Detecting Parental Deception in the Child Safeguarding Context

Abstract

Amid a scarce body of literature examining the ability of practitioners to distinguish between truthful and deceptive behaviours by parents, this qualitative study evaluated how social workers, healthcare professionals and police officers identified parental deception in child safeguarding contexts [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN]. Using constructivist grounded theory, primary data were obtained through interviews and observations with multiagency child safeguarding professionals from three local authorities in England. Results indicate that multi-agency practitioners identify and respond differently to features of parental deception. Social and healthcare practitioners distinguish between malicious and benign parental deception and do not acknowledge benign untruths told by parents as lies. All practitioners in the police, social work and healthcare are familiar with various parental deception tactics in their practices, and they rely on their intuition and practice wisdom in detecting deception.

Key Practitioner Messages

- Child safeguarding multiagency practitioners identify and respond differently to features of parental deception.
- Multiagency professionals identify falsification, omission, evasion and distraction as important behaviour characteristics of parental deception.
- Deception tactics are deployed by parents selectively with different multiagency practitioners: avoidance, intimidation and refusal to engage are the indicators of possible lies in social care; parents are 'sticking together' in police practice; and aggression, parents exaggerating symptoms and having no explanation for children's injuries are present in healthcare settings.

Keywords

Deception detection, disguised compliance, parental deception, child safeguarding professionals, safeguarding children

Introduction

Amid the public's expectations of child safeguarding professionals' ability to identify and manage risk for children, the consequences of a practitioner failing to identify

deceit can be dangerous and, in some cases, as in the highly publicised deaths of Victoria Climbié (Laming, 2003), Peter Connolly, sometimes known as Baby P (Warner, 2013) and Daniel Pelka (Sangaleti *et al*., 2017), catastrophic for the children involved [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN, i.e. 'The consequences of a practitioner failing to identify deceit can be dangerous and, in some cases, ... catastrophic for the children involved']. This can also have a debilitating effect on professionals in child safeguarding as the public are often too quick to blame the child protection system and its 'inadequate' workers (Munro, 2011; Pinkney, 2018). Therefore, for practitioners involved in child safeguarding, whether social workers, police officers or health workers, assessing a parent amid the circumstances of suspected or verified child abuse is fundamental to their roles. For the purpose of this study, the term 'parent' should be taken to mean the child's primary caregiver.

Parental deception is 'a significant feature of everyday child protection practice' (Tuck, 2013, p. 5) and in their relations with professionals, parents sometimes are 'intentionally deceptive or manipulative' (Laming, 2009, p. 51) and capable of going to 'great lengths to hide their activities from those concerned for the wellbeing of a child…' (Laming, 2003, p. 3). Deceitful practices are also demonstrated in 'assessment savvy' parents who adapt their behaviour in order to come across to practitioners as agreeable to make positive changes (Brandon *et al.*, 2008, p. 65), thus demonstrating so-called 'disguised compliance', a term that was coined by Reder *et al*. (1993) and which continues to be associated with parental deception.

Yet despite evidence that people tell lies on a daily basis (e.g. Ekman, 2009) and acknowledging that deception is embedded in child protection work (Ferguson, 2011; *Reder et al.*, 1993), the literature examining the ability of child safeguarding professionals to detect deception in abusive parents is largely non-existent [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN].

In particular, when addressing parental deceptive behaviours, research into 'disguised compliance' highlighted a number of limitations (Hart, 2017); for example, in Leigh *et al.*'s (2019) recent study, the typical 'diagnostic' symptoms (Hart, 2017) such as tidying the house, deflecting attention etc. that were demonstrated in the parental deceptive narrative, were also often associated with parental fear or lack of trust in professionals and confrontation-avoidance behaviour, which subsequently made the accurate assessment and prediction of risk factors in relation to children challenging, if not altogether improbable.

