# Munchausen Syndrome by Proxy

## *Child Abuse in the Medical System*

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Munchausen syndrome by proxy often is managed differently from other forms of child maltreatment, although it is differentiated from them only by the active engagement with the medical profession in the production of morbidity. We suggest a more rigorous approach to Munchausen syndrome by proxy, with explicit acknowledgment that it is abuse and that the medical system is critical to its genesis. This leads us to question the broadness with which the label is applied (eg, in cases of imposed upper airway obstruction) and to argue for management strategies closer to those accepted for other forms of child maltreatment.

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**Editor's Note:** This thought-provoking article from our colleagues "down under" should raise our collective consciousness about a very complex syndrome.

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Munchausen syndrome is a condition manifest by persons feigning or inducing illness in themselves for no other apparent gain than adopting the sick role and thus exposing themselves to painful and sometimes damaging and disfiguring medical procedures.

The term *Munchausen syndrome by proxy* (MSBP) was first used in reference to child abuse to describe children with parentally produced symptoms (failure to thrive) for which the parents provided a false medical history,[1] and "parents who, by falsification, caused their children innumerable harmful hospital procedures."[2] Consequently, from its first usage, there has been inconsistency about whether the term applies to the parent, the child, or both. Further, the suggestion in the original articles of an etiologic commonality with Munchausen syndrome has not been borne out (and therefore the term *Munchausen by proxy syndrome* is preferable). Confusion has been further compounded by the failure of much of the subsequent literature to make it explicit that MSBP is a form of child abuse, or at least failure to apply the usual principles of child-abuse management.

Clinicians have regarded MSBP as different from other forms of abuse for 3 reasons:

1. Some claim that MSBP is, or is symptomatic of, a specific psychiatric disturbance in the perpetrator.
2. Reported mortality and morbidity rates are higher.[3,4]
3. Munchausen syndrome by proxy seems to be premeditated rather than motivated by acute frustration or rage.[5]

None of these criteria have been shown reliably to distinguish MSBP from any other form of abuse. For example, certain clusters of characteristics in the suspected perpetrator raise the index of suspicion for MSBP (eg, somatoform disorder and Munchausen syndrome itself), but no specific characteristic or group of characteristics is diagnostic. The same applies to physical abuse, in which perpetrators of physical violence against children manifest certain clusters of characteristics (eg, history of childhood abuse and poor impulse control), none of which is diagnostic. The diagnosis of any form of child abuse, including MSBP, relies primarily on allegations made by or on behalf of victims. Confir-

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mation is by physical examination and other forms of victim assessment.

Therefore, strong arguments exist for dispensing with the term *MSBP* altogether[6,7] and classifying cases in which children have spurious symptoms (which would include MSBP and various other situations) according to the nature of the symptoms and their presumed explanation or cause. Thus, just as the diagnosis in cases of physical abuse is descriptive and victim-focused, stating the actual damage done to the child (eg, fractured femur secondary to assault), we might refer to exaggerated asthma, fabricated or spurious hematuria, or seizures secondary to poisoning. Samuels et al[8] go some way toward this approach by their use of the term *imposed upper airway obstruction*, clearly differentiating such suffocation from spurious (ie, reported, but not occurring) apnea. However, it is unlikely that the term *MSBP* will be dispensed with now that it is the subject of hundreds of published articles. We therefore argue for a refinement of the term. In this article, we explore the role of the medical system in MSBP, question the inclusion of imposed upper airway obstruction within MSBP, argue for a tightening of the definition of MSBP, and discuss the implications of our arguments for management.

## THE ROLE OF THE MEDICAL SYSTEM

If there is a justification for continuing to treat MSBP as a specific form of child abuse, it is the special role that the medical system plays in its genesis and maintenance. The average length of active medical involvement in cases of MSBP is several months.[3] Several authors[6,7,9-12] have drawn attention to the role of physicians and nurses in the exacerbation and perpetuation of MSBP. We believe that we must go further in examining the role of the medical profession in the genesis of MSBP. For example, Morley[6] argues that poor history taking contributes to the misdiagnosis of MSBP. We contend that poor history taking is central to its etiology. We argue that medical interest and active participation with the child and parent(s) through the investigative and diagnostic process is the crucial factor in the maintenance of the syndrome. The centrality of this medical role needs to be examined from the perspective of the perpetrator of MSBP and the medical profession.

