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PPM 03-06 CPI Physical Abuse Allegations for Factitious Disorder by Proxy/Munchausen by Proxy Syndrome and Threatened Harm

REF: OCS Program Policy Manual, Chapter 4, Child Protection Investigation, Sections 4-400 C. 2. a., 4-410 E. 4-515, 4-535, Appendices 4-B, 4-C, and 4-F

The purpose of this memorandum is to advise staff of policy and practice guidelines for the use of the new CPI physical abuse allegations of Factitious Disorder by Proxy/Munchausen by Proxy Syndrome and Threatened Harm. These allegations are included in the June, 2003 reissue of Appendix 4-B, Definitions of Allegations; Appendix 4-C, Allegations by Investigation Levels; and, Appendix 4-F, Report Categorization for Report Acceptance.

Factitious Disorder by Proxy or Munchausen by Proxy Syndrome Allegation

The allegation of Factitious Disorder by Proxy which is more commonly known as Munchausen by Proxy Syndrome has been added as a physical abuse allegation requiring a Level I investigation. This is in response to recognition of this disorder both with reports to OCS and in the current child welfare literature. Currently both terms are used to describe the parent or caretaker who fabricates and/or induces illness in a child in their care for their own needs. Therefore, both terms are used in the allegation.

The allegation is defined in Appendix 4-B as follows:

> Factitious Disorder by Proxy/Munchausen by Proxy Syndrome - A parenting disorder in which the parent or other caretaker fabricates, exaggerates or induces symptoms of physical or psychological illness in the child in order to obtain unnecessary medical treatment while disclaiming knowledge of the etiology of the illness. The behavior is motivated by the parent or caretaker's psychological needs and the abuse to the child victim is a result of the child being regarded as ill or impaired. This can result in complex medical investigations and tests, hospitalizations, and needless surgeries. The efforts to induce the symptoms or illness can also result in death to the child victim.
>
> This allegation does not include cases in which a parent's motive is child custody, an overanxious parent who exaggerates a child's symptoms as a result of their concern for the child or fabrications for monetary gain.
>
> FINDING: The determination that the parent/caretaker induced or fabricated illness, symptoms of illness and/or physical/emotional injury in the child shall be from one or a combination of the following: medical diagnosis, coroner verification, law enforcement verification, victim statement, confession of the perpetrator, or witness statement.

It is expected, although it is not required, that reports with this allegation will be received from medical reporters. Identification of such cases are usually made as the result of medical confirmation. It is

unusual for there to be witnesses to the parental behavior, unless a medical facility has video taped the parent. It is also unusual for a perpetrator to confess even when confronted with evidence.

Signs, Symptoms, and Characteristics of Victims and Perpetrators

The current literature describes the mother as the perpetrator in over 90% of FDP/MBP cases. If there is another parent in the household, he is usually described as passive and unaware of the mother's fabrication or induction of illness. The mother appears to be very caring and concerned about the child in front of others, but she may show little interest when alone with the child.

The victims are most commonly infants and toddlers who are too young to talk, but older children may also be victims. The older children may come to believe that they are disabled or actually participate in the medical hoaxes.

The most common symptoms in child victims are seizures, apnea, vomiting, and diarrhea. In some cases a child may be smothered in order to induce the appearance of apnea. The symptoms only occur in the presence of the perpetrator and the child improves when separated from the perpetrator. The temporary smothering is dangerous behavior that can result in brain damage or death. Cases in which one or more children in a family are believed to have died from Sudden Infant Death Syndrome and other children are described as experiencing apnea only in the presence of the mother are considered suspicious.

Schreier and Libow in HURTING FOR LOVE describe the most common signs that should raise suspicions. They are as follows:

- A child who presents with one or more medical problems that do not respond to treatment or that follow an unusual course that is persistent, puzzling, and unexplainable.
- Physical or laboratory findings that are highly unusual, discrepant with history, or physically or clinically impossible.
- A parent (usually the mother) who seems medically knowledgeable and/or fascinated with medical details and hospitals gossip, seems to enjoy the hospital environment, and often expresses interest in the details of others patients' medical problems.
- A highly attentive parent who is reluctant to leave her child's side and who herself seems to require constant attention.
- A parent who appears unusually calm in the face of serious difficulties in her child's medical course while being highly supportive and encouraging of the physician, or one who is angry, devalues staff, and demands further intervention, more procedures, and the like.
- The suspected parent may work in the health care field herself or profess interest in a health-related job.
- The signs and symptoms of a child's illness fail to occur in the parent's absence.
- A family history or unusual or numerous medical ailments that has not been substantiated and raises questions about the reporter's veracity.
- A family history of similar sibling illness or unexplained sibling illness or death.

