

Fabricated or Induced Illness and Perplexing Presentations

Abbreviated Practice Guide for Social Work Practitioners

Written by Cathleen Long, Dr Judy Eaton, Sally Russell OBE,
Dr Fiona Gullon-Scott, and Professor Andy Bilson



BASW

The professional association for
social work and social workers

INTRODUCTION

This practice guidance for social workers on Fabricated or Induced Illness (FII) and other perplexing presentations, has emerged from discussions with practitioners, academics and family members. The guide is intended to enable social workers and other practitioners to adopt professional curiosity and respond ethically to concerns about FII whilst ensuring safeguards are in place for children and young people at risk of harm. The guidance encourages social workers to work collaboratively and creatively with other agencies, whilst reflecting on their own knowledge, skills, autonomy and independence. Promoting social approaches and relationship-based practice, it also provides some examples of practical interventions social workers can take when responding to concerns regarding FII.



Social Work is about life, treasuring humanity, building connections, sharing, and promoting fairness ... A social worker should be someone to trust and someone to believe in – someone who helps you believe in yourself”.

Dr Ruth Allen, BASW Chief Executive

Recommendations for social work practitioners:

- Social workers need to exercise professional curiosity when a referral is made suggesting a child has a perplexing presentation or a Fabricated or Induced Illness (FII).
- Social workers need to be aware of the lack of evidence for currently used indicators for FII and perplexing presentations and the high incidence of these indicators identifying children where illness is neither fabricated or induced.
- Social workers need to be aware that the behaviour of autistic and neurodivergent parents and children is easily mistaken for FII as is the case in multisystemic conditions such as Myalgic Encephalomyelitis and Ehler’s Danlos Syndrome.
- Social workers need to understand that complex presentations in suspected FII can often be due to rare or misdiagnosed illnesses, so it is essential to work with parents/ caregivers and children to determine what support is required and to ensure specialists with knowledge of relevant conditions are involved.
- Social workers need to accept the potential for interprofessional differences about FII and be confident in their knowledge and skills to promote a social perspective.
- Social workers should use reflective supervision to support their own learning and confidence in FII, identifying the potential for their own biases and limitations in their understanding of different conditions/presentations.
- Social workers need to refer to the BASW Code of Ethics to ensure their practice aligns with the principles of human rights, social justice, and professional integrity.

Cover: Original artwork by Esther Whitney

SECTION 1: WHAT IS FABRICATED OR INDUCED ILLNESS AND PERPLEXING PRESENTATIONS AND WHY THIS IS RELEVANT TO SOCIAL WORK PRACTICE

When a child or young person is presented by their parents/caregivers with a condition which cannot be medically explained, it is deemed as a Perplexing Presentation (PP). PP is an alerting sign to possible Fabricated or Induced Illness (FII) which is described by the Royal College of Paediatrics and Child Health (RCPCH) as 'a clinical situation in which a child is, or very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health and neurodevelopment is impaired (or more impaired than it actually is)' (RCPCH, 2021, p. 11). FII is not in itself a diagnosis and more about professionals suspecting a parent is creating or exaggerating their child's difficulties, with no identifiable evidence to substantiate their existence. Often there is a misassumption by professionals that FII is the same as Factitious Disorder Imposed on Another (FDIOA), which is an extremely rare psychiatric diagnosis and used to be more commonly known as Munchausen Syndrome by Proxy (MSbP). The RCPCH suggests FII can cause emotional and physical abuse and can lead to neglect. The guidance proposes a spectrum from cases where the caregiver will often truly believe their perception of their child's difficulties, with no intention of deception. At the other end of the spectrum, caregivers will deliberately induce symptoms in their child.



However, the RCPCH itself recognises the lack of stringent evidence-based research for their proposed approach to FII, stating: *"In the absence of published evidence, we relied on extensive consultation and expert consensus"* (2021, p.6). Given their admission that their assertions are not founded on solid, indisputable evidence and the apparent need for an interprofessional consensus, it is notable that in the list of consultees who "agreed to be listed" (p.6), there is an absence of organisations representing key safeguarding bodies including social work, education, and the police. This is a particular omission as the guidance focuses on safeguarding issues and guidelines for making Education, Care and Health Plans (EHCPs) and which are areas of practice highly relevant to social workers' professional roles.

If social workers were to follow the RCPCH guidance, the proposed assessment criterion for FII is likely to cast suspicion on many families who are *not* harming their children, including children and young people with disabilities and illnesses that are undiagnosed, or where their presentations have been misunderstood and subsequently misdiagnosed. Therefore, within this guidance we are seeking to work with the knowledge we do have: that the prevalence of FII/FDIOA continues to be extremely rare, although we do not discount its existence. The authors acknowledge that the Medical and Social Models of each offer their own unique interpretation of the systemic context of a specific situation.

a) Medical Model

This perspective identifies difficulties within an individual such as a physical or mental illness, impairment, or personality which causes them to be in the position they are in. It utilises a diagnostic approach where, once an illness or condition has been identified by a doctor, this can be medically treated and potentially cured. There is an emphasis on a person's impairment, disability or mental health problem being a deviation from the norm and once it has been diagnosed, treatment options explored and prescribed. The extreme of the Medical Model leads to the person with the 'impairment' or 'disability' needing to be excluded or removed from society if they cannot fit in (Maclean & Harrison, 2015, pp. 59-60).

b) Social Model

A social perspective identifies an individual's difficulties as emanating from society or their environment, aiming to adopt a strengths rather than deficits approach. Diversity is recognised as an inherent aspect of the human condition and is to be celebrated and embraced, rather than treating a person's difference. It is often society that further compounds an individual's difference because disability and impairment is often perceived negatively leading to discrimination. The social model encourages individual and collective challenging of the stigma associated with the various labels attributed to people. It seeks to champion the expertise of each person, on the premise that only the person themselves knows what is best for them.

The social model realises that individuals who challenge services might have experienced the trauma of broken relationships, difficult social circumstances, and feelings of powerlessness (Maclean & Harrison, 2015, p. 60).

Having set out the context for FII and perplexing presentations, Section Two provides practice guidance for social work practitioners.

