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## Munchausen Syndrome by Proxy

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### Introduction

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Munchausen syndrome by proxy (MSBP) is a covert, potentially lethal, and frequently misunderstood form of child abuse. Although not uncommon, this syndrome is difficult to detect and confirm.<sup>[1]</sup>

In 1951, Dr Richard Asher originally used the term Munchausen syndrome to describe adults who fabricated illnesses to get medical attention, with no secondary gain except to adopt the role of illness through unnecessary medical procedures and treatments.<sup>[2]</sup> The term was used in reference to the 18th-century military mercenary Baron von Münchhausen, who was known for fictional and dramatic accounts of his travels.

In 1977, Roy Meadow coined the term Munchausen syndrome by proxy to describe 2 mothers who fabricated, lied, and induced symptoms in their 2 children.<sup>[3]</sup> One of the children had a history of prolonged and recurrent passing of purulent bloody urine, and the other had a history of recurrent hypernatremia. The first child, whose symptoms occurred only in her mother's presence, improved during psychiatric treatment of the mother for her abusive behavior. The second child's symptoms occurred only at home, and he died as a result of severe hypernatremia. In 1994, Meadow reported that the boy's mother admitted to her psychiatrist that she killed her son by salt poisoning.

These 2 cases underline the importance of early recognition of Munchausen syndrome by proxy and the seriousness of its consequences. In this discussion, several aspects of Munchausen syndrome by proxy are reviewed, including its definition, prevalence, characteristics of the perpetrators and their victims, complications, diagnosis, and management strategies.

In 1994, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, used the term factitious disorder by proxy (FDP) to describe a psychiatric illness of the perpetrator who fabricates or inflicts illnesses on her victims.<sup>[4]</sup>

The American Professional Society on the Abuse of Children (APSAC) introduced the following term pediatric condition falsification (PCF) to describe the condition in the abused child. PCF may or may not be associated with FDP. However, the APSAC requires the presence of both FDP and PCF to diagnose Munchausen syndrome by proxy.

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### Incidence and Prevalence

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Although not precisely known, incidence and prevalence of Munchausen syndrome by proxy are almost certainly more common than once estimated. More than 700 cases from 52 countries have been reported in the literature, but these reflect only the most severe cases and cases that have been substantiated.

A handful of investigators have reported various incidences of Munchausen syndrome by proxy. One group found that 1% of children with asthma had been subjected to Munchausen syndrome by proxy.<sup>[5]</sup> In another report of children with food allergies, 16 of 301 children (5%) had been subjected to Munchausen syndrome by proxy.<sup>[6]</sup> In an English town with a population of 200,000, 39 cases of intentional suffocation of children were reported over 20 years (rate of 1 case per 25,000 population).<sup>[7]</sup> A

survey by the British Pediatric Association Surveillance Unit found 128 cases of reported Munchausen syndrome by proxy in the United Kingdom and Ireland over 2 years, with an incidence of 2.8 cases per 100,000 children younger than 1 year and 0.5 cases per 100,000 children younger than 16 years.<sup>[8]</sup>

In 1991, Schreier and Libow surveyed 880 pediatric neurologists and 388 pediatric gastroenterologists in the United States, with return rates of 21.8% and 32.4%, respectively.<sup>[9]</sup> Among physicians who responded, 212 reported contact with 192 suspected and 273 confirmed children exposed to Munchausen syndrome by proxy.

Given these data, approximately 625 cases of poisoning and suffocation attributable to Munchausen syndrome by proxy can be expected in the United States each year. Schreier had predicted an incidence of 1200 of new cases per year in United States, but this number was recently revised to about 200 per year. This estimate basically refers to clinically significant cases diagnosed or treated in a hospital setting and may underestimate the number of cases seen in outpatient clinics.

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## Perpetrators

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In more than 95% of cases of MSBP, the mother is the perpetrator of the child's illnesses. In a review by Sheridan (2003), mothers were the perpetrators in 76.5% of 451 cases.<sup>[10]</sup>

The mother was the perpetrator in almost all the cases in a series of 135 patients reported by Feldman et al.<sup>[11]</sup>

The child's symptoms usually occur solely in the presence of the mother and subside in her absence. The mother's partner, other family members, and healthcare workers are sometimes called to witness symptoms or a physiologically normal event, such as mild discoloration with crying. The perpetrator later uses these witnessed events to substantiate an alleged illness of the child.

