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Psychological Treatment of Factitious Disorder Imposed on Another/ Munchausen by Proxy Abuse

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Abstract
The purpose of this article is to propose management and treatment protocols for family members impacted by MBP abuse. A brief review of psychopathology, co-morbidities, MBP risk level, treatment outcomes, and rationale for treatment is presented, followed by detailed guidance regarding psychological treatment and management. We propose five components of psychotherapy for abusers, best remembered by using the acronym of ACCEPTS: ACknowledgement, Coping, Empathy, Parenting, Taking charge, and Support. Guidance for the treatment of spouses/partners of the abuser, other involved family members/friends, and child victims are also provided.

Keywords Munchausen by proxy · Factitious disorder imposed on another · Family treatment

Munchausen by proxy (MBP) remains the most recognizable term used to refer to a form of abuse and neglect when someone volitionally falsifies physical, psychiatric, or developmental disorder symptoms in a child, adult, or pet. This form of abuse involves exaggeration, simulation, fabrication, and/or inducement of physical or psychiatric illness. It can also include medical or other neglect. Abusers (mostly mothers) meet diagnostic criteria for the psychiatric diagnosis of Factitious Disorder Imposed on Another (FDIA) (APA, 2013). A diagnosis of FDIA includes a persistent and repetitive drive to place the victim in the sick role in order to satisfy a psychological need of the abuser, such as attention or to appear as a caring and competent parent. FDIA is not always present in the abuser in cases of abuse by pediatric condition falsification, caregiver-fabricated illness in a child, or medical child abuse. However, the MBP term specifically refers to this form of abuse by one who meets criteria for FDIA (APSAC Taskforce, 2018).

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The primary purpose of this article is to propose a management and treatment protocol for family members and others impacted by MBP abuse. This paper provides a brief review of related psychopathology, co-morbidities, MBP risk level, observed treatment outcomes, and rationale for treatment, followed by detailed guidance regarding psychological treatment and management. In cases in which a parent is seeking excessive medical care for the child but deception is not part of the presentation, treatment approaches will differ based on the factors that led to the over medicalization, such as parental anxiety, delusion of illness, or factitious illness or conversion disorder originating in the child (Kozlowska, Foley & Savage, 2012; Roesler & Jenny, 2009). Guidelines for specialized evaluation techniques and general management advice for psychologists in medical settings are published separately (Bursch, Emerson & Sanders, under review; Sanders & Bursch, 2002).

In order to treat families impacted by MBP, it is important to understand the FDIA psychopathology of the abuser. Factitious Disorders have similarities to disorders such as addictions, eating disorders, impulse control disorders, and pedophilia, related to both the persistence of the behavior and to the intentional efforts to conceal the disordered behavior (which may also constitute a crime against others). They are similar to, and often on the differential with Somatic Symptom Disorders (APA, 2013), because both include long-term, persistent problems related to illness perception and identity and can include unexpected and/or unexplained

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symptoms. Many with FDIA have the ability to superficially appear "normal" if not "superior" as caregivers. Therefore, it is common that a basic psychiatric interview and/or psychological testing may suggest no psychopathology is present. Claims by professionals that deception has not occurred based solely on clinical interview or psychological testing of the suspected abuser or victim do not conform to the basic standard of care required to assess and diagnose a factitious disorder.

Prior to developing a treatment plan, it is important to be aware of and assess for the common co-morbidities. Most MBP abusers are also found, when carefully assessed, to be suffering from personality disorders (Ayoub, 2010; Bass & Jones, 2011; Bools, Neale & Meadow, 1994) or Somatic Symptom Disorders, including Factitious Disorder Imposed on Self (Ayoub, 2010; Bass & Jones, 2011; Bools et al., 1994) and may have engaged in other criminal activity (Bass & Jones, 2011; Bools et al., 1994). A number have been found to have insecure attachments (Adshead & Bluglass, 2005) and unresolved trauma/loss and PTSD (Adshead & Bluglass, 2005; Ayoub, 2010; Grey & Bentovim, 1996) and reported past experiences of child abuse (Bass & Jones, 2011; Grey & Bentovim, 1996). Very few acknowledge their abusive acts (Ayoub, 2010). Abusers appear to have impaired coping skills and low self-esteem, but a desire to feel important and admired by doctors as well as wanting to "best" the doctors at times. They seem to have an ability to deny or repress knowledge of the abuse. They have sometimes experienced a past incident in which they gained attention due to an illness or medical condition (Adshead & Bluglass, 2005).

