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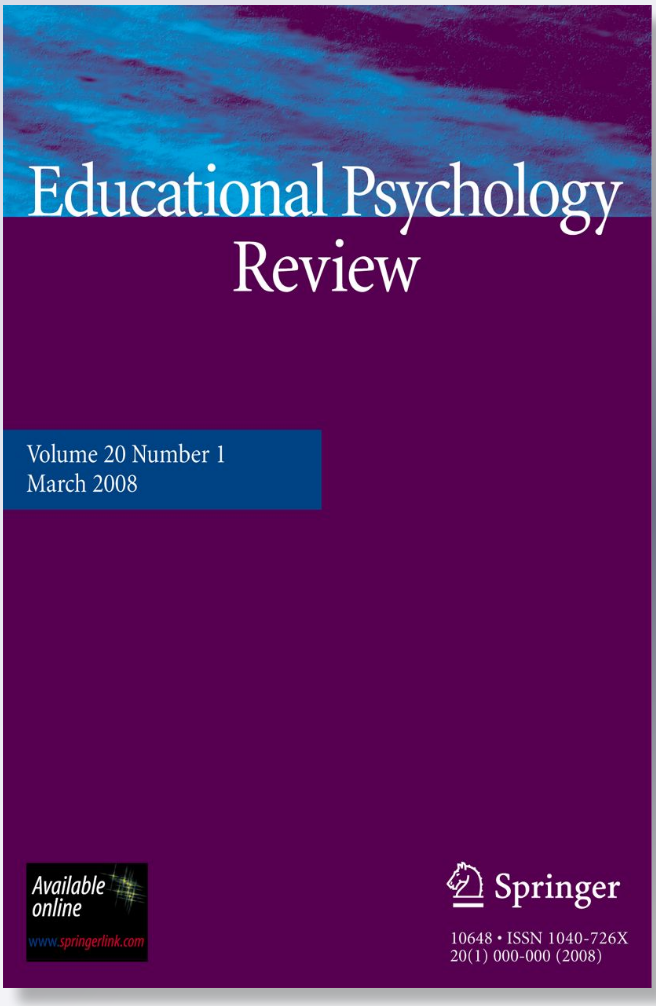

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REVIEW

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Ellen M. Frye · Marc D. Feldman

Abstract Factitious disorder by proxy (FDP), historically known as Munchausen syndrome by proxy, is a diagnosis applied to parents and other caregivers who intentionally feign, exaggerate, and/or induce illness or injury in a child to get attention from health professionals and others. A review of the recent literature and our experience as consultants indicate clearly that FDP has emerged in educational settings as well. Variants of educational FDP include parents of children with real or fabricated physical disabilities who request excessive or unneeded school health services and parents who request extensive education-related evaluations for children who do not demonstrate any educational need. If such cases continue to emerge, school districts will be asked to test more students who do not have disabilities under the Individuals with Disabilities Education Act. Also, special educational directors will be weighing the cost of providing unneeded testing and educational services against the cost of defending themselves in litigation to prove that the testing and services are unnecessary. A table of guidelines is provided for school and other personnel confronted with repeated requests for unwarranted special education services. Suggestions for future research are included.

Keywords Factitious · Munchausen · Proxy · Illness deception · Sick role · Special education

“I think my child has a disability I read about on the Internet. I want to request a medical and psychological evaluation for it. Don’t you think it would help my child if he had additional services and accommodations?” Teachers, special education administrators,

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educational diagnosticians, and school psychologists have heard variations of this question, sometimes from anxious parents who genuinely fear that their children are suffering from an undiagnosed educational disability. However, they also face requests for additional evaluations from parents who know that their children do not suffer from whatever unusual condition they may have read or heard about. These parents enjoy the attention they get from requesting evaluations and specialized services for their children.

Ayoub *et al.* (2002b) were among the first to identify a new manifestation of factitious disorder by proxy (FDP) that appeared in schools, and this article is an update to and an expansion of their findings. At a time when many educational administrators are looking for ways to maintain their current levels of special education services, performing unnecessary evaluations and providing unneeded services to students is not an efficient use of available funds or time. Still, some school districts expend those resources to avoid expensive litigation initiated by parents who appear to thrive on being in the spotlight, advocating for a child who, in reality, has no educational impairments.

