Fabricated or induced illness in children: The paediatrician's role

Paul Davis

Abstract

FII is an uncommon form of child abuse which challenges the very core of the doctor-patient relationship. The unspoken contract of "You tell me what's wrong and I'll do my best to help you." is breached by a parent who fabricates their child's symptoms and sometimes even their physical signs. Anecdotally these diagnoses tend to be very delayed and children often suffer extreme harm in the process. In 2002 RCPCH produced the first definitive guidance on FII. In 2008 the Government produced updated guidance for all professionals which led to RCPCH producing a new Practical Guide in 2009. This paper incorporates much of the 2009 RCPCH guidance and is intended to be a brief guide for the busy Paediatrician who may come across one of these most difficult and time consuming cases.

Keywords FII; Fabricated or Induced Illness in children; MSBP; Munchausen Syndrome By Proxy; child abuse; neglect; iatrogenic harm

Definition and spectrum of concerns

The term FII was introduced in the UK by the Royal College of Paediatrics and Child Health (RCPCH) to help to describe and respond to various types of child abuse which involve a child being presented for medical attention with symptoms or signs which have been fabricated or induced by the child's carer. The ways in which children may suffer harm are so varied that FII is difficult to define in terms of precise medical diagnostic criteria and some variation has emerged in how the term is used by different clinicians. The RCPCH view is that FII should be a term reserved for children whose illness has been deliberately and consciously fabricated by their carer, and who in the process have suffered, or been placed at risk of, significant harm. In other words it is a type of child abuse. This may include deliberate manipulation of a genuine physical illness. Others may use the term in a broader sense to include other children whose carers persist in reporting illness that has no objective basis and yet who may not be deliberately or consciously fabricating. The important common ground is the focus on the child and the harm they are suffering and that should be the starting point for any paediatric overview.

Of course, all Paediatricians (and probably all doctors) will encounter patients or carers who do not or can not accurately describe their symptoms or signs. That does not always mean that the patient/carer is deliberately fabricating. There may be anxiety, cultural issues, a lack of understanding of medical terminology or bodily functions, or the patient/carer may have a learning disability of a mental health problem. Inadvertent misinformation by carers is something that every Paediatrician needs to be able to deal with and this is a key skill in history taking and clinical assessment. This may be time consuming but rarely needs a child protection response. It is always important to avoid iatrogenic harm in these situations (Table 1).

The various situations which raise concern about FII have been clarified in the 2009 RCPCH Guidance.

This categorisation is not exhaustive, for example it does not deal with situations where carers are malingering or attempting to defraud the state by lying about illness, not does it encompass those situations where children actively fabricate their own illness, but it provides a useful basis for a differential diagnosis.

Of these examples only type 3 would correctly be called FII by Paediatricians but it is important to recognise that others may use terminology differently and as long as the focus is on what harm the child is suffering then any confusion over semantic terminology should be minimised.

Epidemiology

Incidence and prevalence

The British Paediatric Surveillance Unit (BPSU) epidemiological study in UK in the early 1990's included new cases which had been confirmed at least at the level of a Child Protection Case Conference. Most had also been confirmed in Family Courts. There were 97 new cases of FII in two years which means that a large teaching hospital will only see one or two new cases per year and an average paediatrician will only manage one or two cases personally in their entire career.

In practice, however, these cases are encountered more frequently due to the chronic nature of the presentations, the large number of professionals who may be involved and the broad spectrum including milder cases which may not all require a formal child protection response. Watson et al surveyed Primary care Teams and identified FII concerns in almost one in 1000 children, most of whom had not been identified as being 'at risk'. This indicates that the prevalence of FII concerns in children is substantial although many cases do not immediately enter the child protection arena.[1]

In the BPSU study, boys and girls were equally affected with a median age at onset of 20 months and 77% of index children below 5 years of age. There were large unexplained variations in reported incidence between different regions in the UK.