Therapists should be aware of the level of risk involved with this form of abuse. Available literature indicates that children are less likely to be returned home if poisoning or suffocation is involved (Davis, McClure, Rolfe, et al., 1998). The re-abuse rate for children returned to the home (further falsification and/or emotional abuse) ranges from 17 to 50% (Bools, Neale, & Meadow, 1993; Davis et al., 1998). The abuse of siblings born following removal of the index child who was poisoned is estimated to be as high as 20%. Thirty-five to 50% of percent of previous siblings were abused, sometimes fatally (Davis et al., 1998; Grey & Bentovim, 1996).

Information regarding treatment outcomes is extremely limited. When considering the larger child abuse literature, child abusers who are less likely to have positive treatment outcomes have a parental history of severe childhood abuse, persistent denial of abusive behavior, refusal to accept help, severe personality disorder, or engaged in severe abuse (Davis et al., 1998; Jones, 1987). MBP is considered severe abuse and, thus, falls into this category.

There are no formal treatment outcome studies for those diagnosed with a Factitious Disorder for several reasons. First, the determination of whether someone has engaged in MBP behaviors is a complex and often disjointed process. Unless the individual confesses, the evaluation is often the result of a child protection concern that has risen to the level of a legal proceeding. The data are usually gathered at different points and in various ways and stored in separate locations by medical and mental health professionals, social services professionals, and legal experts (Sanders & Bursch, 2002). Second, diagnoses of Factitious Disorders are rare, and thus it is not possible to obtain research funds to develop treatments and to recruit into large treatment studies. Third, most treatment is court-ordered and the individuals involved are frequently not voluntarily seeking therapy. Thus, the number of individuals who engage in treatment is limited and they are unlikely to volunteer to be included in a research study. Finally, the confidential nature of child abuse legal cases make summarizing court-ordered treatment difficult.

In terms of treatment outcomes, published case reports support extensive clinical observations by national experts that it is extremely difficult to successfully treat abusers with FDIA, especially those at the severe end of the spectrum (APSAC Taskforce, 2018; Berg & Jones, 1999; Black & Hollis, 1996; Klepper, Heringhaus, Wurthmann, Voit, 2008; Mehl, Coble, Johnson 1990; Nicol & Eccles, 1985; Sanders, 1996). Congruent with the larger child abuse literature, treatment success appears to be positively impacted by (1) lower severity or lack of personality disorder, (2) acknowledgement of abusive behaviors, (3) family support, and (4) other personality strengths. The ability to acknowledge the abuse is an important positive prognostic indicator.

Given the potential risks to the child as well as evidence that this is a very difficult problem to treat, one may question whether treatment should offered. There are several reasons to attempt treatment if it appears that it could be successful. First, if the parent(s) are able to engage in appropriate parenting, the child may be returned to the home and able to grow up in his or her nuclear family. Second, treatment of the abuser can improve functioning for all family members, including the abuser, spouse (who may have failed to protect the child victims), extended family, and other children. Finally, those engaging in the treatment and management plan on a long-term basis can learn tools that help them develop a safety net for their present and future children.

Proposed Treatment and Management Protocol

We are proposing five components of successful therapy, informed by limited research data and a considerable amount of expert experience using the model. For simplicity, we refer only to child victims abused by a female parental figure

in this paper. However, the same framework is useful for other victims and abusers. The five components may be best remembered by using the acronym of ACCEPTS. See Table 1.

Using the ACCEPTS model, we propose the treatment and management protocol below. However, we first present important pre-therapy agreements we have found to be extremely helpful to implement when feasible. This includes developing a contract between the family and with child protective services (CPS) to create therapeutic boundaries and various safety measures. We discuss these approaches within a CPS frame because it is rare for an MBP abuser to independently seek treatment for their maladaptive behaviors. We agree with others regarding the use of a step-wise approach to the treatment (Ayoub, 2006, 2010). See Fig. 1 for important decision points.

Phase I: Preparing for Therapy

Prior to the initiation of treatment, therapists are encouraged to work with CPS to develop a therapy agreement, a safe and clear path of treatment, a solid plan for progress assessment, and an adequate treatment team.

Pre-therapy Agreement

Most treatment of MBP abuse is court-mandated and sometimes the child has been removed from the home. Many times the motivation for treatment of the parent is the return of the child to the home and/or to be released from active status through CPS. Court-mandated therapists will be most effective if they are able to establish helpful boundaries related to the therapy. A sample of an ideal CPS Pre-Therapy Agreement is provided and described in Fig. 2. While not always feasible, it is recommended that therapists attempt to limit the information they provide to the court system in order to optimally preserve the therapeutic relationship and potential efficacy of the therapy. Ideally, the therapist provides a separate evaluator of therapy progress with information related to treatment attendance, modalities used, skills taught, and general impressions of progress. However, it is strongly encouraged that it be an external evaluator who assesses important indicators of therapy success (such as self-understanding, empathy, coping and parenting skills, safety planning) and makes recommendations regarding next steps. Even the most seasoned of MBP experts are encouraged to request an outside evaluator of progress, whenever possible, to preserve the integrity of treatment and to guard against being successfully misled by the abuser or others. Of course, the feasibility of following these procedures may be limited by local resources. Nevertheless, therapists are encouraged to present this model to CPS representatives, along with the rationale for adopting it.

