Child Protective Services Management of Cases of Suspected Child Abuse/Neglect Due to Factitious Disorder Imposed on Another

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The purpose of this article is to provide child protective services (CPS) professionals with detailed guidance on the effective management of suspected child abuse or neglect by a caregiver who has factitious disorder imposed on another (FDIA). For a description of terminology and a general overview, readers are referred to the "APSAC Practice Guidelines: Munchausen by Proxy: Abuse by Pediatric Condition Falsification/ Caregiver-Fabricated Illness in a Child/ Medical Child Abuse Due to Factitious Disorder Imposed on Another" (APSAC Taskforce, 2018).

These guidelines reflect current knowledge about best practices. They are not intended to establish a legal standard of care. Best practices will continue to evolve and change as new evidence becomes available. Some jurisdictions have created protocols and guidance to support CPS professionals and may provide further guidance (Arizona Department of Child Safety, 2012; Michigan Governor's Task Force, 2013).

Brief Background

FDIA is a psychiatric diagnosis characterized by an individual using deceptive tactics to falsify illness or impairment in another without obvious external incentives to fully explain the behavior. Individuals with FDIA can cause considerable suffering for their victims, and their behaviors can lead to accidental death. Unsuspecting friends, family, and professionals who work with the child may also feel betrayed by the individual with FDIA. Such secondary victims may respond protectively with disbelief or may be devastated when they learn of the abuse or neglect.

The child abuse and neglect that results from the behaviors of the caregiver with FDIA has been referred to with various labels over time, including Munchausen by proxy, abuse by pediatric condition falsification, caregiver-fabricated illness in a child, and medical child abuse. While there are minor differences among these terms, they generally all refer to the same type of child abuse and neglect.

Similar to child sexual abuse, the experience of FDIA-related abuse and neglect for a child can be far reaching due to distortions in the child victim's self-concept, perceptions of important relationships, and approach to the world. This can include the child's relationship with health care providers due to associations of their medical care encounters with fear, pain, manipulation, and secrecy. Child victims often experience the ultimate sense of betrayal as they are harmed by the person upon whom they are most dependent. They may also feel betrayed by nonoffending friends, family members, and professionals who offered no protection or disbelieved or blamed the child when the abuse or neglect was first discovered. Finally, as in child sexual abuse, the experience of FDIA-related abuse and neglect can be a disempowering process for child victims whose will, desires, decision making, and sense of self-efficacy are

violated.

Despite the similarities described above, FDIA-related abuse and neglect can be even more insidious and omnipresent in the child's life than sexual abuse. Victims of FDIA-related abuse and neglect may have no safe escape or temporary reprieve from the abuser when in other settings. Those with FDIA often seek to exert control over the victim in all spheres of life, and they can significantly influence how others behave toward the child. Thus, the child may be surrounded by individuals all day, every day who unwittingly reinforce and strengthen the child's distorted perceptions about his or her own health and abilities. Therefore, interventions are required in all settings to appropriately address the problem. In this regard, child protective services professionals may best view this form of child maltreatment as similar to the

Table 1. Examples of Common Abuser Behaviors While Child Is in CPS Protective Care.

Setting	Behavior
Foster Home	• Threatening or intimidating foster families. • Attempting to communicate with child. • Watching child from car. • Attempting to establish friendly relationships with members of the foster family.
Monitored Visits	• Exposing the child to inappropriate health-related topics. This includes direct discussion about the child's health, the parent's health, or the health of individuals unknown to the child. This can also occur non-verbally, such as sharing photos of someone in a wheelchair, wearing a tee shirt with an illness or disability theme on it, or gifting the child something that will remind him or her of health challenges. • Reciting prayers with message to not trust anyone but family members. • Providing child with gifts that include hidden messages to encourage the child to report or exhibit symptoms, run away, or falsely report abuse in the foster home. • Poisoning the child via food, beverages, medicines, toys, injections, central lines, feeding tubes, or lotions. • Cultivating dependent or regressed behavior in the child by not treating them at an appropriate developmental level, by discouraging normal development, and/or by enacting an enmeshed dynamic. • Attempting to establish friendly relationships with visitation monitors.
School	• Advocating for unwarranted accommodations. • Watching child on playground from car. • Attempting to establish friendly relationships with school officials who have access to the child.
Health Practitioners	• Providing false history and symptom/disability reports. • Advocating for unneeded assessments, accommodations, and/or treatments. • Attempting to establish friendly relationships with physicians, therapists, and other health professionals treating the child.
Court	• Requesting increased contact with and control over the child, using any and all available arguments. • Lodging complaints, filing lawsuits, providing stories to the media, and engaging in other behaviors to undermine, intimidate and/or harm the professionals involved in the case. Foster parents may also be targeted. • Using the Internet to communicate with the child, solicit community advocacy, raise money, complain about the court proceedings, disparage everyone associated with the case. • Creating chaos by arguing about each CPS requirement, making numerous requests of CPS or the court, firing attorneys, representing oneself, inviting protesters to court hearings, and attempting to pit various professionals against each other.