A parent who induces illness in a child may or may not have a preexisting pattern of seeking and achieving personal gratification through illness. In cases in which the parent has had somatizing disorder,[13] MSBP can be conceptualized as the further development of a lifelong pattern of a pathologic attitude to illness that has facilitated the development of a pathologic relationship with the medical profession. In other cases, however, the capacity to gain such gratification may be learned by a parent as part of nursing or other medical training, as a result of interaction with the medical system around a genuine illness in the child, or when he or she succeeds in misleading physicians into accepting the effects of abuse as indicators of true disease. Thus, it is plausible that MSBP might begin with an injury that was not inflicted with the intention of fabricating illness, with the factitious quality developing when attempts to hide the abuse lead to an interaction with the medical system that the parent finds gratifying in its own right.

We believe that it is the parent's seeking of gratification from the interaction with the medical system that authors are trying to capture and highlight when they separate MSBP from other forms of child abuse. By focusing on the perpetrator, however, the medical profession fails to recognize its own contribution to the development of MSBP and ignores the victim's perspective. If we as medical professionals do not recognize the cause of symptoms as abuse, we contribute to the damage.

Munchausen syndrome by proxy therefore evolves as a product of the relationship between a parent who has both the capacity for abuse[5] and the potential to be gratified by the medical system and a medical system that is specialized, investigation-oriented, fascinated by rare conditions, often ignorant of abusive behaviors, and too accepting of reported histories. Munchausen syndrome by proxy has been recognized for only 20 years. Of course, it may have existed before then, but its apparently recent evolution is understandable in the context of the sociological, technological, and litigious changes in medical practice in our society.[14] As the degree of medical specialization increases, more extensive "routines" for the investigation of specific symptoms are developed. We suggest that the adage "If you are not getting mainly negative results, you are not doing enough tests" typifies such medical practice. Freer visiting arrangements and increased consultation with parents are positive changes in medical practice, but they have also increased the opportunity for parents to engage in this form of abuse. Not only are more technological avenues open to us for the investigation of symptoms, but also, there is more encouragement, and sometimes insistence, on these additional channels. As physicians who are responsible for the care of children, we are vulnerable to pressures from the parents to provide them with answers. We usually accept that the patient and parent tell the truth, and that they wish to recover. Taylor[15] suggests that the use of the euphemism MSBP reflects our resistance as physicians to accept behavior contrary to this implicit contract with our patients. We are not naturally suspicious, and when we do become so, the induced or fabricated symptoms can change, raising again the possibility that a real disease is present, indicating the need for further investigations. Parents who present their children with factitious symptoms or illnesses for medical attention and "diagnosis" are therefore in a position to hold the upper hand in their struggle to remain in control. The quality of the perpetrator's interaction with medical staff can vary, perhaps influenced by the perpetrator's personality or interpersonal style.

One of our patients blustered, demanded, and was unpopular with all staff, yet she got her way through bullying hostility; another argued politely, but firmly, and became an active part of the medical decision-making process.

We have seen cases in which physicians and the parent have seemed equally excited by the unusual and apparently rare nature of the illness. One of our physicians spent up to 2 hours a day with an inpatient's parent, debating the pros and cons of different interventions. When this


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physician found out that she had been duped, she felt foolish and angry. In individual cases, the process continues until the physician recognizes MSBP, or there is a falling out between physician and parent, or the "disease" stabilizes (possibly reflecting some kind of steady state in the relationship among the various protagonists). Case reports in the literature suggest that some staff are traumatized by their experience[16] or never accept the reality of the abuse.

