Position Paper: Definitional Issues in Munchausen by Proxy

APSAC Taskforce on Munchausen by Proxy, Definitions Working Group

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PURPOSE

In 1996, a multidisciplinary task force of experts was created to develop working definitions for the constellation of behaviors currently described as Munchausen by proxy (MBP). The aim of the task force was 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 to facilitate the identification and treatment of this complex clinical problem.

The term Munchausen by proxy was first used by Roy Meadow (1973), 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 to assume the sick role. MBP was initially described as “the intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual’s care for the purpose of indirectly assuming the sick role” (American Psychiatric Association, 1994, Diagnostic and Statistical Manual of Mental Disorders, 4th ed. [DSM-IV], p. 475). The fact that Munchausen syndrome and MBP share the same name has resulted in considerable confusion.

Although once thought to be quite rare, most experts now believe that MBP is fairly common. Using the results of a careful but conservative British study (McClure, Davis, Meadow, & Sibert, 1996), we estimate that a minimum of 600 new cases of just two forms of MBP (suffocation and nonaccidental poisoning) will present in the United States each year. Given the wide spectrum of pediatric conditions that have been known to be feigned, the problem is far from trivial. Furthermore, experts now agree that MBP
cases are likely to go undetected because of the covert nature of their presentation, the striking ability of the perpetrators to fool those around them, and the many obstacles to the identification of these cases by professionals.

MBP has been described as both a pediatric and a psychiatric entity. Some of the work in the field focuses on the child's victimization whereas other work focuses on the parent's psychiatric disorder. Some literature discusses the interaction between the mother and the child whereas other works describe the interaction of the mother and the health care system. A number of authors depict MBP as a disorder that involves family dysfunction. There have been more than 400 papers and half a dozen books in the medical and psychological literature on MBP. Major pediatric and child psychiatric texts now contain descriptions of MBP. The synthesis of definitional constructs presented below exemplifies the current multidisciplinary consensus in the field.

The purposes of these definitional refinements are to enhance the ability of clinicians and the courts to more effectively identify and protect victims, parents, and families as well as to improve the mandate for fair and appropriate services. Crafting clear definitions from a multidisciplinary perspective allows for a more comprehensive understanding of MBP assessment and treatment. Such clarification and elaboration will in turn significantly reduce confusion and help to differentiate MBP from other forms of child maltreatment, from problematic parental behavior that should not be construed as maltreatment, and from other adult psychiatric disorders.

DEFINITIONAL ISSUES

MBP consists of two components. It involves a child victim and an adult perpetrator. The child is victimized by a variety of means including being inappropriately placed in the sick role and being subjected to unnecessary hospitalizations, tests, procedures, and treatment; illness may be exaggerated, fabricated, and/or induced. The second component is the identification of the motivation and the clinical presentation of the perpetrating caregiver. This caregiver, most often the child's mother, intentionally falsifies history, signs, and/or symptoms in her child to meet her own self-serving psychological needs.

In addition, MBP has been described as a family disorder. Nonperpetrating 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. Health care professionals are often the authorities that caregivers attempt to engage, impress, and at the same time deceive. These professionals frequently play a central role in contributing to the interactions in MBP.

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 subgroup of the larger abuse-by-condition falsification category of abuse 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 underreporting 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.

Psychiatric consequences in the child may be evident at identification or may be delayed in their presentation. Many are serious and long lasting (Ayoub, Deutsch, & Kinscherff, 2000; Libow, 1995). Psychiatric effects may be present in the absence of serious physical harm and relate in part to issues of betrayed trust between parent and child. The child may be involved as an active or passive participant in the deception.

A child who is subjected to this behavior is a victim of PCF and should be coded as such (Child Abuse, 61.21, when focus is on perpetrator, and Child Abuse-995.5, when focus is on victim, see DSM-IV, p. 682) using the 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 are the same and may also be used to designate the type of victimization to the child (995.5) or the perpetrator (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 are 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. Others appear to be motivated by the need to covertly control, 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; however, they are not the primary motivation for the MBP behavior.

