FABRICATED INDUCED ILLNESS: A RARE FORM OF CHILD ABUSE?

Anne Lazenbatt & Julie Taylor
Queen’s University Belfast and NSPCC
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Anne Lazenbatt: NSPCC Reader in Childhood Studies, Institute of Child Care Research, QUB

Professor Julie Taylor: NSPCC Thematic lead (Physical Abuse in high risk families)

Fabricated Induced Illness: the terminology

Does FIll exist, is it real, rare or just a moveable feast?
Terminology

- Munchausen syndrome by proxy (Meadow 1977)
- Fabricated or Induced Illness by Carers (Bools 1996; Jones & Bools 1999)
- Illness Induction syndrome (Gray et al 1995)
- Fabrication or induction of illness in a child (FII) (RCPCH, 2002; Department of Health 2002)
  - ‘doctor shopping with the child as proxy patient’ (1988)
  - ‘exaggeration in paediatric patients’ (1992)
  - ‘outlandish factitious illness’ (1992)
Does Munchausen Syndrome by proxy exist?

- Significant differences of opinion on whether Munchausen Syndrome by Proxy exists.
- Coined by Roy Meadows (1977); Lancet with little or no scientific basis – anecdotal study of 2 cases!
- Paper merely accepted – peer reviewed?
- Theories’ of child abuse by Meadow have come under intense scrutiny. Following the Clarke/ Cannings judgements where the medical evidence of Meadow and others was found to be seriously flawed and as “manifestly wrong and grossly misleading” and as “misrepresentations”
Does Munchausen Syndrome by proxy exist?

- MSbP has never been listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association as a clinically diagnosable personality or psychiatric disorder.

- In cases in which a carer is found to have fabricated or induced illness in a child it is not accurate to say that the carer had a personality disorder or mental illness called “MSbP”, because as yet, it has not been recognised as part of DSM-IV.
‘I would consign the label MSBP to the history books and however useful FII may apparently be to the child protection practitioner I would caution against its use as other than a factual description of a series of incidents or behaviours that should then be accurately set out (and even then only in the hands of the paediatrician or psychiatrist, psychologist...

What I seek to caution against is the use of the label as a substitute for factual analysis and risk assessment.'
Does FII exist?

- “Factitious Disorder” is listed in the DSM-IV (SPECTRUM pattern of behaviour)
- “Fabricated or Induced Illness by Carers” does appear to exist as some carers do fabricate or induce illness in children
- The central definitional issue is whether or not carers who fabricate or induce illness in children have the personality profile “MSbP”
- Whether assigning a carer a syndrome label such as FIIIC or MSbP is sufficient to demonstrate protective concerns about the child
What is fabricated induced illness (FII)?

- Fabricated or induced illness (FII) in a child is a condition whereby a child suffers harm through the deliberate action of her/his main carer and which is duplicitously attributed by the adult to another cause.

  (Royal College of Paediatrics and Child Health 2002:164)
FII as a recognised form of child abuse

- UK Government guidance on *Safeguarding Children in whom Illness is Fabricated or Induced* (DH, 2002; DCSF, 2009), it is a form of abuse that has been subject to debate regarding its prevalence and indeed its very existence.

- The guidance highlights that the task for key professionals is to distinguish between the over anxious carer who may be responding in a reasonable way to a very sick child and those who exhibit abnormal behaviour.
Key aspects of FII

- Form of child abuse ON A SPECTRUM
- Perpetrated by those who have care for the child (usually the mother) and usually involves secondary medical services (although it may first be manifested, although undetected, in primary care settings)
- Detection requires detailed and painstaking enquiry involving the collection of information from many different sources and discussion with different agencies, e.g. social services, general practice staff and the police
## FII versus CPA: Distinguishing characteristics

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<tr>
<th><strong>Child physical abuser</strong></th>
<th><strong>FII abuser</strong></th>
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<tr>
<td>Child’s stepfather or mother’s boyfriend</td>
<td>Child’s mother</td>
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<td>Reluctant to seek medical care</td>
<td>Seeks medical care/insists on tests and treatments</td>
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<tr>
<td>Typically bullying, hostile, or threatening</td>
<td>Eager to impress staff with medical knowledge</td>
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<td>Feels threatened by and avoids medical staff and is fearful of specialists</td>
<td>Viewed as “the devoted mother”</td>
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<td>Craves attention and approval of medical staff</td>
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RED FLAGS FOR FII