Clinical experience suggests that in some centers, there has been an improvement in the capacity to recognize MSBP, shortening and reducing the morbidity; however, excessive and unnecessary investigations still occur, acted on by enthusiastic physicians, and children continue to suffer from parentally induced and fabricated illness. Of course, increasing medical sophistication might be accompanied by increasing sophistication in the production of factitious symptoms. Even so, to the extent that we, the medical profession, contribute to the production of MSBP, the syndrome can be seen as highlighting some of the failings of modern technological medicine. We therefore conclude that the extent and quality of medical involvement is the most useful basis on which to differentiate MSBP from other forms of child abuse.

## IS IMPOSED UPPER AIRWAY OBSTRUCTION A FORM OF MSBP?

In the late 1970s, case reports appeared of infants with apnea, apparently induced by their mothers' suffocation of them (imposed upper airway obstruction [IUAO]). When these apneic infants were presented for medical attention, their mothers characteristically did not admit any responsibility for producing the breathing disturbance, but claimed that it had occurred spontaneously. This denial led to the condition being conceptualized as *factitious apnea* and categorized as MSBP. As more of these babies were identified, their mothers were discovered to have characteristics similar to those of perpetrators who had been identified as inducing other symptoms or diseases in their children. Further, observations made during covert videotaped surveillance showed that IUAO could occur in the absence of any difficult or demanding infant behavior, and indeed often was seen to be premeditated and planned. Finally, it was found that IUAO often occurred in a hospital when the infants were admitted for investigations. Thus, presentation with illness and denial of the cause, perpetrator characteristics, premeditation, and further symptom production in the hospital supported the classification of IUAO as a variant of MSBP.

But to consider these features in turn, first, denying responsibility for illness production is not of itself sufficient grounds to diagnose factitious disorder. It is the rule for the suspected perpetrator of any form of child abuse to vigorously deny the abuse, and certainly not to accept any responsibility for it. Second, as we have previously indicated, no perpetrator characteristics define MSBP. Third, the quality of premeditation is characteristic of MSBP, but not exclusively so.[5] Finally, as Samuels et al[8] point out, in IUAO, the perpetrator often does not engage in an intense relationship with the medical system. Often the child who is a victim of IUAO is brought to the hospital for short-term treatment. The request by the parent for apnea mats and alarms could be construed as an attempt to cover up the abuse by showing concern for the baby's future well-being. As with other forms of abuse, apnea might be induced for various reasons—an impulsive, violent response to excessive crying, or a conscious wish to injure an infant. Perhaps the abusive parent is in some way gratified or excited by almost killing the baby and witnessing its subsequent return to life. The claim of illness becomes a way of hiding abusive behavior rather than an end in itself. Unless there is active engagement of the medical system, the 3-sided transaction among victim, physician, and perpetrator does not occur, and IUAO remains an interaction between mother and infant, best conceptualized as physical abuse rather than MSBP.

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The case for regarding IUAO as factitious, and therefore as MSBP, may be somewhat stronger when the abuse occurs in the hospital. This situation is similar to a mother's inducing illness in a hospitalized child by injecting something into the child's intravenous line. We do not, however, believe that the 2 situations are necessarily equivalent. The intent of the mother who injects something into the intravenous line seems to be to maintain her interaction with the medical system—to sustain the medical mystery, to stay ahead of the diagnostic endeavors of the medical staff, or to feel a part of exciting medical activity. Thus, her attacks on the child often seem to be timed accordingly. For example, the mother of one of our patients misled physicians into believing that her child had a disorder of glycerol metabolism that made him unable to tolerate oral or intravenous feedings. Whenever physicians told her that they were trying a new feeding regimen, the mother would poison the child with glycerin, apparently to sustain the impression of his food intolerance.

It is not as clear that IUAO induced in the hospital is necessarily aimed at engaging medical staff. It simply may be the continuation of the abusive behavior, unmodulated by the hospitalization. Abusive behavior in the hospital is not automatically MSBP. Munchausen syndrome by proxy is an appropriate label if, and only if, the defining transaction among mother, infant, and physician develops.

