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Comfort and Knowledge as Predictors of an Accurate Diagnosis of Factitious Disorder Imposed on Another Among Counseling Professionals

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This is to certify that the doctoral dissertation by

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Proposal Submitted in Partial Fulfillment

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Abstract

This quantitative predictive study examined comfort and knowledge as predictors of an accurate Factitious Disorder Imposed on Another (FDIA) diagnosis among master-level mental health counseling professionals in Washington State. This study also explores why researchers have struggled to develop a collective body of knowledge that can predict an accurate diagnosis of FDIA. The person-centered theory model guided this research. Data from the online platform SurveyMonkey was used to collect participant demographics, answers to the diagnostic questionnaire, and answers to the knowledge and comfort survey. All data collection took place between June and July 2024 and all data collected was electronically gathered. Binary Logistic regression results indicated that both comfort and knowledge were not statistically significant and did not predict an accurate diagnosis of FDIA. However, the Hosmer and Lemeshow Test did suggest that comfort could be an overall better predictor of an accurate FDIA diagnosis over knowledge of the disorder. These findings indicate that variables other than comfort and knowledge should be considered when predicting an accurate diagnosis of FDIA. Implications for positive social change include preventing harm to victims by understanding that FDIA has a higher likelihood of danger than other mental health diagnoses. To effect social change, master-level mental health professionals must know about mental health disorders that have the potential for increased criminal behavior.

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Chapter 1: Introduction

Counseling professionals are less aware of FDIA than other professional groups in mental health and medical psychology (Osfeld, Feldman, et al., 1996; M. Feldman, personal communication, 2020, February). Factitious Disorder Imposed on Another (FDIA), also known as Munchausen by Proxy will be used interchangeably in this study. Researchers have found that knowledge and awareness of FDIA vary significantly among master-level and doctorate-level mental health professionals (Osfeld, Feldman, et al., 1996) and is reflected in the unknown national and international prevalence rate of the disorder (APA, 2022). Knowledge refers to an individual's familiarity with an existing topic. Boswell and Scharff (2022) determined a lack of research on the availability of knowledge of FDIA. A lack of understanding of FDIA may contribute to the unknown prevalence rate (M. Feldman, personal communication, 2020). Associate master-level counseling professionals are particularly prone to inaccurate diagnosing and discomfort with disorders because of the lack of information that is provided in diagnostic courses in mental health counseling programs (Boswell & Scharff, 2022; Murphy & Joseph, 2016). Comfort refers to a counseling professional's sense of psychological ease (Boswell & Scharff, 2022) when diagnosing a mental health client for the sake of treatment (Murphy & Joseph, 2016; Pineau, 2008).

Accurate diagnosing refers to a counseling professional's competence in utilizing the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition – Text

Revision (APA, 2022). “Clinical training and experience are needed to use the DSM for determining a clinical diagnosis” (APA, 2022). The DSM is intended to serve as a guide that aids in the accurate diagnosis and treatment of mental health disorders. The DSM criteria are concise, explicit, and intended to facilitate symptom presentations in mental health settings (APA, 2022). This textbook is designed for students and professionals who need a structured and professional way to diagnose mental health disorders (Anastasi & Urbina, 1997; APA, 2022).

Knowledge and comfort level of FDIA impact competent diagnosing and it is important to have both when diagnosing all disorders in the mental health and medical profession (Boswell & Scharff, 2022; Murphy & Joseph, 2016, Osfeld, Feldman et al., 1996). A counselor’s familiarity with the existence of FDIA, as well as experience through training and case studies (APA, 2022) that provide an understanding of history, prevalence, and diagnostic criteria (Schreier & Libow, 1993), is an important part of counseling professional’s knowledge. The American Counseling Association Code of Ethics (2014) stresses the importance of counselors’ ability to provide proper diagnosis. Competency-based expertise and comfort level are important when diagnosing FDIA (Osfeld, Feldman, et al., 2020). Counselors should understand that refraining from understanding FDIA causes significant harm to the victim (Bass & Holligan, 2014; M. Weber, personal communication, 2020).

Measuring a counseling professional’s comfort level in diagnosing mental health disorders and knowledge of diagnostic criteria is assessed throughout the coursework in a

master-level counseling training program (Falender & Shafranske, 2014). Mental health competency-based approaches in coursework, supervision, and internship inform a counselor's knowledge of mental health diagnosis (Anastasi & Urbina, 1997; Corey, 2009; Falender & Shafranske, 2014). Given the focus of the competency-based approach in mental health programs, one key element of measuring comfort and knowledge of the material is through evaluation and assessment of clinical outcomes (Corey, 2009 Falender & Shafranske, 2014). When a counselor graduates from a master–level training program and completes a designated amount of internship hours, be considered competent in basic assessment a diagnostic skill. When a counseling professional completes three years of full-time counseling or 3,300 hours of post-graduate supervised mental health training and passes the National Counseling Exam then the counselor is considered to have advanced competency in assessment and diagnosis skills (doh.wa.gov, 2022).

Psychologists and psychiatrists often have earlier and broader opportunities for training in specialty disorders such as FDIA, increasing competence in diagnosing skills (Osfeld, Feldman et al., 1996). In contrast, adequate training to improve counselors' comfort and knowledge in specialty disorders has not been studied (M. Feldman, personal communication, 2021 February). Comfort diagnosing and knowledge of FDIA have a significant impact on how counseling professionals accurately diagnose the disorder (M. Feldman, personal communication, 2021). Studying variables that impact the likelihood of accurate diagnosing provides a better understanding of how information and training

can be created to improve statistics and the prevalence of FDIA (Feldman & Xiong, 2020).

In Chapter 1, I will present an overview of this study, including the description of the social problem, gaps in the literature, and hypotheses. I will introduce Carl Rogers's Person-Centered Theory (1940) which will provide a framework for the study and define terms and variables present in the research design. Finally, I will discuss the limitations, delimitations, assumptions, and significance of this study.

Background

Osfeld and Feldman's 1996 study to determine the level of awareness of FDIA among mental health practitioners was a seminal work for this study. The researchers conducted a study that polled 687 professionals who worked in the medical and mental health field. Anonymous questionnaires were sent to 687 primary care physicians and mental health practitioners. Psychiatrists and psychologists were most aware of and comfortable diagnosing FDIA (psychiatrists 89%; psychologists 69%) compared to master-level social workers (42%). Psychiatrists were more likely than psychologists or social workers to have had exposure through an actual case or their professional journals (Osfeld, Feldman, et al., 1996).

Diagnosing FDIA is very difficult because of the dishonest nature of this disorder (Bools, Neal, et al., 1994; Cleveland Clinic, 2021; M. Feldman, personal communication, 2020; Bass & Holligan, 2014; M. Weber, personal communication, 2022; Schreier & Libow, 1993; Sheridan, 2003). Individuals diagnosed with FDIA can be manipulative and

charming. Manipulation, charm, and deceit are common indicators of a significant personality disorder (M. Weber, personal communication, 2021). Two common personality disorders associated with FDIA are borderline personality disorder and narcissistic personality disorder (Cleveland Clinic, 2021). Confronting a client exhibiting signs of a personality disorder can be difficult for counselors (Greenstein, 2018). Often, master-level mental health professionals' theoretical orientation may prevent focusing on negative personality traits such as manipulation or deceit (Bass & Holligan, 2014; Boswell & Scharff, 2022). A common training model in counseling programs focuses on providing a safe space of unconditional positive regard regardless of negative personality characteristics (Hays, 2017; Moderna Healthcare, 2021). Additionally, research has indicated that a counselor's comfort and knowledge of mental health evaluation and assessment can have an impact on diagnosing (Moderna Healthcare, 2021). Further, research into the personal belief of a counselor's conceptualization of a client based on a holistic model of therapy (Bass & Holligan, 2014; Hays, 2017) may also explain the aversion to diagnosing. Finally, FDIA may also go undiagnosed because of general discomfort with confrontation as a tool in the therapeutic process (Murphy & Joseph, 2016; Nicole & Eccles, 1997).

Mental health training in counseling skills suggests that confrontational topics can lead to the disruption of the therapeutic alliance, therefore many professionals are unaware of how to conduct difficult conversations with deceptive and abusive clients (Nicole & Eccles, 1997). The prevalence of FDIA is unknown most likely due to the

deception in this population and because healthcare professionals infrequently understand the diagnosis, even in recognized cases (APA, 2022; Bass & Holligan, 2014; Feldman & Ford, 1994: Felman & Xiong, 2022; Feldman & Yates, 2018). There has not been a study addressing the link between mental health professionals and their knowledge or comfort of FDIA and their diagnostic accuracy of the disorder (M. Feldman, personal communication, 2021). I intend for this study to contribute to the literature on the topic of FDIA by increasing the understanding of how knowledge and comfort level affect the accuracy of diagnosing the disorder.

Problem Statement

The purpose of this quantitative predictive study is to examine comfort and knowledge as predictors of an accurate FDIA diagnosis among counseling professionals. There is no reliable statistic regarding the number of people in Washington State who are diagnosed with FDIA by counseling professionals, and it is difficult to assess how common the disorder is because many cases go undetected due to a lack of knowledge and comfort (Cleveland Clinic, 2021; M. Feldman, personal communication, 2020; M. Weber, personal communication, 2020; Sheridan, 2003; Stein, 2014). The research problem is to predict which variables affect an accurate FDIA diagnosis among counseling professionals in Washington State. All previous research of this time focused on doctorate-level professionals and social workers in the counseling and medical field.

Counseling professionals cause damage by not understanding all the disorders in the DSM and by avoiding diagnosing because of discomfort (A. Dunlop, personal

communication, 2020; Hays, 2017, M. Feldman, personal communication, 2020; Zeshan, Cheerman, et al., 2018). Based on a literature search of many databases, as well as personal communication with experts in the field, I found only one peer-reviewed journal article that addressed the link between mental health professionals' comfort and knowledge and accuracy of diagnosing FDIA (Osfeld, Feldman, et. al., 1996). I found one peer-reviewed article (Nicole & Eccles, 1997) and one book (Murphy & Joseph, 2016) addressing comfort with diagnosing FDIA. Research does not provide reliable statistics on diagnosing FDIA in the United States because of nuances in understanding, identifying, and diagnosing this disorder (Feldman & Xiong, 2020; M. Feldman, personal communication, 2020; Schreier & Libow, 1993). According to Dunlop (2020), building upon the previous research by examining the variables of knowledge and comfort in diagnosing FDIA among counseling professionals is needed to increase the knowledge base in the field (Feldman, Osfeld, et al., 1996; M. Feldman, personal communication, 2020; M. Weber, personal communication, 2020; Zeshan, Cheerman et. al., 2018).

Purpose of Study

The purpose of this quantitative predictive study is to examine whether comfort and knowledge predict an accurate FDIA diagnosis among counseling professionals. The independent variables are comfort and knowledge, and the dependent variable is the accurate diagnosis of FDIA. The diagnosing section of the questionnaire was developed with a specific focus on diagnosing FDIA. All cases have verified diagnoses from the book *Dying to be Ill: True Stories of Medical Deception* by authors Feldman and Yates

(2018) and *All in Your Head* by author O'Sullivan (2015). In the diagnosing section, the participants will be offered four cases of individuals who have a professional mental health diagnosis. The last two cases have confirmed FDIA.

Research Question and Hypothesis

RQ1: Are comfort and knowledge factors that predict an accurate diagnosis of FDIA?

Ho1: Comfort and knowledge do not predict an accurate diagnosis of FDIA.

Ho2: Comfort and knowledge do predict an accurate diagnosis of FDIA.

