

FII and Perplexing Presentations: What is the Evidence Base for and against Current Guidelines, and What are the Implications for Social Services?

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Abstract

Fabricated or induced illness (FII) and perplexing presentations (PPs) are the terms used by the Royal College of Paediatrics and Child Health (RCPCH) in the UK. FII is presented as if synonymous with Munchausen syndrome by proxy, a rare presentation which is now known in Diagnostic and Statistical Manual of Mental Disorders, 5th Edition as factitious disorder imposed on another (FDIoA). However, FII is not a diagnosis, and the definition is far broader than FDIoA. RCPCH admit that there is a limited evidence base for the prevalence, specificity or sensitivity of FII and the associated 'alerting signs', and yet local authorities across the UK have Child Protection Policies developed directly from the RCPCH guidelines. An increasing number of families of children with neurodevelopmental presentations (such as autism), or presentations of complex or less well-known conditions such as Ehlers-Danlos syndrome, are finding themselves being investigated for FII by Social Services, and consequently labelled as potential 'perpetrators' of child abuse, on the basis of FII guidelines. The present article discusses the issues relating to FII and PP, how current guidelines are creating implicit and explicit bias against certain kinds of families and the implications for Social Services.

Keywords: autism, child development, child protection, fabricated induced illness, policy

Accepted: February 2022

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Introduction

Professionals working in social care, as well as health, education, schools, the police and the independent sector are expected to have an awareness and understanding of possible ways in which a child or young person's illness can be induced or fabricated. Equally, it is essential that professionals have an acute appreciation of their respective roles and responsibilities to effect collaborative working, where the needs of the child or young person remain central to any decisions specific to their well-being (HM Government, 2008). Multi-agency safeguarding partnership arrangements require strong leadership to ensure the effective protection of children, and their actions must be accountable to scrutiny (HM Government, 2008, pp. 73–74). However, recent reports have raised concerns relating to child protection processes, indicating, for example, that current practice with regard to families with disabled children (including autism) is institutionalising parent carer blame (Clements and Aiello, 2021), that families of autistic and learning disabled children are being traumatised in their encounters with a system supposed to support them (Challenging Behaviour Foundation, 2020), and that there is an urgent need for the current social care system in England to be changed (Independent Review of Children's Social Care, 2021). Whilst there is no one cause for these issues, fabricated and induced illness (FII) allegations are reported to have increased substantially against parents of autistic children and children with special needs (e.g. Autism Eye, 2014; Blower, 2021), with these families subsequently being pulled into the child protection system (CPS) and reporting trauma as a result. This article aims to critically explore the evidence base and current knowledge around FII and to explore the implications to Social Services, with a view to helping social workers to make informed decisions when faced with families being investigated for possible FII.

Background

FII and perplexing presentations (PPs) are terms used by the Royal College of Paediatrics and Child Health in the UK (RCPCH, 2021). They are not clinical diagnoses and are not included in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (American Psychiatric Association, 2013). FII is often presented as synonymous with Munchausen syndrome by proxy (MSbP) and with factitious disorder imposed on another (FDIoA) (e.g. Bass and Glaser, 2014; RCPCH, 2021). MSbP was the term used for parents or caregivers who intentionally caused or fabricated illness in a dependent, usually a child, for their own personal gain. It was a term first coined by Meadow in

1977 and focused on children under seven years of age (Meadow, 1977; Meadow, 1982) but which Meadow himself reported as lacking specificity with ‘many different occurrences’ fulfilling the description, having been used originally for ‘journalistic reasons’, and whose ‘over-use has led to confusion for medical, social work and legal professions’ (Meadow, 1995, p. 534). MSbP is no longer a term used within the UK. MSbP was not a diagnosis, although it described a mental health presentation. Current diagnostic practice in DSM-5 (American Psychiatric Association, 2013) now outlines FDIoA, a psychiatric condition in which a person falsifies or induces physiological or psychological symptoms in another (usually a child) with the intention to deceive, and where there is no alternative mental health explanation for their behaviour.