It is recommended that the therapist have access to all the information necessary for successful treatment. This would include a copy of any evaluations that were preformed, any legal documents that specify the facts of the case, and any medical records that may be necessary to

Table 1 ACCEPTS treatment model acronym

ACKNOWLEDGE (AC) The most important treatment goal is to acknowledge and take responsibility for (intentional and/or unintentional) inappropriate behaviors that harmed or could have harmed the child victim(s). Without achieving this goal, it is extremely difficult to make progress in other important domains. Successfully achieving this goal requires the abuser to describe their maladaptive behaviors in detail and to genuinely accept and understand how specific maladaptive behaviors placed the child victim(s) at risk. This extremely important treatment goal is a prerequisite to the ability of the abuser and spouse/partner to recognize that they have power over their behaviors and, thus, are able to change them. Acknowledgement can feel risky to those parents who may be under criminal investigation, underscoring the value of confidential therapy and assessment procedures

COPING (C) The second component of treatment includes the goal of developing a wider range of effective coping strategies to manage personal emotional needs, with the recognition that past abusive behavior is no longer a coping option

EMPATHY (E) The third component of treatment includes the goal of developing the ability to empathize with the child victim(s). This requires that the abuser and spouse/partner experience an appropriate emotional response to the harm and suffering that the child victim(s) experienced or could have experienced as a result of the abuser's past maladaptive behaviors. This can also include empathy related to the harm caused due to a failure to protect the child victim(s) by the spouse or partner of the abuser (or other involved caretakers)

PARENTING (P) The development of appropriate parenting skills is extremely important. This treatment component includes the recognition and the ability to make decisions with the priority that the child's needs come before the needs of the abuser

TAKING CHARGE (T) Many abusers report feeling disempowered and taking power/control indirectly through gaining attention/nurturance from health professionals by having a sick or disabled child. This goal of therapy is designed to help the abuser recognize her power and utilize it appropriately. Spouses/partners may also feel disempowered by the abuser and have similar therapy needs in this regard

SUPPORT (S) As is evident in the treatment outcome reviews, MBP abusive behaviors may persist despite intervention. Taking a lesson from the treatment of other compulsive, surreptitious, self-destructive behavior disorders such as Eating Disorders, Obsessive–Compulsive Disorders, and Pedophilia, an important component of successful treatment must also contain a support and monitoring system such as supportive family and professional forms of monitoring/oversight (by child protective services and/or health professionals). It is important that the abuser demonstration appropriate coping and parenting skills, with monitoring, over a long period of time in order to move toward reunification (Ayoub, 2006; Parnell & Day, 1998)

