The experience of professionals working in child protection and Fabricated and Induced Illness (FII): A thematic synthesis of qualitative evidence and a qualitative empirical study

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Overall abstract

Protecting children from harm is a multi-faceted endeavour. Professionals who work in child protection are frequently exposed to high stake, complex, and emotionally demanding situations, which can have significant psychological implications. Vicarious trauma (VT) and secondary traumatic stress (STS) refer to cognitive, emotional and behavioural changes resulting from the indirect exposure to traumatic events. Research has increasingly started to acknowledge and explore this construct amongst the helping professions, but a qualitative review focusing on the experiences of child protection professionals specifically was warranted. Additionally, one specific situation that child protection professionals may be exposed to is the involvement in a case of Fabricated and Induced Illness (FII), which refers to a child being harmed due to parental behaviour and action. The current approach to FII in the UK has been argued to be unsatisfactory in terms of its definition, identification and approach, and there is a limited understanding of professional perspectives. Further curious investigation is needed to understand this experience for professionals.

A systematic search of qualitative evidence was completed to thematically synthesise and critically appraise the existing literature on the experiences of VT and STS for child protection workers. It was hoped that the identification of knowledge gaps could enhance understanding and guide future research and practice. Thematic synthesis helped to develop six interconnected themes from 13 identified studies. Findings suggest that VT/STS significantly impact the psychological well-being of child protection professionals, and the experience is much the same as direct trauma survivors. Most significantly, a vicarious trauma-informed awareness is needed at every level, in order to prevent psychological harm. Further cross-cultural research and research specific to this population are needed to inform specific interventions.

Professional experiences of FII specifically were explored qualitatively, to develop insights into the use of guidance, behaviours associated with FII, and clinical decision-making. Online semi-structured interviews were held with nine professionals who have been involved in an FII case. Six themes and 12 subthemes were developed using Reflexive Thematic Analysis. Findings revealed facilitators and barriers to clinical decision-making at an individual, team and systemic level, as well as the trauma that professionals and families experience from involvement in these cases. Professionals reflected on their learning and ways forward. It was concluded that current guidance lacks ecological and construct validity, and further understanding of the psychological basis of FII is needed in order for a trauma-informed approach and system-wide understanding to occur.

Findings from both the literature review and empirical project highlight the considerable psychological burden on child protection professionals as an issue which demands urgent attention. Both illustrate the combined perspective that iatrogenic harm can and does occur at all levels, and this is in part due to a system that lacks understanding of concepts such as VT, STS and FII. Ultimately, the results highlight the need for a system-wide, trauma-informed approach to practice and policy in the child protection field.

Acknowledgement of contributions

Dr. Fiona Gullon-Scott (Deputy Research Director and Senior Clinical Psychology Lecturer at Newcastle University) was the supervisor for this project. Fiona, I recently learnt about “Ikigai”, a Japanese concept which translates to a unique “reason for being” or purpose, based on values, skills, and what you can contribute to the world. It made me think of you, as in this area of research, policy and practice, you have clearly found your Ikigai. Being mentored and guided by somebody who tirelessly advocates for others with such determination, bravery and dedication has been a privilege. You have shown me the true power and impact of research. Thank you.

Thank you to every person who expressed an interest to take part in the empirical project. To the nine participants who kindly took part in the interviews, I would like to sincerely thank you for generously taking the time to participate. Your openness, honesty and vulnerability about your experiences are what made this project possible, and it has been a privilege to hear about the incredibly challenging and often unseen work that each of you do. Each and every one of you called for change. I hope that this project services justice to your experiences, and is able to play a part in that change that is so desperately needed.

Marian Rixham and Richard Lumb, Senior Library Assistants at Newcastle University, were fundamental to the development of comprehensive search terms and strategy in the initial stages of this project. Thank you both for your patience and support.

Several professionals engaged in reflective conversations at Newcastle University’s Research Conference in 2024 following the presentation of the research

poster. Your reflections and insights provided helpful considerations for the final interview schedule and project as a whole. Thanks also to peers from my cohort of Trainee Clinical Psychologists at Newcastle University, who provided a supportive space to reflect on the evolving thematic structure.

Finally, the study was funded by the Doctorate of Clinical Psychology at Newcastle University. Their financial support allowed for participants to receive an incentive for taking part. Thank you.

Personal acknowledgements

The submission of this thesis is a momentous time in my life, which would not have been possible without many special people.

Firstly, to my partner Dillon. You put your own life on hold, and agreed to move up to the North East with me to pursue this Doctorate with no hesitation, and for that I am eternally grateful. Your patience, making me laugh when I needed it, and helping me to enjoy life outside of the screen have provided me with a constant foundation which has allowed me to push through the challenges.

To my family; my Mum, Dad, Grandparents and little brother. This achievement is for all of you. You have always instilled in me the importance and power of hard work, education, and doing the right thing. Throughout this journey you have provided infinite amounts of love, encouragement and belief. Despite the distance of 186 miles, your support has never felt far away. You have truly never let me forget how proud you are of me every single day. Thank you will never be enough.

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Literature review

What are child protection workers' experiences of vicarious trauma and secondary traumatic stress? A thematic synthesis.

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Abstract

Background: Vicarious trauma (VT) and secondary traumatic stress (STS) refer to cognitive, emotional and behavioural changes resulting from the indirect exposure to traumatic events. Increasingly, research has explored this experience for helping professionals. The majority of research with child protection professionals has been empirically driven, so the current review focusing on experience is therefore warranted.

Aims: To thematically synthesise and critically appraise the existing qualitative literature on the experiences of VT/STS within child protection workers. To identify any knowledge gaps in this area in order to enhance understanding and guide future research and practice.

Methods: The systematic review followed Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), and a qualitative evidence synthesis of peer-reviewed and grey literature sources using Thomas and Harden's (2008) thematic synthesis. The CASP (2024) checklist assessed methodological rigour.

Results: Six themes represent the collective experiences of professionals from 13 studies: “Conceptual setting”, “The heart of the wound”, “It's all encompassing”, “Change in world view”, “Trying to survive” and “A way forward: the role of systems”. The development, experience, consequences and the role of systems in VT/STS are interconnected.

Conclusion: VT/STS significantly impacts the psychological well-being and overall functioning of child protection professionals. Contributing factors are unique, but the experience is much the same as direct trauma survivors. Most significantly, a vicarious trauma-informed awareness is needed at every level, in order to prevent psychological harm. Further cross-cultural research and research specific to this population are needed to inform specific future interventions.

Introduction

What is trauma?

Traumatic events are defined by The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as exposure to threatened death, serious injury or sexual violence (American Psychiatric Association [APA], 2013). Exposure to traumatic events is a common human experience worldwide, with over two thirds of individuals reporting exposure to a trauma event within their lifetime (Benjet et al., 2016). Immediate psychological reactions following these events can vary to include exhaustion, confusion, sadness, and anxiety, yet most people experience minimal distress and recover with time (Center for Substance Abuse Treatment, 2014).

A proportion of people who experience trauma develop Post-Traumatic Stress Disorder (PTSD), a mental health condition. Diagnostically, this can include intrusive memories of the event (memories, flashbacks, nightmares), avoidance of trauma-related stimuli, negative changes in mood, and trauma-related alterations in arousal (hypervigilance, sleep disturbance, heightened startle response) (APA, 2013). Whilst many people are exposed to trauma, only a small minority develop PTSD (Atwoli et al., 2015). The notion of the PTSD risk has therefore been the subject of considerable research.

With that said, it is well understood that exposure to trauma contributes to the development of a plethora of negative consequences. For instance, Sahle et al.'s (2021) umbrella review concluded that adverse childhood experiences are consistently associated with increased risk for common mental disorders and suicidality. Furthermore, children exposed to trauma are at a higher risk in adulthood of experiencing early onset mental disorders, as well as poorer global outcomes such as education and employment (Teicher et al., 2016; Xie et al, 2018).

Due to the permeating nature of trauma and correlations with negative outcomes, the presence and development of trauma research has grown considerably (Felitti et al., 1998). Mental health services have developed in accordance with awareness of the high prevalence of trauma within the population of those accessing mental health services, and there are now worldwide pressures for health services to deliver trauma-informed care, an approach which is founded on the principles of safety, trustworthiness, choice, collaborating and empowerment (Fallot & Harris, 2008).

Vicarious trauma (VT)

Over the past two decades, there has been considerably more attention given to the impact of *working with* traumatised individuals, as opposed to the direct exposure to a traumatic event itself. McCann and Pearlman's (1990) seminal paper acknowledged, for instance, that exposure to clients' traumatic material can also be traumatising for the therapist hearing about it. They termed this phenomenon vicarious traumatisation, viewed as a normal consequence of working with trauma clients and highlighting cognitive changes as the defining characteristic.

Theoretically, VT can be understood through McCann and Pearlman’s (1990) Constructivist Self Development Theory (CSDT) as a useful explanatory framework, highlighting increasingly negative beliefs around safety, power, independence, esteem, intimacy and frame of reference as a result of exposure to a client’s traumatic experiences. For instance, research with female psychologists and rape crisis therapists indicated that the percentage of sexual violence survivors in the clinician’s caseloads significantly correlated with more disrupted beliefs, more self-reported VT, and PTSD symptomology (Schauben & Frazier, 1995).

Secondary traumatic stress (STS)

STS (Figley, 1995) refers to the behaviours and emotions which result from the process of helping a traumatised person. This construct describes the development of symptoms parallel to PTSD, via exposure to knowledge about a traumatising event by another, and is described as a natural consequence of helping others. In addition to the aforementioned PTSD diagnostic criteria, STS includes cognitive shifts and relational disturbances.

More recently, research has expanded to explore both notions of VT and STS in the wider context of other helping professionals, with a growing recognition that the safety and well-being of professionals is a critically important aspect of their work. A recent integrative review (Isobel & Thomas, 2021) identified VT as a workplace hazard for nurses at individual, team and organisational levels. Firefighters and paramedics who have been questioned in post-mortem inquiries have been found to display higher levels of traumatic stress symptoms (Regehr et al., 2003), and police personnel in the United Kingdom have been found to be at an increased risk of experiencing secondary traumatic stress as a result of the nature of their work (Sheard et al., 2019).

Conceptual clarification

It is important to note that many terms exist in the literature to describe exposure to another person's traumatic experiences, as well as empathy-based strain. According to Genovese and Wang (2023), VT and STS are the most commonly used, but others include counter-transference, burnout and compassion fatigue. Some researchers use these terms interchangeably, and whilst there is conceptual overlap there are some subtle but key differences. Countertransference refers to the emotional responses and projections that a professional can experience in relation to a client (Gelso, 2007). Burnout (Maslach, 1982) refers to a constellation of symptoms and behaviours revolving around emotional exhaustion, but is non-specific to working with traumatised populations. STS is often operationalised as compassion fatigue, yet compassion fatigue is driven by cumulative emotional exhaustion as a result of caregiving (Figley, 1995), whilst STS relates to indirect exposure of trauma.

VT and STS in Child protection

Child protection workers play a pivotal role in the safeguarding of vulnerable children. Those involved in the early identification of child protection concerns are at the forefront of child abuse investigations and typically witness the effects of physical and psychological abuse of children daily (National Child Traumatic Stress Network, 2016). It is therefore unsurprising that 30-50% of child welfare workers report symptoms of STS (Conrad et al., 2016), with specific professional risk factors including longevity of career, heavy caseloads, and long work hours (Cornille & Woodard Meyers, 1999). Existing reviews of the literature have primarily been quantitatively driven, which further justifies the current review's necessity. Molnar et al. (2020) considered the prevalence and risk factors for VT/STS in this population such as demographic difference, workplace and family factors, by including and considering primarily quantitative studies in the final systematic review. Baird and Kracen's (2006) review sought to clarify the definitions of VT and STS, and used evidence analysis to synthesise research findings and identify predictors of VT/STS. Finally, Bowman (2022) reviewed the literature to consider the organisation's role in mitigating VT/STS and subsequently proposed an organisational child welfare wellness model, focusing on turnover and retention of child protection workers.

Rationale

It has been proposed that ignoring child protection workers' well-being could put the entire child welfare system at risk (Geoffrion et al., 2016), and the development of VT/STS for child protection professionals on an individual, societal, and organisational level has clearly gained momentum. However, the majority of research to date has been quantitatively driven. Subjective understanding forms a wider part of protecting the wellbeing of child protection workers, and contributes to a cultural shift away from a deficit approach and towards a trauma-informed approach (Child Welfare Information Gateway, 2020). This is echoed in the literature as an ethical obligation to protect such professionals, who are at the 'forefront of the struggle' (Sommer, 2008). By reviewing the actual *experience* of VT/STS, it is hoped that a deeper, more nuanced understanding could provide contextual understanding and identify literature gaps. This remains unexplored in the existing literature to date, and is hoped to inform practical implications to ensure that these professionals are supported in their critical work.

VT is defined as the transformation in the inner experience that comes about as a result of empathic engagement with clients' trauma material, the defining feature of which is cognitive changes (McCann & Pearlman, 1990). STS refers to behaviours and emotions resulting from the process of helping a traumatised person (Figley, 1995).

Objectives

1. To thematically synthesise existing qualitative literature on the experiences of VT/STS within child protection workers.
2. To critically appraise the existing literature in this field.
3. To identify any knowledge gaps in this area to enhance understanding and guide future research and practice.

Methods

Guidelines for Enhancing Transparency in Reporting the synthesis of qualitative research (ENTREQ) were followed to present the review process and findings (Tong et al., 2012).

Scoping

Originality of the proposed review was ensured by searching Prospero, Open Science Framework, relevant journals and Google Scholar databases for similar topics. Reference lists of relevant papers were scanned during exploratory searches. One review synthesising the professional experiences of working with trauma was identified (Ireland & Huxley, 2018). However, this focused on the experiences of a range of clinical professionals working with psychologically traumatised children in the care system, with a specific focus on residential child placements. They also included studies about natural disasters and warzones, and experience of therapists, all of which are excluded in the current review. The present review specifically focused on VT/STS for professionals involved in the early identification of child protection concerns (assessment, investigation and protection) across settings, which remained a gap in the literature.

To increase transparency, a review protocol was developed, and this was registered on PROSPERO (reference: CRD42024628802).

Information sources

Relevant studies were identified via a systematic search of five electronic databases in December 2024. These included Medline via Ovid (1946-2024), Embase via Ovid (1974-2024), PsycInfo via Ovid (1806-2024), Scopus, and ProQuest to explore Grey Literature. Moreover, the reference lists of studies selected for the review were hand searched to broaden the available literature.

Search Strategy

Search terms were developed through scoping searches, and reviewing relevant articles and their key words, with assistance from librarians and the project supervisor. Search terms were grouped broadly into three areas: Type of child protection professional, VT/STS, and Qualitative research. Categories were defined using a combination of search terms (Appendix A) which were mapped as key words or subject headings depending on the database. The Boolean operators of 'AND' and 'OR' were used to combine categories and combinations of search terms. The same search terms were adapted accordingly across databases. The searches were capped on 31st January 2024.

Selection Process

Searches were completed across the five databases, identified records were exported, and duplicates were removed. The primary reviewer screened all records by title and abstract against the inclusion and exclusion criteria. Existing reviews, fully quantitative papers, or mixed-methods papers where qualitative data could not be extracted were removed.

Where records appeared to meet criteria, a full text review was completed to inform inclusion or exclusion. For sources where it was more unclear, discussions were held with the project supervisor to deliberate inclusion or exclusion. VT and STS are wide umbrella terms. The researcher utilised aforementioned definitions cited in the introduction to explore how broadly the concept was applied. If the terms were not explicitly used in sources, the decision to include papers was supported by the primary author's clinical knowledge and knowledge of the research area to assume relevance and distinguish from other related concepts (such as burnout and compassion fatigue), as well as discussions with project supervisor who is an experienced clinician.

Child protection professionals were defined as those involved in child protection work (assessment, investigation, protection), or those part of the early identification systems of child abuse concerns (namely child protection workers and Paediatricians). The search was not limited by date ranges, country or any other aspects in order to explore a wide range of experiences cross-culturally and inter-generationally.

Studies focusing on VT/STS in the context of war zones or natural disasters were excluded to maintain the specificity and relevance of the review and focus on child protection professionals who worked in the early identification of child abuse concerns. The nature of trauma exposure in these settings often differ significantly, and these professionals often operate under different organisational structures, cultural contexts and support systems which may compromise applicability of findings to child protection policy and practice.

Table 1

Inclusion and Exclusion Criteria for Eligible Studies.

Factor	Inclusion	Exclusion
Sample	Studies where there is data from professionals who are social workers, paediatricians, child protection workers, members of child protection teams, child welfare workers at the time of the study, even if they are reported to have a different background profession. Sources which include child protection workers in addition to non-child protection workers, where qualitative data on the sample of interest is demarcated between participant groups.	Samples formed exclusively by participants who are Therapists, Psychologists, Psychiatrists, Nurses, interpreters, homeless services workers, teachers, police, detectives, law enforcement workers, first responders or forensic interviewers at the time of the study. Samples which include relevant participants and non-relevant participants, where qualitative data from the sample of interest is not clearly demarcated between participant groups.
Main focus of study	Studies which include qualitative data about the experiences of VT/STS amongst child protection workers. This can focus solely on one specific patch of child protection (e.g., child sexual abuse, domestic violence, or child protection experiences more broadly). Studies that addressed other aims could be included if data about child protection worker experiences	Studies solely reporting on the experiences of compassion fatigue or burnout amongst child protection workers, unless relevant qualitative data is demarcated and can be extracted. Studies which focus on VT of child protection workers relating to warzones, natural disasters, palliative care, or COVID-19.

Factor	Inclusion	Exclusion
	of VT/STS were reported and could be extracted.	Studies which do not relate to qualitative experiences of child protection workers.
Type of study/design	Published peer reviewed research (e.g., journal articles, dissertations, theses). Grey literature which has a degree of scientific and methodological rigour displayed via a review process (e.g., university review) and can be accessed online. Sources where full text is available. Qualitative studies (any method of obtaining textual data e.g., focus groups, interviews, case studies, qualitative surveys and any qualitative analysis type e.g., thematic, discourse, narrative, grounded theory, content) about child protection workers experience of VT/STS. Mixed methods studies could be included if relevant qualitative data could be extracted. Only qualitative data were analysed.	Non peer-reviewed or unpublished studies were excluded (e.g., magazine articles, books, grey literature sources which are not dissertations/theses and have not undergone a review process, conference presentations, existing systematic reviews). Sources with a solely quantitative design. Qualitative studies which do not report on the experiences of VT/STS amongst child protection workers. Sources where full text is not available.
Date	No limit.	No limit.
Language	Written in or accessible in English.	Not written in or accessible in English.

Data Extraction

A data collection tool was developed after several iterations (Appendix B) to present extracted data based on review objectives.

The ‘key findings’ section of the data extraction table comprised of any data relevant to the review questions. The presentation of qualitative research can be variable (Sandelowski & Barroso, 2004), and thus relevant data was extracted from abstracts, findings, discussions and conclusions. Key findings within the data extraction table were documented as per the original source, and were not interpreted at this stage. The review’s aims, qualitative synthesis method, and the critical realist (CR) epistemology meant that it was especially important to capture the role of the researcher, epistemological position and researcher reflexivity of sources to guide appraisal.

Critical appraisal

The current review aimed to identify and synthesise relevant literature about the experiences of VT/STS for child protection professionals in order to provide novel insights. A wide range of perspectives was required to maximise variability (Thomas & Harden, 2008). Additionally, there is a lack of standardised criteria or guidance to rank quality in qualitative research (Noyes et al., 2018). Thus, all identified studies were included in the review regardless of quality. The Critical Appraisal Skills Programme (CASP) checklist for qualitative studies (CASP, 2024) was used to assess methodological rigour (Appendix C). This was used due to its simplicity, clarity and accessibility when compared to other well-known quality appraisal tools. The CASP's structured yet flexible framework complemented the thematic synthesis approach well. A total score was calculated for each paper to indicate overall quality, which was colour-coded to depict areas of relative strength and weakness, as well as uncertainty or instances where there was insufficient information provided to assess.

Synthesis of results

The RETREAT framework (Booth et al., 2016) was utilised to determine the most appropriate review methodology. This framework highlighted the suitability of a thematic synthesis approach, as the review question seeks to capture experiences, and the author's theoretical positioning is a CR approach. There are logistical and resource constraints in terms of the completion date. Within the resource constraints, thematic synthesis was feasible given the researcher's existing expertise in trauma informed practices and qualitative analyses. The researcher therefore had both the methodological skills and experience needed to carry this approach out. This approach was also particularly well-suited to the review question, which aimed to collect descriptive and experiential data about professionals' experiences. It also works effectively with interview transcript data, which allows for line-by-line coding and the development of analytical themes. It is hoped that the review will be disseminated to both clinical and academic audiences. Thematic synthesis allows for the generation of practical insights which can inform clinical practice, organisational strategies and policy development, therefore meeting the needs of a diverse audience.

A CR position assumes that understanding of reality is mediated by our perceptions and beliefs, and thus we can generate knowledge of it (Maxwell, 2012). Therefore, knowledge is fallible, and another perspective is crucial to provide insights into how people make meaning of experiences (Lomillo, 2019). Thematic synthesis

(Thomas & Harden, 2008) identifies common themes across studies, and uses these patterns to draw broader conclusions. These approaches therefore align, as a CR review would aim to explore synthesised knowledge and eventually produce new knowledge (Okoli, 2015).

Thematic synthesis followed Thomas and Harden's (2008) three phases. Only data relevant to the included sample's experiences of VT/STS were analysed. The key findings of each primary study were freely and inductively coded line by line. This resulted in a collection of free codes, which were then condensed with regards to an underlying shared meaning. Codes were subsequently organised into descriptive themes and mapped onto final analytical themes in order to offer further interpretation.

Thematic synthesis requires a balance of combining evidence whilst preserving the context and richness of studies (Thomas & Harden, 2008). Self-reflexivity is crucial, as the researcher's own perspectives can pose a threat to rigour during interpretation. The project supervisor was consulted at the final stage to ensure themes were clearly defined. The primary researcher's views were explored which helped to consider their influence over the development of analytical themes.

Reflexivity statement

Reflexivity can be defined as a set of practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research process. It is a method used to situate the researcher within the analytic process, including an acknowledgement of social location and positionality (Thurairajah, 2018), and should be oriented towards personal, interpersonal, methodological and contextual issues in research (Olmos-Vega et al., 2023). The principles of reflexivity here also align with the CR epistemological stance and the qualitative synthesis methodology (Thomas & Harden, 2008). Reflexivity in this review was considered individually and alongside the project supervisor, who also brought relevant personal and professional experiences.

The primary reviewer is a Trainee Clinical Psychologist with a varied clinical and research background. Relevant clinical experiences for this review include working in the Crisis team for two years, which involved daily clinical contact with adults who were actively suicidal or in acute mental distress. I currently work in a Psychiatric Intensive Care Unit with children and young people, where I am again exposed to high levels of distress. Most of the children I work with have trauma backgrounds, involving significant abuse and neglect, and part of my role is to risk assess and formulate these adverse childhood experiences.

I appreciate the individual and systemic impacts of VT/STS, as I have seen it infiltrate colleagues and teams. The things we see and hear at work are not always acknowledged by the system or understood by personal support systems. This can be damaging and isolating. These experiences have made me passionate about systemic ways of working, trauma-informed care and contributing to the evidence base to raise the profile of VT/STS, which influenced the selection of this topic area.

This stance has influenced the review in numerous ways. The review is being completed at a time where discussions about professional well-being are increasing, but this can feel tokenistic in the context of our exhausted healthcare system, especially when supportive sentiments are not reflected in organisational policy or reality. Discussions around burnout are becoming more common, but VT/STS seems to be broadly understood by society in the context of first responders or veterans, and less so in other professionals.

The need for further understanding and awareness, and the drive to advocate for other professionals lent itself to a qualitative methodology. The CR epistemological stance meant that participant perspectives were valued, as the reality of knowledge is created. In line with this, the inclusion of direct participant quotes and incorporating their views helped to amplify and empower participant voices. This felt like a methodological and ethical standpoint, especially as discussions in this area can feel taboo or stigmatising for some professional groups, and this issue can be dismissed by organisations. Inclusion of their views on systemic barriers maximised the meaning and clinical relevance of the review and lent itself to practical recommendations to help advocate for change.

As a (Trainee) Psychologist, I had some initial hesitations about completing this as an outsider to the core child protection workforce. Although our experiences have probable overlap, our exact experiences are not comparable. However, it felt important to use my position (research opportunity, available resources, and time) to advocate for others. Engaging fully with the literature in this area, and spending hours reading about the experiences of these professionals and the things they witness daily has been shocking, and at points, even haunting. I did not expect to resonate with their experiences as much as I have, but this solidifies the importance of the review even further, and highlights the insidious nature of VT/STS for all of us.

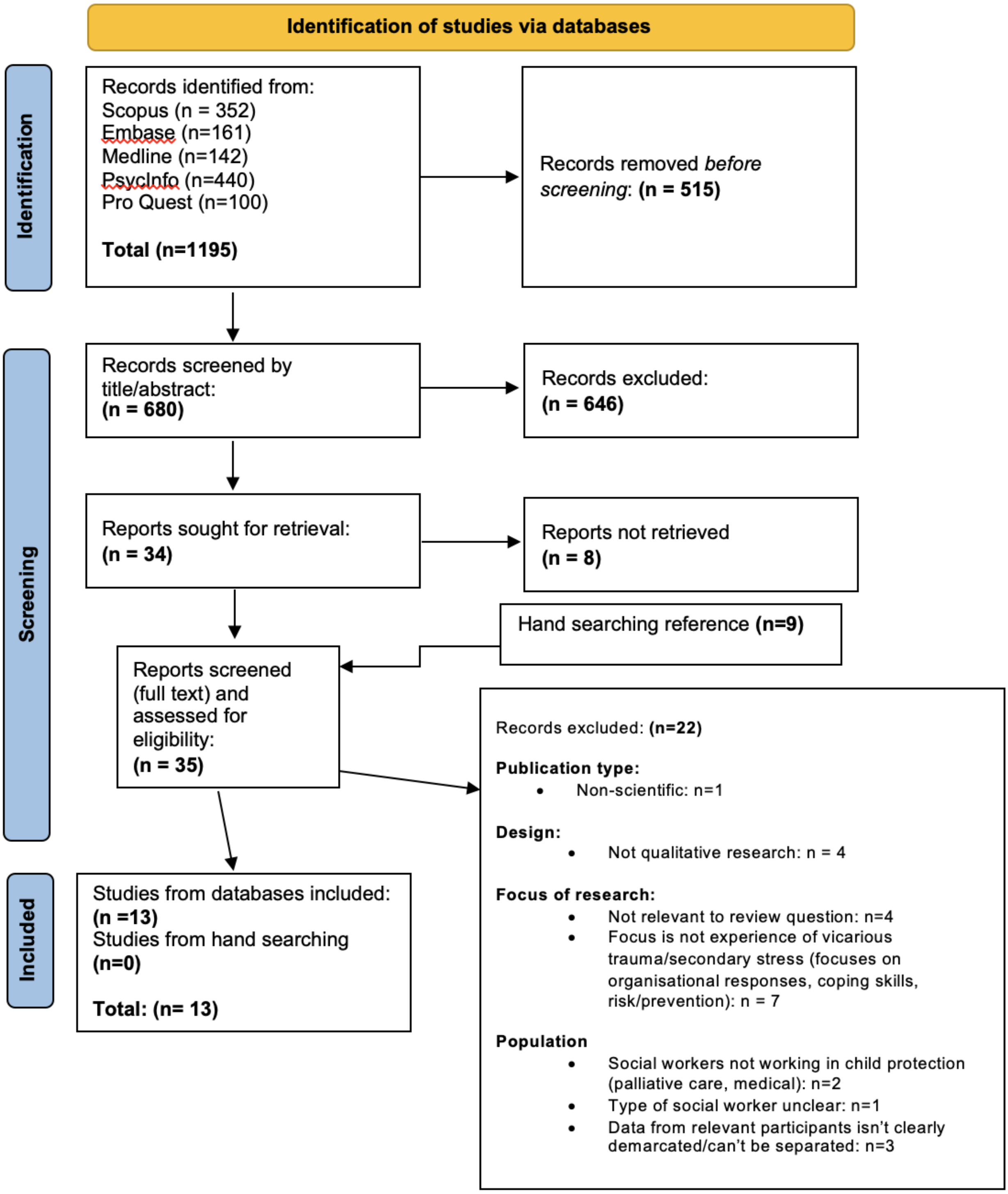
Results

Screening of eligible studies

To guide the searching and selection process, a PRISMA flowchart was utilised (Page et al., 2021; see Figure 1). From the database searches, a total of 1195 studies were identified. Duplicates were removed, and 680 titles were subsequently screened by their titles and abstracts. Nine additional papers were identified through the reference lists of the studies screened at the level of full text. A total of 35 studies were screened by full-text. Following application of the inclusion criteria, a total of 13 papers were selected to be included in the current review.

Figure 1

PRISMA flowchart showing search and selection process.



Study and sample characteristics

Study and sample characteristics are presented below (Table 2) and following this, are discussed in the context of their respective data source with reference to the study number in the Table.

Table 2
Summary of studies included in the synthesis.