Thus, in order to avoid any confusion associated with the term 'disguised compliance', this current research utilised parental deception and conceptualised it based on the adopted definition by Ekman (2009) as intentional withholding of information by parents via physical and non-physical interaction in order to create a false belief in the professional as to the present or past wellbeing and safety of the child.

Secondly, lie detection studies, offered predominantly within the field of psychology and the majority of which involved low-stake stimuli (within experimental settings) (Shaw *et al.,* 2013), demonstrated that similar to laypeople, law enforcement professionals such as police officers, in assessing the veracity of truthful and deceptive statements on a regular basis typically performed at or below average (Bond & DePaulo, 2006; Shaw *et al.,* 2013). In fact, in the absence of physical evidence, the accuracy to detect deception by professionals stands at 40–65 per cent (e.g. Vrij *et al.,* 2011).

Furthermore, Yatchmenoff's (2008) study looking into practitioners' and families' overall perceptions of engagement found that professionals were not able to differentiate between parental compliance and engagement. The two studies that investigated social workers' deception detection accuracy (Vrij *et al.,* 2006; Reinhard *et al.,* 2014) found that social workers had limited skills in discriminating between lies and truths, as demonstrated by their total accuracy level of 51 per cent. And when comparing groups of professionals, Vrij *et al.* (2006) also found that social workers did not differ from police officers or teachers in their ability to detect deception, achieving 54 per cent accuracy.

Performance in deception detection is also thought to be largely influenced by human biases [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN], including lie bias demonstrated by police officers as well as the 'default to truth' bias (Gladwell, 2019), found in laypeople as well as teachers and social workers, particularly with the former 'not seeing their clients as possible cheaters or liars' (Reinhard *et al.,* 2014, p. 343) and tending to believe them in order to maintain an empathetic relationship with their clients.

Considering the bleak outcomes presented above it would be useful to consider why this current research was therefore of any value to academic literature or current professional practice. The following two justifications are offered when highlighting the importance of understanding parental deception and identifying effective strategies to detect it, which this research aimed to achieve.

While having the responsibility to safeguard the child, the professionals are required to identify and appropriately respond to causes for concern that the child is suffering or likely to suffer significant harm when in the care of their parents. Undoubtedly this involves assessing the veracity of parental assertions and positions the detection of deceit at the heart of child safeguarding practice.

A number of methods such as a strategic questionnaire approach (Vrij *et al.,* 2011) and a verifiable detail technique (Nahari *et al.,* 2012) were found to increase the deception detection accuracy in law enforcement practitioners. Despite these strategies in the law enforcement arena, Forrester *et al.* (2012) argued that no practical advice was offered to practitioners on how to interview resistant and deceitful parents in social care settings. The same could be said of healthcare professionals, including dentists, who are tasked with preventing harm to children and routinely involved in child safeguarding work (Royal College of Nursing, 2019).

The arguments above open a debate about whether or not parental deception is fully understood by child safeguarding processionals and whether there exists any opportunity to improve the current ability to detect deception. Therefore, the current research was designed to examine whether child safeguarding professionals are aware of deception practices used by parents and what new methods, if any, could be utilised to enable practitioners to identify deception. The objectives of the current study were thus to examine child safeguarding professionals' experiences of dealing with deceptive parents, to explore current strategies used by professionals to detect deceit in parents of abused children, and to establish any barriers that may inhibit their ability to detect deceit.

With the bulk of child safeguarding research and inquiries focusing on organisational systems and inter-professional communications, this research focused on the practice of key professionals in police, social and healthcare services in England [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN], within the scope of their roles in child safeguarding and in interactions with parents.

When brought into contact with children and families, these key professionals have a legal duty to protect children from harm and promote their welfare (HM Government, 2020). The research design did not allow for data to be collected from a wider range of professionals who may have regular contact with children, but who do not have a statutory responsibility to identify potential harm; hence, practitioners such as teachers, dentists, librarians were not included in the study.