A recent paper by Davis *et al.* (2019) cites literature searches for MSbP in their outline of FII epidemiology, treating the two as effectively the same thing and acknowledging that there is little empirical literature for FII. The RCPCH guidelines on FII published in 2021 state that FII, MSbP and FDIoA are terms which ‘essentially refer to the same entity’ (RCPCH, 2021, p. 10), and yet in the same document FII is also presented as distinct from FDIoA, with FII not requiring intention to deceive (RCPCH, 2021, p. 10), and not being a diagnosis. There is therefore a somewhat inconsistent presentation of FII both as synonymous with MSbP and FDIoA, yet simultaneously distinct from several of the core features, and outside formal diagnostic manuals.

Literature outlines the lack of clarity and agreement as to exactly what FII is (Lazenbatt, 2013; Davis *et al.*, 2019), stating for example ‘The varied terminology currently used reflects uncertainty as to whether the definition should focus on parental behaviour or motivation, or on the harm to the child’ (Davis *et al.*, 2019, p. 111) and ‘The growing body of literature on FII reflects the lack of clarity amongst professionals as to what constitutes FII’ (Lazenbatt, 2013, p. 61).

Despite the lack of professional consensus, the RCPCH has published new guidelines around FII, which incorporate ‘PP’ as a precursor to FII (RCPCH, 2021). A recent publication from Glaser and Davis (2019) argues for the management of PPs/FII, and outlines much of the guidance now incorporated into the 2021 RCPCH revised guidelines. Glaser and Davis (2019) describe PP as ‘where a child is reported to have symptoms or disabilities that impact significantly on their everyday functioning and yet thorough medical evaluation has not revealed an adequate and realistic medical explanation’ (p. 7). They suggest that PP may progress to FII, and that early intervention ‘may reduce the potential for iatrogenic harm ... and may reduce the need for safeguarding interventions’ (Glaser and Davis, 2019, p. 7). Thus, there is the addition of further untested constructs in the form of PP, with these being presented as the early stages of what could become FII if professionals do not intervene.

Glaser and Davis (2019) outline a number of ‘alerting signs’ and detail a number of responses that professionals should make when faced with these signs. These alerting signs and the concept of PP in relation to FII, coupled with RCPCH guidelines, have been the basis of many Local Authority Social Care policies. The authors go on to state ‘While the alerting signs have been widely disseminated, they have not been tested prospectively for specificity and sensitivity’ (p. 10), and in reference to the proposed management of PP and FII state ‘the extent to which this can prevent harm to children, or progression to more damaging FII, remains untested systematically’ (p. 10).

These two statements should raise substantial concern amongst professionals, since evidence-based practice and policies are the ‘gold-standard’ for medicine and social work, and yet what Glaser and Davis (2019) are stating is that they have published and circulated alerting signs and proposed interventions despite there being no research conducted to establish whether these alerting signs really do accurately identify those at risk for FII, and despite no systematic assessment as to whether the proposed interventions have any success in reducing child abuse.

The problem with trying to predict ‘risk’

Whilst there is of course a need to identify children who are being harmed, the practice of casting a wide net in order to capture every true case of FII unfortunately brings with it a high potential for false positives. That is, when we strive for the best sensitivity, it is usually at the expense of specificity.

Statistically speaking there are significant issues around high numbers of false-positive cases when using ‘risk criteria’ to identify what is a rare occurrence within the population. Literature over the years has identified prevalence for ‘broader’ criteria of MSbP and FDIoA ranging from 0.4 in 100,000 to 2.8 in 100,000 (e.g. Bass and Glaser, 2014), but those which involved intentional induction or which led to death of the child being extremely rare.