Characteristics of the child

- Less than 5 years old
- History of frequent contacts with health care providers
- Objective symptoms witnessed only by the mother/caregiver
- Presents with multiple findings that are vague and confusing
- Not helped by treatments
- Has a dead sibling or a sibling with complicated medical history
- Absent or emotionally distant father
- Deteriorates whenever discharge is planned

Characteristics of mother

- Caring and concerned, yet pushes for further tests and hospitalizations
- Is comfortable in the medical setting, makes friends with staff members
- Exhibits a higher than average degree of medical savvy
- Views and describes the child as sum of their medical record
- Becomes aggressively hostile when thwarted
What does evidence tell us?

Epidemiology, incidence and prevalence, some tentative findings
Although the condition is often characterized as “rare,” lack of a standardized definition and centralized reporting repository make it difficult to quantify the incidence.

McClure et al (1996) – 2-year study – the researchers estimated that the combined annual incidence in the UK and Ireland of these forms of abuse in children under 16-years was at least 0.5 per 100,000 and for children under 1-year at least 2.8 per 100,000.
Epidemiology

- Epidemiological studies fraught with difficulty; no population-based studies have been conducted.
- International research findings: 10% children die and 50% experience long-term physical/emotional morbidity.
- Professionals encounter at least 1 case of FII during their careers, paediatricians seeing more!!
- Invisibility - often there are case suspicions, but insufficient evidence exists, so these cases are never officially reported or investigated.
- Diagnosis of FII takes time; average time for diagnosis from 6 to 15 months (Parnell, Day, 1997).
Epidemiology: Some Tentative Findings (1)

- Estimated 2-4 cases per million in the general population (Alexander et al., 1990)

- Of the 2.5 million cases of child abuse reported annually, 1000 are related to MSBP (Volz, 1995)

- Fatality rate for MSBP is approximately 10%
  - 6% died, 25% siblings (Sheridan, 2003)

- Physical morbidity rate of 75%; possibly even higher psychological morbidity rate (Rosenberg, 1997)
Epidemiology: Some Tentative Findings (2)

- Boys and girls are equally affected, and all socioeconomic classes are represented
  - 52% males, 48% females
- 79% Caucasian
- Average age of onset 48 months
- 6% dead, 7% long-term injury
  - Most common symptom of dead victims – apnea

(Sheridan, 2003)

- 25% to 35% of the time, MSBP is perpetrated serially on siblings (Alexander et al., 1990)
Epidemiology: Some Tentative Findings (3)

- Most perpetrators assume the “mother” role; 90% are biological mothers

- 5-10% include the father, babysitter, nanny, or grandmother (Meadow, 1985)

- Characteristics
  - 29% symptoms of Munchausen Syndrome
  - 22% history of childhood abuse
  - 27% history of working in healthcare
  - 23% psychological disorders, such as Personality D/O, NOS; Depression; Borderline PD, Paranoia

(Sheridan, 2003)
What does evidence tell us about the FII triad?

The mother, the child, the doctor
Mothers who harm their children by FII

Bools et al (1994): of 47 individuals who had fabricated or induced illness in children:

- 34 (72%) had somatoform disorders with anxiety and depression*
- 26 (55%) self-harmed
- 10 (21%) misused alcohol and/or drugs
- 5 (10%) previous child death

Of the 19 individuals interviewed, 17 (89%) had a personality disorder

*Somatising behaviour in adulthood is associated with adverse experiences of care and illness in early childhood
Paucity of systematic research on what motivates mothers ‘deception’

- Motive is unimportant in making diagnosis of abuse, in no other form of child abuse do we include the perpetrator's motives as a diagnostic criterion
- Many mothers experienced childhood abuse
- ‘Pseudologia fantastica’ a dramatic form of pathological lying
- Disturbed mother–child attachment bond that reflects on their own parenting; insecure attachment style is associated with higher levels of somatisation
- Unresolved bereavement
- Pregnancy; high rates of antenatal and obstetric complications
- Socialised to seek sympathy and attention
- Claim welfare benefits
Risks to the child