Study information			**Sample**		**Methods**			**Findings**
Author, Year, Title, Country, Type of Source	**Nature of work**	**Aim(s)**	**Sample characteristics**	**Sampling method, Recruitment method, eligibility**	**Data collection method**	**Design, Analysis**	**Epistemology, Role of Researcher, reflexivity**	
1. Beer et al. (2012) Personal and professional impacts of work-related stress alleviation strategies among child welfare workers (CWW) in child advocacy settings. United States of America (USA). Peer-reviewed article.	Child advocacy settings	To increase understanding of how stress impacts CWW's professional and personal lives, as well as stress alleviation techniques.	Total sample (n=885). CWW within this (n=86), mean age of all CWWs = 38.44 years. Females (n=77), males (n=8). Race – white (n=63), African American (n=6), Other (n=9). Length of employment (years): <1 (n=10), 1-5 (n=27), 6-10 (n=14), 11-19 (n=22), 20+ (n=13). Sample of	Convenience sampling - authors utilised a subset of CWW specific data from a larger cross sectional study of child abuse professionals working in child advocacy centres in the USA (Letson et al., 2020). Eligibility not reported.	Online mixed-methods survey with three optional open-ended questions (qualitative).	Mixed methods design with quantitative and qualitative elements. Qualitative data utilised a phenomenological approach, and was analysed by Thematic Analysis (Braun & Clarke, 2012).	Social constructivist approach. No explicit reflexivity statement.	Professionals exposed to child maltreatment are particularly vulnerable to the effects of occupational stress. Psychological and detrimental professional impacts include exposure to trauma and secondary traumatic stress. This is experienced as withdrawal, rumination, intrusive thoughts, affective disorders, anger, detachment.

			interest – (n=53) CWW's answered at least one of three qualitative survey questions (out of total 86). Sub-sample demographics not reported. Question 1 (n=52), question 2 (n=41), question 3 (n=53)					
2. Capri et al. (2012) Child sexual abuse workers' emotional experiences of working therapeutically in the Western Cape, South Africa. Peer-reviewed article.	Daily work with children who have been sexually abused.	To contribute to knowledge of working with child sexual abuse in South Africa by exploring the emotional impacts of those who attempt to help, and by investigating the	Social workers (n=4), ages 27-38. All female sample. All White sample. Range of experience = 4-10 years.	Opportunistic sampling via a non-profit organisation which works to prevent child sexual abuse. Eligibility = worked for organisation and available at the same	Semi-structured interviews.	Qualitative multiple case study design. Analysed via Thematic Analysis (authors not referenced in paper).	Critical realism and contextual constructionist approach. No reflexivity statement. Meaningful participatory approach. Reflexive strategies used to enhance rigour:	Symptoms resembling vicarious trauma were described (vigilance, isolation, guilt, powerlessness, change in world view, stress manifesting as physical issues, anger). Participants disconnect themselves to provide distance against hearing

		psychological impact thereof on social workers active in Western Cape low income communities on a daily basis.		time as the researcher.			member checking.	distressing trauma narratives.
3. Dane (2000) Child Welfare Workers: An innovative approach for interacting with secondary trauma. USA. Peer-reviewed article.	Making home visits to investigate and determine child abuse/neglect, and remove children if necessary.	Phase 1= To examine the nature of secondary trauma and its impact on CWWs. Phase 2 = To create and present a conceptual model based on focus group findings to child welfare workers to improve knowledge and skills.	Phase 1 (sample of interest) CWWs (n=10), age range 20-49, females (n=7), males (n=3). Phase 2 (n=18) CWWs, mean age = 37, gender not reported.	Purposive sampling - researcher obtained participants via contacting directors at 5 child welfare agencies borough offices. CWWs were notified about the study based on a flyer asking them to participate. Eligibility = worked in either the assessment ,	Two focus groups.	Qualitative design. Data was analysed via content analysis (Mostyn, 1985).	Reflexivity acknowledged as the researcher locates themselves as having a background in group work. Researcher acknowledged their potential bias and wish to achieve desired results and how this could have impacted data collection. Epistemological position not reported.	Theme of ‘coping - secondary trauma’. Participants experienced STS as loneliness, abandonment, an inability to separate personal and professional life. Behavioural changes included detachment, staying busy, accepting ones limitations and ‘cutting off’. The workers reported symptoms paralleling secondary trauma after the death of a child on their caseload. These included concentration difficulties, irritability, startled responses, feeling vulnerable,

				investigation or protection units of the agency for at least three years.				anxiety, sleeplessness and intrusive trauma images. CWWs should be equipped to handle complex trauma that they incur as they bear witness to the maltreatment of children.
4. Ezell (2019). First, do no harm to self: Perspectives around trauma-informed practice and STS among rural child protective services (CPS) workers. USA, Peer-reviewed article.	CPS agency in a rural area chosen due to complex client abuse, neglect cases and high child poverty rate. Nature of work involves CPS casework (investigations, child removals and sourcing placements).	To assess the operationalisation of a pilot trauma-informed practice initiative, focusing on a child protection system unit in a rural area, and to examine associated activities and challenges around implementation. To capture experiences around STS and to characterise various contours of an	CPS unit workforce (n=11). This included case investigators, site director, supervisor of case investigator), Females (n=10), male (n=1), age range of 20-55. No other demographics reported to ensure anonymity.	Purposive sampling - researcher intentionally selected the site based on specific characteristics. Eligibility = CPS workers who had participated in the trauma-informed practice training or been exposed to an STS debriefing previously implemented by authors.	Semi-structured interviews.	Qualitative design. Data analysed through ‘coding’ but no specific analysis method.	No explicit reference to epistemology or reflexivity.	Multiple respondents perceived that generational differences in the office led to wide variation in their capacity to manage STS. Respondents experienced STS as feelings of professional and personal isolation, incompetence, and uneasy work-life balances (wanting to protect co-workers and families from their STS), lack of sleep, excessive worry.

		embedded STS mitigation intervention.		Recruitment strategy not reported.				
5. Federico (2017). Identifying the experiences of secondary traumatic stress in rural CWWs: Action Research Study. USA. Grey Literature (Dissertation).	Child abuse, neglect, domestic violence, emotional abuse and death in rural context.	To explore how CWWs in a rural community experience and respond to VT and STS.	CWWs (n=8, 4 from each county). Combined experience of 38.5 years. Other demographics not collected to preserve confidentiality.	Convenience sampling - population are from two rural counties. Recruitment - Email and flyer invitations used. Eligibility - CWWs where entire staff team is less than 15. Participants from county A and B, both rural mountain communities in North West USA. Participants had to have completed one year of employment with the agency. Exclusion -	Individual semi structured interviews using open ended questions	Qualitative Design. Content analysis (Moustakas, 2011). Empirical phenomenological approach.	Epistemology - Interpretist view. Reflexivity statement - Researcher situates self as experienced child protection worker (occupying various roles) with likely STS, and outlines previous research in this area. Reflexive strategies used e.g., reflexive journal, member checking. Meaningful participatory approach.	Rural child welfare workers experience STS, but the experienced trauma depends on the unique perspective and association given to the experience. This includes symptoms such as: depression, difficulties separating personal/professional life, frustration, exhaustion, sleeplessness, crying, hyper vigilance, avoidance, withdrawal in relationships, guilt, loss of appetite, changes to self-identity. Many symptoms were exacerbated by the rural context. Rural child welfare agencies need to engage in providing trauma informed training and include

				refusal to be audio recorded during interview.				secondary trauma as part of their culture in supervision.
6. Freeman (2016) Exploring the lived experiences of supervising child protection workers (SCPSWs). USA. Grey Literature (Dissertation).	Achieving safety, permanency and assuring the well-being of children by managing staff who directly investigate child abuse/neglect allegations.	To explore the lived experiences of SCPSWs, and to describe the essence of those experience to determine whether occupational trauma had an effect on them doing a sufficient job.	SCPSWs (n=10), ages not reported, women (n=6), men (n=4). Years of experience ranged from 10-31. Other demographics not reported to maintain confidentiality.	Recruitment via social media - author refers to this as purposeful criterion sampling. Eligibility - working for a child welfare agency in Southern California and holding job title of SCPSSW. Requirement for face to face availability.	Individual face to face interviews with open ended questions.	Qualitative design. Phenomenological approach identified. In-vivo coding methodology in line with Saldaña (2013).	Role of researcher is clarified as conducting interviews, recording responses and transcribing field notes. Reflexivity - reference made to position as a SCPSW and own experience of VT. Epistemological position not reported.	Within the sub theme of ‘indicators of occupational trauma’, participants reference experience of VT. This is experienced as anger towards abuse, distress regarding seeing abuse, disgust, personal feelings ‘getting in the way’, anxiety about having own children, damaged personal relationships, change in worldview/mistrust, hyper vigilance, insomnia, triggers of previous personal abuse, visualising abuse after reading about it and playing it back in your head. Working in child welfare increases vulnerability to trauma.
7. Genovese	Working directly with,	To gain an understanding	CWWs (n=16),	Convenience sampling -	Semi-structured	Qualitative design. Coding	Reflexive strategies	Participants did not associate their own

(2013). Secondary Traumatic Stress of CWWs: A Qualitative Investigation. USA. Grey literature (Dissertation)	and investigating reports of, abused children, abusive families, schools, attorneys and members of the community.	of the work-related experiences of CWWs and to determine if these experiences resulted in the development of STS.	females (n=14), males (n=2). Highest education level: Associates degree (n=1), Bachelor's (n=12), Master's degree (n=3). Length of employment at the agency: 1-5 years (n=10), 11-15 years (n=3), 16+ years (n=3).	selected due to proximity and current working relationship with these counties. Recruitment - recruited by sending an email to participants who worked in relevant agencies. Eligibility - participant had to be a CWW, not a supervisor, administrator or support staff.	interviews.	analysis used which resulted in themes. Researcher does not reference specific data analysis method.	employed e.g research journal, member checking. Reflexivity - researcher locates herself as a therapist specialising in the treatment of traumatised individuals and discloses professional views on trauma. The researcher critically examines own role i.e potential bias. No epistemological position reported. Meaningful participatory approach	symptoms to the child abuse and neglect that they witness as a part of their job, except in cases of death (which has long lasting effects such as flashbacks, guilt, threat of blame). The unpredictable nature of the job and lack of support were felt to contribute to the development of STS symptoms. Other STS experiences involved sadness, anger, sleep disturbance, agitation, increased anxiety, impacts on parenting (over-protectiveness) and relationships with spouses, elevated startle response, mistrust towards others, feelings of isolation, avoidance.
8. Griffiths (2017). Service before self: The health	Protecting children and families from abuse and neglect.	Overall aim: To explore how the stress of working in public CWW's	Total sample - Frontline public CWWs (n=511),	Secondary sampling – use of a state-wide cross-	Electronic mixed methods survey with qualitative	Study involves the secondary analysis of cross-sectional data. Mixed	Epistemology, role of researcher, and reflexivity	The results support the presence of VT and STS associated with front line work. "Irritable/impatient/a

consequences of working in public child welfare. USA. Grey Literature (Dissertation)		personal health. Qualitative component aim: To analyse the self-reported unhealthy consequences of working as a CWW.	female (85.5%), male (13.5%), mean age = 37.62. Sample of interest (within qualitative component) - mental health theme (n=214), behavioural responses (n=263). Other demographics not reported.	sectional data set of CWWs. Data obtained through a state-wide electronic survey submitted in 2016 to the Public Child Welfare Workforce in Kentucky via their government email. Participation was voluntary.	open-ended questions.	methods design. The relevant qualitative component of data set was analysed via Thematic Content Analysis in line with Braun and Clarke (2006).	not reported.	ngry” sub theme = CWWs experience disturbed sleep due to stress and nightmares. “Mental health theme” = participants experience anxiety, depression, withdrawal, panic attacks, PTSD, constant obsession/worry/unrest about workplace obligations, isolation/withdrawal from their families and the public, hyper startled response, crying, exhaustion, and strain on marriage. The profession must recognise the health implications associated with working in public child welfare.
9. Guarnaccia et al. (2020). Working with children who are victims of	Working daily with maltreated and abused children who are cared for in a residential community.	To explore the emotions of social workers in their everyday relationships with children who are	Total sample (n=37) consisted of social workers, educators, and psychologist	Purposive sampling used to select 6 residential communities according to a	Photolanguage method used (photos used to prompt discussion) in focus	Qualitative design. Content analysis used to analyse transcripts of focus groups.	Reflexivity, epistemology and role of researcher not reported.	Hearing child abuse stories arouse feelings of inner distress amongst social workers, experienced as frustration, anger, guilt, sadness. They

abuse: emotions and representations of professionals in residential children's communities. Italy. Peer-reviewed article		victims of abuse and/or maltreatment. To understand how professionals work on their own feelings and what strategies they use. To detect the social and professional representation which social workers and educators have of their work, of their professional identity and network.	s. Ages not reported. Males (n=4), women (n=33). Relevant sample (number of social workers within overall sample) not reported. Other specific demographics not reported.	similarity criterion (protection of children in danger) and the age group of accepted minors (0-6). Recruited via a voluntary agreement from professional teams which involved initial contact, informed consent and voluntary participation.	groups led by Clinical Psychologist.			experience wanting to isolate, dismiss thoughts of the event and distance themselves emotionally. Future studies should investigate social workers response to the risk of secondary trauma.
10. Jankoski (2002). Vicarious traumatization and its impact on	Working in child protection daily, commonly with child sexual abuse.	How does vicarious trauma affect CWWs and the system in which they	Total sample (n=300) child welfare administrators, supervisors, caseworkers	Mixed purposeful sampling strategy (9 counties requested inclusion,	Eight focus groups and three individual interviews. More were completed	Qualitative, multi-case design grounded in CSDT. Inductive analysis used	Reflexivity statement provided. Researcher locates position in terms of role	Findings suggest that VT has gone unrecognised in the Pennsylvanian child welfare system, and is experienced at the extreme end.

the Pennsylvania Child Welfare System. USA. Grey Literature (Doctoral Dissertation).		work?	and support staff. Average age = 37.5. Only a sub-sample of participants were included in full text (focus groups consisted of n=69, n=56 females and n=13 males). Individual interviews (n=3). Specific ages not reported. All were CWWs in the same agency.	and individuals self-selected after receiving a letter). Inclusion - CWWs within approached counties in Pennsylvania.	overall but not included in write-up.	(Patton, 2002). Uses cross case comparison to find several common themes.	as child protection worker and motivation for study. Reflexive strategies: field notes, member checking. Participatory action focus. Interpretive approach influences data analysis.	Through the CSDT lens, focus groups support all contributing VT factors. CWWs experience PTSD symptoms (intrusive images, nightmares, flashbacks, startle responses, avoidance). Participants experience distrust, isolation (especially following child death), change in world view, hypervigilance, constant anxiety state, disrupted relationships, avoidance.
11 Lewington et al. (2013) The experience of paediatric residents participating	One month responding to inpatient/outpatient referrals of maltreated children in a hospital child protection	To explore how Paediatric Residents experience a mandatory rotation within a hospital	Senior Paediatric Resident Trainees (n=8). Other demographics not reported.	Purposive sampling - recruited based on inclusion criteria - trainees who	Individual semi structured interviews.	Qualitative design. Data was analysed using a phenomenological approach and Thematic Analysis	Researcher contextualises role as having no involvement with the rotation and discusses	The sub-theme ‘expressed emotion’ captures residents' difficult emotional experiences during the rotation. They experienced anger towards alleged

in a child protection rotation: A qualitative study. Canada. Peer-reviewed.	team.	based child protection team from an emotional and professional standpoint.		completed the rotation in the study period, preceding 24 months, or were still working at the hospital where the research took place.		(Braun & Clarke, 2006).	researcher bias in discussion. Epistemology not reported.	perpetrators, sadness, and rumination/preoccupation with feelings around cases. Findings highlight the importance of maintaining open dialogue and debriefs.
12. Mudd-Fegett (2016). Exploration of child welfare through action research. USA. Grey literature (dissertation).	Assisting child abuse victims and victims of violent crimes on a daily basis.	What impact does secondary trauma have on CWWs' ability to perform the duties of his or her position?	Frontline CWWs (n=86). Most common age range = 21-30. Vast majority reported as female. Sample of interest - frontline CWWs (n=11) (focus group participants). All female. Age not reported. Years of experience	Purposive sampling. Recruited via email invitation to participate. Eligibility - frontline CWWs in Kentucky.	Online questionnaire and focus groups.	Mixed methods design. Action research approach. Deductive coding and narrative analysis (Taylor et al., 2015) used to analyse focus groups.	Locates self as having experience of frontline child welfare work and kept a research journal. No formal reflexivity statement. No epistemological position reported.	Frontline CWWs are routinely exposed to intrusion, avoidance, and arousal symptoms as a result of secondary trauma exposure (namely child removal and child fatalities) which led them to detach from others and experience psychological distress. This impacts both their lives and professional practice.

			varied from 6 months to 28 years.					
13. Tavormina & Clossey (2014). Exploring crisis and its effects on workers in CPS work. USA. Peer-reviewed article.	First response to severe child abuse (assessing risk and investigating allegations)	To investigate CPS workers' perceptions of crisis, and their subjective assessment of the impact of the work on their personal lives.	CPS workers (n=12). All female sample. Aged 20-30 (n=6), 31-40 (n=4), 41-50 (n=1), >51 (n=1). Ethnicity – Caucasian (n=11), African American (n=1). Education background – Bachelors (n=10), Master's in Social Work (n=1).	Purposive sampling. Recruited via approaching child welfare agencies in rural USA and use of flyers. Inclusion criteria - CPS workers in the approached agencies.	Semi-structured individual interviews.	Qualitative design. Grounded theory analysis (authors of data analysis method not reported in paper).	Epistemological position not reported. Role of researcher and reflexivity not reported. Researcher bias acknowledged - steps taken to address this include discussing preliminary findings with a team of University colleagues.	Findings mirror the high level of VT in the field, and workers feel that this impacts them and their lives. Emotional impacts include worry, anxiety, powerless and frustration. It is hard to shut down emotionally when innocent children are harmed. This trauma impacts workers' personal lives e.g., compromised energy, a loss of implicit trust in the world and goodness of others, and feeling more protective of their family.

Study characteristics

Descriptive information about the studies included in the review are presented in Table 2. Seven peer-reviewed studies (1, 2, 3, 4, 9, 11, 13) and six grey literature sources (5, 6, 7, 8, 10, 12) were included in the final review.

Of the peer-reviewed studies, four were from USA (1, 3, 4, 13), one was from South Africa (2), one from Italy (9), and one from Canada (11). All six grey literature sources were from USA. One study was conducted in the year 2000 (3), one in 2002 (10), two in 2012 (1, 2), two in 2013 (7,11), one in 2014 (13), two in 2016 (6, 11), one in 2017 (5, 8), one in 2019 (4), and one in 2020 (9).

Of the peer-review studies, two specifically focused on examining experiences of STS (3, 4) and the remaining five studies had a broader focus around work-related stress, emotional and psychological experiences of social workers, and experiences of working in child protection. The peer-reviewed studies represented the views of more than 98 participants, some within broader sample sets (1, 3). However, one study failed to separate demographics between occupations (9), so an accurate description cannot be included here. Samples of included participants ranged from four to 53. Studies varied with the type, number and quality of sample characteristics collected and reported. Commonly reported sample characteristics included occupation, age, race and length of employment. Data suggests the total participants typically represent a subgroup of CPS workers who are predominantly White females aged 20-40.

Of the grey literature, the majority had a specific VT/STS focus (5, 7, 10, 12). and two had a broader focus i.e., occupational trauma, and the impacts of work stress on health (6, 8). The grey literature studies represented the views of at least 103 participants. One study cannot be included here as an accurate report of the relevant sample size is unclear (8). Commonly reported sample characteristics included occupation and gender. Data suggests the total participants here typically represent a majority female, presumably American, Child Welfare Workforce.

Two studies collated data using a mixed methods survey (1, 8), seven utilised semi-structured interviews (2, 4, 5, 7, 10, 11, 13), one used open-ended interviews (6), three used focus groups (3, 10, 12), and one utilised the less common ‘Photolanguage’ method (9). Several analytical approaches were used: thematic analysis (1, 2, 8, 11), content analysis (3, 5, 9), grounded theory (13), in-vivo coding (6), narrative analysis (12), non-specific ‘coding’ analyses (4, 7), and non-specific ‘inductive analysis’ (10). Two of the grey literature studies used meaningful participatory approaches (2, 13) as did three of the peer reviewed studies (5, 7, 10). Four studies reported their epistemological position (1, 2, 5, 10). Eight studies orientated the reader to the researcher’s role (3, 4, 5, 6, 7, 10, 11, 12), yet only five included a detailed reflexivity statement (3, 5, 6, 7, 10). However, six discussed reflexive strategies used to enhance trustworthiness and rigour e.g., member checking (2, 5, 7, 10, 12, 13).

Quality appraisal

Methodological strengths and weaknesses across selected studies were identified using the CASP (2024) qualitative checklist. Quality appraisal ratings can be found in Table 3.

In line with CASP criteria, 10 studies showed no or very minor concerns (1, 2, 3, 5, 6, 7, 10, 11, 12,13). As aforementioned, five included explicit reflexivity statements to acknowledge the role of the researcher (3, 5, 6, 7,10), whilst the remainder did not include formal detailed statements about reflexivity but made effort to critically reflect on the researcher’s position within data collection, analysis and interpretation which lent itself to a credible narrative (5, 6, 11, 12, 13). The two remaining studies did not acknowledge the reflexive relationship between researcher and participants, but this did not impact their overall rating (1, 2).

Whilst the CASP checklist does not explicitly assess epistemological positions, epistemological assumptions influence the clarity of research aims, choice of sampling, approach to data analysis and researcher reflexivity. Four of the aforementioned studies (1, 2, 5, 10) declared their epistemological positions which aided the quality assessment. All 10 studies showed transparency and coherence between the aim, design, and methods.

Two studies showed minor methodological concerns (8, 9). One study provided insufficient information e.g., about the rationale for data collection methods (8). Both failed to satisfactorily report on researcher reflexivity or the role of the researcher within the data collection, analysis or interpretation. Both made some reference to ethical principles i.e., anonymity, but neither paper made reference to ethical approval. Study nine did not include participant quotes which raises questions about rigour of analysis and whether sufficient data is presented.

As per the inclusion criteria, grey literature which had a degree of scientific and methodological rigour displayed via a review process (e.g., University review) were included in the review. These studies underwent multiple academic and peer-review processes and thus could be assessed by the CASP checklist and included in this review. Four of the included grey literature studies showed no/very minor methodological concerns (6, 7, 10, 12) and one showed minor concerns (8). Their quality ratings further increase the confidence in the findings of these papers.

Moderate concerns were identified for one study (4). The study offers important information about eligibility and sampling, but provides a lack of information on the recruitment process itself and non-participation. Data collection methods are not justified and saturation isn’t discussed. The relationship between researcher and participants is not adequately considered, with no critical examining of the researcher role or reference to reflexivity. There is also no in-depth description of the process followed for data analysis, which made it impossible to comment on the quality of findings.

Table 3

Quality appraisal grid.

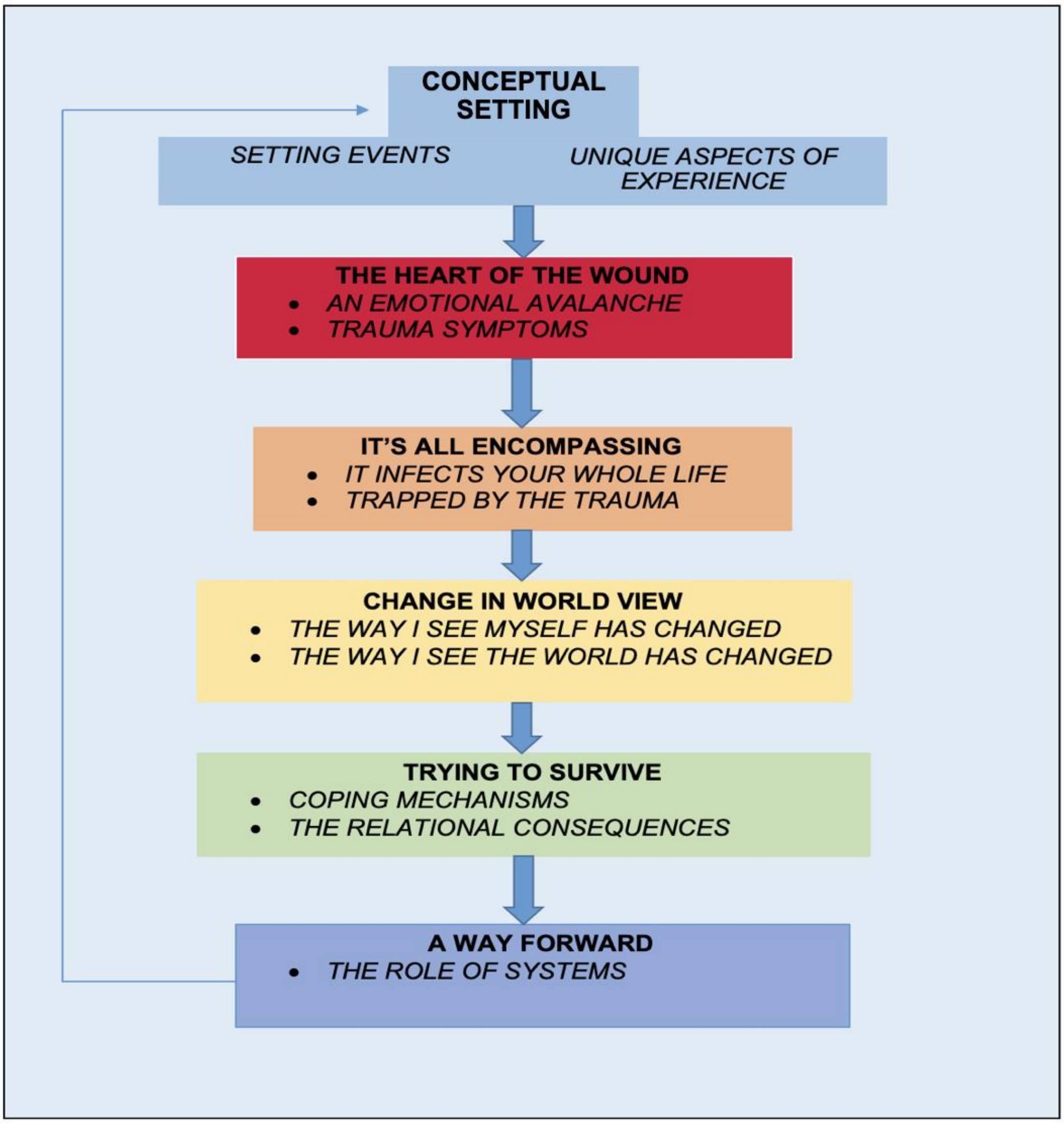
Study	Type	Statement of aims	Appropriate methodology	Appropriate design	Recruitment strategy	Data collection	Researcher reflexivity	Ethical considerations	Analysis rigour	Statement of findings	Research value	Methodological concerns
1)Beer at al. (2021)	Peer-reviewed	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	No - very minor concerns
2)Capri et al. (2012)	Peer-reviewed	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	No - very minor concerns
3)Dane (2000)	Peer-reviewed	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	No - very minor concerns
4)Ezell (2019)	Peer-reviewed	Y	Y	N	?	?	N	Y	?	Y	Y	Moderate - major concerns
5)Federico (2017)	Grey literature	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	No - very minor concerns
6)Freeman (2016)	Grey literature	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	No - very minor concerns
7)Genovese (2013)	Grey literature	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	No - very minor concerns
8)Griffiths (2017)	Grey literature	Y	Y	Y	?	?	N	?	Y	?	Y	Minor - moderate concerns
9)Guarnaccia et al. (2020)	Peer-reviewed	Y	Y	Y	Y	Y	N	?	?	Y	Y	Minor - moderate concerns
10)Jankoski (2002)	Grey literature	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	No - very minor concerns
11)Lewington et al. (2013)	Peer-reviewed	Y	Y	?	Y	Y	?	Y	Y	Y	Y	No - very minor concerns
12)Mudd-Fegett (2013)	Grey literature	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	No - very minor concerns
13)Tavormina & Clossey (2014)	Peer-reviewed	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	No – very minor concerns

Synthesis of results

Thematic synthesis resulted in six analytical themes and 10 subthemes. All extracted data is provided in Appendix D. Illustrative quotes can be found in at the end of this section (see Table 4) to enhance transparency and depth of findings. The six analytical themes were developed from the subthemes, and are all interconnected.

Figure 2

Visual depiction of Analytical and Subthemes.



Conceptual setting

Different aspects of the context in which VT/STS occurs were referenced across the reviewed primary studies. Two *subthemes* were included: ‘Setting events’ and ‘Unique trauma’. This theme encapsulates the trauma context, which lends itself to an understanding of the cultural and contextual predisposing factors of the phenomenon within this population in terms of how it develops, particular vulnerabilities, and common contributing experiences.

Setting events

This *subtheme* refers to particularly traumatising events or experiences which significantly contribute to child protection professional experiences of VT/STS. Child fatalities and child removals were consistently cited as universally traumatising events to be involved in, for instance *“I cry during every removal”* (12) and *“when children die as a result of maltreatment and neglect, it is a trauma for all concerned” (3).* Some participants referred to the experience of having to return children where they are exposed to abuse and neglect as distressing, *“I thought I’d go out of my mind. I will never forget the look in that child’s face when I brought him back home”* (7). Importantly, indirect exposure via hearing about cases or reading reports also played a significant role in the development of distress, *“consulting cases with workers is as if not more traumatic than working the cases myself”* (12).

Unique aspects of experience

Generally, child protection professionals face distinct trauma due to the unique nature of their work. Thus, they are uniquely impacted. For instance, *“social workers (..) mention great confusion linked to the reality of abuse”* (8), and “*unlike* *other responders, CWWs have continued exposure to the trauma of child maltreatment with every report, change in placement, and discussion”* (5).

Within this, child protection professionals’ experiences differ depending on their cultural, geographical and professional contexts. Factors across the socio-cultural context likely influence the development of VT/STS i.e., professionals in child advocacy settings were found to have *“particular vulnerabilities”* to the effects of occupational stress (1). This may also influence the experience of VT/STS itself, for instance, *“salient features of doing child sexual abuse work in South Africa”* (2), *“generational difference”* leading to a variation in response (4), and symptoms being exacerbated by “*the remote, rural community as there were few outlets and venues for discussing and debriefing in privacy.”* (5).

The heart of the wound

This refers to the ‘core’ emotional experience described across all studies. Within the sub themes ‘An emotional avalanche’ and ‘Trauma symptoms’, the range of emotions, feelings and psychological impacts of child protection work are captured.

An Emotional Avalanche

This subtheme refers to the extensive range of overwhelming and intense emotions which professionals experience. Emotions are referred to as “*charged*” (13), “*ramped up*” (7), and participants report “*almost blacking out”* (2) from the emotional intensity evoked by the work. Specifically, participants report affective disturbances such as anxiety and depression (1, 5), emotional dysregulation, *“I am on the verge of crying or laughing”* (8), feelings of guilt for “*not doing enough”* (5), self-blame (3), disgust (6) and sadness, “*it makes me so sad for these kids”* (7), *“it’s* *just so upsetting"* (7) and (11, 12). Anger was by far the most common emotion reported (1, 2, 7, 10, 11), *"I can carry on like a banshee – people think I've completely lost it"* (2), "*my temper is more present than it's ever been"* (7), feeling angry *"every minute of every hour of every day"* (10), and wanting to "*yell at the perpetrator, (..) sink them to violence"* (11).

Importantly, across two studies, the emotional experience seemed to be heightened if the worker had a child of their own (6, 13). Participants describe becoming more sensitive to the issues of child abuse due to understanding what it is like to be a parent, and visualising their own children in distressing situations, *"as a Mother, I want to cry with them, 'oh my god if this was my kid'. I cry now when I talk about it."* (13)

Trauma Symptoms

PTSD or STS symptomology is broadly referenced across four studies (6, 8, 12, 13). This is broadly summarised *as "agitation, nervousness, lack of sleep, hyper startled response"* (8), and one study confirmed that frontline CWWs are routinely exposed to *"intrusion, avoidance, arousal symptoms (..) of their secondary trauma exposures"* (12).

More specifically, hypervigilance and safety fears were commonly experienced (1, 2, 6, 10, 11, 13). This seemed to occur most commonly in public. For instance, feeling *"constantly distracted in public"* and ensuring children have *"clothing, no marks/bruises"* (1), *"I check my doors and windows several times"* (10), *"I lock my door as soon as I get into the car"* (11). Again, this distrust tended to be exacerbated if the worker had their own children, with participants reporting being *“very protective”* (13), and “*it hits close to home (…) those traumatised (..) kids can obviously be mine”* (6).