Theoretical Foundations

The theoretical framework for this study is the Person-Centered Theory (Murphy & Joseph, 2016). Since the development of person-centered theory, Carl Rogers (1902 - 1987) has been supported by an extensive body of empirical research evidence. The non-directive approach to Person-Centered Theory is best understood as embracing the client by extending non-judgment and total acceptance (Levitt, 2005; Murphy & Joseph, 2016). Between 1942 and 1951, Rogers's studies focused on the role of non-directivity in the process and outcome of psychotherapy (Snyder, 1945). Most person-centered counselors do not rely on diagnosis to guide the course of therapy and treatment (Murphy & Joseph, 2016). This non-directive approach to diagnosing is intended to support the client's autonomy and reduce the stigma of labels (Murphy & Joseph, 2016) According to Boswell and Scharff (2022) precise clarification of psychiatric disorders is important to conduct accurate treatment. Clinical observation validated self-reports, assessment tools

and an ability to diagnose mental health diagnosis are critically important components in counselors' training (Murphy & Joseph, 2016) as effective assessment and diagnosis serve a specific purpose toward growth, insight, and recovery. Client-focused assessment in training has research and knowledge gaps that "should be acknowledged."

Psychological assessments are conducted by doctorate-level psychologists, prohibiting master-level clinicians from familiarity with measures that help identify early deception (Murphy & Joseph, 2016). Basing this study on Person-Centered Theory adds to the understanding of how the non-directivity of the therapeutic relationship contributes to the discomfort of diagnosing psychiatric diagnosis and supporting minimal knowledge of disorders that may be considered harmful to the public. The goal of this study is to contribute to the literature on FDIA by understanding the predictive relationship between comfort and knowledge and an accurate diagnosis of FDIA among counseling professionals in Washington State.

Nature of Study

The nature of this quantitative predictive study is to examine whether comfort and knowledge are predictors of an accurate FDIA diagnosis among counseling professionals. In the seminal research for this study, Osfeld, Feldman, et. al., (1996) sent out anonymous questionnaires to doctorate-level professionals. The authors do not specifically indicate if this was a regression study, however, stated it was quantitative. I will use a multiple logistic regression design to examine the relationships and predictions among knowledge,

comfort, and an accurate diagnosis of FDIA among master-level counseling professionals.

Definition of Key Terms

Comfort: Mental health professionals' comfort in this study is defined as a sense of psychological ease (Boswell & Scahrff, 2022) when diagnosing a mental health client for the sake of treatment (Murphy & Joseph, 2016; Pineau, 2008). A lack of comfort in diagnosing significant mental health disorders is a barrier between medical professionals, reporting agencies, and law enforcement (M. Weber, personal communication, 2020).

Diagnosis: The mental health professionals' ability to use appropriate assessment techniques that lead to accurate diagnosing is defined as an act of identifying disorders from their signs or symptoms (APA, 2013). Assessment and diagnostic techniques include personal interviews to determine the type of treatment, client care, recommended follow-ups (ACA, 2014), and follow-up reporting measures for diagnoses deemed to cause harm to others (M. Feldman, personal communication, 2020; M. Weber, personal communication, 2019). By accurately diagnosing FDIA, victims' intervention can occur sooner (Osfeld, Feldman, et al., 1996; M. Weber, personal communication, 2020).

Diagnostic and Statistical Manual – 5th Edition (DSM5): was published in 2013. It is a taxonomic and diagnostic tool used by healthcare providers to determine symptom classification of mental health disorders (APA, 2013).

Diagnostic and Statistical Manual – 5th Edition – Text Revision (DSM5-TR): was published in 2022. It was completed by more than 200 experts, the majority of whom

were involved in the development of *DSM-5*. In addition, four cross-cutting review groups (Culture, Sex, and Gender, Suicide, and Forensic) reviewed all the chapters, focusing on material involving their specific expertise (APA, 2022).

Factitious Disorder Imposed on Another (FDIA): FDIA is a current term used in the DSM5-TR for "a psychiatric disorder in which individuals fabricate, exaggerate, and/or induce problems in another person or animal" (APA, 2013). "The individual seems to have little or no tangible gain from this behavior and is typically referred to as [perpetrators] of maltreatment" (M. Feldman, unpublished manuscript, 2019). Induced, fabricated, or exaggerated problems can be diagnosed in the medical field, the psychiatric field, and the educational arena (APA, 2013). Past and present terms also used for FDIA include FDIA and medical child abuse (Bass & Holligan, 2014).

Knowledge: A mental health professional state of being familiar with the existence of FDIA, as well as having experience with training, case studies, courses, (APA, 2022), or some other form of understanding the history, prevalence, and diagnostic criteria of the diagnosis (Schreier & Libow, 1993). An individual's familiarity with an existing topic (ACA, 2014).

Medical Child Abuse (MCA): "is a term most often used by physicians to describe FDIA or FDIA (MBP) when the falsified illness is medical, psychiatric, and developmental and when the victim is a child" (M. Feldman, unpublished manuscript, 2019, Sheridan, 2003). Law enforcement and other first responding and protective

agencies use this term most commonly when identifying individuals who conduct this criminal behavior (M. Weber, personal communication, 2019).

Multiple Logistic Regression: a widely used analysis that is like linear regression analysis except that the outcome is dichotomous [e.g., success/failure or yes/no or died/lived]. Multiple logistical regression is used in various fields including most medical and social science fields (Terrell, 2015).

FDIA (MBP): The fabrication, exaggeration, and/or induction of signs and symptoms (the abusive behavior) by an individual suffering from Factitious Disorder Imposed on Another (APA, 2013). This falsified problem can be "medical, psychiatric, educational, and/or developmental and the victim can be of any age, human or animal" (APA, 2013).

Assumptions

I will make many assumptions in a quantitative predictive study. I will assume counseling professionals want to accurately diagnose the cases and will fill out their questionnaire and survey with honest and accurate information. I will assume that the participants will willingly volunteer, and their answers will not reflect an impairment or agenda that was given under duress. Because the participants will answer anonymously, they fully understand the informed consent packet and how anonymity and confidentiality work as it pertains to this survey. These assumptions are necessary to meet the demands of social science research standards as laid out by Creswell and Creswell (2013).

Scope and Delimitations

I will limit the study to counseling professionals who live in Washington State and have graduated from a master-level training program with basic competency in assessment and diagnosis. The study will focus on the quantitative gaps in the research specifically if a counseling professional's knowledge and comfort predict an accurate diagnosis of FDIA. This researcher-designed questionnaire will be conducted by using SurveyMonkey, an online service that allows users to create web-based surveys that can be uploaded to an email address (surveymonkey.com). The generalizability of this study will be limited because I will only draw participants from Washington State. The theoretical perspective of Person-Centered Theory can also be viewed as a delimitation. I will not include the accurate diagnosis of other disorders in the DSM5 and DSM5-TR because they will be beyond the scope of this study.

Limitations

Creswell and Creswell (2018) defined a limitation as characteristics of the design or methodology that impact or influence the interpretation of the findings. Pyrczak and Bruce (2000) describe a limitation as a weakness that could provide limits to the validity of the results (Terrell, 2015). In this study, there may be limitations related to internal validity, including methods of sampling, instrumentation, testing, and administration. This study does not include in-person methods to collect data because the study is web-based. Therefore, nonresponses may increase due to a lack of accessibility or ability to understand the link to SurveyMonkey (Miller & Dillman, 2011). Internet surveys are

efficient and can reach a broad range of people who might otherwise not have access to this research (Creswell & Creswell, 2018).

Some counseling professionals may not answer questions because of their potential for being too personal, which could lead to professionals not returning the survey or exiting the survey early because they did not want the information to be known even though they will be assured anonymity. Furthermore, all participants will reside in Washington State. Although Washington State parallels the rest of the United States regarding licensing and education for professional counselors, (doh.wa.gov) a sample population taken exclusively from Washington State may raise generalizability issues if the data is used outside of Washington State. Finally, a limitation of this study may be counseling professionals choose to diagnose the cases without accessing the DSM textbook or link to find diagnostic criteria for each case.

Significance of the Study

Counseling professionals need to be comfortable and knowledgeable about FDIA (M. Feldman, personal communication, 2020; M. Weber, personal communication, 2020; Schreier & Libow, 1993) “We do not have information on how prevalent the diagnosis of FDIA is among mental health professionals” (Schreier & Libow, 1993). I will conduct this study to address comfort and knowledge as variables that predict an accurate diagnosis of FDIA. Osfeld, Feldman, et al., (1996), Dunlop (2020), and Weber (2020) asked “What effect do knowledge and comfort have on the accurate diagnosis of FDIA among mental health professionals?” I will attempt to answer this question to further

understand the intended variables and the prediction of accurately diagnosing FDIA. According to the literature review, few researchers have studied diagnosing FDIA, and no research has been conducted among counseling professionals and the accurate diagnosis of FDIA. This gap is impacting everyone who may encounter an individual who needs this diagnosis (M. Feldman, personal communication, 2020). The results of this study may inform the mental health community education curriculum to prepare professionals for postgraduate work (training methods used in workshops, supervision, internships, and practicums).

Summary

In Chapter 1, I provided an overview of the scope of this study concerning counseling professionals' comfort and knowledge and the prediction to accurately diagnose FDIA. I reviewed the independent variables addressed in the study (comfort and knowledge) and the dependent variable of accurately diagnosing FDIA. I described the research design, including the survey method. Theoretical considerations, assumptions, limitations, and delimitations were discussed. The results from this study may be used to start a conversation within the mental health community and educational institutions about FDIA. In Chapter 2, I will conduct an in-depth literature review and present the foundation for this study.

Chapter Two: Literature Review

A current problem within the counseling community is that there are no reliable statistics regarding the number of people in or outside of the United States who are diagnosed with FDIA (Cleveland Clinic, 2021). It is difficult to assess how common the disorder is because so many cases go undetected (APA, 2013; M. Feldman, personal communication, 2020; M. Weber, personal communication, 2020; Sheridan, 2003; Stein, 2014). There is little research regarding how accurate all mental health and medical professionals are at diagnosing FDIA (M. Feldman, personal communication, 2020; M. Weber, personal communication, 2020; Sheridan, 2003; Stein, 2014). The purpose of this study is to examine comfort and knowledge as predictors of an accurate FDIA diagnosis among counseling professionals. A better understanding of how these variables interact with each other may contribute to the body of research in this area.

Synopsis of Current Literature

Physical, sexual, and psychological abuse of children is well-researched and it's a devastating occurrence. A lesser-understood, yet equally severe form of child abuse is called medical child abuse (Feldman & Xiong, 2020). Osfeld and Feldman (1996) studied levels of awareness of FDIA among mental health practitioners and found that psychiatrists were more likely than psychologists or social workers to have had exposure to FDIA through an actual case or their professional training experiences. There is no reliable statistic regarding the number of people in or outside of the United States who are diagnosed with FDIA by a counseling professional, and it is difficult to assess how

common the disorder is because the prevalence is not readily available (Cleveland Clinic, 2021; M. Feldman, personal communication, 2020; M. Weber, personal communication, 2020; Sheridan, 2003; Stein, 2014).

Diagnosing FDIA is very difficult because of the dishonesty that is common in the personality construct of the person with the disorder (Cleveland Clinic, 2021; M. Weber, personal communication, 2022). The prevalence of FDIA is unknown due to the deception in this population and because counseling professionals report little knowledge of the diagnosis, (APA, 2022; Bass & Holligan, 2014 Feldman & Xiong, 2022). Parents who have FDIA are abusive, manipulative, and charming. Deception can be a primary characteristic of two personality disorders that are commonly present in individuals who have FDIA (M. Weber, personal communication, 2021). Assessing and evaluating if a client has deceptive tendencies is important and can be difficult for a counseling professional to do (Greenstein, 2018).

Literature Search Strategy

The literature search review was conducted by using Walden University resources and the following databases: Academic Search Complete, eBOOK Collection (EBSCOhost), Elsevier, ERIC Database, and Thoreau Multi-database Search Expanded Academic ASAP, Google Scholar. MEDLINE with full text, Medscape, PsychINFO, PsychARTICLES, PubMed, Sage Premier, ProQuest, and the Walden University Library.