Key definitions

The following key definitions are used throughout the research:

Child safeguarding refers to all agencies working with children and their families to take all reasonable measures to minimise the risks of harm to children's welfare (HM Government, 2018). Representing a shift from the long-established child protection approach to encompass wider concerns about the welfare of a child, the concept of 'safeguarding' was redefined by the Victoria Climbié Inquiry (Laming, 2003), and subsequently, formalised in the Children Act 2004.

Children's services authorities (social services) have specific duties in respect of children under the Children Acts 1989 and 2004. They have a general duty to safeguard and promote the welfare of children, provided this is consistent with the child's safety and welfare, while working in partnership with parents (HM Government, 2020).

Healthcare professionals working with children and families are also responsible for assessing risk factors and carrying out any examinations or observations in order to assess any potential impairment in a child's health or development (HM Government, 2020).

The police are responsible for safeguarding and promoting the welfare of children. Their duty is to investigate criminal offences against children, understand the risk factors and assess the needs of children and the capacity of parents to meet their children's needs (HM Government, 2020).

Research methods

This study utilised constructivist grounded theory (Charmaz, 2006) as the chosen qualitative research methodology in order to explore the professionals' understanding of parental deception and their perceived ability to detect deceptive practices, while taking into account their professional lives within which the decisions were made. Primary data were collected through interviews with child safeguarding professionals [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN] in England, including 'key participants' (sometimes referred to as 'key informants') with an enhanced level of expertise and experience in their respective field, and a sample of frontline staff. The interview approach allowed the researcher a considerable degree of freedom to follow the voice of a practitioner, often encouraging them to 'ramble' and 'go off at tangents' into the directions of newly emerging issues (Bryman, 2016, p. 466).

Additionally, as supported by the principles of 'corroboration' (Uruquhart, 2013) or 'crystallization' (Richardson, 1994) to involve different datasets to examine the nuances surrounding parental deception and practitioners' interaction through a different prism, data collection was also informed by observational data. The observational approach allowed the researcher to understand the rationale that guided the professionals' decision-making through observing them in their interaction with each other in an informal, low-pressure and low-consequential setting of a child safeguarding training event, and thus address the power imbalance that often takes place during interviewing (Lewis, 2016).

Recruitment of participants

A few 'key participants' were selected using the researcher's personal network in the area, whereas others were identified using snowball sampling (Bryman, 2016). The recruitment of the main research sample of 'frontline practitioners' was conducted by the researcher sending the invitation letter (along with appropriate information sheet and informed consent form) to three local authorities (England) via appropriate 'gatekeepers' to invite child safeguarding professionals to participate in the research.

Selection criteria

Using convenience sampling, a total of 21 current multidisciplinary key (8) and frontline (13) professionals representing three local authorities in England were selected to participate in individual interviews. The key participants included experienced academics, policy makers, strategic leaders, Serious Case Reviewers and child welfare specialists, who were selected because of their recognised unique roles and positions in the field. Frontline professionals were selected to ensure a mix of roles from within child safeguarding as well as a geographical spread.

Observational data were collected from 15 practitioners using participant, unstructured observations during the researcher's attendance at an immersive Level 2 training course on *Working with Hostile Families and Disguised Compliance,* delivered by a Local Safeguarding Board in England to child safeguarding professionals. The one-day interactive course aimed to provide the practitioners with tips and strategies to deal with resistant parents as well as those demonstrating 'disguised compliance'. Thus, this type of observation allowed the researcher to gain meaningful insights into some of the rationale that underpinned professional decision-making and to draw inferences

about the effect of an 'exposure' (simulated 'real-life' situation involving potentially deceptive parents) on practitioners.

Prior to the observation, the researcher's identity and the purpose of the study were revealed; such a transparent approach was adhered to in order to avoid ethical issues related to deception of participants, yet allow adequate observation and recording of data. The researcher recorded the observations in the field notes in as much detail as possible to reflect the participants' behaviours and specific utterances.