Factitious disorder by proxy, sometimes called Munchausen by proxy (MBP), is the phenomenon in which a caregiver (usually a mother) intentionally feigns, exaggerates, or induces illness, injury, or impairment in a child to garner emotional satisfaction (Ayoub *et al.* 2000; Meadow 2000; Rosenberg 1987; Sheridan 2003). Usually recognized as a form of child maltreatment, the typical motivation for a parent to harm a child in this way is to assume the "sick role" vicariously and get attention and nurturance for being a long-suffering parent of a chronically ill child (Ayoub and Alexander 1998; Ayoub *et al*. 2002a; Schreier 2002a; Schreier and Libow 1993). In the USA, Schreier (2002b), Feldman (2004), and Ayoub *et al.* (2002b) have suggested that, indeed, schools are prime settings for FDP to occur. Jennons (2009) illustrates that FDP in educational settings is also of concern in the UK, and Heubrock (2001) describes a case study of a child with fabricated neurological symptoms whose mother applied for special services at a school in Belgium, indicating that FDP in educational settings is a concern in other countries

Whereas "Munchausen by proxy" (or "Munchausen syndrome by proxy") is the better known term for the phenomenon, "factitious disorder by proxy" and "factitious disorder imposed on another" are diagnostic terms being considered for the upcoming edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; Dimsdale *et al*. 2009). In this paper, "Munchausen by proxy" or MBP will be used when summarizing articles that used that particular phrase; "factitious disorder by proxy" or FDP will be used when summarizing articles that used that phrase. Otherwise, the term "FDP" will be used.

DSM-IV-Text Revision (DSM-IV-TR; American Psychiatric Association 2000) includes criteria for factitious disorder that specify three different subtypes—the first with primarily physical symptoms, the second with primarily psychological symptoms, and the third with both psychological and physical symptoms. FDP is included within the residual category of "factitious disorder not otherwise specified." However, DSM-IV-TR recognizes in its Appendix B that further study of FDP is needed before it can be fully accepted as a mental disorder.

Review of Symptoms of MBP/FDP

Asher (1951) first used the term "Munchausen's syndrome" in 1951 to describe illnesses or symptoms that were provoked or simulated by patients themselves. He described patients who fabricated illnesses and made repeated visits to physicians. Over time, these patients traveled from hospital to hospital and received innumerable tests, procedures, and surgeries that found no cause for the symptoms. Asher named the condition "Munchausen's syndrome" in reference to Baron Münchhausen, an eighteenth century German cavalry officer who often entertained his friends with exaggerated, sometimes fantastic tales from his military experiences.

Meadow (1977) reported two cases of children who received medical treatment for conditions that were highly unusual and for which appropriate treatment did not lead to recovery. In both cases, the medical personnel eventually determined that the children's mothers had intentionally harmed them and sabotaged the medical treatment. According to Meadow, the mothers "thrived on the attention the [hospital] staff gave to them." Meadow applied the phrase "Munchausen syndrome by proxy" to describe the two cases.

Rosenberg (1987) reviewed the available literature on MBP and identified a four-symptom cluster that was common to all identified cases of MBP at the time. These symptoms were:

1. Illness in a child which is simulated (faked) and/or produced by a parent or someone in loco parentis
2. Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple procedures
3. Denial of knowledge by the perpetrator as to the etiology of the child's illness
4. Resolution of the acute symptoms and signs of the child when the child is separated from the perpetrator

Most of the definitions and explanations for MBP since 1987 have agreed with these four criteria and elaborated on them. The first indicator of intentionally falsifying illness in or injury to a child by a parent is critical to the identification of FDP (Ayoub *et al*. 2000; Pearl 1995; Sheridan 2003). The second sign, repeatedly taking the child to different hospital emergency rooms or clinics for medical treatment, is commonly noted in the literature and is referred to as "doctor shopping" or "hospital shopping" (Lasher and Sheridan 2004; Ostfeld and Feldman 1996). In relation to the third indicator, consistent denial of how the child's illness or injury was caused, several authors note that the perpetrator's denial is most commonly entrenched and unshaken, even when the illness fabrication is proven by video surveillance or other means (Berg and Jones 1999; Feldman 1994; Parrish and Perman 2004). The fourth indicator, in which the caregiver has been denied access to the child and the child's physical symptoms have resolved, is also noted consistently (Atoynatan *et al*. 1988; Zylstra *et al*. 2000).

In 1998, the American Professional Society on the Abuse of Children convened a task force to study the definitional issues of MBP. The task force's report recommended that the term "pediatric condition falsification" (PCF) be used when a parent or other caregiving adult "falsifies physical and/or psychological signs and/or symptoms in a victim, causing the victim to be regarded as ill or impaired by others" (Ayoub and Alexander 1998). The task force believed that only when perpetrators deliberately fabricate a medical history or symptoms in a child to satisfy their own psychological needs should the diagnosis of "MBP" per se be made. They agreed with Meadow (1995), who gave some specific examples of parents who had induced illness or injury in their children in a manner that fit Rosenberg's four criteria, but were not necessarily instances of MBP. Meadow's examples of non-MBP included mothers with a delusional disorder who incorrectly believed that their child was ill, or mothers who took their children repeatedly to a physician to keep them out of school and dependent on the parent/caregiver. For Schreier (2002b), the unique goal of FDP is to attract attention from influential professionals while simultaneously manipulating them. Schreier (2002b) and Ayoub *et al*. (2002b) pointed out that some parents used the same methods in educational settings, with school psychologists and teachers serving as the focus of their manipulation.