Based on the 2020 UK population data, there are around 13,397,869 children under eighteen years in the UK. Using the prevalence rates above, we would expect between 53.59 and 375.14 true cases of MSbP or FDIoA. This is where sensitivity and specificity of risk criteria for identification of cases is important. Let us imagine that Glaser and Davis’s ‘alerting signs’ are superbly accurate and that they correctly identify true cases ten times out of ten (sensitivity of 100 per cent), and accurately reject non-cases nine times out of ten (specificity 90 per cent). Whilst the alerting signs would successfully identify the 53–375 true cases, they would simultaneously provide 1,339,789 false positives if applied to the child population as a whole. Of course, proponents of FII

may argue that the prevalence is greater than the 2.8 in 100,000 top end reported in the literature, but since there is no up-to-date epidemiology this simply cannot be known. Even if the prevalence is ten times what has been reported in the literature for FDIoA, we would still be looking at a contrast of 3,750 true cases of FII versus the 1,339,789 possible false positives—and that is assuming 100 per cent sensitivity and 90 per cent specificity. Unfortunately, given the alerting signs outlined it is highly likely that there would be substantially more than only 10 per cent false positives.

The reality of the ‘risk criteria’ approach to identification of cases of child abuse generally has been beautifully demonstrated by Lauren Devine (2016). She presented the accuracy levels of a risk prediction exercise exploring cases of child abuse in 10,000 children. The findings demonstrated that the risk predictors had over 97 per cent false positive rate—i.e. of the 1,228 predicted cases, 1,195 had no abuse occurring—whilst simultaneously missing 17.5 per cent of the forty true cases—of the 8,772 not predicted to be abuse cases, seven actually were abuse cases.

It is vital that there is a serious consideration of the balance between sensitivity and specificity, and the impact and implications of this, particularly when dealing with rare occurrences. Families who have been investigated—erroneously—for FII, report extremely high levels of trauma, distress, family breakdown and similar as a direct result of being viewed as possible perpetrators of child abuse.

If it were the case that being a false positive brought with it no harmful or negative consequences, then perhaps we could argue that the potential for very high numbers of false positives to identify the relatively rare true cases of FII would not be a problem. Unfortunately, that is not what is being reported from families.

When we then consider that the broader criteria included within FII—and outlined in the RCPCH (2021) updated guidance—go beyond intentional fabrication or induction of illness, and include erroneous reporting (even if unintentional), mistaken beliefs and anxiety-driven help-seeking behaviours, all without intention to deceive, this has additional implications. For example, Davis and Glaser outline a potential ‘starting point’ for FII as ‘erroneous beliefs, extreme anxiety and concern about the child’s state of health’, leading to ‘inadvertent’ child abuse (Davis *et al.*, 2019, p. 111). These broader criteria are treated as if equally significant to intentional fabrication or induction of illness, with literature using the terminology of ‘perpetrators’ of FII, and authors arguing that it is the end-state—the purported abuse of the child, whether intended or unintended—which matters, and not the motivations or behaviours of the parent (e.g. Davis *et al.*, 2019).

However, the RCPCH provides no scientific evidence to support the argument that anxiety-driven help-seeking behaviour is ‘abusive’ or

causes psychological or emotional harm to the child. What is being suggested is that being taken to numerous professionals for investigations into possible health issues is, by definition, harmful to the child and a form of emotional abuse. However, it is harmful only if the child has no identified medical cause for the reported symptoms—i.e. because it encourages a ‘sick role’ which is argued to be emotionally damaging. This is an odd stance—either taking a child for multiple investigations is harmful or it is not. It is a little like saying that corporal punishment is only harmful if given to a child who had not misbehaved, but it is fine to apply it to children who have misbehaved because there was a reason to do it—something which we are certain few professionals, if any, would agree with.

In contrast, there is a wealth of scientific literature outlining the psychological and emotional harm caused to a child as a result of separation from the parents, even if temporarily (e.g. [Hawk and McCall, 2010](#); [Paccione-Dyszlewski, 2018](#); [Skelton, 2019](#)). And whilst not every case of FII results in removal from parents, the emotional and psychological trauma to the families of being ‘investigated’ and viewed through the lens of ‘child abuse’ is widely reported in the media and elsewhere (see e.g. <https://childprotectionresource.online/fabricated-and-induced-illness/>):