**DIFFERENTIAL DIAGNOSIS**

**Issues in the Identification of Abuse by PCF**

PCF is a form of abuse. Some of the documented physical conditions alleged in these children include but are not limited to allergies, neurological problems (seizures and apnea), poisoning, and gastroenterological problems (vomiting, diarrhea, pain, intestinal pseudo-obstruction, and failure to thrive). There may be a bona fide illness in which the abuse takes the form of over- or undertreatment due to exaggeration, fabrication, or induction of symptoms. Children may be healthy at birth or start life with prematurity and/or a valid illness. 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 may be at particular risk of serious physical consequences of PCF (Feldman & Hickman, 1998).

Child abuse by condition falsification through psychological or developmental symptoms has been documented but appears to be less common than physical symptoms (Schreier, 1997). Such symptoms in the child may have some basis in truth; conditions such as attention deficit disorder, Tourette syndrome, bipolar disorder, post-traumatic stress disorder, and psychosis may be overstated or falsified.

False accusations of child sexual abuse have also been attributed to abuse by PCF, in which the mother is diagnosed with FDP (Meadow, 1998, 1995). In these situations, the primary motivation is psychological and involves maternal attention-seeking behavior with the aim of gaining recognition in the parenting role from professionals seen as powerful (Meadow, 1993, 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 several children either simultaneously or serially (Alexander, Smith, & Stevenson, 1990). There is an increased likelihood of a history of another child in the family who was ill and/or who died. The first course of action when MBP is suspected is to identify and report the presence of maltreatment in the child, herein defined as child abuse by PCF. Such findings may be documented by circumstantial evidence (such as a positive toxicology screen, symptoms occurring only when the parent is present, a significant discrepancy between the symptom reports of the parent and the observed health of the child, and/or the child’s improving with supervision of or separation from parents) or by direct observation, including 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 mothers have been apprehended. In many cases, mothers are likely to continue to abuse their children under close scrutiny, under surveillance, after confrontation and mental health treatment, and when their children are returned to them (Bools, Neale, & Meadow, 1994; Kinscherff & Famularo, 1991). Safety issues to the child and treatment planning for the family will hinge on an assessment of motivation of the parent in conjunction with the extent, lethality, and chronicity of the abuse to the child.

The psychiatric morbidity to the child is often serious in 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 (Ayoub et al., 2000; McGuire & Feldman, 1989). The relationship between the mother and the child at times appears quite close. It is typical for mothers as well as other family members to express concerns that the child cannot cope physically or emotionally without the mother’s ongoing attention and will likely be harmed by separation. However, preliminary findings indicate that these children tend to do quite well upon separation. A number of children are quite indifferent to separation once it occurs. They tend to embrace wellness and proceed to engage with those around them (Ayoub et al., 2000).
"Doctor shopping" may occur and be a sign of PCF when the motivation is 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 FDP**

FDP is a psychiatric disorder that 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* states that in FDP, the abuse, which may be physical, psychological, or both, takes place in a situation in which 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, in FDP, they are not primary in the sense that the driving force for the parent is other than these coexisting incentives. Motivation in this condition as in others is often arrived at through the careful scrutiny and understanding of circumstantial evidence.

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 definitively 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 FDP are women (Rosenberg, 1987)—either mothers, nurses, or foster care parents. Personality problems and disturbances are found quite often; psychosis is rare. It is important to note that psychotic delusions may rarely be present in someone who has FDP. However, parents or caregivers with true somatic delusions that their child is ill may appear to be suffering from FDP, but the diagnosis should be delusional disorder, somatic type. One third of mothers suffer or have suffered from FDP either as adolescents or as adults (Rosenberg, 1987), and many more showed symptoms of somatization disorder. Mothers may exhibit this behavior concurrently with causing illness in their children. The mothers, although not always in professions involving health care, are themselves often very medically knowledgeable and have a good command of medical language and terminology. They have an uncanny ability to convince others of their deep caring for their children although the opposite, when the facts are verified, is true.

Although lying is a critical component of FDP, it is felt that these adults have the ability not only to lie but also to "impostor." They simulate a caring and believable parent and convince others of their cause while engaging in behavior harmful to both the child and 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 imposing of these parents, and the professional-parent relationships may also be intense and more enmeshed than the usual professional-parent relationships.

Women with FDP are frequently married to men who are passive, although in a subset of cases, the partners may be subtly or overtly 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, the husband or nonperpetrating partner comes to his wife's 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 socioeconomic class, race, or lifestyle orientation. When the mother is diagnosed with FDP, families, particularly maternal grandparents, may play a powerful role in maintaining the deception process.