Each interviewee had the opportunity to review their interview transcript for accuracy and make any amendments as necessary; following the observations, the field notes were checked for accuracy and representation by the course facilitator. To ensure confidentiality, a protocol has been put in place by the researcher to minimise the need to collect and maintain identifiable information about research participants.

A favourable ethical opinion by the Research Ethics Committee of the Faculty of Humanities and Social Sciences at the University of Portsmouth was sought and awarded prior to conducting the fieldwork.

Sample size

The current study was informed by primary data sought from 36 child safeguarding professionals in England [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN] (21 through interviewing and 15 through an observation). Interview data were collected from eight key and 13 frontline participants; eight key participants were represented by three police, three social care, and two healthcare professionals. Thirteen frontline participants were represented by six social workers, five police officers and two health visitors. The size of the sample was influenced by data saturation, as supported by Glaser and Strauss (1967) and Charmaz (2006). All interviews were digitally recorded and transcribed.

Using the field notes, observational data were collected from a separate group of 15 practitioners, represented by 11 social workers, two family workers, and two health visitors. Throughout the event these practitioners engaged in discussions of their experiences of working with deceptive parents.

Data analysis

Data were analysed using the constructivist grounded theory method (Charmaz, 2006) with the assistance of a type of Computer Assisted Qualitative Data Analysis Software (CAQDAS). The transcripts from the interviews and the typed field notes from the observation were imported into CAQDAS for coding purposes. When analysing data in this format, responses were not grouped according to pre-defined categories, but rather relevant categories of meaning, and relationships between categories were originated from the data itself through a process of coding. Having been subjected to four cycles of coding, these categories allowed the researcher to seek theoretical insights into what parental deception 'looked like' to professionals and how it could be detected.

By being a former child safeguarding practitioner herself and having a relevant professional background, the researcher had an advantage as it allowed the interviewees to explore finer details of their practice and intricacies of organisational culture. However, in order not to appear collusive to the respondents and not to fall into this trap herself, the researcher more often than not asked the participants to clarify their point, which allowed for the clear demarcation between the researcher and the participant and promoted the perception of the researcher as being an academic, rather than an expert. The researcher has been able to bring the necessary level of objectivity to this current research and mitigate against possible researcher's bias by adhering to mix-methods research design and by maintaining a reflexive journal during the research process.

Findings

What Constitutes Parental Deception in Child Safeguarding

All child safeguarding professionals (N=36) generally shared the view that parental deception came in different forms including falsification, omission, evasion and distraction. However, there were significant variations in the perception of parental deception among the police, social care and healthcare professionals engaged with parents in the child safeguarding context.

A notable distinction was made by social and healthcare practitioners (N=21) between parents who deceive in order to cover up intentional harm they were causing their children, conceptualised in this research as *malicious* deception, and those who deceived because they were reluctant to be open with professionals for perceived less

sinister reasons, including the possible concealment of poor parenting, otherwise categorised in this research as *benign* deception. It was the view of social and healthcare professionals (N=21) that *malicious* deception often took place in sexual, physical and emotional abuse cases, whereas *benign* deception was perceived to be prevalent in cases of neglect [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN].

Furthermore, it was acknowledged by these practitioners that while the parents deceiving *benignly* were likely to be exhibiting unpalatable behaviour towards their children, it was not intended to cause them intentional harm. This was demonstrated by the following utterance by a social worker:

> *'In sexual abuse cases, for example, parents are doing intentional harm, and in those cases, a parent will obviously set out to deceive because they don't want to be found out … There is also unintentional harm where parents [find themselves in a situation] not by choice. Most people do not choose to become addicted to drugs. They don't choose to be with an abusive partner. They find themselves in a situation of neglect. It is not intentional. It's just they don't want you to know everything.'*

It was also reported by a health worker that:

> '*Parental deception was far more common coming out of parental anxiety and fear rather than deliberately setting out to be deceitful.*'

An example of *benign* deception could perhaps occur when a toddler accidentally bruises their head while not being watched, but in a misguided attempt to stop a doctor thinking that the parent had committed some criminal or neglectful act, the parent fabricates what they believe to be a plausible explanation, such as a sibling knocking the toddler over. While the parent may think that there is no harm in the 'white lie', in fact a falsification of the history could result in a child receiving the wrong type of medical testing or treatment. This distinction becomes particularly relevant when professionals rationalise parental deception in order to decide on a subsequent intervention response.

Malicious deception, on the other hand, was more often than not rationalised as being harmful to children by social and healthcare professionals, and therefore viewed disapprovingly and with reprehension. The view that the two types of deception needed

to be differentiated was shared by a consultant paediatrician who stated that in relation to parents:

> *'...deception more commonly arises out of parental anxiety, not understanding the system and basically, being fearful and therefore, not coming out with everything upfront. But it has only been my perception that this is far more common, that it is coming out of parental anxiety and fear rather than deliberately setting out to be deceitful. Whereas there have been other situations where I felt parents have come with a nice, polished version of events ... And those ones I would be more concerned about.'*

Healthcare professionals (N=3) felt that those who lied to cover 'intentional harm' did not generally experience any sense of anxiety or remorse when they were confronted about their lies, thus reinforcing the view of these parents as being wicked and bad. Therefore, if perceived to be lying to cover physical abuse, a father was seen as a 'reprehensible person' as reported by a healthcare professional.

Benign deception was accepted as almost permissible as it was not seemingly motivated by the *intent* of parents to cause harm to children [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN, i.e. 'Benign deception ... was accepted as almost permissible as it was not seemingly motivated by the intent of parents to cause harm to children']; therefore, it was looked upon in a compassionate way. Hence, if a parent was lying to cover abuse that stemmed from their persistent drug use or being a party to domestic violence encounters, the professional's reaction was of understanding and support. Thus, the above *benign/malicious* taxonomy provides a framework to guide social care and health practitioners in understanding and interpreting parental deception.

While acknowledging that parents were not always forthcoming with information due to them feeling apprehensive, the police professionals (N=7) did not differentiate between malicious and benign deception and generally felt, as demonstrated by a police officer, that:

> *'parents will lie because they are trying to conceal what they are doing'.*

This was not to say that police professionals always viewed parents with suspicion; it was claimed (N=5) that parents did not resort to deception if they felt that the truth was sufficient for them to maintain the advantage.

As reported by a senior police detective:

> *'They* [parents] *will be truthful in 99 per cent of what we are asking them about. But the real nugget of what we are trying to drill into, they will just lie about.'*

Therefore, parental deception was perceived by police practitioners as one of the strategies used by parents to hide abuse and subsequently avoid agency intervention.

Interestingly, it was also accepted by social and healthcare professionals (N=21) in child protection practice that parents were likely to resort to deceit. However, for these professionals, parental deception presented itself as either being *malicious* or benign, with the former being attributed to certain categories of wicked parents and relatively rare in occurrence.

There was a shared conviction among social and healthcare professionals (N=21) that the vast majority of parents did not wish to hurt their children. This was underlined by the response of an experienced designated nurse who believed that she had:

> *'…never met anybody who was lying* [with malicious intent]'

Thus, social and healthcare professionals (N=21) argued that many parents who lied, did not do so to conceal abuse of their children, but rather because of their distrust of professionals and their reluctance to be intruded upon in their private lives.

Deception Tactics Used by Parents

This research found that practitioners in the police, social work and healthcare settings (N=36) were familiar with numerous 'deception' tactics utilised by parents to deceive professionals. The concept of 'disguised compliance' and the behaviours that were associated with it were also familiar to all child safeguarding professionals.