SECTION 2: PRACTICE GUIDANCE FOR SOCIAL WORK PRACTITIONERS

Due to an awareness of an increase in the prevalence of FII referrals made to social care, there is a need to ensure social workers have the relevant information to support how they screen referrals and, when necessary, to undertake unbiased, holistic assessments which do not immediately discriminate against and disempower children in need of social care support. Whereas we appreciate the need for social workers to be fully committed to responsibly safeguard all children from *any* harm, they also have a duty to ensure parents/caregivers are appropriately supported, rather than them being subjected to unnecessary child protection proceedings, when inappropriate and wrongful accusations of FII are made.



The following are statements made by parents about their experiences of accusations of FII:



“I’m a single autistic mum and have been fighting for some support for my little girl who is very much like me and masking in school ... and now she’s on a child protection plan as I am accused of making her difficulties up – I’m screwed”



“My son is six. He has PANS/PANDAS and when he has a flare up, I find his behaviour hard to manage. I complained about his paediatrician and now she’s accused me of FII ... Social Services have taken her seriously and I am terrified I will lose my son”



“My wife died of breast cancer, and I was on my own looking after my four-year-old son. I took him to see the doctor because he was listless, he kept being sick and said his tummy hurt. After presenting one too many times, our GP referred me to social services. Professionals all thought it was because his mum had died, and I was making things up because I was grieving. This all changed when he was rushed into hospital in agony and almost died because his bowel was twisted”.

This section gives guidance on ethical practice in this contested area, to ensure social workers are aware of their responsibility to uphold professional practice and to maintain the standards expected of a registered social worker.

Principles on which this guidance is based

As social workers, ethical awareness is fundamental to social work practice. The core principles which must underpin and guide all social work actions are laid out in the BASW Code of Ethics for Social Work (2021), which includes:

- **Human rights** – respecting the inherent worth and dignity of all people where social workers uphold and defend their physical, psychological, emotional, and spiritual wellbeing. This includes supporting self-determination and involving people in decisions which affect their lives. Everyone must be treated as a whole person and understood within the context of their family, community, society, and ecological environments.
- **Social justice** – an inherent aspect of social work practice is to proactively challenge and

oppose any form of discrimination on the grounds of ability, age, culture, gender, sexual orientation, marital status, appearance, political opinions, cultural heritage, physical differences, or spiritual beliefs. Social workers must respect diversity, and both individually and collectively challenge any matters which contribute to social exclusion, stigmatisation, or subjugation. Social workers should encourage people to reach informed decisions about their lives thus promoting their autonomy and independence unless this conflicts with the safety and rights of others.

- **Professional integrity** – social workers have a responsibility to respect and uphold the values and principles of the profession by acting in a reliable, honest, and trustworthy manner. Social workers should clearly explain their roles and avoid deceptive and manipulative practice which undermines people who use their services. (The British Association of Social Workers, 2021, pp. 6-8)

Responding to concerns about FII?

Social workers can be involved in situations where there is a concern relating to FII at a range of levels from early help or an initial referral, through to working with families where serious harm, caused by fabricating or inducing illness, has been confirmed in court. The steps necessary, where there are concerns about significant harm to a child, are laid out in statutory guidance in each of the UK's countries, and nothing within this document should be understood to contravene these legal duties. Where there are concerns about harm to a child, children's social care is responsible for leading a multidisciplinary assessment to decide on the appropriate course of action, in accordance with statutory responsibilities.

Nature of the concerns

The very broad definition of FII proposed by the RCPCH means that concerns are likely to cover a wide range of situations, and these are discussed in turn below. Each presentation must be dealt with on its merits, and in all situations parents and children need to be treated with dignity and, apart from exceptional circumstances, their views and participation is central to social work practice. It is important to remember that there is no evidence that the separate areas of concern detailed below are in any way connected, and there is no evidence for progression between them.

The nature of the concern will determine the type of intervention required and how speedily decisions need to be made. The different areas of concern and their implications for initial actions are broadly as follows:

Deliberate fabrication or induction of illness

In the very rare situations where there is concern about a carer deliberately inducing symptoms, particularly where concerns about poisoning or suffocation are raised, or where the concern is with carers interfering with treatments by over-dosing, not administering medication, or interfering with medical equipment such as infusion lines, then there is likely to be reasonable cause to suspect significant harm. In such situations, child protection procedures and investigations

involving the police must be considered. Where the concern comes from a credible source, a strategy discussion or the equivalent will need to be held to determine next steps. In this situation, a decision needs to be made as to when to inform the child and carer(s) about actions to be taken in order not to jeopardise a police investigation, or to potentially continue to place the child at risk of significant harm.

Fraudulent representation of a child as disabled

Where a concern has been raised that a carer is presenting their child as disabled with the intention of committing fraud, the police are expected to become involved to carry out a criminal investigation. In addition, the likelihood of serious harm to the child will need to be assessed, and a decision will be needed about when to inform carer(s) and child(ren) about actions to be taken and, as above, in order not to jeopardise a police investigation, or to place the child at risk of significant harm.

Requesting invasive treatments in dispute with medical professionals

There are some less prevalent situations where a child has multiple physical matters, sometimes combined with neurodevelopmental issues. In these types of rare situations where the concern is that a child is being harmed or likely to be harmed if an invasive treatment is undertaken, careful assessment and consideration of the action to be taken is needed. If the concern is raised by the doctors involved in the treatment, then the invasive treatment can be withheld, until the situation has been explored with carers and professionals, and a full assessment undertaken. The medical diagnosis is *not* the responsibility of the social worker, but the assessment undertaken by the practitioner, in these circumstances, needs to establish the nature of the dispute and to ensure the child's health situation has been fully assessed. It will be important to know whether there have been "significant disagreements between health professionals about any important aspects of the diagnosis and medical management of the child" (RCPCH, 2021, p. 26), even if there was a subsequent change of position, as this would be an important part of the explanation for the dispute. It is also important to check that specialists, with specific expertise in the health concerns of the child, have been involved in their diagnosis and that sufficient work has been carried out to rule out rare, undiagnosed medical conditions, misdiagnosed medical

conditions, or children who have uncommon presentations of diagnosed conditions. It is imperative to know if this is an area in which there can be divided medical opinions (such as in the case of PANS and PANDAS) and, if so, whether experts in these areas have been involved, ensuring that the right decisions are reached.

