Munchausen by Proxy: Risk Assessment, Support, and Treatment of Spouses and Other Family Caregivers

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Child victimization in cases of Munchausen by proxy (MBP) spans all spheres of a child's life, influencing both physical and emotional health and impacting clinical medical and other related appointments and hospitalizations, school, social settings, and home. Thus, collusion of other adults involved with the child is an important aspect of the abuse. Spouses of MBP abusers are described in the literature with less frequency than are the MBP abusers themselves. Often considered a "nonoffending" parent, spouses may have failed to protect or failed to be present for the abused child for a variety of reasons. They require extremely careful consideration, including a specialized parenting and mental health evaluation if being considered as a potential placement or visit supervisor option.

For purposes of this article, the term *spouse* will be used to refer to the other parent of the abused child regardless of marital status or living arrangement. Additionally, the information conveyed is applicable to other friends or family members who are involved in the life of the child or who wish to be considered as a potential placement or visit supervisor. The goals of this article are to present detailed recommendations for risk assessments, important support, visitation, and custody considerations and treatment options.

Background

Although there are cases in which both parents are fully aware of and engaged in deceptive behaviors congruent with factitious disorder imposed on another, the psychopathology associated with MBP, MBP abusers more typically direct the abuse and neglect without meaningful input from the spouse. This arrangement does not arouse suspicion because it is not uncommon for women to take the lead in their children's educational and clinical settings (Berge, Patterson, & Rueter, 2006) and MBP abusers are overwhelmingly female, mostly mothers of the abused child(ren) (Rosenberg, 1987). Nevertheless, grandmothers, aunts, foster mothers, babysitters, fathers, and others have also been identified as MBP abusers. Data from child protection cases are congruent with expert experience and suggest differences that are frequently seen in the role of the spouse in two-parent families opposed to families in which one parent is estranged (Ayoub, 2010).

Within intact families, the spouse (typically a husband or partner) most often knowingly or unwittingly supports the false family story of child illness, condition, or disability (Fulton, 2000; Guandolo, 1985; Kahan & Yorker, 1990; Orenstein & Wasserman, 1986; Sanders, 1995; Sullivan, Francis, Bain, & Hartz, 1991). The spouse may deliver messages from the abuser to the child, encourage the child to cooperate with the abuser, participate in medicating a child or implementing other clinical recommendations, discuss the child's problems with professionals, friends, and family, and argue for unnecessary clinical or educational interventions alongside the abuser (Ayoub, 2010). Others are more passive, never effectively questioning the decision-making or other pertinent

behaviors of the abuser. In some situations, spouses may be completely naïve to the abuse. This may occur more often when the spouse does not live in the same home. In the case of Gypsy Rose Blanchard, her father was surprised to find his daughter could walk after believing her to be wheelchair bound for years (Dean, 2016).

Spouses, regardless of living arrangement, may be directly instructed by the abuser to support the false family story of child impairment under threat of harm or abandonment to be inflicted upon the child or spouse for resisting. Without a major shift in behavior, such spouses are most likely to continue to support abusers after detection of the abuse, making them unreliable protectors of their children (Lasher & Sheridan, 2004; Parnell & Day, 1998). Examples of these varying scenarios have appeared in the popular media. For example, the father of Jennifer Bush refused to accept the allegations despite extensive evidence and criminal charges (Schreier, 2002). Mr. Bush actively supported his wife's point of view even after her conviction of criminal charges.

Spouses who are estranged from the abuser are more likely to identify concerning behaviors in the abuser and to acknowledge that abuse has occurred (Ayoub, 2010). Some spouses put forth great effort to intervene on behalf of the abused child. Popular media reporting described the case of Christopher Bowen Crawford, in which his father worked for years to convince physicians and judges that his son was being abused (Boyd, 2017). Barriers to spouses effectively raising MBP concerns include being unaware of the abuse, not knowing how to intervene, being prohibited from communicating with the child and with professionals caring for the child, being discounted or disbelieved by professionals due to the estranged relationship with the abuser, and fearing that the child will be punished by the abuser if concerns are raised.

