MUNCHAUSEN-SYNDROME-BY-PROXY

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Introduction

The term "Munchausen syndrome by proxy" (MSbP) was first used in 1977 to describe two children who had incurred severe abuse as a result of their mothers' persistently fabricating illness over a long period of time. One of the children died as a result of salt poisoning; the other suffered greatly as a result of the mother's false story and her fabricating the child's hematuria. Both children had many hospital admissions and had incurred many needless, unpleasant investigations, procedures, and treatment because of their mother's false story and creation of factitious signs, in much the same way as adults who have Munchausen syndrome incur needless investigations and treatment. For these two children the falsification was not by the children, but by another person acting on their behalf (a proxy). Therefore, the term "Munchausen syndrome by proxy" was used to describe the abuse which the two children had incurred.

Deliberate poisoning and other forms of child abuse had been reported before, but the originality of the 1977 report was, as its title implied, in drawing attention to parents who seemed to abuse children in order to gain the benefits of the child's illness for themselves. In both the initial cases, the mothers themselves had a degree of somatoform behavior and they extended their own behavior to the children, causing death in one case and severe harm in the other.

MSbP is an uncommon, but not rare, form of child abuse throughout the world; similar abuse may occur to elderly or other dependent relatives for whom an adult fabricates illness, and also to pets whose owners may fabricate illness. Nevertheless, the term is used primarily to describe the type of abuse incurred by children who have illness persistently fabricated by an adult.

In most countries MSbP describes a particular form of child abuse, though some psychologists and psychiatrists use the term to describe the behavior of the adult perpetrating the abuse, rather than the abuse itself. There has been considerable debate about the use of MSbP and many synonyms have been proposed or used, including factitious illness by proxy, fabricated disorder by proxy, illness induction syndrome, induced illness syndrome, and fabricated or induced illness. In this review, the term "Munchausen syndrome by proxy" (MSbP) will be used to describe a particular type of child abuse, rather than as a psychological/psychiatric diagnosis applicable to the perpetrator.

The criteria for MSbP abuse are as follows.

1. Illness fabricated (faked or induced) by the parent or someone *in loco parentis*.
2. The child is presented to doctors, usually persistently; the perpetrator (initially) denies causing the child's illness.
3. The illness disappears or diminishes when the child is separated from the perpetrator.
4. The perpetrator is considered to be acting out of a need to assume the sick role by proxy, or as another form of attention-seeking behavior.

It should be noted that this definition stresses the persistent presentation of the child to doctors, who are unwittingly part of the abusive process. The fourth criteria, identifying the motive of the perpetrator, is necessarily somewhat subjective, but helps to distinguish MSbP from other forms of harm that come to children as a result of misunderstandings and mismatches between parental expectations and anxieties, and medical beliefs and practices.

Features

A child incurring MSbP abuse will always have had a false story of illness provided by the carer. Sometimes the parent will also fabricate signs or induce illness in the child. There may be escalation from the first stage to the third, but each on its own can be very harmful to the child.

False-Illness Story

Even if a parent is not directly harming the child, a false medical history given to a doctor results in needless investigations, treatments, and admissions, and may result in advice limiting the child's life, education, or opportunities.

Fabricated Illness Story and Falsification of Signs and/or Samples

The perpetrator fabricates signs, alters samples from the child, or interferes with charts and records.

Induced Illness

In addition to the false-illness history, the parent (usually the mother) harms the child with drugs/poisons, or by smothering and other physical injuries so that she can present the child to doctors with the features of serious illness. This third stage is less common than the other two, but tends to feature in court cases because of the strength of evidence, which may include detailed toxicology, video recordings, or other robust forensic evidence.

Epidemiology

Boys and girls are equally affected. Most are young preschool children, for whom the doctor relies on the story of illness from the carer, and who are not under the regular observation of teachers or persons other than their parents. The abuse is most common in the first 2 years of life, and usually starts within a few months of birth. It is often many months, or even years, before the false nature of the child's illness is discovered. MSbP is identified much less often in children of school age. In such older children sometimes the child is complicit in the deception, having been taught by the parent to give a false-illness story to others, and to feign illness by deception. In some cases the older child appears to have been "brainwashed" into adopting an illness role, and in others to have been taught to deceive so that the young adult presents him/herself to doctors with the features of Munchausen syndrome.

