Definitional Issues in Munchausen by Proxy

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In 1995, an APSAC Taskforce was created and charged with exploring the condition or conditions sometimes known as Munchausen Syndrome by Proxy, other times called Munchausen by Proxy Syndrome and on still other occasions referred to as Factitious Disorder by Proxy. It was clear to the group that before guidelines for practice could be developed, a clinical description of the entities above was imperative. A subgroup of professionals in the field undertook the task of exploring and committing to writing a new and comprehensive definition of these entities described across the pediatric, psychiatric, law enforcement, legal and social work literature. This position paper is the product of the group's work. We hope to use these definition as the basis for future guidelines. We welcome comments from the membership.

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Purpose

In order to clarify the constellation of behaviors currently described as Munchausen by Proxy (MBP), a multidisciplinary group of professionals with expertise in the field has developed a composite of the facets of MBP. Our attempt has been to develop a synthesis of the most current thinking in pediatrics, psychiatry, psychology, child protection, and law and to articulate the current consensus among professionals in order to facilitate the identification and treatment of the disorder.

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The term Munchausen by Proxy (MBP) was first used by Roy Meadow (1977), a British pediatrician, to describe illness producing behavior reminiscent of adult Munchausen Syndrome, but using the child as a proxy. Adult "Munchausen Syndrome," described in 1951 by Asher, is a psychiatric disorder in which an adult intentionally induces or feigns symptoms of physical or psychiatric illness in order to assume the sick role. The fact that Munchausen Syndrome and Munchausen by Proxy share the same name has resulted in considerable confusion.

Munchausen by Proxy has been described as both a pediatric and a psychiatric entity. The term has been used globally to refer to the child's victimization, to the parent's disorder, and to the interactional component of the victimization and the psychological interchange between parent and child. There have been over 300 papers published in the medical and psychological literature on MBP. Although once thought to be quite rare, the disorder may well be more common than previously believed. Using the results of a very careful, but conservative British study (McClure, Davis, Meadow & Sibert, 1996) we estimate that a minimum of 600 new cases a year will present in the United States. Most experts now agree that MBP is not as rare as previously believed and many cases are likely to go undetected due to the covert nature of their presentation, the lack of public awareness, and the many obstacles to the identification of these case by professionals.

Some discrepancies in the use of the term MBP have arisen both within and across disciplines as the use of the term has expanded, limiting the effectiveness of clinicians involved in diagnosis and treatment, child protection systems in appropriate assessment and intervention, and other professionals asked to educate courts or advocate for the parties in the legal arena. In exploring the approaches to and descriptions of MBP within a variety of disciplines, we have concluded that crafting definitions that take into account the multidisciplinary nature of MBP assessment and treatment can significantly reduce the confusion.

It is essential to describe MBP as accurately as possible within a multidisciplinary context. This requires that MBP be differentiated from other forms of child maltreatment, valid pediatric problems, as well as from alternative forms of adult psychiatric illness. Clear definitions will enhance the ability of clinicians and courts to more effectively protect victims and families, as well as to improve the mandate of fair and appropriate services.

Definitional Issues

Munchausen by Proxy consists of two components, which may result in the identification of a variety of clinical disorders. The first component of the definition of MBP is the identification of the victimization to the child. The second component is the identification of the psychological motivation and the characteristics of the psychiatric difficulty in the perpetrating parent. In addition, MBP has been described as a family disorder. Non-perpetrating spouses, parents and others may support and participate in the deception that is at the core of the perpetrating parent's victimization of the child and must be considered in the assessment and treatment process.

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The Child as Victim

Pediatric Condition (illness, impairment, or symptom) **Falsification (PCF)** is a form of child maltreatment in which an adult falsifies physical and/or psychological signs and/or symptoms in a victim, causing the victim to be regarded as ill or impaired by others. It is a sub-group of the larger **Abuse by Condition Falsification** category of victimization in which the victim is another individual, adult or child.

Falsification includes but is not limited to the following forms of deception: directly causing conditions, over or under reporting signs or symptoms, creating a false appearance of signs and symptoms and/or coaching the victim or others to misrepresent the victim as ill. Only the imagination and sophistication of the perpetrator limit the number and extent of the presenting symptoms. The presence of valid illness does not preclude exaggeration or falsification.

A child who is subjected to this behavior is a victim of **Pediatric Condition** (illness, impairment, or symptom) **Falsification** and should be coded as such (Child Abuse - 61.1 (when focus is on perpetrator) and Child Abuse - 995.5 (when focus is on victim, see DSM-IV, p. 682) using the Statistical Manual for Mental Disorders – IV (DSM-IV). If the falsified signs and symptoms are physical, it is coded as **physical type**. If the falsified signs or symptoms are emotional, it is coded as **emotional type**. If both physical and emotional signs or symptoms are falsified, it is coded as **combined type**. Codes for child neglect may also be used to designate the type of victimization to the child (V61.21).

