At a Glance; Fabricated or induced illness in a child.

Fabricated or induced illness by carers is a relatively rare form of child abuse in which a parent or carer seeks medical intervention by fabricating or inducing symptoms in a child. There is a range of terminology used to categorise this form of abuse, although it is often known as Munchausen's Syndrome (Asher, 1955) by Proxy (Meadow, 1977). In today's literature, particularly in the UK, the term fabricated or induced illness in a child by a carer (FII) is preferred. FII is a descriptive term and not a discrete medical syndrome, ensuring it covers a wide range of situations, whilst also shifting the focus to the child. According to HM Government (2008) there are three ways a carer may fabricate or induce illness, see Table 1. All Heath Care Professionals need to be aware of this issue; many perpetrators do have increased and fabricated illness themselves, so may be seen frequently in various health care settings (Lazenbatt & Taylor, 2011).

To the editors, please can you put this in a table box?

How illness is fabricated or induced in a child (HM Government, 2008)

- Fabrication of signs and symptoms. (May include fabrication of past medical history)
- Fabrication of signs and symptoms and falsification of hospital records and specimens of bodily fluid. (may include falsification of letters and documents)
- Induction of illness by a variety of means

Epidemiology, Incidence and prevalence

The first population wide estimates were made by McClure and colleagues (McClure, Davis, Meadow, & Sibert, 1996) by collating 128 reports of Munchausen syndrome by proxy, non-accidental poisoning and non-accidental suffocation made to the British Paediatric Association Surveillance Unit (BPASU) over a two year period. They described an annual combined incidence of Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation as 0.5 per 100,000 children under 16 with males and females affected equally. Their analysis highlighted that cases mostly included children less than 5 years old, with children under 1 having the highest incidence of 2.8 per 100,000 children (McClure et al, 1996). Nonetheless, studies have identified that there is significant under- reporting of FII (Davis, 2009; McClure et al., 1996). The reasons for this are complex; the plethora of professionals involved can complicate and delay diagnosis, especially in cases with repeated presentations, and the broad spectrum of FII including milder cases that may never be reported (Davis, 2009; McClure et al., 1996).

Although FII is relatively uncommon, it is associated with high morbidity and mortality and is often not recognised until the child has suffered significant harm (Lazenbatt & Taylor, 2011), thus heightening the need for earlier recognition and intervention. Research suggests the death rate for FII could be as high as 10% with a further 50% of children suffering long-term morbidity (HM Government, 2008). A systematic review identifying 451 cases of FII found that 6% of children had died, and 7.3% suffered permanent or long-term injury (Sheridan, 2003). McClure et al. (1996) found that 8 out of 128 (6%) children identified by the BPASU died and 15 (12%) children required intensive care.

The evidence available shows that FII affects both sexes equally (McClure et al, 1996; Sheridan, 2003) but is most common in children under 5 with the age of diagnosis between 20 months (McClure et al, 1996), 21.8 months (Sheridan, 2003) and 2.7 years (Denny, Grant, & Pinnock, 2001).

According to (Morrell & Tilley, 2012) women are implicated with FII abuse in an estimated 90-98% of cases. Mothers are identified as the perpetrator in approximately 76% of cases (Sheridan, 2003). Figure 1 has been adapted, this illustrates the increasing concern of HCPs in relation to parental/carer behaviours and attitudes toward their child's health and wellbeing.