Other disagreements about diagnosis, treatment and plans with medical staff

These concerns cover a range of different situations. The lack of diagnostic criteria, or research into prognosis and treatment of FII, mean that there is a high likelihood that children referred for these reasons will be children with rare, undiagnosed medical conditions, misdiagnosed medical conditions, or children who have uncommon presentations of diagnosed conditions, rather than children whose parents are intentionally harming them. This area can include parents who are anxious about their child's health, in some cases due to their experience of previous illnesses, or who are struggling to get an accurate diagnosis, or parents who themselves are neurodivergent and may appear antagonistic or demanding, when the reality is they are intent on gaining an accurate assessment of their child's differences and needs. For these reasons, care must be taken to respond in a way which prevents harm caused by intervention, and to support families where a child has an illness or hidden disability. It is the role of social work to lead an assessment, with full participation of carers and children, to determine what support is needed for the family and to discover whether there is reasonable cause to suspect the child is suffering or is likely to suffer significant harm. Disputes about diagnosis or treatment plans will need to be carefully explored, by getting the views of all parties involved, including parents and children (depending on their age and stage of development).

Schools and non-medical bodies or individuals referring with concerns about FII

This area also covers a range of different circumstances which need to be carefully considered before assuming FII. For example, when assessing for Autism, the National Institute for Health and Care Excellence (NICE) Guidelines (2018) advise that to ensure a full and thorough assessment of a young person across context and time, information should be sought from third party informants such as schoolteachers or Special Educational Needs

Co-ordinators (SENCO's). The guidelines explicitly state, in section 1.2.2, that professionals should 'always take the parents', or carers' concerns and, if appropriate the child or young person's, concerns about behaviour or development seriously, *even if these are not shared by others'* (author emphasis). Section 1.2.3 urges individuals to be 'critical about their professional competence'. However, it can be the case that an assertion by a schoolteacher, or teaching assistant, that the child is 'fine in school' is taken as evidence that the parent is either overanxious or exaggerating the difficulties they experience once the child is home from school. Sadly, once this narrative has been accepted, it can, and does, lead to the child either being turned down for a comprehensive need's assessment, or the parent feeling they have no choice but to request a second (or third) opinion, until such time as they find a professional or team of professionals, who are sufficiently well-informed to see behind the 'mask'. There is a growing evidence base to support the concept of social 'camouflaging' in Autistic individuals (Hull et al., 2019; Cage & Troxell-Whitman, 2019), which is often motivated by a 'sense of alienation and threat' and an attempt to avoid social ostracization. It should not be used as evidence to suggest possible FII, particularly when the different communication approaches and needs of autistic parents are often misunderstood. These and similar issues apply to children with a range of other illnesses and diseases.

Issues to consider during assessment

Whilst a referral may express a concern about FII, the task of the assessment is twofold: a) to identify the very rare cases where parents may be fabricating or inducing their child's illness; and b) to ensure the child and family receive the assistance required to promote effective child development. The first task is difficult because there are no diagnostic criteria for FII. In addition, the indicators for FII proposed in the various guidance documents include behaviours that are common to parents whose children have a range of illnesses which are not being fabricated. The second task is difficult because adopting a safeguarding approach is likely to further alienate parents and children, many of whom will be already aware that they are being accused of harming their child.

Medical disputes/controversies/ developing knowledge

In August 2021, NICE paused finalising and publishing their draft guidance on ME/CFS because despite their assertion of adhering to their usual rigorous methodology and process to develop their document, they have declared they have not successfully produced a guideline that is supported by all (NICE, 2021a). The NICE draft guidance illustrates how the understanding of medical practitioners is often partial and can evolve particularly in areas where there are disputes within the medical profession. ME/CFS sufferers have often experienced disbelief by medical practitioners about the validity or reality of their condition (NICE, 2021b p. 55). These concerns are not limited to ME/CFS and are experienced by those with a range of diseases. For example, recent reports about responses to children with long Covid-19 show how parents and children are being disbelieved and categorised as FII (Munblit et al, 2021 p. 1): “The issue of not being believed is a common one, and the fear of being considered over-anxious and/ or Munchausen’s by proxy is very difficult.”

Medical disputes, controversies and developing knowledge are not limited to ME/CFS and are found in a range of illnesses including, but not limited to, Pathological Demand Avoidance (PDA), Ehlers Danlos Syndrome (EDS), Paediatric Acute-onset Neuropsychiatric Syndrome (PANS), Paediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal infections (PANDAS) and, according to recent reports, long Covid¹.

It is important, therefore, to assess whether the concern is linked to a medical dispute, controversial diagnosis, or an area where medical knowledge is still developing. In such cases it will be important that specialists coming from different perspectives on the presenting issues should be involved to offer opinions and provide understanding of likely symptoms.

Additionally, in instances where a parent asserts their child is autistic with PDA, and this is perceived as untrue and a potential safeguarding issue, professionals involved in the decision-making and subsequent assessment(s) must have specialist knowledge about these specific

presentations. Parents caught up in such disputes or controversies should be supported in finding the most effective care and assistance for their child.

Diagnosis

A key basis for FII is that children have symptoms that do not have a medical explanation or do not respond well to treatments. However, it is a relatively common occurrence in medicine that symptoms are medically unexplained because of the limitations of diagnostic science and practice.

In complex, chronic medical conditions affecting multiple body systems, such as ME/CFS but including many others, symptoms can vary over time and change unpredictably, affecting each person differently. Thus, the NICE guidance (p.21) states that “physical symptoms that do not fit a commonly recognised illness pattern” are not in themselves indicators of abuse.

It is not social work’s role to diagnose illness but an assessment of concerns about FII needs to ensure that appropriate specialists have been involved in the diagnostic process. Otherwise, there is a significant risk that the unresearched indicators of parental behaviour, used to identify FII, are being applied to understandable behaviour of a parent who is concerned that their child’s health problems are not being resolved. It is also important to explore whether there was a dispute between medical practitioners about the child’s diagnosis.

Also, in many cases where FII is a concern, the child already has a diagnosis of a condition. It is vital that specialists in the field of the child’s illness need to be involved, to ensure that the child’s symptoms are not misinterpreted as signs of abuse.