The Parent or Caregiver as Perpetrator

Persons who intentionally falsify history, signs or symptoms in a child to meet their own self-serving psychological needs have been diagnosed with **Factitious Disorder by Proxy (FDP)** and should be coded as such (Factitious Disorder Not Otherwise Specified - 300.19, see DSM-IV, p. 475). Different kinds of self-serving psychological needs may motivate this behavior. Some individuals appear to need or thrive on the attention or recognition that results from being perceived as the devoted parent of a sick child. A second motivating factor may include the need to covertly manipulate or deceive authority figures or those perceived to be powerful. Typical cases describe doctors and other health care personnel as the targets of such deception, but professionals including but not limited to lawyers, social workers, judges, school psychologists, teachers, law enforcement, and media representatives have also been identified as targets. These motivations and their corollaries may occur simultaneously or at different times in the same individual. External incentives in **FDP** may also be present and do not preclude the diagnosis.

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Differential Diagnosis

Issues in the Identification of Abuse by Pediatric Condition Falsification

Pediatric Condition Falsification is a distinct form of abuse. Some of the documented physical conditions alleged in these children include but are not limited to neurological problems (seizures and apnea), gastroenterological problems (vomiting, diarrhea, pain, intestinal pseudo-obstruction and failure to thrive) and allergies. Children may be healthy at birth or start life with prematurity and/or a valid illness. There may be a history given by the mother of difficulties with pregnancies and premature births. Children may present with illnesses whose signs and symptoms are not substantiated by physical and/or laboratory findings; illnesses may not conform to the typical presentation of the condition. Other findings may be increased rates of infection and delayed healing. Children with nasogastric or intravenous indwelling lines or reduced immunity to infection are more vulnerable to serious consequences of **PCF**. Failure to thrive is another finding in **PCF**. Non-accidental injuries also may be present.

Child abuse by **Pediatric Condition Falsification** through psychological or developmental symptoms have been documented, but appear to be less common than physical symptoms (Schreier, 1997). Such symptoms in the child may have some basis in truth and conditions such as attention deficit disorder, Tourette syndrome, bipolar disorder, post traumatic stress disorder, and psychosis may be falsified.

False accusations of child sexual abuse have also been attributed to abuse by **Pediatric Condition Falsification** where the mother is diagnosed with **Factitious Disorder by Proxy** (Meadow, 1995). In these situations, the primary motivation is psychological and involves parental attention-seeking behavior in order to gain recognition for herself in the parenting role from professionals seen as powerful (Meadows, 1995; Schreier, 1996). Issues and motives such as the acquisition of custody may be present, but are NOT the primary motivation that precipitates the child's being brought for repeated sexual abuse examinations.

The abuse may involve one child in the family or it may involve several children either simultaneously or serially (Alexander et al, 1990). There is

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an increased likelihood of a history of another child in the family who was ill and/or who died. The initial concern when MBP is suspected is to diagnose and report the presence of maltreatment in the child - herein defined as child abuse by **Pediatric Condition Falsification**. Such findings may be documented by circumstantial evidence (such as a positive toxicology screen, symptoms occurring only when parent is present, child improving with supervision of or separation from parent) or by direct observation including through the use of video surveillance.

The specific form or physical consequence of the abuse is not necessarily representative of the intensity or potential harm to the child. Pediatric providers should be aware that there is a high recidivism rate in MBP even after the parents have been apprehended. In many cases parents are likely to continue to abuse their children under close scrutiny, under surveillance, after confrontation and psychiatric treatment, and when their children are returned to them (Kinscherff & Famularo, 1991; Bools, Neale & Meadow, 1994). Both safety issues to the child and treatment planning for the family may hinge upon an assessment of motivation of the parent, in conjunction with the extent, lethality, and chronicity of the abuse to the child.

Factitious Disorder by Proxy is a psychiatric disorder which is applied to a person who intentionally falsifies signs or symptoms in a victim (usually, but not always a child).

The psychiatric morbidity to the child is often serious in both cases of near-lethal inducement of illness as well as in the chronic false reporting of symptoms. The psychological impact of the parent's deception can be debilitating to the child (McGuire & Feldman, 1989).

"Doctor shopping" may be a sign of **Pediatric Condition Falsification** when the motivation is not to actually get help for the child but to subject the child to the abuse of repeated investigations and needless procedures by doctors, in order to maintain relationships with health care personnel. In other instances "doctor shopping" is not present; physicians and other health care providers have long-term treating relationships with the children being victimized.

Issues in the Identification of Factitious Disorder by Proxy

Factitious Disorder by Proxy is a psychiatric disorder which is applied to a person who intentionally falsifies signs or symptoms in a victim (usually, but not always a child). In regard to the issue of motivation of the adult perpetrator, the DSM-IV recognizes that in **Factitious Disorder by Proxy (FDP)**, the abuse, which may be physical or psychological, takes place in a situation where external incentives for the behavior, such as economic gain, are absent. However, it is clear from the work of people experienced in the field (Meadow, 1995) that external incentives such as economic gain, escaping difficult life circumstances, and/or wresting attention or custody from an inattentive or abandoning spouse may be present. However, they are NOT primary in the sense that the driving force for the parent is other than these co-existing incentives.