- A parent with symptoms similar to her child's own medical problems or an illness history that itself is puzzling and unusual.
- A suspected parent with an emotionally distant relationship with her spouse. The spouse often fails to visit the patient and has little contact with physicians even when the child is hospitalized with serious illness.
- A parent who reports dramatic, negative events, such as house fires, burglaries, car accidents, and the like, that affect her and her family while her child is undergoing treatment.
- A parent who seems to have an insatiable need for adulation or who makes self-serving efforts at public acknowledgment or her abilities.

Sanders and Bursch in "Forensic Assessment of Illness Falsification, Munchausen by Proxy, and Factitious Disorder, NOS" include additional signs to those identified above with their discussion of the MBP profile:

- Parent/caretaker's life revolves around child's "illness"
- Does not appear relieved with normal test findings
- Promotes invasive test or procedures
- Overly familiar with physicians or staff members
- Seems to enjoy excitement and being in the "spotlight"
- Predicts deteriorations or relapses in the child's condition that would be seen as nearly impossible to predict or highly unlikely to occur

Feldman in PATIENT OR PRETENDER includes additional warning signs:

- The apparent disease is extremely rare
- Mother is less anxious than the medical staff regarding the inability to diagnose the cause of the child's illness
- Child has been to numerous medical providers without a cure or clear diagnosis
- Medical problems do not respond to appropriate treatment

Two types of perpetrators are identified in the child welfare literature, the inducers and fabricators. Inducers are parents who induce disease or injury into or onto the child. An example is a parent who smothers the child. Fabricators do not induce disease or injury but they lie about its presence or stage it. An example is a parent who gags and vomits and claims it is the child's.

This disorder does not include a parent who believes their child is ill and is acting as an advocate for the child. Such parents are generally relieved when tests rule out an illness. The FDP/MBP parent is aware that the child is not ill and the behavior to seek medical care and treatment is motivated by their psychological needs rather than concern for the child or a mental illness such as psychosis. It is often difficult for medical personnel to distinguish between an overly concerned parent and FDP/MBP parent because they appear so caring and normal.

Dr. Feldman describes the FDP/MBP parent as a person whose intense emotional needs motivate the illness fabrications in their children. They have always used somatic symptoms as a way of coping and may themselves meet the criteria for a factitious disorder. In general, they may have not learned more appropriate ways to obtain attention and nurturance and are likely to have been childhood victims of abuse. He describes them as inclined to be selfish in that they abuse their children for their own emotional benefit.

Investigations with Suspected Factitious Disorder by Proxy

When a report is received with this allegation, it is expected that the supervisor will assist the worker with the investigation plan. Because these cases are complex and difficult to verify the supervisor shall determine if it is necessary to jointly investigate the report with the worker. Initially there should be a determination of whether the case should be jointly investigated with law enforcement or when appropriate with the local Child Advocacy Center. This will depend on the local jurisdiction as well as the potential severity of the abuse to the child victim.

The case decision making and validity determination will require working with the medical professional who is responsible for the child's care as well as contacts with other physicians as the child's current physician may not be the reporter. It is not unusual for physicians to differ in their opinions regarding the mother's conscious fabrications. These perpetrators are described as convincing, clever and manipulative. They tend to establish positive relationships with physicians. It may require numerous incidents with one or more children in the family before a physician or nurse becomes suspicious of the mother's behavior. Also the perpetrator may be seeking medical care for the child victim from more than one physician without the physicians being aware of the others' treatment of the child. Therefore, it may be important for the worker or the physician providing medical verification that the child is not ill or that the symptoms have been induced, to obtain as many medical records as possible from all physicians and hospitals that have ever treated any of the children in the family.

