

# ADVISOR

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Abuse by pediatric condition falsification/caregiver-fabricated illness in a child/ medical child abuse (APCF/CFIC/MCA) is a perplexing phenomenon frequently going undetected until an astute observer first challenges the illness presentation. Any illness or condition can be falsified by simply providing inaccurate information, while simulation and/or induction of illness can be particularly challenging to uncover. The following table, which is a companion article to the 2017 “APSAC Practice Guidelines on Munchausen by Proxy,” summarizes a variety of ways that illnesses may be simulated or induced. This is not an exhaustive list of all the possible presentations of APCF/CFIC/MCA or means of simulation and induction, but can be utilized as a starting point.

page **53** **Investigation of Medical Child Abuse/Factitious Disorder Imposed on Another** | *Michael Weber*

Investigating medical child abuse, or any other fabricated condition in a child, presents many challenges beyond the realm of typical physical child abuse evidence collection. This article uses several high-profile legal prosecutions to illustrate the importance of early involvement of law enforcement personnel who are knowledgeable about this unusual presentation. The importance of specific interviewing techniques, crime-scene investigation in both the hospital and the home, social media, and computer evidence collection are described. Examples of successful practices in Tarrant County, Texas, provide guidance for effective interdisciplinary team collaboration among physicians, child protective service workers, prosecutors, law enforcement, and therapists. Offenders are typically very convincing and comfortable lying to doctors, family members, and psychiatric evaluators. The proper tools for investigating medical child abuse are evidence based and follow the Practice Guidelines.

page **61** **Munchausen by Proxy in Educational and Mental Health Settings** | *Herbert A. Schreier and Brenda Bursch*

Falsified behavioral problems and developmental delays are commonly documented in the literature, but victims of Munchausen by proxy (MBP) presenting in educational and/or mental health settings are challenging to detect. Because teachers, school nurses, and mental health professionals typically see children more frequently than pediatricians, they are in an ideal position to identify possible MBP abuse and neglect, especially falsified learning, developmental, psychiatric, and behavioral problems. Debilitating long-term negative consequences have been associated with thwarted developmental milestones, developmentally inappropriate socialization, incorrect self-perceptions of ability and functioning, and iatrogenic harm from medications designed to treat behavioral disorders. This article serves as a complementary guide to the 2017 “APSAC Practice Guidelines on Munchausen by Proxy” for school and mental health professionals.

page **66** **Munchausen by Proxy: Risk Assessment, Support, and Treatment of Spouses and Other Family Caregivers** | *Mary J. Sanders and Catherine C. Ayoub*

Spouses of Munchausen by proxy (MBP) abusers and other family caregivers are frequently considered for possible placement or visit supervision for the child victim, or both. They require careful evaluation to insure the child does not continue to be victimized. The purpose of this article is to provide assessment suggestions as well as support and treatment considerations. The ultimate outcome for the child will depend not only on protection from the abuser but also the ability of caregivers to provide realistic support for health and wellness.

page **76** **Child Protective Services Management of Cases of Suspected Child Abuse/Neglect Due to Factitious Disorder Imposed on Another** | *Brenda Bursch*

Due to the compulsive, pervasive, and insidious nature of this form of psychopathology, management of cases of abuse or neglect by a caregiver with factitious disorder imposed on another (FDIA) must be detailed and comprehensive to ensure safety. Most notably, individuals with FDIA can be highly skilled in misleading and convincing intelligent others that they are being truthful. As a companion to the 2017 “APSAC Practice Guidelines on Munchausen by Proxy,” this article provides child protective services professionals with detailed information on the effective management of suspected child abuse or neglect by a caregiver with FDIA, including guidance for interactions with the suspected abuser, placement decisions, case management, treatment planning, visitation, reunification, evaluation of progress in psychotherapy, and transition home.

page **83** **The Influence of Electronic and Internet Advances on Munchausen by Proxy** | *Debra Esernio-Jenssen, Randell Alexander, Kenneth Feldman and Beatrice Yorker*

The advent of WebMD, online communities, and blogs provide unprecedented access to medical information and online communities for people suffering with diseases. Social media platforms allow people to share any personal information, photos, and stories they choose to post. This article examines the positive aspects of technology to aid in detection, provide evidence of deception, and even conduct research, along with the ways the Internet has fueled or created venues for potential perpetrators to access medical knowledge, share information about a sick child, and receive social and monetary support. The authors also discuss how the Internet has provided forums for suspected perpetrators to organize against medical diagnoses and child protection, and they explore the influence of electronic medical records and online consumer satisfaction surveys on clinicians and on parents who might engage in fabricating illness in a child.

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# Munchausen by Proxy: Abuse by Pediatric Condition Falsification, Caregiver-Fabricated Illness in a Child, or Medical Child Abuse Due to Factitious Disorder Imposed on Another

*Beatrice Yorker, JD, RN, FAAN*

*Randell Alexander, MD, PhD*

*Mary Sanders, PhD*

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It is a pleasure to serve as Guest Editors for this focus issue of the *APSAC Advisor*. The Practice Guidelines and companion articles reflect years of data collection, experience, ongoing discussions, and consensus building among the members of the APSAC Munchausen by Proxy (MBP) Taskforce and others.

Beginning in the early 1990s, a small multidisciplinary group of professionals who were publishing and presenting on MBP began meeting during professional conferences—including the San Diego International Conference on Child and Family Maltreatment, the Academy of Pediatrics' Committee on Child Abuse, the APSAC Colloquium, the ISPCAN International Conference on Child Abuse and Neglect, and the Academy of Child and Adolescent Psychiatry—to share knowledge, experience, and challenges with this form of child abuse and neglect. In 1996, APSAC invited a group to develop working definitions to clarify the two components of MBP (the abuse and neglect and the associated psychopathology) and the Taskforce was formed. This work resulted in a position paper about MBP (Ayoub et al., 2002) within a special issue of *Child Maltreatment*, guest edited by Drs. Catherine Ayoub, Herbert Schreier, and Randell Alexander. At that time, the term *pediatric condition falsification* was developed to capture the abuse and neglect experienced by child victims of individuals with a factitious disorder.

Since then, the field of MBP, the terms used to describe it, and activities of our Taskforce and of other professional groups have evolved. To increase awareness and a sense of responsibility among pediatricians, the term *medical child abuse* (MCA) was introduced to describe when a child receives unnecessary and harmful, or potentially harmful, medical care at the instigation of a caregiver (Roesler & Jenny, 2009). In 2013, the American Academy of Pediatrics referred to this form of abuse and neglect as *caregiver-fabricated illness in a child* (CFIC) (Flaherty, MacMillan, & Committee on Child Abuse and Neglect, 2013). Also in 2013, *the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition* (DSM-5) (American Psychiatric Association, 2013) was published with an updated name for the associated psychiatric disorder factitious disorder imposed on another (FDIA) and updated diagnostic criteria that were informed by our Taskforce, represented by a Taskforce member who also served as an Invited DSM Advisor, Brenda Bursch, PhD. Finally, most recently, the original 1996 Taskforce updated the term *pediatric condition falsification* to *abuse by pediatric condition falsification* (APCF) to define the abuse and neglect associated with MBP (APSAC Taskforce, 2018).

In 2013, the *Boston Globe* ran an editorial about this disorder: “Medical Child Abuse’ Lacks Adequate Standards, Guidelines.” It pointed out that

very few guidelines exist for the handling of

such cases.... Given an apparent rise in the number of children being removed from their parents' custody due to suspicions of medical child abuse, this is the rare situation in which assembling a blue-ribbon panel of medical and child-protection experts as well as attorneys could help dramatically in providing standards for ensuring a child's best interest. A good start would be establishing a clear, systematic approach for identifying medical child abuse.

We believe that assembling the Taskforce and developing these Guidelines will greatly assist those attempting to identify, properly assess, and effectively manage these extremely challenging cases, while also being and responsive to the media coverage regarding the need for interdisciplinary approaches to this type of abuse.

In 2015, the Taskforce reconvened at the San Diego International Conference on Child and Family Maltreatment to discuss the latest developments in the field. Additional members joined, and we committed to further the research, publish our data, and update best practices in the field. In 2016, Dr. Kathleen Fallor, Publications Chair, and Tricia Gardner, President of APSAC, invited the Taskforce to develop the Practice Guidelines for this issue of the *APSAC Advisor*. We reached out beyond our core Taskforce to professionals who were publishing, presenting, conducting trainings, and working to educate the public about this type of abuse and to ensure disciplinary and geographic diversity. Our goal was to integrate the sometimes confusing differences that had emerged over time into one coherent document, and ultimately to improve the timeliness and quality of care received by child victims and their families.

Members of the Taskforce receive requests for experts who can evaluate and assist in cases of suspected MBP on a weekly basis, revealing the dire lack of qualified experts at a national level. Requests for assistance have increased over the last two decades as awareness has grown due to media coverage. Taskforce members also see surges of requests when high-profile cases are in the news or portrayed in other media outlets. It has become clear from the requests received as well as from many of these publicized stories that there is

a persistence of systems failures in cases of suspected MBP and of confusion among professionals about the nature of this extremely toxic and dangerous form of child abuse and neglect.

As an example, the well-researched reports on the Gypsy Blanchard case by Michelle Dean (2016) and the HBO True Crime documentary *Mommy Dead and Dearest* (Carr, 2017) described a horrific MBP case that resulted in the 23-year-old victim arranging for the murder of her abusive mother. These reports provided education for a lay audience about the fact that Gypsy tried several times during her childhood and adolescence to get away from the abuse, but Dee Dee, her very convincing mother, managed to persuade doctors to conduct many unnecessary surgeries and prescribe a plethora of medications that could cause the symptoms she presented. Dee Dee also lied to the police about Gypsy's age, convincing them to return Gypsy to her care when she ran away. The murder trial of Gypsy and her boyfriend brought national attention to how entire communities who interacted with this family failed to recognize numerous fabricated illnesses and even engaged in fund-raising for fraudulent conditions. The case also illustrated how the healthcare, law-enforcement, and child welfare systems failed to protect Gypsy or prevent her mother's murder.

The APSAC Practice Guidelines for MBP reflect the Taskforce's efforts to reach consensus regarding approaches to MBP that have transpired in the last two decades. They also meet the need for comprehensive education for all disciplines involved in recognition and protection. They are the first nationally endorsed and published multidisciplinary guidelines for the identification, assessment, and management of suspected cases of MBP. They provide detailed education and guidance on terminology, warning signs and identification, assessment of abuse and psychopathology, reporting requirements, case management, treatment, and reunification. The APSAC Board engaged in a lively discussion with the Taskforce that resulted in final approval of the Guidelines in October 2017. Kathleen Fallor (Publications Chair), Tricia Gardner (President), and David Corwin (President Elect) of APSAC responded to the Board:

This document reflects not only learned discourse representing the best minds in the world about MSBP, but also demonstrates efforts that have been truly attentive to the input from APSAC and timely in your responses to input. This is now the definitive statement on this complex and difficult form of child maltreatment. Thanks for your commitment to getting the Guidelines into such a fine, comprehensive, carefully vetted, and considered set. Your work will benefit thousands of professionals grappling with these kinds of cases! (personal communication, October 23, 2017)

The companion articles in this issue provide even more detailed information in specific areas beyond what could be covered in the Guidelines. For those interested in learning more about the various ways that pediatric conditions may be simulated or induced, Kelly and Wang categorize and summarize a vast array of presentations in the literature to aid diagnosis. Schreier and Bursch provide descriptions of how MBP can present in school and mental health settings. Weber describes his extensive experience with sixteen investigations of MBP Medical Child Abuse with recommendations for evidence collection, interviewing, and successful child protection. Bursch offers specific guidance for child protective services case management. Ersenio-Jenssen, Alexander, Feldman, and Yorker discuss how electronic and Internet advances have impacted the presentations, evaluations, backlash, and interventions in cases of MBP. Finally, Sanders, Ayoub and Bursch provide guidance for assessing safety parameters and supporting relatives or family friends who are potential placement options for MBP victims.

Future activities planned by the Taskforce include presenting the Guidelines at the 2018 APSAC Colloquium and submitting research and scholarly articles. The Taskforce is also working with the International Society on the Prevention of Child Abuse and Neglect (ISPCAN) to expand these guidelines for an international audience. Members of the Taskforce are also planning local and regional trainings that will include the new guidelines. The California State

Chapter of APSAC will offer specific outreach on MBP in 2018. The APSAC virtual “Circle” for Munchausen by Proxy hosted by Michael Weber (see [apsac.org](http://apsac.org)) was initially formed to answer questions involving investigative strategies for Law Enforcement and CPS, but it has the potential to provide resources and responses to any questions on this form of abuse and neglect. Finally, there is a need for psychotherapists who understand this form of abuse and neglect to work with victims, abusers, and other family members when circumstances dictate. Developing a reservoir of such talent will be an ongoing challenge that the Taskforce is willing to assume. Most important is developing the means to prevent the underlying reasons for this form of abuse. Such prevention will require better understanding of the effects of adverse childhood experiences at the individual level, and why some turn to medical, educational, or mental health professionals to satisfy their own psychological needs at the expense of their children.

### About the Authors

**Beatrice Yorker, JD, RN, FAAN**, is Professor Emerita of Nursing and Criminal Justice at California State University, Los Angeles. She has published on case law of Munchausen by proxy, covert video surveillance, Munchausen by proxy among healthcare professionals, and serial murder in hospitals.

**Randell Alexander, MD, PhD**, is Professor of Pediatrics, the University of Florida—Jacksonville; a member of the International Advisory Board for the National Center on Shaken Baby Syndrome; President of the Academy on Violence and Abuse; and chair of the Committee on Child Abuse Florida Chapter, American Academy of Pediatrics.

**Mary J. Sanders, PhD**, is Clinical Associate Professor at Stanford University Medical School in the Division of Child Psychiatry. She is Program Director of the Comprehensive Care Inpatient Unit at Stanford. She has published and presented nationally in the areas of child abuse, Munchausen by proxy, and eating disorders.

# Munchausen by Proxy: Abuse by Pediatric Condition Falsification, Caregiver-Fabricated Illness in a Child, or Medical Child Abuse Due to Factitious Disorder Imposed on Another

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# Munchausen by Proxy: Clinical and Case Management Guidance

## APSAC Taskforce

These Guidelines reflect current knowledge about best practices related to the identification, reporting, assessment, and management of *Munchausen by proxy* (defined here as “Abuse by *pediatric condition falsification*, caregiver-fabricated illness in a child, or medical child abuse that occurs due to a specific form of psychopathology in the abuser called factitious disorder imposed on another”).

There are two components to the guidance presented: (1) Identification, assessment, and initial management of suspected cases of abuse or neglect meeting the definition for abuse by *pediatric condition falsification*, *caregiver-fabricated illness in a child*, or *medical child abuse*, regardless of the motivation or co-morbid psychopathology of the abuser, and (2) Education, assessment, and management guidance for cases of these forms of abuse and neglect due to factitious disorder imposed on another in the abuser.

In cases of Munchausen by proxy (MBP), some victims have genuine symptoms, disorders, or impairments that are intentionally exaggerated, undertreated, or exacerbated by the abuser. In other cases, all symptoms, disorders and impairment are completely fabricated by the abuser. The guidance provided in this document applies to both situations.

Guidance is not provided for the ongoing management of families in which the suspected abusers have anxiety, psychosis, malingering, or other explanations for episodes of abuse or neglect that do not meet criteria for factitious disorder imposed on another (FDIA). Such families are generally easier to assess,

treat, manage, and reunify using standard evaluation and treatment approaches.

These guidelines are intended to provide guidance to medical providers, mandated reporters, child protective service workers, law enforcement, attorneys, therapists, and any other professionals who may be involved with reporting, assessing, and treating children affected by this form of child abuse and neglect and their abusive caregiver(s). Guidelines are not intended as a standard of practice to which practitioners are expected to adhere in all cases and are not meant to establish a legal standard of care. Best practices will continue to evolve as new evidence becomes available. As experience and scientific knowledge expands, further revision of these guidelines is expected.

## Terminology and Definitions

### Original Terms Describing the Abuse and Neglect Combined With the Psychopathology

**Munchausen syndrome by proxy (MSBP) / Munchausen by proxy (MBP)** The MSBP/MBP definition encapsulates both the psychopathology of the abuser and the abuse of the victim. MSBP/MBP was never a formal *International Classification of Disease (ICD)* or *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnosis (American Psychiatric Association, 2013). It is a term that has historically been used (and still is often used) to describe situations in which an individual diagnosed with factitious disorder imposed on another (FDIA) engages in falsifying a condition or illness in another.

The victims of this form of abuse span the age range and may include animals (American Psychiatric Association, 2013).

Dr. Roy Meadow (1977) first described MSBP in the literature when he coined the term to refer to mothers deliberately falsifying illness in their children. Meadow used the term to describe the combination of the abuse (and neglect) and the motivation of the caregiver. Since that time, thousands of cases have been described in the literature. This is a form of abuse and neglect that can lead to significant child morbidity and mortality. *Munchausen syndrome by proxy* is the most widely recognized term, but the means of diagnosis, psychodynamics, and outcomes continue to be misunderstood. Due to confusion surrounding whether the term should be applied to the child as a victim of abuse or to the abuser who intentionally falsifies illness, several other terms have been proposed

## Terms Describing the Abuse and Neglect

### Pediatric condition falsification (PCF)

In 1996, APSAC created a task force to more clearly define this type of abuse and neglect (Ayoub et al., 2002, 2004). The task force coined the term *pediatric condition* (illness, impairment, or symptom) *falsification* (PCF) to refer to a form of child maltreatment in which an adult falsifies physical or psychological signs or symptoms in a victim, causing the victim to be regarded as more ill or impaired than is objectively true.

### Abuse by pediatric condition falsification (APCF)

The words *abuse by* have been added to make it very clear that this term refers to child abuse and neglect.

### Caregiver-fabricated illness in a child: A manifestation of child maltreatment (CFIC)

CFIC is the most recent term recommended by the American Academy of Pediatrics to describe this type of abuse and neglect of the child victim (Flaherty & MacMillan, 2013).

### Medical child abuse (MCA)

*Medical child abuse* is a term used by many medical providers to describe when a child receives unnecessary and harmful, or potentially harmful, medical care at the instigation of a caregiver (Roesler & Jenny, 2009). This term substantially overlaps with APCF and CFIC. APCF includes MCA and also false or induced problems presented to non-medical providers.

## Term Describing the Abuser's Psychopathology and Actions

### Factitious disorder imposed on another (FDIA)

FDIA is a *DSM-5* psychiatric diagnosis (American Psychiatric Association, 2013). It is used to describe the psychopathology of some APCF, CFIC, or MCA abusers. Individuals with this diagnosis have falsified or induced physical, psychological, or developmental signs or symptoms in another individual. Intentional deception is associated with this behavior, differentiating it from a delusional or other psychiatric disorder. The deceptive falsification behavior persists even when there are no evident external rewards for the behavior such as money, child custody, or access to drugs, although these motivations may co-exist. The victim of this behavior is presented to others as ill, impaired, or injured.

Compared with the previous version, the primary DSM changes include (1) an increased emphasis on deception as the cornerstone of the disorder (and subsequently, a need to identify deception as part of the FDIA evaluation process); (2) the fact that malingering (by proxy) may be a co-morbidity; (3) a simplified approach to motivation by requiring evidence only of internal motivation (primary gain) and not needing to determine a specific motivation (attention, sick role, or other); and (4) the ability to diagnose after a single episode of illness or condition falsification if the criteria are met.

A diagnosis of FDIA does not indicate decreased responsibility for harm or freedom from legal liability; however, the abuser's intention is generally not to torture or kill the child, though this may occur. This

diagnosis may be similar to making a diagnosis of pedophilic disorder, with the primary goal of the behavior to satisfy a psychological need of the abuser. While secondary gain (malingering) may be present, it is not the driving force. Individuals with pedophilic disorder or FDIA ignore the needs and wellbeing of the victim in order to satisfy their own needs.

## Background

### Epidemiology

The American Academy of Pediatrics (Flaherty & MacMillan, 2013) reports an estimated incidence of approximately from 0.5 to 2.0 per 100,000 children younger than 16 years. However, this form of abuse and neglect is significantly underrecognized and underreported. Therefore, these estimates likely underrepresent the actual extent of this abuse. Bass and Glaser (2014) identified published cases from 24 countries, indicating that this form of abuse and neglect spans the globe.

### Methods by Which Conditions May Be Intentionally Falsified or Induced

Falsification of illness may take many forms and may occur along a broad spectrum of severity. See Table 1 (p. 11) for examples. Falsification always includes a caregiver giving or producing false information or withholding information in order to deceive. The abuser may also exaggerate symptoms, simulate symptoms, and withhold medications, nutrition, or treatments to exacerbate symptoms or induce illness. Abusers may coach others, even very young victims, to collaborate with them or corroborate false claims. Corroborating parties may or may not be aware of the fabrications. Due to the persistent and often escalating nature of this form of abuse and neglect, even seemingly mild presentations that are solely based on false reports of symptoms have the potential to lead to death. Additionally, the abuse and neglect typically extends far beyond the clinical setting. Abusers typically maintain the false story and behave accordingly in all settings and with all friends, family, and professionals. Nevertheless, it is clear from reports of abusers and hidden video surveillance that the deceptions are conscious and often carefully planned, and that efforts are exerted to conceal the deception. Thus, this form of abuse is pervasive and typically

includes emotional abuse and neglect.

Varying patterns of abuse and neglect have been identified. Some individuals with FDIA target all children in their care and others serially focus on the youngest child, the most challenging child, the children with genuine underlying medical problems, or the children with whom they have disrupted attachments. Intergenerational abuse and neglect has been identified. There may be periods of time in which no abuse occurs for some time but then restarts.