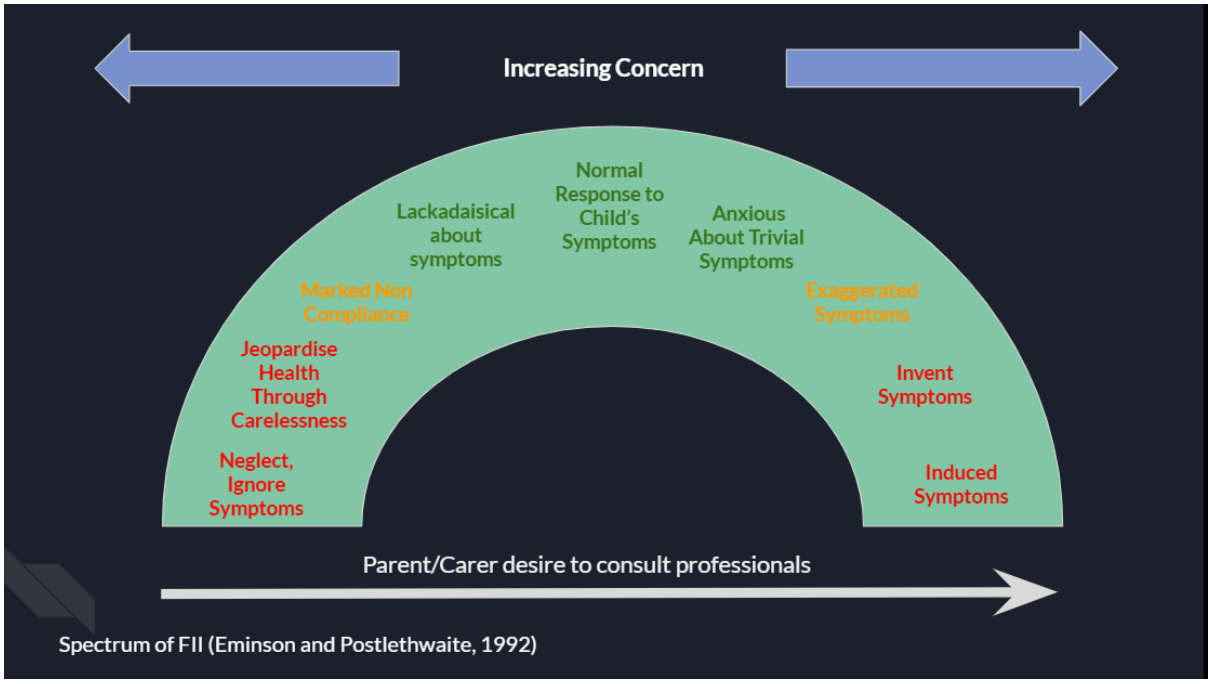

Figure 1 Spectrum of FII, adapted from (Eminson & Postlethwaite, 1992)

Warning signs and symptoms of FII

Often the symptoms are non-specific, intermittent; rely heavily on the history acquired from the carer. Often anomalies in test results and/or examinations are not repeated in further presentations (Davis, 2009; RCPCH, 2009). Feeding problems and bowel related symptoms are frequently reported (RCPCH, 2009). Other presentations include unexplained collapse/ ALTE (apparent life threatening event) or seizures. Paramount to note; FII may present to any speciality, anywhere.

Table 2 illustrates the variant indicators of FII adapted from RCPCH 2009. Editor can please put these into tabular form

- Multiple and/or repeated symptoms.
- Symptoms that are unexplained and do not match the clinical observation or results.
- Symptoms that are witnessed exclusively by or in the presence of the caregiver.
- An inexplicably poor response to prescribed medication or treatment.
- Upon resolution of symptoms, new symptoms arise or become apparent in other siblings.

- Activities of daily life limited beyond what is expected of a known disorder or developmental stage, e.g. poor school attendance or unnecessary use of aids such as wheelchairs.
- Caregiver seeking the opinion of a wide range of professionals, despite multiple reassurances the child is well.
- Caregiver's level of concern does not match that of healthcare professionals or is preoccupied with the results and outcomes of investigations and tests.
- There may be a history of frequently changing GP or attending multiple hospitals for treatment, especially if views about the child's treatment are challenged.
- Caregiver tries to maintain a close relationship with healthcare professionals, but can become defensive and argumentative if their views are challenged.
- The non-perpetrating caregiver is distant and has little or no involvement in caring for the child.
- History of unexplained illnesses or deaths or multiple surgery in parents or siblings in the family
- Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported

Impact on the child; morbidity and mortality

As a result of the magnitude and diverse nature of FII, the child is likely to undergo many tests, investigations and procedures with an inherent risk of harm and even death (HM Government, 2008). Some procedures may be irreversible or may promote the reliance on medical aids such as nasogastric feeding or wheelchairs. On the whole, investigations are usually non- invasive, but can involve long periods of hospital admission (Zeitlin, 2016). These investigations are often unnecessary and perpetuate the sick role which ultimately inhibits the child's participation in normal activities of daily life (Bass & Glaser, 2014). Such experiences of iatrogenic illness can result in the child having a distorted view of health and believe that they are ill (RCPCH, 2009).