Perpetrators are frequently described as caring, attentive, and devoted individuals. However, not all perpetrators fit this impostor parent profile. Some can be hostile, emotionally labile, and obviously dishonest. Although they have no obvious psychopathology, perpetrators can be deceiving and manipulative. Their ability to convince others should not be underestimated. Their abuse is premeditated, calculated, and unprovoked. The mother may have previous healthcare knowledge or training,<sup>[12]</sup> and she is often fascinated with the medical field. In one study, 80% of the documented perpetrators, all mothers, worked in healthcare or child-care facilities. Perpetrators aspire to establish close relationships with medical staff and frequently become a source of support for staff members or the families of other patients.

The mother is usually calm in the face of the perplexing medical mysteries that her child is experiencing. She tends to pursue additional diagnostic and therapeutic options regardless of the pain and discomfort they may inflict on her child and almost always resists discharge orders and negative diagnostic findings. A physician's suspicion or reluctance to continue evaluations may encourage the mother to take the child to another facility for further consultation and workup. The perpetrators recognize their wrongful behavior but take great care to conceal their actions and rarely admit to their abusive activities. Relationships among the mother, the child, and the primary physician may be long term and complex. Such involvement may hinder the physician from considering Munchausen syndrome by proxy as a differential diagnosis.

The mother's partner is often disengaged from the family and rarely plays an active role in the child's medical care. Trusting and unsuspecting partners may support the perpetrators and unknowingly become passive accomplices of the ongoing abuse. Other partners are abusive or uncommitted in their relationships with the mothers. In some cases, the abusing mother may be fabricating her child's symptoms to bring her partner back into the family.

Approximately 10-25% of perpetrators also induce symptoms in themselves. The pattern of lying and fabrication may extend to other aspects of their lives, including employment, education, marital status, and previous illnesses. The perpetrator rarely has a severe mental illness (eg, schizophrenia), although several reports indicate that the presence of one or more personality disorders is common. She may also have a life history of an excessive drive to seek attention. The perpetrator's family history may reveal various types of abuse, unusual diseases in multiple family members, and family interactions that reward illness.

Few publications have reported fathers as the primary perpetrators in substantiated cases of Munchausen syndrome by proxy. In these situations, the fathers did not fit the devoted parent profile but were described as emotionally disturbed and mentally unstable. Other reported perpetrators have been stepparents, grandparents, foster parents, and caregivers (eg, baby-sitters).

## Children and Their Symptoms

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### Age at onset

Abuse of the child commonly starts early in life. Munchausen syndrome by proxy is most common among infants and young children. According to Rosenberg, the median age when MSBP is diagnosed is 39.8 months, although children older than this have also been affected.<sup>[13]</sup> McClure et al (1996) similarly reported a median age of 20 months at diagnosis, with a distribution skewed toward younger patients.<sup>[8]</sup>

In a report by Meadow, suffocation began between the first and third months of life and lasted 6-12 months or until the patient died.<sup>[14]</sup> In a review of 451 cases in 154 articles published in medical and psychosocial journals, Sheridan (2003) found that affected children were usually younger than 4 years.<sup>[10]</sup> Awadallah et al reported one 14-year victim and 9 children older than 6 years who were reported by their institution to be victims of Munchausen syndrome by proxy and were referred to child protective services between January 2001 and June 2003.<sup>[15]</sup> In their literature review, they also found 42 victims reported from 1966-2002.

### Signs and symptoms

Children usually present with an array of ailments in different organ systems. Reports from the first 20 years after the condition was identified describe 68 symptoms, signs, and laboratory findings in 117 cases of MSBP, with approximately 70% of induced or fictitious symptoms occurring in the hospital.