Any medical condition can be created, falsified, or exaggerated (Levin & Sheridan, 1995). However, this form of abuse is not confined to medical conditions. Falsified symptoms may also be behavioral or psychiatric (e.g., falsely reporting the child is harming himself or others, or falsely reporting symptoms consistent with a mental illness or disability) (Schreier, 1997) or educational (e.g., falsely reporting learning disabilities, attention deficit disorders, or autism) (Ayoub et al., 2002; Frye & Feldman, 2012). Common medical conditions that are falsified or induced include the following: allergies, asthma, apnea, gastrointestinal problems, failure to thrive, fevers, infections, and seizures (Roesler & Jenny, 2009; Rosenberg, 1987; Sheridan, 2003). Clinicians and forensic experts have observed an increase in frequency of false reports of autism and mitochondrial disorders in recent years. Finally, classical forms of child abuse and neglect may occur co-morbidly or may also be volitionally falsified (Schreier, 1996). All reports of suspected abuse or neglect of any type should be evaluated by adapting the best available assessment practices with the cautions outlined in these guidelines, especially the need to rely upon objective data and to consider ways in which the signs and symptoms of abuse and neglect could be simulated or induced. If it is determined that false abuse and neglect allegations are the result of an abuser attempting to meet his or her own psychological needs, this would also meet criteria for FDIA.

### Risk and Harm

Victims may be directly harmed by the abuser's induction behaviors, frequently undergo unnecessary and invasive evaluations and interventions, be kept out of appropriate school settings, miss social and

**Table 1. Types of Falsification.**

Type of Falsification	Examples
Producing false information	Providing false information about current symptoms and limitations in the child; the child's medical or other history; and prior findings, recommendations, or treatments. Examples include saying a child has seizures when there are none and providing altered diagnostic medical documentation.
Withholding information	Failing to provide pertinent information that would help to explain the child's presentation. An example is not informing the clinician that the child is vomiting due to poison that was just administered.
Exaggeration	Providing clinical information that is based on a genuine symptom or limitation, but is enhanced in order for the child to be seen as more severely ill or impaired than is true. An example is reporting more frequent or treatment-resistant seizures than truly exist.
Simulation	Altering biological specimens or medical test procedures to yield abnormal results. Examples include presenting contaminated urine samples, placing one's own blood in child's stool sample, or interfering with a diagnostic test to produce abnormal results.
Neglect	Withholding medications, nutrition, or treatments to exacerbate symptoms. An example is failing to administer seizure medication as prescribed.
Induction	Directly creating symptoms or impairments. Examples include poisoning, suffocating, starving, and infecting.
Coaching	Manipulating another to answer questions by clinicians and others in a manner that substantiates the false claims of the abuser. Adults and very young victims can be effectively coached to (knowingly or unknowingly) collaborate with the abuser and corroborate the false claims of the abuser. Examples are spouses who repeat what the abuser has told them to be true as if it were fact or a child victim who is reminded to report specific symptoms to the clinician.

developmental opportunities, and misperceive themselves to be excessively ill or disabled. Iatrogenic medical conditions may arise from unnecessary interventions, and the child may become ill or permanently physically or mentally harmed as a result of well-intended diagnostic and treatment efforts.

Permanent physical harm that has resulted from APCE, CFIC, or MCA child abuse and neglect includes blindness, altered gut function, brain damage, hearing loss, scarring, removal of organs, surgical alteration of anatomy, limbs, and other sequela, including death. Children who survive this form of abuse

and neglect are often left with severe psychological damage and significant confusion about their health and relationships. Psychological harm varies, but may include overly compliant or aggressive behavior, adoption of self-falsification or somatizing behaviors, loss of a positive self-image, posttraumatic stress disorder, and disordered eating. This form of abuse and neglect can permeate every aspect of the victim's life. Occasionally, children and teens may be aware of the abuse, but do not inform others of what is happening to them. More frequently, they vigorously defend the abuser and do not grasp what has happened to themselves. Thus, it can take a significant

amount of time for specialized and comprehensive intervention to yield positive outcomes.

Family members, friends, professionals, and community members may also be affected by long-term emotional concerns for the child they believe to be ill and by revelation of the truth.

## **Etiology**

Based upon cases in which intent has been revealed or determined, APCF, CFIC, or MCA child abuse and neglect occurs when abusers' psychological needs take precedence over the needs of the child, paving the way for them to harm the child in order to have those needs met. Needs cited by those who have admitted to this behavior have included the need to receive care and attention; to be perceived as smart, caring, selfless, or in control; to manipulate and humiliate a powerful figure; to manipulate a spouse; or, for the excitement of being in a medical setting. Some who have admitted to this behavior consider addiction to a substance to be an appropriate analogy to describe their persistence and single-mindedness in engaging in falsification behavior. Those who engage in this behavior often report a personal history of childhood abuse or domestic violence; however, when possible to verify this, these reports frequently turn out to be false. They may falsify or induce symptoms in themselves, and may themselves be victims of APCF, CFIC, or MCA.

## **Abuser Psychopathology**

Individuals with FDIA are predominantly female and have typically been found to have a coexisting personality disorder, usually cluster B disorders (i.e., borderline, histrionic, sociopathic, or mixed) (Bass & Jones, 2011). Bools, Neale, and Meadow (1994) found that of 47 mothers who had induced illness in their children, 72% had personal histories of a somatic symptom disorder or factitious disorder imposed on self. Twenty-one percent had a history of substance misuse, 55% had histories of self-destructive behaviors, and 89% had a personality disorder. They discovered that five of the 19 women they interviewed (26%) had histories of learning problems. Some abusers have no obvious or diagnosable personality disorder, or the presence of a personality disorder may not be known due to insufficient data.

## **Approaches to Identifying APCF, CFIC, and MCA**

Clinicians should consider the possibility of APCF, CFIC, or MCA in children with highly unusual clinical presentations, when clinical findings are unexpectedly inconsistent with the reports of the caregiver, or when a child's response to standard treatments is surprising. The cornerstone of determining if APCF, CFIC, or MCA is present is identifying unexplained discrepancies, deception, induction, or intentional neglect by the caregiver who created the clinician's misperceptions regarding the true functional and symptom status of the victim.

One major misconception among clinicians is the idea that underlying medical or other disorders that could account for the signs or reported symptoms need to be ruled out for a conclusion of APCF, CFIC, or MCA to be made. In fact, children with genuine underlying medical, psychological, or developmental problems are often the targets of this form of abuse and neglect. Some abusers of genuinely ill or impaired children recognize that their own psychological needs are being met by continuing engagement with the medical, mental health, or educational professionals who are treating their children, thus sparking the abuser's desire to keep these rewarding relationships in place.

Some abusers are attracted to diagnoses that encapsulate a large array of possible symptoms, perhaps to evade detection. An example is a parent who falsely attributes a wide variety of symptoms or behaviors to a nonexistent or equivocal mitochondrial disorder. As is true with any genuine illness, if the child has a mitochondrial disorder (or other genetic disorder) and the parent is exaggerating or falsifying symptoms so that it appears to be more severe than is true, this would also be considered abuse.

## **Role of the Physician and Other Clinicians in Diagnostic Assessment**

Pediatricians and other primary care medical providers are a common point of contact for this type of abuse and neglect. Thus, it is important for primary care providers, as well as specialists and emergency room personnel, to include APCF, CFIC, or MCA in

their differential diagnosis of children with complex, confusing, or multiorgan system disease. In mental health settings, the point of contact and evaluation may be a psychiatrist, psychologist, or other mental health specialist.

The history provided by a parent is commonly used to determine which tests to order, formulate a diagnosis, support school or other accommodations, and determine what treatments, procedures, medications, and surgeries to recommend. Healthcare providers are trained to rely on the truthfulness of the child's caregiver. Medical and other clinical training does not prepare pediatricians or specialists to doubt or question the history provided by a caregiver or patient, particularly when the caregiver appears dedicated, competent, and well versed in clinical terminology. Highly competent clinicians can be misled into providing unnecessary or harmful care to the child. Some abusers seek out clinicians who provide nonstandard or substandard care to further their goals.

Fragmented care among multiple providers facilitates deception. Ideally, primary care providers serve as gatekeepers of care, but often specialists cross refer without coordinating with the child's primary care provider. All primary care clinicians should be familiar with the warning signs in Table 1 and the recommendations in Table 2. The AAP (Stirling, J. & American Academy of Pediatrics Committee on Child Abuse and Neglect, 2007) recommends that pediatricians answer three questions in the consideration of reporting possible abuse:

1. Are the history, signs, and symptoms credible?
2. Is the child receiving unnecessary and harmful or potentially harmful medical care?
3. If so, who is instigating the evaluations or treatments?

As in all forms of child abuse and neglect, the motivation of the parent may or may not be evident to the clinician. Regardless of motivation, if the child is receiving or is at risk of receiving unnecessary, harmful, or potentially harmful medical care at the insistence or instigation of a caregiver, the clinician should consider the need to report to the proper

authorities (consulting with others, as needed).

## **Warning Signs**

### **General Clinical Approach**

Some abusers have an uncanny ability to portray themselves as, and persuade others that they are, caring and good caregivers (Schreier, 2002; Schreier & Libow, 1993). Some become social hubs for caregivers of other chronically ill children in the hospital or in their community. Some attempt to establish personal relationships with the professionals supporting them, sometimes successfully luring clinicians or other professionals (including legal professionals) to cross important role boundaries. Further, doctors, therapists, social workers, friends, family, victims, lawyers, and judges are routinely successfully misled to believe the false claims and denials of the abuser. Some abusers are adept at enlisting professionals to serve as their advocates. Such professionals may strongly oppose colleagues and data suggesting that the suspected abuser is the agent of harm to the child. Such staff splitting is typical and underscores the need for an objective analysis of the data and clear guidelines for contacting Child Protection Teams.

1. Reported symptoms or behaviors that are not congruent with observations. For example, the abuser says the child cannot eat, and yet the child is observed eating without the adverse symptoms reported by the abuser.
2. Discrepancy between the abuser's reports of the child's medical history and the medical record.
3. Extensive medical assessments do not identify a medical explanation for the child's reported problems.
4. Unexplained worsening of symptoms or new symptoms that correlate with abuser's visitation or shortly thereafter.
5. Laboratory findings that do not make medical sense, are clinically impossible or implausible, or identify chemicals, medications, or contaminants that should not be present. An example is a serum sodium level that is not clinically within reason.
6. Symptoms resolve or improve when the child is separated and well protected from the influence and control of the abuser.

7. Other individuals in the home or the caregiver have or have had unusual or unexplained illnesses or conditions.
8. Animals in the home have unusual or unexplained illnesses or conditions—possibly similar to the child’s presentation (e.g., seizure disorder).
9. Conditions or illnesses significantly improve or disappear in one child and then appear in another child, such as when another child is born and the new child begins to have similar or other unexplained symptoms.
10. Caregiver is reluctant to provide medical records, claims that past records are not available, or refuses to allow medical providers to discuss care with previous medical providers.
11. The abuser reports that the other parent is not involved, does not want to be involved, and is not reachable.
12. A parent, child, or other family member expresses concern about possible falsification or high-healthcare utilization.
13. Observations of clear falsification or induction by the caregiver. This may take the form of false recounting of past medical recommendations, test or exam results, conditions, or diagnoses.

Healthcare providers, including mental health experts, do no better than the general public in determining through an interview whether someone is lying. Because it is not possible to detect deception by clinical interview (ten Brinke, Stimson, & Carney, 2014), the value of traditional mental health assessment and evaluation techniques is limited. Table 2 (p. 12) summarizes evaluation and treatment recommendations for clinicians caring for a suspected victim.

Hospital protocols have been published to provide guidance for assessment and management (Parnell & Day, 1998; Sanders, 1999). Optimally, a Board Certified Child Abuse Pediatrician or another professional with APCF, CFIC, or MCA expertise would be involved in all assessments.

### Clinical Documentation

Careful documentation is as important as a careful

evaluation. Details can be extremely helpful to those conducting a medical or educational record analysis, including information such as,

1. Who reported that they witnessed the child with symptoms or impaired functioning (and if they saw the symptoms or impaired functioning at the onset),
2. The names of past clinicians who made diagnoses of the child,
3. Exactly what education or clinical instruction has been provided to the caregiver and that caregiver’s ability to understand the education or clinical instructions using the teach-back method,
4. Episodes of nonadherence or leaving (or threatening to leave) the hospital against medical advice,
5. Requests by the caregiver for specific assessments or interventions,
6. Episodes of unexplained equipment malfunctions or suspected tampering, and
7. Other concerning behaviors.

For example, documenting “emesis x3” does not reflect if someone informed the clinician that the child had vomited three times, if the clinician saw the emesis, if the clinician saw the child vomit, or the amount or appearance of the emesis. The documentation is far more helpful when attention is paid to including these details in the medical record. All involved professionals should be reminded of the importance of carefully documenting all pertinent details in the chart related to each interaction with the patient, suspected abuser, and other caregivers.’

### Record Analysis

Analysis using the available records is the cornerstone of evaluation of this form of abuse and neglect. While clinicians often review records as a standard part of providing care, analyzing the records for behavioral evidence of falsification allows for a broader assessment of the child and suspected abuser. Additionally, a medical record analysis sometimes provides information that reduces the suspicion of abuse or neglect. A task that is typically not covered by health insurance, record analysis often falls to forensic experts who are hired after an initial report of

**Table 2. Recommendations for Clinicians Caring for a Suspected Victim.**

1. Gather all medical records from past and present treating professionals (see procedure to analyzing caregiver behavior documented in the records in Tables 3 and 4).
2. Make contact and regularly communicate with both parents (all caregivers).
  - a. Provide all caregivers with ongoing education and feedback about findings and recommendations.
  - b. Ask all caregivers to repeat back the information provided to them.
  - c. Carefully document all education and other discussions with the caregivers.
3. Collect collateral data from school personnel and other independent observers who have regular access to the child.
4. Review suspected abuser's online social media activity.
5. Carefully devise evaluation and rehabilitation plans that systematically and objectively challenge claims made by the suspected abuser or victim.
  - a. All descriptions of symptoms and disability made by family members must be considered possibly inaccurate. For example, in suspected victims, g-tubes and other non-oral feeding interventions should not be placed based solely on verbal reports of symptoms. Objective inpatient observations by clinicians of feeding attempts provide important data for clinical decision making.
  - b. Family members cannot be relied upon to properly prepare the child for diagnostic assessments or treatments. For example,
    - i. Consider performing a toxicology screen prior to manometry testing to ensure no gut-altering substances have been ingested.
    - ii. Consider having a sitter in the room for a pH probe test to ensure that the child is provided only the prescribed oral intake and to ensure the probe position is not changed.
6. Meet with the other clinicians involved in the care of the child to compare data and coordinate plans.
7. Alert other clinicians (verbally and in the chart) about the poor reliability of symptom reports or behavior of the suspected abuser, the importance of relying upon objective data, to proceed conservatively, and the need to document well.
8. Minimize school accommodations, prescriptions, and invasive testing and treatments.
9. While devising evaluation and rehabilitation plans, consultation with an expert is recommended.
10. Report reasonable suspicion of child abuse and neglect to the proper authorities.

suspected abuse or neglect has been made. To maximize the validity of the record analysis, all medical records of each child should be obtained whenever possible. When feasible, such as in some legal settings, the medical records of the alleged abuser(s) are also useful to obtain due to the high co-morbidity of falsification upon self and others. It is helpful to analyze the records of all the children in the household because evidence of falsification of illness in siblings may be present even if not initially identified (Bools, Neale, & Meadow, 1992). Any clinician, regardless of discipline or degree, with expertise in the evaluation of this form of abusive and neglectful

behavior may analyze the records to evaluate behavior patterns. A comprehensive description of the medical record analysis is described in Sanders and Bursch (2002).

The gold standard medical record analysis requires the creation of a chronological table of nearly every telephone call, office appointment, emergency room visit, pharmacy record, and hospitalization. Missed appointments and hospital discharges against medical advice (as well as threats to leave against medical advice) are also important to include in the table. The table will reveal patterns of healthcare utilization,

including the number of healthcare facilities and specialty services involved in the family's care. Columns to include in the table are as follows: Date, name of patient, who brought child in for care, healthcare contact information (location, name, and specialty of clinician), history and problems reported by the caregiver, objective data (clinical observations and test results), diagnosis, recommendations, and other important or historical data. Table 3 (next page) gives an example. This table can be used as a reference for evaluators and legal professionals, especially if it is in an electronic format that allows for quick searching.

Unlike a simple review of records, a chronological table allows for pattern analysis of the individual family members and the involved clinicians. A thorough, carefully organized table lends itself to complete analysis of the family's illness and medical treatment trajectories as well as the behavior of family members during medical care encounters. It also allows the evaluator to crosscheck information presented by the patient or suspected abuser about past healthcare encounters and medical problems against the objective data. Table 4 (next page) presents key points related to conducting a record analysis.

### Video Surveillance

Video recordings of illness induction, whether hidden (covert) or through visible video cameras (overt), can provide compelling direct evidence to judges, juries, and to the family and the abuser. Some abusers have confessed, or been more willing to explore their behavior, after viewing such recordings. Based on the existing laws in the United States, including the Fourth Amendment right to privacy, video surveillance of the child in the hospital room may be permissible for (1) protection of the child patient, (2) assistance in diagnostic evaluations and treatment, much as the way cardiopulmonary monitors are routinely used to monitor inpatients, or (3) protection of the facility and employees from allegations of negligence. Video surveillance is best used to document caregiver attempts at illness induction (e.g., suffocation) or simulation (e.g., tampering with equipment or interfering with tests), or to document the absence of falsely reported symptoms (e.g., apnea, seizures).

Some recommend that video surveillance be reserved

for situations in which the child cannot be otherwise properly assessed and protected. It can be a helpful tool if there is a reasonable expectation that, within a reasonable observation period of time, the caregiver will be found to induce (e.g., suffocate or attempt to contaminate IV fluid) or falsely report transient events (e.g., apnea or seizures) for which video surveillance could disprove the caregiver's reports. If it is used to identify induction, continuous monitoring is strongly recommended to allow staff to immediately intervene if the child is being harmed. Video monitoring might also provide information that would help confirm or explain the symptoms, indicating they had not been falsified by a caregiver (Hall, Eubanks, Meyyazhagan, Kenney, & Johnson, 2000; Southall, 1995; Yorker 1995).

If the surveillance is covert, the most legally robust procedure is to obtain a court-ordered warrant prior to starting such surveillance. The petition for the warrant should specify what area will be searched (viewed) and what possible evidence may be found. However, case law exists to suggest that a hospital room is not a place that offers a constitutionally protected reasonable expectation of privacy. On the contrary, parents may expect their child to be monitored and observed, particularly in pediatric settings when infants are at risk of or being evaluated for apnea (Yorker, 1995) or other life-threatening conditions. It is recommended that hospitals add a sentence to the consent for treatment form that parents sign upon admission to a hospital that acknowledges the possibility of video surveillance in any public space in the hospital (Yorker, 1995). State laws may vary depending on whether the hospital is private or public. To provide as much privacy as possible, it is recommended that the camera be focused on the child's bed. Audio can also be helpful, such as to capture coaching behavior or a child arguing with the parent about a symptom or the need for an intervention. However, audio recording can represent an additional invasion of privacy that is not necessary in other situations, such as when suffocation of an infant is suspected. State laws vary related to consent for audio recording.

While video surveillance may be useful, congruent with other forms of child abuse and neglect, it is not necessary to make a determination of APCF, CIFC,

**Table 3. Chronological Table of Patient Health Care.**

Date	Patient / BIB	Health Care Contact	Subjective Caregiver Reports	Objective Findings	Diagnosis / Recommendations	Other
9/17/16	Alexis BIB Mom	Dr. Lee, Emergency Medicine, Memorial Hospital ER	Hx of constipation since birth. Followed by GI who advised her to go ER. Reports 6 days of projectile emesis and food refusal.	NAD. Labs & vitals WNL. Exam benign except for mild diaper rash. KUB WNL. Eagerly took 4 oz. of formula from bottle. No emesis in ER.	Diaper rash – Advised mom to keep baby’s skin clean and dry. Hydrocortisone cream prescribed. AGE suspected – Provided IVF and return if sxs persist.	Mom accurately summarized all guidance and agreed to plan. However, she did not remember the name of GI doctor.

**Table 4. Key Points: Record Analysis.**

Key Point	Example
Identify and consider the source of the documented information.	Did the documenting clinician actually witness the child vomiting?
Determine if suspected abuser should reasonably have had accurate information.	<ul style="list-style-type: none"> <li>Was the caregiver provided with adequate education, feedback, and recommendations?</li> <li>Is there evidence that the caregiver understood the information provided to him or her?</li> </ul>
Examine primary data and check norms utilized for interpretation.	Review test results, not just the interpretation of test results.
Determine if diagnoses or conclusions match objective data.	Was the diagnosis based on the verbal report of the caregiver or was it based on objective data?
Determine if objective findings could have been falsified or induced.	In a child victim found to have slowed motility, consider assessing for external agents or dietary manipulations that might have caused that finding.
Determine if the illness history makes sense.	<ul style="list-style-type: none"> <li>Are there genetic explanations for several children in the same family having similar problems or diagnoses?</li> <li>Is there a way that a child can be allergic to water?</li> </ul>
Compare timelines of healthcare-seeking behavior with other records and collateral data.	Identify circumstances and stressors that coincide with healthcare crises.
Review available literature.	<ul style="list-style-type: none"> <li>Differentiating sudden infant death syndrome from suffocation (Meadow, 1990; Southall &amp; Samuels, 1995),</li> <li>Identifying falsified chronic intestinal pseudo-obstruction (Hyman, Bursch, Beck, DiLorenzo, &amp; Zeltzer, 2002),</li> <li>Detecting failure to thrive due to illness falsification (Mash, Frazier, Nowacki, Worley, &amp; Goldfarb, 2011).</li> </ul>

or MCA. Because video surveillance evidence can be misleading or may not be admitted into evidence, clinicians are encouraged to collect and provide additional corroborating data to child protective and police investigators, if safe and feasible. For instances in which the diagnosis is clear, video surveillance may be counterproductive by exposing the child to an unnecessary risk by prolonging the evaluation phase when immediate protection is needed.