Flashbacks of traumatic events, trauma triggers, and intrusive memories were also reported (3, 5, 7). The job seems to continuously re-traumatise professionals through repeated traumatic exposure. Participants report memories of child removal *“stayed alive”* and “*became repeated at the next removal”* (3), *“it flashes in my mind (…) I can’t let the picture go”* (3), *“triggers came back (…) the exact same feeling*” (5*), “I will visualise that happening (..) it’s like re-experiencing it”* (7). In line with PTSD symptomology, two studies referenced a heightened startle response (5, 7), for instance, ”*her ice machine made the noise (…) she flew up out of bed thinking (…) there’s gunfire in my kitchen”* (5).

It’s All Encompassing

This theme refers to the relentless nature of the trauma and distress, in the sense that it takes over every aspect of life.

It infects your whole life

Professionals’ personal and professional lives gradually become enmeshed into one, with little separation (1, 3, 4, 5, 6, 10). Participants reported feeling unable to separate the two, leading to “*fragile and uneasy work life balances”* (4), feeling as though they are “*never released”* from duties (10). Participants report “*giving my personal phone number to clients”* (1), and being told “*you need to learn boundaries”* (4).

Feeling utterly consumed by their work is commonplace, for instance *“taking some of the job home*” (4), *“the whole job has just taken over my life”* (6), and *“it’s hard to have a life*” (5). Work constantly occupies their mind, even in their personal leisure time*, "before I go to sleep, when I wake up, in the bath"* (2) and in public *"we see clients everywhere we go"* (10). There is a sense that their jobs claim their whole identity, and even if they want to, they are unable to separate from this.

Trapped by the trauma

The job itself, as well as the traumatic experiences, consumes participants at work, then follows then home. This is completely all encompassing, unrelenting, and disturbing. Participants report thinking about work "*all the time"* (5), "*horrific stuff"* being "*burned into your memory forever"* (10), and *"it lingers there"* (11). The majority of studies report on sleep disturbances. Reports of trauma nightmares are very common, *"I relive some of the incidents in my head, I wake up screaming"* (10), *"I wake up with him coming after me with knives (..) My sleep is my time"* (10), and other sleep issues "*I've had insomnia ever since I started"* (7), *"it's not uncommon for me to cry myself to sleep (..) thinking about the children"* (8).

Participants also engage in rumination in a seemingly passive and repetitive way, often going over the same thoughts and events in their mind, which contributes to mental exhaustion. For example, *"I often find myself thinking about horrible things that have happened to children"* (1), *"I would stay in the parking lot sometimes if i got a lot on my mind"* (6), thinking about clients *"when I wake up (..), in the shower, at the dinner table"* (8), and not being able to sleep due to "*thinking too much"* (7).

Change in world view

VT and STS profoundly changes individuals, and triggers a lasting shift in how they see others, life and the world.

The way I see myself has changed

Changes in perceived self-identity were commonly reported (1, 2, 3, 4, 5, 7, 10, 13). Participants felt disconnected from their former selves, such as a *"completely different person"* (5). Most participants report a dislike for who they are now, *"I hate who I have become"* (10), "*I have become a real b*tch"* (10), it's *"made me hard and impatient*" (2). They report becoming more worn down, diminished, and desensitised over time, and seem to perceive this negatively (5, 10, 13), *"I think it hardens you" (13), "things that appalled me when I first started this job don't even affect me"* (10), *"I look a little haggard"* (5).

Conversely, many participants were able to find positives amongst adversity, highlighting the nuance within this experience (1, 2, 4, 5, 13). Participants report that seeing the impact of abuse and the complexities of their jobs made them "*really appreciate my life"* (13), gave them "*increased confidence"* (1), and knowledge of trauma has prevented them from *"getting stuck in the mud"* (4). Participants describe feeling "*more tolerant of people*" (13), and acquiring knowledge which has helped them to *"work through a lot of personal issues from my own childhood"* (5).

The way I see the world has changed

Participants across most studies (1, 2, 6, 7, 8, 9, 10, 13) report a significant shift in the way they see the world after working in child protection. This seems to begin as the job shatters beliefs they once held about the world, and the traumatic reality of abuse becomes evident. For instance, *"I was aware that kids were being hurt, but I never knew how bad"* (10), *"it can be hurtful (..) to know that people actually neglect their children"* (1). This disillusionment seems to lead to a shift in how the world is perceived, *"there's ugliness in our world"* (6), *"this world is a messy* *place"* (2), and therefore a loss of trust for others*, "it has affected how I trust people"* (6), *"the goodness of others had been lost"* (13).

The changed view of human nature has an impact on participants' personal lives, for instance *"I'm like waiting to have a family*" (7). This also leads to a shift in parenting style, with increased hypervigilance, a skewed perspective, and an assumption that people are inherently a danger to their children. For instance, *"you walk down the mall and you say perp, perp, perp"* (10), "*you think everyone's a sex offender"* (7).

Trying to survive

This theme portrays the range of psychological and behavioural strategies which participants use to attempt to cope with the trauma they have experienced. Engaging in such strategies can have detrimental wider relational consequences, which are explored.

Coping mechanisms

Participants understandably utilise a range of mechanisms both to survive day to day, and to defend themselves from the trauma and associated symptoms that they experience. To distance and protect themselves from the pain and distress, participants across studies describe emotional detachment or numbness, which is sometimes intentional and sometimes a consequence of the work, "*one gets numb sooner or later"* (2), *"incest cases are the worst, I numb myself*" (2), *"it didn't touch me (..) I was not affected by it at all*" (5), *"you can't be emotional"* (13).

Participants utilise various defence mechanisms such as a *"sick sense of humour"* (7) and suppression, *"you put the client's pain away, and you put your guilt away"* (2). They talk about "*disconnection"* as a protective measure to prevent overwhelm (2), and one referred to engaging in self-harm as a way of coping (8).

Additionally, participants engage in several forms of avoidance, such as not watching certain television (3, 5, 10), particularly with *"violence, death, or any type of abuse"* (10). They also avoid *"people, places, or situations"* (10*), "certain families"* (10), *"I will not even allow a can of stewed tomatoes in my house"* (10, referencing a trauma trigger).

Unfortunately, social and emotional withdrawal is common, mainly due to the feeling that others won't understand, *"10 years ago I came to a point where I stopped talking about work at home"* (6), *"lost interest in (..) socialising with others"* (1), *"I don't talk about it"* (5), "*you have emotions that you can't share because they won't understand"* (2). To the other extreme, other participants' hypervigilance, distrust and safety fears manifest as checking behaviours, 'over planning' and use of clear strategies to keep themselves and their families safe. For instance, *"people who were convicted pedophiles (..) I would point them out to my children"* (7), *"in public (..) I walk 10 paces behind"* (10), *"I don't want anybody to know that I have a kid and what he looks like"* (7).

The relational consequences

The experience of VT/STS itself, as well as the strategies used to try to manage it, has relational consequences. Firstly, participants describe a fear of passing their STS on to others, referenced as "*contagious aspects of trauma"* (4) and a ripple effect, "*my ex told me (…) because I'm stressed out, stresses him to the point where it's unhealthy"* (7). Participants show awareness that their work is *"hectic for others"* (2), a "*desire to protect others"* (4), and a recognition that sharing their experiences would make others "*uncomfortable"* (2), "*this ugliness (…) they just don't want to hear it"* (10). Participants reference a reduction in sexual intimacy because of the impacts of VT and not wanting to share “*any of the ugliness”,* or be touched (10).

The aforementioned withdrawal leads to significant relationship shifts and isolation. Studies reference lost friendships (4), *“huge differences such (..) with my parents”* (5), loneliness (2), *“distance in relationships”* (5), “*never go out with friends as I no longer have any” (8), “I have no support system anymore”* (7).

Participants describe a sense of alienation from loved ones, *“You bring it home with you and they don’t get it”* (7), *“You guys don’t understand what I’ve been through today. We removed six kids”* (4). Moreover, participants describe the impacts of feeling depleted of all resources and having *“no energy for my kids when I get home”* (10), and being “*numb and unresponsive to my family”* (10). Hypervigilance also leads to other undesirable family dynamics. Participants describe their children as being “*so over protected that I (..) felt sorry for them”* (7), “*try explaining to your nine-year-old why she can’t ride her bike”* (10)

A way forward: The role of systems

This theme acknowledges the role of the wider system in the development or perpetuation of VT/STS. Systemic limitations hinder professionals from doing their job effectively which causes feelings of powerless, and contributes to emotional distress. Participants report feeling “*Useless. You have no control (…) you want to help them, but you’re incapable”* (13), and *“frustration (…) not being able to provide adequate support”* (9).

Navigating the system can cause moral dilemmas for professionals, who often have to enforce things that they don’t agree with, “*I was enforcing the law (..), having my own issues about that it (…) I was very torn”* (6), and *“indefinable feelings which* *often cause conflict (..) between their own emotions and what they have to do”* (9). Participants also acknowledge that the system could have contributed to iatrogenic harm for children, and therefore themselves in parallel. For instance, questions about how “*the system allows that to happen to kids”* (7), and the perception that injustices suffered by minors are *“at the hands of the institutions (…) provoking new traumas”* (9).

Significantly, participants across multiple studies assert that it is not always the traumatic event itself that causes VT and STS, but equally, it is the organisational response to the traumatic event which contributes to the development of VT and STS, or negatively influences an individual’s appraisal of traumatic events which hinders processing. For example, *“it’s not really what we see (..) it’s coming back and not having the support”* (7), “*when you talk about secondary trauma, then you add the organizational stress, because [the state] keeps adding work”* (4), *“impacted me (…) not so much the death (…) but the lack of support”* (7).

Discussion

This review aimed to synthesise existing qualitative evidence on child protection professional’s experiences of VT and STS to address gaps in existent literature, with hopes of informing further research and practice. Six themes were developed, representing the collective perspectives and experiences of an estimated 201 participants from 13 primary studies: “Conceptual setting”, “The heart of the wound”, “It’s all encompassing”, “Change in world view”, “Trying to survive”, and “A way forward”. The themes depict an interconnected and cyclical process between the context in which trauma occurs, the core experiences of trauma itself, coping mechanisms, their impacts, and the wider systemic context.

Theme one provides an insight into the unique traumas experienced by this population, supported by the notion that event specific trauma may affect the expression of STS symptoms in a manner similar to PTSD (Ben-Porat & Itzhaky, 2009). Specifically, child fatality and child removals were universally traumatising ‘setting events’ or contextual predisposing factors as central to the development of VT/STS. This aligns with previous research, where child removals are reported to be ‘traumatic for everybody involved’ (Garcia, 2019). CWWs who experienced a fatality on their caseload and feel culpable report higher levels of PTSD symptoms (Douglas, 2013). Importantly, indirect exposure via hearing or reading about cases also played a significant role in the development of distress in line with findings in trauma therapists (Pearlman & Mac Ian,1995). Child protection systems should therefore hold in mind that these events are particularly distressing for professionals, and act accordingly in terms of implementing adequate trauma-informed processes to support staff.

Other contributing experiences included professionals having to return children to harmful environments. Existing research supports the idea that child protection professionals experience moral injury, such as an ability to function in a system which they view as deeply flawed (Haight et al., 2017). However, the conceptual basis for moral distress has primarily occurred in military and nursing contexts (Haight et al., 2016; Stahlshmidt et al., 2020). This review highlights the need for further relevant research in this context to adequately understand and support child protection professionals further.

Findings indicate that socio-cultural factors such as country and specific setting influence the development and experience of VT/STS. For instance, the review captures salient features of this work in South Africa (Capri et al., 2012), and the exacerbation of symptoms in remote, rural communities (Federico, 2017). This is mirrored in the literature, for instance, Sprang et al. (2011) found that rural residence is a significant predictor of STS. Cultural competence and the intersection of culture, trauma and child welfare has been considered with regards to working with families (Stephens et al.,2018). However, the current review highlights the need for a culturally sensitive understanding of professional experiences in order to tailor VT/STS interventions across specific settings, regions and countries*. Findings indicate that the manifestation of VT/STS is deeply shaped by the socio-cultural cultural and geographical contexts in which professionals work. Therefore, recognition of these systemic influences is essential for developing contextually appropriate interventions which go beyond individual-level strategies, address societal and systemic influence, and are therefore more likely to be sustainable. Interestingly, factors such as length of exposure to trauma or type of employment did not appear to influence the findings. This could be considered further in future research.*

Theme two depicts the intensity of emotion which the work evokes for professionals. Participants report affective disturbance, emotional dysregulation and anger. Additionally, they experience hypervigilance, safety fears and more ‘typical’ trauma symptoms such as flashbacks, intrusive memories, and a heightened startle response. Four studies explicitly reference PTSD symptomology, but all reported experiences map onto the diagnostic criteria for PTSD (APA, 2013). This supports claims that STS can be measured by symptoms virtually identical to PTSD, termed as PTSD which is ‘caught from a person’ (Figley, 1995). A recent systematic review highlighted the effectiveness of various evidence-based interventions for reducing work-related trauma symptoms (Woeginger, 2023), however this focused on first responders, nursing, palliative care professionals and mental health workers. More research is needed to explore whether the same applies to child protection professionals, in order to offer the same evidence-based support.

Theme three highlights the all-encompassing nature of distress experienced by professionals. Sleep disturbances (particularly trauma nightmares and insomnia) were described, both of which are core symptoms of PTSD (Lancel et al., 2021) and are associated with significant distress and functional impairment (Nappi et al., 2012). Professionals also referred to poor work-life balances, lack of boundaries and the cognitive process of rumination which ultimately contribute to exhaustion. A repeated empathetic engagement with victims can lead to blurred boundaries between the self and others (Ellis et al., 2018), but these specific processes describe burnout, defined as the experience of physical, emotional and mental exhaustion arising from emotionally demanding work situations (Maslach et al.,1996). Burnout holds conceptual overlap with VT/STS, and it has been suggested that STS may contribute to burnout (Ormiston et al., 2022), which the current review supports.

Theme four encapsulates the way in which VT and STS profoundly changes an individual. Findings indicate that participants barely recognise their former selves, reporting personality changes and increased desensitisation. These findings are consistent with the existing understanding that VT involves an ‘internal transformation’ caused by over-empathising with a client’s trauma (Dombo & Gray, 2013), and that the intra-individual processes evident in STS are underpinned by engaging with traumatised individuals (Ellis et al., 2018). A lack of connection with oneself following traumatic events is widely recognised in the literature, and can be understood via concepts such as internal self-alienation and CSDT as a framework to understand how trauma impacts the ability to maintain a cohesive sense of self (Fisher, 2017; Pearlman, 1996).

Findings also indicate that working in child protection significantly changes professionals' world view. They describe original beliefs about the world being shattered when they realise the significance of abuse that exists. Findings indicate that this realisation causes them to see human nature in a negative light, assuming that people are inherently dangerous and untrustworthy. Janoff-Bulman's (1992) 'shattered assumptions' theory describes that traumatic events can challenge our assumptions about the world as benevolent, and the inner world can therefore become disintegrated. More recent research has found associations between world assumptions and the development of PTSD symptoms (Biram et al., 2024).

Importantly, findings also suggest that many participants were able to find positives amongst adversity, such as an increased confidence, tolerance to others, and cite a knowledge of trauma as protective in terms of self-care and processing personal trauma. Post-traumatic theory posits the concept of 'vicarious post traumatic growth', where vicariously traumatised individuals can experience growth by creating new meanings and rebuilding their world view (Tedeschi & Calhoun, 1996; Zeligman et al., 2019). This highlights the importance of individual differences in terms of resilience and subsequent VT/STS development. In line with findings, VT awareness is a key component that serves as a protective measure against VT itself (Branson, 2018), highlighting the importance of further trauma-specific training for child protection professionals. A recent review found that positive workplace characteristics have been associated with post traumatic growth and lower VT/STS (Molnar et al., 2020), suggesting that organisations play a pivotal role in the prevention of distress for professionals.

Theme four outlines the range of coping strategies which professionals use to navigate their distress. For instance, emotional detachment, which has been found to be a common and effective self-regulation strategy amongst child protection workers to buffer against emotional exhaustion (Leigh, 2013; Ying, 2008). Professionals commonly utilise avoidance mechanisms to manage distress, such as particular places, people, and families. This is commonly used when child protection workers feel overwhelmed, but can be troublesome in terms of client relationships and absenteeism (Rienks, 2020). Professionals also socially, emotionally and sexually withdraw from partners, family and friends, partially due to the desire to protect others, fears they won't understand, or having no resources left. Existing research with nurses experiencing STS suggested that they can become chronically unavailable to their families, in the same way that direct trauma victims are (Goldblatt, 2009). Similarities have subsequently been replicated in child protection professionals (Kaplan, 2015; Nen et al., 2011).

To the other extreme, others use hypervigilant safety-seeking behaviours in an attempt to keep themselves and loved ones safe, which is replicated in existing research with child protection workers (Lamothe et al., 2018). Importantly, findings of the current review revealed that professionals having a child of their own contributed to the development of VT/STS and particular exacerbation of hypervigilant behaviours, as reported in forensic interviewers (Brady, 2017). Having children has been implicated as a risk factor for VT/STS specifically in child protection workers (Steinlin et al., 2017). The understanding of this as a risk factor lends itself to the development of vicarious trauma-informed practice.

The dichotomous nature of coping evidenced in the review represents what is already known about trauma, and what many researchers refer to as ‘avoidant survivors’ versus ‘hyper-aroused survivors’ (Higgins, 2022). Importantly, the review findings highlight that such strategies can be problematic in the sense that, in their extremes, they may contribute to a plethora of wider relational consequence such as isolation, conflict and a limited support system. This presents parallels with Complex-PTSD symptomology, which is characterised by core elements of PTSD in addition to enduring disturbances in interpersonal relationships and difficulties maintaining relationships (Maercker et al., 2022). Reflection on and modelling of adaptive coping strategies should therefore be integrated into training to enhance worker resilience.

The final theme highlights the role of the wider system in the development and perpetuation of VT/STS. Firstly, professionals often feel hindered by systemic constraints which causes feelings of powerlessness and frustration. They often experience internal conflict in the face of navigating a system which they know causes harm, linking back to the first theme and the role of moral injury in the development of VT/STS (Haight et al., 2017). Significantly, findings also suggest that it is the organisational response (primarily a perceived lack of support and increasing demands) to the traumatic event which leads to the development of VT/STS, rather than the event itself. Organisational responses to VT/STS have been extensively researched, with key findings suggesting that organisational isolation is a risk factor for its development (Bride et al., 2009), support of supervisors and colleagues as a protective factor against symptoms (Bride et al., 2007), and more recent longitudinal research which highlights that organisational efforts can improve perceived level of distress (Sprang et al., 2021). Organisations can therefore both contribute to, and bear an ethical responsibility to prevent, their employees’ distress. This can be achieved via a trauma-informed awareness at an organisational level, which may involve an awareness of risk factors, encouragement of supportive strategies, supervisors acting as role models for self-care, peer supervision, and the implementation of safe spaces to help workers feel supported to reflect on and thus process VT.

More broadly, the synthesis of results strongly aligns with CSDT in some aspects, as expected. This review supports the idea of CSDT's core principles, such as schema disruption across the self, others and the world. In addition, the review supports the idea that these disruptions are filtered through the individual's personality, history and context. However, the results also challenge dominant assumptions about trauma and professional practice in child protection. Instead of solely individual psychological distress, the findings reveal moral, systemic and relational dimensions. CSDT focuses largely on the individual's internal meaning-making process, but findings of this review indicate that organisational culture and response also mediate schema disruption. The current review therefore proposes refinements in terms of organisational context and systemic factors to be incorporated into the model to better reflect the realities of child protection work and the trauma processing context.

Implications

Child protection services must implement trauma informed systems, including support after child removals or fatalities, which are key triggers for the development of VT/STS. Systems must be particularly sensitive to and be ready to support workers who have children of their own, as this often increases vulnerability to VT/STS. As STS can often mirror PTSD, more research is needed to understand whether it can be treated in the same way in this population. Tailored interventions must be culturally sensitive and consider socio-cultural and geographic contexts (e.g., rural vs. urban settings, country specific) to be effective. Workers frequently experience moral injury from systemic failures e.g., returning children to unsafe environments. Clinical support must incorporate moral distress frameworks. The overlap between VT/STS and burnout highlights the need for regular supervision, manageable caseloads, and the promotion of work-life boundaries. Knowledge of trauma and VT/STS is protective, and training should be implemented with a view to increase knowledge and therefore resilience. This could mitigate the impacts of VT/STS. Crucially, organisational responses can play a pivotal role in the development of VT/STS, and their response can prevent VT/STS from occurring at all. Organisations must respond appropriately to both the prevention and support of those experiencing VT/STS. Specifically, reflective practice, peer support, reflective spaces and the modelling of adaptive coping strategies by senior staff can promote a supportive culture and contribute to a vicariously-trauma informed system.

Strengths

This novel review searched several databases to capture all available qualitative data from existing peer-reviewed research and grey literature on child protection professional's experiences of VT and STS. This was synthesised to broaden and update understanding from previous reviews (Baird & Kracen, 2006; Bowman, 2022; Ireland & Huxley, 2018; Molnar et al., 2020).

Capturing detailed study characteristics helped to preserve the context of primary studies. Thematic synthesis was appropriate given the CR epistemology, and subsequently allowed for a transparent link to be made between individual study's findings and conclusions (Thomas & Harden, 2008). This provided novel insights into professional experiences across various socio-cultural contexts and stages, lending itself to the review aims and allowing for real-life, clinically meaningful implications to be put forward.

Several reflexive strategies were used throughout to enhance rigour (Yardley, 2000), such as the provision of a detailed reflexivity statement, underpinned by findings from a reflexive journal which the reviewer kept to note potential influences. Reflexive supervision with the project supervisor allowed for reflection upon the final thematic structure. Illustrative quotes from contributing studies were embedded within findings to uphold integrity and preserve the context of findings. Additionally, extensive engagement with historical and current research on the topic allowed further contextualisation of findings. The inclusion of grey literature was valuable in order to ensure a comprehensive search and reduce publication bias (Paez, 2017).

Limitations

Limitations relating to the characteristics and methodological rigour of primary sources must be acknowledged. Whilst ten of the studies were of moderate to high quality, over half failed to state their epistemological position which decreases transparency and methodological rigour of qualitative research (Yardley, 2000). There was also significant variation in the amount and type of demographic information provided across sources. This made it difficult to report an accurate description of the ‘represented view’ in terms of sample characteristics, and was based on estimations from available information. Overall findings across both peer-reviewed and grey literature sources are assumed to represent the experiences of female, Caucasian child protection workers. Ten of the studies were from USA which may have influenced their experiences. Whilst there was no difference identified between these studies and others from different countries, the review does highlight the role of socio-cultural factors, and further cross-cultural research would provide more detailed understanding.

The CASP qualitative appraisal tool is the most frequently recommended (Ma et al., 2020). However, in qualitative evidence synthesis, its ability to measure research design and conduct has been questioned (Long et al., 2020). The CASP doesn’t allow the reviewer to provide novel responses, meaning that appraisal may be partly subjective. Additionally, a second reviewer for study screening, quality appraisal and data analysis was not possible due to limitations inherent to the Doctoral programme. This would be rectified in the case of publication.

Despite the comprehensive search strategy, there is a possibility that not all relevant sources were included. Firstly, the search was capped in January 2025, and relevant emerging research could therefore be missing from this review. There are many closely related terms to VT/STS, and a recent review found that the lack of consistency across definitions can undermine the reliability and validity of research (Branson, 2019). For instance, the reviewer included studies which may not have explicitly referenced VT/STS, but were included based on the reviewer’s clinical knowledge of the phenomenon. Sources omitting VT/STS from their titles and abstracts may remain unidentified, and studies which referred to the same experience under a related term may have been excluded.

Conclusion

Child protection professionals face unimaginable situations, and the exposure to events which are unique to their field can lead to the development of VT/STS. This review found that psychological and emotional processes in terms of emotional experience, coping strategies and relational consequences are parallel to what is already known about the experiences of direct trauma survivors. VT/STS can therefore be understood in the same way that we understand PTSD. The findings highlight several risk and protective factors for the development of VT/STS, which should be carried forward. Specifically, findings indicate that effective organisational support could prevent VT/STS. Further cross-cultural research and research specifically focusing on this population are needed to inform specific interventions for this group. A vicarious trauma-informed awareness is needed at every level, in order to prevent psychological harm.

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Appendices

Appendix A – Search Terms

The search terms were entered as keywords and aligned with the recommended subject headings in each database. Combinations varied slightly across databases.

Type of professional	Vicarious Trauma/Secondary Traumatic Stress	Qualitative research
Child welfare professional* Child welfare worker* Child protection professional* Child protect* worker* Social worker* P?diatrician* Child safety officer* Child advocate* Family support worker* Child protective services worker* CPS worker* Youth Protection worker*	Vicarious trauma* Secondary stress* Secondary trauma* Compassion fatigue	Perspective* Impact Experience Qualitative Findings Interviews

Appendix B – Data Collection Form

Study information

Authors:

Year:

Title:

Country:

Study Type:

Nature of Work:

Aims/Objectives:

Participant information:

Participant demographics (age, race, gender, occupation, years of experience etc.):

Sample size:

Sampling method:

Recruitment strategy:

Eligibility criteria:

Methods

Data collection method:

Design:

Data analysis:

Epistemology:

Role of researcher:

Reflexivity:

Key findings

Key themes/summary:

Appendix C –Quality Appraisal Tool

CASP Checklist:
For Qualitative Research

During critical appraisal, never make assumptions about what the researchers have done. If it is not possible to tell, use the "Can't tell" response box. If you can't tell, at best it means the researchers have not been explicit or transparent, but at worst it could mean the researchers have not undertaken a particular task or process. Once you've finished the critical appraisal, if there are a large number of "Can't tell" responses, consider whether the findings of the study are trustworthy and interpret the results with caution.

Reviewer Name:	
Paper Title:	
Author:	
Web Link:	
Appraisal Date:	

Section A Are the results valid?	
1. Was there a clear statement of the aims of the research?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
2. Is a qualitative methodology appropriate?	☐Yes ☐ No ☐ Can't Tell

CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
3. Was the research design appropriate to address the aims of the research?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
4. Was the recruitment strategy appropriate to the aims of the research?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher has explained how the participants were selected* • *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* • *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
5. Was the data collected in a way that addressed the research issue?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	

6. Has the relationship between researcher and participants been adequately considered?	☐Yes ☐ No ☐ Can’t Tell
CONSIDER: • *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
7. Have ethical issues been taken into consideration?	☐Yes ☐ No ☐ Can’t Tell
CONSIDER: • *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	
8. Was the data analysis sufficiently rigorous?	☐Yes ☐ No ☐ Can’t Tell
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account*	

• *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
9. Is there a clear statement of findings?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the findings are explicit* • *If there is adequate discussion of the evidence both for and against the researcher's arguments* • *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* • *If the findings are discussed in relation to the original research question*	
Section C: Will the results help locally?	
10. How valuable is the research?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature* • *If they identify new areas where research is necessary* • *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*	

Appendix D – Illustrative quotes (All extracted data)

Sub themes	Illustrative quotes
Analytical theme 1: Conceptual setting	
Setting events	*“The workers reported symptoms paralleling secondary trauma after the death of a child on their caseload. The symptoms were inability to concentrate, irritability, increased startled response, feelings of vulnerability, anxiety, sleeplessness and intrusive images of the trauma.” (3)* *“When children die as a result of maltreatment and neglect, it is a trauma for all concerned.” (3)* *“One of the things that’s always been the hardest is the day that you do like an actual . . . you know an . . . an actual removal, of removing a child from their parents. That’s heart breaking. I don’t know that I… probably the first 20 that I did I went home and cried. I mean it’s terrible, it’s a horrible thing.” (5)* *“I really struggled with removing babies from young parents with drug abuse problems. They’re crying and you know you’re trying to prevent yourself from crying because you’re a professional” (5)* *“That baby just had no trust in no one and seeing that little girl beat like that…I mean, that was really, I mean, my goodness. that kind of really tugged on me” (6)* *“I went home many times crying thinking about how do people recover from such damage, how the children recover from such damage, how they recover from abuse and neglect?” (6)* *“We read the reports and hearing the stories of what children are going through is also really hard, you still empathise with whatever abuse that child went through” (6)* *“Oh yeah, I have flashbacks terrible. I have flashbacks of the little boy. Because he starved to death. And I didn’t know[that he was starving]”(7)* *“I thought I’d go out of my mind. I will never forget the look in that child’s face when I brought him back home. He was terrified” (7)* *“I had to send two very sick and needy babies to a home that did not deserve those kids...I cried the entire weekend” (10)* *“For me, it brought back all the shit from Vietnam. it’s all trauma related. it’s like a ripple effect. I know I’m not responsible for this kid’s death, but I feel responsible because it’s my job” (10)* *“I hate removing children. I hate to see the conditions that some of these kids live in” (10)* *“I cry during every removal” (12)* *“My first removal will forever be engrained in my brain” (12)* *“Consulting cases with workers is as if not more traumatic than working the cases myself” (12)* *“Had a worker with a child fatality three months after closure; it was horrible, I about lost my mind” (12)*

Unique aspects of experience	*“CWWs in Child Advocacy Centre settings are uniquely impacted by occupational stress” (1)* *“Professionals working within CAC settings are particularly vulnerable to the professional and personal effects of occupational stress” (1)* *“Salient features of doing child sexual abuse work in South Africa also came to the fore.” (2)* *“Nothing you planned can be dealt with. I think that’s how one becomes screwed’’ (2)* *“Multiple respondents perceived that generational difference in the office led to wide variation in staff members’ (…) capacity to manage STS” (4)* *“Unlike other first responders, child welfare workers have continued exposure to the trauma of child maltreatment with every report, change in placement, and discussion” (5)* *“Many of these symptoms were exacerbated by the characteristics of the remote, rural community as there were few outlets and venues for discussing and debriefing in privacy.” (5)* *“We learned that behaviors of avoidance, client scanning, and problematic social interactions are much more prevalent, frequent, and intense.” (5)* *“Social workers (…) mention great confusion linked to the reality of abuse, a complex reality, made up of complex stories and experiences” (8)*
	10 contributing studies: 1, 2, 3, 4, 5, 6, 7, 9, 10, 12
Analytical theme 2: The heart of the wound	

An emotional avalanche	*“Many participants described reported experiences of depression and anxiety due to the nature of their work” (1)* *“find myself getting into moods where I am depressed or angry or detached.”(1)* *‘My defences were down. I often get annoyed with unhelpful people, but never that furious. I almost blacked out. I didn’t realise how angry [child sexual abuse] makes me. You are either ready and hard for this work, or you’re not’’ (2)* *‘I can carry on like a banshee—people think I’ve completely lost it (2)* *The CWW stated that they blame themselves for situations for which they could in no way be responsible (3)* *There was a physical abuse, and it was pretty bad. That’s the only case where I can think of it’s really probably caused me a bit of a depression . . . stress, anxiety for sure (5)* *there’s constant guilt . . . I mean constant guilt. As . . . as far as like just not doing enough.(5)* *“after i had children (…) i became even more sensitive to what i saw. i went home crying every day. i think i just became more sensitive to the issues of child abuse because i understood the challenges of being a parent” (6)* *“theres a lot of things that disgust me…any part of violence if disgusting to me” (6)* *“makes you very hard to people. and just sad. it makes me so sad for these kids because i think, what shot do they have?”” (7)*

