

Assessment of factitious and fabricated illness in children

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Terminology

Terms defining child abuse/ neglect and psychopathology

- Munchausen syndrome by proxy
- Munchausen by proxy syndrome

Dr. Roy Meadow (1977) first described MSBP in the literature when he coined the term to refer to mothers deliberately falsifying illness in their children. Meadow used the term to describe the combination of the abuse (and neglect) and the motivation of the caregiver.

Motivation

- Evident: child custody, money, access to drugs
- Primary gain: attention, sympathy, sick role

Terms describing abuse and neglect

- Paediatric condition falsification
- Abuse by paediatric condition falsification
- Fabricated or induced illness in a child by a carer
- Caregiver fabricated illness in child
- Illness induction syndrome
- Medical child abuse

Terms describing the abuser's psychopathology

- Factitious disorder by proxy
- Factitious disorder imposed on other

Factitious disorder imposed on another DSM-V Criteria

When an individual falsifies illness in another (child, adult, pet), the diagnosis is factitious disorder imposed on another.

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception
- The individual presents another individual (i.e., the victim) to others as ill, impaired, or injured
- The deceptive behaviour is evident even in the absence of obvious external rewards
- The behaviour cannot be better explained by another mental disorder, such as delusional disorder or another psychotic disorder

Factitious Disorder Imposed on Another - focus away from child

Inclusion under DSM suggests it is a diagnosis that needs to be made by a psychiatrist

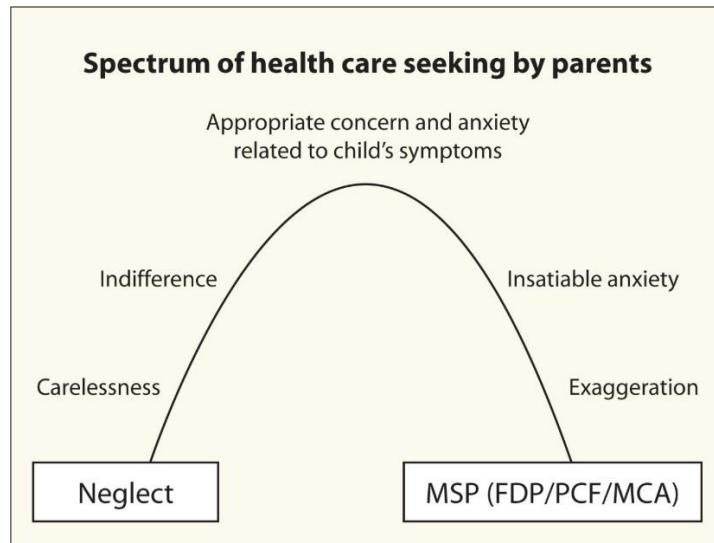
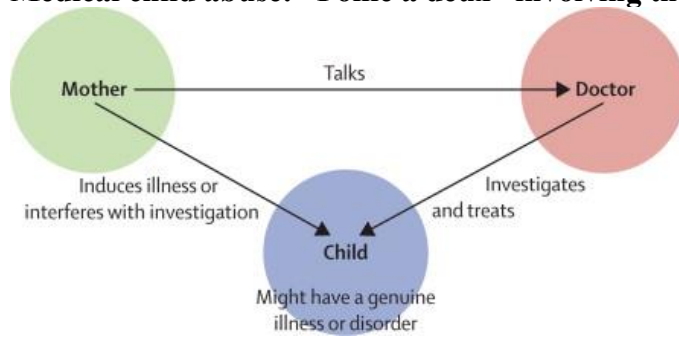
Diagnosis is to be made by careful review of the child's medical history and gathering of medical evidence to show that illness has been fabricated or induced or symptoms falsified by a carer who is not delusional or psychotic. Diagnosis can be made by a paediatrician. Psychiatrist will confirm that mother is not delusional or psychotic

- **The focus should be on CHILD-stop abuse, ensure safety**

Focus on What? How?

Not Why?

Medical child abuse: “Follie a deux” involving the carer and the doctor



Epidemiology

- 0.5-2 per 100,000, <16 yr
- Published cases from around the globe; >in developed countries where health is covered by insurance/government
- Usually >2-year delay in diagnosis
- 15-20 cases per year in Australia
- Usually mothers
- All children in family, or the youngest, one with a medical problem, most challenging child or one with disordered attachment.

Conditions falsified

- Any medical condition can be created, falsified, or exaggerated
- Common medical conditions that are falsified or induced: allergies, asthma, apnoea, gastrointestinal problems, failure to thrive, fevers, infections, and seizures
- Behavioural or psychiatric (e.g., falsely reporting the child is harming himself or others, or falsely reporting symptoms consistent with a mental illness or disability)
- Educational (e.g., falsely reporting learning disabilities, attention deficit disorders, or autism)

Types of falsification	Examples
Producing false information	saying a child has seizures when there are none and providing altered diagnostic medical documentation.
Withholding information	not informing the clinician that the child is vomiting due to poison that was just administered.
Exaggeration	reporting more frequent or treatment-resistant seizures than truly exist.
Simulation	presenting contaminated urine samples, placing one's own blood in child's stool sample, or interfering with a diagnostic test to produce abnormal results
Neglect	withholding medications, nutrition, or treatments to exacerbate symptoms
Induction	directly creating symptoms or impairments-include poisoning, suffocating, starving, and infecting.
Coaching	spouses who repeat what the abuser has told them to be true as if it were fact or a child victim who is reminded to report specific symptoms to the clinician.