After 16 years of successful parenting, without any Social Services involvement, my family was suddenly ambushed by two Social Workers, during a national pandemic, when our children needed us the most. The Social Workers informed us they had received a referral from Health in March, and since then two strategic meetings had been held. A decision was made to escalate the referral to Child Protection. We were informed we would be required to attend a Child Protection Conference within 15 days of their visit. The Social Workers, in our opinion, were dismissive, did not appear to listen to us, and we felt constantly challenged by them. Our son already had an Education, Health and Care Plan as he has additional needs and yet we were being accused of Fabricated or Induced Illness (FII), despite his Paediatrician and Occupational Therapist providing very detailed information to Social Services about his complex needs. Social Workers failed to cross-reference evidence we had provided although they reassured us that they wanted copies of our documents for that purpose. The first report prepared for the Child Protection Conference was full of false information, which had been edited to suit their desired goal. After seeking legal advice, we insisted on a meeting with senior staff, where they started to assimilate the evidence which discredited any notion of FII. Consequently, the Child Protection proceedings stopped. The more layers we peeled back through diligent investigative work, the more frighteningly alarming the inaccuracies were becoming ... it was not just inaccuracies, it was purposely fabricated to build a case. The irony! Families should be able to trust that ‘professionals’ have genuine intentions towards them and their children but, instead they are committing systematic abuse causing an

immense amount of trauma to families who are already under significant pressure ... Their actions could be catastrophic!

I am a former teacher and parent of 3 children with special educational needs and health difficulties. It took years to reach the diagnoses for my eldest – joint Hypermobility syndrome (HMS), Ehlers Danlos syndrome (EDS), Postural Orthostatic Tachycardia syndrome (POTS), Attention Deficit Hyperactivity Disorder (ADHD), Autism traits causing severe sensory processing difficulties, Dyslexia and visual stress/Irlens syndrome. My middle son struggled with the transition to high school, due to ADHD and Dyslexia, resulting in school refusal. The real problems of FII began when my youngest developed similar symptoms to his older brother, and he was subsequently diagnosed with joint HMS. The Head Teacher disputed these medical diagnoses and refused to meet me to discuss a support plan. In a telephone conversation, the Head thought I was ‘projecting illness from my older children to my youngest because of my need for my children to have health and SEN difficulties, and obviously gained something from it’. Two months later she reported her concerns to the local authority. Initially, the Social Worker was supportive and agreed my son needed a support plan to facilitate his return to school. No concerns of FII were reported by my children’s consultants’ and General Practitioner, but then one community Paediatrician said she was suspicious of me as my middle child was not recovering from Chronic Fatigue Syndrome (CFS). A Child Protection Conference was held for my 2 youngest children. I was accused of FII. The safeguarding doctor said I knew too much about health, due to my claims of being a Nurse, even though he eventually admitted he had mixed me up with someone else. I was also accused of isolating my children from society to home educate them. Each school reported my children were “Fine in school” but my youngest son stated, ‘I am frightened at school, get hurt by children who are mean to me. I feel poorly, my tummy, my legs, and my head hurts. I get told off if I am late and I never want to go back’. There was a further year of FII investigations where it became evident that few professionals understood the comorbidity of my children’s conditions. All could have been explained if I had been given the chance to explain, and if the medical notes had actually been read ... I was finally cleared of the allegations of FII. I am mystified as there was no accountability for the school. Social Workers chose to believe the word of a Head Teacher and failed to adequately investigate our case.

The RCPCH has updated their guidance on FII such that the 2021 guidance now advises that FII allegations should not be raised solely from education and must be supported by health professionals, which may go some way to lessen examples such as the second outlined above, but the fact remains that the alerting signs around PP and FII are untested, broad, and—due to the simple statistical reality of how sensitivity and specificity works when a presentation is rare but the population being targeted is large—likely to lead to far more false positives

than true cases. When we consider the number of likely false positives, this ‘alerting signs’ approach has the potential to cause emotional and psychological damage to over 1,000,000 children and families in the UK in order to protect a few hundred true cases.

