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Fabricated and Induced Illness

Part of the Success in Social Work Series

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Identifying FII

Dr Fiona Gullon-Scott
Consultant Clinical Psychologist

What exactly IS Fabricated Induced Illness?

- Presented as synonymous to MSbP, but is NOT a formal diagnosis.
- NOT the same as DSM-5 Factitious Disorder Imposed on Another (e.g., does not require intent to deceive).
- Lacks clarity or agreement - '*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, pp 111) and '*The growing body of literature on FII reflects the lack of clarity amongst professionals as to what constitutes FII*' (Lazenbatt, 2012, pp 61).

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How common is FII?

- There is no epidemiology for FII, only MSbP or FDIoA.
- Literature on MSbP suggests prevalence ranging from 0.4 in 100,000 to 2.8 in 100,000 if use ‘broader’ criteria.
- There are around 12,540,000 children under 16 in the UK. Therefore we would expect between 50 and 351 ‘true’ cases of MSbP in the UK.

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Using ‘Risk’ Criteria to Identify Cases

- There is an inherent problem with using risk to identify cases of a low prevalence condition.
- This is compounded further if the ‘risk’ indicators or ‘alerting signs’ overlap with other more common conditions.
- The Sensitivity and Specificity of the risk indicators are hugely important, and impact on the number of ‘false positive’ cases compared to ‘true positive’ cases.

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Imagine the ‘risk indicators/alerting signs’ have 100% sensitivity, and 90% specificity:

- They successfully identify all 350 ‘true’ cases of MSbP
- They inaccurately classify 1,254,000 ‘false’ positives - children who are NOT cases of MSbP, but who met the risk criteria.

Risk criteria have been shown to be poor indicators. Devine (2016) presented a risk prediction exercise on 10,000 children, exploring child abuse.

Risk predictors had a 97% false positive rate, and also missed 17.5% of true cases of child abuse.

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‘Broader’ criteria and ‘alerting signs’ for FII include:

- Erroneous beliefs, possibly driven by anxiety
- Extreme anxiety about the child’s health ‘to the detriment of the child’
- Frequent health-seeking behavior
- Symptoms not observed independently
- Reporting of new symptoms
- Claims of ‘rare’ conditions such as Ehlers-Danlos or Autism Spectrum Disorder in the child

Davis et al., (2019)

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Consider Autism:

- Prevalence at least 1 in 100
- Around 125,400 autistic children in the UK
- If 10% were to be ‘false positives’ of FII, this would mean the families of 12,540 autistic children falsely considered FII cases.

- Pohl et al (2016) reported 1 in 5 mothers of a child with autism had been investigated by social services.
- Griffiths et al (2019) identified that 19% of intellectually able autistic adults who were parents had professionals question their ability to parent, 14% had been investigated by social services, 9% had been put through CP investigation, and 4% lost custody of their children.

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- FII argues ‘equifinality’ – the belief that taking a child for multiple health investigations is inherently emotionally abusive, and that the reason why a parent does so is not relevant.
- FII lacks clarity, has no evidence base, is poorly defined, and actively includes anxious and concerned parents. It is not a diagnosis.
- FDIoA *does* exist, but is RARE. It is a formal psychiatric diagnosis. It *requires* intent to deceive. It requires no other explanation for the behavior (ie., it *excludes anxious parenting*).
- Care must be taken to balance desire to find true positive cases, against the risk of high numbers of false positive cases, and the damage that false FII accusations bring to families.

Conclusion?

It is FAR MORE LIKELY that a child has a complex condition that is difficult to identify or diagnose, than a family is Fabricating or Inducing Illness.

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The World of ‘Hidden Disabilities’

Sally Russell OBE, FRSA

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Changing understanding

- Multi-systemic conditions and neurodevelopmental conditions are common
- Research is developing quickly and stereotypes aren’t helpful
- Difficulty of single diagnosis assessments
- Inherent complexity for an individual or a family often isn’t understood holistically

An example: Pathological Demand Avoidance

- Originally thought controversial, now all leaders in the field agree that there is an ‘identifiable cluster of symptoms
- Best understood as a profile of autism, but individuals *appear* more socially at ease
- Key feature is that ‘demands’ cause intense anxiety and have to be ‘avoided’

> *Demands include what you ‘ought to do’, and because you ‘ought to’ you can’t.*
> *It can affect the ability to eat, dress, wash, go to a dance class, and affects all ages.*
> *It can create the feeling of a need to control much of what happens in the household.*
> *A young person can become either very dependent or completely shun their parents.*

- The usual parenting techniques don’t work – routine, rewards, choices and consequences. Instead you have to negotiate, be indirect and flexible.
- 7 in 10 aren’t able to cope with a school setting, so are home schooled or refusing.

