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Fabricated or induced illness: From “Munchausen by proxy” to child and family-oriented action



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ABSTRACT

Background: In fabricated or induced illness (FII), a child is harmed due to caregiver(s) behaviour and actions, carried out to convince mainly doctors that the child's physical and/or psychological health is more impaired than in reality. Harm is caused directly by the caregivers(s) and also often inadvertently by doctors' responses.

Objectives: To describe: dynamics underlying FII; wider definition of FII; alerting signs for early recognition of possible FII; respective responsibilities of health, social care, education.

Methods: Literature review, clinical experience, expert opinion.

Results and conclusions: Caregivers are motivated by gain from having their child treated as ill, and/or by erroneous beliefs about their child's health, either way needing medical confirmation about their contentions. Their behaviour is therefore directed primarily towards doctors. Most cases of FII present unexplained discrepancies between caregiver reports/actions and independent observations of the child. More rarely, the child has actual signs of illness, induced by the caregiver, occasionally fatal.

Children are harmed in all aspects of life: health, daily functioning including education, and psychologically. Harm emanates directly from the caregiver(s) but also unintentionally from medical responses.

Illness induction and clear deception by the caregiver require immediate child protection. Otherwise, the initial focus is on assessing the child's current health and functioning rather than caregiver's mental health. If, beyond verified illness, there is no medical explanation for the child's reported ill-health, the family require help to function better. This requires co-ordinated, multidisciplinary rehabilitation and long-term monitoring. If caregivers refuse rehabilitation, child protection is required. Several unanswered questions remain.

1. Introduction

In 1997, Professor Sir Roy Meadow coined the term Munchausen Syndrome by Proxy (MSBP) in the UK, presenting it as a newly recognised but rare form of child maltreatment (Meadow, 1977). As Meadow described the condition, what differentiates this form of child maltreatment from other forms is the active, if unintended and inadvertent, contribution of doctors to the harm to the child, in response to the parents' presentation of the child. At its core, the caregiver elicits medical (physical or mental health) care for her child, based on her need for the child to be recognised and treated as unwell, rather than on the child's actual state of health. A triangle is thus formed involving caregiver, child and doctor (Bass & Glaser, 2014). As Roesler (2018) outlined, the understanding of the nature of this condition has become far more complex with divergence in nomenclature and differences in management

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approaches, which emphasise different aspects. While it is still regarded by some professionals as rare, its true prevalence with a wider definition awaits research. There have, nevertheless, been reports of this form of maltreatment from different countries (e.g. Al-Haidar, 2008; Feldman & Brown, 2002; Foto-Özdemir et al., 2013; (Fujiwara, Okuyama, Kasahara, & Nakamura, 2008).

Having briefly noted the different terms used to describe the condition, this paper proposes a wider definition of FII, which includes caregiver behaviour which is not deceptive. It describes the position, role and relationships between the three 'members' of the triangle. It then goes on to consider ways of early recognition of FII and intervention, taking into account societal and system adaptations to case management and support. Some aspects of the proposed intervention have been more recently developed. The implementation of this approach has been shown to be acceptable and feasible with good outcomes, at least in more economically developed countries. However, the outcomes await formal evaluation and prospective studies.

2. Terminology

While the original term Munchausen (Syndrome) by Proxy (MbP) continues to be used in the USA (Sanders & Bursch, 2019) and other countries, several other terms have been added en route (e.g. Factitious Disorder by Proxy). Pediatric Condition Falsification (PCF) (Shaw, Dayal, Hartman, & DeMaso, 2008) and Medical Child Abuse (MCA) (Roesler & Jenny, 2009) continue to be in use, especially in the USA, while in the UK, Australia and New Zealand the term in current use is Fabricated or Induced Illness (FII). Factitious Disorder Imposed on Another (FDIoA) was added in the Diagnostic and Statistical Manual of Mental Disorders (DSM) produced by the American Psychiatric Association (DSM-5) as an adult diagnosis and recently added in the latest International Classification of Diseases (ICD-11) (Reed et al., 2019). The various terms reflect a focus on different aspects of the condition, emphasising variously the mindset or behaviours of the abuser, the setting of the abuse and the paediatric subject.