All professionals (N=36) reported that some parents tried to appear nice, put on 'disguised compliance', play professionals off against each other, attempt to control and manipulate facts, and exploit cultural differences and religious affiliations with practitioners. At an organisational level, for practitioners in the police (N=5), the parents 'sticking together', and thus, avoiding a deviation from each other's accounts, warranted consideration that they were likely being deceptive. This theme was supported by a police respondent who stated that:

> *'They* [parents] *may well have heard before we knock on the door that something is going on, they may well have heard that we are going to be*

alongside social services, we will be asking them some tricky questions about what's been happening in their lives and they've had an opportunity to collude together. And again, if you got two accounts that are pretty much identical, you can end up being conned into the fact what they are actually corroborating each other here, that adds a certain amount of weight to both of their stories, whereas actually they could be very good at covering up because they've had an opportunity to collude.'

For social workers (N=15), avoidance, intimidation and refusal to engage served as indicators of possible lies. For health professionals (N=4), parental deception was associated with aggression, parents exaggerating symptoms and having no explanation for children's injuries. A social worker reported that:

'The parents would pretend that they are not in, or when they are in, distract you with a crisis which is completely separate from the real reason you are there, deflect you by maybe talking about a neighbour and the concern they've got there.'

Thus, child safeguarding professionals (N=36) demonstrated acute awareness of parental deception tactics and recognised these as inhibiting factors in relation to the planned interventions [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN].

Perceived Ability to Detect Parental Deception

All child safeguarding practitioners (N=36) felt that it was relatively easy for parents to deceive professionals. When asking respondents whether they were able to spot the signs of deception, two senior social workers noted:

'Do any of us in a way? I don't know if we always do…'

and

'I don't think you will ever know hundred per cent.'

When enquiring about possible reasons as to why this might be the case, a healthcare respondent provided:

'I think it's because people basically are trusting of other people.'

The perception of deception as being mostly *benign* and the empathy felt by healthcare and social workers (N=21) towards parents as a result, had a debilitating effect on their objective ability to recognise potential parental deception. The ability of social and health care professionals (N=21) to detect deception in parents was linked to their perceptions and views of deception itself. In other words, *benign* deception was not viewed by professionals as deceit as such because it seemed harmless; it therefore did not trigger any alarm bells that a parent might be putting a child in danger. Thus, despite being confronted by a 'deception tactic' maintained by a parent, these professionals (N=21) often concluded that a lie was justifiable and thus to be tolerated. It could be inferred however, that tolerance by a practitioner of such deceit might mean that it is not mentioned in case notes or in multiagency meetings thereby leaving colleagues in the dark. Additionally, despite professionals being largely aware of the predominant deception tactics used by parents, the majority of professionals (N=30) recognised these only with the benefit of hindsight, while not being entirely confident in their ability to recognise and accept them as such when assessing parents in real time situations.

Child safeguarding professionals represented by all groups of professionals (N=28) spoke of somewhat greater confidence in their ability to detect deceit when relying on their intuition and practice wisdom, as well as by looking for cues for deception. For example, when asked if professionals were able to tell when parents were untruthful in their accounts, a social worker who has been working for children's services for almost eight years, stated:

> *'It's kind of gut feeling and the practice wisdom … And we know our parents, well, we don't know them very well. But you kind of see most parents, every three weeks, so you get a good feeling of their tell-tales, them looking up, avoiding eye contact, looking down, they are kind of shoving past the subject.'*

This intuition, as well as verbal and non-verbal cues for deception, were also relied on by police professionals (N=7), as demonstrated by child abuse investigation team detectives:

> *'I watch their eyes, and how, if people look left, it is not true...'*
>
> and
>
> *'So when they cannot tell detail, there is something wrong. And [also] it is their body language, the way they speak to you…'*

Social and healthcare practitioners did not receive any specific deception detection training from their employer to enable them to recognise and authoritatively challenge deceit. Some professionals (N=6) had received training in respect of 'disguised compliance' which encouraged them to be authoritative in their practice, albeit in the absence of any specific deception detection techniques.