¹ Munblit et al (2021 p. 1) also identify a range of on-going symptoms that include tics and Tourette’s similar to PANDAS - another illness that is disputed in the UK though recognised in, for example, the USA.

ME/CFS NICE GUIDANCE AND SAFEGUARDING

The section on children's safeguarding highlights the need to:

Recognise that the following are not necessarily a sign of abuse or neglect in children and young people with confirmed or suspected ME/CFS:

- *physical symptoms that do not fit a commonly recognised illness pattern*
- *more than 1 child or family member having ME/CFS*
- *disagreeing with, declining or withdrawing from any part of their management plan, either by the child or young person or by their parents or carers on their behalf*
- *parents or carers acting as an advocate and communicating on behalf of the child or young person*
- *reduced or non-attendance at school.*
(NICE, 2021b, pp21-22)

The third bullet point directly challenges the RCPCH guidance which says that parents who disagree with or refuse to accept the proposed health and education rehabilitation plan are potentially causing their child significant harm and are indicators where consideration should be given to referring on to children's services for a child protection investigation. Similarly, the ME/CFS guidance in bullet point 4 recognises the requirement for parents to speak on behalf of the child in contrast to this being an alerting factor in the RCPCH guidance. The final bullet point shows the need to be careful in interpreting reduced attendance at school as an alerting sign.

Complaints and second opinions

Where parents are concerned for their child's health and treatments offered are ineffective, it is unsurprising that they will attempt to get further medical opinions, scour the internet for information and make complaints. Where there have been complaints or requests for further opinions, it is important to explore these sensitively with parents and the child (where appropriate).

The ME/CFS guidance also recognises that parents' and children's' negative experience of elements of the health and social care system may result in a breakdown of the therapeutic relationship, lack of trust and hesitation to engage further in health and social care services (p.5). This breakdown of trust may also lead to various responses by parents that may be misinterpreted as alerting signs, such as insisting on continued investigations, objection to communication between professionals, complaints, and not being able to accept reassurance.

Making complaints, requesting further opinions, refusing to share information, or disagreeing with a diagnosis, do not in themselves cause harm to children. However, some parents report that concerns about FII are raised in the context of them requesting more support for their child or when raising a complaint. It may be significant, therefore, that a concern is raised after a complaint has been lodged against an agency, or when a parent is applying for a child to have an Education, Health and Care Plan, or when they are appealing an existing one.

Disagreeing with or withdrawing from a treatment plan

The RCPCH guidance states that parents who disagree with or refuse to accept the health and education rehabilitation plan that they create whilst exploring 'Perplexing Presentations' are causing their child significant harm and should be referred to children's services for child protection investigation. This is directly challenged by the NICE guidance on ME/CFS (see box 1) which follows years in which Cognitive Behaviour Therapy (CBT) and Graded Exercise Therapy (GET) have been the recommended treatments for patients with ME/CFS, despite patients consistently reporting this approach does not reduce nor alleviate their symptoms – a situation that has been recognised in the new NICE Guidelines. Therefore, caution and an open mind must be

afforded when faced with parents and children referred because they disagree with health and education rehabilitation plans.

Harm caused by multiple assessments

The RCPCH guide says that one source of harm is that the “child undergoes repeated (unnecessary) medical appointments, examinations, investigations, procedures & treatments” (RCPCH 2021, p. 16). Concern that a parent was directly responsible for the child having unnecessary invasive treatments may have caused harm and this would need to be assessed. However, we can find no evidence base in the literature to support the stance that presenting a child to multiple professionals for assessment, or querying the possible existence of undiagnosed conditions, is harmful to the child. In cases of some diseases, the World Health Organisation acknowledges the problems in diagnosis, with children needing to see many specialists over several years to gain an accurate diagnosis of their condition. It is important as professionals that we understand why a caregiver is behaving in such a way, and to work with the family around this. It is also important that as professionals, social workers maintain a balanced, measured approach in their work, and do not, through implicit bias, assume child abuse, without clear evidence that the behaviour is indeed abusive or that the child is being significantly harmed.

Discrimination

Issues of discrimination arise in this area, particularly relating to the focus on mothers as the ones fabricating and inducing illness, and on the area of discrimination regarding disability. The RCPCH guidance says that mothers are nearly always the instigators of FII (2021, p.13). The basis for this claim is case studies of Munchausen’s Syndrome by Proxy (which is exceedingly rare and not the same as FII) and ‘clinical experience’ since there are no statistics nor research on the incidence of FII. The launch of the new guidelines was accompanied by headlines such as *Why are more and more mothers using Dr Google to convince medics that their children are ill to get attention?* (Nelson, 2021). This headline, whilst sensationalist, provides a crude representation

of the description of motivation and behaviour of mothers given by the RCPCH. The assertion that it is mothers who use internet search engines to ‘get attention’ is both demeaning and inaccurate. There is no doubt that over the past few years there has been a proliferation in the growth of social media support groups and individuals offering advice, support, and training in, what are seen as, complex and ‘perplexing’ presentations of conditions, including Autism and the Pathological Demand Avoidant (PDA) profile. However, part of the reason for this growth in mothers seeking information is, undoubtedly, the lack of understanding of and clarity about these conditions amongst some professionals. Alongside this sits the ever-increasing demand for diagnostic assessments that has grown exponentially over the last twenty years. Whilst official NHS data suggests that of the 2989 recorded diagnoses of Autism in Quarter 2 of 2020, 43% were carried out within 13 weeks of initial referral, this clinical picture varies considerably across the country, with some families waiting years for assessment.