More than 100 symptoms have been reported. The most common symptoms include abdominal pain, vomiting, diarrhea, weight loss, seizures, apnea, infections, fevers, bleeding, poisoning, and lethargy. One group reported multiple illnesses in 64% of 56 index children subjected to Munchausen syndrome by proxy.<sup>[16]</sup> Other reports indicate that some children initially present with a single serious event, such as a severe episode of apnea with no previous history of fabrication. A 2004 meta-analysis showed that PCF was the cause of 0.3% of all cases of apparent life-threatening episodes (ALTEs).<sup>[17]</sup> Another report suggested that intentional suffocation was the cause of about 10% of all sudden infant death syndrome (SIDS).<sup>[18]</sup> In a series of 135 cases reported by Feldman et al, 25% of the children had renal or urologic related issues.<sup>[11]</sup>

Older children subjected to Munchausen syndrome by proxy often collude with their mothers by confirming even the most unlikely stories about their medical histories, sometimes out of fear of contradicting their mothers and other times because of their mothers' persuasion over time. Some of these children believe that they are ill with a mysterious disorder that the physicians cannot figure out. In other cases, the child is aware that the mother's explanation is improbable but fails to speak, fearing the mother's revenge or that no one will believe him or her. In a report from Awadallah et al, 57% of cases of older children (>6 y) had induced illnesses, 14% had tampering with records or specimens, and 62% had false reporting.<sup>[15]</sup>

Several warning signs have been proposed to alert healthcare workers to the possibility of Munchausen syndrome by proxy. These include extraordinary, prolonged, and unexplained symptoms; ineffective or poorly tolerated treatments; and allergy to a wide variety of foods and medications. Warning signs also include symptoms that start or occur only in the presence of the perpetrator and a clinical presentation involving extraordinary and multiple symptoms and illnesses. Patients usually have normal or negative results on laboratory tests, and their illnesses do not respond to known medical treatments.

### Questions to ask on clinical assessment

Siegel and Fischer suggested that pediatricians ask themselves the following questions:<sup>[19]</sup>

- During clinical assessment, is the child's medical status consistent with the mother's description?
- Does objective diagnostic evidence support the child's reported medical condition?
- Has any staff member, including the pediatrician, witnessed the symptoms?
- Do negative test findings reassure the mother?
- Is treatment being provided to the child primarily because of the mother's persistent demands?

Physicians must remember that persistent fabrication, exaggeration, and simulation reflect pathologic seeking of healthcare and are not benign. In some cases of Munchausen syndrome by proxy, fabrication of symptoms may escalate to the induction of illnesses if the mother wishes to continue her involvement with the medical system or if the physician's response seems inadequate or unsatisfactory to her. Finally, clinicians should remember that the presence of a real illness does not preclude Munchausen syndrome by proxy.

## **Siblings of the Affected Child**

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Siblings may receive the same abuse the patient receives from the same parent. According to Rosenberg, 8.5% of siblings were abused.<sup>[13]</sup> In a series of 27 infants who were suffocated, 48% had a sibling who allegedly died of SIDS.<sup>[14]</sup> From a survey of pediatric neurologists and gastroenterologists, almost 25.8% of children who were abused had siblings who also were abused.

In a survey of 83 index cases of Munchausen syndrome, 15 children had 18 siblings who previously died, and 5 of these deaths were classified as SIDS. In another recent report, 28 children subjected to Munchausen syndrome by proxy had 41 siblings, 12 of whom died suddenly; 11 deaths were classified as SIDS, and one was attributed to gastroenteritis. Five parents admitted to killing 9 of the siblings. A recent meta-analysis of 451 cases of Munchausen syndrome by proxy with 210 siblings revealed that 61% of the siblings had symptoms and 25% had died.<sup>[10]</sup>

In a series of 135 victims reported by Feldman et al from 1974-2006, 31 of 34 children had siblings who were also victimized resulting in the death of 6 these siblings.<sup>[11]</sup>

## **Morbidity and Mortality**

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The incidence of death and serious medical complications is not precisely known. Mortality rates are 9-31% among index cases, with most investigators reporting a mortality rate of 9-10%. In a review of the literature, Sheridan (2003) reported a mortality rate of 6% and a rate of long-term injuries in 7.3% for index cases.<sup>[10]</sup>

Morbidity can be the direct result of the abuse or a consequence of multiple diagnostic and therapeutic interventions performed by unwitting physician facilitators. McClure et al (1996) reported that 122 of 128 abused children were admitted into the hospital as a result of abuse.<sup>[8]</sup> Of the 128 children, 119 (93%) received unnecessary invasive interventions, 45 had major medical illnesses, 31 had minor physical ailments, and 8 died. In an earlier survey of 51 clinics treating infant apnea, 54 (0.27%) of 20,090 children had been subjected to Munchausen syndrome by proxy.<sup>[20]</sup> Cardiopulmonary resuscitation was performed in 21 of 54 children, and 24 were hospitalized.