### Separation From the Abuser

Although fraught with clinical, legal, and ethical concerns, separating the child from the suspected abuser is often the only way to objectively evaluate the wellbeing of the child. Clinicians can consider utilizing an escalating approach to achieve separation. A suspected abuser may first be asked to voluntarily refrain from caregiving duties or from visiting the child in the hospital for a period of time. In some situations, an alternate parent or caregiver who does not live in the home may be willing to temporarily care for the child. If a suspected abuser directly asks if he or she is being suspected of illness falsification, an honest answer is typically recommended, pending consideration of safety issues related to sharing this information (for the child, the suspected abuser, and the evaluator). One can highlight that evaluators who assess for this diagnosis if warning signs are present are providing high-quality and comprehensive care. Further, it may be helpful to inform the suspected abuser that the goal of the evaluation is to help the family regardless of the identified cause, including if it is determined to be a case of child abuse or neglect. Some locations allow for hospital personnel to impose strict visitation or caregiving boundaries on caregivers or to place clinical observers in the hospital room. However, court orders are sometimes required to achieve a diagnostic separation. If the clinical evaluation indicates that the child has been or is at risk for harm, such separations may be lengthy or permanent.

If the child's condition or functioning improves when sufficiently protected from the influence of the suspected abuser (at the same time that the child is receiving support for normal or improved functioning), many courts will use the concept of *res ipsa loquitur*, which translated from Latin

means “the thing speaks for itself,” to consider the improved condition or functioning to be compelling circumstantial evidence of APCF, CFIC, or MCA. As with video surveillance, however, separation should not be the only component of the evaluation.

Well-implemented diagnostic separations require several safeguards and caveats. First, the separation must be for a sufficient length of time to be valid. For example, if the child with reports of uncontrolled epilepsy for several years normally has a grand mal seizure once a week and the longest reported time between seizures is one month, then the separation would need to be inclusive of these timelines. Additionally, the strength of the conclusion of seizure falsification would depend on how long the child is objectively observed.

Second, all tests must be done with the utmost of care and fairness to the suspected caregiver(s) and child. Unmitigated symptoms following separation from the suspected abuser are an indicator that a child's symptoms may be genuine. However, it is important to be mindful that APCF, CFIC, or MCA victims with pre-existing medical conditions may only have some of their problems resolved or may only experience a change in the level of severity of symptoms after separation. In some cases, a victim may have iatrogenic illnesses or conditions due to having received unnecessary treatment in the past. Such iatrogenic problems may or may not resolve following separation.

Third, care and vigilance are needed to ensure that the victim is fully protected during the separation. Abusers may surreptitiously poison, intimidate, or coach a child victim, thus perpetuating illness or impairment during separation. They may try to gain access and influence the child by convincing the visit monitor or foster parent that they are not a threat to the child. Please see the recommended visitation guidelines (Table 5, p. 25).

Fourth, evaluators must be mindful of how changes in treatment around the time of separation can influence a child's symptoms. If treatments are changed right before or after the child is placed in protective care, the change in treatment might account for the change

in symptoms. Related, improvements in symptoms or functioning can be incorrectly attributed to treatment changes made at the time the child is taken into protective care. Thus, it is helpful to be thoughtful about how to systematically implement changes in the treatment plan for optimal clarity regarding cause and effect. For example, one would not expect seizures to stop because an antiepileptic medication was stopped. If a child had a genuine seizure disorder, one would expect an increase in seizures in this situation. However, one might not be surprised if that same child reported being less sleepy at school once the medication was stopped.

Finally, if a history of symptom or impairment induction by poisoning is suspected, it is helpful to have an assessment plan in place so that all visit monitors and foster parents know what to do if there is an occurrence of acute symptoms during or within hours of a visit. The plan may require bringing the child to a medical setting or submitting a biological sample to a laboratory for analysis, in which case it will also be important to have clear chain of evidence protocols in place. Toxicology experts can be invaluable in developing toxicology screening plans based on symptom presentations and in considering cross-reactivity that could cause false positives (Holstege & Dobmeier, 2006). Lastly, it is a good idea to ensure the lab preserves serum from any blood draws so that confirmatory or additional tests may be performed, if needed.

### **Example of Differential Diagnosis of APCIF, CFIC, and MCA**

Consider the example of a parent who persistently interprets or reports a child's movements to be seizures despite repeatedly normal medical evaluations and feedback. If such a parent persists in exposing the child to unneeded evaluations and treatments, and persistently requests unneeded school accommodations, this may be abusive and require a mandated report to CPS, regardless of the parent's motivation or psychopathology.

Because the child in the example above received unnecessary and harmful, or potentially harmful, medical care at the instigation of a caregiver, the MCA term applies to the situation (Roesler & Jenny, 2009). If

deception is apparent, the APCF and CFIC terms also apply (Ayoub et al., 2002, 2004; Flaherty & MacMillan, 2013).

If the parent is reporting that an EEG showed, or that a physician diagnosed the child with, epilepsy when it is known by the parent that this is not true, this deceptive behavior may reflect malingering (if external, or secondary, gain is the primary motivation) or be due to FDIA (if internal, or primary, gain is the driving motivation).

If the child is having seizures due to smothering by the parent, this child abuse could be due to malingering, FDIA, or physical abuse (e.g., a parent attempting to stifle a crying child).

If the child has a seizure disorder that the parent is knowingly undertreating or significantly exaggerating for the parent's primary gain (psychological reasons), this would satisfy the criteria for FDIA. If the same parent were engaged in this neglectful behavior for external gain, the parent would be considered to be malingering. Regardless of the reason for the behavior, it would also constitute medical neglect.

If the parent has an inaccurate belief (without the presence of deception) related to reports of seizure activity, the resulting abuse by overmedicalization might be due to a delusional disorder or anxiety in the parent. This behavior would be considered MCA. Delusional disorders typically can be distinguished from FDIA and malingering by the lack of deception and by the morbid (and less feasible) nature of the symptom description (e.g., a delusional person might report that seizures are being caused by a melting brain or by a nonexistent parasite infestation, but no previous clinician has believed them).

The above scenario could also be enacted in a mental health setting with a parent falsely claiming his or her child suffers from psychogenic nonepileptic seizures. While not meeting the definition of MCA if medical intervention is not being sought, this scenario would meet the definition for APCF.

Regardless of the scenario, any clinician who suspects an individual is being harmed by abuse or neglect is

legally required to report reasonable suspicions to Child Protective Services (CPS) or police in order to protect the suspected victim.

## **Approaches to Psychiatric Evaluation of Alleged Abuser**

Evaluation of the psychopathology of the suspected abuser generally occurs after the suspicion of abuse or neglect has been reported to child protection agencies. Because caregivers are not registered patients when they are in clinical settings for their children and because they rarely admit to any wrongdoing, mental health clinicians embedded in pediatric clinical settings are generally not able to evaluate if the caregiver meets criteria for FDIA or a related disorder. It typically requires the mandate of a court to obtain cooperation to participate in a psychiatric or psychological assessment.

Mental health professionals are as vulnerable as any other professionals to being misled by a factitious disordered individual, so it is important that any such evaluators have expertise on this topic or have access to consultants who can guide them.

Clinical interviews and psychological testing cannot be used as evidence that abuse or neglect did not occur. In fact, as in all forms of child abuse and neglect, an abuser may appear completely normal upon testing or interview. While the record analysis and other collateral information generally allow one to determine if illness or condition falsification or overmedicalization has occurred, the mental health evaluation allows for the formulation and evaluation of hypotheses about the driving causes of the caregiver's behavior. For example, if the suspected abuser demonstrates clear signs of extreme anxiety or of a psychotic thought process, this information might explain why they engaged in the abusive behavior. Diagnostic clarity and consideration of possible motivations allow the evaluator to opine about the likelihood that treatment will be successful and to provide appropriate treatment recommendations, including specific modalities for an abuser with identified psychiatric co-morbidity. A protocol for performing these evaluations is described in Sanders and Bursch (2002).

## **Reporting Requirements and CPS and Police Investigations**

### **Medical, Mental Health, and Education Professionals**

Many mandated reporters want to be sure the caregiver is volitionally falsifying prior to reporting possible child abuse or neglect. Such caution may lead to substantial delays in protecting victims, particularly in cases in which the suspected abuser thwarts efforts to challenge medical claims or refuses to provide access to collateral sources of information (such as records, past providers, or the other parent). In such cases, CPS can assist clinicians in conducting proper evaluations. Referral to CPS is based on child harm, not the motivation of the suspected abuser.

Most states require providers to report to CPS or police if they suspect or have reasonable cause to believe a child is a victim of abuse or neglect, and if they are reporting suspected abuse in good faith. If a mandated reporter writes in the chart, suspected Munchausen by proxy, that reporter is charting that this is a case of suspected child abuse or neglect. As with any form of abuse or neglect, a CPS report is indicated unless the mandated reporter adequately ruled out MBP (or APCF, CFIC, or MCA) and documented how it was ruled out. Unreported suspicions of abuse or neglect can result in criminal or civil penalties for the mandated reporter. Although a clear conclusion of APCF, CFIC, or MCA is not required for the suspicion to be reported, inclusion in the CPS report of any of supporting data is extremely helpful to child abuse authorities who may not have the expertise to conduct such an evaluation.

### **Family Meeting and Informing Conference**

When it becomes apparent that a child is not as ill or impaired as the caregiver reports, the treatment team may need to hold a meeting to inform the parents of the diagnostic findings and treatment recommendations. It is extremely important that both parents obtain this information. The team should decide on a case-by-case basis how best to inform both parents as one parent may not be aware of the overmedicalization of the child due to the behavior of the other parent. In this family meeting, conclusions

that the child is not as sick or impaired as reported are presented along with recommendations to remove unneeded treatments and interventions and to use a rehabilitation model to treat the child. The offending caregiver's response to this information and subsequent compliance with withdrawing treatments may reveal how amenable the parent is to intervention. However, in all cases of APCF, CFIC, or MCA, a protective services referral will be necessary to ensure the suspected abuser does not sabotage treatment. Furthermore, the literature documents cases of maternal suicide, psychiatric decompensation, suicide attempts, flight, or child abduction upon being presented with evidence that the child is healthier than presented, or of illness fabrication, exaggeration or medical child abuse (Vennemann et al., 2006; Yorker & Kahan, 1991). Whenever the diagnostic or other potentially stressful update meetings occur, a safety plan should be in place and psychological support available.

In some cases, the information may not rise to the reasonable cause to believe reporting threshold, but be concerning enough to alert hospital colleagues (verbally or within the medical record) to document any conflicting data or statements and to be circumspect in their efforts to evaluate and treat the child, with an emphasis on using objective findings for diagnosis and treatment.

### **Child Protection Services (CPS)**

Some jurisdictions have created CPS protocols and guidance to support caseworkers and supervisors (Arizona Department of Child Safety, 2012; Michigan Governor's Task Force, 2013). However, most CPS professionals have not been trained to understand and investigate this form of child abuse and neglect. Even if they are, this is a very labor-intensive and specialized form of abuse and neglect to investigate. As previously mentioned, it is recommended that the mandated reporter help the CPS agency understand exactly what and why they are reporting. For example, medical neglect might be reported for a parent who is not properly administering medications in order to cause increased seizures. CPS might incorrectly close the case because the child has frequent contact with medical clinics, not appreciating the risks related to the medication noncompliance. It is recommended

that the mandated reporter make it very clear what types of abusive behaviors are being reported along with the observed or suspected harm to the child. If a child has a genuine seizure disorder, failure to administer prescribed medications is hazardous and negligent. Additionally, the child may be exposed to excessive amounts of medical intervention (such as escalating doses of anti-seizure medication), may be missing out on school and social events, and may be repeatedly informed that he or she has an unstable or dangerous medical or mental problem, thus harming the child's self-perception. Overall, then, the CPS report might include concerns about medical abuse, emotional abuse, and medical, educational, and social neglect.

CPS will likely need outside resources to adequately evaluate these cases. As described before, all medical records should be obtained for the index child as well as other children, alive or dead. If possible, it is recommended that the medical records of the caregivers also be obtained. Once all of the records are obtained directly from the treating facilities (not records provided by the suspected abuser or another family member), a professional with expertise in assessing suspected APCF, CFIC, or MCA should organize and analyze them. It is not sufficient to have a clinician with general medical knowledge read the record. The primary goal is to systematically analyze the behavior patterns of the suspected abuser to detect deception and signs of illness induction. School and other records may also be very helpful, if available. Some states give CPS legal access to all the child's records once a report is filed. This can be utilized to obtain records when the parent refuses access to them.

It is recommended that at least one CPS worker in each county be trained in this form of abuse and neglect. The CPS worker should be able to take the lead in any reports of this type of abuse and have expert consultation available as needed.

In some jurisdictions, CPS must notify the suspected abuser that he or she is the subject of a child abuse investigation—often within several days of the initiation of the case. This notification can jeopardize the investigation and put the child at risk if the child is not taken into protective custody at the same time.

It is recommended that, in locations in which such notification procedures are mandated, a protocol be established about how to safely handle such cases. Bursch (2018) provides additional CPS guidance.

### Police and Legal Investigations

Many states require cross-reporting, and it is recommended that police be notified along with CPS when abuse or neglect is first reported. Depending on the nature of the abuse, there could be physical evidence present in the victim's hospital room or other locations that police will need to collect. It may not become clear until later in the investigation that induction of symptoms occurred. Police access to a possible crime scene at the time of the report is important to an effective law enforcement investigation. Police may immediately attempt to locate and preserve all social media accounts, blogs, or any other electronic writing activity by the suspected abuser. If involved, police should coordinate closely in a multidisciplinary manner with Child Protection Services, medical personnel, and prosecutors to ensure all facets of the investigation are covered. Finding and preserving the social media accounts of the suspected abuser before the first CPS interview is very important, as the suspected abuser may delete his or her social media accounts once the nature of the allegation is apparent.

Police and CPS should coordinate obtaining all medical records for the victim. Police should also attempt to locate cooperative witnesses outside the medical community that knew the victim and abuser. Police need to obtain, by consent or search warrant, all electronic communication (text messages, emails) between these witnesses and the abuser if these witnesses state that the abuser communicated electronically about the health of the victim.

Consideration should be given to including all text messages, emails, and social media posts into the medical record spreadsheet, sorted by date (Brown, Gonzalez, Wiester, Kelly, & Feldman, 2014; Feldman & Brown, 2002; Sanders & Bursch, 2002) as part of the behavior analysis. This document can also be used as a reference for prosecutors and others, especially if in an electronic format that allows for quick searching.

The police investigator should also be prepared to

obtain and execute search warrants for the suspected abuser's computing devices, including smart phones, if probable cause can be established. Probable cause may be established with a combination of friends reporting their concerns, the abuser researching medical ailments, toxic substance or other incriminating topics on the computer that were subsequently presented to clinicians (documented in the medical records or reported by a clinician), or by the existence of a false or exaggerated medical history in the social media records.

The police investigator should attempt to interview the suspected abuser. All interviews should be recorded (both video and audio if possible). The timing of this interview is case specific. In cases of suspected illness induction, it should be delayed until the child is safe. The investigator should approach the suspected abuser in an open, curious manner. This stance will allow the alleged abuser to simply give his or her story. If the story does not fit the evidence, these data then allow the investigator to review the discrepancies with the alleged abuser. Review of discrepancies with the abuser may result in an admission. Although they frequently maintain a stance of denial, those with FDIA are typically legally competent and aware of their deceptive actions.

Investigators should confirm every detail reported by the suspected abuser. This includes details not related to the abuse. For instance, if the suspected abuser reports attending nursing school, investigators should subpoena the suspected abuser's transcript from that school. Investigators should also obtain the suspected abuser's own medical history and medical records as there is the possibility that the suspected abuser has also feigned his or her own illness.

Coordination and cooperation among law enforcement, Child Protective Services, clinicians, and the prosecutor's office are essential for a successful criminal prosecution (Weber, 2014).

### Case Management and Treatment

Case management of MBP cases can be extremely challenging and resource depleting due to the severe and insidious nature of the associated

psychopathology. Thus, it is extremely important that case managers and all treating clinicians have ongoing access to medical and mental health MBP experts for appropriate consultation and guidance. This expert input is particularly valuable when important decisions are being made, such as decisions related to placement, reunification, visitation guidelines, and treatment and rehabilitation plans.

### **Child Protection and Placement**

Following an allegation of abuse or neglect, the first priority is the protection of the child from further harm. Siblings may also be at risk. Research has suggested that 35%-50% of siblings are abused (sometimes fatally) prior to the identification of MBP abuse in the index child (Davis et al., 1998; Grey & Bentovim, 1996). As with other forms of child abuse and neglect, even typically developing and verbal teens may not be able to protect themselves or even be aware that they have been the targets of MBP abuse or neglect.

If children are removed from a suspected abuser, placement decisions must be made very carefully. Per usual CPS protocol, child abuse victims are frequently placed with a nonabusing parent (in the case of divorced families) or extended family members (e.g., grandparents). In cases of suspected MBP, this placement choice can be insufficient to adequately protect the children. Placement with relatives of family friends should be done only if such individuals acknowledge the abusive behaviors, agree to protect the children, and have the ability to protect them. It is important to remember that parents or other relatives of the suspected abuser may be at increased risk to abuse or neglect the children as this behavior is sometimes multigenerational. The victim's parent may have previously been similarly abused or neglected by the child's grandparent (Libow, 2002). Since one possible motivation for illness falsification and healthcare utilization is to escape an abusive family member, this possibility will also need to be evaluated before placement with a family member. Further, the relentless pressure by those with FDIA to gain access to and control over the child victim can wear down even the most resilient or well-meaning and skilled caregivers. In most cases, a specialized assessment is needed to fully ascertain their willingness and ability

to protect the children from an abusive caregiver. Most frequently, the children are best placed with foster parents who do not know or interact with the suspected abuser. Sometimes a medical foster home is indicated, as the child may have genuine medical needs or may need to be weaned from care under skilled medical observation.

Re-abuse (further falsification or other abuse or neglect) is a risk for children who have been deemed by CPS or the courts to be safe to return to the home of the abuser. Re-abuse rates have been found to range from 17% for mild cases of MBP to 50% for moderate cases (Bools, Neal, & Meadow, 1993; Davis et al., 1998). Reunification is often not possible in cases of severe MBP abuse or neglect.

### **Reunification Services**

In assessing the risk to the current or future children, factors regarding the original abusive acts as well as the alleged abuser response to the allegations are important safety variables to consider. The younger the child victim and the more severe and chronic the MBP abuse or neglect, the greater the possibility of future lethality. There is evidence that individuals with FDIA are very difficult to treat and a significant number of them have continued to abuse or neglect their children during and following treatment (McGuire & Feldman, 1989; Rosenberg, 1987). Treatment has been successful in rare cases, only when the abuser has been able to acknowledge his or her abusive behaviors and alter behaviors related to the child's health. The abuser must develop increased empathy for his or her victims, and learn and consistently use more effective coping skills (Berg & Jones, 1999; Roesler & Jenny, 2009; Sanders, 1996).

If the family is offered reunification services, a case plan must be put into place that provides safety as well as appropriate treatment. A treatment team consisting of child protection, foster care parents, physicians, visitation supervisors, and therapists must have open communication and should have access to all assessments that have taken place. The team must check the veracity of everything the caregiver says as ongoing deception is common and team members are frequently pit against each other by the deceptive abuser. The case plan should be court ordered and

supervised. Voluntary services are insufficient. Simple compliance with these plans does not assure reunification. It is necessary for the caregiver to not only comply but also *benefit* from the interventions provided in order to truly provide a safe environment for his or her child(ren).

Caregivers should not be permitted to have telephone contact with the children or attend medical visits, except as supervised by either Child Protection or another team professional. Components of a comprehensive case plan appear in the following paragraphs.

### Supervised Visitation

Ideally, staff that is highly trained in child development and MBP should oversee supervised visitation. These cases are very difficult to safely supervise and typically require a higher level of supervision than is commonly provided to families. Ideally, this should be Therapeutic Supervised Visitation, which is provided by staff with master's degrees. These staff should be included in the treatment team.

The visit supervisor should be watchful for subtle messages suspected abusers and other caregivers give to the children during visits (verbal, nonverbal, or written) that maintain focus on medical complaints. They should be alert to efforts by the children to use physical or other complaints to obtain the abuser's care and attention. They should be aware of the significant impact of the prior abuse and neglect on the children's development, identity, and self-image.

Most children have a strong desire to maintain contact with their caregivers, including the suspected abuser. It may be in these children's best interest to continue visitation with caregivers if properly supervised, especially if they are older. However, the supervisor must not leave the child alone with the alleged abuser at any time. They must not allow the alleged abuser to give the child anything to consume or apply any topical products to the child, as there have been numerous cases in which an abuser has given the child substances to induce illness during supervised visits. Visit supervisors are encouraged to document comments and behaviors of family members during the visits to provide ongoing information about

the caregivers' behaviors, family dynamics, and the progress they make in therapy.