One may of course argue that PPs are not observed in the whole population, and that therefore the potential false-positive figures outlined above are extreme. However, as has previously been stated, the RCPCH confirms they have no specificity and sensitivity information at all on PP or the alerting signs. Furthermore, there are grave concerns that particular parent groups—e.g. parents of autistic children, autistic parents, anxious parents, parents of children with complex or rare presentations—are immediately discriminated against in terms of the likelihood that they would meet several of those ‘alerting signs’. This is further compounded by the RCPCH claims that ‘common’ presentations indicative of FII include such conditions as autism and Ehlers–Danlos syndrome. Bass and Glaser (2014) explicitly cite autism as a potential fabricated or induced illness, yet the single paper which they reference that explores autism in relation to MSbP (McNicholas *et al.*, 2000) actually identified that of the three case families who were being investigated for MSbP after telling professionals that they believed their child to be autistic, two children were genuinely autistic, a fact that non-specialist professionals had failed to identify, and the remaining child presented with emotional and behavioural difficulties. The authors urge caution about assuming MSbP, the polar opposite of what Bass and Glaser (2014) suggest. McNicholas *et al.* state in their paper ‘inaccurate diagnosis of MSbP may have devastating consequences for the child, family and professionals involved’ (p. 69), that ‘it is equally important not to make a diagnosis of MSbP when it does not exist. We suggest that this may result from: (i) Failing to recognise developmental disorders in children, particularly if the presentation is mild; (ii) Attributing incorrect motives to the parent; (iii) Failure to assess the child adequately in multiple situations; (iv) Failing to consider the impact of both parenting abilities and parent mental health on the style of presentation of problems; (v) Failing to take cultural factors into account and a family’s expectation of health care delivery (Amirali *et al.*, 1998); or (vi) by being unduly influenced by the biases of other professionals who may have previously been dealing with the case’ (pp. 70–71), that ‘The distinction needs to be made between exaggerated symptoms and fabricated ones. The former may stem from anxiety by the parent, a defence against continuously being unheard or disbelieved, and a poor sense of what is developmentally appropriate. *Exaggeration does not equate with fabrication* (emphasis in original) (p. 74), adding ‘The fact that some of these children functioned much better in an environment other than home, typically the school environment, should not lead the professional to equate this with maternally induced and fabricated symptoms’ (p. 74), and ‘Parents caring for

chronically ill children by necessity become well informed on medical matters, may be overprotective, even ‘symbiosed’ with the child, may fight for investigations and treatments in an authoritative fashion, and may become socially isolated’ (p. 75). Thus, some nineteen years prior to Glaser and Davis’s (2019) paper on PP and FII on which the current RCPCH updated guidelines (2021) are based, McNicholas *et al.* (2000) were trying to highlight the risks to families of inappropriate assumptions based on lack of professional expertise in neurodevelopmental presentations. Davis *et al.* (2019) explicitly state in relation to FII that ‘these beliefs... may be associated with a carer’s autism spectrum disorder’ (p. 111), using as their evidence reference to the aforementioned Bass and Glaser (2014) paper that inaccurately presents the work of McNicholas *et al.* (2000). That is, they misinterpret the entire tenet of the McNicholas *et al.* (2000) paper, and then use that one paper as their evidence base for autism being linked with FII.

In fact, a thorough search of the evidence base and literature relating to autism and possible links with MSbP, FDIoA or FII by the first author failed to identify a single article demonstrating any such association. In personal communication with the first author, Dr Glaser stated that the assumed association was based on *anecdotal reporting* of autism in cases by Dr Bass. Since the 2014 paper, Dr Bass has co-authored an article with the first author which categorically outlines the need for caution in assuming FII where a parent may present with undiagnosed autism, particularly in instances where a child has a known autism spectrum condition (Gullon-Scott and Bass, 2018)—something of a shift in perspective.

There are currently no data that we are aware of on the ratio of families/parents investigated for possible FII and those where FII is confirmed, but the suspicion is that far more families are being investigated than are actually true cases. An informal survey conducted in 2019 by the charity Flightback, which supports families where FII has been suggested by professionals, found that in families where both parent and child were autistic, 22.5 per cent of children had been removed into foster care, and in families where the child was autistic, and not the parents, 16 per cent had been removed into foster care.