Rand and Feldman (1999) acknowledged the difficulty of deciding whether the term MBP should apply to the perpetrator who harms the child, to the child victim, or to the abusive situation. They agreed with Meadow (1995) that the use of MBP should be limited to the precise form of abuse in which "active deception is involved and the primary motive of emotional gratification can be established." Meadow (1995) and Parrish and Perman (2004) emphasized that the motivation for fabricating illness is important in diagnosing MBP, even though it is sometimes difficult to determine.

Two motivations for PCF that point to MBP/FDP appear consistently in the literature. The first incentive is gaining attention for being the devoted parent of a child who is constantly sick (Atoynatan *et al*. 1988; Meadow 2000; Shaw *et al*. 2008). The second is deceiving and manipulating physicians and other medical staff who are usually respected for their knowledge and influence (Ayoub and Alexander 1998; Feldman 2004; Shaw *et al*. 2008). In addition to doctors and school personnel, the targets of manipulation can include judges, media representatives, and law enforcement personnel (Ayoub *et al*. 2002b).

Differential Diagnosis

The DSM-IV-TR diagnosis of malingering is similar to factitious disorder, but with a significant difference (American Psychiatric Association 2000). Cases of malingering require a primary external incentive for the behavior, such as benefiting financially, obtaining narcotics, or evading military duty. For example, if a parent intentionally administers large doses of laxatives to a child, resulting in a diagnosis of a chronic gastrointestinal problem, and the parent then applies for Social Security disability benefits for the child, this action fits the definition of malingering (or "malingering by proxy") because the goal is external.

Other instances of parents' intentionally inducing illness in or injury to their children have occurred when parents are divorcing and pursuing full custody (Schreier 2002a; Parrish and Perman 2004). In these cases, one parent inflicts an injury to a child and attempts to make it appear that the other parent is responsible for the harm. The motivation behind the injury is to deny the other parent custody and visitation privileges with the child, not to mobilize attention from others or the opportunity to outwit professionals. These instances are not examples of FDP.

Prevalence Estimates from Medical Settings to Schools

Estimates of the prevalence of FDP in medical settings vary. Schreier and Libow (1993) reviewed the work of several authors who concluded that they did not have enough data to make statistically meaningful statements. Most of the studies they cited were anecdotal case histories, which are limited in their ability to produce statistical information.

Schreier (1997) next extrapolated numbers from a 1996 study in the UK (McClure *et al*. 1996) and gave a "minimal estimate" of 625 new cases of MBP per year in the USA. Later, Ayoub and Alexander (1998), Schreier (2002b), and Shaw *et al*. (2008) cited this study with the same prevalence of approximately 600 new cases of MBP annually in the USA.

In an interview by Bucuvalas (2003), Ayoub mentioned a study of families affected by MBP. She revealed that "educational problems" were fabricated in six children out of 52 in the sample, resulting in a prevalence rate of 11.5%. Ayoub stated that this was "a large enough subsample of children to raise questions about presenting patterns" of MBP in educational settings.

Because there is no requirement to report cases of FDP to state education agencies and no requirement to report incidents for Medicaid or other insurance purposes, estimating the prevalence of FDP in school settings is not possible. Therefore, the cost of testing and identifying students with induced or feigned disabilities, or the cost of providing services for them, cannot be precisely calculated at this time. It is currently unknown whether it is really cost-efficient to provide unneeded services rather than go to a legal hearing to deny services.

Cost of FDP to School Districts

Under federally mandated special education procedures, parents can claim that their children suffer from severe educational and emotional problems (such as learning disabilities, autism, or emotional disturbances) or physical handicaps (such as seizure disorders or cerebral palsy). Once students are identified with disabilities, parents can then request services for their children, including specialized instruction, personal tutoring, ongoing nursing care, individual counseling, occupational therapy, and physical therapy. Whether the school is public or private, providing these services can become costly (Feldman 2004).

The Individuals with Disabilities Education Act of 2004 (IDEA) requires step-by-step procedures that include evaluation and specialized instruction for students suspected of having disabilities requiring special education. Special education services are provided only after a full individual evaluation (FIE) is completed and an individual education plan (IEP) is approved by a committee that includes the parent of the child with a disability, a special education representative, a general education representative, an assessment/evaluation professional, and a school administrator (IDEA 2004). Other school personnel—such as school counselors, school nurses, occupational therapists, and physical therapists—also may attend an IEP meeting if they are either providing services to the student or if their services are being considered for the student.