Specific visitation guidelines based on the abuser's behavior are typically required. General recommendations are presented in Table 5 (next page).

### Child Therapy

Children may not realize they are or were being victimized. Therefore, it may be confusing for them to consider this possibility. It is important to be aware that their sense of reality may be significantly impacted. If the abusive caregiver is able to admit to his or her behavior and explain it to the child, this may be helpful for both the caregiver and child in moving forward. If the caregiver is unable to do this in a timely manner, the therapist may help the older child (about 10 years of age or older, depending on the child's developmental capacity for abstract thought) gather past medical information and use a neutral stance to allow the child to independently consider (and potentially reformulate) his or her past experiences (Bursch, 1999). Thus, the child may begin to gain some understanding of how the past abuse and neglect may have created a lifestyle of illness that may now cease or change. Therapists need to be alert to the possibility that the child has developed iatrogenic medical trauma symptoms, attachment disorders, somatizing disorders, anxiety, collusive condition falsification behavior (even in young children), and other commonly seen problems developed by children who have suffered abuse or neglect. Those who have been prevented from eating may struggle with eating normally. Those who have suffered physical harm, from induction or medical intervention, may continue to exhibit associated signs and symptoms.

Therapists may work closely with rehabilitation staff to support independent functioning with behavior plans and to support appropriate self-perceptions of health and abilities. School and social reintegration are important components of treatment.

### Abuser Therapy

Falsification behavior due to FDIA is highly unlikely to stop simply upon diagnosis and confrontation. Because most abusers with FDIA also have personality disorders and deny their abusive behaviors, treatment

**Table 5. General Visitation Guidelines.**

- A professional familiar with the case and with the court orders should closely monitor all visitations in a neutral location.
- The suspected abusers (and related caregivers) should not discuss health-related issues, including diet, with their child.
- They should not give their child food, drinks, candy, gum, lotions, or medicine.
- They should not attempt to influence the child to distrust children’s services staff, his or her foster family, or treatment team.
- The child should be visible at all times.
- All conversation must be audible to the monitor.
- All physical contact must be developmentally and socially appropriate.
- All gifts and cards must be socially and developmentally appropriate, with only one gift allowed per visit and examined before it is provided to the child.

**Table 6. Indicators of Successful Treatment.**

1. The caregiver is able to fully admit to the abuse and neglect, including details;
2. The caregiver is able to demonstrate empathy for the victimized child(ren);
3. The caregiver has developed strategies to better identify and manage his or her needs in order to avoid abusing the child(ren) in the future; and
4. The caregiver has demonstrated these skills, with monitoring, over a significant period of time.

success is frequently not possible. Indicators of successful treatment that apply broadly to many forms of child abuse and neglect are presented in Table 6 (Berg & Jones, 1999; Flaherty & MacMillan, 2013; Sanders, 1996). Those less likely to benefit from therapy include those with severe personality disorders and those who have engaged in more lethal forms of abusive behaviors, such as suffocation or poisoning (Davis et al., 1998; Jones, 1987).

Treatment approaches vary, but all should include a focus on the caregiver taking responsibility for abusive behaviors and developing more effective coping strategies. The need for effective therapy pertains to the offending parent as well as to the other parent if he or she failed to recognize abuse or protect the child. One narrative therapy approach includes the deconstruction of the dominant story of illness and disability in favor of the acknowledgment of the alternative narrative of improved health and wellness that would support appropriate parenting and safety (Sanders, 1996). Evidence-based therapy that addresses the abuser’s co-morbidities may be helpful. Examples include dialectical behavioral therapy or trauma-focused cognitive behavioral therapy. Treatment with psychotropic medication

may also be indicated for psychiatric co-morbidities. Those abusers who acknowledge their behavior and make good therapy progress should also have a social support network and a relapse prevention plan in place prior to any reunification attempts. The original evaluator optimally conducts all evaluations of progress. Therapists are not appropriate evaluators as they may be charmed or misled by abusers and may overestimate therapy progress. Additionally, therapy is compromised if the abuser is aware that the therapist is advising the court.

### **Family Therapy**

If the family moves toward reunification, the child may be introduced to the caregiver therapy once both are well prepared for such an exposure. These sessions may be helpful to the child if the caregiver is able to acknowledge the APCF, CFIC, or MCA behaviors and take responsibility for those behaviors with the child. This type of encounter may give the child the opportunity to gain clarification about the past abuse and neglect and to express how the abuser has impacted him or her. A protocol that provides guidelines for this type of therapy is currently under review for publication (Sanders & Bursch, 2018).

Intensive family-focused hospital-based interventions can be effective with abusers who are less severely impaired by a personality disorder and who acknowledge the abusive behavior (Berg & Jones, 1999).

### Reunification of Family

Reunification efforts should consider the child's need for early permanency. These needs may have a much shorter timeline than that required for caregiver treatment. Reunification with the abuser is especially dangerous in cases of illness induction or when the caregiver-child dynamic is highly dysfunctional.

If partial or no progress has been made in therapy, typically within six months of receiving appropriate therapy, reunification is not recommended. Partial progress that is deemed to be genuine suggests that further treatment may be effective. In such cases, reunification may be a reasonable case plan. If significant progress has been made in therapy and reunification appears feasible, a forensic evaluation by an expert should take place to confirm that meaningful progress has been made and that sufficient supports are in place. Reunification, if it is attempted, should occur over a significant period of time with support and long-term monitoring in place.

### Long-Term Monitoring

Long-term monitoring should occur after reunification, including frequent communication with the child's pediatrician, therapists, and school. The ability of the parent to refrain from future abuse and neglect must be proven over several years, optimally throughout the childhood years of the children in the home. 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.

### Clinical Monitoring

To attempt to identify any reoccurrence of APCF, CFIC, or MCA behaviors, the caregivers should be required to engage in a clinical monitoring plan. The child should have a primary care clinical home that can direct and be aware of all investigations and interventions. Caregivers must agree to authorize

all treatment through a clinical team that has been informed about the past APCF, CFIC, or MCA abuse and neglect, believe the allegations to be true, and accept responsibility for case management and communication with involved others. It is best if the primary clinician is the clinician who identified the APCF, CFIC, or MCA behaviors, with a second clinician back up, such that all treatment is authorized by one of these two clinicians only. Typically, this clinician would be the child's primary care physician and a backup. This physician team is asked to take on the responsibility of monitoring the family's access to care throughout the childhood years of all the present and future children. If the physicians retire or the family needs to move, the family must authorize a release of information regarding the past abuse and neglect allegations to the accepting physician team. The court-mandated plan should not allow the caregiver to switch healthcare providers without justification and approval.

Caution must be taken to ensure that a clinical monitoring plan is not the only safety net in place. Abusers engage in abusive and neglectful behavior outside the clinical setting, often on a daily basis, in service of the larger illness story they perpetuate with the victim(s) and others. Therefore, the clinical monitoring is only one component of a larger safety plan. For example, children should also be enrolled in daycare or school to assist monitoring. If the abuser has sufficient resources to pay cash for clinical care or medical equipment, it may require additional planning and effort to track healthcare utilization.

Clinicians caring for children with a history of suspected APCF, CFIC, or MCA provide a basic level of safety when they are conservative in prescribing practices and other treatment recommendations, as well as in their support for school accommodations. They should take suspected caregiver and patient reports of symptoms with a dose of skepticism and engage the other parent or protective adults in the care of the child, if possible. Effective clinicians provide ongoing feedback to the caregivers about any problematic behavior they encounter. They do not allow themselves to be pressured to provide treatments or recommendations that are not necessary. They document clearly and with details, maintain

professional boundaries, and consult with colleagues and experts as needed. Finally, they provide education about normal development and body functions to caregivers, documenting such education was provided along with the caregiver's reaction to the education and understanding of the information when asked to repeat it back to the clinician.

## About the Authors

**Randell Alexander, MD, PhD**, is Professor of Pediatrics, the University of Florida–Jacksonville; a member of the International Advisory Board for the National Center on Shaken Baby Syndrome; President of the Academy on Violence and Abuse; and chair of the Committee on Child Abuse Florida Chapter, American Academy of Pediatrics.

**Cathy Ayoub, EdD, MN, RN**, is a psychologist and nurse practitioner, and is Associate Professor at Harvard Medical School with a clinical practice at Massachusetts General Hospital. She provides assessment and testimony to courts across the United States and Latin America on issues of child maltreatment, victimization, parenting, and the impact of trauma.

**Brenda Bursch, PhD**, is Professor of Psychiatry & Biobehavioral Sciences and Pediatrics at the David Geffen School of Medicine at UCLA. Practicing as an expert, consultant, and clinician on Munchausen by proxy since 1994, she served as Invited Advisor on Factitious Disorders for the American Psychiatric Association DSM-5.

**Kenneth Feldman, MD**, is an attending physician at Seattle Children's and Clinical Professor of Pediatrics at University of Washington, School, General Pediatrics. He was Medical Director of the Children's Protection Program and maintains a 1½-day primary care practice. He previously attended the emergency department, general wards, and intensive care unit at Children's.

**Marc D. Feldman, MD**, is Clinical Professor of Psychiatry and Adjunct Professor of Psychology, the University of Alabama, Tuscaloosa, Alabama. Distinguished Fellow of the American Psychiatric Association, he is the author of more than 100 peer-reviewed, published articles in the professional literature as well as five books.

**Danya Glaser, MBBS, DCH, FRCPsych**, initially developmental pediatrician, is Child and Adolescent Psychiatrist at Great Ormond Street Hospital for Children, London, where she headed an integrated child protection service for many years. Past president of ISPCAN, she co-authored with Christopher Bass the article "Early Recognition of Fabricated or Induced Illness" in *Lancet* (2014).

**James C. Hamilton, PhD**, is Associate Professor of Psychology, and Clinical Associate Professor of Internal Medicine, at the University of Alabama. He coordinates the Clinical Health Psychology Doctoral Concentration. He studies the motivational bases of excessive illness behavior, and serves as a consultant on cases of alleged medical child abuse.

**Carole Jenny, MD, MBA, FAAP**, is Professor of Pediatrics at the University of Washington School of Medicine. She directs the Fellowship Program in Child Abuse Pediatrics at UW and at Seattle Children's Hospital.

**Michael Kelly, MD**, is a board-certified general, child, and adolescent, and forensic psychiatrist. He is Clinical Assistant Professor at Stanford University, where he also serves as Director of Training for the Program in Psychiatry and the Law.

**Bethany Anne Mohr, MD**, is Clinical Associate Professor at Michigan Medicine (University of Michigan, Ann Arbor), where she is Medical Director of the Michigan Medicine Child Protection Team and Pediatric Hospitalist. She worked on the Michigan Governor's Task Force Document on Medical Child Abuse.

**Continued on next page...**

**Thomas Roesler, MD**, is a psychiatrist at Seattle Children's Hospital in Seattle, Washington. He has spent his career treating children with medical, emotional, and family problems. He and Dr. Carole Jenny co-authored a book on medical child abuse and together have evaluated and treated well over 500 children and their families that meet criteria for MCA.

**Mary J. Sanders, PhD**, is Clinical Associate Professor at Stanford University Medical School in the Division of Child Psychiatry. She is Program Director of the Comprehensive Care Inpatient Unit at Stanford. She has published and presented nationally in the areas of child abuse, Munchausen by proxy, and eating disorders.

**Herb Schreier, MD**, is Clinical Professor of Child Psychiatry at UCSF Benioff Children's Hospital Oakland. He has published and lectured in the U.S. and abroad on Munchausen by proxy (MBP) and gender variant children. He co-wrote a seminal book on MBP titled *Hurting for Love*.

**Suzanne Schunk, BA, MSW, LCSW**, is Vice President of Family Support Services at Southwest Human Development in Phoenix, Arizona. She has a Harris Institute Infant Family Practice Certificate and is a Certified Clinical Trauma Professional. Her intervention for medical child abuse is now a national model.

**John Stirling, MD, FAAP**, is a pediatrician with career interests in general pediatrics, child abuse, and foster care medicine. He currently serves on the medical staff of the Chadwick Center at San Diego's Rady Children's Hospital.

**Claudia Wang, MD, FAAP**, is Clinical Professor of Pediatrics at the David Geffen School of Medicine and Mattel Children's Hospital at UCLA. She is board-certified in pediatrics and child abuse pediatrics, and directs the UCLA Suspected Child Abuse and Neglect Team.

**Michael Weber, BS**, is Investigator with the District Attorney in Tarrant County, Texas. He has 33 years of experience as a police officer, including 11 years as a crimes against children investigator. He received the National Center for Missing and Exploited Children's 2016 Texas Hero for Children Award and has investigated 16 cases of Medical Child Abuse.

**Beatrice Yorker, JD, RN, FAAN**, is Professor Emerita of Nursing and Criminal Justice at California State University, Los Angeles. She has published on case law of Munchausen by proxy, covert video surveillance, Munchausen by proxy among healthcare professionals, and serial murder in hospitals.



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# Diagnostic Aid to Identify Simulation and/or Induction: Abuse by Pediatric Condition Falsification/ Caregiver-Fabricated Illness in a Child/ Medical Child Abuse

*Michael Kelly, MD*

*Claudia Wang, MD, FAAP*

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Abuse by pediatric condition falsification/ caregiver-fabricated illness in a child/ medical child abuse (APCF/CFIC/MCA) frequently goes undiscovered despite the fact that the victims of this type of abuse can spend a substantial amount of time being evaluated and/or treated. Table 1 summarizes a variety of ways that illnesses may be simulated or induced. This table can be utilized as a starting point, but it is not an exhaustive list of all the possible presentations of APCF/CFIC/MCA or means of simulation and induction.

Any illness or condition can be falsified by providing inaccurate information to clinicians and others, thus all descriptions of symptoms and disability made by suspected abusers (and their friends and family members) must be considered possibly inaccurate. Further, a suspected abuser cannot be relied upon to follow instructions to prepare or monitor a child for or during diagnostic assessments or treatments (APSAC Taskforce, 2018).

Methods of illness fabrication include the following: giving or producing false information; withholding pertinent information; exaggerating symptoms; simulating symptoms; withholding medications, nutrition, or treatments to exacerbate symptoms; and/or inducing illness (APSAC Taskforce, 2018). Abusers

may also coach others to collaborate or corroborate the false claims of the abuser.

Simulation and/or induction of illness due to poisoning can present as a challenge as routine toxicology screens only target common drugs of abuse and are not inclusive of all possible poisons. Clinicians should consider the utility of performing toxicology screens prior to diagnostic assessments in order to determine if an exogenous agent may be responsible for puzzling symptoms, disability presentations, and/or unexpected diagnostic test results.

Consultation with a toxicologist may be helpful in attempting to narrow down possible toxins. Review of the child's presenting signs, symptoms, and laboratory and ancillary tests may clue one into possible toxins. Inquiring about other medications utilized by household members may divulge possible agents. Consultation with a pharmacologist may also be useful in understanding pharmacokinetics of various drugs. The information within the table below is derived from a review of the literature, case reports, the known effects of commonly used medications, and the authors' clinical experiences.

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Types of Illness	References	Methods of Simulation and Induction* <i>*Any illness can be fabricated by falsely reporting medical history and symptoms</i>	Clues for Detection* <i>*Separation of child from caregiver or increased 1:1 monitoring may lead to abatement of signs and symptoms in many, but not all situations such as the case when a child has a true underlying illness or colludes with the perpetrator</i> <i>*Maintaining chain of evidence for tests</i> <i>*Video surveillance: see APSAC Taskforce, 2018</i>
<b>NEUROLOGY and PSYCHIATRY</b>			
Altered mental status, central nervous system (CNS) depression	Baldwin, 1994; Bartsch, Risse, Schultz, Weigand, & Weiler, 2003; Kintz, Evans, Villain, Salquebre, & Cirimele, 2007; Lansky, 1974; MacGregor, 1995; Meadow, 1982; Rosenberg, 1987; Saladino & Shannon, 1991; Rogers et al., 1976; Woolf, Wynshaw-Boris, Rinald, & Levy, 1992	Alcohol, anticholinergics/ anti-histamines/ tricyclic antidepressants, anticonvulsants (e.g., barbiturates, benzodiazepines), aspirin (severe toxicity), chloral hydrate, clonidine, diphenoxylate and atropine (e.g., Lomotil); ethylene glycol, insulin, methaqualone, opioids, phenothiazines, salt poisoning; suffocation; repaglinide, sulfonylureas	<p><u>Anticholinergic toxidrome</u>: blurred vision (mydriasis), hyperthermia, tachycardia, flushed skin, dry mouth/skin, urinary retention, decreased bowel sounds, confusion/coma/psychosis/seizures</p> <p><u>Toxicology</u>: specific/selective testing for drugs not included within the routine toxicology screen (e.g., serum diphenhydramine level, clonidine level)</p> <p><u>Hair analysis</u> (chronic exposure)</p> <p><u>Benzodiazepines</u>: give selective benzodiazepine receptor antagonist flumazenil to immediately reverse effects</p> <p><u>Opioids</u>: give antagonist drug naloxone to immediately reverse effects</p> <p><u>Aspirin</u>: elevated anion gap metabolic acidosis</p> <p><u>Ethylene glycol</u>: elevated anion gap metabolic acidosis, hyperglycinemia, urine organic acids with elevated glycolic acid, and/or urine with calcium oxalate crystalluria</p> <p><u>Exogenous insulin</u>: *see Endocrinology: hypoglycemia</p> <p><u>Surreptitious repaglinide and/or sulfonylureas</u>: *see Endocrinology: hypoglycemia</p> <p><u>Salt poisoning</u>: *see Fluid, Electrolytes, Nutrition: diabetes insipidus</p>

## Munchausen by Proxy: Diagnostic Aid

Types of Illness	References	Methods of Simulation and Induction*	Clues for Detection*
		<p style="text-align: center;"><i>*Any illness can be fabricated by falsely reporting medical history and symptoms</i></p>	<p style="text-align: center;"><i>*Separation of child from caregiver or increased 1:1 monitoring may lead to abatement of signs and symptoms in many, but not all situations such as the case when a child has a true underlying illness or colludes with the perpetrator</i></p> <p style="text-align: center;"><i>*Maintaining chain of evidence for tests</i></p> <p style="text-align: center;"><i>*Video surveillance: see APSAC Taskforce, 2018</i></p>
Ataxia	Gomila et al., 2016; Martinovic, 1995; Poretti, Benson, Huisman, & Boltshauser, 2013; Rosenberg, 1987; Schreier, 2002	Alimemazine, barbiturates, benzodiazepines, phentermine, methaqualone, carbamazepine	<p><u>Toxicology</u>: specific/selective testing for drugs not included within the routine toxicology screen</p> <p><u>Hair analysis</u> (chronic exposure)</p> <p><u>Benzodiazepines</u>: give selective benzodiazepine receptor antagonist flumazenil to immediately reverse effects</p>
Developmental disability (e.g., autistic spectrum disorder), learning disorders, attention deficit hyperactivity disorder (ADHD), and cognitive impairment	Ijff & Aldenkamp, 2013; Loring & Meador, 2004; Stevenson & Alexander, 1990	Anticholinergics/tricyclic antidepressants, anticonvulsants, benzodiazepines	<p><u>Anticholinergic toxidrome</u>: *see Neurology: altered mental status</p> <p><u>Toxicology</u>, specific/selective testing for drugs not included within the routine toxicology screen</p> <p><u>Psychiatric</u> examination, collateral input from teachers and/or other independent third-party observers, and/or psychological testing</p>
Childhood onset schizophrenia	Gochman, Miller, & Rapoport, 2011; Marcus, Ammermann, Bahro, & Schmidt, 1995; Shaw et al., 2006	Benzodiazepines	The onset of schizophrenia before puberty is extremely rare.
Seizures	Braham et al., 2017; Burton, Warren, Lapid, & Bostwick, 2015; Fernandez-Jaen, Martinez-Bermejo, Lopez-Martin, & Pascual-Castroviejo, 1998; Gomila et al., 2016; <i>cont.</i>	Anticholinergics/antihistamine, tricyclic antidepressants, phenothiazines, exogenous insulin, lamotragine, hydrocarbons (e.g., camphor), rat poison (e.g., chloralose), repaglinide, sulfonyleureas, salt poisoning, suffocation leading to hypoxic seizures, <i>cont.</i>	<p><u>Anticholinergic toxidrome</u>: *see Neurology: altered mental status</p> <p><u>Toxicology</u>: specific/selective testing for drugs not included within the routine toxicology screen</p> <p><u>Hair analysis</u> (chronic exposure)</p> <p><i>cont.</i></p>