The following keywords were used: *Munchausen Disorder, FDIA, Factitious Disorder Imposed on Another, Medical Child Abuse, Medical Diagnosis, Master's level*

Mental Health Diagnosis, FDIA Training, FDIA Education in Mental Health Programs, Understanding Diagnosis, FDIA Cases, Psychiatric Intervention of FDIA, Assessment and Diagnosis of FDIA, Profiles of FDIA Perpetrators, Somatization, Somatization, and other related disorders, and Impact of FDIA on Healthcare Professionals. I combined these search terms with the words *history, counselors, mental health professionals, knowledge, comfort, diagnosing, Rogerian theory, diagnostic theories, willingness to diagnose, medical, therapists, physicians, and discussion.* For example, one search included the words "FDIA education and the willingness to diagnose".

Most authors published their materials within the last 5 years, and I took a substantial amount of information from personal communications with leading experts in the field. Personal communications and peer-reviewed journal articles constitute most of the literature in this chapter. I also reviewed doctoral dissertations, textbooks, and handbooks.

Because the focus of this study is collecting information regarding the comfort and knowledge of counseling professionals and diagnosing FDIA, I included all the available research on comfort, knowledge, identification, willingness to learn, education programs, and accurate diagnosis of this disorder. The seminal work is Osfeld and Feldman's (1996) study regarding psychologists, psychiatrists, and social workers' knowledge and comfort level with diagnosing FDIA. It was the only peer-reviewed research related to this area as applied specifically to mental health professionals. I found limited literature available on these subjects, so I expanded my review to include research

on why FDIA is challenging to detect, the importance of correctly identifying FDIA, and personal communication with professionals in the field of research. This proved helpful and illustrative of the issues facing diagnosing FDIA in clients.

FDIA

History of FDIA

In 1951, Munchausen Syndrome became a recognized term (Askill & Sharpe, 1993) and was defined as “individuals who intentionally produce signs and symptoms of disease in another”. Roy Meadow (1977) coined the term Munchausen Syndrome by Proxy and elaborated on the definition to include parents “fabricating” physical illness symptoms in their children to seek attention from the medical community. Among one of Meadows's important works of research, he documented the very first cases of FDIA. The two children he studied were from different families, and both children underwent painful, repeated, and unnecessary medical procedures at the hands of their mothers. Additionally, the mothers seemed to significantly enjoy, and even “flourish” with the attention received in the medical setting (Meadow, 1977; Bryk & Seigel, 1997).

In 1988, Meadow extended his study to include male subjects and conducted the most comprehensive data we have on fathers who have FDIA. Fifteen fathers were observed, and the significant findings from these cases were that male children were more likely to be victimized than female children, and the average death was around 19 months of age (Brown & Caitlin, 1997). The re-abuse rate of children (male and female) who were returned home to a male perpetrator was as high as 50 percent (Sheridan,

2003). In 2002, the American Professional Society on the Abuse of Children (APSAC) proposed clarification of the definition of FDIA, suggesting that the term Pediatric Condition Falsification be used as it seemed to be a more appropriate term for the behavior. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders chose to use the term Factitious Disorder by Proxy (FDP) (Sanders & Bursch, 2002). The DSM5-TR (2022) edition states that the recording procedure of FDIA (under the heading somatic symptoms and related disorders) is when the perpetrator "falsifies illness in another". Criteria for diagnosing FDIA include (a) falsification of physical or psychological signs or symptoms, induction of injury or disease, in another, associated with identified deception (b) the individual presents another individual (victim) to others as ill, impaired, or injured (c) the deceptive behavior is evident even in the absence of obvious external rewards (d) the behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder. The perpetrator, not the victim receives the diagnosis, and the specification can include single episode or recurrent episodes (APA, 2022).

Personal Communication One

Dr. Marc Feldman is a Clinical Professor of Psychiatry and Adjunct Professor of Psychology at the University of Alabama, Tuscaloosa. A Distinguished Life Fellow of the American Psychiatric Association, Dr. Feldman is an international expert in factitious disorders, Munchausen Syndrome, and FDIA, as well as other forms of medical deception and malingering. He is the author of five books, and more than one hundred peer-reviewed

articles, and has appeared as an expert in dozens of television programs, print media, and documentaries throughout the world.

> "Many people, including many health care professionals, assume that 'successful' perpetrators must have a level of intelligence that is very substantial to mislead--even defeat--physicians and others. FDIA is so counterintuitive that even individuals with below-normal intelligence can successfully deceive doctors about their child's health status. Physicians are not taught to doubt what they are told; some are even instructed during their training that doing so causes inherent disruption to the alliance with the physician. As a result, they passively accept even very discordant or inconsistent information as valid. In many situations, even the most audacious lies are accepted as truth" (M. Feldman, personal communication, 2020).

Personal Communication Two

Michael Weber has been a law enforcement officer for 35 years. A graduate of the University of North Texas with a Bachelor of Science Degree, Investigator Weber retired from Arlington PD in 2008 with 23 years of service as a Texas police officer, including 4 years as a Crimes Against Children detective for Arlington PD. From 2008-2015, Weber worked as an investigator in the Tarrant County DA's Office Special Victim's Unit. Weber investigated all claims of Medical Child Abuse (Munchausen Syndrome by Proxy) that were generated in Tarrant County, Texas from 2008 to 2015.

> "Criminal offenders in this form of abuse present in a professional police interview setting like any other offender in any other form of child abuse. These offenders are not skilled criminals. They run a medical confidence scheme. Once that scheme is examined thoroughly, the scheme falls apart. When confronted with evidence that contradicts what they have just told the detective, these offenders will change their story to fit the new facts presented by the detective. If continue to be confronted with facts of their criminal offenses, these offenders may eventually make admissions that they offenders believe paint them in the best light without ever admitting the full scale of their criminal conduct. In this respect, they are no different from any other child abuse offender: they first lie, and when confronted with facts they will change their story, sometimes eventually giving admissions to criminal conduct without ever admitting their complete role in the abuse of the child. This also demonstrates that offenders in this abuse know what they are doing and know it is wrong when they are doing it, establishing a consciousness of guilt in the offender and eliminating the possibility of an insanity defense." (M. Weber, personal communication, 2021).

Personal Communication Three

Andrea Dunlap is an author and consultant in Seattle, Washington with over a decade of publishing. Dunlop has personal experience with FDIA because a member of her family has been diagnosed with the disorder.

> "Discovering that someone you love is a FDIA perpetrator is devastating and disorienting. For me, it was the culmination of many years of strange behaviors and inexplicable medical mysteries, all underscored by the knowledge that something was deeply wrong. When a child entered the picture and the abuse became apparent, it was a moment of horrible rupture for my family. I knew that in confronting the abuse, I would have to say goodbye not only to the family member and her children but to my entire picture of what my family was. MBP perpetrators are so manipulative that they distort reality and cut off anyone who challenges them; leaving themselves surrounded by a coterie of true believers. The fact that the family court and criminal justice systems are so ill-equipped to handle this form of abuse made everything infinitely worse. We kept hoping for help that never came. Ten years later, the victims remain in peril and the trauma of the situation continues to reverberate" (A. Dunlop, personal communication, 2021).

Healthcare Professionals and Understanding FDIA

Feldman & Oswald (2018), authors of the most recent cases of FDIA in their book *Hurting for Love: FDIA Syndrome,* provide an example of a caseworker who has experience with a mother who has FDIA.

> "These Munchausen parents act differently from any other individual who is accused of child abuse…the ones that I have seen seem to have no semblance of guilt. They seem to be very, very normal. 'Normal' in the sense of being so sure of

> themselves. And, what gets me is that they are very, very cooperative. Now usually in our cases of 'normal' child abuse, we figure that if a person is extremely cooperative, it means they have nothing to hide. If they invite you in the door, that is always a more positive sign. If they become defensive, then it makes us suspicious. We would say, 'What are you hiding?' But this kind of person is so genuinely nice and so very, very cooperative, that it throws you off. For example, I asked her to sign this piece of paper saying our agency could be involved in her case. And most people would not have signed it, because they would say, 'Why should I?' She signed it, even after I told her all the legal consequences. She signed releases of information; she signed all kinds of things that most people would not."

Development and Course of FDIA

An individual with FDIA exhibit patterns of repeatedly making their children physically sick, taking them to a medical facility, participating in making their children better, and then repeating the cycle (Feldman & Ford, 1994, Feldman & Yates, 2018; Feldman & Xiong, 2020). Individuals will continue to make their children sick as long as they get the reward of attention from the medical community (APA, 2022). A pooled analysis finds that two-thirds of perpetrators are women and one-third are men (APA, 2022). Disorders which include deception and malingering are difficult to identify because of the nature of the deception (M. Weber, personal communication, 2020), and the DSM5-TR includes six disorders that need to be considered when diagnosing FDIA. Deception to avoid legal responsibility, somatic symptoms and other related disorders, malingering,

functional neurological symptom disorder (conversion disorder) borderline personality disorder, and medical conditions or mental disorders not associated with intentional symptom falsification are six differential diagnoses that need to rule out when diagnosing FDIA (APA, 2022)

Differential Diagnosis

A differential diagnosis is a systematic way of identifying disorders by making a list of symptoms and possible explanations and eliminating them one by one (Cleveland Clinic, 2021). The DSM provides six mental health disorders that need to be ruled out of options when diagnosing FDIA. The term "rule out" is used by mental health professionals who are trying to make an accurate diagnosis (APA, 2022). Misdiagnosis can lead to serious problems (Carnahan & Jha, 2021; Freath, Vitelli, et al., 2012; Hoffman, 2022; Garriga, 2007; M. Feldman, personal communication, 2020). The following diagnosis should be ruled out by using a differential diagnosis protocol when diagnosing FDIA. Deception to avoid legal liability, somatic symptoms, and related disorders, malingering, functional neurological symptom disorder (conversion disorder), borderline personality disorder, and medical conditions or mental disorders not associated with intentional symptom falsification.

Prevalence and Associated Features of FDIA

The prevalence of FDIA is unknown, likely because of the role of deception in this population (APA, 2022). According to Sheridan (2002), the average age of the victim of FDIA is four years old. In her research, 32 percent of cases were diagnosed in the first

12 months of life, while 52 percent of cases were diagnosed by month 24. Three–fourths of these cases were diagnosed by age six. The average age of death was estimated at around 19 months of age. The oldest deceased child found in this review was eight years old. One-third of the victims continued to be abused in the hospital. Abuse that does not occur in a hospital setting is much more difficult to detect and can go on for years (Brown & Catlin, 1997). In another article by Sheridan (2003), cases of 404 victims were studied and it was found that males were slightly more victimized (54 percent) than females (48 percent). The re-abuse rate for children who return home after removal from the perpetrator ranges from 17 to 50 percent. The abuse rate of a new sibling following the removal of a previous sibling is estimated at 20 percent (Davies, McClure, et al., 1998).

According to research by Rosenberg (1996), all victims studied suffered at least short-term harm from their abuse. Thirty-three percent of them suffered long-term health effects. Long-term effects of medical child abuse include medical trauma, feeling betrayed, a lack of trust, poor self-esteem, poor academic performance, lack of age-appropriate interactions with peers, and post-traumatic stress disorder symptoms. Further effects include codependency, highly entwined relationships with the perpetrator, and the possibility of developing factitious disorders later in life (Bools, Neale, et al.,1993).