	“when it’s gotten really stressful, my temper is more present than it’s ever been” (7) *“it’s just so upsetting, and i feel (…) like an anxiety thing, where i’m just talking really fast, and im ramped up, and then i just spill” (7)* *“i continually feel that i am on the verge of crying, or laughing, and can’t decide which one would be best” (8)* *““what if those babies die? i didn’t do anything to save them” (10)* *“i feel angry every minute of every hour of every day while im at work” (10)* *the main categories of difficult emotions were anger towards alleged perpetrators (11)* *the main categories of difficult emotions (…) sadness about situations encountered (11)* *“it makes you angry i think. it made me angry anyways, and all i wanted to do was just go in and yell at the perpetrator and beat them and sink them to violence” (11)* *“it's always sad when a child has to leave their family and then when you learn more about the family it becomes all the more sad” (11)* *during face to face focus groups participants appeared visibly upset (…) one participant crying as she recalled trauma she had experienced (12)* *their emotions are charged. they feel fatigue, emotional shutdown and/or overload, and they experience safety fears (13)* *“as a mother, i want to cry with them. ‘oh my god, if this was my kid’. i cry now when i talk about it” (13)*
Trauma symptoms	*“i am constantly distracted in public when I see children and ensuring they have appropriate supervision, clothing, no marks/bruises, etc.” (1)* *“And I’m hypervigilant...from hearing these (child sexual abuse) things all day’’ (2)* *"It did not end at that juncture, but feelings of sadness kept me awake at night and the memory stayed alive and became repeated again on the next removal." (3)* *"To this moment, it flashes in my mind. I picture the child wandering from the stroller and going to the neighbor's swimming pool and drowning. Even though I know it was an accident, I can't let the picture go (3)* *A lot of people do suffer from secondary trauma (..) [relates incident of co-worker witnessing parent shoot self]. She seemed to be fine with it, but in the middle of the night her ice machine made the noise (..). She said she flew up out of bed thinking, ‘Oh my god, there’s gunfire in my kitchen.’ So that got to her (5)* *my mind went back to the old referral, and to the old . . . just kind of state of mind like, ‘How is this happening again?’ And just like triggers kind of came back. It was like the same exact feeling that I was having through the previous situation of just like numbness, and just knowing I needed to protect this other kid, because it could have been as bad as the other situation (5)* *“it hits close to home because those traumatised and abused kids can obviously be mine. it’s getting me to be a little bit more hypervigilant-ish” (6)* *“i have experienced a vicarious traumatisation. working directly with children there was an impact” (6)* *“it's like claustrophobia. i’ve even done it with my own children like ‘you can’t touch me! don’t touch me right now!” (7)* *“i start visualizing what happened. i will visualise that happening and so for me it’s like re-experiencing it with them. it will*

	playback on my head" (7) *he is experiencing "symptoms of PTSD - agitation, nervousness lack of sleep, hyper startled response" (8)* *a child welfare worker with 13 years of experience at the agency stated that he "would dare say i have some PTSD" (8)* *"i check my doors and windows several times a night and when i wake up" (10)* *"i lock my door as soon as i get into the car. my awareness has increased (…) i am constantly looking around as i walk" (11)* *it can be confirmed that frontline child welfare workers are routinely exposed to intrusion, avoidance, and arousal symptoms and experience physical, emotional, and mental side effects of their secondary trauma exposures (12)* *"how do you know it's not a false call, that somebody's getting you there to kill you? you don't know (…)we're out there. and you come out alone" (13)* *CPS workers reported the following impacts: preoccupation with work, withdrawal and avoidance, emotional and physical stress, decreased family and personal time, and changed outlook on life (13)* *"i'm very, when it comes to my son, i'm very protective because i have to make sure that whoever is watching him, they're watching him, they're not doing anything else. if im out somewhere, that there's no one touching my child" (13)*
	11 contributing studies: 1, 2, 3, 5, 6, 7, 8, 10, 11, 12, 13
	Analytical theme 3: It's All Encompassing
It infects your whole life	*"(It) is extremely intrusive into my personal life. I find myself often giving out my personal phone number to clients" (1)* *"it feels like i bring home work-related stress and anxiety." (1)* *'I often feel bad and guilty...but there's no time to be depressed'' (2)* *'You can't get it out of your head. This stuff gets stuck and influences your life'' (2)* *'I think about [work] before I go to sleep, when I wake up, in the bath (2)* *You see your clients everywhere. It took me five years to say: 'I can't talk now, phone for an appointment', without feeling guilty (2)* *"It took me three years to get over removing a child from his home. I could not separate my per- sonal from my professional life. (3)* *"Explaining the palpable effect of STS on staff members, touched on workers' fragile and uneasy work-life balances" (4)* *most respondents discussed "taking some of the job home" (4)* *'Give me your phone, give me your computer, you're done. And you need to learn boundaries (4)* *just a little bit of anxiety about . . . separating personal life versus work life . . . so it's been a trip. (5)* *"So it's affected my personal well-being that I have to become more hypervigilant as to what I'm doing in my personal time because it is such a small town." (5)* *"Cause I would bring it home, I would bring it home and I'd dwell on it. And I would rethink what I've done, and you know, second guess myself, and think of new ideas on how I could approach." (5)*

	“It is very hard for me to separate my personal life from . . . from my work. Like I go home and I’m thinking about it, and you know, without breaking confidentiality, I’ll talk about it with frie . . . my coworkers or also my friends. And it’s like it never . . . I don’t ever like take off the social worker hat.” (5) *“It can be rewarding . . . but at the same time it’s hard to have a life, and have a life outside of that.” (5)* *“it is difficult to do our jobs and not allow our personal feelings to get in the way. i know that also bias places a role” (6)* *“the whole job has just taken over my life” (6)* *“not at work - more at home. i lose it more often” (7)* *“you’re never released from a caseworker’s job no matter how much you separate yourself” (10)* *“everyone is a perp, we see clients everywhere we go.” (10)* *“you get to a point where it’s just so much bad that we never see the good part of it” (13)* *“the work is emotionally intense and workers report that it is hard to shut down emotionally when innocent children are being harmed” (13)*
Trapped by the trauma	*“i feel overwhelmed at times” (1)* *“since it requires all of your senses and being alert the entire workday, which is always 8 h a day, am often exhausted, physically and mentally drained” (1)* *“I often find myself thinking about horrible things that have happened to children” (1)* *“i may lose sleep at times” (1)* *I had a nightmare about someone trying to attack us...rape somebody and kill her. That’s where [the work] sits’’ (2)* *My first year, I had to keep a notepad besides the bed because I couldn’t sleep (4)* *for the first few weeks you just don’t sleep. And then you go to the pad on the nightstand to just write it down to get it out of your head, so you can go back to sleep (4)* *“I’d wake up and think, ‘Oh my gosh, I should have done this, I could have done that, I need to do that.’” (5)* *“think about my work all the time.” (5)* *“i even felt like i was having insomnia, i really couldnt sleep” (6)* *“i would stay in the parking lot sometimes if i got a lot on my mind because the stress that is associated with you now whether or not you are discerning the correct information” (6)* *“i sleep on it and it gets conjured up in my dreams” (6)* *“i think about my clients when i wake up at night, in the shower, at the dinner table, it consumes me” (8)* *“i stay up at night either worrying about all i still need to accomplish, worrying about the safety of my clients” (6)* *all of the participants in this study reported having some level of sleep disturbance, including difficulty falling asleep, difficulty staying asleep and nightmares (7)* *“there are times when i don’t get to sleep because i’m thinking…i’m thinking too much” (7)* *“i’ve had insomnia ever since i started this job (…) i’m like every night with the ambient and the melatonin because it’s all my casework is in my head at night” (7)* *“when you go to sleep, you think about the cases. when you wake up at night (…) you’re like ‘oh my gosh, i forgot to do this’*

	“ (7) *“i don't sleep as well as i used to” (7)* *“it's not uncommon for me to cry myself to sleep at night thinking about the children i have dealt with earlier in the day” (8)* *“i have nightmares nightly, about this one guy. he has never threatened me (…) i wake up with him coming after me with knives and that’s not fair. my sleep is my time” (10)* *“you never forget it. you never forget this horrific stuff. it’s burned into your memory forever” (10)* *“i used to dream about cases, wake up picturing kids faces (…) i still have those dreams.” (10)* *“all i have to do is hear about it and it’s burned into my memory” (10)* *“i would leave here after talking with my friends and colleagues and still have nightmares; at times i felt i was reliving the whole situation again” (10)* *“i can’t sleep at night, i relive some of the incidents in my head. i wake up screaming, so i guess there is something wrong with me” (10)* *“i have nightmares. i constantly replay the situations over and over again” (10)* *“ruminating about cases, conscious and subconsciously was also common” (11)* *“it lingers there. you think about it. even if you dont think about it you are somehow preoccupied with feelings” (11)*
	11 contributing studies: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 13
Analytical theme 4: Change in world view	
The way I see myself has changed	*“some participants reported increased confidence and improved abilities to communicate regarding risk and protective factors of child abuse” (1)* *“This job has changed me, made me hard and impatient. I developed the ability to cut people away. That’s something I couldn’t do before” (2)* *“‘The day I don’t get upset over a case I’ll leave.” (2)* *“"I am programmed to think there is a deficit in me." (3)* *“I really credit getting through that period and not getting stuck in the mud to my knowledge and experience with trauma and understanding it.” (4)* *“Like I see pictures of myself before this job, and I felt like I was really bright and had like a lot of light. And I don’t . . . I look at myself, and I look a little haggard” (5)* *“you know, everything that’s going on at work that’s . . . that’s become who you are” (5)* *“But it’s like the level of taking things. . . like even like jokes, that maybe I would just let roll off, like I can’t . . . I can’t just let that roll off anymore” (5)* *“Prior to me working in child welfare I never had that experience . . . I never felt that anxiety” (5)*

	“I think it’s . . . it’s made my relationships better . . . because I have . . . I have the understanding and the experience to know what I have, what I can do, what . . . what is out of my control” (5) *“you’re not the same person because those same people are like, ‘Where have you been? I haven’t seen you in months.’ . . . because I don’t go out . . . I don’t socialize.” (5)* *“[My experience has] . . . enriched and uhm . . . destroyed parts of my life at the same time . . . I have learned a lot about myself . . . . I have been able to work through a lot of personal issues . . . from my own childhood . . . and even adulthood.” (5)* *“I think that has the biggest thing is that, you know, after a while you just kind of [don’t] even recognize yourself . . . that you’re just a completely different person than like, when you were before” (5)* *“it's kind of weird to look at your life and say what’s so different” (7)* *“i am very tired at times. at other times i am so upset. and there are times i go home, and i hate who i have become” (10)* *“things that appalled me when i first started this job don’t even effect me on the outside.” (10)* *“i am totally different today than i was nine years ago when i started this job. i used to be outgoing and fun loving, not i have become a real bitch” (10)* *“i am so very defensive, i can’t take a joke” (10)* *“we have become harder. we lock our emotions away. i just became a bitch (…), i have become desensitised to violence, drugs and alcohol, sexual abuse” (10)* *“i think it hardens you (..) it definitely makes you more of a rigid person, less trustworthy” (13)* *“i’d never seen the effects of actual abuse (…) it made me really appreciate my life” (13)* *“i'm much more tolerant of people too” (13)*
The way I see the world has changed	*“it can be hurtful at times to know that people actually neglect their children and abuse them” (1)* *“tend to be cynical at times and mistrustful of others” (1)* *““I constantly worry about my children” (1)* *‘This world is a messy place. I was nicer about people and things. It changes your whole life’’ (2)* *““I don’t look at [the town] like a tourist would. I question people’s motives…” (2)* *“One wishes sometimes to have a normal life’’ (2)* *“when i had my children… i was very scared to leave…because of all the ugliness that i have seen like broken bones, shaken babies, all of that…just those type of almost like a hyper vigilance” (6)* *“we see the ugly of our society every single day…there’s ugliness in our world. theres people that hurt children just to hurt children” (6)* *“knowing the things that people have done to their children or home environments that they have let their kids live in…it has affected how i trust people” (6)* *““in this line of job you see death, you see sadness..you see relationships being torn apart (…) i think thats why im like waiting to have a family” (7)*

	“i have a two year old who i would never leave with a daycare provider…you think everyone’s a sex offender. you dont know what people are doing behind closed doors so it makes you very cautious of people” (7) *“"i have some mistrust about the world. not in all aspects. but im gonna say in terms of dealing with children” (7)* *““we are exposed to so much sad things about human nature, the maltreatment of children that, it is kind of excessive mentally sometimes” (7)* *“view of the world is no longer positive” (8)* *“the reality of the abuse, the revelations, and the stories, arouse feelings of inner distress among the social workers” (9)* *“this job changes how you see people, the world, and yourself” (10)* *“i will not let me kids spend the night at their friends home until i do a background check. i am very distrusting with lots of people” (10)* *“i’m walking in the park with my kids and im watching some mother beat on her son, and i wonder should i be calling this in?” (10)* *“you walk down the mall and you say, perp, perp, perp” (10)* *““this changed me for life. i don’t trust anyone. at times it causes difficulties with my husband because of the distaste i have for fathers” (10)* *“everyone i meet, i think they’re drug involved, or every husband beats his wife (..) my whole perspective is skewed” (10)* *“i was aware that kids were being hurt, but i never knew how bad. this is not a nice place to raise children, our world is not child friendly” (10)* *“workers felt that their sense of implicit trust in the world and the goodness of others had been lost” (13)*
	11 contributing studies: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13
Analytical theme 5: Trying to survive	
Coping mechanisms	*have lost interest in working out and socialising with others outside of my work group” (1)* *“I need to stand with one foot in empathic connection, and the other in disconnection...get distance to think. Then I don’t get overwhelmed” (2)* *‘‘It’s probably their road’’ (2)* *“‘Their first reaction is usually: ‘Children are prone to lying’. People don’t want to hear any of this.” (2)* *“it’s not a pleasant thing we work with. You have emotions that you can’t share because they won’t understand.” (2)* *“One gets numb sooner or later to protect yourself” (2)* *“Incest cases are the worst. I numb myself...look past that detail, and focus on the humanity and personhood of the child” (2)* *““You put the client’s pain away, and you put your guilt away, because you can’t help at that moment...” (2)* *I think one [defends] to survive. Like, maybe there’s some good in it...otherwise I won’t get through it’ (2)* *‘‘I think I use denial and suppression. I’ll be watching ‘Oprah’ or a makeover show, then I’ll sit and cry about that. I don’t really cry about things I should’’ (2)*

	“These behavioral changes included: 1) detachment; 2) staying busy; **(…)** 5) "cutting off." (3) “I could not listen to the TV reports” (3) “i would say that my well-being has been . . . has become more stressful. I mean I don’t talk about it . . .” (5) “We . . . recently had a case here in early [month] that was horrific . . . horrific, the worst that anybody’s seen around here. And the [parent’s] being prosecuted for murder of the sibling . . . I mean it’s just [repetitive speech] bad, bad, bad, bad. And somehow I just . . . it didn’t touch me. Like I . . . I was not affected by it at all.” (5) “So yes, I have avoided people, places, or situations because of my job.” (5) “I do avoid TV shows that are . . . have a lot of . . . I don’t know . . . foster care or a lot of substance abuse. I hate violence, against women. I hate rapes, uh, you know, that kind of stuff I cannot stand. And if I see a scene [I’m] like ‘click’, I’m . . . I’m outta there.” (5) “Before we can go places and do things, I have to ask, ‘Where are we going? Who’s going to be there?” (5) I do avoid TV shows that are . . . have a lot of . . . I don’t know . . . foster care or a lot of substance abuse. (5) “my daughter wanted to go to someone’s house for sleepover..you talk about my paranoia. we wanted to know the nightly routine..movies going to watched…are you married..do you have a boyfriend…is he coming over” (6) “hard for me to trust people because of all the lies, because of all the bad things we’ve seen and it’s in my to be like an investigator with everything” (6) “im also exhausted in terms of outside realtionships..im very insightful about what relationships are going to be complicated and how i can avoid that” (6) “it's really cause me to maybe be more to myself” (6) ““i would say probably about 10 years ago i came to a point where i stopped talking about work at home” (6) “it’s kind of a sick sense of humour (…) i kind of gravitate towards that” (7) “driving down the street, i would see certain people who were convicted pedophiles, and i would point them out to my children” (7) “i avoid a lot of places and my husband gets irritated about that… i dont want anybody to know that i have a kid and what he looks like” (7) “checking and double checking my work and other people’s work out of fear” (8) “the job causes me to want to isolate myself from others when not working” (8) “i have engaged in self harm due to work place stress” (8) “continued crying, but i can stop on an instant” (8) “social workers recognise that (..) defensive distancing becomes a form of personal protection for professionals in a helping relationship (9) the difficulty in managing the emotional burden of abuse victims leads them to want to isolate, to dismiss thoughts of the event, and distance themselves emotionally” (9) “complexity and emotional intensity often leads to avoidance and pushing the painful events out of their mind” (9)

	“i will not even allow a can of stewed tomatoes in my house because this is the picture that comes to mind…it’s still vivid today” (10) *““if i see a client, i will walk away from my husband and kids until the coast is clear” (10)* *“my wife and i decided that when we are out in public together, i walk 10 paces behind her (…) i fear for my family’s safety” (10)* *“i know there are certain families that i have to see, and i will try anything to avoid them” (10)* *“i dont want any of my clients to know what my husband and/or children look like. so, i walk in front of them, close enough to hear them yet far enough so no one can identify them” (10)* *“i did not want to see anything that had to do with violence, death, or any type of abuse” (10)* *“but you’ve got to keep that in check, you can’t be emotional” (13)*
The relational consequences	*“have a daughter and i am even more protective of her because i know what is out in the world” (1)* *“It makes one feel lonely. If I want acknowledgment, I have to find friends with the same heart’’ (2)* *‘I won’t tell [my father] about my work, it would make him uncomfortable.” (2)* *“It’s hard to see how it affects others. We are involved in the battle. It’s hectic for others” (2)* *“respondents recounted losing friends whom were concerned they would “rat” them out for “spanking their children” (4)* *“detailing persistent feelings of professional and personal isolation and incompetence” (4)* *“situating these feelings as arising from a desire to protect others—including co-workers and family members—from their STS.” (4)* *“my kids come home and they’re like, ‘Well, so-and-so did this,’ or ‘so-and-so got this,’ or whatever, and it’s like ‘You guys don’t understand what I’ve been through today.’ We removed six kids in one day, from two different families one time.” (4)* *“it’s really hard because you caught yourself and you’re like, ‘No, I need to turn around and walk away for a minute and take a deep a breath, go outside, do whatever.’ Figure out what’s gonna work for you, so that you don’t pass on the secondary trauma. (4)* *“the CPS workers interviewed attempted to adopt a First, do no harm to self pathos focused on untangling the seemingly contagious aspects of trauma encountered in contemporary child welfare case work.” (4)* *“I don’t allow my kids to go to certain places. When . . . my husband doesn’t answer the phone I go to . . . I have anxiety . . . anxiety because of it. And I . . . I . . . not extreme, but I notice my heart racing. I notice . . . things going on.” (5)* *“I feared for my (…) children’s safety.” (5)* *“I’ve noticed in personal relationships huge differences such as with my parents” (5)* *“I actually caught onto it myself. It was like, ‘Oh my gosh. I really have stopped going out with friends. I’ve stopped calling people. I’ve stopped texting a lot of people.’ I do a lot of things that aren’t engaging with other people. “(5)* *“My relationship has probably taken the biggest toll . . . just trying to work through [the stress of each of our jobs].” (5)* *“I can’t talk about it, I can’t process it, there’s none of that. I think it does create distance in relationships” (5)* *“my friends and family hardly seen me since i’ve started this work” (6)* *“our poor children were so over protected that i kind of felt sorry for them” (7)*

	“i cant come home and talk about it, so it affects that. And it strains it, because he gets angry. He gets angry at me. ‘why can’t you just talk about it?’” (7) *“my ex told me that since starting this job, i brought more stress into his life. that just because im stressed out, stresses him to the point where it’s unhealthy” (7)* *“you can’t turn it off when you go home. you bring it home with you and they dont get it. they dont understand” (7)* *“i have no support system anymore. none, i trust no one. it’s that cut and dried” (7)* *“the stress and anxiety have negatively affected my relationships” (8)* *““i seldom leave my house after work and never go out with friends as i no longer have any” (8)* *“i hate when my kids get the fallout of this job. then, you feel even worse” (10)* *“he said you have an hour to get rid of it. don’t bring it home. that’s how bad it was getting for us” (10)* *“i have no energy for my kids when i get home, i have nothing left to give. my daughter always yells, i hate your job mom, you never let me go anywhere” (10)* *“i feel numb and unresponsive to my family, and they hate to see me come home at times” (10)* *“there are times i dont want my husband to touch me in any way. it hurts and being sexually intimate hasn’t happened in months” (10)* *“my friendships have changed. i tried numerous times to talk about some of this ugliness and they just don’t want to hear it” (10)* *“try explaining to your nine year old why she can’t ride her bike around the block or why she can’t spend the night. it affects me at home, all the time” (10)* *“my husband constantly tells me that i should quit my job; it’s not worth tearing our family apart” (10)* *“even intimacy with her has changed. i dont want to hold her or even be touched by her. i really dont want to share any of the ugliness i see and i feel” (10)*
	11 contributing studies: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13
Analytical themes 6: A way forward	
The role of systems	*“when you talk about secondary trauma, then you add the organizational stress, because [the state] keeps adding work.” (4)* *“i was enforcing the law, enforcing the policies and i was having my own issues about it, but i still had to do what i had to do because it is the job..i was very torn” (6)* *“he (the officer) kept saying: ‘why didn’t you know that? what didn’t you know that?’ – quote referring to child fatality case (7)* *“ive had two death cases and they both impacted me because of what happened (..) not so much the death (..) but the lack of support” (7)* *“i don’t know how this system allows that to happen to kids. i just…so traumatised? absolutely?” (7)* *‘the lack of support she received from her supervisor and the mandate (..) to return this badly abused child to his parents was the primary source of STS, not the exposure to the child’s injuries” (7)*

	“Honestly it really is not the caseload..that adds stress, but it’s not really what we see or have to deal with. It’s coming back and not having the support” (7) *“they speak of frustration faced with the feeling of not being able to provide adequate support for the minors (…) of being powerless faced with the minors’ revelations, and of their distress” (9)* *“indefinable feeling which often cause conflict, conflict between their own emotions and what they have to do to fulfil their support” (9)* *“the perception of not being able to adequately carry out these missions is often a source of guilt and anger” (9)* *“the perception of the injustices suffered by the minors at the hands of the institutions which, on the contrary, should protect them, provoking new traumas” (9)* *“exposure can be directly attributed to the clientele with whom they interact on a daily basis as well as the expectations of their positions in child welfare.” (12)* *““it's frustrating. you feel useless. you have no control (…) so you want to help them, but you’re incapable of that” (13)*
	6 contributing studies: 4, 6, 7, 9, 12, 13

Empirical Paper

A qualitative exploration of Fabricated and Induced Illness: The views and experiences of the professionals making decisions

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Abstract

Background: Fabricated and Induced Illness (FII) refers to a child being harmed due to parental behaviour and action. The current approach to FII in the UK has been argued to be unsatisfactory in terms of its definition, identification and approach. Further curious investigation is needed to understand this experience for professionals.

Aims: To qualitatively explore the professional experience of involvement in an FII case, in attempt to develop insights into the use of guidance, behaviours associated with FII, and clinical decision-making.

Methods: A qualitative approach underpinned by a critical realist epistemology. Nine individual semi-structured interviews were conducted with professionals. Data was analysed using Reflexive Thematic Analysis.

Results: The final thematic structure consisted of six analytical themes and 12 sub themes. Themes illustrated the facilitators and barriers to clinical decision-making at an individual, team and systemic level, as well as the trauma that professionals and families experience from involvement in these cases. Professionals also reflected on their learning, and ways forward.

Conclusion: The current approach to FII in the UK is arguable described to be chaotic, inconsistent and causes significant iatrogenic harm at all levels. Current guidance lacks ecological and construct validity, and further understanding of the psychological basis of FII is needed, in order for a trauma-informed approach and system-wide understanding to occur.

Introduction

Fabricated and Induced Illness (FII)

The Royal College of Paediatrics and Child Health (RCPCH) (2021), define

FII as a clinical situation in which a child is, or is very likely to be, harmed due to parental behaviour and action. This is reportedly carried out in order to convince doctors that the child's state of physical and or mental health and neurodevelopment is impaired for parental gain. FII is presented as synonymous with Munchausen by proxy, a presentation now known as 'factitious disorder imposed on another' in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). It is also referred to as Paediatric Condition Falsification and medical child abuse.

The RCPCH (2021) guidance outlines several alerting signs, or indicators of possible FII which professionals should be aware of. In terms of child behaviours, this includes reported symptoms which aren't observed independently in their reported context, unusual investigation results, and an inexplicably poor response to treatment. In terms of parent behaviour, to name a few, this includes an insistence on continued investigations, repeated reporting of new symptoms, 'inappropriately' seeking multiple medical opinions, an inability to accept reassurance, and 'vexatious' complaints about professionals. Perplexing presentations (PP), a related concept, is defined by RCPCH (2021) as the presence of alerting signs when the child's physical or mental health is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life.

The conceptual definition, identification and approach to FII is currently generating considerable dialogue and active debate within the field. The RCPCH guidelines (2021) refer to the evidence base as 'limited' in terms of the specificity and sensitivity of FII, and the guidelines themselves have been criticised as not being evidence based, suggesting that previous epidemiological research is flawed (Bilson, 2020). The broad nature of the alerting signs which range from parents presenting their children to professionals frequently, to professionals being unable to identify a medical cause, is considered symptomatic of the alarming lack of stringent evidence-based or peer-reviewed research underpinning the guidelines (Gullon-Scott & Long, 2022). Incidence and prevalence also remain an unclear picture and have been subject to debate. Whilst the possibility of illness being induced or fabricated by a parent in a child is real, it is reportedly extremely rare (McClure et al., 1996) and no accurate prevalence rates exist (Davis et al., 2019). Overall, FII has been referred to as an 'admittedly poorly defined concept' located on a continuum of parental health-care seeking for a child, ranging from perceived emotional abuse to induced illness (Bass & Glaser, 2014; Gullon-Scott & Long, 2022). Recent research suggests that over 80% of FII cases are initiated on the basis of emotional abuse, which is highly subjective (Bilson, 2025).

Child protection

In practice, the identification of FII follows a risk criteria approach, where a set of predefined criteria (RCPCH guidelines) are used to identify the likelihood that a child may be at risk. However, there are concerns that if these 'warning signs' are not evidence-based, and accuracy for diagnostic tests for FII is questionable, then this results in 'false positives' and innocent parents being accused of abuse (Bilson, 2020; Gullon-Scott et al., 2020; Gullon-Scott & Long, 2022). This represents a wider concern around accuracy of risk assessments in child protection, and therefore the over representation of certain populations within the child protection arena. For instance, the literature evidences that parents with a disability are stigmatised, not given the support they seek and are unfairly judged (Murphy, 2021). Such biases are mirrored within child protection processes, as assessments of disabled children have been found to frequently utilise a child protection lens which focuses on the failings of the parents rather than the needs of the child (Clements & Aiello, 2021). The concept of ‘parent blame’ is often utilised, which is defined as an epistemic injustice and highly toxic practice. Essentially, this includes professionals placing blame on parents, potentially due to their own limited understanding or bias, which manifests as accusations of poor parenting and FII accusations (Ferguson & Hollingsworth, 2024).

A recent systematic review of the literature identified that FII is an emerging sub-theme of parent blame (Hollingsworth et al., 2023). Authors highlighted that the parents of autistic children in particular are being suspected and accused of FII. Fiightback, a charity who supports families wrongly accused of FII, found that 22.5% of families where both the parent and child had autism had a child removed into foster care (Fiightback, 2019; Gullon-Scott & Long, 2022). This results in the infliction of harm through intimidating assessment processes. Families subject to such processes, autistic or not, experience judgement, shame, punishment and potentially inappropriate removal of children which inevitably leads to ‘life-long trauma’ and a deep mistrust of services (Clements & Aiello, 2021; Gullon-Scott & Long, 2022; Hollingsworth et al., 2023; Xiong et al., 2022).

Such discriminatory practices represent a longstanding, limited understanding of disability-related challenges amongst professionals, and discriminatory practices such as these have been attributed to an unprepared and biased system (LaLiberte et al., 2016). Consequentially, implemented policies can create a default position where the clinicians assessing disabled children assume parental failings.

The importance of understanding the professionals

The ‘invariably’ difficult positions that doctors are in during situations of possible FII is somewhat acknowledged in the literature (Glaser, 2020). However, paediatricians in the United Kingdom have been criticised for indirectly colluding with parents who are inducing illness in their children, even when their clinical judgement suggests otherwise (Davis et al., 2019). Fundamentally, the growing body of literature reflects a significant lack of clarity amongst professionals with regards to what constitutes FII, the difficulties involved in identification, and the lacking research into psychotherapeutic interventions (Lazenbatt, 2013). Yet, professionals continue to be held to incredibly high standards. There is no single agreed definition of FII, and this study therefore situates itself within the contested and evolving landscape. This lack of consensus underscores the importance of exploring how professionals themselves interpret and operationalise FII in practice, which directly informs the rationale for this project.

Although professionals hold substantial power within the dynamic, their voices are somewhat missing from the conversation. Recent reports indicate that incorrect accusations of FII occur due to a lack of professional experience or skill, biases within decision making, and limited training or awareness. However, to our knowledge, limited research and understanding exists regarding professional perspectives of parental blame (Ferguson & Hollingsworth, 2024), or of the FII experience more broadly. Moral injury (Litz et al., 2009) and moral distress (Corley, 2002) theories can provide frameworks for understanding the psychological and ethical consequences of being involved in a case of FII. Moral injury frameworks (Litz et al., 2009) emphasise the potential for lasting psychological and emotional harm that arises when individuals perpetrate, witness, or fail to prevent actions which violate their values or beliefs. Moral distress theory (Corley, 2002) originally emerged from Nursing research, and highlights the acute psychological discomfort and ethical tensions when individuals feel constrained by institutional, contextual or hierarchical barriers, even though they are aware of the appropriate course of action. In line with the study's aims, these frameworks will provide a lens for exploring how professionals navigate complex ethical dilemmas and make difficult clinical decisions in the uniquely challenging context of FII Professional voices need to be captured in order to shed light upon the clinical picture as a whole, and to understand this phenomenon as it is ‘on the ground’. This is anticipated to have both clinical and theoretical benefits, and will hopefully shed light on the current state of affairs, feeding back into practical recommendations for future delivery of services and support.

For any collaborative change to occur and progress to be made, there must be a mutual understanding between policy makers, professionals, parents and researchers, and not just inferences or assumptions made from existing literature. Given the continued widespread debate, further curious investigation is needed to understand the professional experience of FII entirely, in order to provide necessary insight into systems, processes, practices, challenges and identified needs of professionals.

Aims

This project aims to qualitatively explore the experience of being involved in a case of FII for professionals, to develop a genuine understanding of how professionals are using guidance. By gaining insight into professional experiences, it is hoped that we identify (1) what behaviours professionals are associating with FII (2) how professionals are making clinical decisions, (3) whether current guidance or systems supports them in this, (4) outcomes and impact.