*Munchausen by Proxy: Diagnostic Aid*

Types of Illness	References	Methods of Simulation and Induction* <i>*Any illness can be fabricated by falsely reporting medical history and symptoms</i>	Clues for Detection* <i>*Separation of child from caregiver or increased 1:1 monitoring may lead to abatement of signs and symptoms in many, but not all situations such as the case when a child has a true underlying illness or colludes with the perpetrator</i> <i>*Maintaining chain of evidence for tests</i> <i>*Video surveillance: see APSAC Taskforce, 2018</i>
Seizures, cont.	Holstege & Dobmeier, 2006; Martinovic, 1995; Meadow, 1993; Rosenberg, 1987; Shaw, Dermott, Lee, & Burbridge, 1959; Tekin, Gökben, & Serdaroglu, 2015; Widdess-Walsh, Mostacci, Tinuper, & Devinsky, 2012; Willis, Roper, & Rabb, 2007	withholding anticonvulsants in a child who has a true seizure disorder	<p><u>Camphor poisoning</u>: associated nausea and vomiting followed by seizures tremor, hallucinations, delirium, respiratory failure</p> <p><u>Exogenous insulin, surreptitious repaglinide and/or sulfonylureas</u>: *see Endocrinology: hypoglycemia</p> <p><u>Salt poisoning</u>: *see Fluid, Electrolytes, Nutrition: diabetes insipidus</p> <p><u>Video telemetry</u>: see “Video Surveillance” in APSAC Taskforce, 2018</p> <p><u>Withholding of needed anticonvulsants</u>: Check anticonvulsant level and consult with pharmacologist regarding drug half-life and metabolism. Unexplained fluctuations in serum levels may indicate improper dosing or failure to give dose.</p>
Syncope and dizziness	MacGregor, 1995	Diuretics (e.g., chlorthalidone, furosemide)	Screen for specific diuretics
Tremors and movement disorders	Gomila et al., 2016; Kintz et al., 2007	Anticholinergics/antihistamines (e.g., benztropine, diphenhydramine), betablockers (e.g., propranolol), metoclopramide, phenothiazines and phenothiazine derivatives	<p><u>Anticholinergic toxidrome</u>: *see Neurology: altered mental status</p> <p><u>Toxicology</u>: specific/selective testing for drugs not included within the routine toxicology screen</p> <p><u>Hair analysis</u> (chronic exposure)</p>
<b>RESPIRATORY</b>			

Types of Illness	References	Methods of Simulation and Induction* <i>*Any illness can be fabricated by falsely reporting medical history and symptoms</i>	Clues for Detection* <i>*Separation of child from caregiver or increased 1:1 monitoring may lead to abatement of signs and symptoms in many, but not all situations such as the case when a child has a true underlying illness or colludes with the perpetrator</i> <i>*Maintaining chain of evidence for tests</i> <i>*Video surveillance: see APSAC Taskforce, 2018</i>
Apnea/apparent life-threatening events (ALTE)	Flaherty, MacMillan, & Committee on Child Abuse and Neglect, 2013; Foto-Ozdemir et al., 2013; Griffith & Slovik, 1989; MacGregor, 1995; Mitchell, Brummitt, DeForest, & Fisher, 1993; Rosenberg, 1987; Rosen et al., 1983; Saulsbury, Chobanian, & Wilson, 1984	Injecting air through intravenous line, suffocation, tricyclic antidepressants, hydrocarbons containing naphtha such as kerosene or mineral oil	<u>Anticholinergic toxidrome:</u> *see Neurology: altered mental status  <u>Toxicology:</u> specific/selective testing for drugs not included within the routine toxicology screen  <u>Sleep study,</u> apnea monitor
Cystic fibrosis (CF)	Leonard et al., 2008; Orenstein & Wasserman, 1986	Tampering with laboratory specimens by adding salt solution to filter paper, adding fat to stool specimens, presenting sputum collected from actual CF patients as victim's specimen	<u>Genetic analysis</u> for CF gene mutations are negative  <u>Tampering with specimen:</u> If administration of the sweat chloride test on the left and right arms simultaneously reveals significant differences between the two samples, this may indicate tampering with the specimen. Repeat test in absence of caregiver.  If test results reveal a very low potassium concentration, this may indicate tampering of filter paper with an agent/solution that is potassium free, but sodium chloride enriched

## Munchausen by Proxy: Diagnostic Aid

Types of Illness	References	Methods of Simulation and Induction*	Clues for Detection*
<b>FLUID, ELECTROLYTES, AND NUTRITION</b>			
Bartter syndrome (e.g., dehydration, polyuria, hypokalemia, metabolic alkalosis)	Chan, Salcedo, Atkins, & Ruley, 1986; D'Avanzo, Santinelli, Tolone, Bettinelli, & Bianchetti, 1995	Diuretics (e.g., furosemide)	A screen for diuretics is warranted to differentiate between Bartter syndrome and the ingestion of diuretics because blood and urine electrolytes alone cannot differentiate between the two.
Diabetes insipidus (DI), hypernatremia	Coulthard & Haycock, 2003; Meadow, 1993; Su, Shoykhet, & Bell, 2010; Wallace, Lichtarowicz-Krynska, & Bockenbauer, 2017	Salt poisoning	<p><u>Salt poisoning</u> is associated with vomiting, diarrhea, failure to thrive, coma, and seizures.</p> <p>Salt poisoning leads to an excess of total body Na<sup>+</sup> and increased fluid intake, which can result in recent weight gain or a stable weight if there are ongoing losses secondary to vomiting and diarrhea. DI and dehydration leads to a loss of water, which can result in recent weight loss. Accurate calculations can be made for expected weight change if the hypernatremia was solely due to water loss by calculating free water deficit and comparing it with the observed weight change.</p> <p>Calculation of the fraction excretion of sodium/ FENA will allow one to differentiate between salt poisoning versus hypernatremia secondary to DI or hypernatremic dehydration. FENA for salt poisoning &gt; 2%, but in DI and dehydration, FENA is &lt;1%.</p>

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<b>GASTRO-INTESTINAL</b>			
Chronic constipation/ chronic intestinal pseudo-obstruction (CIP)/gastroparesis	Baron, Beck, Vargas, & Ament, 1995; Hyman, Bursch, Beck, DiLorenzo, & Zeltzer, 2002; Rigaud et al., 1988; Roerig, Steffen, Mitchell, & Zunker, 2010	Anticholinergics (e.g., diphenhydramine, cetirizine, fexofenadine), iron supplements, nonsteroidal anti-inflammatory drugs/ NSAIDs, opioids, chronic laxative use followed by abrupt termination, food and/or water restriction/ dietary manipulation	<u>Anticholinergic toxidrome:</u> *see Neurology: altered Mental status  <u>Toxicology:</u> specific/selective testing for drugs not included within the routine toxicology screen  Normal x-rays and GI motility testing are reassuring that it is not CIP or other motility disorder, but not reassuring related to APCF/ CFIC/MCA. Abnormal motility testing may be difficult to interpret due to variations in interpretations as well as it could be induced by starvation, poisoning, and/or diet.
Diarrhea	Gennari & Weise, 2008; Meadow, 1993; Mehl, Coble, & Johnson, 1990; Roerig et al., 2010; Rosenberg, 1987; Sadilek, Feldman, Murray, Young, & Mazor, 2010; Schreier, 1992; Topazian & Binder, 1994	Addition of diluent/water to stool, excessive volume and/or rate of tube feeds, laxatives, salt poisoning	<u>Diluted stool:</u> measured stool osmolality is found to be significantly lower than plasma osmolality  <u>Laxatives:</u> measure stool electrolyte concentrations and osmolality. Calculate osmotic gap (osmotic gap is the difference between stool osmolality and twice the sum of the stool sodium and potassium concentrations). Osmotic gap >50 may indicate the presence of an unabsorbed agent/laxative in stool. Check serum/stool magnesium levels.  <u>Salt poisoning:</u> *see Fluid, Electrolytes, Nutrition: diabetes insipidus

**Munchausen by Proxy: Diagnostic Aid**

Types of Illness	References	Methods of Simulation and Induction*	Clues for Detection*
Failure to thrive (FTT) and malnourishment	Christ, 2000; Feldman, Christopher, & Opheim, 1989; Ginies et al., 1989; Meadow, 1993; Rosenberg, 1997	Poor nutrition, intentional withholding of food, salt poisoning, misuse of feeding tube, chronic barbiturate intoxication, ipecac poisoning	<p><b>Clues for Detection*</b></p> <p><i>*Separation of child from caregiver or increased 1:1 monitoring may lead to abatement of signs and symptoms in many, but not all situations such as the case when a child has a true underlying illness or colludes with the perpetrator</i></p> <p><i>*Maintaining chain of evidence for tests</i></p> <p><i>*Video surveillance: see APSAC Taskforce, 2018</i></p> <p><u>Toxicology:</u> specific/selective testing for drugs not included within the routine toxicology screen</p> <p><u>Chronic barbiturate intoxication:</u> Hair analysis</p> <p><u>Ipecac poisoning:</u> see *Gastrointestinal: Nausea/Vomiting</p> <p><u>Salt poisoning:</u> *see Fluid, Electrolytes, Nutrition: diabetes insipidus</p>
Nausea/vomiting, gastroesophageal reflux disease (GERD), esophagitis	Beard, 2007; Clin, Ferrant, Dupont, & Papin, 2009; Feldman et al., 1989; Holstege & Dobmeier, 2006; Manno & Manno, 1977; Meadow, 1993; Rosenberg, 1987; Yamashita, & Azuma, 2002	Ipecac (emetine/ cephaeline) administration, salt poisoning, surreptitious pumping of air into a feeding tube, excessive volume and/or rate of tube feeds, ingestion of limescale remover	<p><u>Acute ipecac ingestion:</u> Emesis typically occurs within 20 minutes and can last up to 2 hours. Serum emetine/cephaeline typically peaks within 1 hour after ingestion of ipecac and may be undetectable within 6 hours. Urine emetine and cephaeline can be detected in the urine 40 minutes after administration and may be present in urine for several weeks. Variability in absorption and excretion may alter test results. In cases of suspected ipecac poisoning, testing serum, urine and/or gastric aspirate/vomit should be performed with consultation with a toxicologist regarding test assay</p> <p><u>Chronic ipecac ingestion:</u> May present with cardiomyopathy, proximal muscle weakness, and high CPK level</p> <p><u>Salt poisoning:</u> *see Fluid, Electrolytes, Nutrition: diabetes insipidus</p>

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<b>RENAL</b>			
Hematuria	Bertulli & Cochat, 2017; Feldman, Feldman, Grady, Burns, & McDonald, 2007; Fleisher & Ament, 1977; Lech, 2014; Malatack, Wiener, Gartner, Zitelli, & Brunetti, 1985; Meadow, 1982; Outwater, Lipnick, Luban, Ravenscroft, & Ruley, 1981; Souid, Korins, Dubansky, & Sadowitz, 1993; Tsai et al., 2012	Contamination of urine specimen with colored substance (e.g., phenolphthalein)  Contamination of urine specimen with victim, caregiver's, or other source of blood  Poisoning with anti-coagulant, mercury, or phenolphthalein  Manipulation/injury of urethra or mitrofanoff stoma with catheter	Test specimen for presence of blood (e.g. urinalysis/dipstick)  <u>Blood group typing</u> (major & minor), human leukocyte antigen testing, and Y chromosome staining of specimen may be used to assess for victim versus other source of blood type. Consider forensic tests such as DNA short tandem repeats analysis.  <u>Anticoagulant poisoning</u> : Abnormal coagulation panel compatible with vitamin K deficiency. Check serum anticoagulant level (e.g., warfarin/superwarfarin).  <u>Mercury poisoning</u> : blood and hair analysis should be performed with consultation with a toxicologist regarding different test assays and their sensitivities
Proteinuria	Bertulli & Cochat, 2017; Feldman et al., 2007	Addition of exogenous source of protein to urine specimen	<u>Protein electrophoresis</u> may reveal exogenous source of protein in urine
Renal calculi	Bertulli & Cochat, 2017; Feldman et al., 2007; Senocack, Türken, & Büyükpamukçu, 1995	Addition of sediment or pebbles into specimen and/or into urethra	Absence of signs/symptoms common with renal stones, such as renal colic, macrohematuria, and/or urinary tract dilatation.  <u>Calculi analysis</u> by using infra-red spectrometry
Renal failure	Abuelo, 1990; Mantan, Dhingra, Gupta, & Sethi, 2015; Feldman et al., 2007	Addition of urine to blood samples to mimic uremia, pre-renal azotemia secondary to dehydration, renal toxins	Monitor electrolytes, blood urea nitrogen/BUN, creatinine, and assess for dehydration. <u>Toxicology</u> : testing for renal toxins

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Urinary tract infections	Bertulli & Cochat, 2017; Feldman et al., 2007	Manipulation/contamination of urethra or mitrofanoff stoma and/or urine specimens, interfering/ withholding administration of antibiotics (e.g., disconnecting intravenous infusions of antibiotics)	<u>Microbiology studies</u> reveal multiple and/or unusual pathogens (e.g., oral or fecal pathogens)  <u>Interference/withholding of antibiotic administration</u> : check for therapeutic concentration of antibiotics
<b>HEMATOLOGY/ ONCOLOGY</b>			
Anemia, iron-deficiency	Clayton, Counahan, & Chantler, 1978; Ernst & Philip, 1986; Souid et al., 1993; Zahner & Schneider, 1994	Intentional restriction of dietary intake of iron or iron supplements, diluting blood samples, phlebotomy	Anemia resistant to treatment with iron therapy at home, but responsive while hospitalized
Bleeding (e.g., bleeding disorder, hemoptysis, hematemesis, hematochezia, menorrhagia)  * bleeding ears & epistaxis: see Head & Neck *hematuria: see Renal	Bourchier, 1983; Boyd, Ritchie, & Likhari, 2014; Feldman et al., 2007; Fleisher & Ament, 1977; Lee, 1979; Malatack et al., 1985; Meadow 1982; Mills & Burke, 1990; Rosenberg, 1987; Souid et al., 1993; Tsai et al., 2012; White, Voter, & Perry, 1985	Exogenous source of blood (e.g., victim, caregiver's, or other source of blood); simulation with colored substance, inflicted trauma; poisoning with anti-coagulant (e.g., warfarin/ superwarfarin); phenolphthalein.	Test specimen for presence of blood (e.g., vomitus, gastric aspirate, guaiac stools)  <u>Blood group typing</u> (major & minor), human leukocyte antigen testing, and Y chromosome staining of specimen may be used to assess for child versus other source of blood. Consider forensic tests such as DNA short tandem repeats analysis.  <u>Anticoagulant poisoning</u> : Abnormal coagulation panel compatible with vitamin K deficiency. Check serum anticoagulant level (e.g., warfarin/ superwarfarin).

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<b>INFECTIOUS DISEASE</b>			
Fever	Meadow, 1982; Rosenberg, 1987	Tampering with thermometer by rubbing, immersing in hot liquids, contact with hot object	
Sepsis, immunodeficiency	Blyth et al., 2007; Feldman & Hickman, 1998; Galanos et al., 2003; Hodge, Schwartz, Sargent, Bodurtha, & Starr, 1982; Kohl, Pickering, & Dupree, 1978; Liston, Levine, & Anderson, 1983; Schreier, 2002	Contamination of intravenous line, indwelling catheter, interfering/withholding administration of antibiotics (e.g., disconnecting intravenous infusions of antibiotics)	<u>Microbiology studies</u> reveal multiple and/or unusual pathogens (e.g., oral or fecal pathogens)  <u>Interference/withholding antibiotic administration</u> : check for therapeutic concentration of antibiotics
<b>ALLERGY/ IMMUNOLOGY</b>			
Angioedema	Boyd et al., 2014; Wittkowski et al., 2017	Mechanical manipulation, application of creams/ patches containing patch capsaicin containing capsaicin (used for pain relief), ingestion of known allergic substances	
Autoinflammatory disease/ autoimmune	Tamay et al., 2007; Tlacuilo-Parra, Guevara-Gutierrez, & Garcia-De La Torre, 2000; Wittkowski et al., 2017	Mechanical manipulation, application of topical creams/patches containing capsaicin (used for pain relief), ingestion of caustic substances (e.g., sodium hydroxide)	

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<b>DERMATOLOGY</b>			
Rashes, skin infections, irritations	Boyd et al., 2014; Foto-Ozdemir et al., 2013; Harth, Taube, & Gieler, 2010; Jones, 1983; Rosenberg, 1987; Tamay et al., 2007; Venneman et al., 2006; Wittkowski et al., 2017	Mechanical manipulation (e.g., scratching, rubbing, squeezing), applying caustic (e.g., sodium hydroxide, capsaicin containing ointment) or thermal agents, poisoning, painting skin (e.g., blue dye simulating Raynaud), injecting foreign matter into skin, anti-wart patches	
<b>ENDOCRINOLOGY</b>			
Cushing syndrome	Cizza et al., 1996; Thynne, White, & Burt, 2014; Witt & Ginsberg-Fellner, 1981	Exogenous glucocorticoids	<p>Due to cross-reactivity of synthetic corticosteroids and their metabolites with immunoassays measuring plasma and urinary cortisol the study of choice is high pressure liquid chromatography tandem mass spectrometry (HPLC-MS/MS) for the analysis of plasma and urine cortisol as well as for analysis of synthetic steroids.</p> <p>Variable or suppressed urine-free cortisol levels and abnormally low/suppressed serum adrenocorticotropin /ACTH are typical findings. However, intermittent corticosteroid ingestion may present with a clinical picture of Cushing without the complete suppression of the hypothalamic-pituitary adrenal axis.</p> <p>Radiologic imaging reveals absence of pituitary microadenoma, and small/atrophic adrenal glands.</p>

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Types of Illness	References	Methods of Simulation and Induction*	Clues for Detection*
		<p><b>Methods of Simulation and Induction*</b></p> <p><i>*Any illness can be fabricated by falsely reporting medical history and symptoms</i></p>	<p><b>Clues for Detection*</b></p> <p><i>*Separation of child from caregiver or increased 1:1 monitoring may lead to abatement of signs and symptoms in many, but not all situations such as the case when a child has a true underlying illness or colludes with the perpetrator</i></p> <p><i>*Maintaining chain of evidence for tests</i></p> <p><i>*Video surveillance: see APSAC Taskforce, 2018</i></p>
Hypoglycemia	Akin et al., 2016; Giurgea et al., 2005; Hirshberg et al., 2001; Holstege & Dobmeier, 2006; Rabbone et al., 2015	Insulin, repaglinide, sulfonylureas	<p><u>Exogenous insulin</u> is associated with hypoglycemia, elevated insulin, and low c-peptide levels</p> <p><u>Surreptitious repaglinide and/or sulfonylurea</u> induced hypoglycemia accompanied by elevated insulin and elevated c-peptide levels which can mimic an insulinoma.</p> <p>Surreptitious administration progesterone along with insulin and/or sulfonylureas has been known to mimic the hirsutism and blood glucose changes characteristic of the insulin receptoropathy, Rabson-Mendenhall syndrome</p>
<b>HEAD AND NECK</b>			
Conjunctivitis	Baskin, Stein, Coats, & Paysse, 2003	Caustic agent applied to eyes	
Ear discharge (e.g., outer ear infection, otorrhea; bloody discharge )  Epistaxis	Rees et al., 2017; Zohar, Avidan, Shvili, & Laurian, 1987; Tsai et al., 2012	Trauma and/or application of caustic substances; insertion of foreign body and/or inflicting lesions to ear canal or nares; exogenous source of blood (e.g., victim, caregiver's, or other source of blood); simulation with colored substance, poisoning with anti-coagulant (e.g., warfarin/ superwarfarin)	<p>Test specimen for actual blood (e.g., vomitus, gastric aspirate, guaiac stools).</p> <p>Blood group typing (major &amp; minor), human leukocyte antigen testing, and Y chromosome staining of specimen may be used to assess for child versus other source of blood. Consider forensic tests such as DNA short tandem repeats analysis.</p> <p><u>Anticoagulant poisoning</u>: Abnormal coagulation panel compatible with vitamin K deficiency. Check serum anticoagulant level (e.g., warfarin/ superwarfarin).</p>

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Oral lesions, dental injury	Clin et al., 2009; Olczak-Kowalczyk, Wolska-Kusnierz, & Bernatowska, 2015; Tamay et al., 2007	Caustic agents, induced trauma	<p>*Separation of child from caregiver or increased monitoring with 1:1 staffing may lead to abatement of acute signs and symptoms in many, but not all cases including special circumstances if the child has a true underlying medical illness</p> <p>*Maintaining chain of evidence for tests/studies</p> <p>*Video surveillance: see APSAC Taskforce, 2018</p>
<b>MUSCULO-SKELETAL</b>			
Fractures, osteomyelitis	Libow, 1995	Inflicted trauma, contamination of wounds	
<b>MISCELLANEOUS</b>			
Mitochondrial disease	Cameron et al., 2016	Inhaled $\beta$ -2 agonist presenting with recurrent hypokalemia, supraventricular tachycardia, and lactic acidosis	<u>Toxicology</u> : Specific/selective drug assay should be sought out with consultation with a toxicologist regarding possible agents which can produce the given symptomatology.

### About the Authors

**Michael Kelly, MD**, is a board-certified general, child, and adolescent, and forensic psychiatrist. He is Clinical Assistant Professor at Stanford University, where he also serves as Director of Training for the Program in Psychiatry and the Law.

**Claudia Wang, MD, FAAP**, is Clinical Professor of Pediatrics at the David Geffen School of Medicine and Mattel Children's Hospital at UCLA. She is board-certified in pediatrics and child abuse pediatrics, and directs the UCLA Suspected Child Abuse and Neglect Team.

# Diagnostic Aid to Identify Simulation and/or Induction: Abuse by Pediatric Condition Falsification/ Caregiver-Fabricated Illness in a Child/ Medical Child Abuse

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# Investigation of Factitious Disorder Imposed on Another or Medical Child Abuse

*Michael Weber, BS*

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Since 2009, 19 cases of medical child abuse (MCA), or factitious disorder imposed on another (FDIA, as it is referred to in the DSM-V), have been investigated in Tarrant County, Texas, which includes Fort Worth. Of these, seven were filed as criminal cases with five of the defendants pleading guilty to Felony Injury to a Child, one defendant pleading guilty to misdemeanor theft by Medicare fraud, and one case pending trial. Three cases are currently under investigation by the Fort Worth Police Department. This is compared with one case in Harris (Houston) County in the last three years and no cases in Bexar (San Antonio) County (Boyd, 2015 b). The author has investigated 16 of the 19 cases, including all six cases in which a conviction was obtained, and has consulted with Fort Worth Police Department on the three pending cases. All seven of the victims in convicted cases had a feeding tube needlessly inserted into their stomachs. Of the seven offenders, three had false claims about their own cancer and three had lied about their educational or employment status to employers or friends, or both.