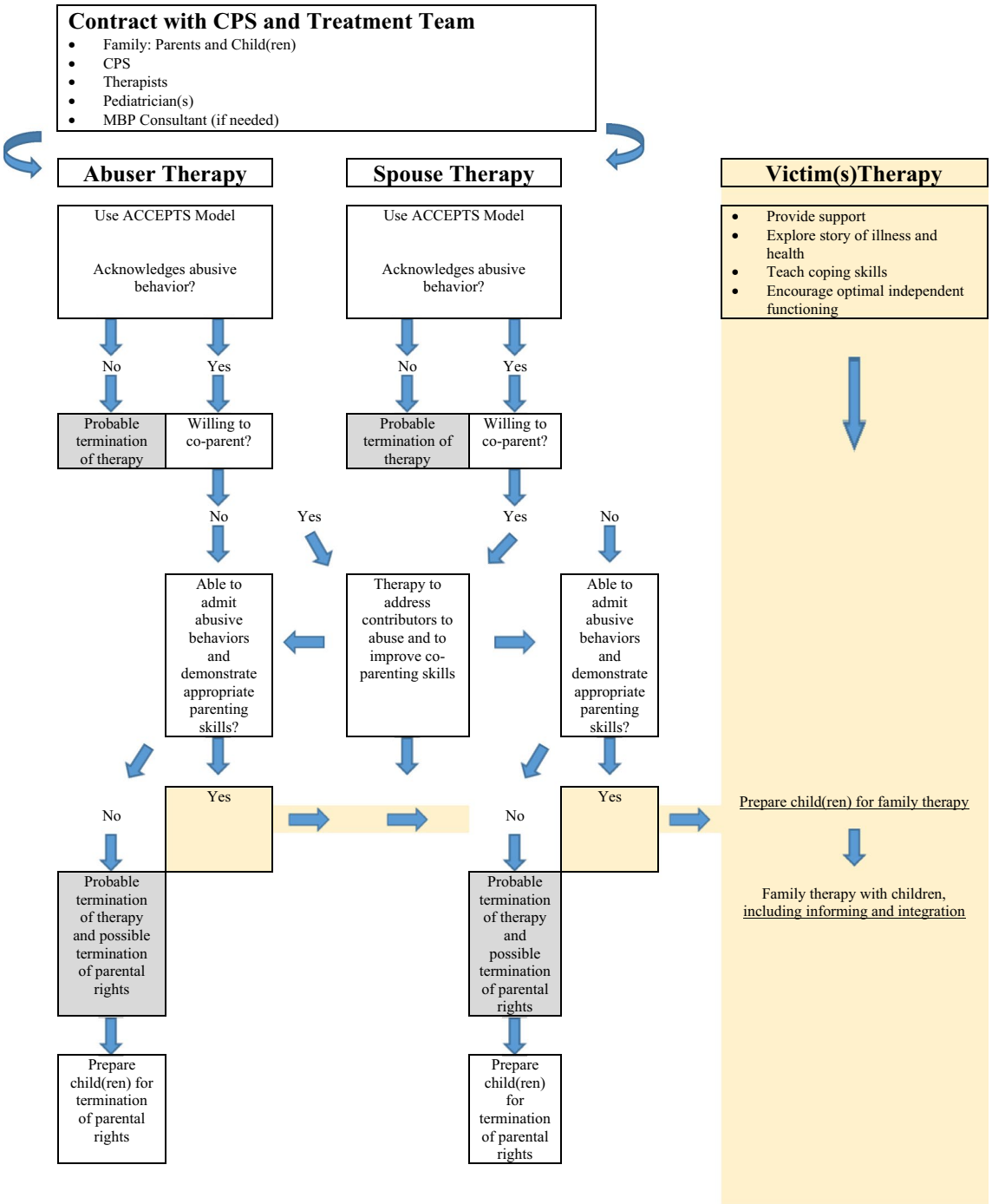

Fig. 1 Treatment protocol steps

explore allegations of abuse and/or neglect. In accordance with ethical principles, if the treating therapist does not have expertise in treating individuals who may have engaged in MBP abuse, he or she must have ready access to consultation with a MBP expert. Therapists are as likely as any other professional (or nonprofessional) to be successfully misled by an abuser (ten Brinke, Stimson, & Carney, 2014). The exceptional ability of those with FDIA to successfully deceive others is a core aspect of the FDIA psychopathology. It is crucial to keep this fact in the forefront of one's attention in order to effectively adapt usual assessment and treatment procedures. MBP consultants can assist the therapist by monitoring for blind spots and illogic as it inevitably emerges. Even expert

Fig. 2 Sample treatment contract

It is agreed that _____ (Mother, Father, Child, Other) will enter into therapy with _____ (Therapist) as part of mandated therapy requested by Child Protective Services. The client will be seen weekly, unless mutually arranged by the client and therapist. The cost of the therapy will be $ ___per 50-minute session. _____ (Payer) has agreed to pay for the sessions.

1. The therapists will be provided with any court records and medical records they deem necessary.

2. A MBP consultant will be available to the therapists if requested. Any information discussed with the consultant will also be confidential and not shared with CPS.

3. The therapists for each family member will also be released to share confidential treatment information with each other.

4. In order to protect confidentiality and the integrity of the treatment process, the treating therapists will NOT provide recommendations toward change in supervision status and/or reunification of the family.

It is agreed that the therapist will provide _____ (Child Protective Services) with the following information:

1. The attendance history of the client, including any missed sessions or problems with scheduling and the reason(s) given.

2. Whether it appears the client is benefitting from the sessions and whether any further or different treatment(s) are recommended, or if the therapist feels treatment is not likely to progress and should be discontinued.

3. Any other issues that must be reported due to limits of confidentiality, such as danger to self or others or child abuse that has not been previously reported.

4. Any information that the client would like the therapist to release.

SIGNED BY: Clients, Therapists, Consultant, CPS, Payer(s).

MBP therapists benefit from access to an external MBP consultant.

Before entering into therapy, the therapist should attempt to assess the likelihood for success. While one of the most important predictors of treatment success is a confession to the abusive behaviors, it is rare for someone accused of MBP abuse to confess when initially discovered. Some feel that treatment may only be possible when the parent "confesses" or acknowledges his/her behaviors and is open to treatment and, thus, will not agree to treat clients until this had occurred. We have found that, while the client may not initially take responsibility for her behavior, this may occur in the beginning stages of treatment, once rapport and trust is established. However, if the client is unable to build trust and enter into the treatment in a timely and genuine manner, the therapist may consider ending treatment. It is recommended that an initial agreement for treatment include an agreement to assess viability of success to be evaluated early in treatment.

