Recognising factitious and induced illness in children

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Abstract

Whilst it is unusual for carers to deliberately make a child ill, misrepresenting symptoms and even falsifying signs of disease is more common. The recognition that fabricated or induced illness (FII) is occurring usually emerges over time. It is rarely if ever a single event but rather an evolving pattern. Children of both sexes and all ages can be harmed in this way however, younger children and those who have had previous significant medical conditions appear to be more vulnerable. Whilst carers might have emotional and mental health needs seeking to understand their psychopathology may detract from addressing the impact on the child. In order to protect children from harm it is important for paediatricians to be aware of this condition and be alert to warning signs seen in clinical practice. This article aims to give an overview of FII and describes some clinical cases and the red flags that can prevent cycles of over investigation and potential harm to children.

Keywords clinical supervision; fabricated or induced illness; medically unexplained symptoms; safeguarding

Fabricated and induced illness

The role of parents and carers in representing their child's symptoms is fundamental, so much so that the medical care of children can be considered to be a triad of information sharing between doctor, carer and the child. These are relationships based on trust. When carers misrepresent the illness of a child, the doctor and parent may inadvertently collude because of that trusting relationship and in so doing may cause harm to the child. The identification and the management of child abuse and neglect challenges these relationships. It is an area of practice that may bring medical professionals into conflict with parents.

Concerns about the veracity of reported illnesses is also extremely challenging for the wider safeguarding community. Social workers, the police and the courts look to medical professionals for guidance. However, this information can be confusing and conflicting and attempts to unravel the motivation of parents who may have fabricated symptoms adds another layer of complexity.

Most paediatricians will have experienced the challenge of managing a family who initially appear to present with completely plausible concerns but over a period of time a pattern of difficulties emerges. This might include:

- Failure of symptoms to improve despite appropriate treatment
- Emergence of new symptoms as the previous problems have resolved
- Emergence of symptoms that seem mysterious and without a logical explanation
- A need for further investigations, second opinions or spurious requests for onward referral

These patterns may emerge slowly over a long time and in the context of an established relationship between the child and carer and doctor. The doctor entered the triad in good faith with the intent to establish what was wrong with the child and to make them better.

Defining a complex phenomenon

Unlike other forms of child abuse, fabricate and induced illness (FII) is not an event. It is a gradual realisation that occurs over a period of time. The trust that the clinicians have in the parents' story gradually breaks down until there is a consensus that the child is experiencing some form of harm that is disproportionate to any real illness symptoms that they might experience. It is not surprising that this lack of a single verifiable event makes FII such a complex area of safeguarding practice.

The definitions of both FII and the closely related challenges of medically unexplained symptoms (MUS) were originally derived from the adult literature. Whilst the definitions are not unhelpful they do not really assist professionals to identify that point at which is clear that a parent is not acting in the child's best interest. Since FII is a direct challenge to the truthfulness of the parent or carer it is a topic that is highly emotive.

Sir Roy Meadows described a form of abuse where parents intentionally harmed children in their care and were presumed to have done so in order to seek attention from professionals. He coined the term 'Munchausen by Proxy'. More recently, the term fabricated or induced illness (FII) has replaced Munchausen by Proxy. The 2008 supplement to *Working Together to Safeguard Children; Safeguarding Children in whom illness is fabricated or induced*, subdivided into fabrication, falsification and induction of illness (FII). It describes three main ways in which a carer may cause harm in this way and it cautions that they are not mutually exclusive:

- Fabrication of signs and symptoms. This may include fabrication of past medical history
- Fabrication and falsification of hospital charts and records and bodily fluids. This may also include falsification of letters and documents.
- Induction of illness by a variety means.

The 2008 guidance also defines 'carer' as any adult that has parenting responsibility and includes foster carers, grandparents and offers guidance when a member of staff is suspected. The guidance forms a helpful framework within which to consider the potential harm to the child however it is a model that is reliant on identifying the motivation of the carer.

In 2013 DSM-5 introduced the term *Factitious Disorder Imposed by Another (code 300.19)*. This definition really described the motivation of the perpetrator as opposed to the impact of abuse on the victim. The diagnostic criteria are:

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- Falsification of physical or psychological signs or symptoms of injuries or disease in another; associated with identified deception
- The individual present another individual (victim) to others as ill, impaired or injured. The perpetrator, not the victim received the diagnosis
- The deceptive behaviour is evident even in the absence of obvious rewards
- The behaviour is not better explained by another mental disorder such as a delusional disorder or another psychotic disorder

This supersedes the 2007 guidance from the American Academy of Pediatrics, which clearly outlines a spectrum of concern.