For the immediate management of life-threatening events, the distinction between factitious and nonfactitious IUAO is unimportant. What is required is the recognition that abuse has occurred in a small but significant proportion of otherwise unexplained acute life-threatening events. The distinction between factitious and nonfactitious disorder does, however, become important to subsequent management. For example, it must influence judgments about the future safety of the child in the care of the abusive parent and shape the long-


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term psychosocial intervention with the perpetrator. It also is critical in future research into infant apnea and MSBP.

## HOW SHOULD MSBP BE DEFINED?

We believe that the current lack of clarity in the use of the term *MSBP* and the ambiguities in its definition lead to overinclusiveness in its use, trivialization of abuse, and a lack of clarity about prognosis and long-term management. The definition of MSBP must be explicit, not only in relation to the factitious nature of the perpetrator's abuse, but also about the role of the medical profession.

The most widely accepted definition of MSBP was offered by Rosenberg in 1987.[3] It has 4 elements: fabrication or induction of illness, presentation for medical attention, denial of responsibility for illness, and resolution of symptoms on separation.

We find at least 3 problems with Rosenberg's definition:

1. It does not specify the nature of the presentation or the denial. For a condition to be factitious, denial of responsibility by the perpetrator must be motivated by something other than the desire to avoid the consequences of abusive behavior. Rosenberg's definition is met by any parent who assaults a child and, say, fractures its skull (inducing illness), presents the child for medical attention, and then denies responsibility for causing the injury. Thus, we suggest that the definition be altered, consistent with the description by Meadow,[2] to make it explicit that the perpetrator actively seeks involvement with the medical system. The *Diagnostic and Statistical Manual of Mental Disorders*[17] and others address this failing in Rosenberg's definition by requiring that the motivation for the perpetrator's action be "presumed to be a psychological need to assume the sick role by proxy." We have 3 reasons for being critical of their approach. First, it seems unrealistic to be able to presume motivation, given our limited knowledge of the syndrome. Although we might make reasonable inferences based on our clinical observations that a perpetrator actively seeks involvement with the medical system, our understanding of the perpetrator's motivation will remain unclear in most cases. Second, in the frequent cases in which motivation is not apparent, the risk is that the abuse will be dismissed along with the MSBP diagnosis, and as a consequence, the child will not be adequately protected. Third, to speak of the perpetrator as "assuming the sick role" too strongly locates the problem within the perpetrator and avoids implicating the medical profession.

2. Rosenberg ignores the role of the medical profession in the genesis and maintenance of MSBP. Other critics and reviewers of MSBP[11,14,15,18] address this deficit to varying degrees, but we go further and suggest that the definition of MSBP contain a fifth criterion that makes explicit the central role of the physician in the process, that is, misattribution by physicians of the illness or injury to some medical cause(s), not necessarily clearly defined. This additional criterion emphasizes the importance of medical misdiagnosis and infers that the episode of factitious illness is terminated through correct recognition. More often, continued misleading of physicians by the perpetrator and continued failure of physicians to recognize the abuse causes diagnostic uncertainty, leading to further investigations; treatment resistance, leading to multiple treatment interventions; or change or development in the symptoms as medical investigation becomes more intensive and usually more invasive.

3. Notwithstanding the position taken by *DSM-IV*[17] that the label applies to the perpetrator, it remains unclear whether it is useful to label the parent or the child as suffering from MSBP.[7,12] Such uncertainty is consistent with the contradiction present in the first descriptions of the condition.[1,2] We believe that MSBP best describes a complex *transaction* among at least 3 persons—a parent, her or his child, and the physician consulted by the parent on behalf of the child.[11] To understand better the complexity of the transaction, it is important to consider the parent-child and the physician-child interactions.

***definition of MSBP must be explicit . . . about the role of the medical profession***

The parent-child interaction is abusive by virtue of the production or reporting by the parent of factitious symptoms or disease in the child. The physician-child interaction is characterized by iatrogenic damage (and possibly disease) produced as the factitious disorder is investigated and treated.