Although most case reports and series have come from Europe or North America, there have been reports from all parts of the world, and it is clear that MSbP occurs in countries that have very different social and medical systems, and that it is not confined to affluent societies or to those in which healthcare for children is free.

The only large-scale epidemiological survey is the 2-year prospective study, 1992–1994, of the British Pediatric Surveillance Unit concerning the incidence of MSbP, nonaccidental poisoning, and nonaccidental suffocation in the UK and the Republic of Ireland. For children under the age of 1 year, the combined annual incidence was found to be at least 2.8 per 100 000 children. A follow-up study 2 years later did not identify any child, originally diagnosed as MSbP, who had subsequently been found to have a genuine illness; thus there were no clear false-positive diagnoses of MSbP, suggesting a clinical tendency to underdiagnose such abuse. In fact, because doctors are such an integral part of MSbP (i.e., criterion 2), the pressures from both professional pride and litigation can be a forceful barrier to the identification of abuse and the safeguarding of children. It is less easy for doctors to identify abuse when they know that they are implicated actively or passively in that abuse.

As with most child abuse, there is a high incidence of abuse in the siblings of the index child; at least 50% are likely to have incurred, or be at risk of, similar abuse or other forms of child abuse.

Presentation

Particularly common presentations are seizures and apnea, partly because the doctor rarely sees such periodic events, and relies mainly on the story of the child's carer as the basis for investigation and treatment of the child. Alleged bleeding, diarrhea, vomiting, fever, and rashes are common presentations. Although some children present with apparent multisystem disorder, it is more usual for them to be presented with symptoms and signs suggesting a single-system disorder, thus after initial assessment they tend to be referred to one of the pediatric specialties, such as pediatric neurology, nephrology, or gastroenterology. Others will be referred to ear, nose, and throat, ophthalmic, orthopedic, or to system specialists who may have much less familiarity with

disorders of young children than of adults. There are certain services and groups of children who are more likely to include children with MSbP, for instance those with intractable or unusual epilepsy, infants presenting with recurrent severe apnea or near-miss sudden infant death, older infants referred for Nissen fundoplication, or for sleep studies, and children receiving long-term parenteral nutrition, or who have had gastrostomies created because of unusual feeding problems (both groups of children provide easy access for insertion of drugs or foreign material directly into the body).

The commoner presentations of MSbP in relation to the different systems are shown in Table 1; Table 2 shows some of the ways in which signs have been fabricated or induced by a parent.

Diagnosis

Child abuse is sufficiently common for it to be a necessary part of the differential diagnostic list for many childhood illnesses and accidents. The diagnosis of abuse depends on assessing carefully the clinical story and background to seek a genuine natural reason for the child's illness or injuries, and at the same time seeking positive evidence of falsification or induction of illness.

In the first instance the clinician is likely to have become suspicious because of a child's illness being unusual, unexplained, and prolonged, with symptoms and signs that are incongruous or apparent only when the mother is present, or because of standard treatments being either ineffective or not tolerated. Study of the family may reveal other unusual

Table 1 Clinical presentations of Munchausen syndrome by proxy

Nervous system	Seizures, apnea, drowsiness, ataxia
Gastrointestinal	Vomiting, diarrhea, failure to thrive, bleeding
Respiratory	Apnea, breathlessness, hemoptysis
Renal	Hematuria, biochemical chaos
Endocrine	Glycosuria, hypernatremia, biochemical abnormality
Allergy	Rashes, diarrhea, vomiting, fever
Otorhinolaryngological	Chronic otitis, foreign bodies
Educational	Dyslexia, disability, special needs
Skin	Dermatitis artefacta, abscesses, burns
Orthopedic	Locked joints, arthritis
Hematological	Anemia, bleeding
Cardiovascular	Sick sinus syndrome, hypertension
Child abuse	False allegations of sexual or physical abuse
Immune system	Immunodeficiency, fevers, osteomyelitis