Autism spectrum conditions have a prevalence rate of around 1.1 in 100. If autism is considered an ‘alerting sign’ for FII, and we take our previous generous specificity rate of 90% to those alerting signs, then 10 in every 100 families with an autistic child will be inaccurately believed to be a case of FII—they will be false positives. There are believed to be at least 695,000 autistic people in the UK—a widely cited estimate based on recent prevalence studies indicating 1.1 per cent adults (Brugha *et al.*, 2012) and 1.76 per cent children (Roman-Urrestarazu *et al.*, 2021) are autistic. On the above numbers if every family with an autistic child or parent were to be considered against the RCPCH

(2021) alerting signs at least 69,500 of these families would be potential false positive FII cases. One might be forgiven for thinking that these figures cannot bear any resemblance to reality, but the evidence base sadly tells us otherwise.

What is the evidence around child protection involvement for autistic or developmentally disabled families?

Pohl *et al.* (2016) reported that one in five mothers of an autistic child had been investigated by Social Services, and of those mothers one in six had their children removed into foster care or placed for adoption. A study by Griffiths *et al.* (2019) of 426 autistic adults (verbally fluent, no learning disabilities, living in the community) identified that 19 per cent had had an educational, medical or social work professional question their ability to look after their child, 14 per cent had been referred to Social Services because of assumptions that they could not parent their child, 9 per cent had become subject to child protection investigations (equating to 62,550 families if generalised to national rates) and 4 per cent had lost custody of their child as a result of professionals believing that they could not parent appropriately (equating to a national rate of 27,800). These figures are strikingly similar to the literature reflecting the bias against parents with intellectual and developmental difficulties (IDDs) more broadly in the child protection arena (e.g. McConnell and Llewellyn, 2002; LaLiberte *et al.*, 2017).

LaLiberte *et al.* (2017) conducted a longitudinal population analysis in the USA of over 303,000 people and identified that parents with IDD—intellectual and developmental disabilities including autism—were over-represented in the CPS at all stages, and that this was ‘likely a combination of both an un-prepared, and biased, system’ (p. 528). They state ‘Overall, this study provides suggestive evidence that there is a pattern of increased disparity for parents with IDD throughout the life of their CPS case as compared to parents without disability. Because the disparity begins prior to or at the beginning of the CPS process, the disparity is presumably about bias (Hayman, 1990; Glaun and Brown, 1999; Swain and Cameron, 2003; Lightfoot *et al.*, 2010; Proctor and Azar, 2013) and prejudice (Aunos and Feldman, 2002; Willems *et al.*, 2007; Proctor and Azar, 2013; Lewis *et al.*, 2015) that exist within society and the CPS system’ and ‘This disparity may also be reinforced by the presence of policies that work against parents with IDD (Collentine, 2005; Lightfoot *et al.*, 2010; Watkins, 1995) or absence of policies that serve to support the role of parents with IDD (National Council on Disability, 2012)’ (pp. 528–29).

McConnell and Llewellyn (2002) reviewed international research from USA, Australia, UK and Europe around parents with IDD in the child

protection system, and state ‘In this review, we identified disturbing findings that have a dramatic impact on the lives of parents with intellectual disability and their children’ (p. 310) outlining ‘The non-specificity of child protection statutes and the broad discretionary powers of child protection authorities can encourage liberal interpretation based on judgements not substantiated by appropriate evidence’ (p. 307). They also highlight how in most cases ‘where allegations of neglect or abuse were substantiated, the parent-child relationship was severed before any support services were offered or provided’ (p. 302).

The current guidelines and literature around FII and PP seem to not only be ignorant of the vast literature about bias in the child protection system against families who have developmental differences, but to perpetuate the argument that parent or carer motivations towards their child are irrelevant, and all that matters is the (purported, but not evidenced) emotional or psychological abuse to the child. It is vital that Social Workers maintain their focus on the needs of the child when making decisions critical about their lives, but equally it is important to recognise the wider needs of the family, to enable them to maintain good enough parenting and support. As outlined in Government safeguarding literature, ‘A high quality assessment is one in which evidence is built and revised throughout the process and takes account of family history and the child’s experience of cumulative abuse’ (HM Government, 2018, pp. 28–29) and thus ignoring potential parent motivations or alternative explanations for the observed behaviours can and does lead to failure to identify how to best support the family.