Methodology

Design

A qualitative approach, defined as the study of the nature of phenomena, is proposed over any other type. Qualitative research allows for in-depth studies of personal experiences, especially in areas of limited research. In health research, it can focus on intervention improvement (Busetto et al., 2020) and promote empowerment to give participants a voice (Corbin & Morse, 2003) in line with the aims.

Recruitment and participants

Proposed inclusion criteria for professionals are (1) professionals who are in the relevant post at the time of data collection, (2) 18 years old and over, (3) of any gender, (4) living and working in the UK, and (5) have had experience of involvement with an FII case in a professional capacity. Participants may have included (but were not limited to) Social Workers, School Workers, and medical colleagues (GPs, Paediatricians, Health Visitors, CAMHS Workers, Nurses).

Recruitment initially involved a purposive sampling strategy, where the recruitment poster (Appendix A), was posted on relevant social media groups to target professionals. A snowball sampling strategy was also utilised, whereby participants circulated the advert with their network of colleagues.

Whilst 17 professionals expressed initial interest, eight did not pursue further contact after the initial information about the study was sent. The final sample consisted of nine participants. Participants consisted of six Clinical Psychologists, one Paediatrician, one General Practitioner, and one Paediatric Gastroenterologist working in differing clinical contexts across the UK. Demographics details such as age, geographical region, and clinical context were collected but will not be included in order to maintain privacy given the potentially sensitive topic area.

Qualitative methods offer flexibility, and an adequate sample size is considered in terms of its ability to reach information power, a model proposed by Malterud et al. (2016) to determine appropriate sample sizes within qualitative research. Braun and Clarke (2023) recommend the utilisation of this tool, especially in Reflexive Thematic Analysis studies. This places value on the researcher's subjective judgement about having sufficient data for analyses, whilst also reflecting on the research aims, design, analyses, sample specificity and use of existing theory.

Information power was firstly increased in this study via the narrow aim, which explores a specific, under-researched experience, within a specific population in the UK. The completion of in-depth and comprehensive interviews generated rich dialogue, meaning fewer participants were needed to fully explore the complexity of the phenomenon. Additionally, purposeful sampling increased information power, as the sample consisted of a highly specific target group in line with the study aims. Malterud et al. (2016) assert that information power can be further increased when there is some variation within the experiences being explored. Interviews were conducted on a first come first served basis, but as the first six participants were all Clinical Psychologists the decision was made to wait for non-Psychologists to register interest before continuing interviews. This ensured variation and that data revolved around a diverse range of experiences. The more information the sample holds, the lower number of participants needed, thus 9 participants was deemed suitable, with limited variances in participants' experiences reported at this point. One additional participant expressed interest following the completion of nine interviews. At this point, however, the final number was deemed sufficient in terms of capturing unique and collective experiences, therefore data collection was discontinued.

Development of interview schedule

An interview schedule was generated through several discussions, and in line with quality guidance (Braun & Clarke, 2021a) (Appendix B). The schedule followed a sequential timeline in line with aims of understanding clinical decision making processes, but also allowing open discussion. This took several iterations, discussion in reflexive supervision, consultation of existing FII literature, and via discussions with professionals after presenting the project at a research conference (Appendix C). The interview schedule was revised after the first interview, whereby a question was added to ensure it captured a full range of experiences. The interview schedule was employed flexibly, allowing space for participants to expand on areas they felt particularly passionate about or areas they resonated with. The researcher used ad-hoc follow-up questions, prompting the researcher and participant to generate meaningful reflections together.

Data collection

Participants contacted the principal researcher by email to express initial interest. They were then assessed for suitability in terms of eligibility criteria and an informal verification of identity, e.g., use of a professional email address. If suitable, they were provided with the information sheet, outlining study aims, procedure, right to withdraw and data management information (Appendix D). They were sent a consent form which was signed and returned electronically (Appendix E) and given the option to ask questions prior to taking part. An interview was arranged at a time and date convenient to them.

Individual semi-structured interviews allowed the researcher to probe deeply into participant experiences, enabling generation of rich data. This is suited to research exploring complex, subjective experience where flexibility is required (Kallio et al, 2016). Interviews lasted approximately 60 minutes each on Microsoft Teams, a securely encrypted platform which was also used to record and transcribe the discussion.

The researcher introduced themselves and the study, reminding participants of the purpose, their right to stop or withdraw at any point, as well as confidentiality. Consent was confirmed again here, and the participant was offered an opportunity to ask questions before the interview commenced and recording started.

Post interview, participants were offered space to check that there were no further aspects of their experiences they wanted to discuss. All participants were asked if they would like the results to be shared with them following completion and write-up. They were provided with an Amazon E-Voucher as a token of reimbursement for their time and participation. They were also sent a debrief sheet (Appendix F) which contained information about withdrawing from the study, offered the opportunity for a formal debrief, and outlined signposting information for further individual support in case discussing their experience had caused upset or distress.

As the rich audio material was transcribed electronically by Teams, the transcripts were cross referenced with the recordings to ensure accuracy. This was done on the same day as each interview to ensure the interview recording could be deleted as soon as possible to protect confidentiality. Transcripts were anonymised and the documents were stored securely on an encrypted platform which was password protected and only accessible to the main researcher.

Philosophical paradigm

This qualitative study was underpinned by a critical realist (CR) framework. The distinguishing feature of CR is a realist ontological position, which asserts the existence of a reality which operates independently of our awareness or knowledge (Archer et al., 2016), or whilst there is one reality, there are multiple interpretations of that reality (Bhaksar, 2008). CR accepts that knowledge is historically, culturally and socially situated (Maxwell, 2012), and the social world can only truly be understood if people understand the structures that generate events (Zhang, 2023). The transparent and reflexive nature of this approach thus complements the current study's aims and design in terms of learning about FII experiences in the context of UK society and healthcare systems.

This also allows researchers to examine mechanisms that inform the construction of systems of meaning, and thus interpret meanings more deeply than what is explicitly communicated by participants (Braun & Clarke, 2012). Through this lens, the researcher can consider how wider social contexts facilitate or challenge meaning associated with FII. The CR approach has been praised as a vehicle for closing the gap between research and practice due to being value-situated and social justice orientated (Botha, 2021). Given that FII literature spans multiple fields and practices such as Social Care, Medicine, and Psychology, this approach can provide a common ground to contribute to impactful social change.

Data analysis

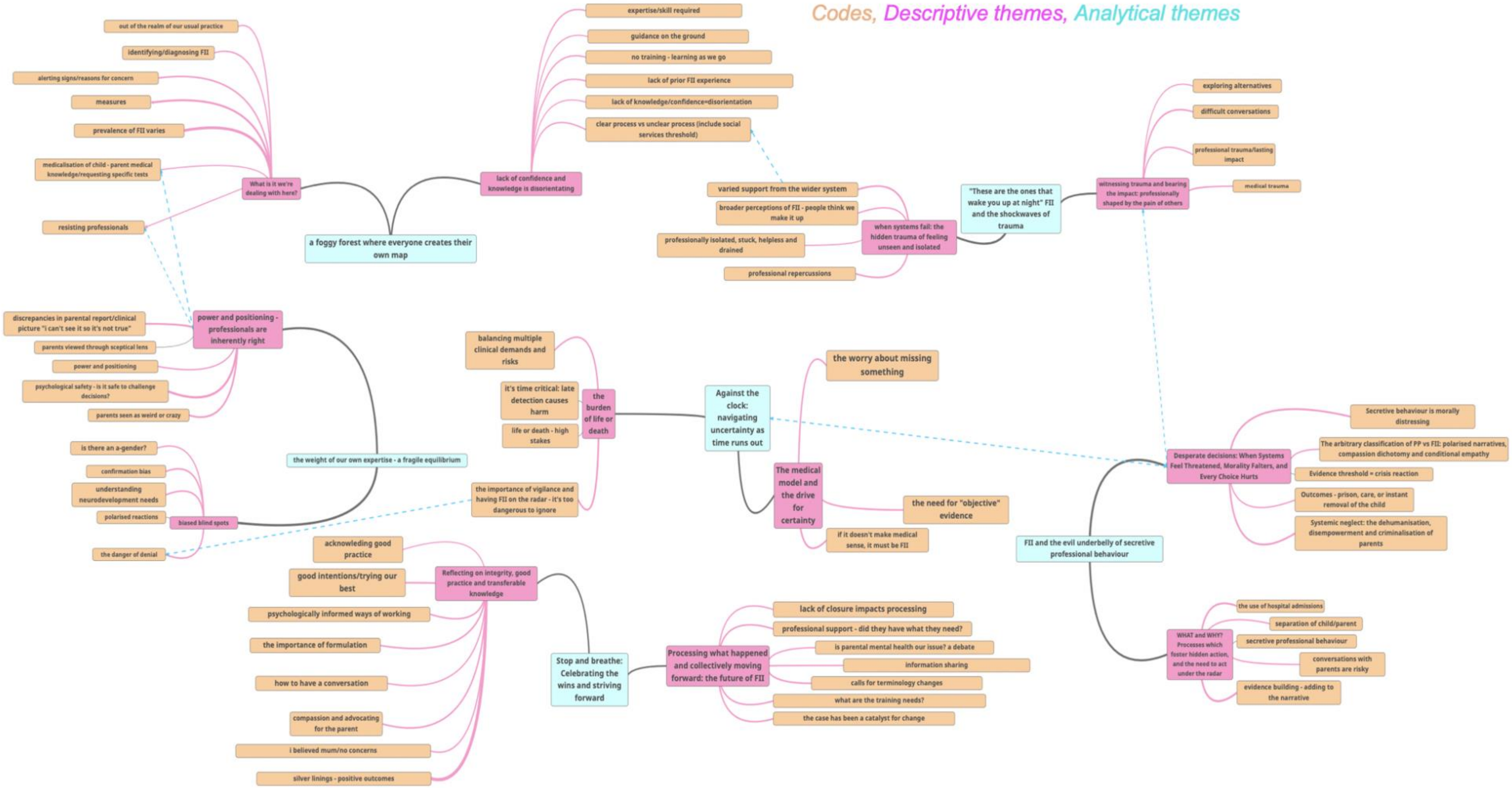
Reflexive thematic analysis (RTA) (Braun & Clarke, 2021b) was deemed the most appropriate approach given it is theoretically flexible whilst also rigorous enough to capture complex phenomena. In line with the study's aims, RTA allows the researcher to explore and interpret how individuals make sense of their experiences, whilst allowing for the consideration of contextual factors within analysis. RTA thus aligns with a CR commitment to understanding both the individual and structural dimensions of experience, which allows knowledge to be generated with clear implications for practice (Braun & Clarke, 2019).

Analyses followed a six-step approach for RTA (Braun & Clarke, 2021b). After conducting interviews, data familiarisation occurred through the active re-reading of transcripts and note taking. The first author coded the transcripts using pen and paper, working systematically through the dataset of which 85 initial codes were developed. This method's flexibility enabled an inductive analysis which focused on both semantic and latent meanings of participants' experiences. Some deductive elements were integrated to deepen analytic interpretation e.g., ideas around cognitive biases, which were informed by the researcher's position as an academic and clinician. This helped to identify similarities, differences and common patterns both within and across the dataset.

After preliminary coding was complete, codes were collated by hand to develop patterns of shared meaning down to 72 codes, which were again a combination of semantic and latent. Codes were initially collated into clusters of similar ideas by hand (Appendix G) to start to develop patterns of shared meanings. Codes were subsequently reduced and collated further to represent a preliminary thematic structure, using mind map software (Appendix H). Themes were continuously refined throughout, with insights and reflections from the project supervisor and qualitative peer groups, until it reached a final structure of 63 codes mapped onto 12 descriptive themes and six analytical themes with interconnected elements. This was used to develop a coherent analytic story about professional’s experiences of FII. A thematic map was developed to visualise the overall story, as well as relationships between codes, subthemes and themes (Braun & Clarke, 2021b). This process is illustrated below.

Figure 1

Illustration of codes, descriptive sub themes and analytical themes.



Ethics

Newcastle University Research Ethics Board approved this project on 21/12/2023 (Appendix I).

Methodological rigour

Yardley (2000) considers the ways in which validity can be promoted within the framework of qualitative methodologies. This project is informed by their four key principles to assess quality: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Sensitivity to Context

The researcher remained sensitive to the theoretical context by immersing themselves in the FII literature. FII remains an inadequately understood phenomenon that provokes significant debate and diverging opinion. Retaining an awareness of this socio-cultural context of the study involved researcher reflexivity, and acknowledgement of FII as an emotive experience at all levels.

Yardley (2000) asserts that attempts to remain neutral are futile. However, the researcher had a limited understanding of FII prior, and thus an open minded, curious and sensitive approach to interviews, analysis and reporting of results was essential. The researcher used skills as a therapist to remain attuned to participants throughout, and help create a safe space whereby they were given an opportunity to freely discuss experiences.

Some findings from the study may be deemed controversial, or raise questions about specific FII practices and systemic inequalities. It was important to present these findings respectfully, as they shed light on the difficulties of working in healthcare in the current socio-political context, as well as lack of policies, and the emotional impact of this work. It felt important to do this to uphold ethical integrity, and provide new insights in order to contribute to system-level change for the benefit of all involved.

Commitment and rigour

Commitment was shown via remaining up to date with emergent findings and grey literature. Data analysis was described clearly and thoroughly, and coding re-runs were used during analysis to ensure breadth and depth of findings, and to ensure themes had a central unifying concept and thus a thick narrative. Coding reliability procedures were used to capture exceptions in the final thematic structure and aid a fuller, more nuanced understanding. Data triangulation was utilised through a process of reviewing, analysing and checking transcripts and reflexive notes (Donkoh & Mensa, 2023). A clear audit trail was kept to allow for verification of decisions, which enabled clear discussions with the project supervisor to take place.

Transparency and coherence

Reflexive strategies helped to maximise transparency. This included the use of direct participant quotes to present findings and increase transparency, the use of a reflexive journal throughout data collection and analysis to monitor potential influence, and the use of reflexive supervision to refine the thematic structure. Coherence is evident between the research question, epistemological position, and data analysis method. Final themes were presented to peers in qualitative supervision to prompt discussion and reflection, and two participants (one psychologist and one non-psychologist given the data spread) were contacted to check the accuracy of final themes and subthemes. Both were unfortunately unavailable to provide comment.

Impact and importance

Yardley (2000) emphasises the need for qualitative research to have a meaningful and practical impact. This is supported by previous research recommendations and the significance of study findings in terms of broader socio-cultural awareness and practical considerations for policy makers and health care services. There was also a felt sense amongst participants that the project was important, especially a need for enriched theoretical understanding.

Reflexivity statement

Research cannot be free of researcher influence (Finlay & Gough, 2003). However, reflexivity in RTA allows CR researchers to engage with their positionality (Braun & Clarke, 2021b). This process highlights the researcher's active role in knowledge production which is ultimately influenced by their values, experiences and assumptions (Braun & Clarke, 2019).

I, the researcher, am a female, Trainee Clinical Psychologist, and a professional working in the NHS. I have also worked in the private sector in the UK, meaning that there is overlap and strong resonance between mine and participants' professional experiences. I have also accessed both private and NHS services for my mental and physical health, and therefore have lived experience of being a patient under the same systems.

I have never worked clinically with FII myself, but have been aware of the concept in the past through various media channels. The project supervisor is an active researcher in the field of FII and is currently challenging the RCPCH (2021) guidance, which has opened my eyes to this work as a significantly divisive and emotive area in need of progression. The project itself has seemed to generate discussion amongst fellow academics and clinicians around me, as mirrored in the literature. I had struggled to know ‘where I sit’ on things, so I wanted to hear from the professionals themselves. The experience of being on ‘both sides’ (professional and service user) underpins my passion for using my position to advocate for others, and has led to my specific interests in concepts such as vicarious trauma and iatrogenic harm. I hope to challenge systematic discrimination, and research a poorly understood area to reduce any potentially unnecessary harm to service users and professionals.

My experiences and exposure to certain perspectives has a propensity to influence the project, particularly data analysis. I am also conscious that my position as a Psychologist interviewing other Psychologists has the potential to lead to over-collusion. However, maintaining a curious, and open-minded approach, reminding myself of my own motivations for the project, and reflecting upon my position felt like second nature due to my psychological background. This helped to stay close to how participants made sense of their world. Reflexive strategies were also used to manage this, as well as transparency with participants about my role and the project’s aims.

Results

The data represents a coherent story of nine health care professionals’ experiences of FII in the UK.

Sample characteristics

Table 1

Participant numbers and occupations.

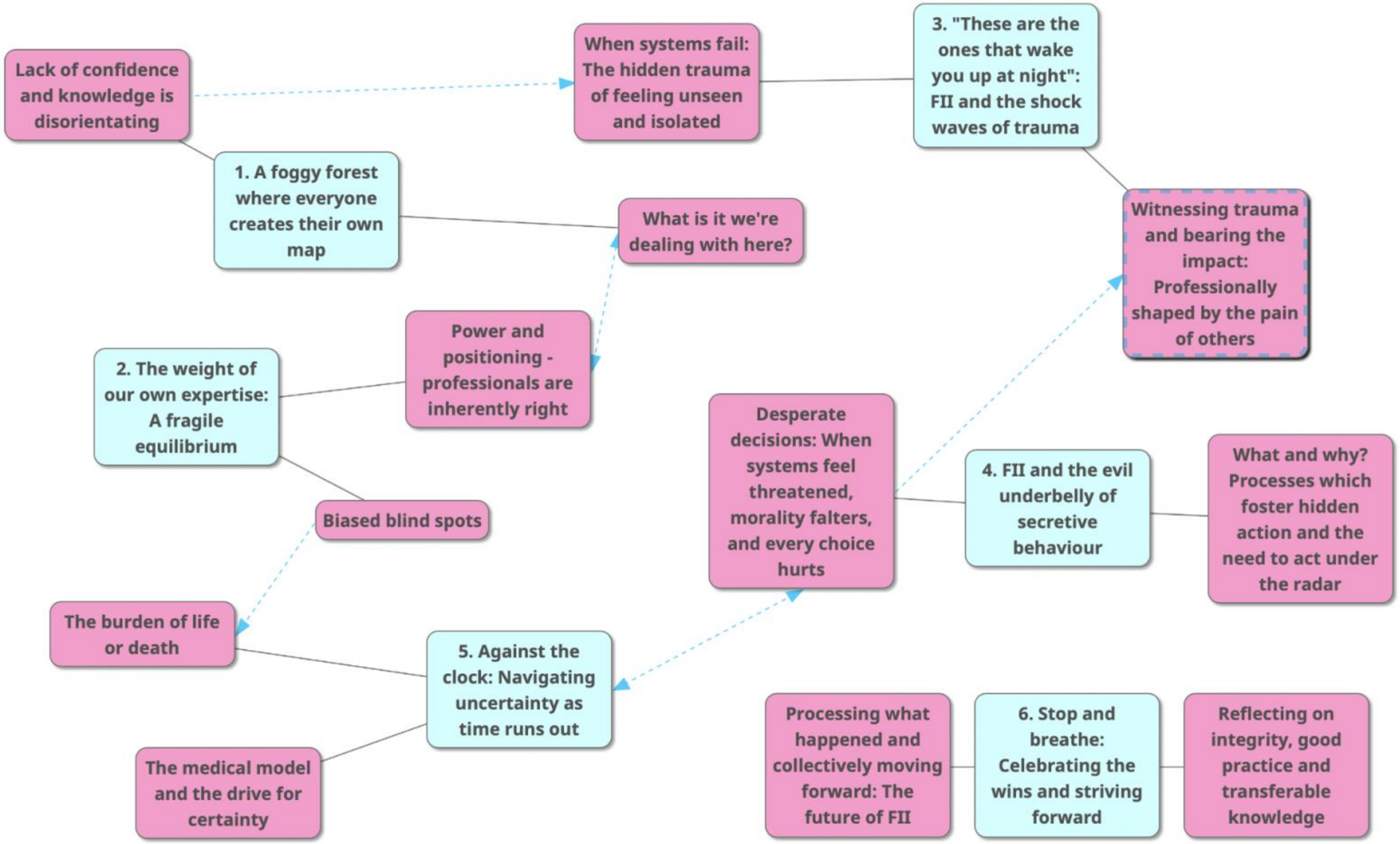
Participant number	Occupation
1	Clinical Psychologist
2	Clinical Psychologist
3	Clinical Psychologist
4	Paediatrician
5	Clinical Psychologist
6	General Practitioner
7	Clinical Psychologist
8	Paediatric Gastroenterologist
9	Clinical Psychologist

Analytical themes

Six analytical themes were developed using RTA (Figure 2). Illustrative quotes are provided in Appendix J.

Figure 2

Visual depiction of analytical themes and descriptive subthemes.



Analytical Theme 1: A foggy forest where everyone creates their own map

An inconsistent and chaotic approach is described in terms of identifying and approaching FII. The lack of clarity in terms of how to approach FII cases causes professionals to feel disorientated.

Descriptive subtheme 1.1: What is it we're dealing with here?

There are mixed narratives around who is responsible for diagnosing FII. This ambiguity creates a grey zone of professional accountability, with evident confusion around whether FII is a clinical diagnosis, a safeguarding label, or a legal finding. Participants frequently expressed that this lack of clarity contributed to professional anxiety and caution.

- *"If you look at the guidelines, it has to be decided by a multidisciplinary meeting" (3)*
- *"FII is a diagnosis that only the court can make. It seems we're not allowed to make it." (8)*

Some participants describe that cases of FII are out of the realm of their usual clinical practice, which means they are unfamiliar with FII-specific processes.

- *"you can get proof that a child is having a particular medication (…) most (..) Consultants don't know because they don't have to." (2)*
- *"FII is not necessarily a big kind of presence of what we do" (7)*

However, others shared that the prevalence of FII is not as rare as people assume, and recognise it as a familiar part of practice. FII seems to be more prevalent in some clinical contexts compared to others.

- *"it's not really rare that we're thinking about this" (4)*
- *"I would lose count at the amount of times it is suggested." (7)*

In the absence of a FII-specific assessment tool, the approach to assessment is inconsistent across the United Kingdom, and professionals all rely on different assessment tools.

- *"Each case is so individual (..) you couldn't write a standardised risk assessment" (4)*
- *"I use an assessment tool called Personality Inventory" (3)*
- *"We did develop this semicircle (..) so it's an informal tool that we use" (4)*

Each participant generally described different alerting signs, and too many to report. The things that professionals would find 'alarming' massively ranged, and many instances which professionals report would worry them are not included in the formal FII guidance.

- *"common themes (..) domestic abuse, (..) maternal mental health issues (..) prescribed substance dependence" (4)*
- *"took on (..) medical knowledge (..) very easily" (8)*
- *"frequency of hospital visits, multiple second opinions being sought, unusual things present." (1)*

It was not uncommon for concerns to emerge based on anecdotal or clinical instinct, such as *how* parents said things rather than a measurable or observable concern. Participants appear to rely on 'gut feelings' in the absence of robust and collective FII understanding.

- *"It's more the way they say it than necessarily how." (1)*

<u>Descriptive subtheme 1.2: Lack of confidence and knowledge is disorientating</u>

Participants describe the level of expertise required to navigate FII cases, and recognise them as requiring specialised knowledge. Many lack prior experience or formalised training, impacting confidence.

- *“Don't feel I've got enough training to tell you what I've done well and what I haven't.” (1)*
- *“I don't have the confidence (…) experience or the expertise to figure all that out” (5)*

Some use RCPCH guidance, but feel its practical application is hindered by systemic constraints. Others aren’t aware of guidance, or rely on internal safeguarding processes to inform their decision making.

- *“it sounds great when it's written down (…) never feels quite as straightforward as that lovely flow chart” (4)*
- *“complete mismatch between the reality of that guidance and social care” (8)*

Some participants describe clear, embedded FII-specific processes.

- *“Everybody knows what to do if you're concerned about (…) immediate threat” (4)*
- *“We've always discussed them as a team (…) it's an MDT outcome (…) often will invite safeguarding.” (1)*

Contrastingly, others describe uncertainty about how to move forward without clear direction.

- *“it wasn't abundantly clear what we were doing apart from (..) safeguarding had agreed our plan” (7)*

- *“it was allowed to go on for so long because the processes weren't in place.” (7)*
- *“There are no real case reports (..) There's just very little understanding” (2)*

Additionally, professionals report confusion around the social care referral threshold, such as how to refer, uncertainty about when to be concerned, and choosing the right time to refer.

- *“Definitely discussion around when or how to involve social services.” (2)*
- *“How much proof do you need (...) before you can raise it with other services.” (1)*

Analytical Theme 2: The weight of our own expertise: A fragile equilibrium

Professionals operate within a fragile equilibrium, where the weight of their expertise, power, unconscious biases and emotional responses can impact complex clinical decisions.

Descriptive subtheme 2.1: Power and positioning – professionals are inherently right

Discrepancies between parental report and clinical picture are concerning, and professionals experience this as concerning, confusing and anxiety provoking.

- *“some inconsistencies about (..) how settled was the child compared to what was reported“ (7)*
- *“reports of children looking unwell, but when they're (…) assessed clinically, they look very well” (4)*

Validity of parental concerns are questioned, and a perception emerges that the issue lies within the parent rather than the child.

- “*what was being presented as illness in the child was actually one of the caregiver’s mental health disorders running rampant” (8)*

Some professionals report derogatory remarks, especially towards Mothers.

- *“the consultant who said Mum's just crazy” (7)*
- *“An odd affect” (8)*

Encouragingly, some participants felt able to challenge decisions.

- “*We readily challenge each other all the time.” (1)*

This was more difficult with medical professionals and judges.

- *“if we'd listened to the newly qualified band 5 and she had felt empowered enough to share her concerns differently, we may not have got to (..)” (7)*
- *“the medical opinion (…) is the opinion.” (6)*
- *“‘I don’t want to hear any more’* [the judge]” (3)

<u>Descriptive subtheme 2.2: Biased blind spots</u>

Mothers appear to be disproportionately accused of FII. Some professionals recognised that this is problematic, and made conscious efforts to reflect on the biased assumptions made about Mothers both in the guidance and in clinical practice. Others spoke about this as if it was reality, in the sense that more Mothers being responsible for FII reflects their reality and experience.

- *“there is a bias to say (…) it's a mum (….), knowing that one (…) was a dad (…) was quite interesting.” (1)*
- *“some of the research they suggest [in the alerting signs], like gynaecological things.” (3)*

Confirmation bias is described. When FII becomes the dominant narrative, professionals may interpret facts to support this.

- **“***You start to look for other things that would think this is a bit unusual pattern of behaviour.“ (3)*
- *“When the focus goes on to this is FII, it’s all about is it or isn’t it and can we prove it” (4)*

A limited understanding of FII could lead to unhelpful assumptions or diagnostic overshadowing, where Autism or FII are missed or assumed to be each other due to gaps in clinical understanding of both.

- *“they thought he was autistic (..) sometimes have unusual relationships with diet, food and processing food” (9)*
- *“they’re three for God's sake they haven't got autism” (8)*

Reassuringly, most professionals showed awareness of different presentations, and adapting approach for neuro-divergent families.

- “*may have trouble managing (..) how you ought to present to the doctors in order to not be over-anxious, over-involved, odd, not caring enough” (5)*
- *“parents with neurodiversity and making sure (...) we've understood concerns appropriately and (...) we have conveyed our views clearly” (4)*

Professionals’ emotional responses when FII is confirmed are broad and polarised. Most participants seemed to have engaged in reflection about how unhelpful this polarised response was.

- *“kind of pride at ‘oh, we've worked it out. Look how great we are (..)’ and ‘Oh my God (..) this poor child’“ (7)*
- *“Quite angry, to distress (…) had a Paediatrician go, ‘Oh my God. I've been…giving this child whatever for all these years’” (3)*

Denial is described as a way to cope with the distressing nature of the cases.

- *“We initially will resist the idea (…) it's too emotionally discomforting to think that humans do this to people that they love.” (1)*
- *“there was a huge fear … that it was FII that was explaining everything.” (2)*

Analytical Theme 3: “These are the ones that wake you up at night”: FII and the shock waves of trauma

Professionals experience significant trauma, partly due to the distress from the cases themselves, but also due to the reverberating impact of the wider system in which these cases are managed. The combination of moral responsibility, institutional pressure and relational strains are experienced as more than just professional challenges, but experienced as profoundly distressing which leave a lasting emotional mark.

Descriptive subtheme 3.1: Witnessing trauma and bearing the impact: Professionally shaped by the pain of others

Professionals describe anxiety around how to approach a parent with concerns. This is experienced as emotionally taxing due to the fear of triggering distress or confrontation, and the awareness of the potential implications of this on the child.

- *“if your mum’s upset, how do you then go and have that conversation” (8)*
- *“I just remember that being very tense” (9)*

Considering alternative explanations to rule FII in or out takes time.

- *“By the time they're in hospital (…) there's been a lot beforehand of what's going on?” (5)*

Professionals feel complicit in harm through the infliction of extensive unnecessary procedures.

- *“that kind of realisation that really we'd been seeing this mum slowly killing her child (..) seeing her (…) and helping her do it” (2)*
- *“we are re-traumatising, (…) torturing this child.” (7)*

Participants describe intrusive memories and thoughts both during the case, but also for a long time after it has happened.

- *“Makes me quite emotional, that memory of seeing him (..) he must have been so scared.” (9)*
- *“These are the ones that wake you up at night” (8)*

Psychological effects include regret, guilt and self-blame. They subsequently doubt their professional ability.

- *“lots of reasons that would have made it easy for her [to inflict abuse]. And I didn't think of any” (9)*
- *“I was fully embedded in a very unhelpful thinking style about my own practice” (7)*

Professionals describe long-lasting trauma and emotional depletion.

- *“The ripples are still there (…) years on.” (9)*
- *“these kids take a huge amount of emotional energy” (8)*

Descriptive subtheme 3.2: When systems fail: The hidden trauma of feeling unseen and isolated

Alongside the personal and clinical burden of FII cases, professionals also describe a less visible and more insidious contributor to stress. Professionals feel disbelieved, unrecognised and abandoned by the wider system, leading to loneliness and isolation. Therefore, trauma doesn't just occur due to the cases themselves, but due to a fractured system which fails to support professionals in their most challenging moments.

- *“if something like this came out in the media, they’d be like, these doctors made it up” (8)*
- *“You can't really talk to anyone about it, so you’re kind of on your own outside the hospital” (9)*

Professionals feel consistently abandoned by social care, which they attribute to limited FII awareness.

- *“’They're in hospital (..) you're keeping them safe’ (..) there's just a level of not understanding what it is that we're talking about.” (8)*
- *“There was very, very little support from kind of safeguarding team social services.” (2)*

The lack of containment from the wider system contributes to feelings of vulnerability.

- *“put on a palliative pathway and just think, OK, there's nothing more we can do” (9)*
- *“there was this, an unease across the team around it.” (2)*

This is compounded by the threat of professional repercussions and aggressive court processes.