Many lessons and have been learned from these complicated criminal investigations and have been shared in the Texas District and County Attorneys Association journal, the Texas Prosecutor, which details some basic concepts for conducting a criminal and child protective services investigation into this subset of physical child abuse (Weber, 2014). The higher than usual number of prosecutions in Tarrant County is attributed to greater sensitivity and recognition of this pattern of abuse as the different entities of the Alliance for Children (child advocacy

center) multi-disciplinary child abuse team (Cook Children's Hospital, Texas Department of Family of and Protective Services, the Fort Worth Police Department, and a specialized investigator with the Tarrant County District Attorney's Office) worked together to learn about, and follow up on, warning signs of MCA.

It is important for prosecutors, judges, and law enforcement to understand the life-threatening potential of fabricated or exaggerated illness. Medical child abuse is significantly more than an overprotective mother worried about her child. This behavior is a conscious, planned pattern of deception that has a variety of motives (described in the guidelines by the APSAC Taskforce, 2018) that result in excessive diagnostic procedures and medical interventions on a child. Such abuse occurs because physicians are trained to rely on the medical history supplied by the primary caregiver to form a diagnosis. If a caregiver intentionally fabricates or exaggerates a medical history, even the best practitioners can come to a false diagnosis. Because the history provided by a caregiver is such an essential component of guiding diagnostic tests, medications, treatments, and surgeries, this type of abuse is easy to commit.

The conviction of Hope Ybarra is a recent high-profile case that illustrates the level of deception and challenge to investigators that medical child abuse presents (Boyd, 2015 d). Ms. Ybarra was a college-educated chemist who held a position as director of laboratories at a food-testing company. For years, Hope presented her youngest female child as having cystic fibrosis, anemia, gastric problems (prompting the placement of a gastric feeding tube), constipation, and a host of other ailments. The victim had tested

positive on multiple occasions for both *Pseudomonas aeruginosa*, a bacterial cause of pneumonia, and *Staphylococcus aureus*, commonly referred to as a staph (bacterial) infection. The Ybarra investigation, along with the cases of Lacey Spears (Roberts, 2016), Elisabeth Hunnicutt (Boyd, 2015 a), Brittany Phillips (Boyd, 2015 b), Cecilia Ransbottom (Boyd, 2015 c), and Gypsy Blanchard (McLaughlin, 2015) are used in this article to illustrate several elements of investigation and prosecution of MCA

### Evidence Collection

Fabricated illness/medical child abuse cases present atypical crime scenes that require an understanding of the depth of deception the perpetrators are capable of. Searches in hospitals, clinics, doctor's offices, as well as the home should be conducted with knowledge of potential deception. The types of evidence that investigators might find during these searches include unused or accumulated prescription medications, used syringes with residue that can be tested, and other substances that show up on toxicology screenings. When prescribed medications are found, the suspect may not have administered it to the child, knowing that she or he does not have the condition warranting the medicine, or, as in the case of Gypsy Blanchard (McLaughlin, 2015), her mother hoarded medications to overdose her daughter and induce symptoms to maintain the appearance of her disabilities. The same goes for prescribed medical devices such as a wheelchair, crutches, and breathing and suctioning equipment that may be used unnecessarily or unused. In the Lacey Spears case, after her son died of sodium poisoning, the police investigators obtained a search warrant for Spears' home. They found feeding bags hanging from an IV-type pole with whitish liquid along with a can of salt behind four or five medicines in a kitchenette table (Roberts, 2016).

### Interviews

As part of any medical child abuse investigation, the law enforcement officer should get an extensive social history from the defendant and interview possible witnesses who have contact with the defendant and victim. They may have information that medical professionals simply cannot provide. For instance, in the Ybarra case, we contacted her former employer

to ask why she had left that job. There were rumors that she presented herself falsely as a PhD, and the employer confirmed that Hope Ybarra had claimed for years that she had a PhD. However, the investigation revealed she had never received a master's degree, much less a doctorate. We also discovered that Ybarra came under investigation by this former employer for ordering pathogens not used by her employer, shortly after which the director of human resources became suddenly ill at work one day and suspected Ybarra of poisoning her water bottle (though it could not be proven through their internal investigation).

The bottle was tested and found to contain *Pseudomonas aeruginosa*, a pathogen to which Ybarra had access as director of the laboratory. The same pathogen was found inside her daughter on multiple occasions and is the cause of pneumonia that is common in cystic fibrosis patients (but not common in those who do not have the disease). Four of the nine pathogens to which Ybarra had access had appeared inside her daughter at some point during her brief 5 years of life, including *Staphylococcus aureus*. This information was vital to the investigation and was not known by the medical professionals.

Hope Ybarra's mother also turned over petri dishes labeled as pathogens (*Pseudomonas aeruginosa* and *Staphylococcus aureus*) in a plastic storage box Hope had left at her mother's house. The dishes were later identified by personnel at Hope's employer, the food-testing company, as stolen from their laboratory. A search warrant was executed at the suspect's residence in which a bottle of liquid laxative was seized; that laxative contained one of the four pathogens found inside the victim during medical testing (details follow in Boyd, 2015 d).

In the Spears case, police interviews of acquaintances and neighbors proved very helpful. One neighbor said Lacey "had asked me to go to her apartment and take the feeding bag off the stand and dispose of it." She said she obliged because she was very emotional that Lacey could be losing her child. After she was told the police had been to search Lacey's home, she had second thoughts about disposing of the bag, so she brought it home. The recovered bags were sent out for testing and showed toxic levels of sodium (Roberts, 2016).

Another important reason to interview the suspected parent early in the process is that he or she typically focuses most conversations toward the victims' medical problems. The Guidelines discuss possible reactions of the suspected perpetrator when interviewed. Often the medical history provided by a suspect during a police interview is inconsistent with medical records, incomplete, or in many cases, just blatantly false. When confronted, perpetrators may say that the doctors and nurses misunderstood what they reported. For example, a perpetrator may say "No, I told them I thought she may have cystic fibrosis, not that she does have the disease. They just wrote it down wrong." Investigators and attorneys can discredit that statement by talking to the suspect's friends and acquaintances and getting statements regarding exactly what was said about the child's condition. When these statements are compared with medical records, any inconsistencies between what is told to people outside the medical community and what is reported as part of the history to doctors and people inside the medical community provide useful evidence of deception.

Interviews and statements from friends and acquaintances regarding how the child victim acted in their presence also provide useful evidence. Ask whether the child appeared ill and ask for specific symptoms or appearance. We frequently found reliable witnesses outside the medical community who stated that the victim appeared to be healthier than the suspect had portrayed. Many will tell you that they were confused by the suspect's reports when they saw the victim in person. In the Gypsy Blanchard case, family members said they knew that Gypsy did not need her wheelchair, but they saw Gypsy get in it when her mother was around. This is important because the suspect typically portrays herself as a victim of a skeptical medical community or that she was just doing what the doctors told her to do in relation to the victim's care. Having witnesses outside the medical community who confirm the suspicions of those inside the medical community is vital to these cases.

## **Social Media**

Social media is one of the most important aspects of medical child abuse investigations. Although the motives for this type of crime may be case-specific, in the cases we investigated the offender was seeking

attention of some sort. Early in the investigation, before contacting the suspect and before he or she has a chance to remove blogs or texts, send a preservation request to every media outlet—Facebook, MySpace, Twitter, CarePages, Instagram, GoFundMe, and any other social media site—on which the suspect might have posted information about the victim's health. Follow up with search warrants for the suspect's account to obtain what the suspect has written about the health of the child. Then, search for postings, blogs, or news articles on the child. When conducting initial interviews of collateral witnesses, ask if they are social media friends with the suspect and whether the suspect posts about the child's health condition on her account. Witnesses will typically say that the suspect was posting constantly about the health of the victim; use that as an entrée to further questions and as probable cause for a search warrant for the Facebook account. Any writing by the offender about the health of the alleged victim is evidentiary in this type of criminal case. Ask if the suspect kept a blog on any other site and if the suspect was active on any medical condition support group sites. These sites should be preserved before the first interview of the offender by either child services or police to ensure the offender does not destroy this evidence.

This approach proved useful in the investigation of Elisabeth Hunnicutt (Boyd, 2015 b), a mother of two who had presented her children as ill for years. The youngest child received the majority of the medical abuse. Hunnicutt regularly posted online that the youngest had four diagnosed serious conditions, including hydrocephalus, agenesis of the corpus callosum, cerebral atrophy, and cerebral palsy. Hunnicutt posted the victim had hydrocephalus on a social media site three weeks after the victim had an invasive medical procedure (brain monitor placement), after which she was explicitly told that the victim did not have hydrocephalus. Two of the other ailments she claimed in this social media post were also false, and she had been told by many doctors and specialists that the victim did not have these disorders on multiple occasions.

Hunnicutt would message friends about the health of her child, again presenting the same four false medical diagnoses (that had never been diagnosed by medical

professionals) to those specific friends. Hunnicutt's messages were interesting because she presented the victim differently to those who were only friends through Facebook and had no contact with the victim. To these people, Hunnicutt would present the child with life-threatening or terminal conditions, telling one online friend that the victim "could die at any time." Meanwhile, to friends who saw the victim in person on a regular basis, Hunnicutt presented a much less dire picture of the victim's diagnoses. This demonstrates intentional deception undertaken on the part of offenders when they present differently to friends, family, and treating physicians.

Elisabeth was discovered placing the older child's clonidine pill in the victim's yogurt by the paternal grandmother, who told the father of the victim that evening. The father confronted Elisabeth, who admitted dosing the victim with the clonidine, a powerful sedative. It then dawned on the father what had been occurring, that Elisabeth had been dosing the victim with clonidine and then taking the victim to the neurologist appointment to present the victim as having symptoms of hydrocephalus.

The father immediately took the victim and the sibling into a back bedroom, locked the door, and called the police in an attempt to report the abuse. When the police showed up, the father tried to explain what had occurred, but had no idea what medical child abuse was, much less how to articulate the abuse that had occurred. The police allowed Elisabeth, an attractive woman with no criminal history, to check herself into the county psychological ward. The responding officers did not file an offense report.

The father fought for a full year to get a criminal case filed against Elisabeth. The case was filed with the Tarrant County DA's Office as an accidental overdose, even though there was an affidavit from the neurologist diagnosing Munchausen by Proxy. The father spent approximately \$65,000 in an attempt to terminate Elisabeth's rights, which happened only after she pled guilty to abusing the victim in criminal courts in California (where she had an unneeded feeding tube surgically placed in the victim's stomach) and in Tarrant County.

Typically, offenders will take their children to a doctor, have a test for a certain disease, be told the test is

negative, and then days later take the child to another doctor and give a history of the child having that very ailment. An example of this occurred in the case of Brittany Phillips (Boyd, 2015 b), who presented the victim as ill for years. Phillips had the victim tested for cystic fibrosis in Texas and the tests were negative. This didn't stop Phillips from transporting her daughter to another state and giving a medical history of her daughter having cystic fibrosis to doctors in that state. Brittany also lied about a sleep study, telling early childhood intervention professionals that the victim was positive for sleep apnea when the victim had not shown any signs of apnea during the sleep study earlier that week. Brittany had also falsely presented the victim as ill in order to obtain a feeding tube for the victim. Medical child abuse was reported to CPS four times in Texas without any action being taken.

A full year and several unneeded medical procedures after the CPS case was closed, an emergency room doctor at Cook Children's Hospital was finally able to obtain action when the victim had a highly suspicious polymicrobial blood infection occur during hospitalization. As a result of a diligent police investigation, an examination of Brittany's laptop that she had in the hospital revealed that she had googled an article about another offender who had poisoned her daughter by placing feces in her child's IV line. Brittany's computer evidence also revealed that she had googled terms such as "poop in feeding tube," "pee in veins," and "pee in blood" while in the hospital room with the victim.

Approximately 28 hours after googling these terms, the victim became ill with a polymicrobial blood infection, multiple organisms in the blood. The organisms were E coli, staphylococcus aureus, and strep viridans, three organisms that should not have been in the victim's blood. The infectious disease specialist physician wrote an affidavit stating that was the first time he had seen these three organisms in a blood culture in his 14 years of infectious disease practice.

Obtaining the computer history was the key piece in filing charges against Phillips for inducing a blood infection in her daughter. Obtaining the computing devices is essential to the law enforcement investigation in these cases (see guidelines). Phillips

posted that her child had been to Cook Children's Hospital for blood sugar issues. There were no medical records for the victim at Cook Children's for the date claimed by Phillips, evidence that Phillips had falsified the visit. Phillips also posted pictures of the victim's surgical sites immediately after surgery and had albums of photographs for each hospital visit.

After a hung jury (11-1 for guilty) in her trial, Phillips pleaded guilty and accepted a 5-year prison term. Phillips also forfeited parental rights before the criminal trial took place. The protective foster parent spent over \$20,000 in attorney and civil court fees before Phillips forfeited her rights, even though Phillips did not have the financial means for a long-drawn-out civil court battle.

### **Atypical Presentation**

These offenders rarely have criminal histories and appear to be loving, caring mothers to friends and even close family members. This atypical presentation compounded with the finding that offenders are extremely manipulative and often skilled at deception makes it understandable that a family or juvenile court judge, guardian ad litem (GAL), or even a prosecutor without knowledge of this form of abuse could be deceived by an offender. This has happened and will continue to happen without further education and training on this topic. For example, parents persuaded a judge who had removed a child for MCA to return their child. According to prosecutors, within two years, "either one or both of her parents poured a caustic substance into her cecostomy tube, a medical tube used to flush her intestines. She became critically ill and lost two-thirds of her bowel and part of her bladder." (Everett, 2016).

Another example is Pamela Sue Austin (Austin v. State, 2007). The family court judge returned the older victim to Austin despite the objections of a court appointed psychologist and the child protective service attorney. Austin was suspected of injecting something into the older child's IV line during a hospital stay. That older child died a short time after the return to Austin. Austin was later found to have injected her younger child with insulin in order to induce a hypoglycemic episode. The older child's body was exhumed, and an injection site was found on the body.

The coroner changed the ruling on the older child's death from natural causes to homicide.

It is extremely important for the juvenile or family court to listen to all the witnesses and not believe the convincing presentation of the possible offender due to appearance, social status, character witnesses, or offender's legal counsel. Only the evidence should be given weight.

Proper hearings will be time consuming (multiple days) and should never be shortened for expedience. In an unfortunate example, a judge told a medical expert witness, "I know all about Munchausen by proxy" and was then observed by that witness googling the term while the witness testified. These are alarming examples of the issues in cases of convincing fabricators, and the outcome of poorly conducted hearings is a failure to protect the victim.

### **Separation Evidence**

Criminal investigations into this form of abuse are time consuming and take months to complete. One of the most important aspects of the criminal investigation is having a separation period between the offender and the victim. This allows observation of the victim to occur outside the control of the possible offender. If this is a case of medical child abuse, falsified conditions in the victim will improve very rapidly outside the care of the offender, although other psychological conditions (such as eating disorders) in the victim may be present as a consequence of the abuse. In the Hunnicutt and Phillips cases, the victims were weaned off all medication, eating solely by mouth with no gastrointestinal issues, and gained weight within two weeks after separation from the offender. Problems arise when the victim is placed with a family member who believes the offender is innocent or if the offender is allowed anything other than professionally supervised, extremely short-term visitation at CPS offices with the victim.

### **Issues With Visitation**

If CPS removes the victim from the offender, a hearing may occur very quickly with the offender demanding the return of the child. At this point, the police investigation, if there is one, will have just

begun. Police and CPS will be at the very beginning of a long process that will take months to properly complete. The victim will be in the initial stages of separation from the offender and just beginning his or her recovery. Allowing any form of visitation during this time period is not recommended. If visitation is permitted, it should be supervised only by a person knowledgeable of this type of abuse.

The Phillips case (Boyd, 2015 b) illustrates the rationale for not allowing the abusive parent to give any gifts, food, or items to the child during supervised visitation. Ms. Phillips was allowed to give the victim a backpack filled with items at a supervised visitation at the CPS offices. The foster parent (a nurse practitioner) had driven only one block away after the visit and had to stop the car because of the overpowering scent of cologne. The foster parent had to drive with the windows down the rest of the way home. Upon arrival home, the foster parent was able to pinpoint the smell as coming from the backpack. Phillips had doused the backpack in cologne in an attempt to elicit an allergic reaction from the victim. Phillips had also packed the movie *Tangled* in the backpack for the victim to watch. *Tangled* is a children's movie about a child kidnapped from her mother and contains a song that repeats the line, "Mommy knows best." The foster parent did not allow the victim to view the movie. The victim was 4 years old at the time this occurred.

This form of abuse not only includes physical abuse but psychological and emotional abuse and control as well (Schreier & Bursch, 2018). There are many other examples of the offending parent tampering with snacks and drinks or otherwise surreptitiously harming the child during supervised visitation. As outlined in the Guidelines, the offender should not be allowed to bring anything into the visitation room, to feed the victim, or take the victim to the bathroom. The supervising professional should be extremely attentive to the interactions between the offender and victim, both physically and verbally, and should document these interactions. Visitation in general is not recommended during the investigation (see Guidelines). Even with supervised visitation, offenders often escalate their behavior to induce illness once separated, in order to prove the victim is ill outside of the offender's care. They are highly motivated to prove

to child protective services, the criminal, and/or civil court that the symptoms continue when separated, so are even more surreptitious.

The Gypsy Blanchard case (McLaughlin, 2015) demonstrates a large psychological control element to this form of abuse. If children are told they are sick by a primary caregiver, they will believe they are sick. In the Buzard case (Hayes-Freeland, 2014), the child was placed with a family member who believed the mother and continued to treat the child as sick, presenting her with the same fabricated history provided by the offender. Even more dangerous is a caregiver who allows the offender access to the child. Placing the child with a family member who believes the offender is innocent is harmful to the victim and the criminal case and could slow or stop the recovery of the victim.

Bools, Neale, and Meadow (1993) looked at 54 previous victims of medical child abuse. Thirty had been returned to the offender after the initial report, 10 of the 30 were found to have suffered additional abuse through unneeded medical intervention, and eight were presented at specialty clinics with symptoms reported by the offender but not seen by medical staff. The risk for future abuse is evident in this study.

### Psychological Evaluation

Sanders and Bursch (2002) found that psychological testing and interviewing of the suspected perpetrator may not indicate any psychopathy and were not reliable diagnostic tools. There is not an effective psychological "test" for medical child abuse, although 89% of offenders in one study were found to have a personality disorder (Bools, Neale & Meadows, 1993). These offenders are comfortable lying to doctors, family members, and psychiatric evaluators. The proper diagnostic tool for medical child abuse is evidence based (see APSAC Taskforce, 2018).

### Not Diminished Capacity

Often, the crime is so unbelievable that judges and juries tend to think the person has to be mentally ill to engage in this behavior. The criminal legal standard for insanity in Texas is whether the offender knew right from wrong. A review of liability for factitious

disorders (Yorker, 1998) found that some defendants have tried to use their Munchausen disorder as a defense in cases of MBP; however, in general, the courts are reluctant to consider deliberate falsification a mental illness. The planning, manipulation, and changing of stories by these offenders is a strong indication that they do know right from wrong. Hope Ybarra (Boyd, 2015 d) illustrated in her multiple interviews before and after incarceration that she knew right from wrong. She illustrated this during the investigative interview by first lying about her conduct before changing her story to make admissions without ever giving a full account of abuse. Lying for self-preservation is a strong indication of knowing consequences for one's bad behavior. This is a pattern seen in many child abuse suspect interviews by experienced investigators and is by no means unique to medical child abuse. After several years of incarceration in prison, Hope granted an interview with a reporter, where, facing no further consequences, she made additional admissions and admitted that she has a problem telling the truth on simple matters.

The investigative interview with Cecilia Ransbottom (Boyd, 2015 c) also illustrates how an offender will lie and then change the story to fit the facts presented. On top of presenting her child as ill, Ransbottom had also presented herself as having cancer. In the investigative interview, Ransbottom gave a history of a certain type of cancer. When told that investigators would check her personal medical records to see if she had been diagnosed with cancer, Ransbottom then changed her story and said that she had human papillomavirus (HPV), and was in a pre-cancerous stage. This was in

direct conflict with what she had said just moments earlier and to friends and family for years, including having family care for the child while she supposedly went to chemotherapy treatments. This illustrates how suspected perpetrators will adjust their statements when presented with facts. This type of contradiction demonstrates the mental state of these parents to avoid consequences and provides strong indication that they know right from wrong.

## Conclusion

This is often a confusing and misunderstood form of child abuse that investigators should be aware of. This article is intended to provide guidance to law enforcement, prosecutors, and healthcare providers regarding the atypical presentation of fabricated illness, difficulties with evidence collection, and the importance of a team approach. Social media and computer evidence have been instrumental in several successful prosecutions. The APSAC Taskforce on MBP/FDIA/MCA has worked diligently to provide guidelines for all disciplines that encounter fabrication or exaggeration of a child's condition, fraud, and this type of child abuse.

## About the Author

*Michael Weber, BS, is Investigator with the District Attorney in Tarrant County, Texas. He has 33 years of experience as a police officer, including 11 years as a crimes against children investigator. He received the National Center for Missing and Exploited Children's 2016 Texas Hero for Children Award and has investigated 16 cases of Medical Child Abuse.*



# Investigation of Factitious Disorder Imposed on Another or Medical Child Abuse

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# Munchausen by Proxy in Educational and Mental Health Settings

*Herbert A. Schreier, MD*  
*Brenda Bursch, PhD*

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 services 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.**

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## Munchausen by Proxy in Educational and Mental Health Settings

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.

