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Fabricated or induced illness

Introduction

Fabricated or induced illness (FII) is a rare form of child abuse. It occurs when a parent or carer, usually the childs biological mother, exaggerates or deliberately causes symptoms of illness in the child.

FII is also known as Munchausen's syndrome by proxy. Munchausen's syndrome, also known as factitious disorder, is a condition where a person pretends to be ill or causes illness or injury to themselves.

However, healthcare professionals in the UK prefer to use the term fabricated or induced illness, or factitious disorder imposed on another. This is because the term Munchausen's syndrome by proxy places the emphasis on the person carrying out the abuse, rather than the victim.

The term Munchausen's syndrome by proxy is still widely used in other countries.

Behaviours in FII

The term FII covers a wide range of cases and behaviours involving parents seeking healthcare for a child. This ranges from extreme neglect (failing to seek medical care) to induced illness. Behaviours in FII include:

- a mother or other carer who convinces their child they are ill when they are perfectly healthy
- a mother or other carer who exaggerates or lies about their childs symptoms
- a mother or other carer who manipulates test results to suggest the presence of illness for example, by putting glucose in urine samples to suggest the child has diabetes
- a mother or other carer who deliberately induces symptoms of illness for example, by poisoning her child with unnecessary medication or other substances

Learn more about the signs of fabricated or induced illness.

How common is fabricated or induced illness?

It's difficult to estimate how widespread FII is, because many cases may go unreported or

undetected. In an average population of one million people, around one child per year would be affected.

The British Paediatric Surveillance Unit (BPSU), which is a specialist unit that assists research into rare childhood conditions, carried out a study of FII cases. It identified 97 cases of FII in the UK over a two-year period.

However, it's likely that this figure underestimates the true prevalence of FII.

FII can involve children of all ages, but the most severe cases usually involve children under five.

In over 90% of reported cases of FII, the childs mother is responsible for the abuse. However, cases have been reported in which the father, foster parent, grandparent, guardian, or a healthcare or childcare professional was responsible.

Motivation

It's not fully understood why FII occurs.

In cases where the mother is responsible, it could be that the mother enjoys the attention of playing the role of a "caring mother".

A large number of mothers involved in cases of FII had a previous history of unresolved psychological and behavioural problems, such as a history of self-harming, or drug or alcohol misuse, or have experienced the death of another child.

A high proportion of mothers involved in FII have been found to have so-called "somatoform disorders", where they experience multiple, recurrent physical symptoms. A proportion of these mothers also have Munchausen's syndrome.

A high proportion of mothers also have a type of mental health problem called borderline personality disorder, which is characterised by emotional instability, impulsiveness and disturbed thinking.

There have been several reported cases where illness was fabricated or induced for financial reasons for example, to claim disability benefits.

Read more about the possible causes of fabricated or induced illness.

Child protection

FII is a child protection issue and cannot be treated by the NHS alone.

Medical professionals who suspect FII is taking place should liaise with social services and the police, and must follow local child protection procedures.

If your job involves working with children for example, if you are a nursery worker or teacher, you should inform the person in your organisation who is responsible for child protection issues.

If you don't know who this is, your immediate supervisor or manager should be able to tell you.

If you suspect that someone you know may be fabricating or inducing illness in their child, it's not recommended that you confront them directly. A direct confrontation is unlikely to make a person admit to wrongdoing, and it may give them the opportunity to dispose of any evidence of abuse.

You can contact your local social services department or telephone the NSPCCs child protection helpline, which is open 24 hours a day, seven days a week, on 0808 800 5000.

Read more about diagnosing fabricated or induced illness.

Treatment

The child

The first priority is to protect the child and restore them to good health. This may involve removing the child from the care of the person responsible. If the child is in hospital, it may involve removing the responsible parent or carer from the ward.

They may need help returning to a normal lifestyle, including going back to school.

Younger children and babies who don't understand they were victims of abuse often make a good recovery once the abuse stops.

Older children, particularly those who have been abused for many years, will have more complex problems. For example, many older affected children believe they are really ill. They need help and support to develop a more realistic understanding of their health. They may also need to learn how to tell the difference between the lies of their parent or carer and reality.