The literature documents considerable variance in the intensity and periodicity in which this disorder is manifested. There may be periods of quiescence in which no abuse takes place. It should be emphasized that there is NO particular psychological profile or checklist of symptoms that definitely confirm or exclude this diagnosis; there are common patterns, which should be examined on a case by case basis.

Between 93% to 98% of parents or caregivers with **Factitious Disorder by Proxy** are women (Rosenberg, 1987), either mothers, nurses, or foster care parents. Personality problems and disturbances are found quite often; however, psychosis is less common. It is important to note that psychotic delusions may be present in someone who has **Factitious Disorder by Proxy** and, alternatively, that someone might appear to have **Factitious Disorder by Proxy** when the appropriate psychiatric diagnosis is actually delusional disorder, somatic type. A third of mothers themselves suffered from factitious disorder either as adolescents or as adults (Rosenberg, 1987). The mothers, while not always in professions involving health care, are themselves often very medically knowledgeable and have a good command of medical language and terminology. They convince others of their deep caring for their children while the opposite, when the facts are verified, is true.

While lying is a critical component of **Factitious Disorder by Proxy**, it is felt that these adults have the ability not only to lie, but to "impostor". They simulate a caring and believable parent and convince others of their cause while simultaneously engaging in behavior harmful both to the child and to the professionals involved. The resulting distorted relationship between mother and child is the consequence of the child's victimization, driven by the mother's psychiatric disorder. Doctors and other professionals are particularly susceptible to the impostering of these parents, and such relationships may be intense and invasive of the usual professional-parent boundaries.

Women with **FDP** are frequently married to men who are passive, although in a percentage of cases the partners may be directly colluding with the mother in the abuse of the child. Spouses may be physically or emotionally abusive to their partners. Some abuse drugs and alcohol. Commonly, it is the husband or non-perpetrating partner who comes to his wife's

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defense after she has been discovered. However, in some cases, the spouse becomes aware of the condition falsification and chooses to protect the child. Cases do not appear to be limited to a given socio-economic class, race, or life style orientation. Families, particularly maternal grandparents, may play a powerful role in maintaining the deception process in a number of families where the mother is diagnosed with **FDP**.

Conditions that are Abuse by Pediatric Condition Falsification but are not Factitious Disorder by Proxy

There are a number of conditions, which are abuse by **Pediatric Condition Falsification (PCF)** but are not **Factitious Disorder by Proxy (FDP)**. Such conditions may be equally as grave as **FDP** and should be taken seriously. It is very important to distinguish **Factitious Disorder by Proxy** from other forms of abuse by **Pediatric Condition Falsification**. These include but are not limited to:

1) Parents or caregivers who injure/abuse their children directly and then lie about the circumstances of their illness; children who are presented to hospital overdosed with drugs given to them by harassed parents trying to keep the child quiet. Caregivers with feelings of hatred and violence towards their children which become apparent soon after meeting them; parents who suffocate their children trying to get them to stop crying

2) Children who are neglected and/or fail to thrive, where parents cannot cope with the child and/or fail to feed them adequately.

3) Parents, often called "help seekers", who are overwhelmed and blatantly falsify symptoms, maybe on only one occasion, in order to get assistance caring for their child (Schreier & Libow, 1986)

4) Parents of children with chronic illness who appear difficult because of psychological issues of their own or because they disagree with the medical staff and who are resistive to treatment. Over-anxious parents who are extremely distressed about their children's behavior or health and may exaggerate their children's problems in order to receive attention for their children who they feel are not receiving proper care.

5) Children who present with illnesses or conditions resulting in missed school time where the primary motivation is the parent's wish to keep the child dependent and at home. The child may participate by making him/herself ill in order to stay home. The ongoing deception and manipulation of doctors and other personnel is absent.

6) Parents who are delusional and present their children with illness are generally not found amongst parents with **Factitious Disorder by Proxy**. However, delusional disorders may co-exist with **FDP**. There are cases of mothers who were psychotic presenting but their psychosis appeared to be independent of the **FDP** behavior. Such parents are more likely to present with older children.

Preliminary Recommendations

Pediatricians and other health care personnel should:

1) be alert to the possibility of **Pediatric Condition Falsification** and familiar with the many possible presentations in the child; 2) engage in a careful review of the past medical history of the child to include all available past records; 3) request assistance from pediatric or other professionals with expertise in diagnosing **Pediatric Condition Falsification** and **Factitious Disorder by Proxy**; 4) be fully versed in the expected presentation, course, treatment efficacy, and prognosis of the child's disorder; 5) obtain external verification of as many items as possible provided in the history by the caregiver.

When psychological evaluations are recommended in these cases the mental health professional involved should:

1) be experienced with the diagnosis of **Factitious Disorder by Proxy**; 2) have access to as much medical information on the child and family as is possible; 3) thoroughly understand the diagnosis of child abuse by **Pediatric Condition Falsification**; 4) obtain external verification of as many items as possible provided in the history by the caregiver.

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