- *“they [in court] bloody cross examined me and made out that I’m useless and (…) a gullible idiot” (5)*
- “*“could get yourself referred to the GMC (…) have a long complaint against you. Why bother (…)?” (8)*

Analytical Theme 4: FII and the evil underbelly of secretive professional behaviour

Professionals show awareness that there is an 'evil underbelly' to FII, recognising that aspects of the process feel ethically troubling. Guidance encourages action 'under the radar', which is traumatising for both families and professionals.

Descriptive subtheme 4.1: What and why? Processes which foster hidden action, and the need to act under the radar

Having a conversation with parents to clearly outline FII concerns feels risky, especially as the current guidance suggests advises against this due to the risk that a parent may escalate their behaviour in order to be 'believed' by professionals, resulting in further harm for the child. Professionals are acutely aware of this, and feel hypervigilant to the consequences of raising any concerns directly with families.

- "*the evidence shows that if you have that conversation with a parent (…) they may then kill their child." (2)*
- *"they did challenge (…), the situation deteriorated and (…) she was found to have blood, which was the mother's blood in her urine" (3)*

Professionals therefore need to act under the radar, which limits transparency with families about concerns.

- *you don't mention it until you think there's some evidence (…) you try and build the evidence before" (6)*
- *"'Just document everything in your power, any interaction, any conversation'" (7)*

This feels like the only way to assess concerns thoroughly, and involves excluding parents from conversations, and an air of secrecy or vagueness.

- *"the Doctor sent the Mum out (…), he bamboozled her with science" (1)*

Hospital admissions are used to ensure the child's safety and an opportunity to rule FII in or out.

- *"While we've got them in hospital. Let's make sure every possible avenue has been explored" (6)*

However, professionals usually omit that the hospital admission is in part due to a FII concern.

- *"the paediatrician has said 'Oh, I'd like to admit you for something else (..) related'"* (1)

Professionals acknowledge that the separation of a child and their care giver is distressing for all involved.

- *"to have these two adults (..) pulled from her and then these strangers looking after her." (7)*
- *"when you're doing that with a toddler, well, they want their caregiver (…) it was really difficult." (8)*

Descriptive subtheme 4.2: Desperate decisions: When systems feel threatened, morality falters, and every choice hurts

Professionals describe FII cases as moments in which their usual moral and professional values are challenged. Unlike other safeguarding contexts, professionals describe 'having to' engage in covert processes. For many, this creates a deep sense of moral unease due to a collision between personal morality and protocol.

- *"It felt very uncomfortable to not be able to share those concerns or feelings" (6)*

Interestingly, perplexing presentations are interpreted as a parental anxiety issue, which allows professionals to compassionately support, using transparent processes.

- "*you get a polarising from 'oh it's just an anxious mother' (..) or a complete criminalising" (3)*
- "*the slower burn cases, you know, we should be telling families." (4)*

When the FII evidence 'threshold' is reached, systems feel threatened and act on impulse. This is often the first time that parents find out about concerns. Even when such actions were seen as necessary to protect the child, professionals report visceral discomfort with the experience, and many report that this has stayed with them for long after the case.

- *"We got the result (...) police were called (...) removed the caregiver" (8)*
- *"The first time Mum knew was when the police were called, (...) they came on to the ward and arrested Mum and took her" (2)*
- *"parents not being able to say goodbye like it was (..) messy, chaotic" (7)*

Outcomes which professionals were aware of included instant removal of children and parents being arrested.

- *"I think she went into the homeless system (…) it's gone through the legal system, and now is in prison." (9)*
- *"the Court of Protection got involved and the child went into care." (1)*

Professionals describe systemic neglect and dehumanisation of mothers within legal proceedings, who are criminalised not understood. This is distressing for everybody.

- *"it's criminalised (..) you have to prove that you are innocent else you are going to prison (..) and you're going to lose your child." (3)*
- *"this judge it was, 'this woman is evil and I'm not having this conversation anymore'." (2)*
- *"if that's how they were treating me, when they've got a parent (..) who they have pre-judged as a bad person (..) I can only imagine how bad that is." (5)*

Analytical Theme 5: Against the clock: Navigating uncertainty as time runs out

Navigating uncertainty, time pressures, high-stake situations and multiple clinical demands all amplify stress in decision-making. Professionals describe that both action and inaction carry significant risks. The constant balancing of competing risks generates a deep and enduring anxiety for professionals, and the ordinary pace of medical decision making seems to feel accelerated.

Descriptive subtheme 5.1: The medical model and the drive for certainty

The medical model values categorisation, diagnostic conclusions, and certainty.

- *"you can see the medics bringing these accounts up (…) they're trying to solve the problem." (3)*

The worry of missing a legitimate medical issue is anxiety-inducing.

- *“The moral distress that comes with (…) possible FII or perplexing is a worry that, a) you might miss something medical” (4)*

Things not making ‘medical sense’ can therefore lead to the consideration of FII.

- *“one particular Doctor (…) said the story does not make sense (…) she pursued it.” (9)*
- *“it didn't make sense, and they were looking for reasons to make sense of why” (9)*

Finding objective evidence of FII appears to be strangely relieving, as it reduces uncertainty and guides the way.

- “*something clear to hang your hat on (...) it's much more straightforward” (4)*
- *“the horse manure (…) how does that get there? It's like really clear.” (1)*

Descriptive subtheme 5.2: The burden of life or death

The emotional burden associated with high stake, life or death decisions is palpable. Professionals need to act thoroughly, because if FII is not the issue the child still needs treatment.

- *You still want to treat the child because if it’s not FII, there’s something” (6)*
- *“that was found later to be totally fabricated, but it got to the extent that the child was at risk of dying.” (3)*

Furthermore, professionals have to navigate the risky balancing act of multiple clinical demands.

- *“how do we compassionately investigate, hold FII in mind without making the situation worse (…) Or (…) ultimately getting that family to change doctors” (7)*

- *“these are the sorts of cases that (…) take up 80% of your time” (8)*

Late detection of FII causes unnecessary harm, making decisions time-critical. However, FII can take so long to prove for ‘definite’, or to be taken seriously by others.

- *“detect it in the early stages so that people don't progress down that awful pathway” (3)*
- *“if there were (..) things that we could see earlier (…) ways that this child didn't have to get as unwell (…) for us to finally get to the point of proving it” (2)*

FII cases are time-consuming, risky, and clinically complex. Professionals highlight the importance of vigilance, as ignoring FII is simply too dangerous.

- *“most cases will be completely genuine (…) you still can't ignore the elephant in the room.” (6)*
- *“I do believe people, but (…) I'm always open to the possibility” (9)*

Analytical Theme 6: Stop and breathe: Celebrating the wins and striving forward

This theme encapsulates the acknowledgement of good practice despite this difficult terrain, and how we can collectively move forward. Despite the heavy emotional and moral burden of FII work, many participants recall moments of pride, compassion and learning, which helped to remind themselves why the work matters. Even in cases of extraordinary complexity, professionals showed resilience, moral integrity and reflective learning, with a hopefulness for change.

Descriptive subtheme 6.1: Reflecting on integrity, good practice and transferable knowledge

Despite difficult circumstances, professionals have good intentions, and are trying their best.

- *“you've taken decisions, not for any malice or neglect, but because you think you're doing the right thing.” (3)*

Some professionals describe attempts to be transparent within the confines of guidance.

- *“if (…) you need to gather more information (…) it absolutely has to be explicitly with parental knowledge and consent” (3)*

Many professionals expressed empathy for parents, and advocated for them.

- *“I hold so much compassion for that mum (…) there is a reason that she chose to do what she did in the way that she did” (7)*

A psychologically informed approach was seen as important, even by non-Psychologists (collaborative formulations, reflective practice, and curiosity about the psychological basis of FII).

- *“sit with the family and understand (…) if your child walks to school rather than goes in a wheelchair. What are you worried will happen?” (4)*
- *“dealing with these very complex cases (…) it’s about having very good formulation skills.” (3)*

Professionals reflected about how to approach conversations with parents when raising concerns, and highlighted the mechanisms which have enabled successful discussions.

- *“we've built up a good relationship with these families and they're able to hear that” (2)*
- *“being curious about how this doesn’t quite make sense and asking for their help.” (1)*

Finally, professionals reflected on positive outcomes for cases, with the child’s wellbeing at the fore.

- *“She’s doing really well. She’s thriving, apparently” (2)*
- *“There’s some appreciation. He is thriving as far as we know” (9)*

Descriptive subtheme 6.2: Processing what happened and collectively moving forward: the future of FII

Professionals receive varying support post-involvement. Debriefs and peer support are helpful, but others received nothing, especially in senior roles. Professionals who received no support experienced this as challenging, and this can further contribute to isolation and overall trauma.

- *“I’m a consultant (…) when it comes to us having support, there’s very little” (3)*
- *“We had debrief sessions (..) feelings were shared by so many different people” (9)*

A lack of closure on some cases impacts the team’s ability to process events, and collectively move forward together.

- *“I would love to have spoken to this mum after everything, to understand more about what was going on for her” (2)*

Some professionals reported that the case had been a catalyst for positive changes, and they expressed gratitude and thankfulness for this.

- *“we're much more open about it now and getting social services involved much earlier” (2)*

Professionals highlight the need for accessibility of language to aid a transparent approach.

- *“The term [FII] is often unhelpful (…) I don't know that that means very much to non-health professionals or even to families” (4)*

Others wondered whether parental mental health is of concern as a child professional, and this was divisive. Some felt that this knowledge could aid assessment, whilst others had reservations.

- *“I deliberately don’t go into it because I feel that could bias me.” (1)*
- *“I’d be really interested in knowing (...) what kind of caused this to develop for her.” (2)*

Professionals felt challenged by complex information sharing rules, and that FII could be prevented with increased communication between services.

- *“Somebody knew this mum had other struggles and (…) that was never informed” (9)*

Generally, professionals highlight the need for formalised, profession-specific training.

- *“I definitely think that FII training should be kind of mandatory” (2)*

Discussion

This project aimed to qualitatively explore the experience of FII for professionals. By gaining insight into professional experiences, it was hoped that we could identify (1) what behaviours professionals are associating with FII, (2) how professionals are making clinical decisions, (3) whether current guidance and systems supports them in this, (4) outcomes and impact.

Using RTA, six themes were developed which represented the collective experiences of nine professionals. These included: "A foggy forest: Where everyone creates their own map", "The weight of our own expertise: A fragile equilibrium", “'These are the ones that keep you up at night': FII and the shock waves of trauma", "FII and the evil underbelly of secretive behaviour", "Against the clock: Navigating uncertainty as time runs out", and "Stop and breathe: Celebrating the wins and striving forward". Together, these themes represent a rich and compelling narrative about professionals’ experiences of the entire process of FII cases from beginning to end.

The current approach to FII in terms of the definition, identification and pursuing concerns is described as inconsistent and chaotic, which can be disorientating for professionals who often lack prior experience or training in this area. Participants challenge the narrative that FII is rare (McClure et al., 1996), mirrored by research which suggests the under-reporting of FII (Lazenbatt, 2013) or the reported over-identification of FII in recent years (Clements & Aiello, 2021). Professionals described a vast range of parental behaviours which they would be concerned about, and associate with FII. The majority showed consistency with alerting signs proposed by RCPCH (2021) guidance, such as seeking multiple medical opinions or multiple hospital visits. However, others appeared to be random or vague, with clinicians relying upon anecdotal experience or clinical instinct. This is consistent with current criticism about the efficacy of such alerting signs, which remain ‘untested systematically’, and are perceived as based on clinical opinion rather than evidence (Glaser & Davis 2019; Gullon-Scott & Long, 2022). Early detection of FII therefore relies on a solid understanding of the psychological basis of FII rather than a risk criteria approach (Devine, 2016), supported by the current findings which propose the value of collaborative psychological formulation. An evidence-based understanding of commonalities, triggers and patterns of behaviour is needed, which should be guided by further research.

Similarly, professionals who were accustomed with the RCPCH (2021) guidance highlighted that its practical application is constrained by systemic factors, such as the reliance on social care support. The disorganised approach to FII presents significant challenges for professionals, and appears to be underpinned by a general consensus that current FII understanding is limited, as is echoed by existing literature (Davis et al., 2019). Participants who expressed confidence and an ability to navigate cases with ease relied upon the presence of clear and embedded FII-specific processes, highlighting a need for national and realistic standard operating procedures.

Findings suggest that power, positioning and individual biases influence clinical decision-making. Firstly, as guidance states, a child exhibiting symptoms which aren’t observed independently in their reported context is concerning. This study found that this can lead to unhelpful assumptions being made about parents, consistent with ideas around parental blame (Clements & Aiello, 2021). Secondly, professionals reported that some Mothers’ emotional presentations had led them to be perceived as strange and that Mothers are generally over-represented in FII accusations. Literature supports this, with research estimating that 94% of perpetrators are female (Postlethwaite, 2010), representing longstanding discriminatory narratives around motherhood, hysteria and the pathologisation of feminity (Ussher, 2017; Haynes, 2022).

Findings also indicate that confirmation bias, denial and polarised emotional reactions are all present in FII decision-making, and may act as a barrier to the identification of FII concern. Such biases have been shown to hugely impact the quality and accuracy of decision making in healthcare (Featherston et al., 2020; Gopal et al., 2021). Importantly, gaps in clinical understanding may lead to assumptions being made about certain groups, where autism or FII are missed or assumed to be the other, as described in recent research (Eaton, 2023). With that said, most professionals described a compassionate understanding and pre-emptive approach towards clinically adapting depending on presentation.

The importance of psychological safety is highlighted as a mechanism for professionals to feel safe enough to challenge colleagues, and therefore decisions around FII. This is dependent upon position within hierarchical structures and often requires bravery and a level of seniority. Even senior colleagues report that this is especially difficult with medical colleagues and judges. A recent review (Grailey et al., 202) found that responsibility associated with required decisions and the speed at which decisions need to be made are common factors which can oppose the presence of psychological safety, which is relevant here.

An important finding is that FII cases are significantly traumatising for professionals at every stage. Distress is caused by seeing children so unwell, anxiety around having conversations with parents to outline concerns, and feeling complicit in potentially unnecessary medical intervention. This is unsurprising, given that bearing witness to suffering and complicity are commonly implicated as factors central to the development of moral injury in healthcare workers (Čartolovni et al., 2021; Willcox & Gullon-Scott, 2025). Professionals experience trauma symptoms such as intrusive memories, thoughts, and disturbed sleep relating to the case, showing semblance to Post Traumatic Stress Disorder (APA, 2013). They commonly experience regret, self-blame, guilt, and lack of confidence in their abilities, for not detecting FII sooner, and the underhand treatment of parents. This is in line with existing research on moral regret, which, in healthcare personnel has been found to involve a wish that they could have acted differently, judging themselves harshly, even though it may not have been possible (Gibbons et al., 2013).

Importantly, findings suggest that professional distress is exacerbated by the wider system response. Parallels can be drawn to existing Nursing research, where participants who feel ill-equipped or under-supported organisationally thus feel forced to provide sub-standard care, leading to emotional distress (Hegarty et al., 2022). In the current study, professionals regularly feel disbelieved by others that FII happens at all, feel consistently abandoned by social care, face professional repercussions for raising concerns, and their professional integrity is undermined by the courts. Yon (2019) explored paediatrician’s experiences of FII, and found particular frustration with accessing social care, where differing risk thresholds might prevent FII cases being picked up, as the current study suggests. This lack of validation and containment from the wider system appears to be underpinned by a lack of FII-specific understanding and process, but ultimately leads to alienation, isolation and poorer outcomes.

As encouraged by RCPCH (2021) guidance, and potentially due to a lack of confidence in navigating conversations, professionals do not explicitly tell parents about FII concerns due to perceived risk. They describe that to safely assess for FII, professionals sometimes have to ‘act under the radar’. For example, professionals have to focus on building evidence behind the scenes and excluding parents from discussions about concerns, admitting children to hospital to rule FII in or out (without being transparent about the reason), and separating parents and children to investigate concerns further. Importantly, professionals describe that engaging in secretive processes feels necessary in the face of risk and absence of clear process, but uncomfortable, and furthers moral injury (Gibbons et al., 2013).

The findings of this study both support and extend existing theories of moral injury (Litz et al., 2009) and moral distress (Corley, 2002). Participants' experiences of being constrained by guidance and systemic processes reflect the mechanisms associated with moral distress, and can explain professionals' immediate discomfort when their actions feel ethically compromised. Additionally, moral injury helps to explain the persistence of professional guilt, regret and the long-lasting emotional impacts long after an FII case. Moral injury and moral distress frameworks together help to explain why and how FII cases are experienced as uniquely traumatic for professionals, with consequences that exceed day to day professional stress, as both moral injury and moral distress are happening at the same time. The study therefore adds important nuance to the existing evidence base by showing the suitability of applying these frameworks to the understanding of FII, which remains a poorly understood area. In particular, findings of the current study extend and develop both theories by highlighting the role of systemic and policy driven constraints in the production of ethical distress, which echoes recent research in the field of child protection (Willcox & Gullon-Scott, 2025). Additionally, this study provides important insights about the impacts of the two concepts (both moral injury and moral distress) co-occurring simultaneously. In this way, the findings challenge the existing understanding that moral injury and moral distress are separate constructs, but rather supports that they may be better understood on a continuum of moral and ethical suffering.

Professionals describe that once ‘FII threshold’ is reached, systems act recklessly, which often involves the immediate removal of care-givers, although care-giver separation is a known antecedent to developmental trauma in children (Spinazolla et al., 2021). Furthermore, Mothers are dehumanised and systemically neglected via court processes, in which behaviour is criminalised rather than understood, mirroring existing research (Chouhdry, 2019). Findings suggest that current processes are less than satisfactory and being involved in them causes vicarious trauma for professionals (Branson, 2019).

Furthermore, findings indicate that PP and FII are unhelpfully dichotomised, underpinned by RCPCH (2021) guidance for PP which encourages more supportive and transparent processes. The findings suggest that when PP are considered, time is taken to formulate parental difficulties, and parents are often offered therapeutic intervention. The system appears to have more compassion when they are able to understand the drivers for such behaviour, resulting in conditional empathy. Recent research (Watkin et al., 2024) supports this, asserting that psychological formulation and making sense of a service user’s presentation can significantly increase empathic concern amongst healthcare professionals.

In the context of the medical model professionals strive towards diagnostic certainty. However, in FII cases things don’t usually make medical sense, and findings indicate a significant anxiety around missing a serious medical concern. Doctors who work with medically unexplained symptoms report a drive to ‘fix’ and struggle to tolerate uncertainty that they may be missing something serious (Howman et al., 2016). This is implicated as a common driving factor for over-investigation in FII (Yon, 2019). Findings indicate that revealing objective evidence of FII is strangely relieving, as it reduces uncertainty. Doctors can respond unhelpfully to uncertainty, and this has been associated with false positives, iatrogenic injury, withholding information from parents, and allowing unconscious biases to infiltrate decision making (Simpkin & Schwartzstein, 2016), as the current study suggests. In this sense, diagnostic uncertainty is medically and morally necessary in terms of promoting patient-centred care, as asserted by Han (2022).

With that said, professionals in FII cases must navigate a complex system with many layers of context. Findings reveal that many factors add to the psychological burden of decision-making for professionals, making it a challenging and strenuous endeavour. Decisions are high stake and frequently believed to be life or death, thus driving a need to act thoroughly yet quickly. This results in a risky balancing act of multiple clinical demands, which is time consuming and emotionally demanding. Professionals describe that late detection of FII causes unnecessary harm, and FII is too dangerous to ignore. This reinforces Precey and Smith’s (2010) finding that a high degree of skill and vigilance is required when working with FII, as described in theme one. Uncontrollable factors such as demonstrating concerns to the wider system also exacerbate feelings of powerlessness and urgency. Existing research describes the burden of responsibility for doctors as having a cumulative psychological impact, especially in high stake situations (Howard et al., 2018).

Despite having to navigate this extremely difficult terrain, findings assert that professionals are well-intentioned, despite the professional and personal costs. Examples of admirable practice includes professionals attempting to be transparent with families within the confines of guidance, and the enthusiasm at which professionals spoke about children who are now thriving. Professionals expressed empathy and compassion for parents, and within this was a genuine desire to understand the psychological basis of FII, in line with previous recommendations about professional curiosity (Long et al., 2022).

Findings highlight the importance of psychologically informed process such as collaborative formulation, reflective practice to support staff to process emotional aspects of the work, and trauma-informed care for everybody involved, all of which are thought to be best practice in generating psychologically informed environments (Lawton & Flynn, 2022; Westaway et al., 2017). Findings also shed light on factors which enable professionals to have a successful conversation with parents to highlight FII concerns. This includes a curious, non-blaming, non-confrontational approach and a compassionate understanding which often relies on a therapeutic relationship. These findings are supported by previous therapeutic guidelines for working with FII (Kosloswka et al.,2012) and have important implications for practice. Whilst a holistic, whole family approach is consistently recommended as best practice (Bjonnes et al., 2022), the need to become involved with parental mental health concerns in FII is divisive, with some professionals expressing that it may aid assessment, and others reporting that it may generate further bias and blur boundaries. Whilst findings demonstrate that a lack of transparency with parents is discomforting, further research and discussion is needed around how professionals can balance collaboration versus risk.

Professionals receive varying levels of support post involvement which may represent broader issues with the National Health Service (Morgan, 2022). Peer supervision and debriefing processes are viewed as helpful, but a lack of closure on cases can impact ability to process events, as evidenced by existing trauma research (Ehlers & Clarke, 2000). FII cases were described as a catalyst for positive changes within a team, such as an increasingly open culture, and involving other services earlier. Moving forward, findings indicate that earlier identification of FII could be facilitated by better information sharing systems, and clearer and more accessible terminology to allow collaboration with families and non-health professionals. Professionals also sought formalised, profession-specific training.

Clinical and research implications

The early detection of FII is critical and requires an evidence-based understanding. Results suggest the need for a standardised approach to FII identification and assessment, and guidance should address this. There is an urgent need for a system-wide understanding of FII, as this currently impacts professionals' ability to apply guidance and contributes to harmful FII processes, which are traumatic at every level. Teams benefit from FII-specific processes, highlighting a need for national and *realistic* standard operating procedures. Psychological safety is needed for professionals to feel empowered to challenge decisions and share specialist clinical knowledge, thereby aiding a true multi-disciplinary approach. Professional's distress should be acknowledged, as this process is significantly traumatic for them. Peer supervision and debriefs are helpful ways to help process events and could be made available to all staff. Support structures such as reflective spaces and complex case discussions can allow for professional curiosity, examination of individual biases, uncertainty and power dynamics within teams. Clinical Psychologists are well placed to lead on such work within teams. FII processes should arguably align further with PP process, as a psychologically informed approach and formulation helps to avoid punitive treatment for families. Particularly, a non-blaming, non-confrontational, curious and collaborative approach to conversations with families is helpful, but further research is needed around how to bring caregivers into the FII conversation. Professionals seek formal, profession-specific FII training, but this again relies on a multi-agency approach and a robust, psychologically informed understanding of FII. The findings have practical implications for practitioners at an individual level, which can be considered alongside systemic change. For instance, actively seeking peer support or informal professional networks, maintaining professional curiosity, and prioritising moral self-reflection and practice self-compassion. However, a true trauma-informed approach must be top-down, and is only achievable if the wider system is responsive and equipped to manage concerns. It may be beneficial for future research to consider FII through moral distress or moral injury frameworks when considering how to understand the cumulative emotional burden and therefore to support professionals.

Strengths and limitations

The current project provides novel insights into professional experiences, aligning with research aims, and the study has provided clinically relevant and meaningful implications. The qualitative design allowed professional voices to be heard (Braun & Clarke, 2021a), and in line with the CR epistemology allowed an alternative narrative to be represented, balancing against predominant existing research around parents and families. RTA allowed for a ‘coherent and compelling interpretation of data’ (Braun et al., 2019), and the use of several reflexive strategies allowed for more credible and transparent research where methodological rigour was considered via Yardley's (2000) framework. This was especially important given longstanding criticisms around researcher subjectivity in qualitative research (Mwita, 2022). The use of member checking would have allowed for a more collaborative, iterative process of meaning-making with participants, and this must be acknowledged as a limitation in terms of enhancing trustworthiness and transparency. With that said, the researcher's reflexive position was perceived as a strength in terms of data analysis, especially as Clinical Psychologists are in an ideal position to influence policy and practice due to their leadership roles (Heneghan et al., 2014).

The concept of information power (Malterud et al., 2016) was used to logically determine the study's sample size. Efforts were made to recruit a diverse sample in order to increase information power, but there was still an over-representation of Clinical Psychologists (two thirds of the sample). This was valuable, as previous research has focused on paediatrician's experiences (Yon, 2019), however multi-agency representation such as police, social care and school workers were missing, and this variation would have further enhanced information power and generalisability of results. However, such professionals did not show interest in the project despite a purposive sampling strategy, and stronger links may need to be made with these groups to facilitate future research.

Whilst there were some aspects of difference between professionals (clinical setting, geographical location, working in private versus public sector), these were not reported to maintain privacy. FII does seem to be more prevalent in certain clinical contexts, and this likely impacts experience. The trade-off, therefore, was that these valuable contextual factors were not incorporated into the overall analytical narrative, which may have been useful to provide further insights into the FII experience. As participants were professionals operating within UK healthcare systems, findings may not generalise to cross-cultural contexts. Further research into cross-cultural conceptualisations of FII and current approaches could be helpful, in order to share knowledge and best practices.

Conclusion

The current approach to FII in the UK is described as chaotic, inconsistent and harmful for everybody involved. Professionals are hindered by current FII guidance which lacks ecological and construct validity, inconsistent perspectives around the importance of psychological understanding of behaviours, and wider systemic issues. Professionals are well-intentioned, but feel abandoned by the wider system, and have to desperately navigate concerns whilst balancing multiple clinical demands. Individual and cognitive biases, lack of psychological safety, and anxiety can all impact decision making and reduce psychological flexibility. The anxiety of missing something serious, along with current guidance and absence of clear processes, forces them to act under the radar, to navigate life or death situations to the best of their abilities, and they feel complicit in the systemic neglect of parents and children. This is traumatic, morally injurious, and unacceptable for everybody. The current project calls for urgent changes to current FII guidance, and further understanding of the psychological basis of FII, in order to implement psychologically-informed processes and prevent unnecessary iatrogenic harm for both families and professionals.

Reflection on ethical issues (414 words excluded from word count)

It was important that the interview schedule afforded participants the opportunity to talk as widely as possible about different aspects of their experience. This was necessary in line with the research aims, in the sense that this is an under researched area, and also that professionals deserved a space designed for their voices to be heard. The interview schedule’s development as an iterative process was therefore intended to capture the process of FII from start to finish, but also to capture wider dimensions such as systemic factors. The question about emotional impact being added after the first interview, and informal professional discussions during the conference aided a collaborative approach, whereby participants indirectly guided the process of data collection as experts of their own experiences.

The risk of harm to professionals and the researcher in the context of hearing about and recalling traumatic experiences was considered during the early stages of the research cycle and was reflected in the standard operating procedures. Interviews were trauma-informed, which involved explicitly giving participants the option not to answer certain questions prior to them being asked, and the implementation of a robust debrief process. Supervision was used to consider boundaries to my approach in terms of maintaining a researcher role rather than a therapeutic role in this context, whilst still promoting a non-judgemental space to facilitate psychological safety.

The reporting of results was considered prior to the proposal stage, and especially that there is a risk of professionals feeling angry that their professionalism has been challenged, or that I have interpreted the data in a way that doesn’t align with their experience. This has brought up uncomfortable feelings throughout the research, especially anxiety around upsetting professionals or not doing justice to their experiences. This was again addressed through standard operating procedures, and discussed in supervision throughout. A conscious ethical decision was made not to include any of the demographic of participants in the write up, other than their occupation, in order to protect their privacy. Various reflexive strategies were also useful here, particularly coding reliability procedures, to broaden the narrative. This involved keeping notes during the coding of the data and modifying themes to hold more nuance during the refining of themes. The reporting of results is intended to depict a balanced narrative, which captures the difficult positions that professionals are placed in through no fault of their own, whilst outlining their professional strengths such as compassion, good intentions and advocating for change which will benefit the whole system.

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Appendices

Appendix A – Study recruitment poster

Newcastle University

Invitation to take part in research

ARE YOU A PROFESSIONAL WHO HAS BEEN INVOLVED IN A CASE OF FABRICATED AND INDUCED ILLNESS?

We would love to hear about your experience

What are we doing?

This research aims to explore professional experiences of fabricated and induced illness (*cases where it has been suspected that a parent or carer is inducing or fabricating illness in their child*). This is currently a poorly defined construct and we hope that hearing about your experiences can help to develop a genuine understanding of this rare phenomenon in order to reduce unnecessary harm to families.

We are looking for..

- **Professionals** (e.g Allied Health Professionals, Doctors, Psychologists, School workers) etc (list not exhaustive)...
- Who have been **involved professionally in a case of FII**
- **Live/work in the UK**
- **Over 18 years old**
- Still work in the **relevant** post

Receive a £10 amazon e-voucher for taking part

What would taking part involve?