abuse and neglect enacted by a cult leader seeking to control all aspects of a follower's life, and less similar to neglect by a substance-dependent parent or physical abuse associated with anger. With this construct in mind, case management approaches and practices in suspected cases of child abuse or neglect by a caregiver who has FDIA must be detailed and comprehensive to ensure a child's safety. Also, congruent with this frame, it is important to carefully evaluate for other forms of child abuse and neglect by the abuser or partner of the abuser that are frequently co-morbid with FDIA-related abuse/neglect, including more traditional forms of physical abuse, emotional abuse, neglect, and sexual abuse.

See Table 1 for a partial list of examples of ways in which individuals with FDIA have attempted to intervene and take control after a suspected child victim has been taken into protective care by CPS. Note that the motivation of the parental behavior is not always clear. Nevertheless, it is extremely common for those with FDIA to befriend those who have access to the child in order to become trusted and then garner increased access or influence over the child, or increased support in disproving the allegations, or both.

Interactions With the Abuser

Of utmost importance is the need for all CPS professionals, as well as those contracted with CPS, to be aware of the behaviors they are likely to encounter when interacting with individuals with FDIA. The vast majority of individuals with FDIA are women and most have a co-morbid personality disorder. Superficially, they may appear to be excellent caregivers because many of their behaviors may be appropriate, especially if they are aware they are being observed. A minority of those with FDIA are more obviously psychiatrically impaired. Because of their ability to present so well, one of the most significant challenges faced by most professionals who encounter an individual with FDIA is believing they have engaged in abusive or neglectful behaviors. It is critical to remember how skilled such individuals can be in misleading and convincing intelligent others that they are being truthful. It is not possible to discern lying during conversations with most individuals with FDIA.

All information provided to CPS by a caregiver suspected as having FDIA must be considered to be potentially false. Therefore, whenever possible, it is important to obtain objective verification of information. It is also important to remember that family, friends, and professionals associated with the suspected abuser might also have been misled by and believe the abuser. In such cases, those individuals might not be capable of providing objective corroboration of information. Some may strongly advocate on behalf of the abuser.

All professionals on the child welfare team should be prepared to voice any doubts they develop about the abuse and neglect concerns as the case progresses. It is normal to second guess conclusions of this form of abuse and neglect, especially because most of these abusers are generally well-liked individuals with superficially normal social skills and functioning. Engaging in a team discussion when doubts crop up ensures that such doubts are adequately addressed. In some situations, the information that led to the doubts might be helpful in reducing the safety concerns of the team. More commonly, however, discussing the problematic behaviors that led to the child being detained or reviewing the progress that has been made by the child while in protective care is usually sufficient to clarify the potential risk to the child. Having access to professionals who have experience with his form of abuse/neglect has been found to be very helpful to CPS teams.

Due to the increased risk for chaos by those with FDIA, it is strongly recommended that all communication be very clear, specific, and documented in a written format for everyone's records. Documentation of all communication should be detailed. Quotes should be used for verbatim information. It may be helpful to have one point person assigned to communicate on behalf of the team to reduce the opportunity for splitting behavior. Limiting contacts with the caseworker (or others) to a predictable schedule, rather than unlimited contact, is recommended.

