Munchausen by Proxy in Educational and Mental Health Settings

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Although falsified medical conditions are difficult to recognize and treat, falsified conditions occurring in other settings, such as schools or mental health settings, are equally or even more complicated to address. Child victims of Munchausen by proxy (MBP) presenting in educational settings are likely more common than recognized, though there is insufficient data to estimate prevalence. In Sheridan's review of the literature (2003), she found that behavioral problems were reported in 10.4% of the published case reports of suspected MBP she identified, which is the sixth most common problem reported. Developmental delays were reported in 5.7% of the cases, the 14th most common problem out of 100 reported problems that were identified in her review. Reports of speech or hearing problems were also identified in 10 case reports (2.2%). Victims in her review averaged 3.25 reported problems.

Identification

Teachers, school nurses, and other school-based personnel are sometimes the first professionals to identify fabricated conditions. Because school personnel typically see their students far more frequently than the students are seen by their clinicians, teachers and other school personnel are in an ideal position to be on the forefront of identifying possible MBP abuse and/ neglect.

MBP victims may be identified in various educational settings, including within agencies that serve children with special needs, special education classes, home school, hospital-based programs, and/or within mainstream programs. Some victims have genuine conditions and impairments that are intentionally exaggerated, undertreated, or exacerbated by the abuser. In such cases, symptoms may be exaggerated or medication may be withheld to give the impression of a treatment resistant problem. Additionally, medications prescribed for behavioral problems can be used deceptively to induce medical symptoms, or visa-versa (Arnold, Arnholz, Garyfallou, & Heard, 1998; Kelly & Wang, 2018; Mullins, Cristofan, Warden, & Cleary, 1999). In other cases, all conditions and impairments are fabricated by the abuser.

Although it is rare for victims of any age to recognize and report to others that they are being subjected to MBP abuse or neglect, those with genuine mental health or developmental impairments are generally more dependent on their caregivers than their healthy peers, and some have significant communication deficits. Such students are highly vulnerable to victimization and less able to identify and report it (Randall & Parker, 1997).

School personnel should consider the possibility of fabrication in students with highly unusual problems reported by their caregiver or when observations of the student are unexpectedly inconsistent with the reports of the caregiver. School professionals may also receive highly unusual IEP-related requests, notice high rates of student absenteeism, see behavioral or functioning differences based on which parent a student is currently living with, or other concerning signs. School personnel should take notice when the

suspected student victim or the less involved parent expresses reasonable disagreement with the suspected abuser's reports of impairments or with his or her intervention requests.

An abusive parent or caregiver may become very aggressive in demanding accommodations, want to be present part of the day, befriend or verbally attack school personnel in an effort to persuade or intimidate them, and publically express dissatisfaction with the response of the school. Some take legal action against the school, file formal complaints, and turn to online media to complain about the school. Efforts to optimize the child's independent functioning may be thwarted by the abuser and services that are offered might be rejected. For those who thrive on conflict, school officials will never manage to please the continual demands and complaints of the abuser. Frye and Feldman (2012) published a comprehensive review of educational MBP for interested readers.

Clinical and forensic experience suggests that warning signs are often missed. School personnel may be unaware of the possibility of falsified learning, developmental, psychiatric, or behavioral problems. Additionally, schools with a large volume of children with ADHD, learning disabilities, or autism may not have adequate staffing levels to carefully review the data supporting specific diagnoses or to evaluate for potential falsification. In such cases, it may not be unusual for the school to encounter strong caregiver advocates for increased school accommodations and interventions.

As an example of MBP in a school setting, a caregiver might report a learning or behavior problem, such as inattention or hyperactivity, that the school does not observe. The caregiver might have successfully obtained stimulants from a well-meaning pediatrician or psychiatrist who diagnosed attention deficit hyperactivity disorder based solely on the caregiver report of these behaviors. The caregiver might even produce the results of a caregiver-completed screening test that indicates severe symptomatology, as proof of the disorder. On the severe end of the abuse and neglect spectrum are MSP victims who are reportedly highly symptomatic and consequently enrolled in home school, increasing the abuser's control over the victim and reducing the opportunity for school officials to recognize the abuse and neglect.

Approaches for the identification of falsified learning or behavioral disorders are the same as described in the guidelines (APSAC Taskforce, 2018). However, it may be more difficult to engage the assistance of child protective services and the court system given that there is typically less imminent danger present than might be true for a child undergoing repeated medical procedures or treatments (Schreier, 2000). Nevertheless, the long-term negative impact of thwarted developmental milestones, developmentally inappropriate socialization, incorrect self-perceptions of ability and functioning, or iatrogenic harm from medications designed to treat behavioral disorders can be profound. Finally, medical, developmental, learning, and behavioral falsifications often co-occur. Thus, school officials' concern should be heightened if falsification is suspected in multiple domains or if they encounter a child with an unlikely number of problems.