### About the Authors

**Herb Schreier, MD**, is Clinical Professor of Child Psychiatry at UCSF Benioff Children's Hospital Oakland. He has published and lectured in the United States and abroad on Munchausen by proxy (MBP) and gender variant children. He co-wrote a seminal book on MBP titled *Hurting for Love*.

**Brenda Bursch, PhD**, is Professor of Psychiatry & Biobehavioral Sciences and Pediatrics at the David Geffen School of Medicine at UCLA. Practicing as an expert, consultant, and clinician on Munchausen by proxy since 1994, she served as Invited Advisor on Factitious Disorders for the American Psychiatric Association DSM-5.



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

*Mary J. Sanders, PhD*

*Catherine C. Ayoub, RN, EdD*

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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.**

<p>Belief</p> <ul style="list-style-type: none"> <li>• How did you learn about the abuse allegations?</li> <li>• What do you understand happened to the child?</li> <li>• What aspects of the allegations ring true to you and why?</li> <li>• What aspects of the allegations do not ring true to you and why?</li> <li>• What has the alleged abuser told you about what happened?</li> <li>• What aspects of what s/he told you ring true and why?</li> <li>• What aspects of what s/he told you do not ring true and why?</li> <li>• What has the child told you about what happened?</li> <li>• What aspects of what s/he told you ring true and why?</li> <li>• What aspects of what s/he told you do not ring true and why?</li> <li>• Are there other domains in which the suspected abuser is deceptive?</li> <li>• What type of information do you think would be helpful to understand the allegations more fully?</li> <li>•</li> </ul> <p>Protection</p> <ul style="list-style-type: none"> <li>• Do you believe the alleged abuser could harm the child in the future? If so, why? If not, why?</li> <li>• How might the alleged abuser harm the child in the future?</li> <li>• If you have other children, do you believe they may be at risk of harm? If so, why? If not, why?</li> <li>• What safeguards do you feel need to be put into place to protect the child(ren) from possible future harm?</li> <li>• Do you believe that other family members (e.g., grandparents, etc.) will honor your safeguards? If so, why? If not, why?</li> </ul>
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**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.

## About the Authors

**Mary J. Sanders, PhD**, is Clinical Associate Professor at Stanford University Medical School in the Division of Child Psychiatry. She is Program Director of the Comprehensive Care Inpatient Unit at Stanford. She has published and presented nationally in the areas of child abuse, Munchausen by proxy, and eating disorders.

**Cathy Ayoub, EdD, MN, RN**, is a psychologist and nurse practitioner, and is Associate Professor at Harvard Medical School with a clinical practice at Massachusetts General Hospital. She provides assessment and testimony to courts across the United States and Latin America on issues of child maltreatment, victimization, parenting, and the impact of trauma.

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

*Brenda Bursch, PhD*

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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	<ul style="list-style-type: none"> <li>• Threatening or intimidating foster families.</li> <li>• Attempting to communicate with child.</li> <li>• Watching child from car.</li> <li>• Attempting to establish friendly relationships with members of the foster family.</li> </ul>
Monitored Visits	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Reciting prayers with message to not trust anyone but family members.</li> <li>• 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.</li> <li>• Poisoning the child via food, beverages, medicines, toys, injections, central lines, feeding tubes, or lotions.</li> <li>• 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.</li> <li>• Attempting to establish friendly relationships with visitation monitors.</li> </ul>
School	<ul style="list-style-type: none"> <li>• Advocating for unwarranted accommodations.</li> <li>• Watching child on playground from car.</li> <li>• Attempting to establish friendly relationships with school officials who have access to the child.</li> </ul>
Health Practitioners	<ul style="list-style-type: none"> <li>• Providing false history and symptom/disability reports.</li> <li>• Advocating for unneeded assessments, accommodations, and/or treatments.</li> <li>• Attempting to establish friendly relationships with physicians, therapists, and other health professionals treating the child.</li> </ul>
Court	<ul style="list-style-type: none"> <li>• Requesting increased contact with and control over the child, using any and all available arguments.</li> <li>• 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.</li> <li>• Using the Internet to communicate with the child, solicit community advocacy, raise money, complain about the court proceedings, disparage everyone associated with the case.</li> <li>• 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.</li> </ul>

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 diary 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 dissension 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	<b>Acknowledgement:</b> 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	<b>Coping:</b> 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	<b>Empathy:</b> 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	<b>Parenting:</b> The development of effective parenting skills is extremely important. This includes placing the needs of the child before those of the abuser.
T	<b>Taking charge:</b> 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	<b>Support:</b> 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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## About the Author

**Brenda Bursch, PhD**, is Professor of Psychiatry & Biobehavioral Sciences and Pediatrics at the David Geffen School of Medicine at UCLA. Practicing as an expert, consultant, and clinician on Munchausen by proxy since 1994, she served as Invited Advisor on Factitious Disorders for the American Psychiatric Association DSM-5.

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# The Influence of Electronic and Internet Advances on Munchausen by Proxy

*Debra Esernio-Jenssen, MD*

*Randell Alexander, MD, PhD*

*Kenneth Feldman, MD*

*Beatrice Yorker, JD, RN, MS*

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The purpose of this article is to describe how electronic and Internet advances have impacted both fabricators as well as the professionals who identify, treat, and study illness fabrication. Technologies available through the Internet that have influenced MBP include medical websites, social media, blogs, chat rooms, online consumer satisfaction surveys, and electronic medical records. All of these have influenced the presentations, evaluations, and interventions in cases of MBP. On the negative side, abusers have increased access to medical information that aids them in their deceptions, and electronic consumer ratings may deter healthcare providers from appropriate interventions. On the positive side, Internet activities, including searches, texts, and posts by an abuser, can be monitored for evidence of abuse, deception, and motive. This article examines the role that increasing access to searchable medical information plays on the ability to fabricate or induce illness, the influence social media has on those who fabricate illness, the evidence of abuse that these technologies can provide, and the potential for electronic medical records to aid in detection. It also discusses the backlash that is occurring via the Internet as well as innovative research using online discussion data.

## Internet Search Engines and Medical Websites

The advent of WebMD and related medical websites have made accessing detailed diagnostic and treatment options for hundreds of diseases, conditions, and disorders much easier than in the past. Early observations noted that people with fabricated illness as well as many perpetrators of MBP were either in the healthcare field or spent much time studying medical texts, typically requiring access to a library or professional education. Some gained significant familiarity with medical issues and language during hospital stays for prior illnesses in themselves or their children. Currently, however, anyone with access to the Internet can obtain a wealth of detailed medical information.

MBP abusers can now much more easily present their victims to medical professionals with a differential diagnosis, battery of desired tests and procedures, and requests for specific treatments. Following are additional examples of escalating behaviors in which a parent can use the Internet to perpetuate MBP:

1. *Fabrication to friends and family:* This consists of telling neighbors, friends, relatives, and unknown others on a social media platform (such as Facebook.com or CarePages.com) that a child has a medical, behavioral, developmental, or psychiatric condition that is not true.

2. *Fabrication with fundraising:* In the previous example, the abuser may additionally set up a GoFundMe.com or other fundraising account to obtain financial or other rewards.
3. *Fabrication to clinicians:* Abusers can learn how to convincingly present a coherent clinical history, increasing the chances that the unsuspecting clinician will believe the false story. An example is learning the potential signs and symptoms of autism (such as delayed speech acquisition, restricted interests, impaired reciprocal social communication, and repetitive patterns of behavior) so that the abuser can successfully lead the clinician to this diagnostic hypothesis.
4. *Simulating:* Abusers have downloaded clinical reports and medical scans to deceptively present to clinicians as belonging to the victim. An example includes a scan of a tumor or lab results suggesting the victim has a mitochondrial disorder.
5. *Induction:* Abusers have used the Internet to determine the most effective ways to induce signs or symptoms in their victims. An example of this is an abuser who underfeeds a victim to cause slowed motility, dehydration, and cachexia. The abuser may already have the goal of obtaining a feeding tube for the victim. Another example is an abuser who learns to induce an infection or vomiting. Weber (2018) shares examples of Internet searches such as “poop in veins” or the effects of specific medications that have been administered by mothers immediately prior to their children being treated for life-threatening conditions.

### Chat Rooms, Blogs, and Support Groups

Online chat rooms; websites for specific, rare, and complex diseases; and virtual support groups for parents of children with a variety of conditions can impart helpful information and comfort for patients and their families. However, MBP abusers have exploited them in a variety of ways. Feldman (2000) first described four cases in which individuals misused these groups by offering false stories of personal illness or crisis for reasons, such as garnering attention, mobilizing sympathy, acting out anger, or controlling others. He termed this activity Munchausen by Internet (MBI).

As an example, a woman with a long history of MBP behaviors joined a website that provided information and support for those seeking to adopt children. In this case, the MBP abuser solicited prospective parents to adopt her son, who was to be born in several months. She stated that she had previously adopted out one child and that her daughter had a severe disorder requiring her full attention. To be fair to her daughter, she indicated, she was seeking adoption for her unborn son. When the birth date arrived, she posted that the prospective adoptive parents had backed out, so she decided to parent her son herself. (In truth, she had found prospective adoptive parents via another source who had become very involved in her life, only to be disappointed after the birth of the boy when she declined to sign the adoption papers.)

Receiving much support from concerned individuals on the adoption website, this woman remained on the site by posting the many life-threatening medical events that her son experienced starting shortly after birth. (In truth, he was repeatedly hospitalized for falsified illnesses. The information she posted suggested a life-threatening situation rather than being an accurate portrayal of benign findings while her son was hospitalized.) Eventually, she was discovered by one of her supporters to be posting discrepant medical information about her son on another adoption site and was confronted online. Her response was to attempt to explain both sets of postings with a convoluted story and perhaps to solicit support from others on the site. She said that she had become a surrogate in order to “give joy to other couples.”

### Use of Social Media as Evidence

As suggested, social media can be used to provide evidence of illness falsification. When investigating cases of suspected APCF/CFIC/MCA, the more quickly that law enforcement can lock down and preserve accounts such as Facebook, Instagram, and other social media, the less time a suspected perpetrator has to remove them (Weber, 2018). Posts obtained from these sites often contain contradictions, blatantly false diagnoses, and extremely invasive photographs of children. Searches may include cell phones, computers, and other electronic devices,

looking for search histories and themes. Computer forensics may be able to recover such information even if a suspected perpetrator erases posts and texts.

Brown, Gonzalez, Wiester, Kelly, and Feldman (2014) described three children who presented with chronic, complex medical conditions that were ultimately diagnosed with APCF/CFIC/MCA. The diagnoses were made through chart review and separation of the children from their perpetrator, their mother. Once the mothers were excluded from the hospital, all three victims clinically improved and their symptoms decreased significantly. Protective services subsequently removed the children. In each case, the mother maintained a blog documenting her child's illness and hospitalizations.

Brown and colleagues (2014) described blog characteristics that were clues to the diagnosis. In addition, they described common blog themes: distortion patterns, escalation patterns, attention patterns, exposure of the children to public viewing, fundraising and charity, and attitudes toward medical providers. The mothers distorted their child's illness through exaggeration, misrepresentation, and frank deception of the child's symptoms. They reported that their child suffered from illnesses that were already medically excluded. Even though medical providers clearly informed the mothers that their child was not dying, all mothers represented their child's medical condition to being critically ill or nearing death. Mothers received attention from their online followers when describing the difficulties in caring for a sick child. All of the blogs exposed the children through posted images that sometimes depicted graphic images of medical interventions. This was especially concerning since children cannot assent or consent to such exposure. The authors termed this "medical porn"—showing one's child receiving invasive treatments in partial undress, when under any other circumstances, such photos would be considered child abuse. Two mothers reached out to charitable "wish" foundations, and others sought fundraising by establishing online donation sites. Finally, the mothers' posts displayed negative attitudes toward their children's medical providers. They often blogged that the physicians were incompetent and therefore would refuse to follow their recommendations.

They portrayed themselves as the medical experts, as being truly protective of their children with rare, undiagnosed disorders (Brown et al., 2014).

If the themes described here are discovered in the social media accounts of a suspected abuser, concern for MBP abuse and neglect should be heightened. However, it is important to note that parents of genuinely ill children, those who are well meaning and not abusive, also may share excessive or inaccurate medical information and inappropriate photos of their children, may disparage clinicians online, and may engage in fundraising. Thus, the assessment guidelines should be followed for proper diagnosis (APSAC Taskforce, 2018). Interested readers are referred to Box 1 for two recent case studies.

## **Impact of Online and Paper Clinician Rating Systems on MBP**

The goals of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a formal public rating of physicians and hospitals regarding a patient's hospital stay, are designed to allow objective and meaningful comparisons of hospitals on topics that are important to patients and consumers. This also helps create new incentives for hospitals to improve quality of care and enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment.

An unfortunate, unintended consequence of HCAHPS implementation may be that it rewards providers for acquiescing to patients' and parents' demands, even if it means excessive treatment. Although consumer ratings have many advantages, there are some instances in which they adversely influence appropriate medical care. A recent study, involving mostly emergency room physicians, revealed that 48% felt pressure to obtain better patient satisfaction scores. This pressure promoted inappropriate care, which included unnecessary antibiotic and opioid prescriptions, tests, procedures, and hospital admissions (Zgierska, Rabago, & Miller, 2014). Some healthcare agencies and physicians feel pressured

## **Box 1. Case Studies Involving Social Media.**

**Case 1.** A 5-month-old male with mild gastroesophageal reflux was admitted for the third time since birth—twice for a BRUE (brief resolved unexplained event) and then for “intractable” vomiting. He had three prior emergency department visits for serious symptoms, such as gasping episodes, turning blue, and difficulty breathing, reported by his mother but not corroborated by medical providers. All of his physical examinations were documented as normal. He was well appearing, afebrile, and occasionally having nasal congestion. His mother reported that he suffered from Hepatitis C and cystic fibrosis (both were fabrications). He received multiple intravenous line placements, chest x-rays, and blood work, all of which were normal. On the last admission, his mother made him a “Do Not Announce,” so no one could know where or why he was admitted. In the reception area outside the pediatric unit, a medical professional overheard the mother telling family members, “Doctors are telling me he’s terminal. I have to decide whether to pull the plug.”

A child protective services investigation ensued when this behavior was reported. This investigation revealed that the infant lived with his mother, but had frequent contact with his father and paternal grandmother. The mother had informed them that the infant suffered from terminal heart and lung disease. In addition, they discovered Facebook postings of images of the infant at different ages with a nasal cannula. She also described her difficulties coping with a sick infant. The father informed CPS that he had seen the mother administer oxygen via nasal cannula (never prescribed) and was instructed by the mother to administer albuterol via nebulizer every 20 minutes (never prescribed). The infant was voluntarily placed by his mother and subsequently thrived. Similar to Brown’s cases, this mother distorted, escalated, received attention, and exposed her infant through deceptive images via blogging. To maintain her ruse, she also inflicted unnecessary, and potentially traumatizing and/or harmful, medical treatments onto her child.

**Case 2.** This case involved two sisters, the eldest was 11 years old with at least 12 diagnoses, including Ehler Danlos syndrome, gastroparesis, and dysautonomia. She had 10 emergency department visits for dehydration, was evaluated at three different institutions and underwent extensive laboratory and radiologic investigations. She was wheelchair confined and slept in a hospital bed in her home. She recently was granted her “wish” for a shopping spree as her mother informed the foundation that her daughter was terminally ill and had less than six months to live.

Her mother invited all of her physicians to join a fund website page in her daughter’s name. There were multiple postings of her daughter in various emergency rooms attached to machines and intravenous lines. There were numerous followers sympathetic to the mother’s plight and her daughter’s intractable illnesses. The family had raised more than \$30,000. During the last admission for “dehydration,” her mother posted that her daughter was being transferred to an outside hospital for insertion of a central line. The multidisciplinary child protective team was consulted when the admitting team discovered this post.

The second sister was 8 years old with at least six diagnoses, including Ehler Danlos syndrome, chronic tonsillitis, and otitis media, for which she underwent adenoidectomy, tonsillectomy, and tube placement (despite no chronic effusion or hearing loss). She had multiple emergency department visits for varying ailments and had been evaluated with numerous medical tests at three different institutions. Her mother had applied to a foundation for a “wish” and had recently set up a fund page for her. Her fund page had recent images of the child walking with a cane.

In view of the fabricated blog, CPS became involved and the mother was excluded from the hospital. Both sisters had normal physical and neurologic examinations. Two hours after their mother left the hospital the sisters were dancing with their nurse. They remained in the hospital until they could be weaned off all their prescribed medication for their various diagnoses. They were placed in foster care and remained asymptomatic. They were reunited approximately six months later after their mother agreed and complied with all court ordered stipulations: admitting guilt, no longer having any medical decision making, undergoing mental health assessment, and participating in family therapy. The mother may still face criminal fraud charges based on her fundraising efforts and her obtaining “wish” awards for her daughters.

to comply with a caregiver's recommendations or agree to requests for referrals to specialists because they perceive that even a single poor "grade" would have dire consequences and that multiple negative survey responses could impact their standing in the community and even reimbursement rates. Reliance on consumer input may be deterring providers from curtailing excessive healthcare-seeking behavior or from considering illness fabrication, regardless of the cost and harm such behaviors cause.

## Electronic Health Records

There are advantages and disadvantages associated with the increased use of electronic medical records (EMR). Electronic records have improved readability as notes are now typed. Additionally, if participating in a program that allows the clinician to access records from other institutions, the evaluator may more quickly identify high-healthcare utilization, episodes of deception, discrepancies, and lack of continuity of care. However, current patient privacy regulations and EMRs that fail to speak to each other frustrate the goal of understanding past histories. EMR systems can display discrete flags that notify health users of possible concern, but not all systems or providers have adopted this practice. Pharmacy and insurance records can now potentially be tracked more easily. Theoretically, an insurance company could set up a proactive way to look at high utilizers of care to determine if their healthcare utilization makes sense or if further investigation is warranted. However, even if it is possible to obtain all past medical records, analysis of the records is often daunting as many MBP victims have extremely high numbers of healthcare contacts. Also, if providers "cut and paste" information from other providers into their notes, this promulgates unreliable histories or other false information (Squires & Squires, 2010).

Likewise, many EMRs utilize pre-checked information boxes, which must be actively unchecked if not applicable. Thus, it can be difficult to be sure that those checked boxes reflect true clinical observations, and it is sometimes difficult to ascertain who checked or unchecked a box (who saw or did not see a particular symptom or behavior). EMR reports are often lengthy and present all data with equal

weight, making it difficult to sift through them for significant information. Because they also import past information into current notes, it is difficult to identify what is new information or observations. In addition, physicians may be reluctant to document problematic parental behaviors if they think that the caregiver might read the record. Finally, EMRs do not interact with child protective services (CPS) records, with schools, or with all other medical centers.

## Backlash

### In the Press

In September 2002, a *Seattle Post Intelligencer* front-page article alleged that a series of families were being persecuted by MBP diagnoses. A more nuanced article in *People Magazine* followed later that year. In December 2013 (Kreiter), with an update in 2016 (Levenson), the *Boston Globe* published a series of articles raising questions about the diagnosis of medical child abuse, and more recently in July 2015, the *New York Times* published an article by Eichner, who wrote that this potentially fatal form of child abuse has been vastly overused and is a vehicle for physicians to retaliate against parents when parents disagree with them. She stated,

As I've researched medical child abuse over the past year, several advocacy and support groups for patients with rare diseases told me they had seen an alarming rise in medical child abuse charges: MitoAction (which supports patients with mito); the American Partnership for Eosinophilic Disorders (disorders relating to white blood cells); the Ehlers-Danlos National Foundation (a rare disorder of the connective tissues); and Dysautonomia International (autonomic nervous system disorders). Through these groups, I've surveyed 95 parents who have been accused, in 30 states.

Such articles in high-profile publications escalate alarm on the part of parents of children with genuine illness and fuel support for abusers. The *New York Times'* (2015) article initially failed to mention the central feature of MBP, which is a demonstrated pattern of deception, or to obtain collateral confirmatory data, given the need to counter

the expected deception among true MBP abusers. The author also erroneously asserted that lack of a diagnosis in a child with physical or psychiatric symptoms places that child at a significant risk for being reported to CPS. In fact, it is relatively common for children to have unclear diagnoses and extremely uncommon for suspected MBP to be reported to CPS. Rather, like all other forms of child abuse and neglect, MCA/MBP is more likely to be underreported. Common with all these articles, confidentiality laws prevented clinicians from discussing the true reasons for concern and referrals to CPS.

### Via Social Media Sites

In addition to the uses we have described, social media provides an opportunity for individuals to organize and advocate for caregivers who are being investigated or charged with this type of child abuse. Small groups of parents who have been suspected of MBP have utilized social media to coordinate and mobilize their efforts to lobby against those who assess, report, and manage families impacted by this form of abuse. One such website is sponsored by M.A.M.A. (Mother's against Munchausen Syndrome by Proxy Allegations (MSBP), [www.msbp.com](http://www.msbp.com)). Their mission "is to stop the assault on innocent parents from MSBP allegations and to reveal the ulterior motives of the accusers." Their membership includes individuals who report that they are falsely accused and who work diligently to educate others on situations in which there is a risk of misdiagnosis (Patrick, 1997). The truth of the cases cannot be determined by a website synopsis alone, but it includes parents who are believed to have abused or neglected their children via MBP. These individuals are encouraged to file lawsuits against clinicians and hospitals for incompetence, malpractice, and slander (McCulloch & Feldman, 2011). A similar site is at [MedicalKidnap.com](http://MedicalKidnap.com) (part of the Health Impact News network), which devotes itself to a variety of instances in which children are "taken away from their families for simply disagreeing with their doctors" (Mora-Kent, 2017). Facebook has been used to rally protesters to appear at court hearings, outside hospitals, and at professional board reviews of complaints filed against professionals. YouTube has been used to post videos of court hearings, protests, police encounters, hospitalizations, and other related events. At this time, false and personal information about involved

professionals may be posted online with relative immunity.