There is one important distinction between these various terms. While criteria for MbP, FDIoA and PCF require verified deception by the caregiver, this is not required as a criterion in other terminologies such as MCA, and FII. As will be seen, this distinction has important implications for child protection and overall management approaches. In this paper, the term FII will be used, unless otherwise stated.

3. Epidemiology

Since Sheridan's (2003) review describing 451 cases, it is very likely that the current reported prevalence underestimates significantly the true prevalence of FII (Davis, Murtagh, & Glaser, 2019; Ferrara et al., 2013). This is due mainly to the focus in published literature on cases of illness induction with ever more novel, dramatic or unusual clinical presentations. In practice, these are far less common than the many cases which cause serious, but not life-threatening harm to the child. Munchausen by proxy by internet is a more recently recognised example (McCulloch & Feldman, 2011). The true prevalence depends on the definition used (Roesler, 2018). The reported mortality rates vary according to definitions of FII (e.g. 6 % in Sheridan, 2003) and mostly refer to cases of illness induction (e.g. 15 % in McClure, Davis, Meadow, & Sibert, 1996). Prevalence rates of cases falling within the wider definition is awaited.

4. The triangle

The main 'members' of the triangle in FII are, respectively, the primary caregiver(s) who is the instigator of FII, the affected child or children and the health professionals who inadvertently and unintentionally contribute to the harm to the child. Beyond the triangle, there are other persons affected by FII, such as members of the family, particularly siblings or non-abusing caregivers, and other professionals involved.

4.1. The caregiver(s)

FII is a situation which is brought about by the child's primary caregiver or caregivers, nearly always including the mother (Yates & Bass, 2017). Others known to the child are only rarely responsible (2.65 % in Yates & Bass, 2017). The role of fathers varies, from full involvement (Meadow, 1998) to support, to lack of awareness (Morrell & Tilley, 2012). Some mothers are single. The mother may also be supported by other family members (Sanders & Bursch, 2019). The primary caregiver has a need for the child to be recognised and treated as physically and/or psychologically unwell, or more ill than the child actually is, if the child also has a genuine condition. In order to fulfil this need, the caregiver behaves and acts in a number of ways which lead to both direct and indirect harm to the child.

4.1.1. Basis of the caregiver's needs

The caregiver's needs are based on one or both motivations (Davis et al., 2019):

- (i) The caregiver derives a gain or benefit from having her child recognised as more unwell. The gains include attention, sympathy, support and material gain.
- (ii) The caregiver has firmly-held but erroneous beliefs, extreme concern and anxiety about the child's health which she needs to have confirmed by doctors, but to the detriment of the child.

These two motivations appear opposite to each other. Under the first, the child's interests are largely ignored, and the child is used for the fulfilment of the caregiver's needs. In the second, there are anxiety, erroneous beliefs and unjustified over-concern about the child's state of health. Both lead to similar forms of harm to the child (with one notable exception, namely illness induction (see below) which leads to direct physical harm to, and occasionally death of, the child). Furthermore, both face doctors and other professionals with similar requests and pressure to investigate and treat the child. The caregiver is not usually ill-intentioned towards their child *per se*. Her actions cause the child direct harm but only in order to have her assertions that the child is ill reinforced and confirmed.