Abusers may engage in a variety of behaviors to ensure that the spouse is not a threat to the false family story of child illness, condition, or disability. Most notably, abusers frequently and deceptively tell school officials, clinicians, and other professionals that the spouse does not wish to be involved in the life of the child or has abandoned the family. Sometimes, they falsely report a history of violence, child maltreatment, mental illness, or substance abuse in the spouse to bolster the story. In such cases, it is highly recommended that efforts be put forth to locate the spouse through other family or friends, the Internet, insurance records, child support payment records, law enforcement officials, or other means. When found, many spouses indicate a desire to be involved in the child's life, but feel helplessness about how to achieve this goal. Other members of the extended family, particularly relatives of the spouse (usually paternal relatives), are also often estranged and may be positive resources for care of the children (Ayoub, 2006).

When informed of the MBP abuse allegations, many spouses initially express shock and disbelief. Some support the abusers only before the evidence is presented to them and the facts are evident (Gray & Bentovim, 1996; Meadow, 1977; Rosenberg, 1987). Others continue to support the abusers and deny the allegations despite strong evidence of abuse (Mehl, Coble, & Johnson, 1990; Sanders, 1995; Schreier, 2002). However, many spouses believe the allegations and support their children over time (Fulton, 2000; Osterhoudt, 2004; Martinovic, 1995; Moldavasky & Stein, 2003; Morrell & Tilley, 2012). If previously unaware of the abuse, spouses (and other family, friends, and professionals) may also feel betrayed and harmed by the abuser as they recognize that they were also victimized by the abuser's deceptions.

A number of spouses engage in legal action through family courts in the context of divorce and custody and visitation planning. When allegations that include MBP present in this context, it can be particularly difficult. Family courts are oriented to working with custody and visitation issues by offering equal access to parents who are assumed to be competent. Spouses in these situations often are seen as overzealous, anxious, and rigid in their proposals for managing contact. In many cases, the mothers have physical custody and tend to try to manipulate and reduce contact between the child and the other parent. Judges and other court personnel are often swayed by the social interaction with the MBP abuser and her stories, which often go unverified unless the spouse is vigilant in collecting information from health care and other providers.

Risk Assessment

Domains of Risk Assessment

It is easy to underestimate the overwhelming need of a MBP abuser to promote a compelling story of illness and disability in a child victim. Like individuals with addictions to substances, simply being caught is not a sufficient intervention to stop the disturbed behavior. The literature and clinical experience has repeatedly revealed that some abusers go to great lengths to maintain influence over their abused child, even when being closely monitored. Thus, to assess the level of risk of placing a child with a spouse or other family member, the evaluator must assess the spouse's role in the deceptive abuse of the child, determine the degree to which the spouse believes and accepts the allegations, evaluate the spouse's parenting skills, and aggressively test the spouse's ability to protect the child in the face of relentless manipulations by the abuser to impact the child. Additional inquiry regarding feasibility is also helpful. Continued oversight by the judicial body––i.e., juvenile or family court––in which the issues were litigated is often essential to a long-term stable placement for the child. The following domains of evaluation are strongly recommended for spouse:

1. Role: What was the role of the spouse in the MBP abuse and neglect?

Although often referred to as a "nonoffending" parent, it is important to consider the role of the spouse, including his or her role in the family dynamic that supported the MBP abuse. Was the spouse truly unaware of the abuse or neglect? Was the spouse provided feedback from school or clinical staff that was not congruent with the stories being promulgated by the abuser? In what ways did the spouse support the goals of the abuser? Is the spouse able to acknowledge his or her role, even if unintentional, in failing to protect the abused child? Is the spouse an advocate for the child's health in light of the false presentation of the child as ill? If so, how does he or she see future contact or visitation, or both?

2. Belief: Is the spouse able to believe and accept the allegations?

As described, the awareness and role of the spouse prior to the abuse allegations can vary. It is important to determine if, with adequate support and facts, the spouse believes and accepts the MBP allegations. Spouses who question the veracity of the abuse allegations are rarely adequately equipped to protect the abused child and may lack sufficient empathy to optimally emotionally support the abused child. Spouses who are dismissive of or minimize the abuse, or see themselves as not responsible for the child's health, are also at risk of being unable to adequately provide a safe and nurturing environment for the child.