It's also common for older children to feel loyal to their parent or carer, and a sense of guilt if that parent or carer is removed from the family.

The parent or carer

Once the child is safe, it may be possible to treat the parent or carer's underlying psychological problems. This may include a combination of:

- intensive psychotherapy
- family therapy the father may need individual help, especially if he is the main caregiver

The aim of psychotherapy is to uncover and resolve the issues that caused them to fake or induce illness in their child.

The aim of family therapy is to resolve any tensions within the family, improve parenting skills and attempt to repair the relationship between the parent or carer and the child.

In more severe cases, the parent or carer may be compulsorily detained in a psychiatric ward under the Mental Health Act so their relationship with their child can be closely monitored.

Parents or carers involved in FII are difficult to treat, because most do not admit their deceptions and refuse to admit their abusive behaviour. Therefore, in many cases, the child is permanently removed from their care.

The best results occur in cases where the parent or carer:

- understands and acknowledges the harm they have caused
- is able to communicate the underlying motivations and needs that led them to fake or cause illness
- is able to work together with healthcare and other professionals

Outlook

Children affected by FII can experience long-term consequences in terms of their physical health, as well as significant psychological and emotional trauma.

A BPSU study found that one in four victims of FII still had significant physical and/or psychological problems two years after the abuse had stopped.

In cases involving administering unnecessary medicines or other substances, it's estimated that around 1 in 16 will die as a result of this abuse. A further 1 in 14 will experience long-term or permanent injury.

Media controversy

There has been some controversy in the media regarding FII, with some commentators suggesting that it's not a real phenomenon.

However, there's a great deal of evidence to suggest the condition does exist. The evidence of abuse includes hundreds of case files from more than 20 different countries, the confessions of mothers and other carers, the testimony of children and secret video footage.

Signs of fabricated or induced illness

The abuse that occurs in fabricated or induced illness (FII) takes a range of forms and can be difficult to recognise, but there are warning signs to look out for.

Warning signs

The National Institute for Health and Care Excellence (NICE) guidance on when to suspect child maltreatment (PDF, 235kb) states that fabricated or induced illness may first be suspected if:

- physical or psychological examination and diagnostic tests do not explain the reported signs and symptoms

One or more of the following warning signs must also be present:

- symptoms only appear when the parent or carer is present
- the only person claiming to notice symptoms is the parent or carer
- the affected child has an inexplicably poor response to medication or other treatment
- if a particular health problem is resolved, the parent or carer suddenly begins reporting a new set of symptoms
- the child's history of symptoms does not result in expected medical outcomes for example, a child who has supposedly lost a lot of blood but doesn't become unwell
- the parent or carer has a history of frequently changing GPs or visiting different hospitals for treatment, particularly if their views about the childs treatment are challenged by medical

staff
- the childs daily activities are being limited far beyond what you would usually expect as a result of having a certain condition for example, they never go to school or have to wear leg braces even though they can walk properly

Other warning signs

Other identified warning signs include:

- the parent or carer having good medical knowledge or a medical background
- although the parent or carer is very attentive to the child and stays with them constantly in hospital, they do not seem too worried about the child's health or overly worried in relation to the health professional in charge of their child's care
- the parent or career trying to maintain a close and friendly relationship with medical staff, but quickly becoming abusive or argumentative if their own views on what is wrong with the child are challenged
- one parent (usually, but not always, the father) having little or no involvement in the care of the child
- the parent or carer encouraging medical staff to perform often painful tests and procedures on the child (tests that most parents would only agree to if they were persuaded that it was absolutely necessary)

Patterns and levels of abuse

The patterns of abuse found in cases of FII usually fall into one of six categories. These are ranked below, from least severe to most severe.

In the more severe cases of FII, the parent or carer may carry out behaviour from several or all categories.