For the parent-physician relationship to develop and continue, it is critical that the child remain "ill." Thus "illness" is maintained through a combination of abusive behavior by the parent and the iatrogenic production of disease by the physician, with the child's continuing "illness" as the link between physician and parent.

We are therefore proposing a modification to the definition of MSBP to specify the factitious nature of the denial and the characteristic 3-way transaction that actively involves the physician. We see it as an advantage that our definition is not consistent with applying the diagnosis of MSBP to 1 person. As discussed, we would rather medically diagnose the condition of the abused child and, when possible, that of the perpetrator. An example would be a case of MSBP in which the mother, who has somatization and borderline personality disorders, assaulted her child with poison, causing malnutrition and cognitive delay.

With this approach, the immediate medical and legal intervention is not compromised by disputes about whether the MSBP label is appropriate. Immediate action will be guided by recognition of the abuse and the medical diagnoses.

Our definition of MSBP is narrow. There are important similarities in terms of victim and perpetrator characteristics between MSBP and other forms of abuse and other parental interactions with the medical system. However, to subsume these apparently similar cases under the MSBP label loosens the MSBP concept, undermines the recognition of the role of the physician, and potentially


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hinders our understanding of the various behaviors and our capacity to offer clear explanations, eg, to the judicial system. The MSBP pattern of interaction needs to be contrasted with cases in which parents seek help for themselves through their child's illness.[19] In nonabusive situations that involve parental help-seeking behavior, the child might be thought of as a ticket to the physician's consulting room, and the focus should be on offering therapeutic assessment and assistance to the family. In MSBP, the child's illness is essential to the relationship between physician and parent[18] (we have experience of at least 1 mother who seemed unable to speak to the physician in the absence of her child), and when abuse has been recognized, immediate steps must be taken to ensure the child's safety.

Comparisons also might be made with examples in specialist pediatric practice when the parent is controlling, demanding, and changeable in a way that is similar to MSBP. This situation may develop, for example, in the oncology service, where children and parents have usually had extensive, painful, and emotionally draining contact with the medical specialist. Such parents might be recognizable as those who rapidly shift from idealization to denigration of medical staff and for whom nothing is ever right. There may be accentuation of symptoms but no apparent fabrication of illness. We therefore disagree with Godding and Kruth,[20] who propose that parental illness exaggeration and noncompliance in the treatment of asthma constitute MSBP. We also question the proposal by Meadow[21] that false allegations of abuse (usually sexual), when they do not relate to a custody or access dispute, constitute MSBP. His claim is based on comorbidity with more conventional cases of MSBP and similar dynamics in the interaction between the parent and authority, but authority in this case is usually nonmedical.

## IMPLICATIONS FOR MANAGEMENT OF SUSPECTED CASES OF MSBP

In tertiary pediatric institutions, child abuse is investigated and managed by specialized multiprofessional departments. Yet, although MSBP has been considered a form of child abuse because the child is harmed by the parent, cases of suspected MSBP often are referred late to hospital-based child maltreatment teams, perhaps because of discomfort with the implications of the diagnosis. We argue for the early involvement of hospital-based child protection specialists, to ensure an initial emphasis on defining the level of safety or danger for the child, rather than the gathering of evidence to prosecute the suspected perpetrator. The early involvement of state statutory welfare agencies is also critical whenever a child's safety is in question. Many concerns about the diagnosis of MSBP[6] will be defused by a management approach that is guided by child protection specialists and makes appropriate use of state statutory authorities.