In 2017, Yates and Bass conducted research on female perpetrators who had FDIA. Ninety-eight percent of perpetrators were mothers. Forty-six percent of them worked in the healthcare field and 75 percent of them were married. A substantial amount of them had a history of a factitious or somatoform disorder. Several behaviors were

previously associated with female perpetrators noted in studies by Yates & Bass (2017) Osfeld et. al., (1996) and Sheridan et. al. (1993). For example, with almost all hospital accounts, the mother would appear to be completely devoted to the child, yet they were often found far from the child and sometimes commiserating with other mothers who have sick children (Schreier, Libow, et al., 1993). Research conducted by Schreier et al., (1993) indicates that mothers were often quite knowledgeable about medical terminology and procedures, yet they did not know basic information that others knew. Sometimes they would appear incredibly supportive of medical and professional staff but then could turn aggressive when demanding new procedures and interventions for their child. Additional research reported that when a mother claims that her child is sick but is disbelieved, professionals see an increase in injurious behavior toward the child inside the medical setting (Schreier et al., 1993).

Summary

In summary, the literature pointed out that the prevalence of FDIA is unknown, likely because of the role of deception in this population (APA, 2022), and that mental health professionals infrequently record the diagnosis, even in well-known cases (APA, 2022). There is a gap in the research because of the lack of available information on comfort, knowledge and accurate diagnosis FDIA despite seminal work with other mental health and medical professionals (Osfeld, Feldman et al., 1996). Research shows that FDIA is commonly identified as a deceptive disorder (APA 2022; M. Weber, personal communication, 2020; Sheridan, 2003) and the importance of understanding the severity

of this disorder is imperative (Feldman & Ford, 1994; Schrier & Libow, 1993; Sheridan, 2003).

No studies were found that included the independent variables of comfort, knowledge, and the prediction of the dependent variable of an accurate diagnosis of FDIA. Further, no researchers have used the questionnaires and surveys in the manner that I am proposing. The need for this study is further strengthened by the lack of studies on FDIA (M. Feldman, personal communication, 2020 M. Weber, personal communication, 2020).

Chapter Three: Research Methods

This quantitative predictive study examines comfort and knowledge as predictors of an accurate FDIA diagnosis among counseling professionals. As FDIA has been recognized as serious criminal behavior for over a century (Olumuyiwa & Omotola, 2022), there is a need for early and accurate diagnosing. Comfort and knowledge will be examined as possible predictors of an accurate diagnosis of FDIA. Comfort and knowledge of FDIA are reliable methods that may predict an accurate diagnosis. (Feldman & Yates, 2018).

This chapter will include a rationale for the research design and population of interest. The research sampling approach for recruitment strategy is also presented. Finally, a discussion of significant variables approaches to data collection and analysis, and ethical considerations and threats to validity are addressed.

Person-centered theory is used to explain how counseling professionals' comfort in diagnosing FDIA affects the accuracy of any FDIA diagnosis (Murphey & Joseph, 2016). Person-centered theory was used as a framework for the study to define beliefs and actions that may predict an accurate diagnosis of FDIA. According to Murphey and Joseph (2016), Person-centered theory offers an explanation and prediction of the lack of diagnosis of FDIA which leads to inaccurate diagnosis of FDIA. The outcome of interest in their research was clinical observation, self-report, assessment tools, and the ability to diagnose clients in counselor training. Although this study was not focused on accurately

diagnosing FDIA, comfort with diagnosing was closely associated with the accuracy of a diagnosis (Murphey & Joseph, 2016).

Research Questions and Hypothesis

RQ1: Are comfort and knowledge variables that predict an accurate diagnosis of FDIA?

Ho1: Comfort and knowledge do not predict an accurate diagnosis of FDIA.

Ho2: Comfort and knowledge do predict an accurate diagnosis of FDIA.

Research Design and Rationale

A nonexperimental quantitative predictive study will be used to assess whether comfort and knowledge are predictors of an accurate FDIA diagnosis among counseling professionals. A quantitative, as opposed to a qualitative approach, was employed in the study because variables were numerically measured using survey instruments. The quantitative approach allows for objective analysis to determine potential predictive relationships between variables. A nonexperimental design was selected for the study because participants will not be randomly assigned to control and intervention groups. Participants will be asked to respond to the survey based on their current experiences and practices. A predictive design will be employed because the focus of the analysis will be to determine predictive relationships between independent variables (knowledge of FDIA and comfort with diagnosing FDIA) and the dependent variable (an accurate diagnosis of FDIA). Predicting a relationship between the variables and what contributes to an accurate diagnosis is useful because it could contribute to the research. The survey

method will be used to gather data prospectively. Person-centered theory will be used as the theoretical foundation for this research.

Feldman and Xiong (2020) said knowledge of FDIA would improve the potential for an accurate diagnosis of FDIA. Knowledge of FDIA and comfort with diagnosing FDIA both impact an accurate diagnosis of FDIA (Feldman, personal communication, 2020). I will examine whether knowledge of FDIA and/or comfort with diagnosing FDIA will predict an accurate diagnosis of FDIA.

Population

The population of interest for this study is master-level, licensed counseling professionals residing in Washington State who can access the online internet survey that will be written in English. Counseling professionals from all educational institutions will be invited to participate. As of 2017, the Washington State Department of Health identified 8,193 master-level counseling professionals (U.S. Department of Labor, Bureau of Labor Statistics, 2017; Washington State Department of Health, 2022).

Sampling and Sampling Procedures

The sampling plan is to recruit a random sample of randomly selected master-level, licensed mental health professionals who counsel in Washington State using SurveyMonkey. First, online networks of mental health professionals, as well as mental health professional practices will be contacted with invitations to take part in the study. Second, an invitation with a description of the survey and a link to the URL will be

provided to Washington State mental health facilities that have counseling professionals. Specifically, participants living in Washington State will be recruited. Third, the University Participant Pool will be used to allow for additional engagement with the target audience.

Sample size calculations program G*Power v3.1.0 was used to determine the minimum number of samples for the study. In the sample size calculation, I used a power of 95%, a medium effect size of .15, two-tailed logistics regression, and a significant level of .05. Results of this sample size calculation were used to determine a minimum sample of 117 participants.

Procedures for Recruitment

Data will be collected using the SurveyMonkey (SurveyMonkey, Inc., San Mateo) platform. I will email a Letter of Request to multiple mental health agencies and facilities in Washington State to seek voluntary participation from counseling professionals for this study. Participants will be provided with an email link to the survey and a link to the online version of the DSM-5-TR. Measures will be accessible via personal mobile devices that are not limited to tablet computers, laptop computers, internet-connected smartphones, and computers. Each participant will be provided with an electronic statement of consent at the beginning of the survey stating the risks of participating in the research. Individuals will be required to acknowledge that they meet the inclusion criteria for being a master-level, licensed counseling professional in Washington State. Once participants begin the questionnaire, each question will be answered sequentially to

complete the survey accurately and as designed. The survey data will be anonymous and no IP addresses or identifying information will be collected. The survey participants will be provided with an email address dedicated to this research to contact me for more information regarding the study. Email will serve as a point of contact should the participants desire to learn the study results or if additional resources exist. All emails will be deleted when the study is concluded.

Instrumentation and Operationalization of Constructs

Demographic Data

Demographic data will be collected using a researcher-designed demographic questionnaire (Appendix B) included in the online survey to obtain descriptive characteristics of the population. I will collect demographic data. The variables measured will be gender, ethnicity, age, practice setting, practice experience, and graduate specialization.

Operationalization

In the demographics section of SurveyMonkey, participants will be asked four specific questions. One. Age, Two., Gender, Three., Residence Four., License. The last two questions ask participants to self-identify if the participant meets the requirements of practicing location in Washington State and licensure requirements. The results of this information will be used to identify the appropriate participants for this study.

The diagnosing section of the questionnaire was developed with a specific focus on diagnosing FDIA. The verified cases are from the books *Dying to be Ill: True Stories of Medical Deception* by authors Feldman and Yates (2018) and *All in Your Head* by author O'Sullivan (2015). In the diagnosing section, the participants will be offered four cases of individuals who have a professional mental health diagnosis of FDIA. I will use a nominal scale as the answers will only consist of "correct" or "incorrect". The participants will have the opportunity to choose from five diagnoses in the somatoform disorders category located in the DSM-5-TR. Each case will include FDIA as an optional diagnosis.

The following cases are in Appendix C which is entitled Diagnosing Cases. In Case One, the participants will pick from the following diagnoses: (a.) malingering, (b.) factitious disorder imposed on another, (c.) conversion disorder, and (d.) obsessive-compulsive disorder. The correct answer is (c.) conversion disorder.

In Case Two, the participants will have the opportunity to pick from the following diagnoses: (a.) conversion disorder, (b.) factitious disorder imposed on another, (c.) post-traumatic stress disorder, and (d.) factitious disorder. The correct answer is (d.) factitious disorder.

In Case Three, the participants will pick from the following diagnoses: (a.) psychotic disorder, (b.) factitious disorder, (c.) illness anxiety disorder, and (d.) factitious disorder imposed on another. The correct answer is (d.) factitious disorder imposed on another. This will be an example of the psychological form of FDIA.

In Case Four, the participants will pick from the following diagnoses: (a.) dissociative amnesia, (b.) nightmare disorder, (c.) factitious disorder imposed on another, and (d.) depersonalization disorder. The correct answer is (c.) factitious disorder imposed on another. This will be an example of the physical form of FDIA.

In the comfort and knowledge survey, participants will be asked questions regarding their knowledge of FDIA and their comfort with diagnosing FDIA. There are two questions in this section. The first variable question is how comfortable the participant is diagnosing FDIA. This will be measured using a 5-point Likert scale. The answers consist of (1) What is FDIA, (2) I am not comfortable diagnosing FDIA, (3) I would diagnose FDIA only with a consultation team (4) I will diagnose FDIA if the case calls for it and (5) I have taught or explained FDIA to others in my field and am extremely comfortable diagnosing FDIA. The second variable question asks how knowledgeable the participant is of FDIA. This will be measured using a 5-point Likert scale. The answers consist of (1) None, (2) I know FDIA through other means such as media, books, workshops, etc. (3) I have education and experience, (4) With my education and experience, I would feel comfortable diagnosing FDIA in my practice, and (5) I would feel comfortable teaching others and FDIA.

Data Analysis Plan

Software

I will employ IBM SPSS Statistics (Version 28.0.1) predictive software to conduct the required data analysis appropriate to test the null hypothesis of this study. The

following sections discuss this in greater detail regarding the exact applications and analysis.

Data Cleaning and Scrubbing

Once the questionnaire and survey data are downloaded from SurveyMonkey, they will be transferred to IBM SPSS Statistics (Version 28.0.1) predictive analytics software and kept on a flash drive. Data will be screened and cleaned for errors associated with categorical variables. IBM SPSS Statistics (Version 28.0.1) predictive analytics software will have a table that allows me to address the accuracy of values and inform me if data is missing. A table will be yielded containing appropriate descriptive statistics for each variable.

Data Analysis

Before performing a stepwise regression in R, I will examine the data using descriptive statistics. Assumptions of multiple regression include multivariate normality, a linear relationship, and no multicollinearity. Multivariate normality assumes that the variables are normally distributed and can be tested by plotting residual variables on a histogram with a fitted normal curve or reviewing a Q-plot (Frost, 2020). A linear relationship means that there is a linear relationship between the outcome variable and the predictor 60 variables (Frost, 2020) which can be tested by scatterplots.

The assumption of no multicollinearity assumes that independent variables are independent of each other. The presence of multicollinearity can be tested by four

criteria: correlation matrix, tolerance, condition index, and variance inflation factor (Frost, 2020). When computing the correlation matrix, correlation coefficients need to be smaller than .08. Tolerance measures the influence of one independent variable on all other independent variables. When tolerance is greater than 0.2, there might be multicollinearity in the data. If a variance inflation factor of greater than 10 is identified, multicollinearity likely exists. If the value calculated is greater than 30, multicollinearity exists. Multiple regression is generally robust under violation of assumptions (Frost, 2020) but if the data are skewed or show significant violations of one or more assumptions, the researcher may consider transforming the data or using alternative statistical procedures, such as a nonparametric regression. In doing the stepwise regression, SPSS determined which variables were entered based on contributions to the model and statistical significance in a stepwise fashion. According to SPSS, variables with *p* values less than or equal to .05, are identified as statically significant and entered in the regression model. In addition, according to SPSS, when the variable's tolerance value is less than or equal to .10, it is removed from the regression (Frost, 2020).