The categories are:

- exaggerating or fabricating symptoms and manipulating test results to suggest the presence of an illness
- intentionally withholding nutrients from the child or interfering with nutritional intake
- inducing symptoms by means other than poisoning or smothering such as using chemicals to irritate their skin

- poisoning the child with a poison of low toxicity for example, using a laxative to induce diarrhoea
- poisoning the child with a poison of high toxicity for example, using insulin to lower a childs blood sugar level
- deliberately smothering the child to induce unconsciousness

Previous case reports of FII have uncovered evidence of:

- parents or carers lying about their childs symptoms
- parents or carers deliberately contaminating or manipulating clinical tests to fake evidence of illness for example, by adding blood or glucose to urine samples, placing their blood on the childs clothing to suggest unusual bleeding, or heating thermometers to suggest the presence of a fever
- poisoning their child with unsuitable and non-prescribed medicine
- infecting their childs wounds or injecting the child with dirt or faeces (stools)
- inducing unconsciousness by suffocating their child
- not treating or mistreating genuine conditions so they will get worse
- withholding food which results in the child failing to develop physically and mentally at the expected rate

Causes of fabricated or induced illness

The causes of fabricated or induced illness (FII), also known as Munchausen's syndrome by proxy, are not fully understood, and more research is needed.

However, previous traumatic experiences in the life of the parent or carer responsible seem to play an important role.

Recent studies have shown that mothers who carry out the abuse have abnormal "attachment" experiences with their own mothers, which may affect their parenting and ability to secure bonds with their children. An example of this is repeatedly seeing a doctor to satisfy an emotional need to get attention for the child.

Child abuse

One study found that almost half of mothers who were known to have fabricated or induced illness in their child were victims of physical and sexual abuse during their own childhood.

However, it's worth noting that most people who were abused as children do not go on to abuse their own children.

Previous medical history

One or both parents may have a history of self-harm or drug or alcohol abuse.

Some case studies also revealed that the mother may have experienced the death of another child, or a difficult pregnancy.

Personality disorder

A high proportion of mothers involved in FII have been found to have a personality disorder and, in particular, a borderline personality disorder.

Personality disorders are a type of mental health problem, where an individual has a distorted pattern of thoughts and beliefs about themselves and others. These distorted thoughts and beliefs may cause them to behave in ways that most people would regard as disturbed and abnormal.

A borderline personality disorder is characterised by emotional instability, disturbed thinking, impulsive behaviour, and intense but unstable relationships with others. However, it's important to note that not all mothers with borderline personality disorder go on to abuse their children.

Read more about borderline personality disorder.

Sometimes, people with personality disorders find reward in behaviour or situations that other people would find intensely distressing. It's thought that some mothers who carry out FII find the situation of their child being under medical care rewarding.

Other mothers who have been involved in FII have reported feeling a sense of resentment towards their child because they have a happy childhood, unlike their own.

Role playing

A further theory is that FII is a kind of role playing.

It allows a mother to adopt the role of a caring and concerned mother, while at the same time

allowing her to pass the responsibility of caring for a child onto medical staff.

Escapism

Another theory is that FII is a way for the mother to escape her own negative feelings and unpleasant emotions.

By creating a permanent crisis situation surrounding her child, she is able to focus her thoughts on the treatment of her child, while keeping her own negative feelings and emotions at bay.

Diagnosing fabricated or induced illness

It can be very difficult for healthcare professionals to diagnose a case of fabricated or induced illness (FII).

Healthcare professionals will naturally assume that a parent or carer will always act in the best interests of a child in their care, unless there is compelling evidence to suggest otherwise.

If FII is suspected

If a healthcare professional suspects FII, they will usually refer the case to a community paediatrician.

A senior paediatrician will examine the medical evidence to determine whether there is a clinical explanation for the childs symptoms. They may also seek further specialist advice and arrange further testing.

What happens next?

If the senior paediatrician also suspects FII, they will put together a detailed record of all the available information that is related to the childs medical history. This is called a chronology.

They will also contact the local authoritys child protection team (CPT) to inform them that concerns have been raised about the childs safety and that an investigation is underway.

CPTs are teams that consist of a number of different professionals. They are employed by local authorities that are responsible for protecting children from abuse and neglect.

Other agencies that are involved with the childs welfare, such as their school or social services, may be contacted in case they have information that is relevant to the chronology, such as the child being absent from school. It's important to assign a person to construct the chronology, as this is a critical part of the assessment process.

Covert (secret) video surveillance may be used to collect evidence that can help to confirm a suspected case of FII.

