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Munchausen Syndrome by Proxy: Identification and Intervention

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Munchausen Syndrome by Proxy (MSBP), also known as "factitious disorder by proxy," is a mental illness in which a person lies about the physical or mental well-being of a person he/she is responsible for (The Cleveland Clinic, 2008). Most often the dynamic transpires between a mother and her child. The motivation behind MSBP is that the adult seeks the attention typically given to those who are sick, and attempts to get the attention by causing or lying about illness in his/her child. MSBP is a type of child abuse and can result in long-term physical and psychological effects or even death (Roesler & Jenny, 2009).

The DSM-IV outlines the following criteria for factitious disorder by proxy:

A. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care.
B. The motivation for the perpetrator's behavior is to assume the sick role by proxy.
C. External incentives for the behavior (such as economic gain) are absent
D. The behavior is not better accounted for by another mental disorder (American Psychological Association, 2000),

The deceptive nature of the disorder and the difficulty in diagnosis makes MSBP difficult to research. The body of literature regarding MSBP lacks controlled research, diagnostic precision, and general agreement from medical professionals (Butz, Evans, & Webber-Dereszynski, 2009). The research that exists regarding MSBP consists mainly of individual case studies, which serves to demonstrate how elusive a common set of diagnostic symptoms is for MSBP for both perpetrators and victims. Research also exists under several titles. Although the disorder is mostly common known as MSBP, it is also known as Factitious Disorder by Proxy (FDBP), Fabricated and/or Induced Illness (FII; Butz et al., 2009). The form of child abuse is often called Pediatric Condition Falsification (PCF; Ayoub, Schreier, & Keller, 2002).

To better understand MSBP, it is helpful to examine the historical roots of the disorder. In the 1950s the label Munchausen Syndrome was first used to describe a patient who fabricated or induced illness in self to gain the attention given to sick patients. The disorder was named after Baron von Munchausen, who was an 18th century dignitary who told exaggerated stories (Chiczewski & Kelly, 2003). In 1977, Munchausen by Proxy was used as a label for the first time to describe the child abuse that occurred when children were treated for medical conditions that they did not have, as a result of their parents inducing illness or lying about symptoms (Shaw, Dayal, Hartman, & DeMaso, 2008). Examples of symptoms that are produced by the parent are smothering and poisoning. The other cases of MSBP took place because the parent lied about symptoms or deceived in some other way, such as tampering with medical test results.

The following vignette of MSBP illustrates the disorder:

> "Annie was only a few months old when her mother began bringing her to the emergency department saying she was vomiting and turning blue, precipitating multiple hospitalizations and extensive medical workups, all of which were normal. The baby only seemed to have difficulties when with her mother. Finally, an observer was placed in the hospital room and Annie did fine until one time when the hospital employee was called away for a few minutes. During that time Annie turned blue and the staff became concerned she was being smothered. Social services was called and Annie was taken from her mother's care," (Roesler & Jenny, 2009, p. 136).

The mental illness of MSBP is a label given to adults, and MSBP as well as its cousin Munchausen Syndrome (in which individuals feign disease, illness, or psychological trauma in themselves to draw sympathy) are both adult-onset disorders. However, children are affected severely by this disorder, as evidenced by the above case study. Children who are abused by

MSBP often are chronically absent from school, are subjected to numerous, painful, unnecessary medical procedures, are physically and mentally abused by parents, and suffer long-term psychological damage if they survive the abuse (Sheridan, 2003).

A variation of MSBP is Malingering by Proxy, which appears similar but is motivated by external incentives (e.g., economic gain). This is important to note, because medical child abuse is not limited by parental motivation. There have been only two major literature reviews of the research regarding MSBP. The first, which Rosenberg completed in 1987, was the basis for all generalizations made about MSBP as it drew conclusions from the multitudes of case studies that made up the MSBP literature at that time. Since then Sheridan completed a literature review in 2003 to update the findings regarding prevalence of the disorder, demographics of victims and perpetrators, and symptoms seen in children (Rosenberg, 1987; Sheridan, 2003).