Other findings from the BPSU survey included:

- FII, non-accidental poisoning and non-accidental suffocation are inter-related conditions, with 128 cases and 8 deaths reported over a two year period in the British Isles (an incidence of 0.5/100 000 children under 16 per year).
- 97 of the 128 cases reported involved FII, 32 suffocation and 44 poisoning. About half of the poisoning and suffocation cases were in the context of FII.
- Abuse of siblings occurred in 34 out of 83 families.
- There had been 18 previous sibling deaths (around 1 in 10 siblings), suggesting that risks to siblings are great and that the abuse has a high recurrence rate.

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The range of situations where FII concerns may arise (Ref: RCPCH 2009). Starting point: A child is presented for medical attention, possibly repeatedly, with symptoms or signs suggesting significant illness but an appropriate clinical assessment suggests that the child's 'illness' is not adequately explained by any disease. The examples below illustrate the range of possible considerations

Example 1	Example 2	Example 3	Example 4	Example 5
Type of Presentation				
Simple anxiety, lack of knowledge about illness, over interpretation of normal or trivial features of childhood. May in some cases be associated with depressive illness in carer.	Child's symptoms are being misperceived, perpetuated or reinforced by the carer's behaviour. The carer may genuinely believe child is ill or have fixed beliefs about illness	Parent actively promoting sick role by exaggeration, non-treatment of real problems, fabrication (lying), falsification of signs and/or induction of illness (i.e. 'True' FII)[a]	Parents suffering psychiatric illness e.g. delusional disorder	Unrecognised genuine medical problem becomes apparent after initial concern about FII[b]
Underlying Factors				
Carer's need to consult a doctor may be affected by other social stresses, mental health issues or coping abilities of carer	'Illness' may be serving a function for carer, and subsequently for an older child too (secondary gains)	There may be a background history of frequent use of health services or apparent dependency on health care. Carer may have personality disorder or the child's 'illness' may be serving a purpose for the carer	Usually not difficult to recognise	Possibility of 'false positive' child abuse diagnosis must always be considered. Child's clinical progress should always be monitored in case a genuine illness has been missed
Insight				
Carer usually reassurable although likely to present again in future	Difficult to reassure, carer and professionals may not agree on cause of symptoms and/or the need to consult or investigate further.	Not reassurable, carer's objectives are diametrically opposed to those of professionals	Carer lacks insight	Carer's 'illness behaviour' will usually be appropriate for the signs displayed by child, but the child protection intervention may have affected the carer's behaviour
Level of Risk				
Seldom reaches threshold of significant harm	May be disabling: often some risk of significant harm, may be emotional or educational harm, or social isolation	High risk cases. Always some harm, often severe	May be risk of harm	Risk of harm due to inappropriate child protection process and delay in correct diagnosis
Iatrogenic Harm				
Possible iatrogenic harm risk	Significant risk of iatrogenic harm	Very high risk of iatrogenic harm	Hopefully low risk of iatrogenic harm	See above
Management				
Discuss concerns openly with carer. Managed primarily by reassurance. Try to address carer's needs	Discussion with carers may need to be handled very sensitively. If in doubt discuss with appropriate colleagues. Firm reassurance. Avoid iatrogenic harm. Multiagency assessment may be needed to gain understanding of what underpins carer behaviour (either 'Child in Need' or 'Child at risk' referrals may be indicated)	Local Safeguarding Children Procedures apply. Take immediate steps to reduce iatrogenic harm if possible. Do not disclose concerns to carers without first discussing the case within the Safeguarding procedures.	Discuss with carer whether they feel that they have any mental health needs and how those might be addressed. Consider discussing with GP or other relevant professional (bearing in mind the constraints of patient confidentiality). Carer's mental health needs must be addressed. Child may be 'Child in Need'	Consult widely with colleagues if a 'false positive' child abuse diagnosis seems likely. If safeguarding procedures have already been activated, an immediate strategy meeting should be requested and the situation should be discussed with carers without delay

[a] Induced Illness may include inflicted injuries intended to mimic a disease, but generally physical abuse where the perpetrator denies the cause of the injury would not be included.

[b] Erroneous FII diagnosis has been described in the literature and this possibility must always be borne in mind. In the follow-up study by the British Paediatric Surveillance Unit (Davis et al 1998) none of the 97 'MSbP' cases were subsequently found to have been due to misdiagnosed genuine disease (old terminology pertained at that time).

Table 1