Threats to Validity

Threats to internal validity include (a) setting interaction issues, (b) multiple treatment-causing issues (c) pretesting, and (d) the interaction between the test subjects and the treatment (Creswell & Creswell, 2018). Creswell (2009) identified three types of threats to external validity, including the interaction of selection and treatment, the interaction of history and treatment, and the interaction of setting and treatment. To

mitigate biased responses, anonymity will be provided to each study participant. Each participant will be electronically reminded of the anonymous nature of the study and the importance of responses to the survey when they enter the survey. The study design cannot ensure that one individual completes the survey without another person's influence: however, participants will be reminded that they can only participate in the survey once and they should be the only ones to respond to the items.

External validation addresses the ability to generalize data across a large population under scrutiny at varying time points and geographic locations (Creswell & Creswell, 2018; Frost, 2020). I will use a simple random sampling technique to target the accessible population to limit generalizability and strengthen external validity. This study will be a combination of online questionnaires and a survey. The participants may have discussed the survey cases and collaborated on answers. It is also possible that one counseling professional could take the survey for the intended counseling professional. Since there is no way to monitor participants' truthfulness in taking the survey alone, this is a threat to external validity. Further, the internet has an abundance of information on FDIA so the participants may research each of the diagnoses provided and select the best answer based on additional research done during the survey. Finally, due to the nature of this study, all participants will need to employ a certain level of technical knowledge since they will take the survey on a technological device which may influence generalizability.

Threats to internal validity are factors that affect the validity of the study (Creswell & Creswell, 2018; Frost, 2020). FDIA has become more well-known over the last ten years due to media involvement in high-profile cases (Feldman, personal communication, 2020) Therefore, any FDIA media event that occurs before or while the participants are taking this survey may influence the way cases are diagnosed. The cases that are used in this study are from books that validate and verify the mental health diagnosis cases, therefore, participants may already be familiar with the cases presented.

Ethical Considerations and Procedures

The Institutional Review Board (IRB) will provide approval for this study's use of human participants. No personally identifiable data will be recorded from participants to ensure anonymity, and no IP addresses will be collected. I aim to conduct this study with high ethical standards. Participants will be informed that no names or identifying information will be collected. The participants in this study will volunteer after completing the informed consent section at the beginning of the survey to ensure that they understand their answers will be confidential, their participation is voluntary, and they can stop at any time. I will electronically provide the informed consent package before the survey begins.

The participants will first access the consent form and provide consent by clicking on the "I consent" button after which they will be able to access the survey questions. Once data is collected and downloaded, all survey information will be permanently removed from the Survey Monkey site. All data will be stored in a password-protected

computer only accessible to the researcher and will be destroyed seven years after publication. To address any potential psychological distress, a link will be provided to access a counseling hotline.

Summary

The research design will be quantitative and designed to measure the predictive relationships between knowledge of FDIA, comfort with FDIA, and the accurate diagnosis of FDIA (dependent variable). A sample of master-level, licensed counseling professionals in Washington State will be used. A binary logistic regression will be used to determine if there is any predictive relationship between the independent variables and the dependent variable. Questionnaires and a survey will be used to assess independent variables, and the dependent variable will be assessed using a nominal scale. The Rogerian Theory will be used to guide this study. External validity will be supported through a selection of participants, and they will remain anonymous.

Chapter 4: Results

The purpose of this quantitative predictive study was to examine whether comfort and knowledge predict an accurate FDIA diagnosis among master-level mental health counseling professionals living in Washington State. The specific research question is, are comfort and knowledge variables that predict an accurate diagnosis of FDIA? The null hypothesis states: that comfort and knowledge do not predict an accurate diagnosis of FDIA. The alternative hypothesis states: that comfort and knowledge do predict an accurate diagnosis of FDIA.

This chapter contains the results of the data analysis I conducted to address the research question and hypotheses. In this chapter, I describe the sample's data collection and demographic characteristics. Then, I will present the results of the data analysis. This chapter will conclude with a review of the key findings of my research that set the stage for the recommendations and conclusions covered in Chapter Five.

Data Collection

I collected data for this study in June and July 2024. One hundred and eighteen master-level mental health counseling professionals in Washington State completed the survey and questionnaire. One participant was excluded because of missing data and I identified eight outliers as they took the survey but lived outside Washington State The survey was presented online via Survey Monkey, and it included an email invitation to participate along with a consent form. The consent form stated that the purpose of the study was to assess comfort and knowledge of mental health disorders and included an

explanation of the procedures, the voluntary nature of the study, risks and benefits of being in the study, privacy information, and my contact information. The survey was anonymous, so no identifiable information was collected. While no payment was provided for participation in the study, I did donate money to three mental health centers. Participants were informed in the consent form that they should click on the survey link as a form of consent and start the study.

Respondents who agreed to the consent were directed to the survey in Survey Monkey. The survey questions for the diagnostic cases were set to require an answer. The forced validation procedure eliminated missing or incomplete data within a survey. Table Four displays descriptive statistics for the categorical demographic variables. Gender was coded as zero (male) and one (female). Out of 118 participants, the gender for this study consisted of 50 (42.4%) male, 64 (54.2%) female and four (3.4%) nonbinary individuals. There were 117 participants, and one participant was excluded due to missing data from the survey and questionnaire.

The age range of the participants was 45 (38.1%) twenty to thirty years old, 36 (30.5%) thirty-one to 40 years old, 21 (17.8%) forty-one to fifty years old, and 16 (13.6%) fifty-one plus. The frequency distribution for participant locations in Washington State showed that western Washington and eastern Washington had the same number of participants 24 (20.3%) while central Washington (Seattle) had the most participants 32 (27.1%). Northern Washington had 20 (16.9%) participants while South Washington had

the lowest number of participants at 10 (8.5%). eight (6.8%) of participants were outliers as they did not live in Washington State but took the survey and questionnaire.

Counseling professionals were less aware of FDIA than other professional groups in the field of mental health and medical psychology (Osfeld, Feldman, et al., 1996; M. Feldman, personal communication, 2020, February). Researchers found that knowledge and awareness of FDIA varied significantly among master-level and doctorate-level mental health professionals (Osfeld, Feldman, et al., 1996) and is this paucity of understanding regarding this diagnosis was reflected in the unknown national and international prevalence rate of the disorder (APA, 2022). Boswell and Scharff (2022) determined there to be a lack of research on the availability of knowledge of FDIA. A lack of knowledge of FDIA may have contributed to the unknown prevalence rate (M. Feldman, personal communication, 2024). Associate master-level counseling professionals were particularly prone to inaccurate diagnosing and discomfort with disorders because of the lack of information that was provided in diagnostic courses in mental health counseling programs (Boswell & Scharff, 2022; Murphy & Joseph, 2016).

The results of this study indicated that more males (n=64) than females (n=50) participated in the data collection process and the average age range of participants was between thirty-one and fifty years old in Washington State. Most participants were split evenly between East Seattle and West Seattle (20.3%) with eight participants not residing in Washington State. The Chi-Square showed that there is no relationship between license and an accurate diagnosis of FDIA in either the CASEOFPETER (Chi-

Square=9.885, df=7, p=.195) or the CASEOFGARNETT (Chi-Square=1.851, df=7, p=.968).

An additional cross-tabulation between comfort and specific licenses indicated that the majority of participants (n=53) reported that on a Likert scale measured with four points (1=unaware of FDIA and 4=comfortable enough to teach FDIA) the majority of participants (n=53) stated they would feel comfortable diagnosing FDIA with a consultation team (LMHC=6, LMHCA=2, LMFT=6, LMFTA=1, LCSW=9, LCSWA=5, Intern=3, Other=1). Likewise, a crosstabulation was conducted to address the relationship between knowledge and each counseling license. On a five-point Likert scale (1=not knowing about FDIA and 4=having enough knowledge of FDIA that they would teach others about this diagnosis) the average participants (n=45) indicated that they knew of FDIA through outside sources of academics, such as media, (LMHC=13, LMHCA=8, LMFT=1, LCSW= 9, LCSWA= 8, Intern=2, Other=4). To answer research question one (are comfort and knowledge variables that predict an accurate diagnosis of FDIA) I conducted a binary logistic regression. The dependent variables were encoded as an accurate diagnosis of FDIA (0=yes) and an inaccurate diagnosis of FDIA (1=no).

Four cases were provided in the participant survey for master-level mental health professionals to diagnose. Two of the cases provided did not have an FDIA diagnosis and two of the cases did. The two cases that had an FDIA diagnosis were CASEOFPETER and CASEOFGARNETT. Therefore, CASEOFPETER and CASEOFGARNETT were the cases used for data collection.

The model summary for CASEOFPETER showed that 16 percent of the dependent variables were explained by the predictor variable (r=.164). The Hosmer and Lemeshow Test showed the p-value (<.001) was below 0.05 and indicated strong evidence of a real effect or difference, rather than just random variation. A p-value of comfort in diagnosing FDIA (sig=.077) and a p-value of knowledge of FDIA (sig=.007) indicated that both comfort and knowledge were not statistically significant and the null hypothesis should be retained (comfort and knowledge do not predict an accurate diagnosis of FDIA). As comfort diagnosing FDIA increased (EXP(B)=.651) the odds of getting a wrong diagnosis decreased. As knowledge of FDIA increased (EXP(B)=.645) the odds of getting the wrong diagnosis decreased. Comfort diagnosing FDIA could be a better predictor of getting the correct answer of FDIA than knowledge of FDIA.

The model summary for the CASEOFGARNETT showed close to seven percent of the dependent variable is explained by the predictor variable (r=.068). The Hosmer and Lemeshow Test showed the p-value (sig=.267) is above .05 indicating that the model was statistically non-significant and the model was an adequate fit and therefore supported the CASEOFPETER and indicated there was strong evidence to retain the null hypothesis and reject the alternative hypothesis. As comfort increased the odds of an inaccurate diagnosis decreased (Exp(B)=.947) and as knowledge of FDIA increased the odds of an inaccurate diagnosis decreased (Exp(B)=.025). Comfort diagnosing FDIA might be a better predictor of getting the correct answer of FDIA than knowledge of FDIA.

Table 1.

Frequency Distribution for Age

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Twenty to Thirty	45	38.1	38.1	38.1
	Thirty-one to Forty	36	30.5	30.5	68.6
	Forty-one to Fifty	21	17.8	17.8	86.4
	Fifty-one plus	16	13.6	13.6	100.0
	Total	118	100.0	100.0	

Table 2.

Frequency Distribution for Gender

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	50	42.4	42.4	42.4
	Female	64	54.2	54.2	96.6
	Nonbinary	4	3.4	3.4	100.0
	Total	118	100.0	100.0	

Table 3.

Frequency Distribution for Washington State Location

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	West	24	20.3	20.3	20.3
	East	24	20.3	20.3	40.7
	North	20	16.9	16.9	57.6
	Central	32	27.1	27.1	84.7

South	10	8.5	8.5	93.2
None I do not live in WA	8	6.8	6.8	100.0
Total	118	100.0	100.0	

Table 4.