3. Parenting skill: What are the parenting challenges for the spouse?

The evaluator will need to assess basic parenting skills to determine the ability of the spouse to provide a safe placement. Evaluation of parenting skills can follow standard procedures used for other types of abuse and neglect, potentially including assessments of specific parenting practices and skills, parental stress, attachment, and mental health issues impacting the spouse's ability to parent. Children and adolescents who have experienced this type of victimization may demonstrate significant emotional and behavioral difficulties once they are no longer being victimized. It may be a struggle for a spouse and others to fully understand and helpfully respond to the child's posttraumatic responses to their victimization. Parents or other adults who have been disengaged in the face of the ongoing abuse of the child will need to demonstrate increased awareness and actions to support the child's wellness.

4. Protection: Is the spouse able to provide appropriate protection for the child?

It is extremely challenging for a spouse (or other family member) to adequately provide the intense protection required for victims of MBP who have been placed in protective custody by child protection agencies. The spouse must have the awareness, ability, and will to maintain a state of hyper vigilance, sometimes for years, to sufficiently protect the abused child from further physical, emotional, educational, social, and developmental harm. The spouse also needs to be aware of the fact that this protection needs to continue throughout the child's adolescence and young adulthood. Thus, the spouse must be educated in how this abuse could occur in the future and the

requirements for continued protection. Additionally, any other professionals, family members, and friends who remain involved in the child's life must also be informed and agree to protect. For example, a spouse may allow the child to visit a grandparent who allows contact with the abuser (Schreier, 2004). Examples of important safety domains include the following:

(a) Knowledge, ability, and will to prevent the various means used by abusers to falsify, exaggerate, simulate, and induce illness. This includes surreptitious symptom or disability induction through food, drink, lotions, or other means and via verbal coaching of the child to display or report symptoms.

(b) Knowledge, ability, and will to support the child's highest level of health and functioning, which typically involves changing the long-held family story of illness and disability. While this requirement is superficially simple, it is commonly quite confusing for everyone involved to grasp the many deceptions that have occurred and been built upon. It is often only with intensive professional assistance over time that the child's highest level of health and functioning can be established.

(c) Knowledge, ability, and will to abide by all communication restrictions deemed to be necessary by consulting MBP experts and abiding by any court orders to this effect. This might include no contact with the abuser or it might require close professional supervision of the abuser and a mandate to immediately cease communication if the rules are violated. Abusers will often attempt to extend, breach, or manipulate the set boundaries related to their contact with the victim. In addition to seeking direct contact with the child, they also attempt to influence the child via others. Thus, they may also persist in contacting the child's health care providers, school staff, relatives, and others who have contact with the child. Such behaviors by the abuser can be frequent and persistent, exhausting everyone committed to protecting the child. In these situations, a return to family court is often indicated.

(d) Knowledge, ability, and will to accept the relational, financial, vocational, and residential costs associated with serving as a primary caregiver or supervisor of the child.

i. Some spouses are required to choose between their relationships with the abuser (and those who believe the abuser) and the child. Family relationships may be forever altered by the revelation of MBP abuse, especially if there is disagreement about the veracity of the allegations. To ensure that the abuser does not locate the new residence of the child, some family connections might need to be severed.

ii. The spouse may need to find a new way to earn money, reduce work hours to care for the child, or hire a caregiver or other professionals for the child. There may be legal costs as well.

iii. Due to the dangers associated with remaining in proximity to the abuser, some spouses have to relocate to assure safety. This can require both a change in residence and social contacts as well as a change in employment.

iv. In severe cases, long-term monitoring by child protection or law enforcement might be required; thus, a spouse in such a case must also be willing to accept a high level of monitoring over time.

Assessment Techniques

Risk assessment of a spouse will include record review, obtaining collateral information, and interviewing the spouse. Because it often takes time to fully understand and accept the breadth and depth of the abuse and the parenting issues, spouse evaluations often occur over time and can be repeated as circumstances change. Some spouses may fully understand and accept the abuse only after they observe the improvements made by the child in a nonrelative foster placement. The assessment techniques are here briefly described:

1. Record review and collateral information.

a. Medical, school, and other records can be analyzed to assess the knowledge, role, and

behaviors of the spouse prior to the abuse allegations. Spouses may also have had illnesses fabricated, exaggerated, or induced by the MBP abuser. Records for the child and spouse may need to be examined. This is helpful in determining the level of involvement of the spouse in possible falsifications and/or care of the child and the spouse's attitudes and attention to health-related issues. Detailed guidance can be found in the MBP Guidelines (APSAC Taskforce, 2018).

b. Visitation records can be reviewed to assess the knowledge, role, and behaviors of the spouse after the abuse allegations when being closely supervised. This is helpful in determining the spouse's parenting skills, assessing attachment, and evaluating the spouse's ability to alter his or her approach to the child.

c. Interviews with the child's school and health care professionals and others who have observed the spouse interacting with the child can yield helpful data about the spouse's parenting skills, attachment, and ability to alter his or her approach to the child.