1 online interview with the researcher

Duration: **Approx. 1 hour**

Discussion of your **professional experience**

Results will be **anonymised** and your identity will be fully protected

FIND OUT MORE

TABITHA WILLCOX

PRINCIPAL RESEARCHER/TRAINEE CLINICAL PSYCHOLOGIST

EMAIL: T.WILLCOX2@NEWCASTLE.AC.UK

This study has been reviewed and approved by Newcastle University Research Ethics Committee

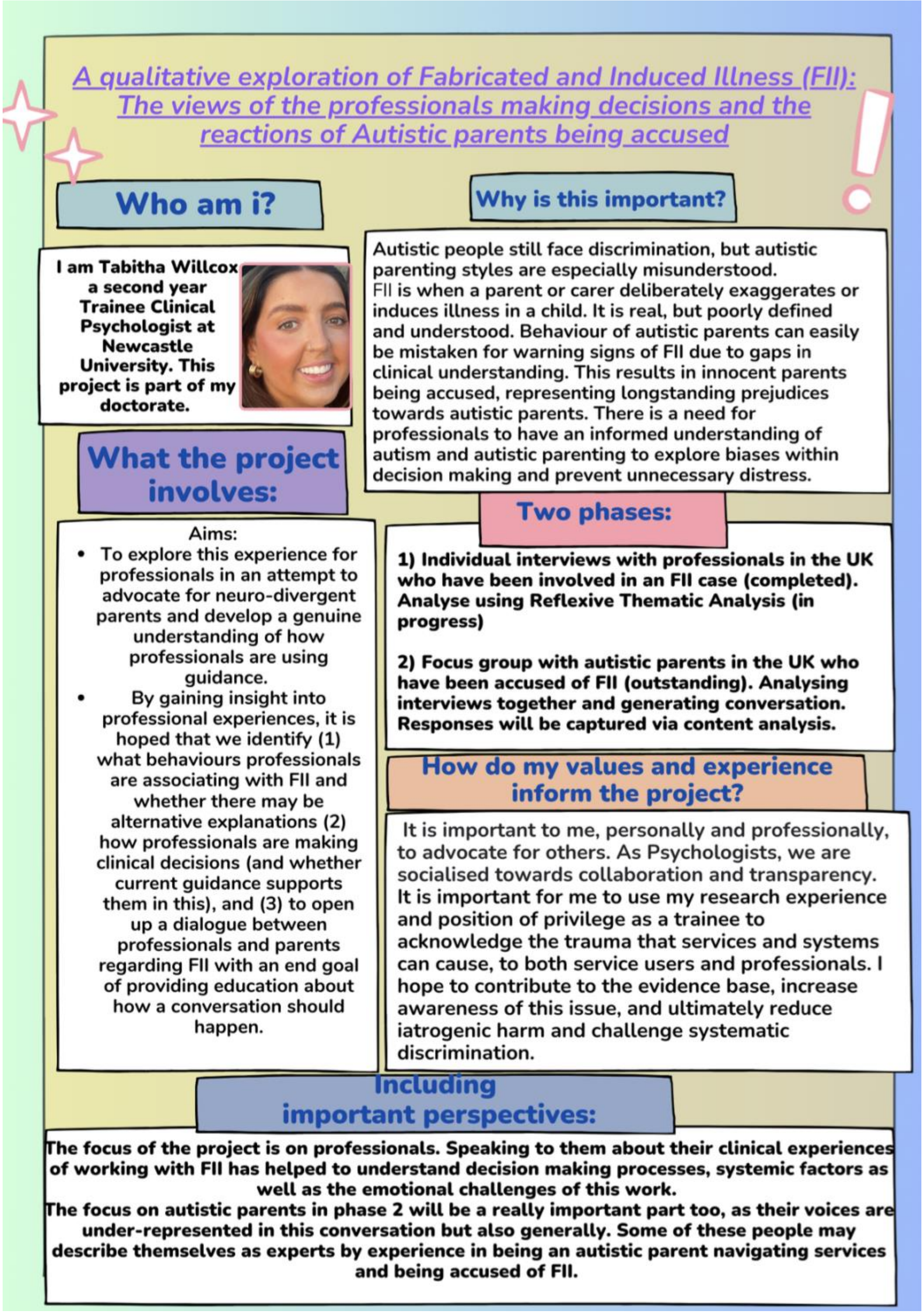
Appendix B – Interview schedule

Topic	Questions Prompts in blue
Personal demographics	• What is your age range (give options e.g (age range 18-25, 26-35, 36-45, 46-60, 60+) • What is your job role/profession? • What area do you work in? (broad e.g LD, older adults, physical health) • Area of UK in broad terms e.g North, South • How many cases of FII have you been involved in? is there one that stands out that you feel you can talk more about? Or would you prefer to answer questions broadly?
Initial concerns	• Start by telling me a bit about the case • What was the initial reason for concern with this case? At what point did you think it was FII? • What was it about this case that meant it was flagged as FII? • Did you think it was a case of FII? Why?
Behaviour of parent	• What behaviours were you seeing from the parent? • Were there any specific behaviours that gave cause for concern/ reinforced the idea that harm was taking place? • Were there any alternative explanations other than FII? How was this considered/what was the team's understanding of this? • Did the parent have any additional needs or other diagnoses to your knowledge?
Moving forward	• How were these concerns raised? • What happened after concerns were raised? • How was this decided? • What kept you moving forward with pursuing the concerns? • What was happening for you to think there was a risk?
Decision making	• Can you describe the clinical decisions that were made? • What was communicated to the family? If so, at what point and what did this look like? • What was the family's explanations for your concerns? • Did anyone raise alternatives or question the decisions that were made? • How did you feel about these decisions? • Was there any guidance available for you to use when you were having these worries?

	• Do you know about the guidance that is available for people who suspect FII? • Are there standardised measures in your service that can be used to decide abuse? • Is this helpful? Did you use them?
Systemic/environmental considerations	• If you wanted to, could you have challenged the decisions that were made? What processes exist for this? • Did you feel that you had enough training to navigate a case of this nature? If not, what would you like more of? • What did you think about the support you received during this case e.g decision making
End result/impact	• What was the end result/outcome of this case? • Where did you take the case? • What was the emotional impact of the case? • Do you have any reflections on the case now? When you consider what was helpful and what wasn't? or what went well and what didn't?
Closing topic	Finally, are there any other aspects of your experiences that you feel are important that I haven't asked about?

Appendix C – Poster presented at Newcastle University Equality, Diversity and Inclusion Conference (2024) midway through project completion.

The original proposed study was 2 phases. Upon completion of the first phase (interviews with professionals), the data was much richer than anticipated, and it was felt that there was a sufficient amount of quality data. The proposed second phase has therefore not been completed as part of this project, and will hopefully be completed at a later date.



A qualitative exploration of Fabricated and Induced Illness (FII): The views of the professionals making decisions and the reactions of Autistic parents being accused

Who am i?

I am Tabitha Willcox a second year Trainee Clinical Psychologist at Newcastle University. This project is part of my doctorate.

Why is this important?

Autistic people still face discrimination, but autistic parenting styles are especially misunderstood.
FII is when a parent or carer deliberately exaggerates or induces illness in a child. It is real, but poorly defined and understood. Behaviour of autistic parents can easily be mistaken for warning signs of FII due to gaps in clinical understanding. This results in innocent parents being accused, representing longstanding prejudices towards autistic parents. There is a need for professionals to have an informed understanding of autism and autistic parenting to explore biases within decision making and prevent unnecessary distress.

What the project involves:

Aims:

- To explore this experience for professionals in an attempt to advocate for neuro-divergent parents and develop a genuine understanding of how professionals are using guidance.
- By gaining insight into professional experiences, it is hoped that we identify (1) what behaviours professionals are associating with FII and whether there may be alternative explanations (2) how professionals are making clinical decisions (and whether current guidance supports them in this), and (3) to open up a dialogue between professionals and parents regarding FII with an end goal of providing education about how a conversation should happen.

Two phases:

1) Individual interviews with professionals in the UK who have been involved in an FII case (completed). Analyse using Reflexive Thematic Analysis (in progress)

2) Focus group with autistic parents in the UK who have been accused of FII (outstanding). Analysing interviews together and generating conversation. Responses will be captured via content analysis.

How do my values and experience inform the project?

It is important to me, personally and professionally, to advocate for others. As Psychologists, we are socialised towards collaboration and transparency. It is important for me to use my research experience and position of privilege as a trainee to acknowledge the trauma that services and systems can cause, to both service users and professionals. I hope to contribute to the evidence base, increase awareness of this issue, and ultimately reduce iatrogenic harm and challenge systematic discrimination.

Including important perspectives:

The focus of the project is on professionals. Speaking to them about their clinical experiences of working with FII has helped to understand decision making processes, systemic factors as well as the emotional challenges of this work.
The focus on autistic parents in phase 2 will be a really important part too, as their voices are under-represented in this conversation but also generally. Some of these people may describe themselves as experts by experience in being an autistic parent navigating services and being accused of FII.

Appendix D – Participant information sheet

The original proposed study was 2 phases. Upon completion of the first phase (interviews with professionals), the data was much richer than anticipated, and it was felt that there was a sufficient amount of quality data. The proposed second phase has therefore not been completed as part of this project, and will hopefully be completed at a later date.

Participant Information Sheet - Professionals

Project Title:
A qualitative exploration of Fabricated and Induced Illness: The views of the Professionals making decisions and the reactions of Autistic parents being accused.

Invitation to take part:
You have been invited to take part in a research study.
This study is being conducted as part of the requirements set out by Newcastle University's Clinical Psychology Doctorate in the UK, by Tabitha Willcox (A Trainee Clinical Psychologist) under the supervision of Dr Fiona Gullon-Scott.

Before you decide whether you agree to take part, it is important for you to understand why the research is being done and what your participation will involve. Please read the following information carefully and take time to decide if you would like to participate. You are also encouraged to discuss it with others should you wish. If you have any further questions, please contact us on the details below.

What is the purpose of the study?
The project aims to explore the rare phenomenon of Fabricated and Induced Illness (FII), which is the possibility of illness being induced or fabricated by a parent in a child. This is currently an under-researched concept with little evidence-base, and there appears to be a lack of clarity regarding guidance for professionals around how to detect FII and how to act upon concerns. Some professionals are concerned that this is resulting in innocent parents being accused of abusing their children, and within this there seems to be a particular over-representation of autistic parents.

The project aims to qualitatively explore this experience for professionals in an attempt to develop a genuine understanding of (1) what behaviours professionals are associating with FII and whether alternative explanations are considered, (2) how professionals are making decisions as to whether to investigate for FII (and whether/how current guidance supports them in this), and (3) to open up a dialogue between professionals and parents regarding FII with an end goal of providing education about how a conversation should happen.

Am I eligible to take part?
We would like to speak to you if you are:

- A professional who has had previous involvement in a case of FII (in a professional capacity)
- Living and working in the UK at the time of data collection

- Over 18 years old
- Participants may include (but are not limited to): Social workers, General Practitioners, Health Visitors, CAMHS workers, Nurses, Paediatricians, Psychologists, Support workers
- You must be in the relevant post at the time of data collection

What will I be asked to do?
If you decide to take part, you will be interviewed by the Principal Researcher (a Trainee Clinical Psychologist) on an individual basis. This will take place online (via Microsoft Teams) and will last for approximately 60 minutes in total. You will be asked a series of questions which will involve discussions about your professional experience(s) of FII e.g., what behaviours gave you cause for concern, whether you feel you had sufficient training and guidance to follow, and what was the end result of the case. If you decide to take part, the interview can take place at a proposed date and time which is convenient to you.

Do I have to take part?
Your participation is voluntary and you do not have to take part. If you decide you would no longer like to take part, you can withdraw without giving a reason.

What are the possible benefits of taking part?
There are no direct benefits to you taking part. However, we anticipate that your involvement will allow us to have an interesting conversation about a topic area which is rarely discussed in the wider clinical context.

Additionally, this is an area which is in critical need of further exploration. By taking part in this research and contributing your professional experiences, you would be allowing us to expand the evidence-base in this under-researched area. We hope that ultimately this can improve communication between professionals and autistic parents and reduce iatrogenic harm, whilst maintaining appropriate awareness of risk in genuine cases of FII.

As a token of appreciation for your time and contribution, you would be provided with a £10 Amazon E-voucher.

What are the possible disadvantages or risks of taking part?
We do not anticipate any direct disadvantages to taking part and your participation is not anticipated to present any risks or discomfort. We do recognise that it might be difficult to reflect on clinical cases and we acknowledge that some professionals may feel that their decisions or professionalism is being brought into question. Measures have been taken to avoid any potential distress when answering questions, and it is your choice what you do and do not disclose. As mentioned, involvement can be withdrawn at any point.

What if something goes wrong?
If you have any complaints or issues arise concerning the study, please contact the Principal Researcher at any point. You will also be provided with a debrief sheet following the interview with signposting information. You can also contact the Principal Researcher following the project if you would like to discuss your experience of being involved in the research.

What if I decide I no longer wish to take part?

You can choose to withdraw your participation or information from this project by contacting the Principal Researcher within 4 weeks of your interview. Following this period, it may not be possible to withdraw your information as the anonymised data may have already been analysed and included.

Will my data be kept confidential and anonymous?
All data collected from you will be kept strictly confidential. Your name will not be linked with the information you share and all data will be securely stored in line with requirements established by Newcastle University in accordance with GDPR. No individual will be identified in the results. Information gathered will only be used for the purpose of this study and will not be disclosed or released to other persons or used for any other purposes. Your data will therefore be kept anonymous.

The recording of your interview will be deleted as soon as an accurate transcription of the information shared has been completed. The final report will contain data (quotes) from the participants, but these will be anonymised and any identifiable information will be removed.
We also request that you do not name or identify any parents or families you may talk about when giving examples, however if this were to happen inadvertently we would remove all identifying details from the data.

Who has ethically approved the study?
The study has received ethical approval from Newcastle University Ethics Committee on 21st December 2023.

Who is funding the study?
The study will be funded by Newcastle University, UK.

What will happen with the results of the study and how could I receive this?
There is another planned phase of the research project whereby the themes extracted from these professionals' interviews will be presented to a focus group of autistic parents in conjunction with the research aims. The results of the entire study will be written up as part of a Doctoral Thesis at Newcastle University. These results will be available in a report which should be completed approximately six months after the study has finished (around Autumn 2025). We will share a final summary of the study with you, if you wish. We hope that the research findings will be presented in academic journals, conferences within the UK and in other formats for non-academic audiences. It will not be possible to identify participants from the reports or publications, so your name or any identifiable information will not be included in the final report.

Who can I contact if I have any further questions?
Tabitha Willcox (t.willcox2@newcastle.ac.uk) - Principal Researcher

Appendix E – Participant consent form

The original proposed study was 2 phases. Upon completion of the first phase (interviews with professionals), the data was much richer than anticipated, and it was felt that there was a sufficient amount of quality data. The proposed second phase has therefore not been completed as part of this project, and will hopefully be completed at a later date.

Participant Consent Form

Project title: A qualitative *exploration of Fabricated and Induced Illness: The views of the Professionals making decisions and the reactions of Autistic parents being accused.*

Researchers: Tabitha Willcox (Principal Researcher) & Dr Fiona Gullon-Scott (Project Supervisor)

Thank you for your interest in taking part in this research. Please read and initial each of the following statements to indicate your understanding and consent.

I have been provided with the corresponding information sheet. I have read and confirm that I understand the information provided.	
I have had opportunity to consider the information and liaise with the research team to have any of my questions answered. I have had my questions answered satisfactorily.	
I agree to being audio/video recorded on an encrypted device.	
Confidentiality processes and the rules about my personal information have been explained to me.	
I understand that my participation is voluntary and I can choose to withdraw my participation or information from this project within 4 weeks of the interview without giving a reason by contacting the researcher. Following this period, I understand that it may not be possible to withdraw my information as the anonymised data from the interview will have been analysed.	
I understand that the results of the research will be written up in a report and may be published for others to read.	
I understand that participation in this research involves the discussion of sensitive experiences and may bring up distressing emotions.	
I confirm that I satisfy the relevant inclusion criteria as outlined in the information sheet and are therefore suitable to take part.	
I agree to participate in the research study.	

Participant **Researcher**

Name: **Name:**

Signature: **Signature:**

Date: **Date:**

Appendix F – Participant debrief sheet

The original proposed study was 2 phases. Upon completion of the first phase (interviews with professionals), the data was much richer than anticipated, and it was felt that there was a sufficient amount of quality data. The proposed second phase has therefore not been completed as part of this project, and will hopefully be completed at a later date

Project title:

A qualitative exploration of Fabricated and Induced Illness: The views of the Professionals making decisions and the reactions of Autistic parents being accused.

Thank you for participating in this research project. This project will be written up in line with the fulfilments declared by the Doctorate of Clinical Psychology at Newcastle University.

The purpose of the project is to explore the experience of being professionally involved in cases of FII and to gather the reactions of the autistic parents being accused of FII in response to this. We hope that this project will give us a better understanding of this phenomenon which will help to educate professionals, facilitate communication between professionals and families, and ultimately reduce unnecessary harm.

Please contact the principal researcher Tabitha Willcox (t.willcox2@newcastle.ac.uk) for any of the following reasons:

- You wish to withdraw from this research. Please make this contact within 4 weeks of taking part. After this time, it may not be possible to remove your information as the research may have already been published or presented.
- You would like any further information about this research project.
- You would like to discuss your experiences of being involved in the research further.
- You would like to request a summary of the research findings.

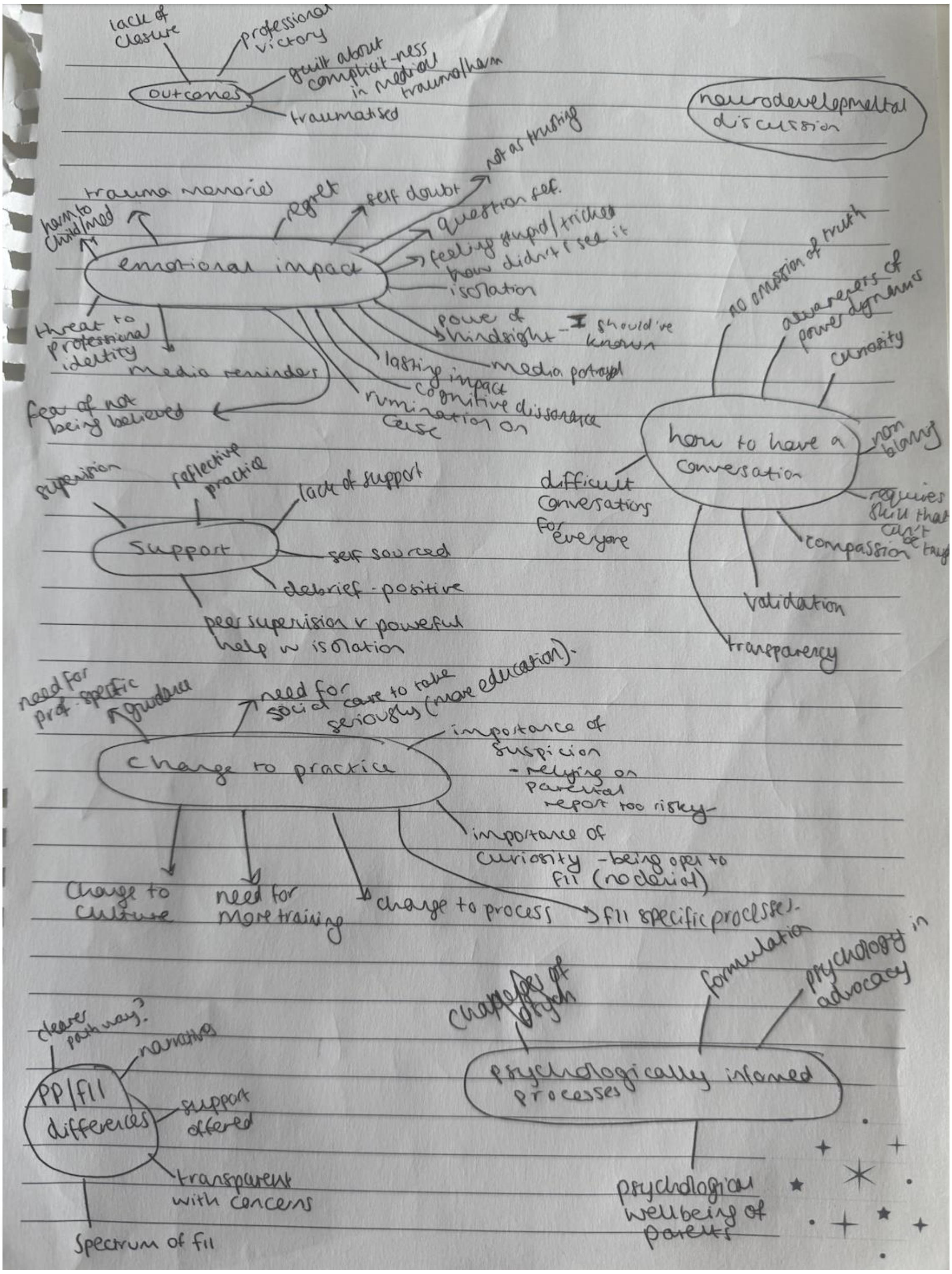
If you have found any of the issues raised in this study distressing, and you feel that you need additional support:

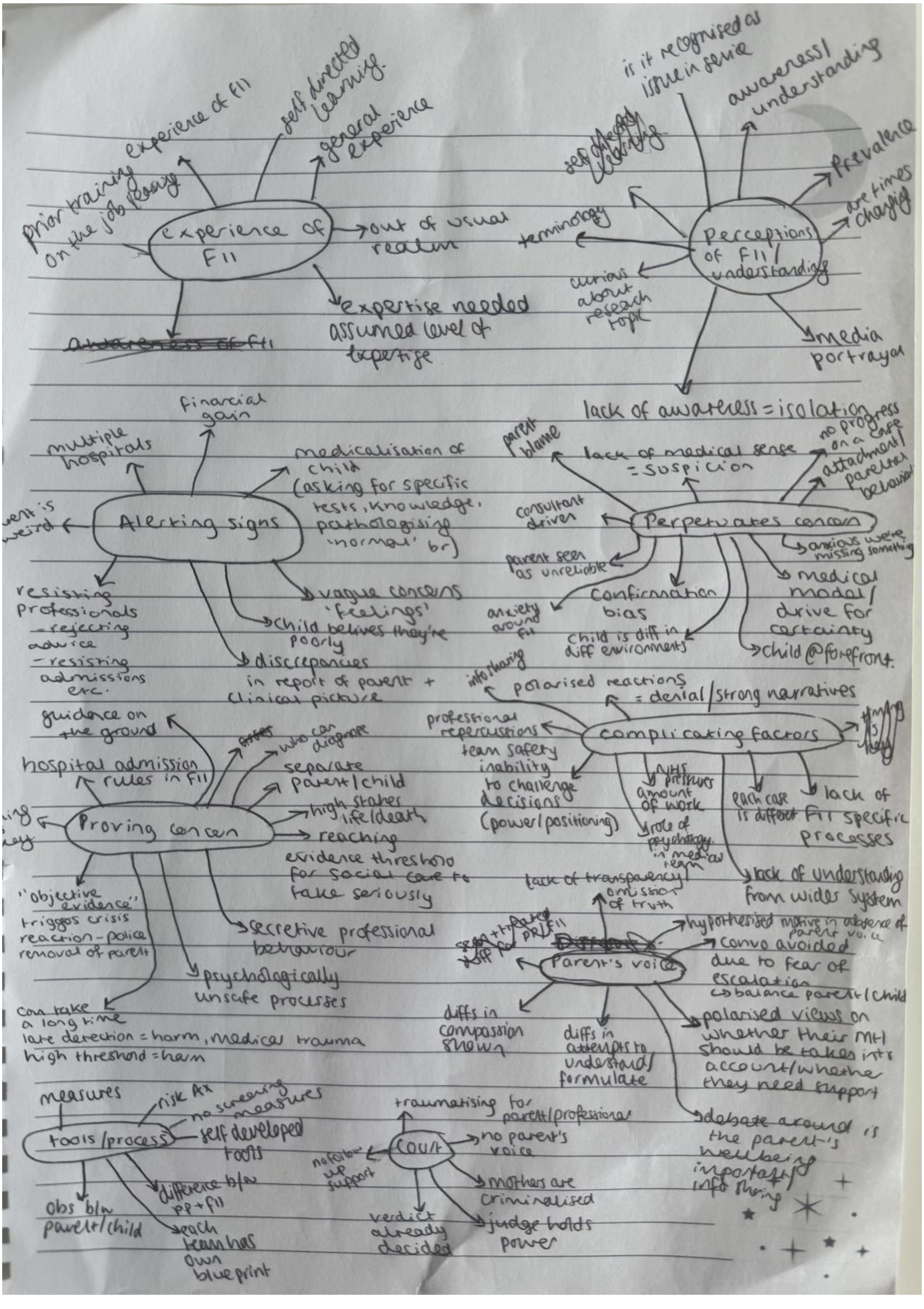
If you are a **professional** and took part in phase 1 of the study (individual interviews):

- We would recommend that you raise this with the appropriate supervisor or manager at work.

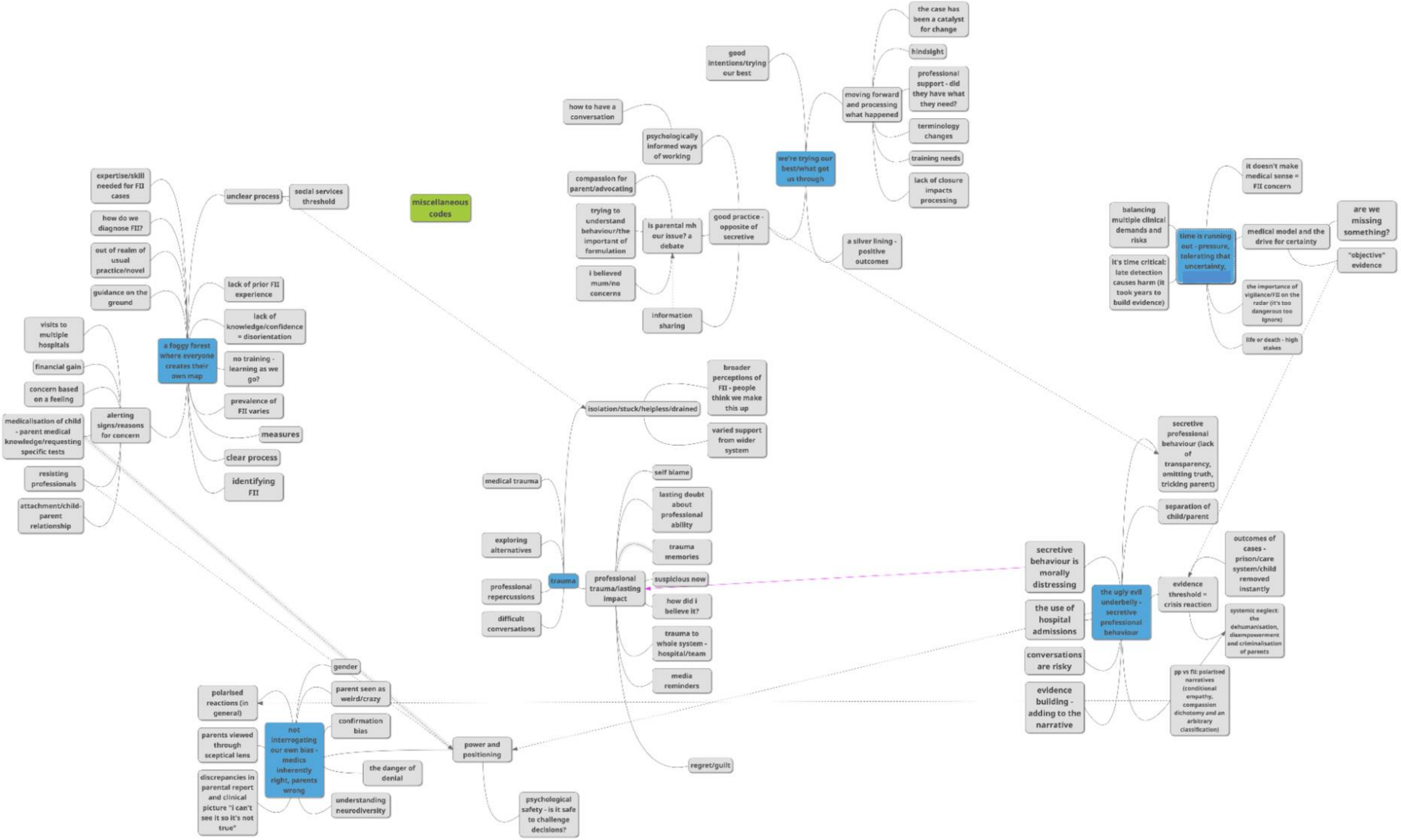
- We would also recommend that you consider seeking support from your relevant Occupational Health service.
- If you do not wish to inform work, you could contact your GP for mental health support and seek further advice.

Appendix G – Depiction of the thematic process: Collating initial codes by hand into patterns of shared meaning

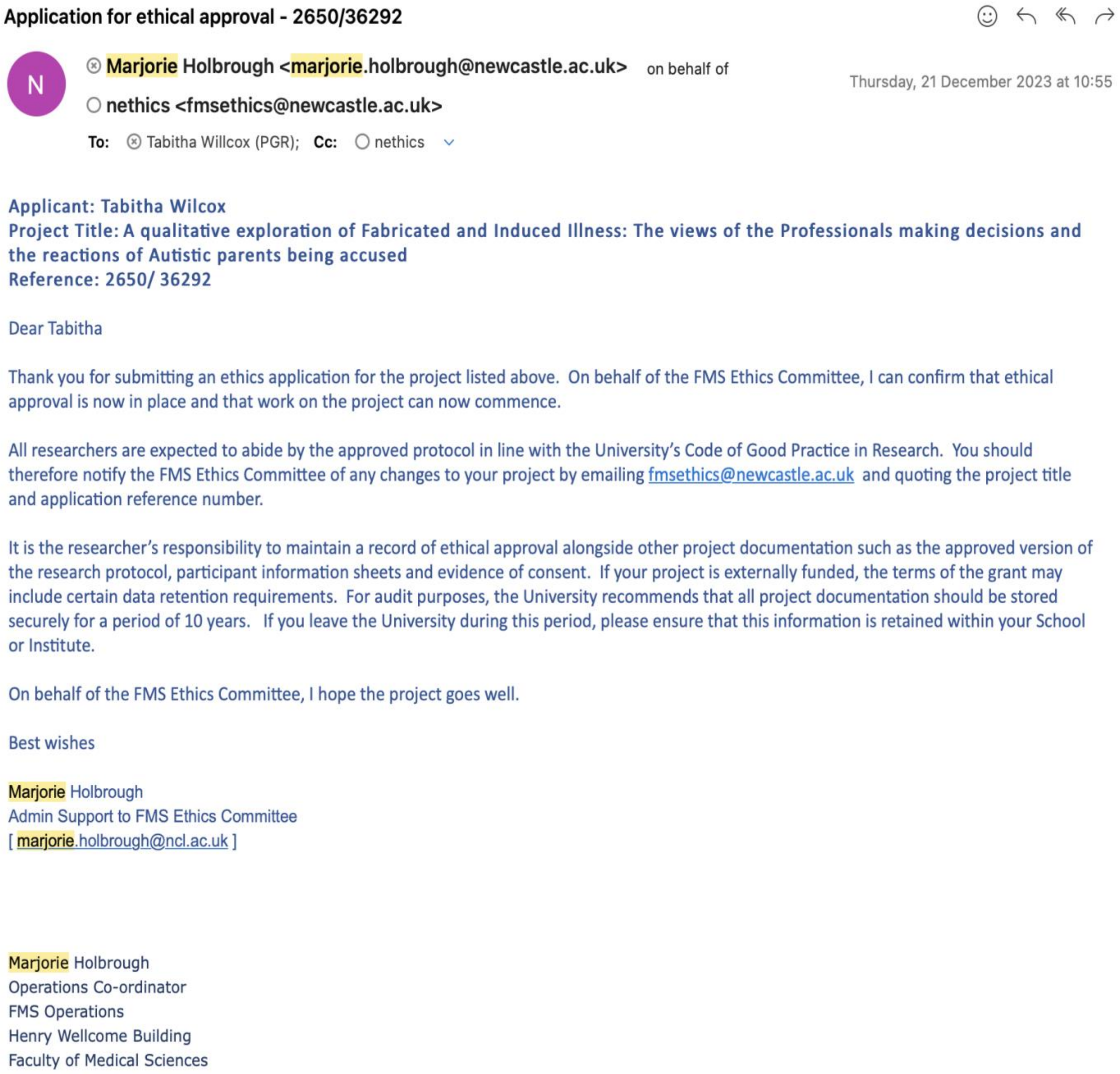



experience of FII
prior training
on the job learning
experience of FII
self directed learning.
general experience
out of usual realm
expertise needed
assumed level of expertise
~~awareness of~~ FII
perceptions of FII / understanding
is it recognised as issue in service
awareness / understanding
prevalence
are times changing
~~self directed learning~~
terminology
curious about research topic
media portrayal
lack of awareness = isolation
Alerting signs
financial gain
multiple hospitals
medicalisation of child (asking for specific tests, knowledge, pathologising 'normal' br)
ent is weird
resisting professionals
- rejecting advice
- resisting admissions etc.
vague concerns 'feelings'
child belives they're poorly
discrepancies in report of parent + clinical picture
Perpetuates concern
parent blame
lack of medical sense = suspicion
no progress on a case
attachment / parent behaviour
consultant driven
parent seen as unreliable
anxiety around FII
confirmation bias
child is diff in diff environments
child @ forefront.
anxious we're missing something
medical model / drive for certainty
Proving concern
guidance on the ground
hospital admission rules in FII
who can diagnose
separate parent / child
high stakes life / death
reaching evidence threshold for social care to take seriously
ing
key
"objective evidence" triggers crisis reaction - police removal of parent
secretive professional behaviour
psychologically unsafe processes
can take a long time
late detection = harm, medical trauma
high threshold = harm
complicating factors
info sharing
polarised reactions = denial / strong narratives
professional repercussions
team safety
inability to challenge decisions (power / positioning)
NHS pressures
amount of work
role of psychology in medical team
each case is different
lack of FII specific processes
lack of understanding from wider system
Parent's voice
lack of transparency / omission of truth
seen + treated diff for PRF FII
~~Different~~
hypothesised motive in absence of parent voice
convo avoided due to fear of escalation
balance parent / child
diffs in compassion shown
diffs in attempts to understand / formulate
polarised views on whether their MH should be taken into account / whether they need support
debate around is the parent's wellbeing important / info sharing
tools / process
measures
risk Ax
no screening measures
self developed tools
obs b/w parent / child
difference b/w PP + FII
each team has own blueprint
court
traumatising for parent / professional
no parent's voice
no follow up support
mothers are criminalised
verdict already decided
judge holds power

Appendix H – Mind map of initial thematic structure following code collation (preliminary themes with codes)



Appendix I – Ethical Approval Confirmation



Application for ethical approval - 2650/36292

⊗ Marjorie Holbrough <marjorie.holbrough@newcastle.ac.uk> on behalf of
○ nethics <fmsethics@newcastle.ac.uk>

Thursday, 21 December 2023 at 10:55

To: ⊗ Tabitha Willcox (PGR); **Cc:** ○ nethics

Applicant: Tabitha Wilcox
Project Title: A qualitative exploration of Fabricated and Induced Illness: The views of the Professionals making decisions and the reactions of Autistic parents being accused
Reference: 2650/ 36292

Dear Tabitha

Thank you for submitting an ethics application for the project listed above. On behalf of the FMS Ethics Committee, I can confirm that ethical approval is now in place and that work on the project can now commence.