4.1.2. Caregiver's behaviour and actions

Given that the caregiver wants to be believed, all her actions are primarily geared towards engaging and convincing doctors and other professionals about the poor state of the child's health. This may involve any aspect of the child's physical or psychological health (Kelly & Wang, 2018). Caregivers engage doctors and other professionals by one or two ways:

- a) Commonly, she presents the child and erroneously reports the child's symptoms, history, results of investigations, medical opinions, interventions and diagnoses. Not all the caregiver's reports constitute actual deception. The caregiver may misunderstand or misconstrue the meaning of the child's symptoms on the basis of her anxiety or beliefs; she may exaggerate or distort the child's difficulties; or she may invent symptoms and even lie, when the caregiver is clearly deceiving.
- b) A less common way of engaging doctors is by the caregiver's actions (using her hands) to make the child appear or become ill, which are always forms of deception. They include falsifying documents, interfering with investigations and specimens (e.g. putting sugar or blood in the child's urine specimen) and, at the extreme end, illness induction – actually making the child ill by, for instance, withholding food or medication from the child (Gray & Bentovim, 1996) or poisoning the child. Illness induction is a form of physical abuse/inflicted injury which is usually denied by the caregiver. The gain which motivates the caregiver to induce illness may not be initially apparent. In FII, a full pattern of deception will usually only emerge gradually or retrospectively. This pattern does not usually accompany more common forms of physical abuse and inflicted injuries,

The issue of deception is very important. If deception is clearly found, the situation will be recognised as child maltreatment, taking the form of MbP, FDIOA and PCF. However, these terms preclude those many situations of harm to the child which are not brought about by frank deception as under a) above, and many children may thus not be protected unless this is recognised.

4.1.3. Caregiver's mental health

While caregiver mental ill-health is not a prerequisite for FII, if present it will help to explain some of the motivations and behaviours of the caregivers. Several adult mental health disorders are found in association with FII (Bass & Jones, 2011). They include a personality disorder, most likely borderline, histrionic, sociopathic or mixed type, in caregivers who use deception and derive a clear gain from having their child regarded as ill/more ill. An anxiety disorder, including illness anxiety disorder (hypochondriasis), may lead the caregiver to have unfounded anxieties about her child's health. Others have somatic symptom disorder, in which the person genuinely feels pain or other symptoms which are, however, not based on any identified pathology. These are usually related to unrecognised or unarticulated underlying emotional difficulties and conflicts. Rarely a psychotic illness or difficulties within the autism spectrum may underpin caregivers' fixed beliefs about the child's ill-health. In malingering and factitious disorder, there is unacknowledged deception about the reported symptoms and signs. Both of these are associated with gain for the person, the former material gain and the latter psychosocial gain. As described above, FDIOA is an adult mental health diagnosis.

An understanding of mental health difficulties in the caregiver will be important in indicating ways of changing the situation for the child. However, at the time of recognising possible FII, the question of the caregiver's mental health is not an issue on which to focus (Hoffman & Koocher, 2019).

4.2. The child and siblings

Clinical experience and reported case examples (Petska, Gordon, Jablonski, & Sheets, 2017) indicate that many (74 % in Roesler & Jenny, 2009) of the children also have a variety of pre-existing illness or disorder, including developmental disabilities.

The harm from FII to the child takes several forms (for a comprehensive account see Roesler & Jenny, 2009). While some of these are caused directly by the caregiver but may be supported by the doctor, others are brought about by the doctor's actions, the harm here being caused unintentionally or inadvertently.

4.2.1. Child's health and experience of health care

- The child undergoes repeated (unnecessary) examinations, investigations, procedures & treatments
- Illness may be induced by the caregiver through e.g. poisoning, suffocation, withholding food or medication, potentially threatening the child's health or life with a recognised mortality.

These constitute physical abuse.

4.2.2. *Effects on the child's development and daily life*

- The child has limited / interrupted pre- and school attendance and education
- The child's normal daily life activities are limited
- The child has a sick role e.g. with the use of unnecessary aids such as wheelchairs or diets
- The child is socially isolated.

These constitute educational and social neglect.

4.2.3. *The child's psychological and health-related wellbeing*

- The child may be confused or anxious about her/his state of health
- The child may develop a false belief about being sick and vulnerable, and adolescents may actively embrace this view
- There may be active collusion with the caregiver's illness deception
- The child may be silently trapped in falsification of illness
- The child may later develop a psychiatric disorders and psychosocial difficulties (Libow, 1995).

