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Fabricated or induced illness by carers (FII)

Synonyms: Münchhausen's syndrome by proxy; 'Munchausen syndrome by proxy' (spelling used by Professor Roy Meadows); factitious disorder by proxy

'Munchausen syndrome by proxy' (MSbP) was a term coined by Professor Roy Meadows in 1977.^[1] Münchhausen's syndrome implies a condition in which the patient attempts to simulate an illness by providing a false history or by fabricating evidence; Professor Meadows proposed that a parent could use a child as a proxy 'Munchausen' patient.^[2]

In 2002, a working party of the Royal College of Paediatrics and Child Health (RCPCH) suggested that the condition be known as 'fabricated or induced illness by carers' (FII).^[3] The working party felt that the old term focused more on the motivations of the perpetrator than on the interests of the child and failed to capture the wide range of presentations and features associated with the condition. The new name also highlights that anyone with parental responsibility, providing long-term or short-term care, could be a perpetrator.

The Department of Health (DH) produced guidance in 2008 in which they recommended the concept of 'fabrication or induction of illness in a child' rather than the use of any specific term.^[4] This document was supplementary to their document *Working Together to Safeguard Children* and concentrates on the impact of the condition on the child's health and how best to safeguard the child's welfare.

The terminology remains mixed and much of the current literature on FII, including research into epidemiology, still refers to the term Munchausen syndrome by proxy (MSbP). Alternative terms include medical child abuse (MCA) and, in DSM-V, factitious disease imposed by another (FDIA).^[5]

How common are induced illnesses by carers? (Epidemiology)

There are very few recent studies of epidemiology, only case reports dealing with unusual presentations.

A two-year prospective study was carried out of cases in the UK and the Republic of Ireland, notified to the British Paediatric Surveillance Unit, categorised as MSbP, non-accidental poisoning, or non-accidental suffocation.

The majority of children were aged under 5 years, the median age being 20 months. On 85% of occasions the perpetrator was the child's mother. In 42% of families with more than one child, a sibling had previously experienced some form of abuse.

The combined annual incidence of these conditions in children aged under 16 years was projected as being at least 0.5/100,000 and, for children aged under 1 year, at least 2.8/100,000.^[6]

A literature review in 2003 analysed 451 cases from 154 medical journals. Children averaged 21.8 months from onset of symptoms to diagnosis. Mothers were perpetrators in 76.5% of cases.^[7]

Presentation

Professor Meadow's criteria for defining FI were as follows:^[2]

- Illness in a child which is fabricated or induced by a parent or someone who has parental responsibility.
- A child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures.
- The perpetrator denies the aetiology of the child's illness.
- Acute symptoms and signs cease when the child is separated from the perpetrator.

The DH working group furthermore identified three main ways in which carers may induce or fabricate an illness in a child:

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

The key presentational features identified in one study and outlined in the RCPCH guidance were:^[3]

- Fits.
- Apparently life-threatening events (ALTEs).
- Drowsy, coma.
- Blood loss in vomit or rectally.
- Failure to thrive; feeding difficulty.
- Bowel disturbance.
- Asthma.
- Vomiting and/or gastro-oesophageal reflux.
- Blood loss; haemoptysis.
- Skin lesions.
- Fabricated disability.
- False allegations of abuse.
- Blood in urine.
- False disclosure of accidental overdose.

The RCPCH guidance emphasised the importance of early recognition of FII. This highlighted indicators such as: a carer reporting symptoms and observed signs that are not explained by any known medical condition; acute symptoms that are exclusively observed by the carer; objective evidence of fabrication.^[3]

Differential diagnosis

This will depend on the presenting symptoms. It will often be difficult during the first encounter to raise more than a suspicion of factitious or fabricated illness but it should be considered in the list of differential diagnoses wherever appropriate.

The diagnosis may only be made clear when a child presenting with acute illness is admitted to hospital for investigations.

The relationship between older children and carers is complicated and some children may be fabricating illness in order to gain approval of the adult or for other motives, in which case the condition could be considered to be early-onset Münchhausen's syndrome *per se*. In some cases there may be obvious secondary gain (such as school avoidance),^[8] whereas Münchhausen's syndrome is a more clinical term which implies a less obvious and perhaps more deeply rooted psychological cause.