To qualify for services under IDEA, a student must be identified with at least 1 of 13 disability categories and be unable to make educational progress without special education services. It is possible for students to have a mild orthopedic condition, mild attention deficit hyperactivity disorder (ADHD), or even mild Asperger's syndrome and be able to function well enough in school to make academic progress without additional support from special education. These students are *not* eligible for special education services. However, if a school district evaluates a student, determines the student is *not* eligible for special education, and denies services, parents have several options available to pursue eligibility and services.

Parents who disagree with an IEP committee's decision not to provide special education services may request an independent educational evaluation (IEE) at the school district's expense before asking for a due process hearing or mediation. IDEA allows parents to request an IEE if the parents disagree with the evaluation provided by the school district (IDEA 300.502(b)(1)). The expense of IEEs varies from state to state and school district to school district. Based on personal communications from special education administrators and private practice educational diagnosticians, the cost for an IEE can run from US $750 in rural areas to US $3,000 in urban areas (O. Thompson, July 2011, personal communication).

However, IDEA also specifies that a parent is entitled to “one independent evaluation at public expense each time the public agency conducts an evaluation with which the parent disagrees” (IDEA 300.502(b)(50)). Therefore, if a school district conducted an initial FIE, which typically includes information from a student’s teacher(s), parents, individual intelligence measures, and individual achievement testing, the parent may request an IEE if he/she disagrees with the results. Also, if the school district requested an additional psychological evaluation by a school psychologist to evaluate behavioral concerns, the parent can ask for an independent psychological evaluation at the school district’s expense. The cost of psychological evaluations also varies from state to state and school district to school district, depending on the availability of appropriately trained school psychologists. Some school districts have school psychologists as part of their assessment staff. Other smaller school districts contract with psychologists in private practice when a student is suspected of having an emotional disturbance, autism, or another condition that requires a psychological evaluation. The expense of psychological evaluations by contracted psychologists varies from US $700 to US $1,600 in Texas (O. Thompson, July 2011, personal communication) to US $5,000 in New Jersey (P. Frawley, July 2011, personal communication).

A parent could also request an independent medical evaluation if he/she disagreed with the school district’s medical evaluation. Fees for medical evaluations in west Texas range from US $500 for an evaluation for ADHD to US $5,000 for a computed tomography brain scan (O. Thompson, July 2011, personal communication). In New Jersey, the cost for a medical evaluation ranges from US $2,000 to US $5,000 or more, depending on the referral question (P. Frawley, July 2011, personal communication).

If a parent requested an independent FIE at a mid-range rate of US $1,500, an independent psychological evaluation at a mid-range rate of US $2,500, and an independent medical evaluation at a mid-range rate of US $3,000, costs would total US $7,000. Paying for several independent evaluations at higher rates could increase the total for one student to US $10,000. However, this amount is considerably less than the cost of a due process hearing, as noted below.

A school district may choose to request a due process hearing to defend its own educational evaluation rather than provide an independent evaluation. The expenses of due process hearings include attorney’s fees, postage and correspondence, and coordination and preparation for testimony, along with court stenographers’ wages and other miscellaneous expenses such as copying documents (Boscardin 1987; O. Thompson, July 2011, personal communication). School districts also incur the cost of outside consultants and expert witnesses. Chambers *et al.* (2003) reviewed information from state educational agencies and concluded that the average expense for a due process hearing in the 1999–2000 school year amounted to US $94,600. They also noted that that this “average expense” estimate could underestimate the actual cost because it may not include time spent by teachers and related service personnel who worked on the cases as part of their jobs as salaried employees of the school district. Personal communications from special education directors report that the current cost of due process hearings ranges from US $50,000 to as much as US $200,000, depending on the state and/or school district as well as the specific issue being contested (O. Thompson, July 2011, P. Frawley, July 2011, personal communications).

If a parent requests a due process hearing, the school district may request mediation from the state education agency. Mediation is a much less expensive alternative to a due process hearing, costing from US $8,160 to US $12,200 during the 1999–2000 school year (Chambers *et al*. 2003). But even these rates are unnecessary for students who genuinely have no educational need for special services.

In some cases, superintendents and special education directors may choose to hire another teacher or paraprofessional (US $27,320 annual salary for a first-year teacher in west Texas, not including benefits; US $12,400 for a paraprofessional) to work with the student since an additional teacher could also work with other students. Hiring an additional teacher would also avoid the costs of litigation to defend their refusal to provide such services. One special education director reported that a school district is more likely to get involved in a due process hearing by denying a student's eligibility and not providing any special education services. This director believed that it was better to provide additional services that can help a student than to refuse (name withheld by request, July 2011, personal communication).