Whilst Glaser and Davis (2019) and the RCPC (2021) guidelines do posit a route with families when PP has been identified of ‘explanation’ and ‘rehabilitation’, what this does not take into account is (1) the possibility that the parents may in fact be correct about their child, and the professionals involved simply do not have the expertise to identify the issue (as per McNicholas *et al.*, 2000) or (2) that the ‘explanation’ and ‘rehabilitation’ relies on convincing the parent that the child’s symptoms are in effect purely psychological, and requiring the parent to accept this without question and consent to following professional guidance. Glaser and Davis (2019) state ‘It will be necessary to follow up the child to ensure that the progress gained in the rehabilitation is sustained and the difficulties...do not recur’ (p. 9)—implying that any deterioration or continuation of symptoms is down to parents failing to rehabilitate, rather than a true but, as yet, unrecognised condition in the child.

Given the ‘alerting signs’ include:

- symptoms not observed independently in their reported context (it is incredibly common for autistic children without a learning disability to contain externalising behaviours in the school setting and then ‘meltdown’ at home, and ‘masking’ of features is a widely acknowledged issue with female presentations in particular,

thus failure to see features during brief observations, or in school settings, is by no means contrary to being autistic);

- symptoms not explained by the child's known medical condition (which assumes that all conditions have been successfully identified, which in the case of complex neurodevelopmental or rare conditions is rarely true without expert detailed assessment, or assumes that professionals are all 'expert' in the various possible associated issues that can present);
- repeated reporting of new symptoms (the anxious, or autistic or concerned parent is highly likely to want to check out any behaviours or symptoms of concern—as highlighted by [McNicholas et al., 2000](#). This is not abnormal parenting); and
- frequent presentation, seeking opinions from multiple doctors (see above, and additionally consider any potential intense focus and need for facts and concrete information in an autistic parent—see e.g. [Gullon-Scott and Bass \(2018\)](#), descriptions of common autistic behaviours and how they can present in this way).

This means that there is a real risk of bias against certain families and parenting styles, consistent with what is reported in the literature on child protection policies and processes in general.

In the [Davis et al. \(2019\)](#) paper they cite two starting points for FII, both of which are stated as 'necessary but not sufficient' for FII to occur. The first is that the child is being used to fulfil the carer's needs, which may include unmet emotional needs for attention, financial or material gain, deflecting blame, maintaining closeness to the child or negativity towards the child which can be justified by evidence of a disorder in the child. The second is the carer having erroneous beliefs, and extreme anxiety and concern about the child's health 'to the detriment of the child'. The present authors' personal experience (over twenty-five-years specialism) of autistic parents, and parents of autistic children, is that the first of these is rarely if ever the case. Parental anxiety and concern is never to do with unmet emotional needs, or any of the other cited possibilities. However, it can easily be misconstrued in this way by professionals who do not have expertise in the field. In relation to the second point, sometimes parental anxiety does lead to erroneous beliefs, but the part which troubles here is around who decides that this is 'to the detriment of the child'? What does this mean? How does it look?

[Davis et al. \(2019\)](#) argue a stance of 'equifinality—a given end state that can be reached by many potential means' (p. 111) with the belief of emotional and psychological harm to the child—and in rare cases, physical harm or death. This is an exceptionally unusual approach in medical or psychological spheres, since the primary aim of both medicine and psychology is to understand—and therefore treat—the underlying cause, because the same or similar symptoms might reflect a multitude of

different causalities. As an example, let us imagine someone has insomnia. This may be a result of anxiety or depression, it may be because they drink caffeine late at night, it may be because they have a poor mattress, it may be because their room is too cold or too hot or too noisy and so on. Without knowing the underlying cause, it is impossible to relieve the insomnia. Let us now imagine that the professional investigating is an expert in mental health and views the situation through that lens alone. He or she may prescribe all kinds of interventions for anxiety or depression. If they do not work, the assumption may be that the individual is not adhering to treatment, or even possibly that they are fabricating the insomnia. Had the professional asked about caffeine intake, or room temperature, then the cause may have been identified and the insomnia alleviated.