Placement

As reviewed in the guidelines associated with this article (APSAC Taskforce, 2018), most children who are suspected victims of caregiver FDIA-related abuse or neglect are best placed with foster parents who do not know or interact with the suspected abuser. A rare exception may be made for a relative who has no personal history of FDIA, believes the abusive behaviors may have occurred, agrees to protect the children, and has the ability to protect them. However, even the most well-intended, skilled, and committed relative may have great difficulty enduring unrelenting pressure by the abusive caregiver (or their proxies) to gain access to and control over the child victims. In general, foster parents can best protect the child if they do not have responsibility for monitoring any visits and if the suspected abuser does not have the name, address, or phone number of the foster family. Likewise, the location of the school and health practitioners should remain confidential to prevent the suspected abuser from attempting to exert influence in those settings (either directly or via other individuals serving as proxies). In some cases, it has been important to ensure that suspected abusers do not follow the transportation vehicle back to the foster home.

Foster parents benefit from receiving education about the suspected abuse and neglect that the child has experienced. They may be asked to participate in the rehabilitation plans of the child's clinicians by advancing diets, weaning medications, or encouraging normal behaviors. Foster parents might need to be taught how to best respond to inappropriate illness behaviors by the child that are utilized to their garner attention and sympathy. In some cases, foster parents can provide helpful information related to the recovery and to ongoing symptoms and disability of the child by keeping a daily dairy of specific symptoms and behaviors. Additionally, from time to time, child victims start to share information with foster parents that knowingly or unknowingly reveals additional abuse/neglect. It can be helpful to prepare foster parents by teaching them to carefully document such revelations (verbatim) and how to appropriately respond to the child if this occurs. Finally, like involved professionals, foster parents may benefit from consultation and support from an expert on FDIA.

Case Management and Plan

All child protection professionals, physicians, and therapists must have open communication and should have access to all assessments that have taken place. Foster parents will also need to understand what the child has endured and what has been objectively determined to be true. All professionals who are chosen to evaluate or treat the child victim must demonstrate expertise with such cases or be open to working closely with outside professionals who have such expertise. A comprehensive description of the approach to forensic evaluation of FDIA-related abuse and neglect is described in Sanders and Bursch (2002) and is currently being updated (Bursch & Sanders, n.d.).

Monthly team meetings or conference calls that include the individuals working with the child can be beneficial for catching problems quickly. Additionally, the individuals working with the child should meet if the child exhibits an increase in symptoms, if problems occur during the supervised visits, if a proposed change is added to the case plan, or if other issues arise to cause chaos or dissention among team members. All relevant records should be obtained regularly to monitor progress in school, therapy, and health. A court-ordered and supervised case plan outlining safety precautions and any proposed treatments must be followed if reunification is to be attempted. The case plan will include parameters for monitored visits and for treatment of the child, the suspected abuser, and, if applicable, the spouse or partner of the suspected abuser. At times, other individuals may also be included in the plan. Additional details related to the rehabilitation of the child victim and visitation considerations appear below.

Rehabilitation Plan

Most victims of this form of abuse and neglect benefit from a rehabilitation plan to optimize health and functioning. With guidance from the child's clinicians and court experts (and close monitoring by the child's clinicians), systematically and sequentially challenging

each of the claims reported by the suspected abuser will ensure that the child is properly evaluated and supported to be as healthy as possible. For example, under appropriate supervision, medications that are suspected to be unnecessary may be weaned one at a time to determine if they are needed or not. Physical therapy may be helpful for a child who has been unnecessarily confined to a wheelchair. Those who have been fed via feeding tubes might require feeding or occupational therapy to develop normal eating behaviors. Children with school accommodations might be similarly challenged to determine their optimal level of functioning and support. Acquired developmental problems will need to be addressed with appropriate remedial services. Many victims have developed mental and behavior disorders that will require psychotherapy.

In addition to developing specific plans designed to address the symptoms and disability reported by the suspected abuser, efforts should generally be made to encourage normal developmental experiences and behaviors. Aspirational goals include return to school, mainstreaming into regular classrooms with no school accommodations, regular attendance at social events with peers, access to recreational and exercise activities that are enjoyable, and increasing levels of independent functioning with increasing age. Realistic goals will vary by child and be partially dependent on the presence of genuine medical, psychological, or educational problems. Careful ongoing documentation of symptoms and functioning allow for an analysis of cause and effect for each change in the child's treatment.

