Fabricated or Induced Illness

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Abstract

Fabricated or Induced Illness (FII) is the preferred term for the form of abuse previously referred to as Munchausen Syndrome by Proxy. This review groups the varied behaviours that result in FII into six Physical Impact Categories (PICs). The age of identification of abuse is inversely related to the severity of physical impact, whereas the age of onset of abuse is early in life in all PICs. PIC 5 (High Toxicity Poisoning) and PIC 6 (Apparent Life-threatening Events) have very significant mortality for both index cases (17% and 12%) and siblings (19% and 57%). 94% of perpetrators are female. The majority of male perpetrators inflict the severest forms of FII (PICs 5 and 6). Intrinsic illness co-exists with FII in 3–56% of cases. Co-morbidity occurred in 15–63% of cases. In PICs 1, 3 and 4 co-morbidity was predominantly FII commonly of the same PIC as the index presentation. In PICs 5 and 6 the commonest co-morbidities were death of a sibling and physical abuse of the index case or sibling. Pregnancy and perinatal problems are common in perpetrators of FII. A number of psychological features have been reported in perpetrators with Personality Disorder and Somatization being the most common features. However, such features may be absent and there is no single 'profile' of behaviour which is pathognomic of perpetrators of FII. Identification of FII depends on a clinical method which integrates process, content and physical findings. The concepts of 'The Bargain in Health Care' and the 'Falsifiability Principle' underpin such a clinical approach. Confirmation of FII abuse is obtained by close observation and separation, toxicology or Covert Video Surveillance.

Keywords Apparent Life-threatening Events; child abuse; Covert Video Surveillance; Fabricated of Induced Illness; Munchausen Syndrome by Proxy; poisoning

Definition

The preferred term to describe this form of abuse is Fabricated and Induced Illness rather than Munchausen Syndrome by Proxy. This preferred term is a descriptive term which substantially defines itself and additionally:

- Focuses on the child
- Concentrates on the harm done to the child and how that harm has been caused
- Separates identification of abuse from consideration of perpetrator characteristics including motivation. This is not to deny the importance of such considerations particularly with reference to management. However, early labelling of possible perpetrators on the basis of assumed 'typical' characteristics distracts from the primary task of being clear about what is happening to the child and tends also to split teams, further distracting from the primary task
- Reflects the wide range of behaviours included in this form of abuse
- Guards against FII being viewed as a discrete medical syndrome
- Avoids the danger of the misapplication of the term to the perpetrator as a psychiatric diagnosis

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Epidemiology

It is perhaps illusory and potentially misleading to attempt to provide a precise estimate of the incidence of FII. By definition FII includes a wide range of behaviours from immediate life threatening to fabrication alone and this merges into the normal range of the spectrum of healthcare seeking by parents for their children. This is reflected in the 50–100 fold difference in the frequency with which FII has been reported in population based surveys (Table 1). Reports from clinical services identified frequencies of FII orders of magnitude greater again (Table 1). This at least partly reflects the major role the medical system has in the genesis and maintenance of FII. Thus all practitioners working with children need to be aware of FII and develop a clinical method that maximizes the chances of identifying FII.

Associations of variants of FII

Given the wide range of behaviours constituting FII it makes sense to group similar behaviours together. This requires a classification of FII. One possible approach is to base the categorization on the physical intrusiveness of the behaviour of the parent/perpetrator and these categories can be referred to as 'Physical Impact Categories' (PICs). This categorization is not difficult to apply as this is what the professional encounters when confronted with a case. The physical impact can be described objectively.

For this review the behaviours have been grouped into six PICs:

Physical Impact Category 1: Verbal fabrications only including falsified specimens and/or charts without physical intrusion to the child.

Physical Impact Category 2: Withholding nutrients or medicines to produce signs. This PIC category overlaps with the concept of 'faltering growth' (non-organic failure to thrive) which is a neutral term to describe infants or young children whose growth is faltering for unknown reasons, which may be intrinsic or psychosocially determined. The authors of the original reports considered cases of 'withholding' (of either nutrients or medicines) to be manifestations of FII if the withholding was used to simulate intrinsic illness and justify unnecessary interventions.

Physical Impact Category 3: Other inductions. This is essentially a catch all category that includes inductions not covered by PICs 4–6.