Etiology and Prevalence

In 57.2% of cases examined by Sheridan, the parent caused symptoms in the child (2003). Overwhelmingly, research indicates that a child's birth mother is the abuser in cases of MSBP. However, in 7% of cases fathers have been found to abuse through MSBP. Beyond the gender of the parent, it is difficult to gather consistent information from the case study articles frequently seen regarding MSBP because they appear in medical journals in which background information about perpetrators has been eliminated. In research where it is available, perpetrators have often been found to have professional training in health care. The most common occupation of MSBP perpetrators is nurse, followed by nurse assistant (Sheridan, 2003).

Perpetrators also are frequently diagnosed with Munchausen Syndrome or demonstrate behavior consistent with such a diagnosis (29.3% showed Munchausen-type behavior). Collectively, 22.8% of perpetrators had a psychiatric diagnosis of some kind, with depression or

a personality disorder being the most common. A nearly equal portion, 21.7%, claimed to have experienced abuse in either childhood or from a partner (Sheridan, 2003). These percentages are considered to be conservative estimates, since the background information is unavailable for many case studies of MSBP.

Approximately 0.4 to 2 children per every 100,000 will be a victim of MSBP before the age of 16 (Shaw et al., 2008); an estimated 600 new cases of MSBP occur in the United States each year (Ayoub & Alexander, 1998). Children who suffer due to MSBP are equally likely to be male or female (52% male, 48% female). However, in the few cases in which the father is the perpetrator, males are 3 times as likely to be the victims of MSBP.

The average age of children at diagnosis is 48.6 months, or 4 years; 75% of all children involved in MSBP diagnoses are younger than 6 years old at the time of diagnosis. The average length of time symptoms persisted before diagnosis was 21.8 months.

The type of symptoms victims of MSBP present to medical professionals varies widely. The most frequently reported problems are apnea (26.8% of cases), anorexia/feeding problems (24.6% of cases), diarrhea (20%), seizures (17.5%), cyanosis (11.7%), behavior (10.4%), asthma (9.5%), allergy (9.3%), fevers (8.6%), and pain. It is identified in some cases of "failure to thrive" because the medical child abuse interferes with healthy infant development (Moldavsky & Stein, 2003). Most victims of MSBP present with about 3 medical problems, in some combination of 103 different symptoms reported in the case studies reviewed (Sheridan, 2003). This range of symptoms is part of what makes MSBP difficult to diagnose, because it rarely follows a pattern.

It can be difficult to differentiate between a parent with MSBP and a parent who is over-concerned or anxious, interpreting every minor symptom as a serious illness, developmental

problem, or mental health issue. MSBP parents also must be distinguished from parents who are frustrated with the fact that there are limits on what can be done for their children (who have bona fide problems) and are fighting for more services. A key difference may be that MSBP is a form of abuse; being a worried and anxious parent is not. The diagnosis hinges on whether the parent fabricated or induced the physical illness or educational problem (Ayoub et al., 2002).

Identification of MSBP

Some general warning signs that may indicate MSBP were developed by the FBI and include the following: a) the medical problem that was described does not respond to typical treatment, b) multiple emergency visits or ambulance requests for the same patient showing similar problems each time or a variety of problems, c) family history of unusual or unexplained illness, or multiple SIDS deaths in the family, d) symptoms of the illness go away when the parent is not in the immediate environment, e) parent attempts to convince doctors of a certain illness even when there are no symptoms (Chiczewski & Kelly, 2003).

In addition to the medical information described above, children who are victims of MSBP often exhibit psychological and educational issues that may be observed in the school setting. Victims of MSBP have been described as "dependent, immature, prone to symptoms of separation anxiety, and more likely to passively tolerate medical procedures," (Shaw et al., 2008, p. 217). These characteristics, though vague, may be something teachers and other school staff can look for when MSBP is suspected based on warning signs described above. Children affected by MSBP also tend to have chronic absenteeism due to induced illness, hospitalizations, or doctor visits (Shaw et al., 2008). For this reason, children who are victims of MSBP may suffer socially and academically in the school setting. These children may also suffer emotionally, but as they are often unaware of their parent's role in their illness, the emotional

effects are sometimes not seen until the abuse has ended. Finally, the medical abuse may have been severe enough to cause physical and/or neurological damage, thus leading to developmental delays. The trauma of victimization may lead to long-lasting mental health issues that need to be addressed in the school and outpatient settings: Emotional responses of victims of MSBP often involve critical disturbances in attachment and social relationships, as well as a desire to protect the parent from having their deception discovered (Ayoub et. al, 2002).