2. Interviews and measurement tools.

a. An interview with the spouse is essential. A list of suggested questions can be found in Table 1. These interview questions have not been standardized, but they have face validity and are a reasonable place to start.

b. While measures of parenting skills and burden may be used to augment the assessment of the spouse, it is imperative to remember that such measures cannot be used to determine if abuse has occurred. In fact, many abusers can recite appropriate parenting skills and can appear superficially normal on standardized testing. Therefore, direct observation over time is more reliable in this type of case.

3. *Direct observation.*

When possible, direct observations of the spouse interacting with the child and with the child's school and health care professionals over time can provide valuable information about the spouse's parenting skills, attachment, and ability to alter his or her approach to the child. Because this is rarely feasible, collateral records or contacts are more commonly used.

Table 1. MBP-SCRNA: Spouse/Caregiver Risk and Needs Assessment.

Belief

- How did you learn about the abuse allegations?
- What do you understand happened to the child?
- What aspects of the allegations ring true to you and why?
- What aspects of the allegations do not ring true to you and why?
- What has the alleged abuser told you about what happened?
- What aspects of what s/he told you ring true and why?
- What aspects of what s/he told you do not ring true and why?
- What has the child told you about what happened?
- What aspects of what s/he told you ring true and why?
- What aspects of what s/he told you do not ring true and why?
- Are there other domains in which the suspected abuser is deceptive?
- What type of information do you think would be helpful to understand the allegations more fully?
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Protection

- Do you believe the alleged abuser could harm the child in the future? If so, why? If not, why?
- How might the alleged abuser harm the child in the future?
- If you have other children, do you believe they may be at risk of harm? If so, why? If not, why?
- What safeguards do you feel need to be put into place to protect the child(ren) from possible future harm?
- Do you believe that other family members (e.g., grandparents, etc.) will honor your safeguards? If so, why? If not, why?

Table 1. MBP-SCRNA: Spouse/Caregiver Risk and Needs Assessment.

Impact of Allegations

- Were you sharing a home with the alleged abuser when the allegations were made?
- What changes have taken place in your household as a result of the allegations?
- How have the allegations affected you emotionally?
- How have the allegations affected you financially?
- How have the allegations affected your relationships?
- How have the allegations affected your housing?
- How have the allegations affected your job?
- How have the allegations affected your parenting role and responsibilities?
- How have the allegations affected the other children and family members?

Communication

- What are your plans for ongoing communication with the alleged abuser? (e.g., face-to-face, phone, text, email, etc.)
- If it is not deemed safe for the child to have contact with the alleged abuser, how will you manage this requirement?
- If the alleged abuser wants to talk to or see the child, how will you handle this?
- If the child wants to see or talk to the alleged abuser, how will you handle this?
- How will you manage requests for contact during big events, holidays, and birthdays?
- How will you manage relatives who do not fully grasp the level of danger posed to the child by the abuser?
- What will you do if the abuser shows up at your house or at the child's school?
- How will you manage social media, both your social media accounts and those of the child and other relatives?
- If the pressure from the abuser becomes too much, are you prepared to move out of town?
- How might the abuser retaliate towards you? How would you respond?
- How might the abuser interfere with your friend, family, or employment relationships?

Parenting Issues

- Who lives in the home? Who visits on a regular basis or during holidays?
- Who provides childcare?
- What is the current employment of guardians? Any financial security issues?
- What supports do you have (family, friends, organizations)?
- What parenting skills deficits do you have? Are you open to parent training?

Legal and Mental Health Issues:

- Any legal history or history of violence in yourself or any family members?
- Any outstanding legal issues that could disrupt your ability to care for the child?
- Any substance abuse in yourself or any family members?
- Any mental illness in yourself or family members that may affect your parenting?
- Any issues of mental illness in family members that may impact the child?

