miss obvious signs of FDP. In moderate or severe cases, it is more obvious as to the correct course, with psychiatric intervention, as well as legal notification of Child Protective Services. However, with mild cases, the correct means of intervention are not as clear.

Treatment

Management of these conditions varies from case to case. It “takes a village” to help these families, and we need other “villagers.” These often include psychotherapists, psychiatrists, social workers, the pediatrician, and so on. With moderate and severe cases, legal intervention is important. However, with the milder cases that I have seen over the years, the correct course is unclear. In the majority of the first seven cases I encountered, confrontation usually led to an angry scene, with the parent stalking out of the office, never to return. In three more recent situations, I have taken a more subtle “dialectical” approach, which has been much more successful. One case was that of a 15-year-old girl with severe daily headaches and multiple diagnoses; she was not in school for 2 years. We gently guided her into individual and family therapy, with little confrontation, and she is now off to college and doing well. Most of the time, however, the parents will resist or refuse psychotherapy. It is apparent that the correct approach to mild FDP/PCF is not known, and we need research and studies on this milder form.

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