To take an admittedly poorly defined concept such as FII, add to it additional concepts (PP) which have no evidence base and have not been tested, provide ‘alerting signs’ which ‘may’ indicate ‘possible’ FII and ‘possible’ child abuse, and then argue that it is irrelevant why a parent may meet those alerting signs or poorly defined criteria because the end result—the alleged child abuse for which there is no literature base or up-to-date epidemiology—is all that matters, and thus lead to some families inappropriately having their children removed, and many others experiencing the psychological and emotional trauma of being investigated as potential child abusers, is truly astonishing.

Concluding comments

FDIoA exists. This is not in dispute. It is a formal diagnosis of a psychiatric condition in the parent, recognised in DSM-5 ([American Psychiatric Association, 2013](#)). There are genuine cases of parents or carers who intentionally fabricate or induce illness in their child for their own gain. FDIoA has a literature and evidence base, and the prevalence is rare. FDIoA excludes from diagnosis parents where an alternative explanation for their behaviour—such as anxiety, other mental health presentations or autism—is apparent. FDIoA requires deception. FDIoA focuses on the reason for the behaviour, not the end result.

In contrast, FII is not a diagnosis, lacks clarity, has no current evidence base, and has not been tested for sensitivity and specificity. The guidelines around FII and PP have broadened the concept of abusive behaviour to scoop up anything that leads to a parent presenting frequently to professionals with concerns about their child and where the professionals are unable to identify a cause (note, this is not the same as saying there is no cause—and yet FII assumes it is). FII does not require deception, and actively includes anxious and concerned parents. FII and PP actively suggest that autism, Ehlers-Danlos

syndrome, chronic fatigue syndrome, gastro-intestinal difficulties, gait disturbance and similar may be alerting signs in the child or a factor in the parent (without any evidence basis), and therefore immediately have bias against these parents. FII focuses on outcome and ignores the reason for the behaviour.

It is understandable, given the mixed messages around FII, how Social Workers may mistakenly believe FII to be a diagnosis, and equating to MSbP or FDIoA. The vague guidelines which fail to take into account the complexities of parents supporting children with additional needs, adds further distress to these families as they are accused of being ‘perpetrators’ of ‘abuse’, terms which have alarming connotations, with little or no evidence to substantiate these claims. FDIoA is a rare psychiatric diagnosis, with an estimated prevalence of only two cases per 100,000 ([American Psychiatric Association, 2013](#)), and yet the prevalence of parents being investigated for FII is very much on the increase across the UK. All social work practice must be underpinned by an intrinsic commitment to anti-oppressive and anti-discriminatory practice. Having an enquiring mind and an open approach to understanding the possible differences a child (and parent) is presenting is necessary, rather than assuming FII and collating evidence to support this supposition. This latter approach often results in the coercive power of social workers—the ability to apply punishment or sanctions—which is immensely oppressive and fear-inducing for families within the Child Protection arena. Social workers need to ensure they use the power they have in a responsible manner, whereby they enable individuals to feel supported and valued, whilst retaining and ensuring the child remains at the heart of any decisions being made. The emphasis must be on transparency of practice, with all individuals working together to improve outcomes for the child, as opposed to vilifying their parents/caregivers when FII is suspected. We hope that through this exploration of the evidence around FII we can empower social workers to feel able to carefully consider all information when presented with the possibility of FII, supporting them to be able to act in line with the values and ethical principles of their profession.

Acknowledgements

We wish to thank the parents who spoke with us regarding their experiences of the CPS, local authorities, and Social Services, and who shared their personal and often traumatic stories.

Conflicts of Interest

Authors are both contributors to forthcoming BASW guidance on FII.

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