Another concern comes from IDEA, Part B, which provides funding for services for children with special needs *before* they enter school at the age of 5 or 6 years (IDEA 300.817 1419(g)(2)). School districts are required to provide special education services to children with disabilities from birth to age 3 years in their homes and pre-school classes when they turn 3 years old. Stevenson and Alexander (1990) and Kahn and Goldman (1991) provide examples of children with fabricated symptoms of IDEA disabilities (cerebral palsy, an orthopedic impairment, and an auditory impairment, respectively) being treated by physicians. If these conditions had been confirmed by the treating physicians, these children could have received special education services.

Examples of FDP in Educational Settings

In the work by Ayoub *et al*. (2002b), "educational symptoms" were included along with physical and psychological symptoms as conditions sometimes falsified by parents. ADHD, specific learning disabilities, and behavioral difficulties were listed as the primary problems falsely reported, exaggerated, or induced in their study.

In the medical and social work literature, there are several anecdotal examples of MBP in which the physical conditions fabricated would require health-related services in schools (Schreier 2002a; Stevenson and Alexander 1990; Zylstra *et al*. 2000). The medical conditions falsified in these cases included cerebral palsy, seizure disorders, apnea and breathing difficulties, hearing loss, pneumonia, and gastrointestinal problems such as diarrhea and vomiting.

There are primarily two ways FDP can appear in educational settings. First, parents of children with genuine or falsified medical conditions and physical disabilities can request unneeded assistance, such as individual nursing care or related services (such as counseling, occupational therapy, or physical therapy) as part of their children's IEP under the IDEA. Second, parents of children with no educational need for special education services may refer their children for special education. This second category can include parents of children with genuine IDEA-eligible disabilities who request testing and services beyond those actually needed by the child.

As an example of the first type of FDP in schools, Palladino (1998) reported on a mother who requested homebound services for her child for numerous conditions, including obesity (150 lb when in fourth grade), asthma, bronchial ailments, kidney and urinary tract infections, suspected seizures, and nonspecific heart problems. Homebound instruction was initially provided with the requirement that the school district pursue its own independent medical evaluation of the child. This medical report uncovered no significant medical condition other than obesity and no reason the student could not attend school. After investigating the student's previous school records and other background information, the district reported the child and parent to the local child protection agency. School personnel attended staff meetings with personnel from several governmental agencies, including health and rehabilitation, children's medical services, and family services. When the child was separated from the mother, she thrived. She did not require any treatment for asthma or other physical problems. The child was returned to the mother's care and removed several times before Palladino eventually lost track. During the school district's relationship with this case, the mother told exaggerated stories not only of the child's physical problems but also details of personal family problems and litigation over an accident she had recently experienced. When the student was returned to her mother and transferred to another school, the mother told the guidance staff that the officials and staff members at her child's previous school were "all liars."

Parnell (1998) reported a child who had numerous episodes of otitis media that were treated by surgical insertion of tubes. His mother reported that he suffered hearing loss in both ears and that bilateral hearing aids were recommended. When the child entered school, the mother requested additional support and special education programs not recommended by the audiologist. The student wore amplification devices even though no hearing loss could be documented by the school's examination. Eventually, the case was investigated and the mother was accused of exaggerating physical symptoms and overmedicating both of her children.

In a case study detailed by Hahn *et al*. (2001), after extensive hospitalizations from the age of 2.5 to 8 years that included medical care by two general pediatricians, two pediatric gastroenterologists, three pediatric pulmonologists, two pediatric neurologists, a pediatric urologist, and a child psychiatrist, a mother attended school with her daughter to make certain she would be safe from possible seizures or "blue spells." The parent did not trust the in-class nursing supervision provided by the school because the school nurse did not believe the child had any genuine physical problems. The school reported frequent absences and provided some homebound instruction for the student. Feldman (2004) described another mother who insisted that a registered nurse sit next to her child in school all day. When the school superintendent indicated that the child did not appear ill or need a nurse's attention, the mother complained to local and state officials that her child was being poorly treated by the school district. The superintendent promised that the matter would be reconsidered, and the parent's request was ultimately granted.

In these cases, school personnel suspected the mothers of falsifying medical illnesses and the need for nursing care at school. As a result, the parents received attention from principals and superintendents in the form of repeated meetings and conferences. The school districts also had to pay for the extra nursing care, homebound services for one of the children, and the cost of preparing for IEP meetings and conferences with the parents to discuss their concerns regarding the educational needs of the students.

The second presentation of FDP in schools occurs when parents request educational and behavioral evaluations for children who do not need special education services. In some cases, a child may already be identified with a disability under IDEA, but the parent asks for additional evaluations and testing, claiming the child needs even more special education services. Examples of falsified special education eligibilities include autism, other health impairments (ADHD and mild paralysis), and emotional disturbance.