Investigations

Investigations will depend on the presenting symptoms and signs. Clinicians should be aware that it has also been recognised that healthcare systems can be part of the problem if they subject children to unnecessary or unjustified medical care.^[9] It is key that genuine illness be recognised and managed but it should also be borne in mind that genuine illness may co-exist with FII. Investigations should be led by a nominated paediatric consultant.^[3]

Legal issues

Laboratory results can become legal evidence and should be handled appropriately. A record of when and where the sample was taken and how it was conveyed to the laboratory should be kept. As few people as possible should be involved in the transfer of the specimen to the laboratory, to avoid accusations of tampering.

Video surveillance

Overt video surveillance may be helpful in corroborating the carer's history (eg, filming a convulsion in a child in an inpatient setting).^[3] Covert video surveillance is no longer routinely recommended and should only be used in conjunction with a police investigation.^[4]

Associated diseases

In the perpetrator – [personality disorder](#) and [Münchhausen's syndrome](#) (approximately 25% of perpetrators have induced factitious symptoms in themselves).

In the child – [sudden infant death syndrome \(SIDS\)](#) and behavioural problems (this can include feeding disorders in infants, withdrawal and hyperactivity in pre-school-aged children, and adoption of Münchhausen's syndrome behaviour in adolescence).

Treatment^[3] ^[4]

The first priority is to exclude organic disease, stabilise the child and treat any presenting symptoms. The child will need to be admitted to hospital if the presenting condition is severe or life-threatening. Hospital admission may also be required if FII is recognised early and it is deemed that the child is at significant risk of harm, or if separation from the carer is required to confirm the diagnosis.

Once FII is suspected, a multi-disciplinary approach should be used, involving paediatricians and social services. The police may also need to be contacted. Child protection procedures will need to be invoked and a strategy meeting held to decide whether to proceed to a formal Section 47 enquiry. This is a section of The Children Act 1989 which precedes possible entry on to the Child Protection Register.^[10]

FII invokes strong feelings in clinicians and there is a temptation to feel anger against the perpetrator. This should be recognised but it should not obstruct the opportunity to review the case dispassionately and assess what is best for the future of the child and the family as a whole.

FII is a spectrum and in cases deemed to be 'mild' (little harm to the child and low possibility of future harm) then an open and honest discussion with the child, the perpetrator and the rest of the family may help to rebuild bridges and lead to a more healthy relationship.

On the other hand, the situation may be irretrievable, significant future harm may be very likely and the child may need to be removed to a foster home on a temporary or permanent basis. These decisions need to be taken in a multi-disciplinary setting in the context of the local child protection procedures.

Psychiatric intervention for the child has proven helpful in some cases. It has proven less successful for the treatment of the perpetrator, possibly because many such individuals have a deep-seated personality disorder.

Although the mother is the perpetrator in the majority of cases, the family dynamics need to be assessed. The mother's partner should also be interviewed and involved if possible.

The possibility of abuse of the siblings of the index patient should also be given urgent consideration.

Prognosis

Prognosis is dependent upon a number of factors:^[3]

- The length of the abuse.
- The degree of harm.
- The degree of psychopathology in the perpetrator.
- The relationship between the child and the perpetrator.
- The degree of long-term supervision by professionals.
- The social environment.

Obtaining information about outcomes is difficult, as many children are lost to follow-up once family supervision ceases. Mortality rate from studies has been reported between 6-10%.^[11] A UK study found that 8 out of 128 children (6%) died as a direct result of abuse. A further 15 (12%) required intensive care and 45 (35%) suffered major physical illness.^[6] The limited studies available suggest that there are significant emotional problems in adulthood, including insecurity, avoidance of medical treatment, [post-traumatic stress symptoms](#) and Münchhausen's syndrome.^[4]

Prevention

There is little advice available about the prevention of an initial case of FII. Indeed the condition is so wide-ranging that some authorities believe research in this area would be fruitless.^[12] Most work has focused on the prevention of further episodes of harm. This involves child protection strategy meetings as outlined above and surveillance of siblings.

Further reading

- [Faedda N, Baglioni V, Natalucci G, et al](#); Don't Judge a Book by Its Cover: Factitious Disorder Imposed on Children-Report on 2 Cases. *Front Pediatr*. 2018 Apr 18;6:110. doi: 10.3389/fped.2018.00110. eCollection 2018.
- [Walters IC, MacIntosh R, Blake KD](#); A case report and literature review: Factitious disorder imposed on another and malingering by proxy. *Paediatr Child Health*. 2019 Jun 17;25(6):345-348. doi: 10.1093/pch/pxz053. eCollection 2020 Oct.

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