Confusion exists in the literature between factors that are diagnostic of MSBP and those that merely raise suspicion.[6] A physician will most often suspect the possibility of MSBP for the following reasons:

1. A child's medical problems do not respond to treatment, or they follow an unusual course.
2. Physical and laboratory findings made in relation to the illness cannot be explained, are very unusual, or are considered implausible.
3. The signs and symptoms of a child's illness fail to occur in the parent's absence.
4. The family history discloses numerous medical problems that are difficult to substantiate, and their veracity is doubtful.
5. The family history discloses similar unexplained illness in other children.[22]

When suspicion occurs, it should be followed up by legitimate inquiry into the medical history of the child, siblings, and other family members, and through gathering of information from medical and other sources. If the suspicion becomes stronger, or if the investigating physician believes that the historical enquiry cannot ethically be taken any further, the matter should be referred to a hospital-based child maltreatment team to address the safety of the child, and for further consideration about whether the diagnosis of MSBP is tenable, based on the information that has been gathered ethically. If discussion between the primary pediatrician and child maltreatment team results in confirmation of the suspicion of MSBP, that conclusion should be presented confidentially to the appropriate state statutory welfare agency. At this point the police may also need to be involved. If enough information has not been gathered, but the suspected MSBP is considered to be potentially life-threatening or disabling, discussions with statutory agencies still should occur. The aims of involving the statutory authorities at this time are to notify them of a case of suspected serious child abuse, discuss issues of safety and protection for the child, consider the need for further assessment of the child's and family's situation (for example, through psychological and psychiatric assessment of the child and the alleged abuser), agree to an approach for confronting the parents with the diagnosis, and discuss the need for further information gathering under a court order. Such information should include medical details of the victim and other members of the family not previously available because of ethical constraints. The gathering of this information is equivalent to a forensic inquiry and should occur with the knowledge and the assistance of the state statutory agency and the police, when they consider it necessary.

Subsequent management will be guided by standard local child-protection practice. The most important factors influencing management must be the level of responsibility accepted by the perpetrator in conjunction with the assessed level of danger to the child. It is standard in current management of child abuse and neglect that perpetrators need to accept responsibility for abuse before it is considered likely that victims will be safe in their future care. It rarely has been reported that the focus in management of MSBP has been on the acceptance of responsibility by the perpetrator, but we suggest that this focus is necessary for the child to be considered safe. As in any case of child abuse and neglect, when the safety of the child has been established, it is appropriate to shift to the perspective of the perpetrator.


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Our approach clarifies the contribution made by the psychiatric diagnosis of the suspected perpetrator to the ongoing case management decisions. The aims of perpetrator diagnosis are to prevent recurrence in the victim and protect other children, meet the therapeutic needs of the perpetrator, but not contribute to the decision about whether child abuse has taken place.

Finally, management of MSBP must not ignore the perspective of the physician. Physicians may need counseling about their role in the production of morbidity, an experience that has been distressing and humiliating, but from which a great deal can be learned that is relevant to general pediatric practice. For example, experience with MSBP reiterates the importance of thorough, careful history taking, and suggests an attitude of critical analysis of the information elicited, especially in the face of rare events. In difficult cases, consultation between specialists is often more valuable than referral from one to another. In our experience, the input of child psychiatrists has been important in the assessment and management of MSBP only when there is consultation with, rather than referral to, a psychiatrist. We suggest that the same often applies to the involvement of other specialists in the management of complex medical cases. Clinicians are usually alert to the possibility of problems, but it is often only in the context of a detailed case discussion that an optimal management plan can be developed and potential problems in the treatment system averted. We question the appropriateness of the label "abnormal illness behavior" with its location of deviance primarily in the patient. Our experience with MSBP teaches us to look more widely to the medical system and beyond to understand why illness deviates from our expectations.

## CONCLUSIONS

If we are to persist with the label *MSBP*, we must be more stringent about its use and the place it occupies in relation to other forms of abuse in terms of classification and management. The ambiguity of who has the condition, parent or child, has been answered by recognizing that the syndrome describes a complex transaction among parent, child, and physician. Whether the focus will be on an individual, a dyad, or the whole system will shift according to the dictates of management. The first priority must be ensuring the child's safety and only then on understanding the parent's "pathology" and the role of and effects on the physician. A more rigorous exploration of this unusual syndrome has important implications for our understanding of the relationship among the physician, the patient, and the illness.

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