SECTION 2: PRACTICE GUIDANCE FOR SOCIAL WORKERS

Stages of involvement

Referral

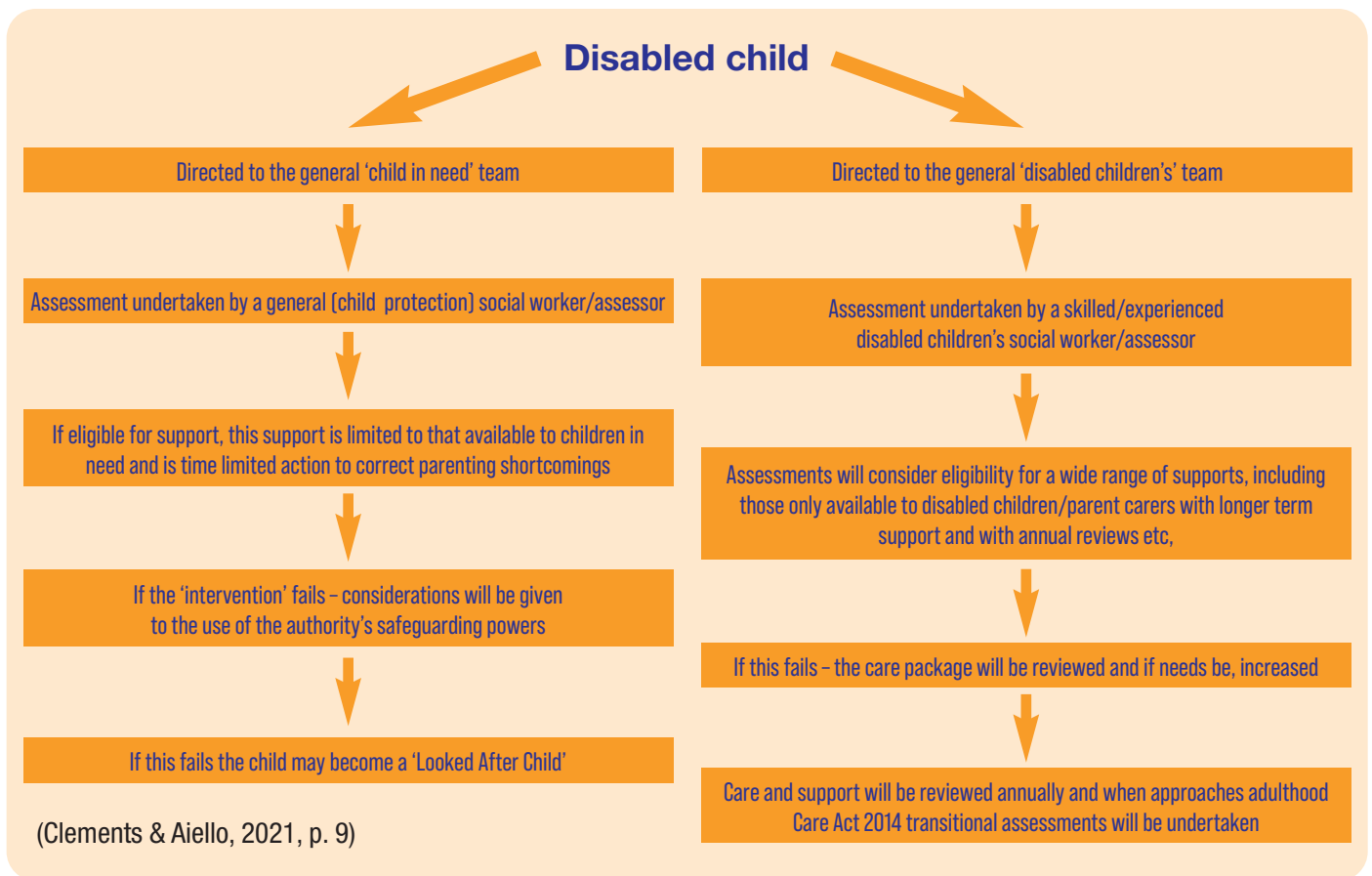
Once a referral has been received by Children's Social Care, a professional assessment by a social worker needs to be undertaken to see if there is need for social care support and, if there are concerns about harm to the child, to ascertain whether there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm. For example, if the child is disabled and the referral is from a school, have there been previous similar referrals which might be attributable to school/parental disputes? Is there a neurodevelopmental condition diagnosis, and is there diagnostic corroboration? Has the parent raised a complaint against a doctor or the school? The issue in question must be that just because someone expresses a concern of FII, it does not necessarily mean the social worker should immediately respond through an investigative approach; the merits of the concerns being expressed need to be assessed in line with organisational procedures.

Checklist

The following checklist has been co-produced using parent/caregiver feedback and incorporates questions for the practitioner to consider before moving into the child protection arena as it offers an antithesis to accepting an FII referral at face value. It is not a scientifically proven formula and is not based on existing research, and merely offers a succinct approach to support open-minded enquiry when a referral is received.

	Yes, or no?	Resolved – Yes, or no?
Does the child have an existing diagnosis?		
Is there reliable evidence to support their diagnosis?		
Could their presentation be attributed to an existing diagnosis or is a further medical/diagnostic assessment needed?		
Do parents or siblings have a diagnosed physical/neurological/psychological condition?		
Are there disputes between medical professionals about a child's diagnosis?		
Is there an interprofessional dispute about the existence of the child's reported condition e.g., ME/CFS, PANS, PANDAS, PDA?		
Does the child present differently in school/college compared to at home?		
Has the parent made a complaint against the referring agency/organisation?		
Has the parent previously made complaints against the local authority?		
Is the parent seeking a child to have an Education, Health and Care Plan, or are they appealing an existing one?		
If parents of the child are separated, if there a disagreement about the child's presentation and diagnosis?		

The following flowchart illustrates the shortcomings of the current approach to child in need services which are often oriented towards parental short-comings and mostly offer short-term support. Once the above checklist has been completed by the lead social worker, where the child or young person meets the criteria as a disabled child in accordance with Section 17(11) of the Children Act 1989, the approach to support under section 17 should be similar to that provided by the specialist team if such a team is not available.



Relationship-based social work

Guidance on the professional standards of social workers is issued by Social Work England, Social Care Wales, The Scottish Social Services Council, and Northern Ireland Social Care Council, as each body seeks to raise professional stands in social care.

Effective social work practice is created when child protection social workers can build meaningful and productive relationships with families.

The social worker actions that facilitate engagement with families, and effective case management include:

- Openness about the concerns raised and what is non-negotiable
- Eliciting the child and parent(s) views, as well as the wider family, when appropriate

- Proactively identifying the needs of the child and parent/caregivers
- Establishing collaboratively how these needs can be met
- Exploring the barriers to positive change
- Utilising a strengths-based approach whilst not diminishing the difficulties being expressed
- Treating all family members with dignity and respect.