Physical Impact Category 4: Low Toxicity Poisoning: the agents administered are commonly used therapeutically in children but in these cases were used without therapeutic indication. This predictably resulted in symptoms, (e.g. diarrhoea with the administration of laxatives), but not in immediate life-threatening emergencies.

Frequency of FII in different clinical situations

Country	Sample size	Cases/10^5	Duration of study	Comments
UK	12,725,936	1.0	2 years	Prospective survey of poisoning and non-accidental suffocation (McClure 1996)
New Zealand	895,860	2.0	1 year	Retrospective survey of all cases from fabrication to non-accidental smothering (Denny 2001)
UK	65,000	89	2 years	Retrospective survey of cases in which there had been concern about significant harm because of excessive healthcare or abnormal illness behaviour of parents for child (Watson 1999)
USA	20,090	1100	NR	Survey of apnoea programmes (Light 1990)
Germany	1648	1031	NR	Asthma clinic (Godding 1991)
UK	1500	1133	4 years	Allergy clinic (Warner 1984)
USA	709	1128	5 years	Single centre review of central venous lines (Feldman 1998)
USA	27	7407	8 years	Cases of intestinal pseudo-obstruction referred for intestinal transplant (Sigurdson 1999)

References are either listed in further reading or easily located in the bibliographies of another source cited in the further reading list.

Table 1

Physical Impact Category 5: High Toxicity Poisoning: the substances administered were either excessive doses of therapeutic agents resulting in acute, often life-threatening emergencies (e.g. large quantities of barbiturates resulting in coma) or substances with no therapeutic role (e.g. bleach or arsenic).

Physical Impact Category 6: Apparent Life-threatening Event: this is defined as a 'sudden event that is frightening to the observer and is characterized by some combination of apnoea (central or occasionally obstructive), colour change (usually cyanotic but sometimes pallor or redness), change in muscle tone (floppiness or rigidity), choking, gagging or coughing'.

Table 2 summarizes the associations of the PICs.

The information is largely self-explanatory but some comments are perhaps helpful.

It has long been recognized that fabrications are identified at an older age than inductions. However, if the onset of abuse is determined, all PICs have a median age of onset early in life. This is consistent with the hypothesis that FII has one of its roots in problems with parenting.

PICs 1, 3 and 4 share the features of low mortality for both index cases and sibling, only occasional male perpetrators and surgery has commonly been performed. PICs 5 and 6 have very significant mortality for both index cases and siblings and, though the majority of perpetrators are still female, there is a significant minority of male perpetrators.

Co-existing intrinsic illness was recorded only when physical signs or test results unequivocally demonstrated the presence of pathology independent of any fabrication or induction (e.g. duodenal atresia, urethral valves). Using a looser definition of intrinsic illness the proportion of cases of FII with underlying illness has been reported as high as 56%. Thus, a simple dichotomization into intrinsic and extrinsic cause of an illness needs to be avoided and where the two co-exist identifications of FII is particularly difficult.

Falsification of charts and/or specimens or charts is commonest in PIC 1 but is reported in all PICs (Table 3). It is an invaluable indication that abuse is taking place but should not be over-interpreted, the overall pattern of abuse, particularly the PIC, is of greater importance.

Role of the medical system in the genesis and maintenance of FII

Certain characteristics of the medical system contribute to the genesis and maintenance of FII. These include subspecialization, risk aversiveness, professional standing and rivalries, and parent involvement. This has been captured by some authors in the maxim 'FII: not only pathological parenting but also problematic doctoring'. The consequences are:

- Failure to identify FII.
- If a doctor has the courage to confront the issue then the mother may leave and assign that doctor to the worthless,

Associations of Physical Impact Categories

PIC	1	2	3	4	5	6	Total
Number of cases	140	27	70	61	144	86	528
Median age of onset (years)	0.25	NR	0.411	0.5	1.5	0.218	0.5
Median age of identification (years)	7	4	2	3.9	2.5	0.71	2.675
Death index	0%	7%	1%	3%	17%	12%	8%
Death sib	4%	8%	6%	5%	19%	57%	17%
Fabrication in index case	NA	41%	51%	38%	23%	30%	33%
Surgery	27%	11%	73%	54%	13%	9%	29%
Central venous line	2%	4%	40%	11%	3%	1%	8%
Intrinsic illness definite	3%	11%	6%	3%	2%	0%	3%
Perpetrator father alone	3%	11%	4%	0%	10%	10%	6%

Table 2