These constitute emotional abuse/psychological maltreatment.

4.2.4. *Siblings*

In some families, only one child is affected by FII; this child may have or had a genuine illness which began the relationship between the caregiver and doctors. In other families, several children may be affected by FII simultaneously or sequentially. Siblings who are not subject to FII may become very concerned and distressed by the apparent ill-health of their affected sibling or may feel, and actually be, neglected.

4.3. *The role of health professionals*

In the situation of possible FII, doctors are invariably in a difficult position. They need and wish to trust and work *with* caregivers of children presented to them. Many children subject to FII also have or had a genuine health condition which makes the task for doctors more complex. The primary concern for doctors is not to miss a treatable cause for the child's reported difficulties. Good medical practice includes ordering investigations to ascertain the correct diagnosis/es; providing treatments; agreeing to further medical opinions; where appropriate supporting the use of aids e.g. wheelchairs, limited school attendance and financial and other material aid; and accepting the caregiver's information about other doctors' involvement and opinions. The problem arises when the doctor is unaware of the caregiver's intentions and responds as she or he would normally do. In cases of FII, good medical practice turns into unintentional harm to the child, by over-investigating, over-treating, making referrals to other doctors, and supporting the child and family in ways which are unnecessary, and harmful, for the child (Stirling, 2007).

5. Recognition of FII and immediate response

Only rarely is action by the caregiver actually observed. Many cases of FII are only recognised after considerable delay during which the child will have been extensively investigated, unnecessarily treated, and physically and psychologically harmed. FII will not have been suspected, recognised or acted upon.

There is a divergence of approaches to recognising and establishing the presence of FII. One approach focuses on seeking evidence of FII based on caregiver behaviour and clear evidence of deception, and focusing on providing evidence for legal child protection and criminal prosecution of the caregiver, as well as on protecting the child, as detailed in recent USA guidance (Taskforce, A. P. S. A. C., 2018). An alternative approach (e.g. Petska et al., 2017; Roesler & Jenny, 2009) and further elaborated here, focuses initially more on the harm to the child, rather than on the caregiver's motivations (Flaherty, MacMillan, & Committee on Child Abuse and Neglect, 2013) which may not be initially apparent. This approach also emphasises ways of earlier recognition of FII (Glaser & Davis, 2019).

5.1. *Severity of FII*

Severity of FII can be considered in two ways: a) the nature and severity of the caregiver's actions; b) severity of the harm to the child.

- Nature and Severity of the caregiver's actions.** This can be considered on a continuum of severity, from anxiety- and belief-related erroneous reports, through to fabricating by false reporting, interfering with specimens and, ultimately, illness induction.
- Severity of harm to the child.** The different aspects of harm to the child may coexist and are not on a continuum. Instead, severity here needs to be assessed according to both the intensity of each aspect of the harm, and the cumulative effect of all the aspects. Moreover, the nature of the caregiver's motivations, whether there is explicit deception or not, and the severity of her actions bear little relation to severity of harm to the child. This is partly due to the additional harm caused inadvertently by the medical contribution. The exception is illness induction, which can lead to serious illness and even rarely death of the child.

In assessing the severity of FII the focus needs to be on the effects on the child, rather than to gauge severity by what the caregiver is saying or doing.

5.2. Need for immediate child protection

In a minority of FII cases, with or without alerting signs (see below), observations are made which call for immediate child protection, involving child protective services and law enforcement. They include observed actual illness induction, a caregiver observed to be tampering with the child's medical equipment, caregiver deceptive actions or indicators that the child's health, and rarely life, is at immediate risk of serious harm. At this point, the caregivers would not be told about the concerns. If made aware, there is a risk that the caregiver may intensify their efforts to convince professionals that the child is truly unwell by inducing illness in the child or by removing possible evidence.