Visitation

As reviewed in the general guidelines (APSAC Taskforce, 2018), close supervision is strongly recommended when visitation between the suspected abuser and child victim is part of the case plan. Therapeutic visitation monitors may be able to best identify dysfunctional dynamics and behaviors, and also provide the parent with real-time feedback about better ways to behave. Visits should be halted if the parent is unable to abide by the visitation rules or if the child appears to be experiencing trauma symptoms upon exposure to the suspected abuser. Unlike visitation for other forms of abuse or neglect, the child must never be left alone with or allowed private communication with the suspected abuser, even for a couple minutes.

The visitation monitors should receive education about this form of abuse and neglect so that they understand how they are vulnerable to being misled by the parent, recognize the level of risk associated with this type of abuse and neglect (and in the specific case), learn the comprehensive menu of concerning behaviors to monitor, and be clear on when to assertively intervene. Specific case information will further augment the monitor's understanding of the past interpersonal dynamic and abuse and neglect concerns. Finally, visit monitors will be most effective if they have access to an expert on FDIA to receive consultation and support.

Documentation by the visit monitors is very important. Careful and detailed documentation will add valuable information to the ongoing assessment of risk and progress. Information to document includes (1) descriptions of the behaviors and discussion topics that occur during the visit; (2) episodes of violating visit rules or nearly violating visit rules; (3) exactly what education and clinical instruction is provided to the caregiver and that caregiver's response to the direction, as well as his or her ability to restate and implement the education or clinical instructions; (4) episodes of attempts to befriend or intimidate the monitor; (5) requests by the caregiver for special favors, advocacy, or case plan alterations; and (6) other concerning behaviors.

Reunification

Evaluation of Psychotherapy

Recommendations for psychotherapy for the child victim and suspected abuser are included in the overall guidelines (APSAC Taskforce, 2018). If the spouse or partner of the suspected abuser is involved in the child's life and failed to protect him or her from abuse or neglect, this person should also participate in psychotherapy with similar treatment goals as set forth for the abuser. CPS workers can use the ACCEPTS model to assess progress in the treatment of the abuser (Sanders & Bursch, n.d.). See Table 2.

Table 2. ACCEPTS Model of Abuser Therapy Progress.

AC	**Ac**knowledgement: The literature suggests that the most important indicator of treatment progress and potential for meaningful change is the ability of the abuser to acknowledge and take responsibility for (intentional and/or unintentional) inappropriate behaviors and being able to describe specifically how those behaviors placed the child at risk.
C	**C**oping: Abusers who (1) develop more effective coping strategies to manage their own stress and emotional needs, and (2) are able to consistently utilize those skills during times of increased stress have a better prognosis and reduced risk of relapse.
E	**E**mpathy: Prognosis improves with demonstration by the abuser of (1) an increased ability to empathize with the child, and (2) appropriate cognitive and emotional responses to past abusive/ neglectful behaviors, the harm caused, and the potential harm the behaviors could have caused the child.
P	**P**arenting: The development of effective parenting skills is extremely important. This includes placing the needs of the child before those of the abuser.
T	**T**aking charge: Those abusers who have done the best have taken charge of their own recovery and stability. They recognize their power in situations and learn to utilize it appropriately. They make proactive plans to ensure they have the support and safety nets in place to catch relapses quickly and to protect the child.
S	**S**upport: Due to the high relapse rate, ongoing support and monitoring are essential. Abusers who agree to such a plan (or, even better, who design such a plan), are at a reduced risk for causing further harm to their children.

Transition Home

If re-evaluation by the consulting expert concludes that sufficient progress has been made to attempt reunification, a slow reunification process is recommended. If reports of symptoms or disability increase during the transition, this could be a signal that the reunification is premature, proceeding too quickly, or contra-indicated. With older children, minor increases in symptoms or disability may be expected due to increased stress and expectations of illness or disability. If these are not remediable, it may be helpful to slow reunification while the child is allowed more time in treatment.

All plans for transition home must include others in a safety plan. Spouses or partners, extended relatives, school officials, therapists, health providers, and others can serve as helpful monitors and intervene if needed. Consistency in providers is recommended. Please see the general guidelines for important components of a clinical monitoring plan (APSAC Taskforce, 2018). The ability to refrain from abuse or neglect must be proven over several years. The courts may recommend a lengthy probation period, during which the abuser would need to receive court authorization to move or travel out of the jurisdiction.

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