CASEOFPETER * License Crosstabulation

			License								
			LMHC	LMHCA	LMFT	LMFTA	LCSW	LCSWA	Intern	Other	Total
CASEOFPETER	Yes	Count	29	12	8	0	9	6	4	5	73
		Expected Count	23.5	12.4	7.4	1.9	10.5	7.4	4.3	5.6	73.0
		% within CASEOFPETER	39.7%	16.4%	11.0%	0.0%	12.3%	8.2%	5.5%	6.8%	100.0%
		% within License	76.3%	60.0%	66.7%	0.0%	52.9%	50.0%	57.1%	55.6%	61.9%
		% of Total	24.6%	10.2%	6.8%	0.0%	7.6%	5.1%	3.4%	4.2%	61.9%
	No	Count	9	8	4	3	8	6	3	4	45
		Expected Count	14.5	7.6	4.6	1.1	6.5	4.6	2.7	3.4	45.0
		% within CASEOFPETER	20.0%	17.8%	8.9%	6.7%	17.8%	13.3%	6.7%	8.9%	100.0%
		% within License	23.7%	40.0%	33.3%	100.0%	47.1%	50.0%	42.9%	44.4%	38.1%
		% of Total	7.6%	6.8%	3.4%	2.5%	6.8%	5.1%	2.5%	3.4%	38.1%
Total		Count	38	20	12	3	17	12	7	9	118
		Expected Count	38.0	20.0	12.0	3.0	17.0	12.0	7.0	9.0	118.0
		% within CASEOFPETER	32.2%	16.9%	10.2%	2.5%	14.4%	10.2%	5.9%	7.6%	100.0%
		% within License	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	32.2%	16.9%	10.2%	2.5%	14.4%	10.2%	5.9%	7.6%	100.0%

Table 5.

CASEOFGARNETT * License Crosstabulation

			License								
			LMHC	LMHCA	LMFT	LMFTA	LCSW	LCSWA	Intern	Other	Total
CASEOFGARNETT	Yes	Count	20	8	6	2	8	7	3	4	58
		Expected Count	18.7	9.8	5.9	1.5	8.4	5.9	3.4	4.4	58.0
		% within CASEOFGARNETT	34.5%	13.8%	10.3%	3.4%	13.8%	12.1%	5.2%	6.9%	100.0%
		% within License	52.6%	40.0%	50.0%	66.7%	47.1%	58.3%	42.9%	44.4%	49.2%
		% of Total	16.9%	6.8%	5.1%	1.7%	6.8%	5.9%	2.5%	3.4%	49.2%
	No	Count	18	12	6	1	9	5	4	5	60
		Expected Count	19.3	10.2	6.1	1.5	8.6	6.1	3.6	4.6	60.0
		% within CASEOFGARNETT	30.0%	20.0%	10.0%	1.7%	15.0%	8.3%	6.7%	8.3%	100.0%
		% within License	47.4%	60.0%	50.0%	33.3%	52.9%	41.7%	57.1%	55.6%	50.8%
		% of Total	15.3%	10.2%	5.1%	0.8%	7.6%	4.2%	3.4%	4.2%	50.8%
Total		Count	38	20	12	3	17	12	7	9	118
		Expected Count	38.0	20.0	12.0	3.0	17.0	12.0	7.0	9.0	118.0
		% within CASEOFGARNETT	32.2%	16.9%	10.2%	2.5%	14.4%	10.2%	5.9%	7.6%	100.0%
		% within License	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	32.2%	16.9%	10.2%	2.5%	14.4%	10.2%	5.9%	7.6%	100.0%

Table 6.

COMFORTDIAGNOSING * License Crosstabulation

			License								
			LMHC	LMHCA	LMFT	LMFTA	LCSW	LCSWA	Intern	Other	Total
COMFORTDIAGNOSING	What is FDIA	Count	0	0	0	0	1	1	0	1	3
		Expected Count	1.0	.5	.3	.1	.4	.3	.2	.2	3.0
		% within COMFORTDIAGNOSING	0.0%	0.0%	0.0%	0.0%	33.3%	33.3%	0.0%	33.3%	100.0%
		% within License	0.0%	0.0%	0.0%	0.0%	5.9%	8.3%	0.0%	11.1%	2.5%
	I am not comfortable diagnosing FDIA	Count	3	0	0	0	0	1	1	3	8
		Expected Count	2.6	1.4	.8	.2	1.2	.8	.5	.6	8.0
		% within COMFORTDIAGNOSING	37.5%	0.0%	0.0%	0.0%	0.0%	12.5%	12.5%	37.5%	100.0%
		% within License	7.9%	0.0%	0.0%	0.0%	0.0%	8.3%	14.3%	33.3%	6.8%
	I would diagnose FDIA only with a consultation team	Count	16	12	6	1	9	5	3	1	53
		Expected Count	17.1	9.0	5.4	1.3	7.6	5.4	3.1	4.0	53.0
		% within COMFORTDIAGNOSING	30.2%	22.6%	11.3%	1.9%	17.0%	9.4%	5.7%	1.9%	100.0%
		% within License	42.1%	60.0%	50.0%	33.3%	52.9%	41.7%	42.9%	11.1%	44.9%
	I will diagnose FDIA if the case calls for it	Count	15	7	2	2	4	2	2	2	36
		Expected Count	11.6	6.1	3.7	.9	5.2	3.7	2.1	2.7	36.0
		% within COMFORTDIAGNOSING	41.7%	19.4%	5.6%	5.6%	11.1%	5.6%	5.6%	5.6%	100.0%
		% within License	39.5%	35.0%	16.7%	66.7%	23.5%	16.7%	28.6%	22.2%	30.5%
	I have taught or explained FDIA to others in my field	Count	4	1	4	0	3	3	1	2	18
		Expected Count	5.8	3.1	1.8	.5	2.6	1.8	1.1	1.4	18.0
		% within COMFORTDIAGNOSING	22.2%	5.6%	22.2%	0.0%	16.7%	16.7%	5.6%	11.1%	100.0%
		% within License	10.5%	5.0%	33.3%	0.0%	17.6%	25.0%	14.3%	22.2%	15.3%
Total		Count	38	20	12	3	17	12	7	9	118
		Expected Count	38.0	20.0	12.0	3.0	17.0	12.0	7.0	9.0	118.0
		% within COMFORTDIAGNOSING	32.2%	16.9%	10.2%	2.5%	14.4%	10.2%	5.9%	7.6%	100.0%
		% within License	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 7.

KNOWLEDGEOFFDIA * License Crosstabulation

			License								
			LMHC	LMHCA	LMFT	LMFTA	LCSW	LCSWA	Intern	Other	Total
KNOWLEDGEOFFDIA	None	Count	0	3	1	1	4	1	0	1	11
		Expected Count	3.6	1.9	1.1	.3	1.6	1.1	.7	.8	11.0
		% within KNOWLEDGEOFFDIA	0.0%	27.3%	9.1%	9.1%	36.4%	9.1%	0.0%	9.1%	100.0%
		% within License	0.0%	15.0%	8.3%	33.3%	23.5%	8.3%	0.0%	12.5%	9.4%
	I know FDIA through other means such as media	Count	13	8	1	0	9	8	2	4	45
		Expected Count	14.6	7.7	4.6	1.2	6.5	4.6	2.7	3.1	45.0
		% within KNOWLEDGEOFFDIA	28.9%	17.8%	2.2%	0.0%	20.0%	17.8%	4.4%	8.9%	100.0%
		% within License	34.2%	40.0%	8.3%	0.0%	52.9%	66.7%	28.6%	50.0%	38.5%
	I have experience and education	Count	4	2	3	2	1	0	1	0	13
		Expected Count	4.2	2.2	1.3	.3	1.9	1.3	.8	.9	13.0
		% within KNOWLEDGEOFFDIA	30.8%	15.4%	23.1%	15.4%	7.7%	0.0%	7.7%	0.0%	100.0%
		% within License	10.5%	10.0%	25.0%	66.7%	5.9%	0.0%	14.3%	0.0%	11.1%
	I feel comfortable diagnosing FDIA in my practice	Count	8	2	2	0	3	2	3	1	21
		Expected Count	6.8	3.6	2.2	.5	3.1	2.2	1.3	1.4	21.0
		% within KNOWLEDGEOFFDIA	38.1%	9.5%	9.5%	0.0%	14.3%	9.5%	14.3%	4.8%	100.0%
		% within License	21.1%	10.0%	16.7%	0.0%	17.6%	16.7%	42.9%	12.5%	17.9%
	I would feel comfortable teaching others about FDIA	Count	13	5	5	0	0	1	1	2	27
		Expected Count	8.8	4.6	2.8	.7	3.9	2.8	1.6	1.8	27.0
		% within KNOWLEDGEOFFDIA	48.1%	18.5%	18.5%	0.0%	0.0%	3.7%	3.7%	7.4%	100.0%
		% within License	34.2%	25.0%	41.7%	0.0%	0.0%	8.3%	14.3%	25.0%	23.1%
Total		Count	38	20	12	3	17	12	7	8	117
		Expected Count	38.0	20.0	12.0	3.0	17.0	12.0	7.0	8.0	117.0
		% within KNOWLEDGEOFFDIA	32.5%	17.1%	10.3%	2.6%	14.5%	10.3%	6.0%	6.8%	100.0%
		% within License	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 8.

Dependent Variable Encoding

Original Value	Internal Value
Yes	0
No	1

Table 9.

Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	140.867[a]	.121	.164

a. Estimation terminated at iteration number 4 because parameter estimates changed by less than .001.

Table 10.

Hosmer and Lemeshow Test

Step	Chi-square	df	Sig.
1	25.838	7	<.001

Table 11.

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Step 1[a]	COMFORTDIAGNOSING	-.429	.243	3.120	1	.077	.651	.404	1.048
	KNOWLEDGEOFFDIA	-.439	.162	7.313	1	.007	.645	.469	.886
	Constant	1.443	.644	5.025	1	.025	4.233		

a. Variable(s) entered on step 1: COMFORTDIAGNOSING, KNOWLEDGEOFFDIA.

Table 12.

Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	156.060[a]	.051	.068

a. Estimation terminated at iteration number 3 because parameter estimates changed by less than .001.

Table 13.

Hosmer and Lemeshow Test

Step	Chi-square	df	Sig.
1	8.807	7	.267

Table 14.

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Step 1[a]	COMFORTDIAGNOSING	-.055	.220	.062	1	.803	.947	.615	1.457
	KNOWLEDGEOFFDIA	-.331	.148	5.015	1	.025	.719	.538	.960
	Constant	.837	.581	2.076	1	.150	2.310		

a. Variable(s) entered on step 1: COMFORTDIAGNOSING, KNOWLEDGEOFFDIA.

Summary

This chapter contained the results of the data analysis I conducted to address the research questions. The research questions asked were "are comfort and knowledge variables that predict an accurate diagnosis of FDIA? I conducted a variety of descriptive statistics, cross-tabulations, chi-squares, and binary multiple regression to answer these questions. In conclusion, there was insufficient evidence from this limited initial pilot study to indicate that comfort with diagnosing FDIA or knowledge of FDIA might predict an accurate FDIA diagnosis.

Chapter 5: Discussion, Conclusions, and Recommendations

Empirical literature indicated that among mental health professionals, FDIA continues to be a challenging, misunderstood, and underdiagnosed form of child abuse when compared to other forms of child abuse (physical and sexual child abuse). The prevalence of FDIA is nationally and internationally unknown, most likely due to the deceptive nature of this disorder. Determining the prevalence of FDIA has been challenging because healthcare professionals frequently misunderstand the symptoms of the disorder.

The purpose of this quantitative predictive study was to examine comfort and knowledge as predictors of an accurate FDIA diagnosis among counseling professionals. There were no reliable statistics regarding the number of people in Washington State who were diagnosed with FDIA by counseling professionals (Cleveland Clinic, 2021; M. Feldman, personal communication, 2020; M. Weber, personal communication, 2020; Sheridan, 2003; Stein, 2014). The research problem was to predict which variables affect an accurate FDIA diagnosis among counseling professionals in Washington State.