Here, child protection should follow the same process as in other acute child abuse situations such as sexual abuse or non-accidental injury. It is preferable to focus initially on the protection of the child rather than seeking and relying on evidence for the prosecution of the caregiver.

Following child protection, the same process of rehabilitation, outlined below, will follow.

5.3. Alerting signs

In practice, recognition of FII is a process which is based on noting alerting signs. (There is no finite number of items as others are added periodically). They indicate or suggest the *possibility* of FII. At the time of being recognised, they should not be regarded as actual evidence of FII. These alerting signs include unexplained discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions, apparently unexplained findings and notable caregiver behaviours. Many of the alerting signs can be recognised by professionals who are routinely in contact with families. They include pre-school and school staff (Schreier & Bursch, 2018), primary and community health professionals, and social workers if they are already in contact with the family. Some of the alerting signs will only be recognised later, in paediatric settings. There are two aspects of alerting signs, which include those in the child and those based on the caregiver's behaviour and actions.

5.3.1. Alerting signs in the child

- Reported symptoms and signs which are not observed independently in the setting in which they are reported to occur (e.g. home)
- Reported (or observed) symptoms and signs which are not fully explained by any known medical condition in the child
- Reported symptoms or signs which are not explained by results of examination and investigations
- Inexplicably poor response to prescribed treatment (e.g. worsening of reported epileptic seizures following increased medication)
- Unexplained impairment of child's daily life, including school attendance, use of mobility aids and social isolation
- Unusual results of medical investigations (which may suggest poisoning)

5.3.2. Alerting signs in caregiver behaviour

- Repeated reporting of new symptoms in the child
- Repeated presentations of the child to and attendance at medical settings
- Seeking multiple medical opinions (doctor shopping)
- Repeatedly not bringing the child to, or cancelling certain medical appointments
- Insistence on more, clinically unwarranted, investigations, referrals, continuation of, or new treatments (sometimes based on Internet searches)
- Objection to communication between professionals
- Frequent vexatious complaints about professionals
- Not letting the child be seen on their own
- Talking for the child or the child repeatedly referring or deferring to the parent
- Repeated changing school, primary health doctor or paediatric team

5.4. Professional response to finding alerting signs

When alerting signs of possible FII are encountered, in whatever setting including school, several steps need to be taken. The first is to look for others; the second is to ask with each one in what way it might indicate harm to the child; the third is to consult a health professional, preferably in paediatrics, with knowledge of child maltreatment. This latter step might well pose difficulties in those countries where there is less awareness of FII. Nevertheless, finding alerting signs, whether within health, education or other settings, calls for action which needs to be led by paediatrics.

5.5. Perplexing presentations

When alerting signs are found with no risk of immediate serious harm to the child's health or life, the alerting signs are termed

Perplexing Presentations (RCPCH, 2020). The term implies that it is not clear what is or is not wrong with the child. In these cases, while the child might well be experiencing harm, the child's health and life are not at immediate risk of serious physical harm.

6. The process of responding to perplexing presentations

The essence of the response to Perplexing Presentations is *not* to establish whether there is FII. Instead, it focuses on ascertaining the actual state of health and functioning of the child. It is equally important to exclude FII by identifying a medical condition in the child (Petska et al., 2017; Rand & Feldman, 1999), which would explain the alerting signs as not indicating FII (Rosenberg, 2003). It is, therefore, appropriate to explain the term Perplexing Presentation and its management approach to the caregivers and the child, in an age-appropriate way. This includes explaining the need for inter-professional communication about the child. If the caregivers object to this, it is important to ascertain their concern. It is helpful to reflect with caregivers about the differing perceptions that they, and health and other professionals, have of the child's presenting problems.

At this point, neither the question whether the caregiver is fabricating or inducing illness, nor the caregiver's mental health are immediately relevant.