Children subjected to Munchausen syndrome by proxy present with induced physical ailments and fabricated psychological symptoms because the effects are not only physical. Similar to those receiving other types of abuse, children subjected to Munchausen syndrome by proxy can have long-term emotional and psychological disorders. McGuire and Feldman (1989) described 6 children who had behavioral problems, including feeding disorders in infants; withdrawal, hyperactivity, and oppositional behaviors in preschoolers; and conversion symptoms in older children and adolescents.<sup>[21]</sup> Older children often tolerated and cooperated with their parents in their own abuse and fabricated medical illnesses of their own.

Bools et al reported the outcome of 54 children aged 1-14 years subjected to Munchausen syndrome by proxy.<sup>[22]</sup> Several children had behavioral problems that included emotional and conduct disorders, achievement problems, nonattendance at school, fears and avoidance of specific places or situations, sleep disturbances, and features of posttraumatic stress disorder (PTSD). Boys had more disturbances than girls. Most of the children who remained with their mothers were exposed to repeated fabrication or were described as having other concerns. Children with unacceptable outcomes were older than others at the time of abuse and were most likely to have siblings also subjected to abuse.

In 1995, Libow reported the results of a 33-item questionnaire administered to 10 adults who identified themselves as survivors of Munchausen syndrome by proxy during childhood.<sup>[23]</sup> At the time of abuse, the respondents felt unsafe and unloved by their parents. As children, they had emotional stress and serious depression problems. They also reported problems with school and education as a result of absenteeism, lack of attention, or anxiety. As adults, they had insecurity, low self-esteem, depression, and symptoms of PTSD.

## Diagnosis and Management

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According to the American Academy of Pediatrics Committee on Child Abuse and Neglect, the health care worker must substantiate the credibility of the signs and symptoms, determine the necessity and benefits of the medical care, and question who is the instigator of the evaluations and treatments. To make the diagnosis, the presence of the following 2 factors must be established: harm or potential harm to the child from excessive intervention and a caregiver who is fabricating illness or pursuing unnecessary treatment. The motivation of the perpetrator is not important in diagnosing the abuse.

The latency between the start of abuse and its discovery can be relatively long. Several barriers often delay the timely detection and confirmation of Munchausen syndrome by proxy. These barriers include the following:

- Failure to consider Munchausen syndrome by proxy in the differential diagnosis
- Lack of familiarity of Munchausen syndrome by proxy by pediatricians and other healthcare providers<sup>[24]</sup>
- Lack of certainty in differentiating parental anxiety or concerns from a pathologic seeking of healthcare
- Tendency of the physician to believe the medical history the mother provides
- Ability of the mother to present a highly persuasive and compelling medical history
- Involvement of several physicians, often in different hospitals and sometimes numerous cities and states
- Fear of making a false accusation and its subsequent legal repercussions
- Lack of collaboration between medical, legal, and child-protection agencies
- Reluctance to separate the child from the family to evaluate the child's medical condition without the mother's involvement

Several authors suggested various criteria for identifying MSBP. In 1998, Parnell and Day developed 18 guidelines based on their experience and the recommendations of other authors.<sup>[25]</sup> These guidelines were divided into 3 categories based on specific features identified in the victim, the perpetrator, and the family. Many of these characteristics are described above. Many institutions have used hidden cameras to video record the child in the hospital for these features to confirm the diagnosis.<sup>[26,27]</sup>

Several authors agree that a timely diagnosis is best achieved if a multidisciplinary team is involved. In 2001, Siegel and Fischer summarized the role of the key professionals needed to diagnose Munchausen syndrome by proxy, as follows:<sup>[19]</sup>

- The role of the physician is to establish the pathologic healthcare-seeking behaviors that have led to medical abuse.