Discussion

What Constitutes Parental Deception in Child Safeguarding

Social care and healthcare workers in England are similar to lay people in that they view deception according to their perception of the admonition of the lie. In other words, they mentally place the deception somewhere along socially acceptable and socially unacceptable ends of the 'harmfulness dimension' spectrum (National Research Council, 1991, p. 180). Since *benign* deception is perceived by professionals as relatively harmless and accepted as almost permissible as it is not seen to be motivated by the intent of parents to cause harm to children, it is looked upon in a compassionate way, in line with Thompson's (2006) arguments in relation to anti-discriminatory practice.

The health and social care workers' response to potential or known deception in parents is influenced by their understanding and rationalisation of a lie, and making a distinction between *malicious* and *benign* deception severely impairs their objectivity. Consequently, these practitioners are unable to view deception dispassionately and objectively and accept it for what it is – a deliberate act by parents to hide the truth about the harm they may be inflicting on their children. One of the implications of this rationalisation is that to explain parental deceit, too much emphasis is placed on the context of the surrounding environment and the expected behaviour by parents that goes with it. To attribute deception exclusively to anxiety and fear, because 'it is what anybody would have done considering the circumstances', is to dismiss the possibility of a parent actively (and ingeniously) covering their abuse [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN, i.e. 'To attribute deception exclusively to anxiety and fear... is to dismiss the possibility of a parent actively (and ingeniously) covering their abuse'].

Additionally, what ultimately is missing from this rationalisation is that parents who find themselves in unfortunate circumstances not by choice are equally capable of

hurting their children. The lines between intentional and non-intentional harm are often blurred in families experiencing domestic violence, substance misuse or mental health issues. Hence, they are as capable of lying in order to cover their abuse as any other deceitful parents. In either case, the distinction between two types of deception is erroneous because it ignores deception as being a deliberate act to conceal the truth.

In police practice, however, deception is seen as rather a pragmatic decision taken by all parents, who would have considered the value of telling the truth against the consequences - an inherent risk that is embedded in child safeguarding. Undoubtedly, this evaluation can be attributed to a lie bias by police professionals (e.g. Reinhard *et al.,* 2014), whereby most responses by parents are likely to be judged as potentially deceptive. This is perhaps instilled by the 'assume nothing, believe nobody, challenge everything' approach which is a key element within the training of police investigators (Stelfox, 2013, p. 167).

Deception Tactics Used by Parents

In relation to deception tactics, while some are utilised by parents to attempt to deceive professionals across all agencies, some tactics seem to be specifically deployed against one particular agency's professionals more than others. Intimidation tactics by parents, present in social care practice, are largely absent in police visits, and it is reasonable to suggest that unlike with health and social care professionals, parents are reluctant to use threats and pressure in their police encounters because they do not consider these to be effective in covering abuse. In other words, based on these professionals' experiences in their respective working environments parents adapt their deception tactics to suit their intended audience while making a rational determination as to what they are able to get away with.

Since for health professionals, lies are often accompanied by parental aggression or parents exaggerating symptoms and having no explanation for children's injuries, this is likely to result in the withdrawal of these practitioners from the scene, whereas with the police it is likely to lead to the arousal of suspicions. The common passive-aggressive tactics employed by parents that are frequently associated with 'disguised compliance' (Reder *et al.,* 1993) or 'pathological communication' in order to appear cooperative and compliant, frequently steer professionals away from maintaining a child centered approach and have a paralysing (Ferguson, 2011) effect on social workers in respect of their ability to recognise them as deception [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN, i.e. 'The common passive-

aggressive tactics employed by parents... have a paralysing effect on social workers in respect of their ability to recognise them as deception'].