Only the police have the legal authority to carry out covert video surveillance. It will only be used if there is no other way of obtaining information to explain the childs symptoms. This power is rarely used in practice.

Once the chronology is complete, the information will be presented to the CPT and the police. The CPT, police and medical staff will meet to discuss the best way to proceed with the case.

Child protection plan

If the child is thought to be at immediate risk of physical harm, social services will remove the child from the care of the parent or carer. The child could be placed under the care of another relative or under the care of social services in foster care.

In many cases of suspected FII, the child is already in hospital. They will then be moved to a safe place inside the hospital so that their medical assessment can continue. Alternatively, the carer may be banned from the child's ward.

A child will be taken into care in almost all cases that involve physical harm and in around half of cases where the mother is only fabricating, not inducing, symptoms of illness.

If it's thought that the child is at risk of significant physical or mental harm, a child protection plan will be drawn up.

The child protection plan will take into account the childs health and safety needs, as well as their educational or social needs. For example, the child may have been deprived of regular education because their parent or carer kept them away from school, due to a fabricated illness.

As part of the child protection plan, the parent or carer may be asked to have a psychiatric

assessment or family therapy. If they refuse to comply with the child protection plan, the child may be removed from their care.

Police investigation

If the police decide that there's sufficient evidence to bring criminal charges, they will begin to investigate the case.

More information

The following documents contain more information about the recommended guidelines regarding the protection of children in cases of FII:

- Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians (PDF, 836kb) produced by the Royal College of Paediatrics and Child Health.

7minutebriefing

Information Sharing

7 What to do

Use the "seven golden rules to sharing information" &

- *Identify how much information to share*
- *Distinguish fact from opinion*
- *Ensure you are giving the right information to the right person*
- *Consider there is a clear and legitimate purpose for sharing information*
- *Record decisions and actions at all times*

See Sefton LSCB Information Sharing Procedure

1 Background

Sharing information is an important part of any frontline practitioners' job when working with children and young people. The decisions about how much information to share, with whom and when, can have a profound impact on individuals' lives.

The Government has issued advice for all frontline practitioners and senior managers working with children, young people, parents and carers who have to make decisions about sharing personal information on a case by case basis. The guidance is clear that concerns about sharing information cannot be allowed to stand in the way of the need to safeguard and promote the welfare of children at risk of abuse or neglect and that no practitioner should assume that someone else will pass on information which may be critical to keeping a child safe.

2 Why it matters

National and local Serious Case Reviews (SCRs) carried out following the death, or serious injury, of a child have repeatedly flagged up the need to share information early and effectively between agencies. A recent analysis of 66 SCRs noted there was only one where information sharing was not specifically mentioned, leading the authors to comment:

"In contrast, in over ten years of analysing serious case reviews, we have not come across a single case where a child has been killed or harmed because a professional has shared information."

3 Principles

The 6 Principles of information sharing tell us that information sharing should be:

1. Necessary & Proportionate

2. Relevant

3. Adequate

4. Accurate

5. Timely

6. Secure

4 Learning

Learning from Serious Case Reviews & local multi-agency practice reviews

1. Practitioners need to provide clear explanations of why they are requesting information.

2. Always follow up direct verbal or face -to-face communication/information sharing with clear & comprehensive documentation.

3. Share both current and historical information, if it is relevant.

4. Once shared, information must be analysed & used to guide decision making & planning.

5 Learning cont'd.

5. Information sharing should be two-way; with practitioners who make referrals, receiving feedback & ongoing information about actions taken.

6. Information sharing is not a one-off process, but should be part of an ongoing dialogue among practitioners to allow for re- assessment of risk and taking into account new information as it arises.

7. All relevant information must be shared at times of transition – for example, when a child moves between schools or Local Authority areas

6 Questions

Is information getting to the right people quickly enough, allowing them to act?

Has information been verified, e.g. confirmation of the accounts given by parents and triangulation of information between professionals?

Are professionals for whom safeguarding is not a core responsibility also aware of the need to share information early?