- The role of the psychologist is to evaluate the mother-child relationship, the mother's psychiatric condition, and the family's psychosocial functioning.
- The role of the child-protection worker is to ensure the child's immediate and long-term safety.
- The role of the juvenile court is to protect the child by making a strong commitment to the child's long-term supervision and to intervention that the family cannot refuse.

Meadow, Schreier and Libow, and others recommended a step-wise approach in diagnosing Munchausen syndrome by proxy.<sup>[28,9]</sup> These guidelines are summarized as follows:

- Obtain and verify the victim's and family's pertinent medical and social histories, previous hospitalizations, and medical records.
- Interview the father and any other family members alone, when the mother is not present to validate her stories.
- Admit the child to the hospital to observe the parent-child interaction, closely observe the suspected perpetrator, and determine the temporal relationship between the symptoms and the mother's presence.
- The child may need to be separated from the perpetrator to protect the child and to confirm cessation of the child's symptoms in the mother's absence.
- During hospitalization and under close observation, obtain the necessary body-fluid samples for toxicology screens and any other relevant investigations. If a multidisciplinary team agrees on the procedure, hidden cameras can be used to record the interactions of the child and the suspected perpetrator in the hospital setting.
- Arrange for social service, psychological, and psychiatric evaluations of the child and the suspected perpetrator.
- Assemble a team or task force to objectively examine the records before the suspected perpetrator is confronted.
- Inform the local child protection and law enforcement agencies before confronting the suspected perpetrator.
- Separate the child and other siblings at risk after the suspected perpetrator is informed of the diagnosis. For adequate protection, relocate the child to a place that is inaccessible to the suspected perpetrator.
- Recommend short-term and long-term psychological and psychiatric treatment for the suspected perpetrator.<sup>[29]</sup>
- Long-term and close monitoring by the court is essential to ensure the child's safety.
- Ensure that reunification criteria, as Meadow, Schreier, and Libow outlined, are met before the court considers reunification.<sup>[28,9]</sup>

## Summary

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Munchausen syndrome by proxy is a covert and serious form of child abuse. In most cases, the mother is the perpetrator. The child may have a combination of symptoms and signs that does not conform to any known disease and that does not respond to routine treatments. Thorough evaluation of the child and verification of pertinent medical and social histories are required. Obtaining medical records from previous hospitalizations and medical evaluations is important in identifying this disorder. Body fluids, including blood, should be tested to ensure any questionable specimens are the child's.

A multidisciplinary team approach is mandatory to confirm the diagnosis and protect the child. Long-term psychiatric follow-up treatment of both the child and the perpetrator is needed. Educating physicians, social workers, and other healthcare workers about Munchausen syndrome by proxy and establishing local task forces may facilitate timely diagnosis and management of the disorder.

Investigating and reporting MSBP can be both challenging and risky to caregivers. This is an emotional subject that incites interesting debate in the courts and in media outlets. Physicians and healthcare institutions may be tried or scrutinized in the public arena, and their judgments and decisions may be challenged. For example, recent uproar occurred in the British media and legal systems because well-known physicians had used creative investigations, which were instrumental in exposing potential perpetrators of fatal child abuse.<sup>[30]</sup> However, in a recent review of 250 cases of parents convicted of killing their young infants in England, only 8 were referred for possible overturning of their sentences.<sup>[31]</sup> Another review of 30,000 children in state custody in Great Britain resulted in a change of status in only one case.<sup>[32]</sup>

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## Keywords

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Munchausen syndrome by proxy, MSBP, child abuse, fabricated illness, factitious disorder, factitious disorder by proxy, FDP, Münchhausen, Münchhausen's syndrome, Munchausen's syndrome, pediatric condition falsification, PCF, Meadow syndrome, Meadow's syndrome, intentional suffocation, poisoning, child abuse, fabricating illness, posttraumatic stress disorder, PTSD, anxiety, sudden infant death syndrome, SIDS, suffocation, intentional suffocation

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