In an example of MBP in a psychiatric setting, an 8-year-old child was hospitalized sequentially in five psychiatric hospitals. The description of the child's behavior was provided by the adoptive mother, herself a psychologist. Based on her report, her child met diagnostic criteria for more than one condition. The mother became upset when her child's behavior on the unit was not abnormal, as she had reported. On the day of discharge, the mother took her child directly from the hospital to an emergency intake unit at another facility with the same story. She explained that her child had done well in the previous hospital setting due to the structure provided by an inpatient facility, but had immediately started having rage episodes upon discharge. Therapists at the fifth hospital contacted the foster care agency to report concerns that the child was being exposed to excessive amounts of behavior health and psychiatric care, including medications, based on the mother's false reporting of symptoms and disability. The agency obtained an outside evaluation from an expert who agreed with the concerns. The agency met with the mother to discuss the concerns, resulting in her moving out of the county. The foster care agency did not contact child protective serves in the new county, thus the family

was lost to follow-up.

Additional published examples of educational, developmental, and psychiatric MBP may be found in the references listed in Table 1. It is important to note that false claims of neurological and other medical problems are also presented by abusers to school personnel and mental health clinicians for intervention and accommodation. Finally, the first case of possible MBP presenting with false claims by a parent that her child is transgender has been reported (Feldman & Yates, in press), raising the possibility that mental health clinicians may see cases of falsified gender dysphoria.

Assessment

As with pediatricians and other medical providers, the most likely barrier to the identification of MBP or other forms of symptom or disability falsification is the failure to consider that falsification may be occurring. Mental health providers may be particularly vulnerable to being misled by deceptive caregivers for three reasons. First, mental health providers, similar to other caring professions, are trained to create an empathic environment through active listening. This typically involves accepting and validating the histories provided by parents and other caregivers. Second, mental health professionals might overestimate their ability to detect deception, given their expertise in human behavior. However, many MBP abusers have an ability to appear superficially normative or superior as caregivers, and their victims are typically unsuspecting and trustful of their abusers. Third, learning, developmental, behavioral, and psychiatric problems are even easier to exaggerate, simulate, exacerbate, coach, and induce than most physical symptoms and disability due to the heavy reliance on caregiver report for diagnosis. Caregiver reports may be the only source of information in diagnostic situations in which there are few objective diagnostic tests and the presenting problem is episodic in nature. Thus, mental health clinicians are urged not to prematurely dismiss warning signs (APSAC Taskforce, 2018). They should

Table 1. Case Examples of Educational, Developmental, and Psychiatric MBP.

Amirali, E. L., Bezonsky, R., & McDonough, R. (1998). Culture and Munchausen-by-proxy syndrome: The case of an 11-year-old boy presenting with hyperactivity. Cana*dian Journal of Psychiatry, 43*, 632–635.

Ayoub, C. C., Schreier, H. A., & Keller, C. (2002). Munchausen by proxy: Presentations in special education. *Child Maltreatment, 7*(2), 149–159.

Coard, H. F., & Fournier, C. J. (2000). Factitious disorder in school settings: A case example with implications for school psychologists. *Psychology in the Schools, 37*, 547–555.

Heubrock, D. (2001). Munchausen by proxy syndrome in clinical child neuropsychology: A case presenting with neuropsychological symptoms. *Child Neuropsychology, 7*, 273–285.

McNicholas, F., Slonims, V., & Cass, H. (2000). Exaggeration of symptoms or Psychiatric Munchausen's syndrome by proxy? *Child Psychology and Psychiatry Review, 5*(2), 69–75.

Schreier, H. A. (1997). Factitious presentation of psychiatric disorder by proxy. *Child Psychology and Psychiatry Review, 2*, 108-115.

Stevenson, R. B., & Alexander, R. (1990). Munchausen syndrome by proxy presenting as a developmental disability. *Journal of Developmental and Behavioral Pediatrics, 11*, 262–264.

Zylstra, R. G., Miller, K. E., & Stephens, W. E. (2000). Munchausen syndrome by proxy: A clinical vignette. *Primary Care Companion to the Journal of Clinical Psychiatry, 2*, 42–44.

ensure that warning signs are clearly documented, including details of discrepancies and other apparent attempts at deception.

Responsible and thorough professionals who are concerned about possible falsification request records directly from former treating professionals and schools for record analysis (APSAC Taskforce, 2018). School records include attendance records, nursing notes, and IEP documents. Such professionals put forth effort to obtain data from and communicate with all caregivers as well as with past schools and mental health providers, and the child's pediatrician. They provide all parents and other caregivers with ongoing education and feedback about findings and recommendations, and they ensure understanding by asking the caregivers to repeat back the information. These discussions are carefully documented in the record. Review of the suspected abuser's online social media activity may also be useful.

Assessment and treatment plans that systematically and objectively challenge claims made by the suspected abuser and victim may clarify the diagnostic picture, recognizing that descriptions of symptoms and disability made by family members must be considered possibly inaccurate. Induction via poisoning or misuse of medications (including the withholding of needed medications) may contribute to symptom presentations (Kelly & Wang, 2018). Consultation with an expert is strongly recommended. While assessing for possible falsification, clinicians are advised to minimize recommendations for school accommodations, prescriptions, and invasive testing and treatments. Finally, clinicians, teachers, and other mandated reporters have the responsibility to report findings suggestive of abuse or neglect to the proper authorities.

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