Glaser and Bass have challenged these descriptions and divided FII into two categories; *Erroneous reporting* and *Deception by use of hands*. Their emphasis shifted back to the impact on the child and less on attempting to understand the motivation of the adult carers.

Ellen Fish and colleagues reviewed the legal issues including the standard of proof required by courts to establish that 'a parent or carer has done or failed to do certain acts and as a consequence a child has suffered or is likely to suffer harm'. Since the judicial system requires evidence to act to intervene in family life, other agencies tend to follow suit in their approach to determining how to act to protect children.

The courts accept ***physical evidence***, X-rays, photographs, laboratory tests; ***direct evidence***, evidence that has been seen or heard by a witness and ***opinion evidence***, 'the opinion of a witness in circumstances where it is established that there are recognised bodies of relevant learning outside the experience of ordinary men and women in which the proposed witness holds relevant qualification'. In cases of suspected FII it may be very difficult to obtain either physical and direct evidence of proof and hence there may be, and has in the past, been an over emphasis on opinion evidence.

Does fabricated and induced illness exist?

FII is recognised as a form of abuse by many authorities including the RCPCH and the Department of Health in the UK. Despite this its existence is it is not un-contentious and the existence of FII as a form of child abuse is not universally accepted. There is no doubt that parents and carers have been identified as deliberately causing harm to their child. Southall et al. used covert video surveillance to identify episodes of induced illness in children admitted to hospital for investigation of acute life threatening events or other serious conditions. However, since the currently accepted definitions of FII assume the harm experienced by the child is for the emotional or psychological gain of the carer the emphasis for multi-professional teams involved in safeguarding children becomes proving or disproving psychopathology in the carer.

The dogmatic approach of some experts and in particular the link to unexplained child deaths has also caused many to question FII as a valid diagnostic entity.

Since the definition is contentious it is unsurprising that the epidemiology is complicated.

Epidemiology

For the most part studies have only considered cases of induced illness. They have described the incidence based on selected populations. The populations include carers and children identified by the courts as requiring psychiatric evaluation, referred to Social Services or identified by paediatricians. However, in reality all of these studies are likely to significantly underestimate a phenomenon or group of related conditions where the impact on the child may vary from attempted murder to an over-anxious parent.

McClure and colleagues considered children thought to have experienced induced illness in the UK between 1992 and 1994 and gave a combined incidence of FII, non-accidental poisoning and non-accidental suffocation of 0.5/100,000 under 16 years (1.2/100,000 under 5 years and 2.9/100,000 under a year). A similar incidence was reported by Denny et al. from New Zealand. The very different rate of 89/100,000 by Watson et al. is likely to be due to variations in inclusion criteria. Feldman et al. reviewed the international context and identified descriptions of FII in 19 countries.

It should be noted that since these studies only considered cases of induced illness the incidence cannot be considered a reflection of fabricated as well as induced illness.

Is FII a single phenomenon or a group of related behaviours?

By bringing together fabrication, falsification and induction of illness there is a tacit assumption that they are variations in severity along the same pathological continuum. Induction of illness by a carer is probably the closest to the original descriptions of Munchausen by Proxy. Deliberately making a child ill is undoubtedly a form of physical harm. The carer's motivation may differ from other forms of child abuse but the act itself puts a child at risk of immediate and serious harm.

The term 'Deception by use of hands' coined by Bass and Glaser is particularly useful in this context. They describe:

- Falsification of records or charts
- Interference with investigations and specimens (e.g. putting blood or sugar into a child's urine)
- Interference with lines
- Inducing of signs of illness in the child by, for example poisoning or overmedication, suffocating or starving

It is a type of abuse that may put the child at risk of serious harm but, as with fabricated illness, it is much easier to recognise in hindsight. The parent induces symptoms of unexplained illness. The doctor trusts the parent and investigates and treats those symptoms. The child suffers the physical and emotional consequences of the investigations and treatment. It is important to acknowledge that much of the physical harm experienced by the child is inflicted by medical professionals.

Bass and Glaser have also suggested that fabrication of illness can be better defined as 'Erroneous reporting (fabrication) of medical history, symptoms, or signs' and this may include:

- Exaggeration
- Misconstruing of real events on the mistaken belief about their meaning
- Reporting of actual events that only happen in the carer's presence
- False reporting