As in all investigations, the safety of the child is the initial concern and the first assessment to be completed. The current literature estimates the mortality rate from this form of child abuse to be from nine to eleven percent.

The American Professional Society on the Abuse of Children's position paper on Munchausen by Proxy recommends that the safety assessment of the child and the treatment planning for the family should hinge on an assessment of the motivation of the parent in conjunction with the extent, lethality, and chronicity of the abuse to the child. All children in the family must be included in the safety assessment as the abuse may involve more than one child.

The paper indicates that placement may be necessary to protect the child. When the alleged perpetrator is diagnosed with Factitious Disorder by Proxy, the paper recommends caution with placement with maternal relatives, especially maternal grandparents, as they may play a role in maintaining the deception process. Therefore, placement with relatives should include an assessment of the relative's belief that the perpetrator has harmed the child as well as a commitment to protect the child from further abuse from the perpetrator. Placement with the non-abusing parent may be considered when the parent

has not colluded with the abuse and is willing to protect the child. These cases are not appropriate for voluntary parental arrangements, therefore, if there is some indication that the child has been victimized, court intervention should be sought to assure the child's safety.

A psychological evaluation may be needed to assist with the case decision making, however, there is no specific psychological profile that is currently recognized as definitive for diagnosis of this disorder. When a psychological evaluation is obtained, it should be with a psychologist with some experience/expertise with the disorder. The psychological evaluation may indicate personality problems and disturbances but psychosis is rare. One study of these mothers indicated many of them showed symptoms of somatization disorder. Also, it is recommended the medical information on the child and family provided by the suspected parent have external verification as much as possible.

For cases with a valid finding for this allegation, the worker and supervisor should usually determine there is a high risk of future maltreatment when completing the formal assessment. The current literature states that a parent may refrain from the abusive behavior while under supervision, but, if the perpetrator continues to deny the abuse and/or treatment has not been successful, it is common for the behavior to resume over time. However, the worker and supervisor should consider the case circumstances in addition to this recommendation when determining the formal assessment of risk.

A Multi-Disciplinary Team staffing shall be considered when needed for assistance with case decision making and planning. Participation by the district attorney's office may be critical in developing a viable course of action.

Threatened Harm

The allegation of threatened harm has been added as a physical abuse allegation requiring a Level II investigation. This new allegation provides for a finding of child physical abuse for situations in which a parent/caretaker's non-accidental dangerous behavior has not resulted in an injury to a child. The allegation is appropriate at intake based on the reporter's knowledge of the incident and awareness that the child was not injured. In addition, cases in which the allegation at intake is Unspecified Physical Abuse when the reporter does not know if the child has sustained an injury may later be validated as Threatened Harm once it is determined there is no injury to the child which meets the definition of another allegation.

The allegation is categorized as physical abuse as the Louisiana Children's Code, Article 603 (1) defines abuse as any act which seriously endangers the health and safety of the child and includes infliction or attempted infliction of physical or mental injury on a child.

The allegation is defined in Appendix 4-B as follows:

> Threatened Harm - Non-accidental and dangerous behavior which places a child at substantial risk of serious physical injury. It includes caretaker behavior which is threatening and/or violent and which a reasonable person would recognize as dangerous and foreseeable to result in serious injury. It also includes violent behavior directed at the child that demonstrates a disregard for the

child's safety or welfare and could result in a serious injury. This allegation is used for behaviors which have not resulted in a physical injury to the child, but if repeated are likely to result in a serious or life threatening injury. Examples include but are not limited to the following:

a. Threatening the child with a weapon such as a gun or a knife. This also includes non-accidental discharging of a gun in the residence or on the premises of the residence with the intent to injure or threaten the child.
b. Throwing or shoving an infant or young child's head against a wall or other surface.
c. Shaking an infant.
d. Interference with a child's breathing such as choking or obstructing the child's breathing.
e. Striking a child on or about the head severely or repeatedly.

This allegation is not used when dangerous or violent behavior has resulted in an injury to a child. In those cases, the appropriate allegation to describe the injury is used.

The allegation addresses cases in which the parental/caretaker behavior is so dangerous that a safety plan would be necessary to protect the child. It does not include cases of corporal punishment such as spanking in which there is no injury to the child.