All researchers are expected to abide by the approved protocol in line with the University's Code of Good Practice in Research. You should therefore notify the FMS Ethics Committee of any changes to your project by emailing fmsethics@newcastle.ac.uk and quoting the project title and application reference number.

It is the researcher's responsibility to maintain a record of ethical approval alongside other project documentation such as the approved version of the research protocol, participant information sheets and evidence of consent. If your project is externally funded, the terms of the grant may include certain data retention requirements. For audit purposes, the University recommends that all project documentation should be stored securely for a period of 10 years. If you leave the University during this period, please ensure that this information is retained within your School or Institute.

On behalf of the FMS Ethics Committee, I hope the project goes well.

Best wishes

Marjorie Holbrough
Admin Support to FMS Ethics Committee
[marjorie.holbrough@ncl.ac.uk]

Marjorie Holbrough
Operations Co-ordinator
FMS Operations
Henry Wellcome Building
Faculty of Medical Sciences

Appendix J – Additional Illustrative Quotes

Themes	Subthemes	Quotes
A foggy forest where everyone creates their own map	What is it we're dealing with here?	*"you're not there to diagnose FII." (6)* *"So there aren't to my knowledge, routine questionnaires that exist that can screen for FII." (4)* *"we tend to work on a case by case basis and you know how I was saying you would put your outcomes in that are relevant to that individual child." (4)* *"it's almost like it gets recognised by accident sometimes." (3)* *"think one of the issues is the identification of the cases in the first place" (3)* *"They're all different (…) you see different (..) patterns of behaviour." (3)* *"somebody who comes from (…) their own medical health background, somebody who perhaps has a pathological need to be (…) seen as being cared for and not centre of attention (…) She had all the red flags this mum" (9)* *"A lot of talk about sickness. An undue emphasis on sickness" (3)* *"Something not feeling right." (1)* *"Well they (parents) often have a string of diagnoses (..) Yeah, but that's part of the feature as well. Tends to be more physical diagnosis." (3)* *"I've seen this as well in terms of people presenting the children having special educational needs as well." (3)* *"the thing that's always highlighted it is multiple admissions" (1)* *"she suddenly started putting stuff on Facebook (…) and they got so many free toys and money and like arriving on the ward" (2)* *"it got to the point where we were being asked to investigate for some genetic thing that clearly this kid didn't have" (8)* *"she kept coming to us saying she had cancer and we were saying they didn't" (1)* *"a continual request to medicalise that child and to explain things that we would see as normal childhood, but just a bit boisterous" (8)* *"there must be a disease process, be that a developmental thing like well, they must have autism." (8)* *"They'd wanted a referral to (specialist hospital) for like a complex feeding assessment like there had just been this pull everywhere." (8)* *"So one of the things often is that you instinctively know have a feel for 'there is something not adding up here'" (3)* *"it was just this kind of complete rejection of the medical advice and this seeking of kind of confirmation."(7)*

		“Particularly liking members of the team and wanting to only see those members of the team.”(1) *“there can be challenges if families don't agree. And I suppose in terms of your asking about what are red flags that would take you more into a safeguarding level of concern.” (4)* *“And denying the presence of mental health issues for either the child or them.” (1)*
	Lack of confidence and knowledge is disorientating	*“I feel like I've read some guidance, read some documents. I've looked in the literature about what it says it does, and I've trusted that the consultant that supervises me has got the enough knowledge (…)“ (1)* *“I doubt whether we've done the right thing. (…) I get caught up in the doubts” (1)* *“particularly uncomfortable for me was that, not being an expert, and it not being something that we would I would commonly deal with” (6)* *“Well the recommendation for GPs (…) we should be escalating to people with specialist involvement” (6)* *“I don't think it's something even across the hospital that we (…) feel skilled enough to manage ultimately” (7)* *“No, I've had no training to navigate cases like this.” (8)* *“Literally through reading journal articles, reading some case studies. And good supervision. And it's also like there's not much formalised training available out there that targets psychologists.” (1)* *“there is a really good article. Well, in the Oxford Handbook of Orthopaedics and Plastic Surgery there’s a bit about FII in there, and I quite often go to that.” (1)* *“our safeguarding team has developed some best practice guide to follow in the hospital so I will use that.* *“it's a clear sort of standard operating procedure. It's what we should be doing, how we should be doing it, why we should be doing it.” (1)* *“the Royal College for perplexing presentations and the FII one are the two main pieces of guidance that we as a team use” (2)* *“I mean there's just very little out there from a kind of psychology perspective.(2)* *“I've done a kind of vague basic literature search to try and understand more about patterns and triggers(…) there is very little out there to try and help us understand what's going on for parents and families.” (2)* *“So I went on a FII training course. God was a long time ago, (..), probably 9 years ago (..) it doesn't feel like things have moved on massively since then.” (2)* *“What we are sadly lacking at the moment is a kind of companion document to the RCPCH guidance“(4)* *“I think we are lacking national guidance or non health professionals in terms of how they should respond, which I think has created a bit of a vacuum”(4)* *“I couldn't tell you a document. I think there is probably one in the child protection” (9)* *“But a real lack of knowledge, understanding, support about how best to proceed” (2)* *“If a paediatrician makes a referral to social services, there has usually been a huge amount of work that's gone on beforehand” (4)* *“hospital’s threshold for referring these cases is so ridiculously high.” (8)*

The weight of our own expertise: A fragile equilibrium	Power and positioning – professionals are inherently right	*“there would be reporting of vomit but (..) the evidence that was provided would be a vomit that was much smaller than described” (6)* *“It was expertly chaired. To be able to clearly point out to both the caregivers what the issue was. That basically what was being presented as illness in the child was actually one of the caregivers mental health disorders running rampant and that person needed specialist help” (8)* *“These are the behaviours that we're worried about. And that we think these indicate not a problem with the child but a problem with you” (8)* *“it was very much like all very unhelpful language like, well, you know, it's the mum. She's crazy.” (7)* *“I think at times could be really warm and chatty and but other times really cold, distant, really weird” (8)* *“Some kind of oddity being around where that shouldn't be there” (1)* *“She was a very stressed woman (…) So there were other psychological factors going on” (3)* *“it's always I think that's quite important to have somebody that disagrees with you.”(1)* *“it is difficult in the NHS (..) you've got to be brave to say actually, can we just stop there? 'cause I'm a bit concerned.” (3)* *“there was some issue about whether actually all consultants would be on board with that, but even if they weren't, there were enough that that's what we were gonna do, regardless of whether everyone agreed.” (8)* “she [other clinician] was very concerned that actually that child wouldn't have had the strength to be pulling out her NG tube (…) she hadn't felt empowered enough to share that” (7) *“But yeah, I think that would have been really hard to say I don't, I don't agree.” (7)* *“adds to the complexity, doesn't it? When you're powerless in systems.” (7)* *“there is a systemic change that needs to happen (…) we're an MDT, everyone's opinion, everyone's point is useful. It helps us understand what might be happening.” (7)* “*these indicate not a problem with the child but a problem with you” (8)* “*just a minute, the mother’s had a number of very iffy diagnoses here.” (3)* *“if you thought that something wasn't FII and somebody else was saying it was, do I feel I could say that? Yes.” (4)*
	Biased blind spots	*“usually Mum, always Mum actually, I don't think we've had any dads… but a mum” (2)* *“if you just looked at my segment,your brain wouldn’t necessarily think FII (..) there’s a whole other reason for those symptoms or behaviours documented” (6)* *“He, his autism, seemed very obvious. He would sit with an iPad and watch things in reverse.” (9)* *“if a parent say is on the autism spectrum or where that's you know may be a factor I think that could have an impact on understanding and a child's symptoms and how that’s generalised” (4)* *“I think that (autism) does that therefore have an impact on that parent's perception and interpretation of physical symptoms of their child” (4)*

		“I don’t think those things (autism traits) would flag for me..are they doing something to the children (…) but I can imagine they would for many medical professionals” (5) *“I think it really, really depends on that person’s views. When I think about it and their own - It's an emotive topic (..)So you will get a very broad response to it.” (3)* *“I think (the emotional reaction) really depended actually on their power in the team” (7)* *“I think they get a very varied response of professionals depending on who they are, their own belief systems, Et cetera.” (3)* *“It was where we were years ago, I think probably in sexual abuse, where people didn't want to believe that people did that” (3)* *“even now in this hospital, people still believe that she didn't do anything” (9)* *“I just saw the ways that she wouldn't do it rather than what the reasons where she could.” (9)* *“you get overzealous reactions. And then other times it can take a very long time because (..) if it's a child has been receiving treatment, the clinicians treating that child don't want to think that they've subjected to that child, to procedures” (3)* *“[A Consultant said] ‘I've been saying all along that this was FII. (..) look at all the evidence that we've gotten’ almost like a pride that they'd rumbled it” (7)*
“These are the ones that wake you up at night” FII and the shock waves of trauma	Witnessing trauma and bearing the impact: Professionally shaped by the pain of others	*“that’s the bit that we’re probably still challenged by because that, that, that conversation is obviously a really tricky one.” (3)* *“Obviously this is something that families find very difficult for us to discuss with them” (4)* *“the potential that the parent was either exaggerating or, kind of, expanding on (…) what symptoms were brought up while I was present. And that was a very difficult conversation to be part of.” (7)* *“Like I definitely noticed lots of kind of self-critical thoughts showing up” (7)* *“I've missed something. I've been tricked or I've been duped” (7)* *“These are the ones that wake you up at night where you go. Oh, what’s going on?” (8)* *“Was everything pretend, fake? Was she just playing a part, playing me? Or was how much of what she was telling me was genuine” (5)* *“what does that mean for my work with other people? And how do I know if they're being genuine with me? Do I suspect everyone now of just making it all up” (5)* *“I find them quite upsetting and I find them quite demanding personally”(1)* *“I found it really challenging I think because I don't like enter into sessions, thinking ‘People are faking this. This is not real’” (7)* *“I hold FII in mind even if I have absolutely no evidence for it, because I'm like, well you just don't know do you?” (7)* *“And I think the ripples are still there or you know years on.” (9)*

		“Well, obviously the court process was really unhelpful and I don’t know if I go as far as to say traumatising, but it was extremely stressful.” (5) *“I cognitively get that none of this makes sense from all of this information together, but actually that mum was perfectly pleasant. Like it's the dissonance. I think that's the traumatising bit as well.” (7)* *“it made me feel like sickened (..) how did I not question things more?” (9)* *“You obviously can't talk to people (…) particularly about these cases” (8)* *“Various different blood tests as well, just to kind of be like, have we covered all bases there?” (6)* *“all these traumas that she didn't need to go through on top of what her mum had done” (2)* *“we'd been giving this child all these tests that they didn't need all these traumas that she didn't need to go through on top of what her mum had done.” (2)* *“multiple medical interventions or multiple medical investigations which are by nature intrusive and distressing” (6)* *“they'd exhausted every test under the sun, like this poor child had been through so many medical procedures and surgeries” (7)* *“You know, that child did not need to have as many holes made as he did.” (9)* *“the paediatrician was so far down treating this kid and sticking needles in her that he didn't want to admit it” (3)* *“I'm slightly scarred with having seen what people are prepared to do.” (8)*
	When systems fail: The hidden trauma of feeling unseen and isolated	*“we would need to refer to kind of social services, not that they’d probably do anything” (2)* *“social services just haven't taken it up and they felt very similar cases. So it does feel like it's very dependent on area and what social worker you get and that kind of thing as to how much they understand about it.” (2)* *“This is no disrespect to our social care colleagues, but it doesn't necessarily always change the situation” (5)* *“But in terms of the wider system, there wasn't a great deal of of support.” (7)* *“what went badly is referral to social care always goes badly.” (8)* *“Although to some extent it would be helpful for some cases to go through and be public, because people just don’t believe you.” (8)* *“it’s moving on and there’s a bit better understanding than it was.” (3)* *“there is things in the press about people being misdiagnosed” (3)* *“as a team we found that tricky to know where and how to get the support from.” (2)* *“a lot of people probably felt quite isolated during it.”(2)* *“There’s plenty of professionals who just wouldn’t believe that this happens” (8)* *“I think there’s plenty of professionals outside of paediatrics who would just be like what you have got to be kidding me,that doesn’t happen.” (8)* *“I'll go along to the family court as the treating clinician. And then, yeah, had a very sort of unpleasant time of that where they were sort of trying to discredit me. And so that I didn't know what I was talking about.” (5)* *“There had also been numerous complaints placed against medical professionals as well in the process.” (7)*

		“they'd contacted the complaints team saying they weren't going to see me because of this conversation where I said I'm really concerned” (8) *“people, I think generally are worried professionally that someone else may come up with a diagnosis so they don't want to be made to look stupid” (8)* *“so they’re quizzing me on what I’d written in the notes and quizzing me on my qualifications and and not being an approved clinician and what diagnosis was I’m making” (5)* *“it's exposing yourself professionally to come under fire and it's also a huge amount of work. So it doesn't make any sense to do it.” (8)*
FII and the evil underbelly of secretive professional behaviour	What and why? Processes which foster hidden action, and the need to act under the radar	*“So the outcome might be the child is at risk from going home. We need to control the environment. Therefore, in the short term, to keep the child safe, we will admit them to the hospital.” (1)* *“the child, was an inpatient and we got some irrefutable proof that she was being given stuff medication that was causing her harm” (2)* *“If we’re not sure what’s happening here, what we always do is try and separate and see if we can see any symptoms without the parent doing any of the care. That is much more mainstream now.” (9)* *“you're on a ward with the expressed reason to parents being given that it's a period of observation. While FII wasn't brought up in terms of what that period of observation was being done for” (6)* *“I quite often go right? Let's ask them. Let's get them away from the parent, not in a rude way.” (1)* *“It's not that you're tricking them [the child] into disclosing, but being really curious about what's happening (..) gets you a disclosure” (1)* *“as doctors, we're looking for the physical evidence of (..) how many mls was the vomit (…) what physical evidence is there” (6)* *“the only thing we haven't done is separate the parent from the child and they did that by putting the child in the (…) unit where there was a big bay” (9)* *“When a meeting has perhaps been held with someone from school as well (..) without perhaps the family being aware (…) my advice is always to be very careful. (4)* *“when things are called FII, that there is still a tendency perhaps to make referrals to social services without parents’ knowledge because strictly speaking under FII Guidance, if you call it FII then you still can't do that legitimately under the current working together.” (4)* *“the message being given it wasn't really given that they thought something was FII, but just more. This isn't making sense. This is what we do in a normal practice to try and rule out everything” (6)* *“the guidance is very clear that you don’t raise it with the parent obviously because they can escalate” (2)* *“we didn’t have a kind of overt conversation with mum where we said we think you are harming your child because the advice at the time was very much not to do that.” (2)*

		“I’m really worried that you’re continuing to seek medical explanations for a child that everyone is telling you is normal (…) that caused a bit of a line in the sand of a deterioration in the relationship between me and the caregiver” (8)
	Desperate decisions: When systems feel threatened, morality falters, and every choice hurts	*“and who's going to explain this to the parents? (…) why all of a sudden are we now not leaving these parents alone with their child”* (7) *“[in normal practice] You can almost share that there is a safeguarding element (..) you explain to the parents that that is something that needs to be done (…) where [FII is] kind of a little bit more removed”* (6) *“I felt that it's an unusual situation to not be sharing all of your like clinical thought processes with a parent”* (6) *“[with perplexing presentations] you do some education and if you see a change (..) then you kind of can say, well it’s not fabricated, it’s an anxious parent”* (1) *“I think those kind of cases [perplexing presentations] cause more of a split in the team about how best to support them because… it feels like they're not actively doing something to harm the child, it's more that their level of anxiety.”* (2) *“And I think often with those anxiety cases, I think often they've got kind of undiagnosed postnatal depression which has just never been treated”* (3) *“I have been involved in cases where it just it is anxiety and that soon resolves, but I've also been involved in cases where it's far more complex, psychopathology is going on.”* (3) *“the police were called and initially, Dad was arrested (..) Mum was interviewed and (...) then the child became under our care as a hospital team”* (7) *“we as a team and a service agreed that this was FII. Just everyone being instantly in their threat mode of like, OK well, we need to act immediately.”* (7) *“I think social care are basically just in agreement with the family that that caregiver will only ever have supervised contact”* (8) *“Dad was arrested and he went to court. Mum also ended up going to court as well and the child was taken to foster care”* (7) *“I think by the time it gets to court proceedings, they've been accused, as in, you're the bad person, you've done it.”*(3) *“there was a meeting with parents to say this is what, this is what we've decided is happening. And then the immediate withdrawal of their contact with the child”*(7) *“I don't remember her being asked or saying anything when I was in the court. Like they didn't ask her to defend herself or anything”* (5) *“I was concerned by the judge’s response because he got me in the witness box (…) I start talking about the psychological basis of it and he just chucked me up and said we thought we decided this woman was evil.”* (3) *“she [the mother] was not examined. I was only allowed to look at the child, but she was not seen by a psychologist or a psychiatrist, so it’s criminalised.”* (3)

		“it was a criminal act, but there was no (…) consideration about why someone would behave in this way and yet there was a very clear psychological profile” (3) *“adversarial, confrontational, discrediting attempts [in court]” (5)*
Against the clock: Navigating uncertainty as time runs out	The medical model and the drive for certainty	*“as doctors, first and foremost, we want to be absolutely sure that we have identified any medical problem and that we would treat that appropriately” (4)* *“Very obvious things, and finding things. So for example finding things (…) the ward reporting they found excessive amounts of ibuprofen” (1) “One of the main anxieties, with (..) health professionals(..), you absolutely don’t want to miss a serious medical problem.” (4)* “*you can see them talking in the medical notes about, well, this doesn’t really fit (..), trying to put it into a category.” (3)* *“parents changing drips, parents tampering with children's lines (…) even poisoning” (4)* *“the child got better within weeks of her mum not being there. So it was kind of irrefutable proof, really.” (2)* *“What made the leap from the isn't to it is was just the facts (…) there was no other explanation for how this amount of [medication] would have got in his system other than her putting it in there.” (8)* *“Because we thought we'd hit a threshold that was just yeah, there was. No, this didn't make any sense.” (8)* *“It took me time. I thought this was them again, accusing her to try and make sense of symptoms.“ (9)* *“And there wasn't a reason for it, which was really worrying, so that that's the kind of that's when and how the conversations first started of lots of the professionals saying, you know, what are we doing here” (2)* *“rumblings along this FII thought process from various professionals of like ‘we're not finding this. This makes no sense’” (7)* *“How is this going to end? Because we're keeping on escalating, and actually we still don't understand the why (…) And kind of flagging how unusual it was.” (2)* *“the way that Medicine works is elimination, and that can cause issues. So thinking broadly is an issue.” (3)* *“the whole healthcare system has shifted over time for us to be able for us to perhaps be more interventional to rule out things by doing a test to to satisfy ourselves that there isn’t evidence of a medical issue” (4)* *“I think it’s very hard working in a physical health setting in the medical model where actually diagnoses are where everyone likes to be.” (7)* *“You have your (difficult cases) list. So your cases where you’re just like, we’re not making progress. I don’t quite understand all the push and pull factors as to why and they’re the ones that niggle and cause you most worry as a paediatrician.” (4)*
	The burden of life or death	*“trying to trying to be fair to families but also keep the focus on the child.” (4)* *“it can be hugely stressful as a clinician managing a case and I think what you’re what you’re weighing up is sometimes call it that that is a whole range of ethical dilemmas” (4)*

		“first and foremost as paediatricians, we are responsible for thinking about a child’s safety and welfare, and when you are concerned about that, that causes a moral distress in terms of when you’re trying to make a call about threshold to act in a case” (4) *“the conflict between knowing that you feel empathetic towards the parents who are reporting ‘I don’t know what’s going on with my child’ (..) you’re having a normal response to a parent who is in distress (..) while still holding on to this suspicion”* (6) *“It was very hard to get mum to engage with psychology and then I felt like she did, but I needed to keep her on side.” (2)* *“one of the things that is a limitation for these cases, particularly if they're soft ones like the first one, relatively, is it's a huge amount of work for what gain”* (8) *“So what you want is this to be spotted as early as possible before it gets really serious? And obviously because I'm working with children… before the child gets damaged.”* (3) *“you want to kind of cover those avenues as much as possible in a time critical way because (…) you haven't got time to wait”* *“everything is done under some form of pressure, of needing to act” (6)* *“And now here is her child dying, and I use those words because we couldn’t understand what was wrong.” (9)* *“a child that they were almost going to not sent home to die, but in a way, put on a palliative pathway and just think, OK, there’s nothing more we can do here.” (9)* *“you know there is a there is a sense of urgency on a doctor’s part to not let it get too far”* (6) *“that conflict between (..) how you normally feel about parents in terms of feeling really (..) empathetic about the situation and the stress they're going through, but also having to think, oh well, might something might be happening.”* (6) *“it's an important thing to have an awareness of and to and to look out for”* (6)
Stop and breathe: Celebrating the wins and striving forward	Reflecting on integrity, good practice and transferable knowledge	*“with parent’s consent gathering information from other healthcare providers such as the tertiary specialist” (4)* *“calling a spade a spade (…) describing we're concerned about health seeking behaviours of the parent or carer that is causing harm to a child (…) I think if we called it that rather than FII it might just be a bit clearer to everybody what it is we're worried about.” (4)* *“for children who are old enough, who are verbal (…) It's talking to them about their experiences and their views and what they want” (4)* *“despite what might get released in the press (…) we do try to think very carefully and individually about family situations and try to work with as much as possible” (4)* *“we want to be fair to families and reasonable and we want to, we want children to be happy, healthy and thriving” (4)* *“You do need reflective practice in everything you’re doing and this is no different than any other thing” (3)* *“They need supportive listening (..) active listening. People need to be accepted and validated and not blamed*

		(..) but that’s a posh way of saying just listen to people and work out what’s going wrong.” (3) *“It’s always about heart, like working on the assumption that they’re telling the truth but holding that in a curious way.” (1)* *“It’s about the psychological profile rather than the actual presenting behaviours.”* (3) *“the health seeking behaviours are a symptom of issues with wider family functioning and and and health of the adults involved” (4)* *“what you hope for is a sensitive handling of the situation (..)Not confrontation and a sympathetic understanding of it. That’s what you hope for. (…) we know this is really distressing for you, but this is what we think” (3)* *“if you say sit somebody down and say ‘you’re doing this on purpose to your child or to yourself’ (…) when I think about it confrontation, I don’t think is helpful.” (3)* *“everyone was able to share their views and that you know, that included the caregivers themselves.”* (8) *“having some of those conversations with people that aren’t skilled just leads to more conflict.”* (8) *“And I felt really sorry for her. She lost a child permanently with no contact and went to prison (…) I remember thinking (…) We need to have a bit more understanding of this.”* (3) *“I was supporting the idea that mum was (…) understandably distressed with her child being in hospital.” (9)* *“to give these parents credit is that both of them were really open minded (…) Goodness me, they were open minded.”* (8) *“hopefully Mum is getting the support that she needs”* (2) *“we got two goodish, well, we did get 2 good outcomes for those. We’ve got two kids that are normalised.“* (8)
	Processing what happened and collectively moving forward: the future of FII	“*I deliberately don’t get involved with the parental mental health. Because I know that that can be an indicating factor of fabricated illness” (1)* *“we need to be cautious. We know we’re not the parent’s health professional. We don’t have access to a lot of information about that that parent’s experiences.” (4)* *“that interaction between adult mental health and children’s physical health because obviously a child usually has somebody looking after them and there’s not a lot of dialogue between those two” (9)* *“Does anyone want to see a prosecution go through? Not really (…) do you need to put everyone through that?” (8)* *“we weren't told very much at all (…) about what happened to her, the mum” (2)* *“maybe a central system or something, so that when people are going across different hospitals and different settings, there is a central place where people are accessing clinical notes from” (7)* *“having those notes somewhere would be everyone could access would be really useful”* (7) *“after the mum had been arrested there was a lot more support. As in from like the trust lawyers and (..) that was all really well supported.” (2)* *“I don’t think we ever had sufficient support, to be honest.” (3)*

		“everybody was saying things like (…) shock, not prepared, you know, felt couldn’t talk about it, worried, anxious, sad, embarrassed, gobsmacked. You know, all those feelings and thoughts were shared so that made me feel that better (…) it wasn’t just me.” (9) *“I didn’t get any kind of resolution to it, like nobody contacted me afterwards to say, are you alright or no kind of debrief or anything” (5)* *“The support I got more there was probably from peer, like peer-to-peer. So other trainees, particularly the paediatric trainees” (6)* *“What I would like to see us all moving towards is a situation where we describe the concerns, as you know, parental health seeking behaviours, which we are concerned are causing harm to a child“ (4)* *“we're a lot more open about having these discussions now very early as a team. And a lot more open about (..) really vocalising alternative explanations” (2)* *“we have open discussions in our (..) weekly team meeting about these cases and we will be very open about well (..) what are the alternative diagnoses… is one of them FII?” (2)* *“just a huge learning curve for professionals if you haven't been involved in a case like this before.” (2)* *“we rarely saw Dad, and that's one of the other things that's actually changed in our practise. So we now get (…) the other partner involved much earlier.” (2)* *“As a team, I think they're definitely (…) more robust about the process a child would go through before they would agree to any procedure” (9)* *“I don't know how you train people for this sort of stuff, honestly.” (8)* *“There perhaps is agreement for specific training for how to use some of the tools that could be available” (8)* *“I'd like somebody to have presented a case study and gone ‘Here was the case. This is what I did. These are the additional factors you need to consider’.” (1)* *“I think probably training for our whole team might be kind of a useful thing” (9)*

Appendix K - Project sign-off sheet

NEWCASTLE UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY
Research Course: Sign off sheet for Research Projects

	Please tick if it does not apply (highlighted yellow)	Please tick if completed. If not ticked, please provide an explanation	**Trainee name:** **Tabitha Willcox** **Project title:** **The experience of professionals working in child protection and Fabricated and Induced Illness (FII): A thematic synthesis of qualitative evidence and a qualitative empirical study** *Please add date for each action* *Please provide brief comment as necessary.*
In line with participant consent, raw and electronic data where consent has been subsequently withdrawn has been dealt with appropriately (e.g. removed) and communicated in writing to the supervisor with responsibility for data keeping.	☐	☐	Date completed: 14.7.25
In line with participant consent, where permission to use data in future studies has been asked for and not been granted, this has been appropriately identified in data bases (e.g. properly labelled) and communicated in writing/document to the supervisor with responsibility for data keeping.	☐	☐	Date completed: 14.7.25
In line with your approved data management plan/ethical approval, the informed consent forms and contact details are a) securely stored in a separate place from any other data, or b) securely destroyed, as the case may be.	☐ ☐	☐ ☐	Date completed: 14.7.25
In line with your approved data management plan/ethical approval, IDs or codes linking personal data to other data have been securely destroyed.	☐	☐	Date completed: 14.7.25
In line with your approved data management plan/ethical approval, recruitment logs and other documents containing personally	☐	☐	Date completed: 14.7.25

identifiable information have been securely destroyed.			
In line with your approved data management plan/ethical/HRA/sponsors approval, the raw data (e.g. questionnaires, test sheets, data collection logs) have been a) pseudonymized, b) properly labelled and c) appropriate arrangements for their storage have been made; d) indications for date of destruction are clearly indicated	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	Date completed: 14.7.25

	Please tick if it does not apply	Please tick if completed. If not ticked, please provide an explanation	*Please add date for each action* *Please provide brief comment as necessary.* :
Any concerns about participants, adverse effects, follow-up with participants due to distress, concerns raised by participants, disagreements/ incidents that could lead to participant complaint, etc., have been discussed with supervisors, suitably recorded in an appropriate manner, addressed (if required), and signalled (if necessary) to the appropriate ethics and governance frameworks, including the Course and the sponsors. Any correspondence about these matters has either been archived (and pseudon/anonymized if necessary) or destroyed as appropriate Please seek guidance about what is appropriate.	☐ ☐ ☐	☐ ☐ ☐	Date completed: 14.7.25
Participants have been debriefed as laid out in Ethics approval.	☐	☐	Date completed: 14.7.25 No formal debriefs requested, but debrief forms sent to all participants post interview as arranged.
Participants have received a lay summary of the results of the study if requested or originally announced.	☐	☐	Date completed: 28.7.25
Gatekeepers and others facilitating access to participants have been thanked and, wherever relevant, sent a copy of the lay summary.	☐	☐	Date completed: 14.7.25 No gatekeepers used for recruitment or data collection.

Participants and/or institutions, groups, organizations that have facilitated access have received the announced vouchers/course credits/reimbursements and/or the prize draw has been completed.	☐	☐	Date completed: 14.7.25
Contact details for gatekeepers have been provided to supervisors.	☐	☐	Date completed: 14.7.25
All study advertisements have been removed from websites or other postings.	☐	☐	Date completed: 14.7.25