Responding to Perplexing Presentations is a complex and time-consuming but necessary process, led by paediatric or child and adolescent mental health services. It is a multidisciplinary process, gathering information from many sources, including child protective services if they have already been involved.

6.1. The Child's health and wellbeing

Information is required

- about the child's investigations and treatments from all medical/health professionals involved with the child, including primary health services. It is vital to note in the information what has been reported and what has been independently observed and by whom
- about the basis of reported diagnoses
- possibly from an inpatient admission for direct observations of the child. (If the caregivers refuse the admission to hospital, a referral to child protective services may be required, in order to enable this)
- about the child's current functioning including at school - attendance, attainments, emotional and behavioural state, peer relationships, mobility, aids, any additional support which the child is receiving at school and on what basis.

Gathering this information may require one or more (actual or virtual) professionals meeting. Notes from meetings can be made available to caregivers.

6.2. Caregivers' information and views

Information is required about

- the child's health history and observations from *all* carers, including fathers, day carers
- the caregivers' views - explanations, anxieties, fears and hopes for the child's difficulties
- family life and functioning and any effects of the child's reported difficulties e.g. difficulties for the caregiver in continuing in paid work
- siblings' health and well-being
- current or past involvement of child protective services
- current receipt of financial and other material support due to the child's reported ill-health
- other sources of support which the caregiver is receiving and using, including social media (Brown et al., 2014).

6.3. Child's view

It is important to ascertain from the child alone (when of an appropriate developmental level) what her/his views are about her/his symptoms, and what illness beliefs, anxieties and wishes the child has. (This is enshrined in the UN Convention on Rights of the Child (UNCRC) specifically under Articles 13 and 16).

6.4. Reaching a consensus formulation

A consensus formulation is reached through a virtual or actual consensus meeting. This includes *all* health and other professionals involved, including education. It summarises all the information collected. The consensus might conclude that the child's difficulties are fully explained by a verified medical condition. In that case, concerns about possible FII are no longer relevant.

Alternatively, agreement needs to be reached about

- any verified diagnoses, which do *not*, however, explain away all the concerns in the alerting signs

- any further investigations and medical opinions necessary in the child's interests
- the fact that the reported symptoms and signs are not life threatening
- the nature of the actual harm to the child and possibly siblings, or the likelihood of harm if there is no change
- what the child's needs are for protection from harm and the family's needs are in order to function better, alongside any remaining symptoms
- the elements of a rehabilitation plan
- the fact that the child will not come to harm as a result.

The concerns about actual or likely harm to the child and or siblings signify FII. It is important to note that this point can be reached by health and education, without the necessary involvement of child protective or law enforcement services. It is, therefore, independent of local child protective legislation, guidance or practice.

6.4.1. *Communication to the caregivers and the child*

The results of the consensus and the nature of the harm to the child, if any, will be explained fully to the family although use of the term FII is not necessary. It is also important to explain that a diagnosis may have no implications for the child's functioning, and that genuine symptoms may have no diagnosis. It is important to acknowledge the child's symptoms rather than dispute them. This 'as of now' consensus opinion is offered to the caregivers with the acknowledgment that this may well differ or depart from what they have previously been told by doctors. It may well also diverge from their views, and beliefs and wishes and the caregivers may be displeased with this feedback.

7. Professional response to finding FII

7.1. *Referral to child protective and legal services*

In some jurisdictions, the consensus finding of FII will need to be reported to child protective services, in order to ensure future protection, and restoring the child to better functioning. The actual harm is caused by psychological maltreatment, physical abuse and/or medical or other neglect, and the term FII may or may not need to be used in the referral. This referral and the reasons for it, can be communicated to the family.

In other jurisdictions, the family's acceptance of the professional consensus and agreement to participating in a rehabilitation plan will not necessitate referral to child protective and law enforcement services. However, if the caregiver(s) denies deception, disagrees with the consensus feedback, disputes the conclusions, requests more investigations, seeks further medical opinions, continues to seek a diagnosis, declines the rehabilitation plan or the rehabilitation is not proceeding fully, a referral to child protective services is indicated. The caregivers will be told about the referral. Without the involvement of child protective services, the child is likely to continue to be harmed.