- Child may be put in life-threatening situations by the perpetrator (e.g. poisoning, suffocation, starving)
- Interfering with drug treatments by over dosing, not administrating them or interfering with medical equipment such as infusion lines
- Harmed as a consequence of the medical practitioner carrying out medical treatments or investigations (e.g. lumbar punctures)
- Child is presented to several different service providers at different times, leading to a number of different lines of medical inquiry being followed
- Failure to provide a nurturing environment to meet the child’s emotional and developmental needs
- Stress and fear
Perpetrators and Providers: Partners in Crime

- Doctor: innocent bystander or guilty party?
- Meta-analysis of published cases, 75% of the morbidity occurred in hospitals and at the hands of the child’s doctor
- Children have undergone as many as 100 operations to treat nonexistent conditions
- Unwitting medical collusion occurs because an FII parent will “doctor shop” until she finds a health care provider who is willing to meet her level of need
- Covert video surveillance - unethical
Do we question a medical model of child abuse?

Is there valid and indisputable factual evidence to support the theory?

Is the theory supported by careful research and reasoned rational and logical argument?
Is there valid, indisputable factual evidence to support the theory?

- Serious lack of consensus regarding terminology
- No standardized definition of the disorder
- FII is a strange spectrum of physical abuse, medical neglect, and psychological mistreatment that occurs with the active involvement of the health and social care professions
- Unique to this form of child maltreatment is the role that health care providers play by actively, albeit unintentionally, enabling the abuse
- Measuring ‘motivation and deceit’
Disproved theories of child abuse

Previously readily accepted theories of child abuse:

- Satanic Ritual Abuse
- Repressed Memory Syndrome
- Shaken Baby Syndrome
- Anal Dilatation Test
- Use of anatomically correct dolls
- ‘Meadow’s rule’ SIDS: ‘two is suspicious and three murder unless proved otherwise
Even when theories of child abuse are seriously challenged

- Many professionals still continue in the belief in their existence and continue to use the theories in their practice.
- Despite the obvious lessons to be learned from the Orkneys/ Nottingham/ Rochdale Scandals and the subsequent research which found no evidence to support the theory, Satanic Ritual Abuse is still promoted and used by sectors of the child protection system and was a major factor in the Isles of Lewis Child Protection Scandal.
1. Overall findings from research:

- Some parents may harm their children in the medical context, however this is extremely rare.

- Even if one insists on its existence, then using Bayes’s Theorem, (Mart 2002), FII is rare and therefore most accusations of FII are going to be false.

- Profiles and unscientific labels must be abandoned in favour of robust evidence - if it is poisoning or suffocation, call it that.
2. Overall findings from research:

- Many miscarriages of justice have occurred and are still occurring, (particularly in the US and Australia). The Clark and Cannings cases in the UK have alerted us to widespread difficulties in medical expert testimony. This is occurring in both civil (child protection) and criminal courts.

- There is no reason for specialists to be afraid of doing child protection work if they use correct protocol!!
Governments must put in place a system whereby all existing and new theories of child abuse are subjected to a stringent system of verification and validation by an accredited national body before they can be introduced into child protection practice.

Authentication by government departments such as happened with FII/MSBP is no substitute for painstaking research using scientific methodology.

Courts – seek fundamental legal requirements that cases are decided on facts and that theories, labels, and profiles of accused child abusers are prejudicial to a fair and just hearing and judgement and should not therefore be admitted into a judicial hearing, nor perhaps into pre-trial procedures such as Child Protection Conferences.
Way Forward? (Research)

- Necessary to develop more specific psychosocial formulations for each of the ‘disorders’ on the FII spectrum
- A definition that allows for both a descriptive account of the stage of continuum and provides a psychosocial /child developmental perspective
- A thorough knowledge of perpetrator features, child-victim features and family features may help with the identification, psychopathological understanding and management
- Child voice – limited evidence from children
Way Forward? (The Child)

Think Clearly:

- Removal of our children and our liberty must demand the highest standard of proof and FII and SBS theories and methodologies provide the least.
- If we truly care about children, we must base our thinking on facts, not rumour, fanciful speculation and warped opinions based on incomplete evidence and suppositions.
- Keeping child safe – primary care team; midwives, HVs, GPs, social workers?