Coard and Fournier (2000) reported a case where a parent provided her child with a wheelchair when the child was enrolled in junior high. The student was eligible for special education services as Other Health Impaired due to mild weakness on her right side caused by a "vascular accident" that occurred 2 months after she was born. The weakness did not interfere with her school activities, and review of previous testing and reports from current teachers indicated that the student's primary difficulty was in social skills, where she was delayed. The mother reported that the student had started "falling" for no apparent reason and had been evaluated by two neurologists. When the school asked for permission to review the neurologists' reports, the mother refused to give consent. The student was evaluated by the school's occupational therapist and physical therapist. The occupational therapist explained that the unusual way that the student "fell" would not result in physical harm. The physical therapist learned that the wheelchair the mother provided for the student was not prescribed by a physician. When the child's father signed a consent form allowing the neurologists to share information with the school, the school learned that repeated testing had found no change in the student's right-sided weakness over the past 2 years and that one neurologist had referred the child to a child/adolescent psychiatrist. The school district considered the possibility of FDP, but, preferring not to confront the mother, the district provided social skills training and included the mother by encouraging her to provide appropriate rewards for the student's improved social skills.

Ayoub *et al*. (2002b) presented the case studies of two parents who requested that their children be referred for special education, even though the children's teachers found no basis for concern. One mother referred her two younger daughters after her oldest son was placed in special education due to behaviors related to Asperger's syndrome. With both younger children, the mother insisted on evaluations by school professionals and independent evaluations paid for by the school district. Medical testing by physicians accompanied the educational assessments. All results indicated no physical ailments or learning problems. In spite of these results, the middle child was taking Ritalin for ADHD and the youngest child was placed in the same special education school her brother attended.

The second case reported by Ayoub *et al*. (2002b) detailed a mother who requested a special education referral for her son when he was in first grade. When informed that his work was average, this mother claimed that he had ADHD, which the school psychologist agreed with based on the history provided by the mother. With this diagnosis, this mother started attending several different support groups for parents of children with ADHD. She attended as many as three meetings in one week and traveled nearly 100 miles to some of the meetings. Once her son started taking Ritalin for the ADHD, she requested further testing for cognitive difficulties, neurological problems, and psycholinguistic issues. Assessments based on information provided by the mother reported more problems than assessments based on information provided by teachers. This mother also began sitting in her son's classes, where she disrupted the class and antagonized the teacher. Eventually, her son was removed from her and placed in foster care, and all medication was gradually stopped.

Ayoub *et al*. (2002b) also briefly described nine children from five families who were identified as displaying "educational condition falsification" (ECF). Eight of the nine children were diagnosed with ADHD. Children in this sample were also falsely identified as having learning disabilities (usually language-based disorders), psychiatric illnesses, and behavioral disorders. In three of the five families, more than one child was a victim of ECF or PCF. The mothers in each of the families were depicted as demanding and adversarial in their dealings with school personnel.

The parents in these cases were depicted by Ayoub *et al.* (2002b) as "bold, insistent, and at times quite adversarial in their demands of the school." Ayoub *et al*. also expressed concern about the “emotional cost to staff and the effect on limited school resources in these situations.” School personnel had invested time and energy in evaluating the students, collaborating with physicians, and meeting with parents to explain alternatives to special education services. Such time and energy can easily result in physical and emotional fatigue.

Feldman (2004) gave another example of a mother who claimed her daughter had an extreme emotional disturbance even though none of the school personnel observed any inappropriate behaviors or emotional problems. This mother claimed to administer medication that was banned in the USA. She was also spending hours at school monitoring her daughter until the school district mandated the mother’s removal from school out of fear for the safety of teachers and other students.

The parents in all of these cases misrepresented the needs of their children to request placement in special classes, additional medical and psychological evaluations, and independent educational evaluations. Much time and attention was spent with these parents in the form of numerous IEP meetings to discuss and review the results of the additional evaluations and explain whether or not the requested assistance would be provided. One of the parents also received attention by attending many support groups for parents of children with ADHD, a diagnosis for her child that was dropped when the child was removed from her care.

Concerns About FDP in Schools

Typically, children with disabilities requiring special education services do not need extended hospitalizations, surgeries, or intricate medical procedures and treatments—the usual result when physical illnesses are fabricated. Therefore, educational settings will not bring FDP caregivers either the intensive attention they might receive from *medical* staff or the opportunity to outsmart respected *physicians*. However, parents can receive similar attention from *educational* professionals. Parents who desire either the attention for being selflessly dedicated to their disabled child or the gratification of deceiving professionals in the educational setting may find similar satisfaction by falsifying physical or psychological conditions or learning disorders in their children.

