Factitious disorder (imposed on another)

An ability to draw on knowledge that factitious disorder is characterised by:

- the falsification of physical or psychological signs or symptoms, induction of injury or disease, in another person, associated with identified deception, where:
  - an individual presents another individual [victim] to others as ill, impaired, or injured
  - the deceptive behaviour is evident even in the absence of obvious external rewards
  - the behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder

An ability to draw on knowledge that the factitious illness usually represents a way for the carer to use the child to fulfil their own needs, for example:

- recognition as heroic / suffering carer
- need for care from health professionals
- financial or material gain
- concerned their child has a problem or disability and seeking a diagnosis
- deflecting blame/responsibility for not coping with parenting challenges
- maintaining closeness to the child

An ability to draw on knowledge that factitious illness can also reflect erroneous beliefs, reflecting:

- concern/anxiety about the child’s health
- misinterpretation
- delusional beliefs,

An ability to draw on knowledge that factitious illness requires health professionals to accept the carer’s contentions/beliefs about the child’s state of health, usually through:

- erroneous and insistent verbal reports that may (but also may not) be motivated by an intention to deceive. e.g.:
  - exaggerating or inventing history, symptoms or signs
  - persistent insistence on further investigations/referrals
  - reporting that the relevant phenomena only occur in the carer’s presence

- active falsification of the child’s state of health by (for example)
  - falsifying reports
  - falsifying or interfering with investigations
  - failing to give medication/food (and so making the child appear ill
  - inducing illness in the child (e.g. by poisoning / over-medicating (laxatives, salt), suffocating

Impact on the child

An ability to draw on knowledge that there will be the same harmful effects for the child regardless of parental motivation or action

- direct harm emanating from the actions of the carer, for example:
  - depriving the child of medications or food in order to make them look ill
  - overlooking genuine illness
  - threats to health and life through illness induction

- iatrogenic harm (albeit inadvertent) from healthcare workers, through repeated (unnecessary) examinations, investigations, procedures and treatments
An ability to draw on knowledge of the impact on the child's development & daily life
- limited and/or interrupted school attendance and education
- limited normal activities of daily life
- adoption of a sick role
- social isolation

An ability to draw on knowledge of the impact on the child's wellbeing, for example:
- insecure attachment
- anxiety or confusion regarding their state of health
- the development of a false view of self as being sick and vulnerable

An ability to draw on knowledge of the possible adoption of carer’s views as the child reaches adolescence, leading to:
- active collusion in ‘illness’ deception
- the development of ‘Medically Unexplained Symptoms (MUS) or somatisation

Assessment of factitious illness
An ability to draw on knowledge of alerting signs for factitious illness, such as:
- perplexing presentations
- discrepancies (‘something does not add up)
- reported symptoms & signs that are not observed independently of their reported context
- reported (or observed) symptoms and signs not explained by child’s medical condition
- physical examination and results of investigations do not explain reported symptoms or signs
- inexplicably poor response to medication or procedures
- repeated reporting of new symptoms
- repeated presentation to different doctors and failing to attend appointments
- a ‘quest’ for a diagnosis (e.g. carers insistent on more, clinically unwarranted, investigations, referrals, continuation of, or new treatment)
- impairment of child’s daily life beyond any known disorder

Managing perplexing presentations
If alerting signs are present along with evidence of deception/illness induction/falsification of documents and results, then an ability to refer to child protection services
If alerting signs are present but with no evidence of deception then an ability to investigate further by:
- consulting relevant medical staff a colleague – named doctor and collating information about all medical/health involvement and diagnoses
- verifying the child’s current state of physical and mental health, including their physical, educational and social functioning
- obtaining the carers’ explanations, fears and hopes of and for the child’s difficulties
- obtaining the child’s views regarding their symptoms, illness beliefs, anxieties, and mood
- obtaining information about family life and functioning
An ability to work with carers to help to develop an alternative model of healthcare issues, for example, by

- indicating that diagnosis may have no implications for functioning
- genuine symptoms may have no diagnosis, and ensuring that there is no dispute about the veracity of reported symptoms (e.g. pain)
- avoiding the use of diagnostic labels (such as Chronic Pain Syndrome)
- conveying a message that reported symptoms and signs are not life threatening, that further investigations and repeated presentations to doctors may be more harmful than helpful and that the child will not come to harm as a result

An ability to offer a ‘rehabilitation’ programme that includes:

- rationalising and coordinating medical care
- reducing or stopping medication for which there is no indication
- active multidisciplinary/multiagency rehabilitation which may require support from social care
- re-establishing full school attendance
- graded physical mobilisation

An ability to work with the carers and family, including:

- exploring the carers’ motivations, anxieties, beliefs, needs
- exploring the implications/likely changes for carers if their child was functioning optimally
- helping carers to ‘fill the gap’ created in their life by having a well (or better) child
- helping the child and family to construct a narrative explanation for improvement in the child
- helping the child to adjust to a better state of health by using coping strategies for symptoms, and/or support for loss of gains of being a sick child

Managing challenges to intervention

An ability to identify when carers contest the development of an alternative view of the child’s presentation, for example:

- disputing the veracity of independent/cclinical observations and seek further investigations
- declining and/or failing to enact rehabilitation plans

An ability to refer to social services and to discuss the rationale for this with carers (because their behaviour constitutes evidence that they are avoidably impairing the child’s functioning)