Imagine…

- Meet a chatty, friendly young person, who appears to like school, misses her friends, but says she can't go, and won't say much more
- On the few days she is there, teachers can't see anything amiss. Doesn't do homework and doesn't concentrate,but appears happy.
- Mother has made a complaint that her request for an ASD diagnosis hasn't been accepted, and the parenting course hasn't helped
- Mum says the child isn't eating enough, is explosively violent, attacks her other child and she is desperate for support, requesting an EHCP and a social needs assessment

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Conditions run in families

…so the mother herself is more than likely to have traits that cause professionals to make assumptions

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PDA Society experience

We regularly support families who are suspected of abuse – some whose children have been put on the at risk register, and some who are being investigated for FII.

Once a suspicion has been raised it can be impossible to go backwards to properly work in partnership. The impacts can be devastating.

PDA is just one example of a condition that can be perplexing for parents and professionals alike.

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Child abuse?

- If there's a sign of a neurodevelopmental condition (special needs) or a perplexing case involving multiple and changing symptoms, be alert to FII, but expect that the difficulties relate to the impacts of neurological or physiological differences within the family, both parents and child.
- It may be that parenting doesn't appear typical, but it may be most appropriate or all that is possible within the family
- A parental excess of concern and desperation for support, or for understanding and acceptance, does not equate to abuse of a child.
- It is our hope that social workers will drill down, look at the specifics of needs, and think about how working with the family can best succeed.

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Women with Autism and how they will often tick the boxes for a FII presentation

Dr Judy Eaton

Independent Clinical Psychologist

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Autistic Parents

- Many individuals remain undiagnosed. This is particularly true for females
- Being autistic continues to carry a degree of stigma (a neurotypical parenting approach is seen as ‘preferable’)
- Autistic mothers often ‘mask’ or hide their difficulties in order to avoid judgement about their parenting
- If an autistic person behaves ‘atypically’ they are often judged negatively by professionals, including those working in social care.

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Autistic mothers' concerns

- An (unpublished) MA thesis by Shona Davison (2018) which included a number of case studies from autistic mothers revealed that they all reported 'anxiety, difficulties in communicating, selective mutism and conflict' when interacting with social care professionals.
- The risk of losing their child was reported as a significant concern
- Many reported feeling 'scared and anxious' because of the perceived power dynamic
- This resulted in challenges for them in knowing how to approach professionals, how much information to give, what interventions to pursue

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- Autism Eye (2018a and 2018b) found that accusations of FII have increased – sometimes as a result of autistic parents seeking further support/assessments for their children
- It was reported that some professionals openly view parental autism as a ‘risk factor’
- However, seeking assessment/support (sometimes seeking multiple or repeated assessments) for a child can take the form of an autistic ‘special interest’ and pursuit of this can appear ‘intense’ or ‘obsessive’

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- This sense of frustration on the part of parents can lead to them either directly challenging the LA or making a formal complaint
- Autistic academic Luke Beardon has pointed out that if professionals have a better knowledge of how Autism presents, many of these difficulties can be avoided

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The Social Workers Role

Cathleen Long
Independent Social Worker

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Concerns of FII

- Concerns may be raised by professionals other than medical clinicians e.g. nursery staff, nurses or teachers.
- Professionals working with the child's parent(s) may note discrepancies between what the parent(s) say about the child's health and development and what they see themselves.
- In any case of suspected FII it is essential to carefully review the child's medical history and gather facts from various sources.

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Children's social care has lead responsibility for undertaking an initial assessment of a child in need, including circumstances where FII is suspected. Children's social care will conduct the initial assessment in conjunction with the doctor who has lead responsibility for the child's healthcare (usually a consultant paediatrician) and possibly other relevant agencies.

Safeguarding Children in whom illness is fabricated or induced – Supplementary guidance to Working Together to Safeguard Children – HM Government (p. 42. para. 4.20)

Assessment

‘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’

(Working Together to Safeguard Children, 2018, Pp. 28-29).

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- Child centred – keeping the child in focus when making decisions about their lives, but also recognising the wider needs of the family e.g. siblings.
- Consider hidden disabilities/differences of the child and parent.
- Work in partnership with families maintaining transparency of practice.
- Thoroughly assess discrepancies in presentations e.g. observe differences between home and school.

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'Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them and their families collaboratively when deciding how to support their needs. Special provision should be put in place to support dialogue with children who have communication difficulties …'
(Working Together to Safeguard Children, 2018, p. 9)

Listen to the views/needs of child - use visual aids, allow them time to process information, check their understanding. But equally, listen to the views/needs of the parent(s).

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- Analyse *all* information gathered from the assessment

- Don’t gather information to fit a picture of FII, maintain an open, unbiased perspective whilst always ensuring the child is protected from harm.

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Any Questions?