Safety Plan and Plan for Reunification

It is important to have a safe structure in place for the family that provides clear guidelines regarding expectations and how possible reunification will proceed. This includes clear guidelines about how they will be evaluated for reunification and how clinical treatment of the parents and child victim(s) will proceed (Sanders & Bursch, 2002).

Treatment Team

Many victims of MBP abuse have genuine medical problems or lingering iatrogenic problems that require medical attention and/or rehabilitation. The goal of clinicians is to optimize health and functioning. Thus, the larger multidisciplinary treatment team often includes pediatricians and others who also benefit from ongoing access to a MBP expert for consultation and support. While not currently feasible to assemble in all jurisdictions, existing well-educated and

developed CPS systems serve as the ideal model of what is possible. In the ideal model, the larger team consists of a medical team for the child (of at least two physicians or other relevant primary care clinicians); a psychotherapy team that includes all psychotherapists engaged in direct treatment; CPS social service workers; and family visit supervisors who will be very active team members during the phase of treatment when the family is being monitored by the court system. Other team members, such as physical therapists, teachers, or child advocates, may be included depending on the case. The treatment team is most effective when they have monthly meetings or conference calls that includes access to an expert on MBP, if there is agreement to assemble for urgent meetings as new problems emerge, and when there is continued court oversight over a period of years (Ayoub 2006; Parnell & Day, 1998; Sanders, 1996).

Phase II: Individual Therapy

Individual therapy may be indicated for the MBP abuser, other parent, family members, or friends who have caretaking responsibilities for the victim, and the victim

Individual Therapy for Alleged Abusing Parents/Caretakers

The five-step ACCEPTS Model applies to the psychological treatment of the abuser. Each of these steps is described in detail below.

Acknowledgement (AC) The first mission of therapy is to provide an environment that would allow the abuser and/or spouse/partner to address self-deception and to acknowledge her or his behaviors within the setting of individual psychotherapy. This means providing emotional safety via a nonjudgmental stance while helping the client cut through denial. One approach has been based on Narrative Therapy (Sanders, 1996) in which the abuser and therapist explore the abuser's "story," identifying elements that may have contributed to a story of illness leading to abusive behaviors.

A similar approach may be used with spouses/partners who may have developed a tolerance for and/or a lack of recognition of the abuse and/or neglect.

It is imperative that the therapist also is able to acknowledge the existence of the MBP behaviors and help the abusing and/or neglectful parents see that these behaviors do not define them. The therapist must be able to separate the behaviors from the person while also helping the parent take responsibility for her behaviors. Thus, the therapist begins to build a long-term, respectful, and supportive relationship with the client while communicating acceptance of the person, but rejection of the abusive behaviors. Therapists who do not believe the abuser or partner is capable of the maladaptive behaviors (previously determined to have occurred) are not in a position to be helpful to the abuser/partner in understanding or changing those behaviors. While doubtful therapists can potentially be effective in treating co-morbidities and providing support, it is a disservice to victims and abusers for CPS to rely upon them to effectively treat FDIA with the goal of reducing the chances of a relapse of MBP behavior.

Therapists can address self-deception by supportively pointing to cognitive lapses and encouraging further exploration of these aspects of the abuser's narrative. An example is an abuser who acknowledged poisoning her child and concealing this behavior from clinicians in order to garner attention, but who also maintained the position that her behavior was not harmful since the illness was under control of the abuser and not a genuine illness. Her initial narrative lacked appreciation for the experience of the child or potential for harm or death of her child. Her narrative allowed her to manipulate her child and the clinicians in order to meet her own psychological needs without concern for the suffering of her child or others. Another example is the parent who minimizes the risk posed to the child and who externalizes blame based on the fact that she never induced illness and/or that there is genuine illness present. This common abuser narrative fails to recognize the central role of the abuser's inaccurate reports of symptoms or disability on clinical decision-making and lacks appreciation for the psychological and physical harm, including death, that can occur from unneeded clinical assessment or treatments and from socially treating the victim as excessively ill or impaired, often across all settings (home, school, clinical venues, and social situations).

Many times acknowledgement of abuse and neglect comes as the abuser/partner explores her or his past history/story. Reviewing one's life history may provide clues about ways in which the abuser (or partner) was mistreated, overlooked, criticized, or demeaned in ways that were disempowering and led to the drive for acknowledgement and compassion from others. This often includes a history of trauma and/or experience with illness that may have led to a means of being nurtured by others. Evidence-based trauma-focused therapies may also be useful when a parent has experienced trauma and is sometimes the first phase of treatment, if remaining trauma symptoms are severe. If the abuser is able to see how her past story may have contributed to her current story of abuse, it is useful to utilize the evaluations/medical records to explore the incidents reported to help the abuser take responsibility for these specific behaviors.