One blog (Luttner, 2015), titled "On Shaken Baby," posted an article in response to Brown and colleagues' (2014) caregiver blog article:

I fear that we are now facing a wave of inaccurate "medical child abuse" diagnoses—... Like shaken baby syndrome, the diagnosis of medical abuse rests on the subjective opinion of the child abuse experts, and it includes the assumption that the child's caretakers are lying, a combination that makes me very nervous. I'm not saying that medical child abuse doesn't happen, only that it's treacherous territory. Most disturbingly, the diagnosis, like shaken baby, is another opportunity for the families of children with rare or poorly understood medical conditions to be wrongfully accused of abuse. (3rd para. from end)

### Online Discussions As Data

Lawler and Kirakowski (2014) conducted a qualitative study of communications posted by individuals who self-identified as suffering from factitious disorder or Munchausen syndrome, gathered from two moderated online mental health support communities. One-hundred twenty-four posts by 57 members amounting to approximately 38,000 words were analyzed using grounded theory. Their analysis revealed that the motivation to induce or fabricate illness was conscious, and that fabricated illnesses met a variety of needs and were both long-term and episodic. Many of the individuals indicated that specific triggers preceded their fabrication, including stressors in their lives or circumstances they wanted to avoid. Over half of the writers described their illness fabrication as similar to an addiction, with the following feelings and behaviors that are consistent with the literature on addiction: shame; going to great lengths to avoid detection; the need to enact fabrication as stronger than the desire to stop; an overwhelming, uncontrollable compulsion to enact; and a cyclical nature to their behavior (p. 213). While this study was conducted on individuals who fabricated illness in themselves, some insights

can extend to those who fabricate illness in another, specifically their child. Bools, Neale, and Meadow (1994) found that 72% of mothers who had induced illness in their children had a history of their own FD. Theories of FDIA perpetrator motivation (Feldman, 2004) are consistent with the motives revealed by these narratives, such as triggering events, the compulsive nature of illness fabrication, the lengths to avoid detection, and the shame associated with the behavior. This study also illustrates how online chat rooms and communications written in a blog or forum provide large sources of narrative data that can be captured for qualitative analysis.

### **Victim Perspectives**

Anderson, Feldman, and Bryce (2017) studied the narratives from 356 posts written by 348 members of an online discussion following a 2007 Dr. Phil show on medical child abuse. The researchers analyzed 37 self-reported cases of being a victim of MCA, nine of which were reports from family members or survivors of situations in which a mother had been formally documented as having engaged in MCA. The data supported the literature regarding motivations of perpetrators. Three themes identified in the narratives were previous experiences of abuse, manipulation, and attention seeking. Another factor considered to be an important motivation was control, either because the perpetrators lacked control in other aspects of their lives or because they gained gratification from the deceitful stories of heroism they told. Mothers who perpetrate MCA seemed to find that fabricated illness provided a reprieve from marital conflict or became a pattern of trying to re-engage a spouse into family life.

Of concern was the fact that almost all of the self-reported victims had made multiple attempts to report the abuse—to social services, the police, or other family members. As in the Gypsy Blanchard case (Dean, 2016), each time the victims reported, their concerns were dismissed. This study highlights the premise that this type of abuse is under-recognized and that there is a powerful need for professionals in all disciplines to be more aware of MCA.

### **Conclusions**

MBP is a serious form of child abuse and neglect

that is complicated to diagnose, which is further compounded by the increased clinical sophistication afforded by the Internet. Social media and blogs are commonly used to access medical knowledge, share information about a sick child, and receive social and monetary support. They also provide forums for suspected perpetrators to organize against the diagnosis and child protection. Fortunately, the same technology can be used to detect illness falsification, provide evidence in prosecutions, and avert future abuse. The Internet has also contributed to avenues for qualitative research on FD and FDIA. The impact of patient satisfaction surveys and electronic medical records on healthcare providers as they deal with this type of child abuse warrants further study.

### **About the Authors**

**Debra Esernio-Jenssen, MD, FAAP**, is Section Chief of Child Protection Medicine at the Lehigh Valley Children's Hospital in Allentown, Pennsylvania. She is Professor of Pediatrics at the Morsani College of Medicine. She is both Board Certified in Child Abuse Pediatrics and General Pediatrics. In 2007, she was invited to join the Ray Helfer Society and served on the Board of the American Professional Society on the Abuse of Children.

**Randell Alexander, MD, PhD**, is Professor of Pediatrics, the University of Florida—Jacksonville; a member of the International Advisory Board for the National Center on Shaken Baby Syndrome; President of the Academy on Violence and Abuse; and chair of the Committee on Child Abuse Florida Chapter, American Academy of Pediatrics.

**Kenneth Feldman, MD**, is an attending physician at Seattle Children's and Clinical Professor of Pediatrics at University of Washington, School, General Pediatrics. He was Medical Director of the Children's Protection Program and maintains a 1½-day primary care practice. He previously attended the emergency department, general wards, and intensive care unit at Children's.

**Beatrice Yorker, JD, RN, FAAN**, is Professor Emerita of Nursing and Criminal Justice at California State University, Los Angeles. She has published on case law of Munchausen by proxy, covert video surveillance, Munchausen by proxy among healthcare professionals, and serial murder in hospitals.

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## News of the Organization

*Janet Rosenzweig, MS, PhD, MPA, Executive Director*

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### **We're Making APSAC Membership Even More Attractive!**

The vibrancy of APSAC comes from our members, and we're working hard to attract as many new members as possible! We have instituted organizational membership rates, offering a low-cost option for staff to take advantage of APSAC resources, and continue to offer group discounts that enable individuals joining together to enjoy the benefits of personal membership in APSAC. Anyone who recruits an APSAC member for 2018 is entitled to receive 10% off their 2019 membership dues; recruit ten people and your 2019 membership will be free! Faculty members--be sure to remind your students that they can join APSAC for \$30 and have all the benefits of full membership.

Perhaps most exciting is the new membership rate for frontline professionals in public services, primarily child protective services workers and law enforcement officers. These colleagues generally work for agencies with a limited budget for continuing education resources and may now join APSAC for an annual rate of \$40. As an introductory offer, frontline professionals can use the discount code CPSLE18 for an additional 25% discount for their first year. Please share this news with the local service providers in your community! What does APSAC have to offer? Our well-known publications continue to be an attractive benefit and will be enhanced this year as we launch an online, searchable archive of all past issues of the *APSAC Alert* and the *APSAC Advisor*. Decades of the most important thinking on critical topics on child maltreatment will be available for students, researchers, and practitioners. YAPSAC, our interest group for early career professionals, offers mentoring, networking (virtual and actual!), career support, and more for people building a career serving children and

families. APSAC's training and conferences continue to set the benchmark for excellence, offering an opportunity to learn and celebrate with and from the best in our field.

Recruiting friends, students, or colleagues to share in APSAC resources? Send their names and email to [info@apsac.org](mailto:info@apsac.org) and we'll make sure you both get the discount! APSAC members get 10% off next year's membership for each new member they recruit. Bring in 10 members and your membership is free!

### **Join Us in New Orleans, June 13–16, for Our 25th Anniversary Colloquium**

Improve your skills while celebrating with friends and colleagues in the Big Easy! [Registration is now open](#) for our 25th Anniversary Colloquium. This year's Colloquium features 7 advanced training institutes, 58 advanced training workshops, and 60 information/discussion roundtables which address all aspects of child maltreatment including prevention, cultural issues assessment, intervention and treatment with victims, perpetrators and families affected by physical, sexual and psychological abuse and neglect. We're celebrating our 25th with a New Orleans-style [second line parade](#) and [fundraising party on a Bourbon Street balcony](#) featuring fine wines and NOLA-style cuisine.

Plan now to be there! Early bird registration rates expire May 14.

### **The APSAC Forensic Interviewing Clinics**

The 2018 schedule for our well-regarded Forensic Interviewing Clinics is in process--meaning there is opportunity to bring our highly skilled training team and innovative curriculum to your community.

APSAC Forensic Interview Clinics focus on the needs of all professionals responsible for conducting investigative interviews. The comprehensive approach we offer is a unique opportunity to participate in an intensive training experience and have personal interaction with leading experts in the field of child forensic interviewing. Developed by top national experts, APSAC's curriculum emphasizes state-of-the-art principles of forensically sound interviewing, with a balanced review of multiple models.

Topics include the following:

- Overview of various interview models and introduction to forensic interview methods and techniques
- How investigative interviews differ from therapeutic interviews
- Child development considerations and linguistic issues
- Cultural considerations in interviewing
- Techniques for interviewing adolescents, reluctant children, and children with disabilities
- Being an effective witness

**Clinics are scheduled for June 4 – 8 in New Orleans, July 9–13, in Seattle and October 22- 26 in Norfolk.**

You can [register here](#). Special training for staff at all levels of expertise can be tailored specifically for your community. For information, [contact Dr. Jim Campbell](#).

## **APSAC Offers Inaugural Symposium on Psychological Maltreatment**

As the new APSAC publication *The Investigation and Determination of Suspected Psychological Maltreatment of Children and Adolescents* began circulating widely, APSAC was pleased to partner with colleagues in New Jersey to offer our first symposium on the topic, featuring the authors of the Guidelines and one homegrown expert. Along with [Prevent Child Abuse New Jersey](#), [The Robert McCormick Center for Child Advocacy and Policy at Montclair State University](#), and [The New Jersey Children's Alliance](#), Guidelines authors Stuart Hart, Marla Brassard, and Amy Baker were joined by Gina Hernandez and received rave reviews from more than 125 professionals from around the state who attended

the event.

APSAC makes a great partner for a statewide organization planning a conference. [Contact Jim Campbell](#) if you'd like us to bring our national resources to your state or community.

## **NEW! APSAC Practice Guidelines Are Now Available for Free!**

To further our goal of “strengthening practice through knowledge,” APSAC is now making all our Guidelines for Professional Practice available for free! [Browse what's available here](#). We encourage distribution far and wide!

## **Ready to Start a State Chapter?**

State chapters are eligible for financial support from APSAC and help provide a unified voice on behalf of all aspects child maltreatment in your state. For information, please contact [info@apsac.org](mailto:info@apsac.org).

## **The APSAC Amicus Committee Stands Ready to Support You!**

If a case involving a critical issue in child maltreatment is being heard in your state, consider asking the APSAC committee to file an amicus brief. APSAC members who are skilled and dedicated attorneys comprise this committee, and they have filed briefs in state and federal courts on issues ranging from the admissibility of sexual abuse accommodation syndrome to procedural issues in child testimony. For more information, [contact amicus committee chair Frank Vandervort](#).

# Washington Update

*Ruth Friedman, PhD*

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Though the federal landscape for 2018 remains fluid, it is unlikely Congress will move major legislation before the November mid-term elections beyond required federal spending bills necessary to keep the government running and possibly legislation to help address the opioid epidemic. A partisan Farm Bill may move in the House of Representatives, but the Senate has stated they will only move forward with a bipartisan bill. Therefore, it is likely that Congress will take up a short-term solution and address the reauthorization in full in 2019. Numerous Congressional Committees are holding hearings and examining different aspects of the opioid epidemic. Legislation aimed at helping address this drug crisis is likely this spring, but no details are publically available at this time.

## Protecting Young Victims From Sexual Abuse and Safe Sport Authorization Act

The *Protecting Young Victims From Sexual Abuse and Safe Sport Authorization Act* was signed into law on February 14, 2018. As described by Senator Feinstein, this law will require the U.S. Center for Safe Sport to ensure that aspiring Olympic athletes can report allegations of abuse to an independent and nonconflicted entity for investigation and resolution, and to make sure that all national governing bodies follow the strictest standards for child abuse prevention, detection, and investigation. The bill also amends the *Ted Stevens Amateur and Olympic Sports Act*, which governs amateur athletics governing bodies, to make it safe and easy for victims to report abuse and mandate oversight to ensure that strong

sexual-abuse prevention policies are implemented. Finally, the bill also reforms the law that allows victims to sue sex-crime perpetrators by extending the statute of limitations until much later on into adulthood. You can find [the text of the law here](#).

## Family First Prevention Services Act Passed Into Law

In early February, Congress passed the Family First Prevention Services Act (FFPSA). FFPSA was a bipartisan effort that includes historic reforms to help keep children safely with their families when they come to the attention of the child welfare system. When placement in foster care is needed, it provides an assurance of quality care for children in the most family-like setting appropriate for their special needs. Family First also offers new supports for preventing and treating families struggling with substance use disorder, including increased support for grandparents and other relatives who have reached out to care for children, regional partnerships to bring systems together to benefit children in families struggling with substance use, and funding to help children be placed in treatment programs with their parents. You can find a two-page summary from the Children's Defense Fund [here](#), a more detailed summary [here](#), and a timeline for the law's implementation [here](#).

## Annual Appropriations

After numerous short-term extensions, Congress passed a final spending bill for FY18 on March 23rd. This bipartisan bill included some important funding increases. The official report that includes a description of HHS funding can be found [here](#). In the area of child welfare, the bill included \$60

million in new funding for the state grants in the Child Abuse Prevention and Treatment Act, \$20 million to fund kinship navigators in all states and territories, \$20 million for Regional Partnership Grants, and \$1 million for startup costs on the evidence clearinghouse. The bill also includes a \$9 million increase for the Family Violence Prevention Services Act, including \$5 million directed toward Native American tribes and tribal organizations. A breakdown of mental health funding under the Substance Abuse and Mental Health Services Administration can be found in pp 37-46 [here](#). The House Republican bill summary and one-pagers can be found [here](#).

FY19 appropriations must be passed by September 30, 2018. The Trump Administration released its FY19 budget proposal on February 12th. The budget proposes to cut the deficit by \$3 trillion over a decade through deep cuts to multiple federal agencies, including a [42.3% cut](#) to non-defense discretionary funding. The President's Budget and related analytical documents from the White House can be found [here](#). Congress is not expected to move the President's proposal. It is likely that in the early fall, Congress will pass a short-term extension that provides continued flat funding in programs that will run past the November mid-terms.

## AFCARS Delay

The Department of Health and Human Services announced in January that it will allow states an additional 2 years to comply with the AFCARS regulations that were finalized in December 2016, as part of a broader Administration effort to reduce burden on states. The current data requirements in AFCARS have not been revised or updated since 1993, when they were first finalized. The AFCARS data system tracks the experiences of children in the foster care system and provides information to policymakers and the public about how federal laws regarding foster care are implemented at the state level. Senator Ron Wyden (D-OR), Ranking Member of the Senate Finance Committee, and Representative Danny Davis (D-IL), Ranking Member of the House Ways and Means Subcommittee on Human Resources, sent a letter to Health and Human Services Secretary Azar to

state their opposition to the delay.

## HHS Releases 2016 Child Maltreatment Data Report

On February 1, HHS released [Child Maltreatment 2016](#). This report presents national data about child abuse and neglect known to child protective services agencies in the United States during federal fiscal year 2016.

## CHIP and MIECHV Reauthorized

Congress reauthorized the Children's Health Insurance Program (CHIP) and the Maternal Infant Early Childhood Home Visiting program (MIECHV) in early 2018. CHIP funds health insurance for nine million children every year. CHIP received a 10-year reauthorization. MIECHV, which provides nearly \$400 million per year to states to fund approved evidence-based home visiting programs, was reauthorized for the next 5 years.

## Social Impact Partnerships

In early February, Congress passed the Social Impact Partnerships to Pay for Results Act (SIPPRA), which allows the federal government to engage in pay for success projects to improve outcomes for kids. This 92 million dollar fund creates a pool of capital to support outcome-based financing for pay for success projects that support a number of different outcomes, including child abuse and neglect prevention, maternal health, income stability, and a wide range of other social outcomes. Specific program outcomes could include:

- Reducing incidences and adverse consequences of child abuse and neglect;
- Reducing the number of youth in foster care by increasing adoptions, permanent guardianship arrangements, reunifications, or placements with a fit and willing relative, or by avoiding placing children in foster care by ensuring they can be cared for safely in their own homes;
- Reducing the number of children and youth in foster care residing in group homes, child care institutions, agency-

operated foster homes, or other non-family foster homes, unless it is determined that it is in the interest of the child's long term health, safety, or psychological well-being to not be placed in a family foster home; [or] Reducing the number of children returning to foster care.

You can [find the legislation here](#).

## Opioids, Children, and “CARA 2.0” Bill

Senators Portman and Whitehouse, along with a bipartisan group of six other Senators, introduced the [CARA 2.0 Act of 2018](#) last week. The bill contains many of the same components as the Comprehensive Addiction and Recovery Act (CARA) of 2016 with higher authorizations, including \$60 million to states to implement the Plan of Safe Care requirement in CAPTA. A section-by-section is available [here](#), and a brief summary is available [here](#). Congress is expected to try to move bipartisan legislation in spring 2018 to help combat the opioid crisis, though perhaps not this specific bill. On February 8, the Government Accountability Office (GAO) released a new report, [Substance-Affected Infants: Additional Guidance Would Help States Better Implement Protections for Children](#). The report examines the steps states are taking to implement CAPTA requirements on substance-affected infants included in the Comprehensive Addiction Recovery Act (CARA) of 2016.

## Congressional and Executive Action on the Safety Net

In late fall 2017, the White House and Republican leaders in the House of Representatives stated their intent to move legislation in 2018 that would dramatically reconfigure and downsize many federal programs that support low-income individuals, families, people with disabilities, and seniors, including programs such as Medicaid, TANF, SNAP, and low-income housing. However, Senate Majority Leader McConnell's opposition to addressing this legislation in 2018 means it is unlikely for Congress

to move through both chambers of Congress. Committees in the House of Representatives have begun to hold hearings on the topic and may eventually introduce and move some legislation. But the Senate is not expected to take up the House bills or its own legislation in 2018.

The Trump Administration is taking executive action to significantly change the nature of some social safety net programs. The Administration has now approved three state waivers under [new Medicaid guidance](#) that will permit experimentation with time limits, work requirements, eligibility, drug testing, and other policy changes. Many child and family stakeholder are concerned about these waivers because they will decrease health coverage for vulnerable populations. Some similar waivers were denied by the Obama Administration because officials ruled that they did not support the core purposes of the Medicaid law. You can find more information about pending and approved waivers [here](#). Lawsuits have been filed to challenge the legal authority of these specific waivers. There is some indication the Trump Administration may also attempt to allow states to change established rules for the SNAP program though their authority to do so is even less clear (formerly food stamps).

## About the Authors

*Ruth Friedman, PhD, is Executive Director of the National Child Abuse Coalition. She is an independent child and family policy consultant and national expert on early education, child welfare, and juvenile justice. She spent 12 years working for Democratic staff of the U.S. House Committee on Education and the Workforce, helping spearhead early learning, child safety, and anti-poverty initiatives. Dr. Friedman has a doctorate in clinical psychology and a master's degree in public policy. Prior to working for Congress, she was a researcher and therapist, focusing on resiliency in children and families living in high-poverty neighborhoods.*

# Conference Calendar

## March 18-21, 2018

National Council of Juvenile and Family Court Judges  
National Conference on Juvenile Justice  
San Diego, CA  
775-507-4777  
[www.ncjfcj.org](http://www.ncjfcj.org)

## March 19-22, 2018

34th International Symposium on Child Abuse  
Huntsville, AL  
256-533-5437  
[www.nationalcac.org](http://www.nationalcac.org)

## April

### April 22-25, 2018

Ray E. Helfer Society Annual Meeting  
Nashville, TN  
[www.helfersociety.org/event-list](http://www.helfersociety.org/event-list)

### April 26-29, 2018

Child Welfare League of America  
Building Resilience in Challenging Times  
Washington, DC  
202-688-4200  
[www.cwla.org](http://www.cwla.org)

## June

### June 6-9, 2018

AFCC 55th Annual Conference  
Compassionate Family Court Systems:  
Trauma-Informed Jurisprudence  
Washington, DC  
608-664-3750  
[afcc@afccnet.org](mailto:afcc@afccnet.org)

### June 13-16, 2018

American Professional Society  
on the Abuse of Children  
25th Anniversary Colloquium  
877-402-7722  
[apsac@apsac.org](mailto:apsac@apsac.org)  
[www.apsac.org](http://www.apsac.org)

## July

### July 9-13, 2018

APSAC Forensic Training Clinic  
Seattle, WA  
614-827-1321  
[apsac@apsac.org](mailto:apsac@apsac.org)  
[www.apsac.org](http://www.apsac.org)

## August

### August 13-16, 2018

Crimes Against Children Conference  
Dallas, TX  
214-818-2644  
[www.cacconference.org](http://www.cacconference.org)

### August 23-25, 2018

National Association of Counsel for Children  
San Antonio, TX  
888-828-NACC  
[www.naccchildlaw.org](http://www.naccchildlaw.org)

## September

### September 5-9, 2018

22nd International Summit and Training  
on Violence, Abuse and Trauma  
San Diego, CA  
858-527-1860, x 4031  
<http://www.ivatcenters.org>

## October

### October 22-26, 2018

APSAC Forensic Training Clinic  
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614-827-1321  
[apsac@apsac.org](mailto:apsac@apsac.org)  
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