To ensure that the referral is received appropriately, it includes the following information:

- (i) A clear explanation of any verified diagnoses, including the implications for the child's life and functioning.
- (ii) Details of the alerting signs which have led to concerns, and who had observed them.
- (iii) Description of independent observations of the child's actual functioning, medical investigations and the consensus medical and professional formulation.
- (iv) That the consensus formulation has been given to the caregivers.
- (v) Description of the help offered to the child and the family to improve the child's functioning and reduce harm (Rehabilitation Plan).
- (vi) The caregivers' response.
- (vii) A full description of the harm to the child, and possibly to the siblings.

A chronology of the child's health and health care will be useful, providing it specifies with each item what was reported, what was observed and by whom, the impact on the child, and what the caregivers' response was. However, it is not always necessary to submit a full chronology before referral as chronologies take time to complete, and the child should not remain at ongoing risk while a chronology is compiled.

The purpose of referring to child protective services is for them to undertake an assessment. This will determine, from their point of view, the nature of harm to the child and siblings and their needs. It should lead to protective intervention. Specifically, some children will also need to be protected from being taken to doctors by the caregiver, if she continues to be an unreliable informant. Doctors will be obliged to respond to the history which she will present, possibly to the detriment of the child. In order to achieve these results for the child, legal involvement may be required, assisted by expert medical and mental health advice. This will require detailed examination of health records (see [Taskforce, A. P. S. A. C., 2018](#)).

A full assessment of the caregiver's mental health will also be important in order to understand the nature of the caregiver's difficulties, any diagnoses and motivations. It will indicate what treatment is required, prognosis and likelihood of the caregiver's capacity to change ([Bass & Glaser, 2014](#)).

The question of criminal prosecution of the caregiver will depend on societal views about its necessity, desirability or usefulness. Criminal prosecution is particularly likely if there has been clear illness induction. If embarked upon, it will require stringent forensic

investigation for evidence of deceptive actions by the caregivers, conducted by law enforcement/police. However, criminal prosecution is neither a prerequisite for, nor guarantee of child protection.

7.2. Rehabilitation plan

Regardless of the involvement of child protective services, the child and the family will require a process of rehabilitation, which can proceed without the involvement of child protective services, as long as the caregivers continue to work with professionals. The rehabilitation plan needs to specify timescales and specific intended outcomes. There needs to be agreement about who, in the professional network, will hold responsibility for coordinating and monitoring progress of the plan.

7.2.1. Child's health and functioning

This requires a coordinated multidisciplinary approach which will include paediatrics, community health, education and possibly child protective services.

The plan requires health to rationalise and coordinate further medical care, discontinuing unnecessary medication, where appropriate resuming a more normal eating and feeding pattern and offering graded physical mobilisation if the child has been using a wheelchair or avoiding physical activity.

7.2.2. Education

If the child has not been attending school regularly, education needs to re-establish full school attendance with appropriate support. Additional support in school is often needed.

7.2.3. Child and family psychological work

This is an important issue fulfilling several needs. It requires a coordinated child and family mental health approach, which may be provided by one of several agencies or professionals (Bursch, Emerson, & Sanders, 2019; Sanders & Bursch, 2019).