Table 2 Fabricated signs

Bleeding	Hematemesis, hemoptysis, hematuria, and bleeding from other sites are fabricated, usually by the mother adding blood to a sample obtained from the child, or alternatively smearing blood around the perineum, nose, or other orifice. Generally she obtains the blood by pricking herself, or using a vaginal tampon during menstruation. Occasionally raw meat is used. Alternatively she causes bleeding by injuring the child
Seizures/apnea	Anoxia caused by smothering or drugs, usually one that has been prescribed for the child or another member of the family
Failure to thrive	Withholding or diluting food, sucking back food from the stomach via a nasogastric tube
Diarrhea	Laxatives
Fevers	Feigned, by falsifying temperature charts or heating the thermometer. Genuine, by injecting contaminated solutions into intravenous lines, or intramuscular injections of foreign bodies
Diabetes and endocrine abnormalities	Addition of sugar, salt, cooking ingredients, or other additives to the child's urine or to a blood sample whilst it is waiting to be sent to the laboratory. Poisoning of child. Deprivation of water
Hypertension	Altering entries on blood pressure charts or instructions concerning size of cuff to be used for measurement. Poisoning
Feculent vomitus	Vomiting is induced by salt administration or pushing fingers down the child's throat and then feces are stirred into the bowl of vomit
Dermatitis	By applying caustic solutions (e.g., oven cleaner or bleach) or repetitively scratching, burning, or rubbing the child's skin
Chronic discharge	From ears, vagina, anus, or other orifice by repetitively poking the orifice with a nail or other small object
Anemia	By disconnecting intravenous lines to drain blood from the child, or by venepuncture
Renal stone	Addition of gravel to the child's urine. Child may be given a stone to eat in food, and then taken with a falsely blood-stained sample of urine to the accident department where X-ray reveals the radiopaque stone

happenings to children, including abuse, unexplained death, a parent who seems deliberately to prevent her partner becoming involved in the child's illness, or a parent who has somatoform disorder.

The clinician has to review all the medical records very carefully and check the history for temporal associations between parental presence and childhood illness, consistency of reported illness episodes, and verification of episodes that are said to have occurred in the presence of another person. The hospital-based specialist needs to liaise with the primary care doctors and nurses, and vice versa, as well as with other family members. Sometimes it will be possible to secure direct forensic proof of induced illness by toxicological analysis of the urine, blood, or vomit, or by DNA or blood group testing of other samples. Polygraphic recordings and, particularly, covert video surveillance of infants being cared for by their parents in hospital have, at times, yielded indisputable evidence of poisoning, induction of vomiting, injection of foreign material into intravenous lines, and smothering by obstruction of the child's airways with the parent's hand, body, or a pillow.

Separation of the child from the parent can be an important diagnostic stratagem, and may be a valuable way of avoiding dangerous invasive procedures. It necessitates very careful assessment before and after separation from the parents, and the need to recognize that, in some cases, the child will have a genuine medical condition, usually mild, which is being magnified and distorted by the parent to create a major life-threatening illness.

Consequences

A false-illness story causes a child to have the multiple assessments, hospital admissions, investigations, and treatments that would be appropriate for a genuine illness. Young children are frightened, hurt, and, at times, put in danger by investigational procedures, treatments, and needless operations. Many have had prolonged therapy with steroids, cytotoxic drugs, and psychotropic drugs.

When the mother induces signs of illness, direct physical harm is involved, for instance, by scarifying, or burning the skin with caustics, obstructing the child's airways to cause anoxia and seizures, by injecting contaminated solutions to cause polymicrobial septicemia, and by the administration of drugs.

A third consequence is that, if the deception is undetected and continues for many years, the child may grow up believing him/herself to be disabled, and to be unsuitable for normal activities and opportunities. In some extreme cases children seem to have been programmed into taking on the role of an adult with Munchausen syndrome, so that by their late teens they are presenting themselves to hospitals with false-illness stories, independent of their parents.

The biggest factor influencing morbidity is the speed with which the deception is uncovered. Most of the worst outcomes, such as blindness, deafness, organ transplant, lengthy parenteral nutrition, and death, have been in children who have incurred false illness for several years. There are many reports of MSbP resulting in the death of one or more children, but mortality rates are difficult to interpret and have been reported variously in the range of 5–30%.

Even with prompt intervention, the long-term outcome may not be as good as was hoped. Studies suggest that risk of recurrence of abuse is significant, and that MSbP abuse, which in the UK is categorized as physical abuse, usually has a much stronger core of emotional abuse and reflects a very abnormal parent–child relationship.