Coping (C) If the abuser is able to acknowledge her abusive behaviors in the past, the next step is to identify the needs that contributed to her abusive behaviors. From a Narrative

Therapy model, the next step includes exploring times in which she was able to cope differently (and more appropriately). The therapist would then help the abuser build on this alternative story of coping in the present. Evidence-based therapies that have been found useful in treating individuals with personality disorders and for increased coping and improving distress tolerance include Cognitive Behavioral Therapy (CBT) (Runyon, Deblinger, & Thakkar-Kolar, 2005) and/or Dialectical Behavioral Therapy (DBT) (Van den Bosch, Hysaj, & Jacobs, 2012) techniques. Specific skills that can be helpful include emotional regulation, goal setting and problem solving, traumatic stress reminder management, family communication, interpersonal boundary management, and social support activation. Relapse prevention approaches can include coping skills that capitalize upon social supports within the family or community. Such individuals can contribute to relapse prevention when they validate the past painful experiences and emotions of the abuser, participate in ongoing meaningful and healthy relationships with the abuser, provide second opinions related to the need for care seeking, accompany the abuser and child to clinical appointments, and/or raise concerns that allow appropriate intervention upon signs of relapse.

Empathy (E) If the abuser (and/or partner) comes to acknowledge the abuse, the therapist will help her take the child's perspective and work toward understanding the child's experience of the abuse. Bass and Glaser (2014) point out that if the parent is able to access their feelings of guilt, shame, and loss, it is to address this in therapy. Sometimes the abuser has objectified the child or seen the child as an extension herself, thus allowing her to feel it was not "abusive" to harm her child. Also abusers have described the use of denial and compartmentalization to cope with the knowledge that she was abusing and/or neglecting her child. The therapist attempts to help the abuser (or partner) mentalize the effects of the abuse on the child and attempt to help her break through the denial and face the reality of these behaviors and the emotional and physical effects. Mentalization-based therapy (MBT) may be helpful toward perspective taking and exploring empathy (Bateman & Fonagy, 2010).

If the abuser is allowed supervised visits with the child(ren), this is an opportunity to help the parent work on empathy and understanding her child's emotions and perceptions. Abusers (and the spouses/partners) sometimes resist attempting to understand what their children are feeling/wanting because they feel inadequate to meet their emotional needs. Some, based on their own neglectful childhood experiences, do not feel that it is the role of the parent to put forth effort to understand the experience of the child. We have used videotaping of parent–child sessions to be viewed later with the therapist. This allows the therapist to explore with the parent her perceptions of what the child is feeling and wanting at various times in the session. Some child victims have written letters to their parents to describe their experiences, feelings, desires, and questions. This approach can sometimes be less intense for parents who are grappling with responding appropriately to their children during visits, allowing them to process the information with the therapist and then practice their responses ahead of time.

Parenting (P) Both general and specific interventions are needed to assist abusers (and spouses) with developing more robust parenting skills. Using a peer support model, some parents may also benefit from seeking out models of good parenting to learn from in their family or community. Evidence-based parenting therapies such as Parent–Child Interactive Therapy (PCIT) (Thomas & Zimmer-Gembeck, 2012) can be used for improving attachment and general parenting skills if the parent is able to safely work directly with the child(ren) in therapy sessions. Nearly all MBP abusers (and spouses) require assistance in honing specific skills designed to support their children's optimal health and functioning. Most need to practice tolerating and supporting increased functioning and developmentally appropriate independence from the abuser, reinforcing health behavior and ignoring attention-seeking illness behaviors, differentiating normal from abnormal symptoms and complaints, and appropriately acknowledging legitimate expressions of confusion and suffering caused by the parents. If the abuser is not allowed visits with the children, the therapist can help the parent initially build basic skills during her or his interactions with others.

Taking Charge (T) Assuming the court and court expert are in agreement that genuine progress is being made, the therapist can next begin to help the parent plan for future interactions with the child victim(s). The criteria for this transition includes that the abuser (andspouse/partner) is able to (1) take full and genuine responsibility for her behavior, (2) experience appropriate emotional responses to her maladaptive behaviors and the harm they have caused (or could have caused) her child, (3) develop an understanding of her child's needs, (4) improve parenting skills in order to meet her child's needs, and (5) develop strategies to better identify and manage her needs to avoid abusing her child in the future. At this stage of treatment, the therapist can explore future scenarios with the parent (and/or spouse/partner), especially in regard to health appointments and concerns. Optimally, the abuser will be proactive in developing relapse prevention plans that include disclosing their problem to others and inviting outside assistance in their ongoing recovery.