Interpretation of Findings

Counseling professionals were thought to be less aware of FDIA than other professional groups in mental health and medical psychology (Osfeld, Feldman, et al., 1996; M. Feldman, personal communication, 2020, February). Researchers have found that knowledge and awareness of FDIA vary significantly among master-level and doctorate-level mental health professionals (Osfeld, Feldman, et al., 1996) and has been reflected in the disorder's unknown national and international prevalence rate (APA,

2020). Boswell and Scharff (2022) determined there was a lack of research on the availability of knowledge of FDIA. A lack of knowledge of FDIA may have also contributed to the unknown prevalence rate (M. Feldman, personal communication, 2020). Associate master-level counseling professionals have been particularly prone to inaccurate diagnosing and discomfort with disorders because of the lack of information that is provided in diagnostic courses in mental health counseling programs (Boswell & Scharff, 2022; Murphy & Joseph, 2016).

The results of this study showed that more males (n=64) than females (n=50) participated in the data collection process and the average age range of participants was between thirty-one and fifty years old in Washington State. Most participants were split evenly between East Seattle and West Seattle (20.3%) with eight participants not residing in Washington State. The Chi-Square showed that there was no relationship between a license and an accurate diagnosis of FDIA in either of the case studies presented in the online survey. Neither in the first case called, the CASEOFPETER (Chi-Square=9.885, df=7, p=.195) nor in the second case, called the CASEOFGARNETT (Chi-Square=1.851, df=7, p=.968).

An additional cross-tabulation between comfort and specific licenses showed that the majority of participants (n=53) reported that on a Likert scale measured with four points (1=unaware of FDIA and 4=comfortable enough to teach FDIA) the majority of participants (n=53) reported that they would feel comfortable diagnosing FDIA with a consultation team (LMHC=16, LMHCA=12, LMFT=6, LMFTA=1, LCSW=9,

LCSWA=5, Intern=3, Other=1). Likewise, a crosstabulation was conducted to address the relationship between knowledge and each counseling license. On a five-point Likert scale (1=not knowing about FDIA and 4=having enough knowledge of FDIA that they would teach others about this diagnosis) the average participants (n=45) indicated that they knew of FDIA through outside sources of academics, such as media, (LMHC=13, LMHCA=8, LMFT=1, LCSW=9, LCSWA= 8, Intern=2, Other=4).

To answer the research question (are comfort and knowledge variables that predict an accurate diagnosis of FDIA) I conducted a binary logistic regression. The dependent variables were encoded as an accurate diagnosis of FDIA (0=yes) and an inaccurate diagnosis of FDIA (1=no).

The model summary for the CASEOFPETER showed that 16 percent of the dependent variable was explained by the predictor variable (r=.164). The Hosmer and Lemeshow Test showed the p-value (<.001) is below 0.05 and indicated strong evidence of a real effect or difference, rather than just random variation. A p-value of comfort in diagnosing FDIA (sig=.077) and a p-value of knowledge of FDIA (sig=.007) indicated that both comfort and knowledge were not statistically significant and the null hypothesis should be retained (comfort and knowledge did not predict an accurate diagnosis of FDIA). As comfort diagnosing FDIA increased (EXP(B)=.651) the odds of getting a wrong diagnosis decreased. As knowledge of FDIA increased (EXP(B)=.645) the odds of getting the wrong diagnosis were decreased. Comfort diagnosing FDIA was a better predictor of getting the correct answer of FDIA than knowledge of FDIA.

The model summary for the CASEOFGARNETT showed close to seven percent of the dependent variable was explained by the predictor variable (r=.068). The Hosmer and Lemeshow Test showed the p-value (sig=.267) was above .05 indicating that the model was statistically non-significant and the model was an adequate fit and therefore supported the CASEOFPETER indicating there is strong evidence that the null hypothesis should be retained and the alternative hypothesis should be rejected. Within this study, it was found that as comfort increased the odds of an inaccurate diagnosis decreased (Exp(B)=.947) and as knowledge of FDIA increased the odds of an inaccurate diagnosis consistently decreased (Exp(B)=.025). Based on those findings, it appears that comfort diagnosing FDIA might be a better predictor of getting the correct answer of FDIA than knowledge of FDIA.

Limitations of the Study

The main limitation of this study was the small sample size of adults from a limited geographic region. The small sample size required a reassessment of the measures used to collect and analyze the data. Individuals in the population resided in Washington State and did not represent the population of master-level mental health professionals in other areas of the country. Consequently, I did not use the results obtained from this study to generalize the U.S. population, only Washington State. A limitation of this study was the lack of research on the topic of variables that predict an accurate diagnosis of FDIA. According to Dr. Feldman, there continues to be a lack of research in the area of FDIA and its prevalence in the nation (M. Feldman, personal communication, 2024).

Additionally, a limitation of this study is the use of the diagnostic word FDIA versus its old diagnostic name of Munchausen by Proxy. This may have changed the results regarding each participant's knowledge of the disorder. Finally, this researcher was unable to interview all licensed mental health professionals and only did a convenient sample, of which the participants who volunteered to respond could have represented a sub-group of the whole population that didn't accurately reflect the population as a whole.

Using SurveyMonkey as a measure to collect data presented limitations to the self-report process as it was impossible to ensure that the person who took the survey was a master-level mental health professional and therefore the results could have been inaccurate. Other limitations included access to an electronic device to take the survey and no access to non-English speaking participants. Finally, due to the dissertation process, there were time constraints in collecting additional participants for this study.

Recommendations

The results of this study could contribute to the body of scholarly data by identifying that there is still limited information regarding the variables that predict an accurate diagnosis of FDIA among master-level professionals. In this study, the research indicated that the null hypothesis should be retained (comfort and knowledge do not predict an accurate diagnosis of FDIA) as the p-values indicate that both comfort ($p=.077$) and knowledge ($p=.007$) are not statistically significant. Additional research on FDIA is still required to develop a model with other independent variables that may create a predictive value. Future researchers should seek out conjunctive variables to

predict a more accurate diagnosis of FDIA, as well as better sampling across the whole sector of mental health professionals. According to personal communication with Dr. Feldman (2024), a possible variable for predicting and accurate diagnosis of FDIA could be fear of diagnosing. From the results of this study, I believe scholars will find it helpful to continue to study what predicts an accurate diagnosis of FDIA.

Implications

Counseling professionals cause damage by not understanding all the disorders in the DSM and by avoiding diagnosing because of discomfort (A. Dunlop, personal communication, 2020; Hays, 2017, M. Feldman, personal communication, 2020; Zeshan, Cheerman, et al., 2018). Mental health training in counseling skills suggests that confrontational topics can lead to the disruption of the therapeutic alliance, therefore many professionals are unaware of how to conduct difficult conversations with deceptive and abusive clients (Nicole & Eccles, 1997). The prevalence of FDIA is unknown most likely due to the deception in this population and because healthcare professionals infrequently understand the diagnosis, even in recognized cases (APA, 2022; Bass & Holligan, 2014; Feldman & Ford, 1994: Felman & Xiong, 2022; Feldman & Yates, 2018). Diagnosing FDIA is very difficult because of the dishonest nature of this disorder (Bools, Neal, et al., 1994; Cleveland Clinic, 2021; M. Feldman, personal communication, 2020; Bass and Holligan, 2014; M. Weber, personal communication, 2022; Schreier & Libow, 1993; Sheridan, 2003). Individuals diagnosed with FDIA can be manipulative and

charming. Manipulation, charm, and deceit are common indicators of a significant personality disorder (M. Weber, personal communication, 2021).

A common training model in counseling programs focuses on providing a safe space of unconditional positive regard regardless of negative personality characteristics (Hays, 2017; Moderna Healthcare, 2021). Further, research into the personal belief of a counselor's conceptualization of a client based on a holistic model of therapy (Bass & Holligan, 2014; Hays, 2017) may also explain the aversion to diagnosing. Finally, FDIA may also go undiagnosed because of general discomfort with confrontation as a tool in the therapeutic process (Murphy & Joseph, 2016; Nicole & Eccles, 1997). Diagnosing FDIA is very difficult because of the dishonest nature of this disorder (Bools, Neal, et al., 1994; Cleveland Clinic, 2021; M. Feldman, personal communication, 2020; Bass & Holligan, 2014; M. Weber, personal communication, 2022; Schreier & Libow, 1993; Sheridan, 2003).

For all levels of mental health and psychiatric professionals, the results of this study may contribute to the collective research, supporting that FDIA is relatively new among professionals and needs more research across all areas of the disorder. The FDIA community continues to support research that could contribute to early and timely detection and reduce harm to others (M. Feldman, personal communication, 2024).

The FDIA community must get much larger and garner more interest in the research to begin to narrow down ways to accurately diagnose FDIA, as well as begin to develop an idea of national prevalence. This research could influence academic and

training programs to teach new mental health professionals the information they need to create a standard profile of the FDIA individual to assist in diagnosis. Similarly, case workers in government and private agencies might use the findings from this study as a tool to advocate for training programs to acknowledge and expedite the latest research on FDIA, namely, how can we improve diagnosing and reduce harm to others.

Research into FDIA diagnosing and the prevalence of this disorder could motivate a discussion with diagnostic writers of the DSM-5-TR to consider creating a criminal/forensic classification section that contains this disorder, as well as other disorders that have a higher-than-average potential of causing harm to others. The potential for a crime classification section of the DSM-6 could lead other professionals who are outside the scope of mental health professionals to begin to understand FDIA more clearly, leading to continued research, and the possibility of early diagnosis and reporting. Researchers have struggled to develop a collective body of knowledge that can predict an accurate diagnosis and this continues to support that more research is needed (M. Feldman, personal communication, 2024).

Implications for Social Change

Newborns and young children who are exposed to frequent medical abuse will not have the ability to use effective methods to report or leave their abuser, thus resulting in continued harm to the victim. For example, suppose a newborn or young child endures medical child abuse at the hands of an FDIA perpetrator, in that case, their chance of survival significantly decreases and the chances that they will develop mental health

issues if they survive is almost guaranteed (M. Feldman, personal communication, 2024). When a victim is exposed to such abuse, the individual has an increase in negative social, cognitive, and behavioral issues that will be present in adulthood and throughout their lifespan. To prevent harm to victims, the practitioner must understand the continued need to be informed about all mental health issues, including FDIA. To effect social change, mental health professionals must take an active look at disorders that have a higher likelihood of criminal behavior and harm (M. Feldman, personal communication, 2024). As professionals continue to learn more about FDIA, perpetrators may be identified early and harm to the victims could be greatly reduced.

Conclusion

There has been limited research regarding the predictors of receiving an accurate diagnosis of FDIA among mental health professionals and there is no research on the prevalence of the disorder internationally. The non-directive approach to Person-Centered Theory is best understood as embracing the client by extending non-judgment and total acceptance (Levitt, 2005; Murphy & Joseph, 2016). Between 1942 and 1951, Rogers's studies focused on the role of non-directivity in the process and outcome of psychotherapy (Snyder, 1945). Most person-centered counselors do not rely on diagnosis to guide the course of therapy and treatment (Murphy & Joseph, 2016). This non-directive approach to diagnosing is intended to support the client’s autonomy and reduce the stigma of labels (Murphy & Joseph, 2016) According to Boswell and Scharff (2022) precise clarification of psychiatric disorders is important to conduct accurate treatment.

Clinical observation validated self-reports, assessment tools and an ability to diagnose mental health diagnosis are critically important components in counselors' training (Murphy & Joseph, 2016) as effective assessment and diagnosis serve a specific purpose toward growth, insight, and recovery. Client-focused assessment in training has research and knowledge gaps that “should be acknowledged.”