**Conditions That May Be Confused With Abuse by PCF and/or FDP**

There are a number of conditions that are abuse by PCF but do not involve FDP in the parent or caregiver. Although the consequences of some of the other conditions may be equally as grave as FDP, it is important to distinguish them from FDP because the interventions needed to protect the child and the course of treatment are quite different. These include but are not limited to the following:

1. Parents who falsely report sexual abuse of their children for the primary purpose of obtaining custody or harming their spouse or partner are perpetrating PCF in the child but do not have a diagnosis of FDP. Parents who falsely present their children as sexually abused for reasons other than the specific mechanisms of portraying the attention-getting role of imposter should not be included in any category of FDP nor should it be called MBP.
2. School refusal: These are children who present with illnesses or conditions resulting in missed school time in which the primary motivation is the parent's wish to keep the child dependent and at home. The child may participate by making himself or herself ill to stay home. The ongoing deception and manipulation of doctors and other personnel is absent.

3. Help seekers: These are parents who are overwhelmed, and to get assistance in caring for their child, they may blatantly falsify symptoms, typically on one or two occasions (Libow & Schreier, 1986).

There are other conditions in which parents may lie about the health status of their child to divert attention from their own abusive actions. These abusive situations are not true PCF or FDP. Such situations include but are not limited to the following:

1. Classic child abuse: This category includes parents or caregivers who injure or abuse their children directly and then lie about the circumstances of the child's condition and children who present to hospital overdosed with drugs given to them by harassled parents trying to keep the child quiet or contained. Caregivers who abuse their children in direct response to feelings of hatred and violence, parents who sabotage their children trying to get them to stop behavior such as crying or whining, or parents who seriously injure their children in an attempt to punish the child for a perceived wrongdoing are classic child abusers (not PCF), not perpetrators with FDP.

2. Classic neglect and/or failure to thrive: This category includes children who are neglected and/or fail to thrive, in situations in which parents cannot cope with the child and/or fail to feed them and/or physically care for them adequately. This includes behavioral feeding disorders, for example, infantile anorexia or food refusal.

Other conditions that may be confused with PCF and/or FDP include but are not limited to the following:

1. Chronic illness: This includes parents of children with chronic illness who appear "difficult" because of psychological issues of their own that are not related to manipulation of authorities or imposing and parents who are difficult because they are oppositional and disagree with the medical staff and may interfere with treatment (Kremer & Adelman, 1988). Difficult parents who express frustration or inappropriate advocacy for their sick child likewise should not be diagnosed with FDP.

2. Overprotective parents: Parents who are extremely distressed about their children's behavior or health and may exaggerate their children's problems to receive attention for their children who they feel are not receiving proper care should not be labeled as having FDP. These parents typically do not engage in active deception or lie about other aspects of their histories.

Failure to diagnose FDP in the parent does not negate PCF in the child. Cross-disciplinary collaboration is often helpful in integrating the components of MBP, that is, PCF and FDP.

PRELIMINARY RECOMMENDATIONS

In evaluating the child, health care personnel should

1. be alert to the possibility of PCF and familiar with the many possible presentations in the child;
2. request assistance or consultation from pediatric and/or other professionals with expertise in diagnosing PCF and FDP when necessary;
3. engage in a careful review of the past medical history of the child to include all available past records and, whenever possible and appropriate, have direct contact with previous caregivers; and
4. obtain external verification for as many items as possible provided in the history by the caregiver of the child, herself, and her family and be well versed in the expected presentation, course, treatment efficacy, and prognosis of the child's real and falsified disorders.

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

1. be experienced with the diagnosis of FDP and its differential diagnosis;
2. thoroughly understand the diagnosis of abuse by pediatric illness/condition falsification;
3. seek as much medical information on the child and family as possible and obtain external verification of as many items as possible provided in the history by the caregiver of the child, the caregiver, and the family;
4. always keep in mind that primary or sole reliance on information from parental interviews without outside corroborations should raise serious doubts as to the validity of the psychological evaluation rendered; and
5. recognize that no specific psychological profile rules in or out the diagnosis of FDP; diagnosis is tied to clinical presentation of the parent with assessment of the child's victimization as the basis for understanding the parent's deceptive behaviors.

REFERENCES


Meadow, R. (1995). What is and what is not Munchausen syndrome by proxy? Archives of Disease in Childhood, 72, 593-599.


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