In MSBP, the fabricated or inducted conditions are typically physical; however, some children have pediatric condition falsification that primarily consists of psychiatric illnesses or educational disabilities (Ayoub et al., 2002). Such conditions include but are not limited to multiple personality disorder, bipolar disorder, ADHD, learning disabilities, and/or behavioral difficulties that affect school performance. As with other cases of MSBP, signs and symptoms may be exaggerated, fabricated, or even induced. This is essential for school psychologists to know because many parents with MSBP cause illness or disability in their children because of their desire to be involved in "intense, although ambivalent, relationships with those they see in authority, be they physicians, mental health professionals, or school personnel" (Ayoub et al., 2002, p. 150). These parents can be quite good at lying and presenting themselves as exceptionally interested and invested in their children. Thus, in cases of factitious educational disabilities, it is often teachers, counselors, administrators, and school psychologists (rather than physicans) who are first misled by the parent. In such cases, the parent often seeks professionals who seem most inclined to "go the extra mile" for her child.

Documented case studies show evidence that children with educational difficulties that are repeatedly exaggerated or fabricated are at risk for academic failure and emotional dysfunction. It appears that often a mild learning or behavioral problem or the presence of an

educational problem in an older sibling sparks a MSBP reaction in a parent, typically the mother. The school assenting to repeated requests for evaluations or services generally leads to additional assessment requests for "new" problems that are reported by the parent but are not evident at school. These children are often prescribed medication based on parent report of symptoms. The medication may then be used by the parent in excess, thus leading to the inducement of further symptoms. Often the parents are professionals in the education system or are in the process of studying to become educational professionals. One such parent who pushed for an ADHD diagnosis for her son attended different support groups in different communities 3 to 5 nights a week for four years. She insisted on four independent evaluations, despite a thorough first evaluation. When talking with the school psychologist, that parent repeatedly made statements such as "We psychologists know how complicated and important it is to help these ADHD children," as if she were a psycho-educational professional. That parent had completed some college and studied psychology, but had not yet even completed the requirements for an associate's degree (Ayoub et al., 2002, p. 153).

In order to diagnose MSBP and remove children from the dangerous living situations, medical professionals have the difficult task of ensuring they have enough evidence to present in a custody hearing to have the child removed from the home, while also bringing the child to safety as soon as possible. A physician typically convenes a multidisciplinary team whenever he/she suspects MSBP. This is done because physicians are trained to trust parents' assessment of their children and it is difficult to look at the case without bias once the physician suspects he/she has been lied to. A multidisciplinary team should consist of the following people: physician, social worker, nurse, psychiatrist/psychologist, legal consultant, hospital administration, child protective services, and a law enforcement officer (Shaw et al., 2008).

As soon as MSBP is suspected by the physician, close monitoring by a nursing staff should be put into place to maintain child safety while in the hospital. Next, a complete record review of medical history for the family should be conducted including parents and other siblings. This is often the most telling piece of evidence, and the task should be taken seriously even though it can be tedious work (The Cleveland Clinic, 2008). Psychiatric evaluations of the parent and child should be conducted to obtain the mental condition and dynamics between the pair. Records in the form of video and photographs should be kept of all symptoms and physical signs of induced illness for evidence in court. Finally, the parent should be confronted by the physician about the possibility of induced illness after sufficient evidence has been gathered that a diagnosis is likely. At this point, the child is often taken into temporary protective custody until legal proceedings take place (Shaw et al., 2008).

Although some parents admit to MSBP when confronted, many deny the allegations. Family reunification is not typically an option for parents who continue to deny MSBP. Across the board, recidivism is common, especially with siblings, and child protective services should closely monitor the family for any symptoms of this after the case is closed (Shaw et al., 2008).

In cases of MSBP, co-morbid diagnoses are often found in the perpetrators. Parents who commit MSBP sometimes also have Munchausen Syndrome, in which they also fabricate diseases in themselves (The Cleveland Clinic, 2008). More generally, perpetrators of MSBP have been found to have some psychiatric diagnosis, commonly depression or a personality disorder (Sheridan, 2003).