Perceived Ability to Detect Parental Deception

One of the main challenges associated with professionals recognising deception using particular tactics is that the tactics rarely stay the same (Brandon *et al.,* 2008). In fact, the tactics become associated with deceit only with the benefit of hindsight, rather than when they are utilised by parents 'live'.

It is likely that despite practitioners being aware of a variety of deception tactics by parents, a professional's somewhat limited ability to recognise deception is guided by a rational decision-making process. Such a decision might be conscious, when practitioners are recognising the signs but are able to rationalise deception as understandable and acceptable and therefore, ignore it. On the surface this supports the findings by Reinhard *et al.* (2014) that social workers tend to trust their clients and refuse to see them as liars, known as truth bias. However, lying in child safeguarding practice is rationalised by some professionals as sometimes acceptable and sometimes unacceptable, and the relationship between what constitutes deception and the ability to detect it is not straightforward. Thus, to claim that the ability to detect deception in parents is shaped by truth or lie biases as related in previous research would be too simplistic.

Arguably the professionals represented in this research would have a differentiated understanding of parental deception that is underpinned by their respective organisational ethos and values. This explains why police practitioners, unlike their colleagues in other agencies, are able to view parental deception objectively as there is no requirement for police practitioners to maintain a relationship with the family. Therefore, although the use of interviewing techniques in the police setting present a useful opportunity to improve deception detection, its usefulness and appropriateness in the social and healthcare settings remain to be determined due to a short-term nature of parental engagement. Conversely, decisions by social and healthcare professionals are framed by the principles of partnership with parents and family support and the culture that favours a non-judgemental and compassionate approach (Pinkney, 2018); for these practitioners, building a 'good' relationship with parents that is characterised by mutual honesty and openness is seen as essential within their respective organisations.

Conclusions

Child safeguarding professionals are aware of the common deception tactics utilised by parents [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN]. It is also anticipated by practitioners that parents are likely to resort to deceit by using 'disguised compliance', evasiveness, aggression, hostility or other forms of resistance to deceive professionals and cover the circumstances of abuse. Yet despite knowledge of these common deception tactics, social and healthcare professionals' rationalisation of suspected or confirmed parental deceit influences their understanding of it. When trying to make sense of suspected deceit, social and healthcare professionals in particular distinguish between *malicious* and *benign* deception.

If deception is rationalised as *benign,* it is accepted as almost permissible and not motivated by the *intent* of parents to cause harm to children and is looked upon in an empathetic way. Largely ignoring the possibility of these parents seeking privacy in order to cover abuse, this view is underpinned by a shared conviction of a general organisational belief that the vast majority of parents do not wish to hurt their children. Even when these professionals recognise the signs of deceit, they attribute them to the signs of *benign* deception where the risk to the child is minimised. This can result in such deception never being reported in case notes or during supervision or multiagency meetings.

Although, police professionals appear to remain detached in their view on parental deception and view it rather objectively, these practitioners are nevertheless expected to work together with their colleagues in social care and health within the multiagency setting. Relying on a risk assessment that may not present an accurate and objective picture of the family might therefore jeopardise the success of any future interventions.

Implications for Practice and Future Research

There needs to be an organisational preparedness to accept that all parents may potentially be deceitful in order to cover abuse. Child safeguarding professionals must accept and anticipate that parents are more likely than not to attempt to conceal information, and therefore resist agency involvement due to the fear of losing their child. Therefore, parental deception must be presumed until evidence to support the contrary is obtained [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN]. Practitioners need to be mindful of unconscious bias in investigating or reporting parental deception, and organisations must encourage practitioners to comment on any perceived parental deception whether or not it is considered *benign*.

Further research needs to be carried out in order to test the child safeguarding professionals' ability to detect deception in order to compare how it might be different to their perceptions. Additionally, although not in the scope of this research, it would be beneficial to examine how child safeguarding professionals respond to suspected deceit and what factors are influencing their decision-making.

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