When a counselor graduates from a master–level training program and completes a designated amount of internship hours, be considered competent in basic assessment a diagnostic skill. Psychologists and psychiatrists often have earlier and broader opportunities for training in specialty disorders such as FDIA, increasing competence in diagnosing skills (Osfeld, Feldman et al., 1996). In contrast, adequate training to improve counselors’ comfort and knowledge in specialty disorders has not been studied (M. Feldman, personal communication, 2021 February). Studying variables that impact the likelihood of accurate diagnosing provides a better understanding of how information and training can be created to improve statistics and the prevalence of FDIA (Feldman & Xiong, 2020).

I designed this study to address variables that could help predict an accurate diagnosis of FDIA among master-level professionals. The purpose of this quantitative predictive study was to examine comfort and knowledge as predictors of an accurate FDIA diagnosis among counseling professionals. There was no reliable statistic regarding the number of people in Washington State who are diagnosed with FDIA by counseling professionals, and it is difficult to assess how common the disorder is because many

cases go undetected due to lack of knowledge and comfort (Cleveland Clinic, 2021; M. Feldman, personal communication, 2020; M. Weber, personal communication, 2020; Sheridan, 2003; Stein, 2014). The research problem was to predict which variables affect an accurate FDIA diagnosis among counseling professionals in Washington State. All previous research of this time focused on doctorate-level professionals and social workers in the counseling and medical field.

I conducted a binary regression to address the question of which variable would predict an accurate diagnosis of FDIA (comfort or knowledge). The model summary for the CASEOFPETER shows that 16 percent of the dependent variable is explained by the predictor variable (r=.164). The Hosmer and Lemeshow Test shows the p-value (<.001) is below 0.05 and indicates strong evidence of a real effect or difference, rather than just random variation. A p-value of comfort in diagnosing FDIA (sig = .077) and a p-value of knowledge of FDIA (sig = .007) indicated that both comfort and knowledge were not statistically significant and the null hypothesis should be retained (comfort and knowledge do not predict an accurate diagnosis of FDIA). As comfort diagnosing FDIA increases (EXP(B) = .651) the odds of getting a wrong diagnosis decrease. As knowledge of FDIA increased (EXP(B) = .645) the odds of getting the wrong diagnosis decreased. Comfort diagnosing FDIA was a better predictor of getting the correct answer of FDIA than knowledge of FDIA.

The model summary for the CASEOFGARNETT showed close to seven percent of the dependent variable was explained by the predictor variable (r=.068). The Hosmer

and Lemeshow Test shows the p-value (sig=.267) was above .05 indicating that the model was statistically non-significant, and the model was an adequate fit and therefore supported the CASEOFPETER. Thus, it indicated there was strong evidence that we should retain the null hypothesis and reject the alternative hypothesis. As comfort increased the odds of an inaccurate diagnosis decreased (Exp(B)=.947) and as knowledge of FDIA increased the odds of an inaccurate diagnosis decreased (Exp(B)=.025). Comfort diagnosing FDIA is a better predictor of getting the correct answer of FDIA than knowledge of FDIA. In conclusion, there was insufficient evidence that comfort with diagnosing FDIA or knowledge of FDIA could predict an accurate FDIA diagnosis.

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Appendix A: Letter of Request

Dear _____,

I am writing to request your support for a research study addressing diagnostic accuracy among master-level, licensed counselor professionals in Washington State. I am a doctoral student at Walden University, and this research is being conducted for a Ph.D. dissertation study. This research aims to provide insight into the diagnostic accuracy of mental health disorders specified in the Diagnostic and Statistical Manual – V-TR.

The research is anonymous; no identifying information will be requested. The research will consist of answering questionnaires and should require no more than 20 minutes of your time. We are specifically interviewing master-level, licensed counseling professionals in Washington State. Please consider sharing the below Survey Monkey link with your colleagues so that they might allow their responses to aid this important research study.

Best Regards,

Ari Gartin

Ph.D. Student

Walden University

Appendix B: Demographics Questionnaire

Section One

Thank you for offering your time by participating! This survey is and will remain confidential throughout this study. These first questions help identify your eligibility for the study.

1. Age:
2. Gender:
    a. Male
    b. Female
    c. Other
3. Where do you live?
    a. Seattle
    b. Olympic Peninsula
    c. Eastern Washington
    d. Tacoma
    e. My location is not listed.
    f. I live outside of Washington State but practice in Washington State
    g. I live outside of Washington State and practice outside of Washington State
4. What license do you have?

a. LMHC

b. LICSW

c. MFT

d. Other

Appendix C: Diagnosing Questionnaire

The following is a list of cases that you will read and provide a diagnosis for. You will first read the case and then diagnose the case. You will have a second option to provide a diagnosis that you would like to be considered.

Case One:

Mathew (49 years old) awoke one day and noticed that he had lost all strength in his legs. His wife took him to the Emergency Room (ER) and after a brain and spine scan that garnered no explanation, he underwent a lumbar puncture. He also had blood tests and electrical nerve studies with no results. Mathew stayed in the hospital for two weeks and slowly improved. A week after leaving the hospital, his wife brought him back. Mathew thought he had multiple sclerosis. He reported that he was feeling paralysis in his right foot, blurred vision, tiredness, and bladder incontinence. Mathew's neurologists evaluated Mathew's nerves in many ways and realized they reacted differently.

Please select the following possible diagnosis/es.

Malingering

Factitious Disorder Imposed on Another

Conversion Disorder

Obsessive Compulsive Disorder

Case Two:

Yvonne is 41 years old and devoted most of her adult life to caring for her family. Things were going well for her until the accident. When Yvonne woke and opened her eyes, she said everything was black and when she tried to get up, she stumbled and tripped. She went immediately to the hospital where tests were run, but in the end, they could not find a course for her blindness. She was sent to another medical center and was in the hospital awaiting her second round of tests. Her results reported that after the next round of tests, her eyes showed up as normal. On her last day in the hospital, she handed her physician's assistant a beautiful card. She said she made it and could do so by feeling the lines of the pencil marks. Not a single outline was broken, nor was there a single leaf or flower left out.

Please select the following possible diagnosis/es.

Conversion Disorder

Factitious Disorder Imposed on Another

Post-Traumatic Stress Disorder

Factitious Disorder

Case Three:

Peter has taken his 12-year-old daughter to a mental health facility because he reports that his adolescent daughter suffers from bipolar disorder with manic episodes, and he has observed violent behavior. In a family and therapy session, he told the

counselor that his daughter was hearing voices that told her to kill her brother. Peter decided that he would always attend his daughter's therapy appointments so that he could help the therapist by providing information that he was seeing. Unfortunately, Peter tended to talk to the counselor more than his daughter, so the therapist never really got to know her. She would sit comfortably and color throughout her sessions. Three weeks later, Peter removed his daughter from her therapy and sent a letter to the administration stating that his daughter had schizophrenia and that unfortunately, she needed more treatment than the mental health facility could provide.

Please select the following possible diagnosis/es.

Psychotic Disorder

Factitious Disorder

Illness Anxiety Disorder

Factitious Disorder Imposed on Another

Case Four:

When Garnett was born, Lacey started blogging about his life. Garnett's birth seemed to be an exceedingly difficult one, followed by many breathing and intestinal problems. Lacey said that when she blogged, it made her feel supported since she lived alone. Often, writing about Garnett's surgeries would help moderate her emotions. Finally, Garnett was placed on a feeding tube, but when they started to have difficulties, the hospital was hesitant to have his feeding tube replaced. Every week his symptoms

seemed to increase, until in a month, he was deceased. She placed his ashes in her locket and increased her social support through this hard time.

Please select the following possible diagnosis/es.

Dissociative Amnesia

Nightmare Disorder

Factitious Disorder Imposed on Another

Depersonalization Disorder

Appendix C: Knowledge and Comfort Questionnaire

The following is a list of questions about your levels of comfort and knowledge of Factitious Disorder Imposed on Another (FDIA). Both questions will have a five-point scale in which you can choose the correct number.

How comfortable are you diagnosing FDIA?

1 – What is FDIA?

2 – I am not comfortable diagnosing FDIA

3 – I would diagnose FDIA only with a consultation team.

4 – I will diagnose FDIA if the case calls for it.

5 – I have taught or explained FDIA to others in my field.

How much knowledge do you have of FDIA?

1 – None.

2 – I know FDIA through other means such as media, books, workshops, etc.

3 – I have education or experience.

4 – With my education and experience, I would feel comfortable diagnosing FDIA in practice.

5 – I would feel comfortable teaching others about FDIA.

Please provide any comments you find relevant to the discussion of FDIA in this survey.

THANK YOU FOR YOUR PARTICIPATION

Appendix D: Consent Form

You are invited to take part in a research study about diagnostic accuracy. I am inviting all master-level licensed counseling professionals to participate. Your contact information has been obtained from mental health and counseling agencies because you have agreed to take this survey and meet the above-required qualifications. This form is part of the process called "informed consent" to allow you to understand this study before deciding whether to take part.

My name is Arista Gartin and I am a doctoral student at Walden University. You may already know me as a counselor, but this study is separate from that role.

Background Information:

The purpose of this study is to understand comfort and knowledge as a prediction of accurate diagnosing among counseling professionals.

Procedure:

If you agree to be in this study, you will be asked to diagnose four cases according to the DSM 5. No electronic identifying information will be collected by me or the web host; however, if you access the survey by an agency computer, I cannot guarantee that your agency will not collect usage information on the agency network. This anonymous survey contains four cases which will take approximately 25 minutes in total to complete.

Here is an example of a case:

Steve has many health concerns. He is a doctor at a local university and noticed that he started to have symptoms of many disorders in grad school. Eventually, he narrowed his problems to an unspecified autoimmune disorder. On the days that he would see patients, he would not think or report feeling his symptoms as much, but on the days that he is alone, he would notice that most of his symptoms would flair up to an almost debilitating extent. What is the possible diagnosis/es?

1- Malingering
2- Illness anxiety disorder
3- Factitious Disorder
4- Generalized Anxiety Disorder
5- Factitious Disorder Imposed on Another

This survey will also consist of two additional questions that will help me better understand your comfort level and knowledge of disorders.

Here is an example of the scale used:

On a scale of 1 (very interested) and a scale of 5 (very uninterested), please tell me how interested you are in diagnosis as part of your car. er?

Please select the best answer to this question

1 – Very interested

2 – Moderately interested

3 – Average interest

4 – Moderately uninterested

5 – Very uninterested

Voluntary Nature of the Study:

This study is voluntary. If you decide to join the study now, you can still change your mind later. You may stop at any time. No one will have the ability to identify whether you participated.

Risks and Benefits of Being in this Study:

There are no foreseen or anticipated risks to your safety or well-being in participating in this study. However, if you find that you are overwhelmed or distressed, please call the National Suicide Prevention Lifeline by telephone at 1-800-273-8255 or by web chat at http://www.suicidepreventionlifeline.org/gethelp/lifelinechat.aspx.

The benefit of participating in the study is that you will help provide a better understanding of the comfort level, knowledge, and diagnostic accuracy of disorders in the DSM 5. This information may contribute to new training or educational courses that can help improve mental health outcomes for counselors who intend to have a diagnosis as part of their career.

Payment:

I will not provide compensation for participating; however, you may receive compensation from the SurveyMonkey platform according to the agreement that you have made with the service.

Privacy:

Any information you provide will be kept anonymous. I will not use your personal information for any purposes outside of this research project. Data will be kept secure by password-protecting all computer data files on a password-protected laptop. No electronic information or IP addresses will be collected by me or the web survey host, SurveyMonkey. Data will be kept for at least 5 years, as required by the university.

Contacts and Questions:

If you have questions regarding this survey, you may contact the researcher via e-mail at arista.gartin@waldenu.edu or via telephone at 360-461-8764. If you want to talk privately about your rights as a participant, you can call Dr. Reba Glidewell. She is the Walden University representative who can discuss this with you. Her phone number is 318-510-8762. Walden University's approval number for this study is XXX. IRB will **enter the approval number** here and IRB approval **expires on this date**.

Please print or save this consent form for your records.