The spouse/partner will need to explore how he or she wants to move forward as a parent. Sometimes the children

are placed with the spouse/partner while the abuser is asked to leave the home. Many spouses/partners feel overwhelmed with suddenly becoming a single parent, especially of high needs child victim(s), and may initially need assistance with parenting skills and daily management. Some spouses/partners have not been as active in the childcare and this may be a new and stressful role for both the parent and the children. The spouse/partner may need skills and practice to take a more protective and active stand. If the abuser has not been able to acknowledge the abuse, the spouse/partner may find himself or herself in the position of choosing between protecting the children or protecting the denial of the abuser.

Support (S) Support can include strengthening the relationship between the parents, cultivating and improving the utility of the available social support network, and utilizing professionals for ongoing assistance. If the abuser and spouse/partner have been able to successfully move through the initial phases of treatment, they may engage in Couples/Parenting therapy together (if they plan to co-parent) and/or move toward integrating with the children. It is recommended that Individual Therapy also continue during this process. If the abuser could benefit from other forms of therapies or medications, the therapist should make these recommendations. The potential role of social supports for relapse prevention was discussed in the section above on coping.

Individual Therapy for Other Family Members or Friends

In some situations, the child may be placed with other relatives or family friends. To effectively protect the child, they must be capable of recognizing the threat and maintaining appropriate boundaries (Sanders & Ayoub, 2018). Thus, these individuals, some of whom may have been intentionally or unintentionally collusive with the abuse, may benefit from the therapy described below.

There is a spectrum of awareness that a spouse/partner, other family members, and/or highly involved family friends may have regarding the abuser's actions ranging from being completely naïve to being appropriately concerned to active participation in the abuse (Sanders, 1995). Acknowledgement of the abusive behaviors is one of the most important aspects of successful treatment and, as described in the previous section, it is imperative that all caretakers are able to acknowledge the abuse. Sometimes family members and friends feel resentful, betrayed, angry, and/or guilty. These feelings need to be explored to come to terms with the abuser's behaviors, to acknowledge any part the family member or friend may have had in enabling the abuse and/or neglect, and to develop appropriate safety plans.

In order to understand what has occurred and acknowledge the abuse, it can be useful to review the court evaluations and medical records. This allows the family member or friend caretaker to understand how the illness or disability story was created. The client will be asked to explore his or her experiences and come to an understanding of the children's experiences as well. Abusers who acknowledge their abusive behaviors may be helpful if they are willing to share their stories with the caretakers.

Individual Therapy for Child(ren)

Any therapeutic approach with child victims of MBP will need to take age and development into consideration. All child victims should receive therapy unless they are infants or pre-verbal. The first step would be establishing safety and helping the child understand the therapy relationship.

Most child victims of MBP believe they are or were ill and/or impaired. Some have great difficulty altering their belief system. Balancing the need to respect the child's beliefs and attachment to the abuser with the child's need to sort out the truth in order to optimize health and functioning requires the therapist to be curious, nonjudgmental, and neutral. Over time, the therapist can help child victims explore their stories of illness and help them understand the reality of their health status. This includes exploring thoughts and feelings about the past, their parents and family, and health providers. For older children, it can be useful to review medical records and court documents to help them sort through their beliefs, experiences, and story of falsified illness. Children who are able to integrate more accurate information into their self-story develop a more reality-based understanding of their health and abilities (Bursch, 1999; Sanders, 1996). For children under the age of 8–10 years and those who have significant intellectual disabilities, use of play therapy may be a more useful initial therapeutic approach for exploring past story of illness and reformulating a story of health.

Children who have been the victims of MBP abuse may have serious and chronic psychological problems. Libow (1995) interviewed adult victims of MBP abuse and found they had problems with social interaction, attention and concentration, oppositional disorders, patterns of reality distortion, poor self-esteem, trauma reactions, and attachment difficulties. They may also remain angry, and struggle with depression and oppositionality. Thus, trauma-focused and attachment-focused therapies may also be particularly useful for victims.

Efforts should be made to normalize the child's life as much as possible, especially with health, appropriate independent functioning, socialization, and school attendance. A formal rehabilitation plan is needed for some children who have experienced severe and/or highly disabling abuse or neglect. If the children have not been removed from their families or are engaged in a reunification plan with

the parent, it is recommended that they receive integrated therapy with the parents to promote a healthy parent–child relationship. If the children are not to be reunified with the parent, it is likely that they would benefit from therapy to promote a healthy bond with the new caregivers.

The new caregivers typically benefit from understanding how to respond to victims' bids for attention using illness behaviors, attempts at recreating an enmeshed or dependent relationship, and expected expressions of grief or anger. They also need to be prepared to respond to intrusive attempts by the abuser to regain control over the victim.