These parents can receive attention by attending numerous support groups for parents with disabled children as an experienced veteran who has dealt with the disability in their child and overcome it (Ayoub *et al.* 2002b). Another way to get attention is by attending open hearings conducted by state and federal agencies to get feedback from citizens. One mother appeared at an open meeting designed to inform the public on how to access state and federal services for persons with disabilities. She identified herself as the parent of a child with autism and spoke for an extended length of time, explaining her child’s needs. The special education director from the local school district recognized her and privately followed up on the parent’s report to ensure that the student was getting proper services. The director learned that the student was receiving special education, but was not identified as a student with autism. The director requested some informal observations of the student by a school psychologist and a clinical psychologist to confirm that there were no indications of autism. One of the student’s teachers reported that the student’s family was well able to take care of the child without public aid (name withheld by request, July 2011, personal communication).

Parents can also repeatedly contact teachers, principals, special education administrators, and superintendents, requesting more evaluations and services for their child. The same special education director described a parent who requested that a school district pay for her child's college education because the district never identified the student's autism. This parent refused to give consent for an initial FIE or for school personnel to test her child. Instead, when the school district agreed to have the child evaluated by a psychiatrist in private practice, the mother went to the psychiatrist's appointment and described her child's symptoms. The psychiatrist reported that the symptoms reported by the parent were the word-for-word textbook description of autism. The special education director, school district superintendent, and several school board members received fax machine reports from this parent that were sent at odd times (such as at 1:30 A.M.) and took hours for the fax machines to print out (name withheld by request, July 2011, personal communication).

The effects of placing students in separate classes in order to provide specialized instruction is an ongoing concern for special education professionals, resulting in the current "inclusion" movement to provide special education services in general education classes (Henley *et al*. 2009). In spite of the drive for inclusion, the prospect of placing students with no educational need for special services into separate classes is a major concern. One of the arguments behind inclusion efforts is that isolating students from their non-disabled classmates decreases self-esteem and fosters negative opinions about school. When general education teachers believe that a student has a learning disability or ADHD, they have lower expectations for that student (Henley *et al*. 2009). For a student to suffer such lowered expectations when not disabled would be unfortunate.

Ayoub *et al*. (2002b) express concern that students with falsified educational difficulties are at risk for school failure and emotional problems. They noted that the students in their sample exhibited temper tantrums, out-of-control behavior, aggressive acting out, symptoms of depression, and symptoms of oppositional defiant disorder. Wilde (2004) notes that children of parents with FDP face the risk of not developing personal responsibility because of their parent's desire to keep them dependent. These children also tend to rely on their parents to shelter them from responsibility. According to a Harvard research study in progress, the long-term psychological and educational morbidities of forged educational presentations of FDP are substantial (C. Ayoub, July 2011, personal communication).

A recent study by Litvack *et al*. (2011) examined the attitudes of general education students in classes where disabled students were included. They concluded that high-achieving and average-achieving students believed that they learned less in these classes because the teachers covered the material slowly, provided fewer learning challenges, and spent less time with them. The high-achieving and average-achieving students also reported minimal interactions and friendships with students with disabilities. These perceptions of high- and average-achieving students can bring more stigmatization and stress to students with feigned learning problems.

Schreier and Libow (1993) reported how FDP in medical settings can escalate from minor injuries that are genuine to serious injuries that are induced. In a similar way, parents can intensify their behavior from falsifying educational problems to inducing physical injury. Alternatively, parents may choose to avoid the possibility of legal charges of physical child abuse inherent in fabricating physical illness by changing to feigning educational handicaps. Creating bogus educational disabilities broadens the continuum of possible FDP behaviors.

Recommendations

Based on our knowledge of FDP, the review of published cases, and our professional experience, we can offer a number of recommendations. If an administrator begins to suspect that he or she may be dealing with a parent with FDP, the safety of the child should be the first concern (see Table 1). If a parent becomes frustrated in her attempts to gain attention and deceive psychologists and teachers, the behavior could escalate into deliberately causing emotional distress and physical disorders in her child to force the attention she is not getting from school professionals. If a teacher suspects that the child is being physically abused to create medical illness or emotionally abused by being manipulated to pretend to need medication, the teacher should document the concerns and notify the appropriate local or state agency mandated to protect children.

Next, school administrators must decide what limits on services (e.g., direct instruction, related services, and classroom accommodations) will be provided to the child in question. Coard and Fournier (2000) demonstrate how providing appropriate services (e.g., group counseling to teach appropriate social skills) based on relevant evaluation information, even to a student with questionable educational needs, can avoid confrontation with a parent over the evidence of fabrication, including the parental denials that predictably follow. Giving the parent specific responsibilities in the school services also allows the school personnel to monitor the student's and the parent's responses to the services.