Perpetrator

In well over 90% of cases the child's mother is identified as the perpetrator. Usually her partner is unaware and disbelieving of the abuse. However, the striking noninvolvement of some partners in the care of their children, at times, implies an element of passive complicity. Fathers are the perpetrators in less than 5% of cases. It is even rarer for both parents to be working together to create a false illness in a child.

Systemic study of perpetrators of MSbP show that over half have personal abnormal-illness behavior in the form of factitious or somatoform disorder. Often the parental illness alternates with that of the child: the self-injurious behavior of the parent may wax and wane as the factitious illness of the child wanes and waxes. The limited information concerning male perpetrators suggests that parenteral abnormal-illness behavior is even more prevalent, with overt Munchausen syndrome (a very rare disorder) being unusually frequent.

Most perpetrators, when assessed by psychiatrists, are found not to have an identifiable mental illness. By virtue of their behavior they are considered to have a personality disorder.

Intervention

Procedures for assessing child abuse and for intervention vary from country to country. In most developed countries there are local guidelines, based upon national guidelines and national laws relating to children and families, which direct the lead clinician. In the UK the lead clinician is likely to be a pediatrician who at an early stage liaises with other medical

colleagues, and with social services. Local authority social services then take the lead in organizing a full multidisciplinary assessment and, if necessary, intervention to protect the child. In the UK the safety of the children is organized through the procedures of the Children Act 1989, whose proceedings are heard in family courts. Although family courts have an adversarial nature, in that the local authority, the parents, and the children all have separate legal representation, the court also has a limited inquisitional role, which is best demonstrated at the highest level in the Family Division of the High Court where very experienced judges adjudicate on the most serious cases of MSbP and unusual childhood death. In these courts it is uncommon to hear the term "Munchausen syndrome by proxy," used, or one of its synonyms, because the task for the court is to decide whether a child has been abused, the detail of it, and whether that child is at risk of significant harm. The motivation of the parent, or the term MSbP, is irrelevant to those decisions. Once the facts and degree of abuse have been established, it becomes more relevant to establish why a parent behaved in a particular way, and such understanding may influence how best to help the family. Such assessment of the perpetrator's personality, motivation, and behavior is an important second stage.

In the UK the Crown Prosecution Service has instigated separate criminal proceedings in only a small proportion of cases, presumably depending on their perception of the public interest and the robustness of the evidence.

MSbP Interrelationships

Since its first description there has been a tendency to overuse the term. Worldwide recognition of MSbP drew attention to many previously unrecognized ways in which young children were being seriously abused. The extent of that abuse was beyond the imagination of most people, and still causes skepticism. Recognition of MSbP led to much wider recognition of nonaccidental poisoning and of repetitive smothering of infants, and to the realization that some dead infants previously categorized as sudden infant death syndrome had been smothered by their parents. In turn this led some people to use the term MSbP for any child who had been covertly killed. That is inappropriate. The British Pediatric Surveillance Unit's survey indicated that, although about half of the cases of nonaccidental poisoning or smothering occurred in the context of MSbP abuse (repetitive episodes causing them to be presented recurrently to doctors), nevertheless just under half of the cases were isolated events more akin to a sudden outburst of physical violence by a parent against a child. Study of MSbP has also led to a better recognition of the many different ways in which the parents' perception of the children's illness and inappropriate health-seeking behavior may combine with overrigid medical practice to cause immense harm to children. The links with somatoform behavior, doctor shopping, unusual health beliefs, delusional disorder, overanxiety, and hysteria are apparent, as well as the harm that may come to children because of combinations of inappropriate actions by parents and doctors. The link between unusual types of parental behavior and discrepant patient–doctor interactions needs to be remembered within the complexity of child–family–doctor consultations.

See Also

Children: Physical Abuse; **Forensic Psychiatry and Forensic Psychology:** Multiple Personality Disorder; **Head Trauma:** Pediatric and Adult, Clinical Aspects; **Imaging:** Radiology, Pediatric, Scintigraphy and Child Abuse; **Injury, Fatal and Nonfatal:** Blunt Injury; Burns and Scalds

Further Reading

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