Managers have an important role in supporting social workers to ensure their practice meets the required standards when working with families who could be deemed as vulnerable, due to the complexity of their circumstances. Therefore, managers need to understand and fully appreciate the power differentials between the Medical and Social Care Models specific to allegations of FII, to ensure parents/families/ children receive a supportive approach, rather than interventions which might inadvertently cause more harm because the presenting

evidence has not been thoroughly analysed. Equally, social workers need their manager to proactively support them when they believe there is a need to challenge the professionals who have formulated a quasi-diagnosis because this can be a daunting and anxiety-evoking experience.

Supervision

The classic functions of supervision are management, support and learning/ development which relate to three categories of human experience: (i) our sense of social responsibility to others and ourselves; (ii) our need for contact, recognition, and actualisation as our individual selves, and (iii) our ability to grow as we meet new situations and assess them (Temple, 2004, cited by Newton, 2012). To maintain the efficacy of supervision, these three factors must be balanced where the importance of rules and professional standards is not the sole focus thus allowing the practitioner to grow and develop their self-awareness and professional expertise (Newton & Napper, 2007, p. 151).

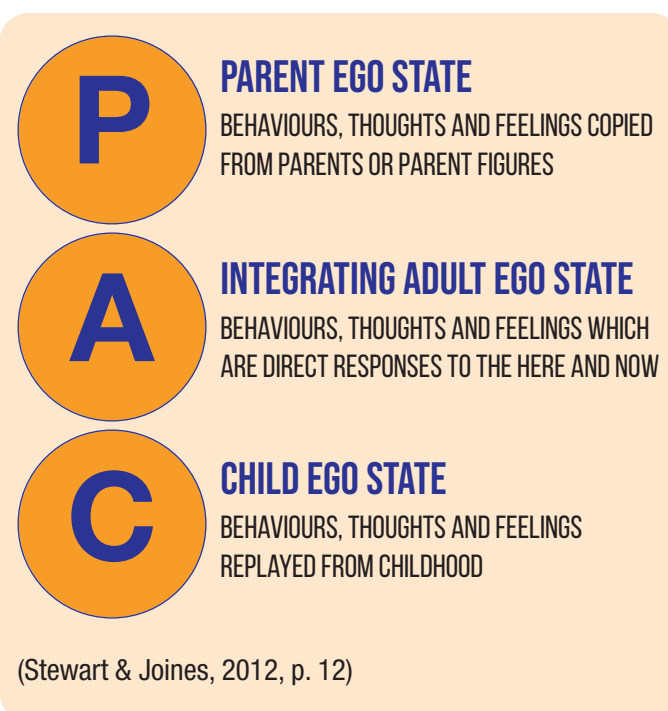
For families where there have been concerns about FII, the interactions between them and Children's Social Care have often compounded their sense of feeling victimised and disempowered. Many parents accused of FII, report their experiences of engaging with social care as traumatic and undignified. Whereas, the social worker has sought to protect and promote the wellbeing of the child or young person, there have been cases where the focus has been on a parent's historical mental health issues and a lack of parental boundaries, rather than considering the bigger picture.

Primarily, within a supervisory relationship, a social worker needs to be supported to maintain their professional integrity when faced with the need to question or challenge the opinions of teaching or health professionals, and the forceful presentations by aggrieved parents. Within supervision, it is essential that the supervisor supports the social worker to identify the different roles adopted by professionals, clients, and their carers, as this will avoid unnecessary conflict and pitfalls which can hinder respectful interagency working, and jeopardise good social work/client relationships. One approach to support effective analysis of interpersonal and interorganisational dynamics is to employ a Transactional Analysis approach.

A Transactional Analysis approach to working with families involved in FII/PP

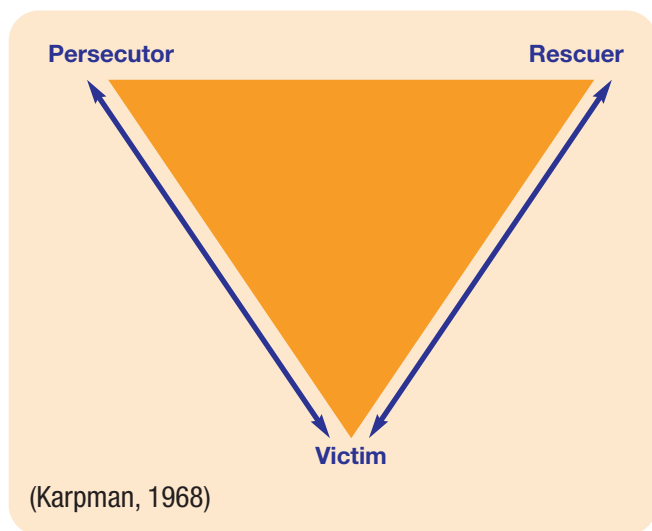
The potential interpersonal and interorganisational dynamics are very aptly highlighted within *Transactional Analysis*, which is a theoretical approach used to explore the changing aspects of relationship dynamics and how to redress them. Within TA, the Ego States Model provides a visual understanding of how interpersonal dynamics can hinder relationships between professionals and families needing social care support:

The First-order structural diagram: The ego-state model



An ego-state model names and describes a person's behaviours, thoughts, and feelings at any given time and lies at the heart of transactional analysis. Whilst the Adult ego state is the most favourable to operate from when a parent/caregiver is communicating with Children's Social Care, sometimes they may subconsciously replay childhood experiences such as feeling unheard or dismissed by the people they are expecting to listen, understand, and support them. Social care is often perceived as a *Parent* body with social workers stepping in to rescue and assist families in crisis. Sometimes a parent/caregivers' expectations are crushed when they perceive social workers as the *Controlling Parent*, because they feel criticised, undermined, and blamed for their child's difficulties. When this happens, the archaic-psyche ego state can react abruptly as their distorted perceptions respond to pre-logical

thinking evoked from their child (Clarke, 2010, p. 157). Thus, the *Parent* and *Child* might step onto the *Drama Triangle* where high levels of tension and struggles for control are unconsciously played out between Children's Social Care and parent(s)/caregivers seeking support. The **Drama Triangle**, used in Transactional Analysis, is a useful way to explain the experiences of many parents when they approach services, including Education, Health, and Social Care.