If the fabricated conditions require medical evaluation or treatment, Coard and Fournier (2000) recommend that a school district and medical setting assign liaison people to assist in deciphering terminology and communicating between the two venues. Moreover, IEP teams need to be diligent about interventions that might be medically contraindicated and avoid inadvertently reinforcing factitious illness behaviors.

Wilde (2004) recommends providing the child with services designed to foster independence and responsibility for his or her education. By falsifying physical and educational disabilities, parents with FDP tend to increase their child's dependency on others. School personnel can alleviate this reliance on others by encouraging students to handle their own problems autonomously and provide emotional support through participation in counseling services available to all students in public schools.

Furthermore, teachers, educational diagnosticians, school psychologists, and school counselors should be continually alert for new indications that parents are falsifying

Table 1 Recommendations if educational FDP is suspected or confirmed

1. The safety of the child is the first priority. If school personnel harbor reasonable suspicions that a parent is engaging in fabrication, exaggeration, or induction of psychological, physical, or educational disabilities, they are mandated to report these concerns to the appropriate child protection agency.
2. Special education administrators, school principals, and school superintendents should decide on the limits on educational services to be provided to the involved student without being bullied by parents into providing expensive specialized instruction or individual assistance that is not recommended by the school's own evaluations. Also, schools should continue to provide support from counseling and tutoring services that are available to all general education students to foster each student's independence and self-responsibility.
3. When limits on educational services are determined, school administrators must be prepared to back these boundaries up by litigating before a hearing officer to defend their decisions.
4. Teachers, educational diagnosticians, school counselors, and paraprofessionals should be alert for indications that parents are falsifying educational disabilities and/or psychological disorders.
5. Educational personnel should be prepared to deal with the additional stress parents with FDP can add to their jobs. They may need to find personal legal counsel and gain emotional support from their employee assistance program.

educational disabilities or psychological disorders. If a parent is not relieved when informed that a child does not need special education services and requests additional testing that is not supported by information from school staff, the school personnel may need to consider FDP. Since attempts to placate these parents by providing additional evaluations and services are sometimes only temporary (Ayoub *et al*. 2002b), the school district may have to formulate a plan regarding how to proceed if the parent continues to escalate the requests for additional testing and services (Jennons 2009).

Once the decision is made to limit education services, every effort should be made to maintain those boundaries. Parents evidencing FDP should be handled in much the same way as children with difficult behaviors: the administrator should not threaten any tactic unless he or she is prepared to follow through. For example, a special education administrator should not tell a parent that the school district is willing to proceed to litigation to defend their IEP unless the district is truly prepared to do it. Administrators should also "do their homework" and be ready to defend their decision not to provide additional services, with appropriate documentation showing that the additional services are not needed. Wilde (2004) suggests that some parents threaten litigation as a way to get their demands met by school districts. He believes that if school districts are prepared to defend their decisions by initiating a hearing first, parents may be less inclined to request unneeded services.

Educational personnel should be prepared to deal with the additional stress FDP parents can bring to their jobs. If the behavior of parents in medical settings transfers to educational settings, they can expect these parents to get angry with them and insult their intelligence, expertise, and competence. This behavior can be expected at IEP meetings and in communications with attorneys, consultants, and other school district administrators (such as superintendents). School district and special education personnel should be prepared to respond if and when parents with FDP go public with their requests for services for their child by contacting newspaper and television media or government officials. Education staff may need personal legal counsel in addition to the counsel representing the school district.

Conclusion

Even though the literature citations are relatively few and the optimal diagnostic criteria are still being debated, available evidence strongly indicates that FDP is occurring in educational settings. Currently, the cost of evaluating and testing these children, as well as the cost of providing special education services to them, can only be speculated. Even though school districts have the option of requesting a hearing to defend their decisions that students do not need special services, these hearings are expensive in terms of time and money.

More research is needed to determine the prevalence, cost, and other impact of FDP in educational settings. However, researching FDP in educational settings is complicated by the fact that educational diagnosticians and school psychologists are trained to identify students in need of special education services, not parents with deep, unmet psychological needs. Even though schools districts have at times provided therapy to families of students receiving special education services, the research on psychological treatment for parents with FDP has produced decidedly mixed results (Berg and Jones 1999; Feldman 2004).

In addition to Ayoub's current research into the long-term effects of FDP on children (C. Ayoub, July 2011, personal communication), research into FDP in educational settings could benefit from qualitative studies that survey special education teachers, educational diagnosticians, school psychologists, and special education administrators who encounter parents who demonstrate behaviors consistent with FDP. Based on this information, it may be possible to find consistent patterns in how the children are presented to school district personnel by their parents and how the requests for services are made that signal falsified symptoms of IDEA eligibilities. Research such as this may also be able to estimate the cost of evaluating and providing services in these cases and to optimize child protection. As the studies accumulate, issues of appropriate intervention can be investigated.

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