The possibility of misdiagnosis exists in cases of MSBP, but often the piece that is misdiagnosed is the motivation behind the medical child abuse. For instance, the term malingering by proxy is used to describe people who induce or lie about illness in others for

external gain (Feldman, 2004). The abuse taking place is the same, but the motivation differs. In some cases, parents have been accused of MSBP only to discover that they were innocent, but as the nature of the research on MSBP is elusive, little information could be found on this topic.

The concept of misdiagnosis leads into misconceptions the public may hold about MSBP. The authors of *Medical Child Abuse: Beyond Munchausen Syndrome by Proxy* worry that if people see MSBP as a psychological illness, they will excuse the resulting behavior, which is medical child abuse. They argue that to call MSBP a disorder would be equivalent of softening language by saying that a person who sexually abused children was sexually disordered instead of calling him/her a sex offender. It softens the term and makes the behavior less reprehensible in light of the disorder term (Roesler & Jenny, 2009). Although this may not be a view held by all researchers of MSBP, it is a controversy that exists within the field.

A second controversy that exists in the field of MSBP is that doctors may not always identify the abuse as soon as possible. Because they are usually involved in proceeding with medical tests based on parental input, they may become afraid or embarrassed that they have misjudged a situation and do not want to admit the error. Once doctors recognize that they may be passively implicated in the abuse, it could be difficult to step forward. Again, this is a hypothesis put forward, but it is not well-documented (Meadow, 2002; Roesler & Jenny, 2009).

Intervention

Unfortunately for the children affected by MSBP, few interventions have entirely positive outcomes. Once the abuse is discovered and enough evidence has been gathered to build a legal case of child abuse against the MSBP perpetrator, the child is typically taken into protective custody and then ultimately placed in a home away from the perpetrator (Shaw et al., 2008). For the child this can be a traumatic experience, as visitation from the MSBP perpetrator is typically

not permitted and family reunification is not likely. Children who have experienced medical abuse brought on by MSBP then must cope with the trauma of being taken from their homes. In 32.4% of cases, children were eventually taken from the custody of the abusive parent (Sheridan, 2003). Emotional effects from the MSBP may not become clear following separation from the perpetrator, but can manifest years after the abuse has stopped. Children of MSBP suffer from issues of betrayal and lack of trust, in addition to any long-term physical damage done by the perpetrator (Shaw et al., 2008).

For children who are not removed from their MSBP situation, it is an unfortunate reality that MSBP causes death to the children who are victimized in approximately 6% to 10% of cases (Rosenberg, 1987; The Cleveland Clinic, 2008). In 7% of cases, the MSBP caused long-term disabilities in the children victimized. Besides providing immediate protection from further medical abuse, intense psychological services can help children copel with their grief.

The treatment of MSBP in perpetrators is difficult because effective treatment requires the person to be honest. People with MSBP have at times become so good at lying that they are unable to discern truth from fiction any longer (The Cleveland Clinic, 2008). If treatment is possible, then it is generally through psychotherapy in the form of cognitive-behavioral therapy.

Perpetrators of MSBP have a difficult time changing their thought patterns and behaviors following confrontation in an MSBP case. A successful treatment experience would result in the perpetrator identifying the thoughts/feelings that lead to MSBP behavior and learning to change those thought patterns. However, in general MSBP is not highly treatable and the best solution is to remove all possible victims from the perpetrator's control (The Cleveland Clinic, 2008).

Some scholars hope that the term "Munchausen Syndrome by Proxy" will be disposed of, as it is thought to excuse the abusive behavior in the name of a psychological illness. However,

this does not seem likely (Roesler & Jenny, 2009). In addition to coming to agreement on terminology, it is important that researchers consider how data on MSBP cases is collected. . A common set of case study information would be helpful so that case studies can be written in similar formats, thus making data compilation from multiple case studies easier (Butz et al., 2009).

MSBP is an issue that interrupts and permanently alters the lives of. Even though this is a disorder that is diagnosed in adults, it severely affects the psychological and physical functioning of children. Thus, it is helpful for school psychologists to be aware of the warning signs and potential impact on children.

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