Risk and harm

- Unnecessary and invasive evaluations and interventions.
- Child kept out of appropriate school settings, miss social and developmental opportunities.
- Misperceive themselves to be excessively ill or disabled.
- Iatrogenic medical conditions.
- Permanent physical harm blindness, altered gut function, brain damage, hearing loss, scarring, removal of organs, limbs, and death.

Psychological harm:

- overly compliant
- aggressive behaviour
- adoption of self-falsification or somatising behaviours
- loss of a positive self-image,
- posttraumatic stress disorder

- disordered eating
- occasionally, children and teens may be aware of the abuse, but do not inform others of what is happening to them
- more frequently, they vigorously defend the abuser and do not grasp what has happened to themselves

Aetiology (note this is not our primary concern)

Very rare admission by perpetrator

When they do the needs cited:

- to receive care and attention
- to be perceived as smart, caring, selfless, or in control
- to manipulate and humiliate a powerful figure
- to manipulate a spouse.
- the excitement of being in a medical setting
- some consider their persistence and single-mindedness in engaging in falsification behaviour as addictive
- personal history of childhood abuse or domestic violence frequently (often untrue)
- they may falsify or induce symptoms in themselves and may themselves be victims of MCA.

Abuser psychopathology

- predominantly female, liars, manipulators, appear overanxious
- typically have a coexisting personality disorder- borderline, histrionic, sociopathic, or mixed
- Bass & Jones, 2011 and Bools, Neale, and Meadow (1994) found that of 47 mothers who had induced illness in their children:

89% had a personality disorder.

72% had somatic symptom disorder or factitious disorder imposed on self

55% had histories of self-destructive behaviours

26% had learning difficulties.

21% percent had Hx of substance abuse

Some abusers have no obvious or diagnosable personality disorder.

Role of the general paediatrician

Be alert to children with

- Unusual clinical presentations
- Clinical findings inconsistent with history
- No response to standard treatments
- Unexplained discrepancies
- Evidence of deception, induction, or intentional neglect
- Underlying medical disorder is often associated

Ask yourself

1. Are the history, signs, and symptoms credible?
2. Is the child receiving unnecessary and harmful or potentially harmful medical care?
3. Who is instigating the evaluations or treatments?

Next

Review past medical records

Communicate with both parents-meet with father

Communicate with school and other independent observers

Review suspected abuser's online social media activity

Evaluation and rehabilitation plans -systematically and objectively (with advice of required from forensic paediatricians)

Clear documentation of what your concerns are and of your observations. Note of you don't document unusual behaviours and inconsistencies over time evidence cannot be gathered.

When a certain threshold is reached:

- Communicate with all clinicians involved
- Discuss with local forensic paediatrician
- Report to Child Protection
- Schedule an appointment with both parents.
- Social work or nurse or CP to be present
- Inform parents your concerns that history is not in keeping with child's presentation and investigations
- Ask mother about "anxiety" and "vulnerable child"
- Offer ongoing review and support

Role of Forensic paediatrician

- Detailed analysis of medical record of child, parent and sibling's hospital- (ED, OP, admissions, mental health, path, radiology), GP records
- Community health, MCHN, ECIS
- Disability services
- School
- Centrelink, Medicare, PBS
- Tabulate every health care visit/contact
- Examine primary data
- Clarify verbally with authors if needed

Date	Historian	Subjective Carer History	Objective Findings	Investigations	Diagnosis/Recommendations

1 Look for patterns of evidence from medical records of:

- Induction
- Feigning
- Unusual persistent/recurrent illness
- Lack of continuity of care
- Inappropriate communication
- Inconsistencies
- Falsification

- Coaching
- Missed appointments

2. Therapeutic separation

This may require a court order

3 Covert video surveillance (useful for apnoea and failure to thrive)

Issues

- Ethics
- Privacy
- Right of parent v child protection
- Entrapment
- Resources
- Manpower

Differential diagnosis

- Maternal Anxiety/illness exaggeration
- Vulnerable child
- Eating disorders in mother
- Psychotic disorder in mother
- Somatoform disorder in child
- Malingering
- Genuinely unwell child with an undiagnosed or difficult to treat disorder

Management

1. Forensic report Good forensic report to convince Children's court re need for protection of child and safety plan
2. Team approach to diagnosis and management: Paeds, CP, police, mental health, social work.
3. Child Safety Plan:
 - Child protection order-monitoring
 - Placement with supervised visitation
 - Health needs of child
 - Therapy for child, abuser and family therapy
 - Extended family involvement/ social supports
 - Reunification
 - Monitoring

What is at stake?

- The child's life (up to 10% mortality)
- The family's integrity and freedom
- **Your career**
- Missed diagnoses with implications for other family members: cardiac arrhythmias, metabolic/ enzyme deficiencies, immune disorders