Phase III: Co-parenting Therapy

If both parents want to work on co-parenting and are both able to acknowledge the abuse, they may be ready to be integrated and work together on helping each other cope and parent appropriately. Joint goal setting, problem solving, communication, role clarification, boundary management, and parenting practices are helpful skills to target. In many cases, abusers do not return to taking responsibility for the child's medical appointments or the other parent agrees to be present at all clinical encounters. This is a safeguard that some abusers appreciate.

Phase IV: Family Therapy

If the abusive parent is able to acknowledge the abuse, it may be beneficial if she (and her spouse, if possible) inform the child about the reality of the falsified illness. The goal of such a session (or series of sessions) is to clarify the story of falsified illness for the child. It should be made clear ahead of time that the goal is not for the abuser to ask for forgiveness, but to provide the child with accurate information and, ideally, express empathy for the child's experience. Parents might benefit from practicing answering questions the child might have for them ahead of time, to ensure their answers are simple, accurate, and sensitive to the child's feelings. The child should not be put in the position of having the parent ask for forgiveness, although the parents can certainly express regret. Ayoub (2006) found that when the abusers were able to inform their children about the abuse and field their questions, this helped the child understand how they came to have false beliefs about their health and decreased self-blame and denial.

During this phase of treatment, the family will continue to build upon the story of health and appropriate parenting and coping. This may include helping the parents increase awareness of the child's communications, needs, and feelings as well as working on ways of expressing nurturance and practicing new parenting skills. The goals for this phase would be to help the parents build appropriate expectations for their child, recognize the child as a unique and separate individual, and re-construct attachments.

With younger children, parents may be engaged in family play therapy designed to help the parent take care of the child in a healthier manner. The parents are "coached" by the play therapists in promoting healthy relationships (i.e., promoting appropriate use of power in their relationships with their children, engaging their children in more congruent and positive interactions, increasing self-acceptance). As mentioned earlier, structured family play therapies such as PCIT (Thomas & Zimmer-Gembeck, 2012) may be useful.

Phase V: Consolidation or Termination Therapy

Within the proposed model, the parent is expected to make meaningful progress for the case to remain open. The rationale for this requirement is to provide the child with the best opportunity for attachment and for the achievement of developmental milestones with optimal health and functioning. There is no set time limit that would dictate when treatment has or has not been effective. Typically progress is evaluated based on court deadlines. If the parent is not able to take any responsibility for her actions in a timely manner, this reflects a lack of meaningful progress. If the parent is not able to do so, the courts may need to move toward an alternate parenting situation. While there is no research to indicate the ideal amount of time to allow a parent to make meaningful progress, the child's need for permanency and clinical experience suggest that abusers will not make meaningful progress if they are unable to acknowledge their role, at least to some extent, within a 6-month time frame. Acknowledging that he or she "trusted the doctors too much," or some other attempt to deflect responsibility while maintaining a stance of relative powerlessness, is not sufficient.

For families who do not make meaningful progress, including the majority of abusers who are on the extreme end of the abuse spectrum, the last phase of therapy is directed at preparing family members for termination. This typically includes the severance of parental rights and an end to the parent–child contact, at least until the child is an adult.

For families who make sufficient meaningful progress, it is ideal if the therapeutic supports can be maintained as long as feasible in order to promote consolidation of gains, to assist the family through the stress of reunification, and/or to provide early assistance when problems emerge. As an example, families with children who have ongoing medical needs often benefit from recurrent evaluation of family roles and behaviors related to health matters. Unfortunately, when CPS is the payor of the mental health services, it is not uncommon for therapy to end upon reunification and/or case closure. Families can prepare for this decrease in support by determining if they have the means to access ongoing care or by developing alternate supports.

Conclusions

We have proposed a treatment protocol for families in which the parent has engaged in MBP abuse. Cases studies and considerable clinical experience reveal that abusers who have been able to genuinely acknowledge the abuse, have effective family support, and are able to experience remorse and empathy for their victim(s) are most likely to benefit from treatment. While extremely difficult to conduct, formal treatment outcome studies would allow for more robust data related to treatment effectiveness and potentially allow for refinement of the protocol. At a larger level, there remains an urgent need for greater awareness, training of legal and CPS personnel, and access to qualified clinicians to assist these families.

Compliance with Ethical Standards

Conflict of interest Mary J. Sanders and Brenda Bursch declare that they have no conflict of interest.

Human and Animal Rights No human or animal research was conducted by the authors for this literature review.

Informed Consent This paper did not include the collection or analysis of data. Accordingly, there is no requirement for review by an institutional research review board or for informed consent.

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