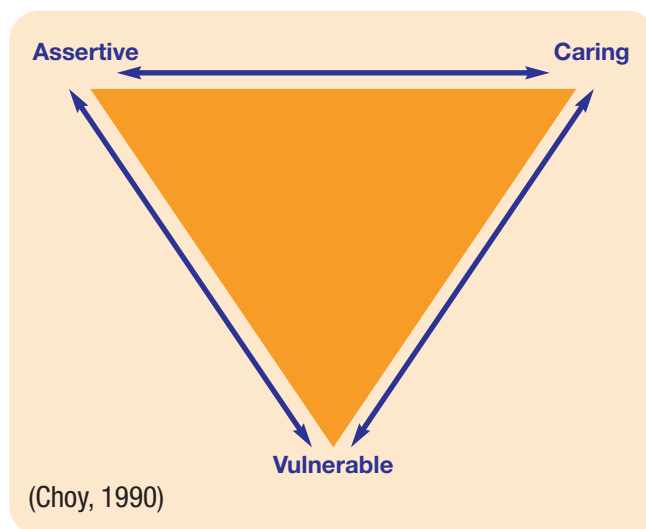


The *Persecutor* is someone who puts others down and belittles them, the *Rescuer* offers help seeing the other person as Less-than and unable to help themselves, and the *Victim* believes they are not-OK and may believe "I can't cope on my own".

The three positions on the Drama Triangle, *Persecutor*, *Rescuer* and *Victim*, represent the dynamics which can occur when a parent/caregiver approaches statutory agencies for support. For example, a parent of a child with a rare genetic disorder, and subsequent behavioural problems, is struggling to manage her child at home. She approaches the Children's Disability Service to request an assessment. This is an Adult-to-Adult transaction. However, once the social worker starts to assess the child and when school is contacted, the Head Teacher suggests the child is "fine in school". Interagency discussions lead to FII being suspected. These suspicions are raised with the parent and subsequently her child is placed on a Child Protection Plan. The mother is now in *Victim* position with Children's Social Care and Education as the perceived *Persecutor*. The parent looks to the school to help (*Rescuer*) and requests an assessment by

an educational psychologist, but this is not forthcoming. As she feels helpless and disempowered, she makes separate complaints about the school and the social worker because she wants things to be different. In doing this, the parent takes the position of *Persecutor*, with the school and social worker temporarily adopting the *Victim* position. As ultimately the professionals hold a position of power, they seek to redress the mother's actions and openly challenge her behaviour by making seemingly unrealistic expectations on her to 'appropriately' parent her child. Effectively, she is blamed for her child's behaviour. Thus, the agencies revert to becoming *Persecutor*. As the parent now feels utterly frustrated and intensely disempowered, she engages a solicitor and independent experts to *Rescue* her from the situation she finds herself in. Whereas this might appear to be overly dramatic, these are common themes when parents challenge statutory agencies.

The antithesis to the Drama Triangle is the **Winner's Triangle**:



Assertive replaces *Persecutor* where the person autonomously acts in their own interests, and the interests of the child, whilst not using their skills to intimidate or bully. The *Caring* position supersedes the *Rescuer*, thus respecting other's ability to think, problem-solve, to ask for what he or she wants, whilst providing a supportive structure to enable and empower them. Being in the *Vulnerable* position instead of the *Victim* is about volunteering our vulnerability: realising and owning emotions, implementing a problem-solving approach to address them, and asking for support as we need it. It entails maintaining an adult logic using self-awareness

and intuitively addressing issues as they arise and engaging in appropriate problem-solving to implement change. The importance of the Winner's Triangle is that parental or professional vulnerability is not frowned upon. Instead encouraging respectful openness between parties will potentially engender trusting relationships and greater collaborative working if the trust is respectful and positions on the Drama Triangle are not adopted when conflicts arise (Choy, 1990).

In professional life, as in family life, unequal relationships will occur. However, if social workers practise with an awareness and confidence in their own ability and recognise the ability and potential of the parent/caregiver, there is synergy. Creating a complimentary relationship between the *Guide* and *Beneficiary* enhances relationships between both parties and elicits joint working, with the social worker facilitating services and support when needed. The aim of the relationship is to support the *Beneficiary* to become the *Hero*, as they are given the resources and tools needed to bring changes in their circumstances. Sometimes this will involve providing specialist services, or it might be a combination of services and facilitating parental learning. Ultimately, the aim is to ensure the wellbeing of the child and to prevent an occurrence of family breakdown.

Safeguarding Procedures

If an assessment following a referral indicates safeguarding concerns, a professional decision needs to be made as to whether this is a Child Protection matter, or are there alternative approaches that might move the focus away from an investigatory path? The issue in question must be that just because someone expresses a concern of FII, it does not necessarily mean the social worker should immediately initiate a Child Protection response. FII is extremely rare and many parents/caregivers can mistakenly be perceived as creating or exaggerating their child's difficulties, when there is only speculative, non-factual evidence to support this notion. The merits of the concerns being raised need to be carefully considered by the practitioner, in collaboration with the designated lead professional for safeguarding children, within the organisation.

If concerns are raised about a parent/carer hindering a child's health, development, or functioning, the key professional involved should meet with them to discuss this. At the same time, it is necessary to find out about any other health professionals involved e.g., private consultants or practitioners.

In meeting with the parents/carers, it might be they are highly anxious about their child not having their needs met, or they may have misunderstood information given to them by health professionals. Therefore, their actions could be because they believe the needs of their child are not being taken seriously by professionals, potentially because their child presents differently in the home environment compared to elsewhere. They are not exaggerating a child's problems, nor fabricating their difficulties, instead they are reporting their observations, experiences, and perceptions of what is happening, in the hope that understanding, and support will be forthcoming.

Complex or rare presentations are not easily identifiable by more general health professionals. Therefore, when the suspicion of FII is ongoing, and the child is not known to a consultant, they must be referred to the most relevant health and social care professionals who have expertise in the signs and symptoms being presented.