Neale, Meadow and Bools followed up McClure et al's study relating to previously identified cases of FII, they concluded that children affected by FII will develop emotional, behavioural and school-related problems (Neale, Meadow, & Bools, 1993). McClure and colleagues (1996) uncovered that siblings also experienced abuse; this occurred in 34 out of 83 families in which the child had at least one sibling. There was no indication that abuse of siblings preceded that of the index case, or abuse was identified concurrently.

Perpetrator

Motivation for FII is complex, involving multiple factors, so compiling a single common profile of perpetrators is futile (Bools, 2007). Rand and Feldman (2001) highlighted that many of the perpetrators were victims of abuse and FII as a child, or lived in a household where such abuse was occurring (Rand & Feldman, 2001). The perpetrators own childhood experiences and more frequently, their own fictitious disorders could precipitate the falsification and induction of illness in children (Criddle, 2010; Feldman & Hamilton, 2006; Morrell & Tilley, 2012). Bass and Jones (2011) considered that up to 65% of perpetrators had evidence of a fictitious disorder in the past or at the

time of investigation (Bass & Jones, 2011). Exaggerating or falsifying their child's illness allows the perpetrator to play the role of a caring parent. Thus, maintaining focus on investigation and treatment of the child to keep their own negative emotions at bay.

Stirling and the Committee on Child Abuse and Neglect (Reading, 2007) proposed that the diagnosis of FII is not dependant on the motives of the perpetrator, in line with other forms of child abuse. Understanding the motives of the perpetrator of abuse may direct the course of action, it is not pertinent to the clinician and nursing staff as the main cause for concern is to protect the child from further harm.

Collaborative working

Documentation is crucial to all aspects of nursing practice (Nursing Midwifery Council, 2015) but is of particular importance in cases where FII is suspected. Many authors agree that thorough documentation and chronologies can provide enough evidence to confirm a diagnosis of FII (Davis, 2009; Dye et al., 2013; Sanders & Bursch, 2002). A heightened awareness of FII may increase a professional's curiosity and desire to examine case notes when exposed to perplexing presentations in practice. Analysing medical records for patterns of abnormal behaviour and inconsistencies are the most common means of identifying FII (Sanders & Bursch, 2002). Once suspicions have been raised, it is important that these concerns are escalated quickly to specialist professionals so swift appropriate action can be taken.

Whilst the process of identifying FII is complex, the primary goal is to protect the child from further harm by working efficiently across all disciplines. It is important to note, that should the perpetrator become suspicious, there is an increased risk of harm to the child with the potential for illness induction to produce measurable symptoms in the child. The best interests of the child (and siblings) are paramount over criminal prosecution of the carer. Fish, Bromfield and Higgins (2005) clarify the distinct difference between child protection hearings and criminal prosecution. Criminal prosecution depends on proof 'beyond reasonable doubt' that the perpetrator of abuse has committed certain acts and has done so with criminal intent (Fish, Bromfield, & Higgins, 2005). This principle does not apply when safeguarding children, in which the goal is to minimise or eliminate the potential of harm. Working collaboratively with the multi-disciplinary team, including police and children's safeguarding services, ensures professionals are working together to protect the child.

Consideration for Clinical Practice

Identifying future cases of FII and safeguarding children is often the result of healthcare professionals examining cases which pique their curiosity and sadly, think the unthinkable. These are the cases in which sharing information and collaborating with other Trusts and Local Authorities is crucial to uncovering potential cases of FII. Evidence of FII relies heavily on thorough documentation across the multi-disciplinary teams and a clear chronology of presentations. Remember, FII is a descriptive term and not a discrete medical syndrome, it can occur in **any** specialty, to **any** child.

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