- (i) Helping the child to accept their better state of health, and adjust by using coping strategies for symptoms e.g. a cognitive behavioural approach for pain. The child might also need support for the loss of gains of being a sick child.
- (ii) Work with the caregiver(s) to accept the child's true state of health. If the caregiver has been actively involved in deception, an acknowledgment of this is a prerequisite for ensuring the future safety of the child, and possibly siblings.
- (iii) Exploring the caregiver(s)' motivations - anxiety; compassion; beliefs; using the child for a gain and to fulfil their needs. The change brought about in child by the rehabilitation plan will have implications for the caregiver(s). This change may create a gap in the caregiver's life. 'Filling the gap' is part of rehabilitation. It might usefully include the family physician offering regular discussions with the caregiver regarding her concerns about the child's health. It might also include referral to adult mental health services.
- (iv) Work with any caregivers and supportive family members who have not been involved in the FII, to enable them to accept the fact of the caregiver's erroneous reporting, fabrication or inducing illness.
- (v) Helping the child and any siblings to understand the reasons for the child's previous medical investigations, treatments and limitations and for the new improvement in the child. This needs to be agreed by all caregivers, be truthful and include the caregiver's actions, but without denigration of the caregiver(s).

7.2.4. Regular review

The rehabilitation plan needs to be reviewed regularly until the aims have been fulfilled and the child has been restored to optimal health and functioning.

7.2.5. Long term follow-up

Even if the rehabilitation plan has been completed, there can be no certainty that difficulties might not recur, either regarding this child or other children in the family (Davis, McClure, & Rolfe, 1998), until the caregiver's motivations are understood, and the caregiver's needs are being otherwise fulfilled or resolved. It will be necessary to continue to be alert to possible recurrence of FII either in the index child(ren) or their siblings. Education and primary health are the appropriate professionals to be monitoring possible alerting signs about these children.

8. Discussion and conclusions

This paper describes a wider conceptualisation of FII, regarding it as a situation which, in its full manifestations is far commoner than the previously reported illness falsification and induction. It is recognised in different countries, although its true epidemiology and world-wide distribution await further study. The wider view presented in this paper includes harmful caregiver behaviour which is based not only on deception and gain but also on extreme anxiety and erroneous beliefs about the child's state of physical or mental health. The considerable harm to the child is not dependent on caregivers' verbal or physical deception. In order to have their needs fulfilled, the caregiver(s) requires doctors and health professionals to confirm the child's reported poor state. In their response, doctors and health professionals may inadvertently and unintentionally contribute to the harm to the child.

Less commonly, recognition of FII will be coupled with indicators that the child's physical health, and possibly life, is at immediate

risk of serious harm. These circumstances call for immediate protection of the child without initially informing the caregivers.

Currently, most cases of FII are only recognised after considerable time has elapsed during which the child will have been extensively investigated, unnecessarily treated and psychologically harmed. This raises the question of how to recognise these cases earlier. One approach, suggested by Greiner, Palusci, Keeshin, Kearns, and Sinal (2013), proposed a preliminary screening instrument. However, Crumm, Culotta, Cruz, Camp, and Donaruma-Kwoh (2018) have found that items in the proposed screening tool are not discriminatory for early identification. A comprehensive list of alerting signs for early recognition of possible FII are suggested in this paper.

For most of the cases, in which there is no need for immediate child protection, a more nuanced approach is suggested. This focuses initially on establishing the child's current true state of health and functioning, and the harm to the child, rather than on establishing the nature of the caregiver's behaviour and actions and verifying FII. This approach is best undertaken by paediatric services. A more open approach with the caregivers is possible and desirable unless it is clear that this will lead to further immediate risk to the child or to evidence.

The necessary process of resolving FII is multidisciplinary, time consuming and dependent on open communication between professionals. It may require legal court intervention. Prosecution of the caregivers is not the primary aim of intervention. The principles of the process suggested here require detailed adaptation in each jurisdiction.

8.1. Unanswered questions for further research

The approach described here is largely based on extensive clinical experience and raises many questions. The true epidemiology of FII, and the proportion, respectively, of caregivers motivated by gain and resorting to deceit and those motivated by erroneous beliefs are not known. The predictive validity and comprehensiveness of the alerting signs remains to be tested. It is also not known which caregiver motivation and what proportion of caregivers will embrace the rehabilitation plan in a sustained way and how many cases will ultimately end in legal action. Research regarding these questions is awaited.

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