Knowledge and Needs

- What was your understanding of the child's health and/or disabilities prior to the allegations?
- What do you understand about the child's health and/or disabilities now (following the allegations)?
- How do you plan to promote and discuss the child's improved health and abilities with the child? And, with others, how will you describe what happened?
- What are your concerns or questions regarding the child's health and abilities?
- What information do you need to better understand the child's health and abilities?
- What resources would be helpful to you in your role as caretaker?

Support Considerations and Treatment Options

In some cases, the evaluation of risk may be expedited if the spouse raised the suspicion of MBP abuse or if the spouse is quickly able to accept the allegations and appropriately protect the child. However, this situation does not represent the norm for most MBP cases identified in hospitals or other facilities and referred to child protective services (CPS) and the juvenile court. However, it is more likely with cases that present through family court. Substantial time and support are more often needed to assist a spouse in fully grasping MBP abuse and neglect. The following are important topics to help the spouse understand:

1. A detailed account of what behaviors demonstrated by the abuser are problematic.
2. How the abuse developed over time and was not detected earlier.
3. Why this type of abuse happens in general and the pervasive and entrenched nature of the associated psychopathology that is typically present.
4. Exploration of the dynamics, including past and current family dynamics that supported the development of the abuse. This includes an examination of the behavior of the spouse that resulted in a failure to protect the child.
5. How best to protect the child from further abuse.
6. How to help promote a new story of health and support the child.
7. How to reach out for help.

This process may involve many meetings and intensive therapeutic assistance with spouses who are not immediately assured of their allegiance to the child. If it is not deemed safe to have the child be placed with the spouse immediately, this process may also involve supervised visits with the child as the spouse becomes more informed and the needed supports and resources are put into place. Once placed with the spouse through CPS or the juvenile court, or both, long-term monitoring by the child protection agency is usually recommended to insure continued protection and support. Helping the child and family transition to a story of improved health and functioning may involve reviewing medical records with a psychotherapist, consulting with the child's treating clinical teams, using a rehabilitation approach to promote the child's optimal level of functioning (including weaning from medications or feeding tubes, engaging in physical or other therapies, returning to school, revisiting the child's school accommodations, and developing appropriate social relationships), and developing appropriate safety plans.

For the spouse who is involved in litigation on family court for custody, issues of support and therapeutic assistance are also necessary, but they are different from those just described. The spouse who has fought in family court for custody based on allegations of MBP has likely been through considerable and often lengthy efforts to protect the child from the MBP abuser. These spouses have frequently spent years trying to gather evidence to prove to a judge the veracity of their concerns. In a number of cases, a comprehensive forensic evaluation is requested through a guardian ad litem or independent evaluator appointment by the court. These evaluations will include the assessments described here. A formal report about the child's victimization and the capacity of each parent to care for the child are part of this narrative. Often a formal trial is necessary for the court to make decisions about the veracity of the allegations and the best interests of the child. After the child is placed with the spouse, there is often need for therapy for the child and some therapeutic guidance for the parent.

Spouses, child victims, and other family members often benefit from psychotherapy. Spouses frequently require assistance processing their feelings, adjusting to becoming the primary caretaker, and learning how best to support a child as he or she experiences and responds to many changes in life (Bass & Glaser, 2014). In many cases, trauma-focused cognitive behavioral therapy is indicated for all family members. Specific guidance for the spouse and the child may be needed to prepare for the day that they need to cope with overtures from the abuser. If reunification with the alleged abuser is to be pursued, psychotherapy is essential (Bass & Adshead, 2007; Bass and Glaser, 2014; Nicol & Eccles, 1985).

Please see the companion article in this issue on

child protective services management (Bursch, 2018) for further guidance related to interactions with the suspected abuser, placement decisions, case management, treatment planning, visitation, reunification, evaluation of progress in psychotherapy, and transition home.

Conclusions

Assessing the risk of placing the child or allowing the child to remain with the spouse is a process that occurs over time and typically includes intensive education and therapy. Ongoing psychotherapy and monitoring are recommended for all family members affected by MBP abuse. The ultimate outcome for the child depends not only on direct protection from the MBP abuser but also evaluation of those key family members who may ask to be the physical custodians of the child or have frequent or ongoing contact with the child. In each case, the situation should be carefully evaluated for each adult with an interest in these types of contacts. This approach to evaluation of the spouse, and other family members who propose being close to the child, provides increased assurance that the child can obtain and maintain the appropriate and realistic experience of health and wellness.

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