FINAL COMMENTS

The issues associated with FII/PP are complex ones and it is hoped this practice guidance has encouraged social workers' understanding of the underlying issues that need to be considered before accusations of FII are made and acted upon. However, it is evident social workers are diligently seeking to safeguard the wellbeing of many children where a clear understanding of their needs has not been established, and where there are interprofessional disputes about what is happening. We want to encourage social workers about the importance of their safeguarding role and the importance of achieving the right outcomes, rather than unintentionally creating unnecessary distress to the many families who have been caught in the web of FII allegations, and where their child's needs have been overshadowed and undermined because of this. We want social workers to celebrate the immense difference they can make when working with families where their children's presentations are perplexing, by utilising all the skills they are trained to use. We recognise the enormous value of informing social workers with the right knowledge to enhance their expertise and appreciate the autonomy of the social work role and the invaluable contributions social workers offer to the lives of many. However, as realised from the many families we know who have been wrongly accused of FII, it can be so easy to 'get it wrong', and the effects of such can be devastating. Therefore, let each of us be the practitioner who questions, challenges and uses our professional curiosity to do all we can to get it right.



PROFESSIONAL PROFILES OF CONTRIBUTORS

Cathleen Long is an award-winning independent social worker with an MA in Autism. With over 28 years of post-qualifying experience, Cathleen has worked within local authorities in both England and Wales. She is an expert witness and provides reports for 'disabled' children, young people and adults for Special Educational Needs and Disability Tribunals, Judicial Review, the Court of Protection, and Family Court. Cathleen is a psychotherapist in advanced clinical training, and is studying Transactional Analysis with Contact Point, Bristol. Cathie delivers training to professional organisations, and live webinars/ training programmes for professionals and parents of children with additional needs. She enjoys writing and her repertoire of publications is growing. Cathleen is neurodivergent and describes herself as "uniquely quirky". Her different neurotype informs her professional astuteness and creativity as a social worker, and drives her passion to promote and encourage sound, ethical social work practice, thus ensuring the best outcomes are achieved.

Sally Russell OBE, FRSA was the co-founder of 'Netmums' and a director for fourteen years. During that time Sally found new ways to support parents and ensure their voices were heard by Government. As the Founding Chair of the Institute of Health Visiting, Sally saw the importance of positive, professional leadership in an essential profession. She continued to work to bridge the gap between parents and professionals in her role as Chair of the PDA Society, having got involved as a volunteer after her child was identified with the condition aged 15.

Dr Judy Eaton is a chartered clinical psychologist with a special interest in neurodevelopmental disorders in both children and adults. Judy participated in a 'mini-pupillage' scheme organised through Phoenix Psychological Services and Coventry Family Court. She is registered to practice as a clinical psychologist with the Health and Care Professions Council and chartered by the British Psychological Society. Prior to working independently, Judy was in practice as a clinical psychologist in the NHS for ten years, where she worked as the lead clinician within an autism diagnostic team. Subsequently she was

employed by a major independent provider of low and medium secure in-patient services as Lead Consultant Clinical Psychologist and worked with both adult and CAMHS services where she worked with patients with mental health and/or forensic histories. Judy has a particular interest in autism in females and in particular mothers with autism and has completed many assessments of autistic mothers for the Family Court.

Dr Fiona Gullon-Scott is an academic and clinician specialising in autism spectrum conditions, with over 25 years' experience in this area. A Chartered Psychologist and Associate Fellow with the BPS, and a Practitioner Psychologist with the HCPC, Fiona is a Lecturer in Clinical Psychology with Newcastle University, an Honorary Senior Lecturer with the Tizard Centre, University of Kent, and a Consultant Psychologist with her own Independent Practice. Over the years Fiona has worked with and for numerous NHS Trusts, and as one of the UK's International ADOS2 and ADI-R Trainers has been involved in delivering training on autism diagnosis to Health Trusts throughout the UK and Internationally. In her research Fiona has authored and co-authored numerous papers relating to autism and neurodevelopmental differences and worked alongside a number of experts in the field' and remove the specific reference to SBC and the ARC in Cambridge. Research interests have included development of validated screening tools for autism spectrum conditions, cognitive processes in autism, epidemiology of autism, and currently research around female and complex presentations. Fiona has been involved in policy development and training around autism spectrum conditions throughout her career.

Professor Andy Bilson is Emeritus Professor of Social Work at the University of Central Lancashire, adjunct professor at the University of Western Australia and visiting researcher at the Cambridge Institute of Public Health at the University of Cambridge. He was a senior manager in social work and the Director of the Council of Europe's and UNICEF's observatory on European children's rights. He was a founder of the Centre for Children's Participation at the University of Central Lancashire and founded the Association for Juvenile Justice in England

and the Know How Centre on Alternatives to Care in Bulgaria. He has undertaken international research and consultancy on child rights and alternatives to care with many governments and organisations. He has published widely and co-wrote the World Bank and UNICEF guidance on gatekeeping and standards for social work as an alternative to institutional care. He was advisor for Eurochild's Childonomics programme developing a tool to determine the long-term social and economic return of investing in children. His work currently focuses on child protection trends and parent advocacy in child protection - he is a founder of the International Parent Advocacy Network and in the UK the Parents, Families and Allies Network. His current research is into children 'born into care'; longitudinal trends in child protection in UK and Australia; an international review of parent advocacy; and the role of health assessments in child protection at Cambridge University.

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GLOSSARY

BASW	British Association of Social Workers
CBT	Cognitive Behaviour Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDS	Ehlers Danlos Syndrome
FDIA	Factitious Disorder Imposed on Another
FII	Fabricated or Induced Illness
ME	Myalgic Encephalomyelitis
ME/CFS	Myalgic Encephalomyelitis/ Chronic Fatigue Syndrome
MSbP	Munchausen's Syndrome by Proxy
MUS	Medically Unexplained Symptoms
NICE	National Institute for Health and Care Excellence
PANS	Paediatric Autoimmune Neuropsychiatric Syndrome
PANDAS	Paediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal infections
PDA	Pathological Demand Avoidant
PP	Perplexing Presentation
RCPCH	Royal College of Paediatricians and Child Health
TA	Transactional Analysis

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