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Peer on Peer Abuse

Peer on peer abuse occurs when a young person is exploited, bullied and / or harmed by their peers who are the same or similar age; everyone directly involved in peer on peer abuse is under the age of 18. 'Peer-on-peer' abuse can relate to various forms of abuse (not just sexual abuse and exploitation), and crucially it does not capture the fact that the behaviour in question is harmful to the child perpetrator as well as the victim.

Research suggests that girls and young women are more at risk of abusive behaviours perpetrated by their peers; however it can also affect boys and young men, those with learning difficulties or disabilities, LGBTQ Children and young people (CYP) and those who are from different communities.

Situations where young people are forced or coerced into sexual activity by peers or associates can be related with gang / serious youth violence activity but that is not always the case. Peer influence or peer pressure is a major factor in the decisions made by young people to join groups. Many young people see it as a "way out" from their day to day life and feel a strong bond with their peers, one which they may be lacking at home.

Definition

There is no clear definition of what peer on peer abuse entails. However it can be captured in a range of different definitions:

- **Domestic Abuse:** relates to young people aged 16 and 17 who experience physical, emotional, sexual and / or financial abuse, and coercive control in their intimate relationships;
- **Child Sexual Exploitation:** captures young people aged under-18 who are sexually abused in the context of exploitative relationships, contexts and situations by a person of any age - including another young person;
- **Harmful Sexual Behaviour:** refers to any young person, under the age of 18, who demonstrates behaviour outside of their normative parameters of development (this includes, but is not exclusive to abusive behaviours);
- **Serious Youth Crime / Violence:** reference to offences (as opposed to relationships / contexts) and captures all those of the most serious in nature including murder, rape and GBH between young people under-18.

Child Sexual Exploitation (CSE)

Many of the warning signs and indicators of CSE tend to refer to adult perpetrators, e.g. associations with older boyfriends / girlfriends, relationships or associations with risky adults and / or entering or leaving vehicles driven by unknown adults. As per the revised definition of CSE it "occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity". The key element of CSE is the imbalance of power and control within the exploitative relationship. Many CYP are not aware of the exploitation as they have a genuine belief that they are loved by their boyfriend / girlfriend or are acting in accordance with their peers. CYP are often recruited into exploitation by those who they trust, those of a similar age and with similar hobbies, often the nature of peer on peer exploitation encompasses a sense of peer pressure and wanting to fit in. In peer on peer exploitation, schools and youth clubs are also locations where children and young people can be exploited.

Harmful Sexual Behaviour Including Sexting

Sexually harmful behaviour from young people does not always occur with the intent to harm others. There may be many reasons why a young person engages in sexually harmful behaviour and it may be just as distressing to the young person who instigates it as well as the young person it is intended towards. Sexually harmful behaviour may range from inappropriate sexual language, inappropriate role play, to sexually touching another or sexual assault / abuse. This also includes sexting when someone sends or receives a sexually explicit text, image or video. This includes sending 'nude pics', 'rude pics' or 'nude selfies'. Pressuring someone into sending a nude picture may occur in any relationship and to anyone, whatever their age, gender or sexual preference. However, once the image is taken and sent, the sender has lost control of the image and these images could end up anywhere. By having in their possession, or distributing, indecent images of a person under 18 on to someone else, young people are not even aware that they could be committing a criminal offence.

Gang Activity and Youth Violence

A child or young person can be exploited (sexually and / or physically) by a gang, but this is not necessarily the reason why gangs are formed. The Office of the Children's Commissioner has defined CSE in gangs and groups as:

- Gangs - mainly comprising men and boys aged 13-25 years old, who take part in many forms of criminal activity (e.g. knife crime or robbery) who can engage in violence against other gangs, and who have identifiable markers, for example a territory, a name, or sometimes clothing.
- Groups - involves people who come together in person or online for the purpose of setting up, co-ordinating and / or taking part in the sexual exploitation of children in either an organised or opportunistic way.

Contact Us

To find out more about working with tri.x contact us on: Telephone: 024 7667 8053 or visit our website [illegible].

[illegible] is part of the [illegible], which also includes [illegible] (Positive approaches to challenging behaviour) and [illegible] (Training, consultancy and direct work). As a group we provide those working with children and vulnerable people with the best information, practice guidance, training and consulting available.