

5. Pediatric Condition Falsification (Munchausen by Proxy)

Factitious and Falsification Forms of Child Abuse

Munchausen by Proxy (MBP) is a form of child abuse in which a parent/guardian/caregiver deliberately produces or feigns physical or psychological symptoms in a child who is under their care. The child is presented for medical treatment and the parent or caregiver fails to acknowledge the deception. MBP often involves physical abuse, neglect, and emotional abuse. Some definitions of MBP include a statement that the intent is to gain attention and to meet self-serving psychological needs.

Definitional Issues:

The term Munchausen Syndrome by Proxy came into broad use following the work of Dr. Roy Meadow (1977) in identifying fabrication of illness in another person. Since then, hundreds of cases have been identified around the world and reported in the professional literature. There have been discrepancies in the application of the terms Munchausen by Proxy, Munchausen Syndrome by Proxy, Factitious Disorder by Proxy and other terms by the various medical, mental health, child protection, and legal agencies involved in assessing, investigating, and prosecuting these cases. The term Munchausen by Proxy has been used to refer to the child's victimization, the parent's disorder, and/or the interactional dynamics. A task force of the American Professional Society on the Abuse of Children (APSAC) undertook the exploration of MBP in 1995 and published a position paper on definitional issues in 1998. The intent was to identify the components of MBP (the victimization of the child and identification of the psychological motivation) and the characteristics of the psychiatric difficulty of the parent

The following definitions assist in distinguishing the terms that could be applied to the abuse and the perpetrator:

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. ***A child who is subjected to this behavior is a victim of child abuse by PCF*** (Diagnostic and Statistical Manual of Mental Disorders DSM-IV p. 682).

Factitious Disorder by Proxy (FDP) is a psychiatric disorder which applies to a person who intentionally falsifies history, signs, or symptoms in a child to meet their own self-serving psychological needs. The motivation is primarily internally driven by the need for attention or recognition that results from being seen as the devoted parent of a sick child and/or the need to covertly manipulate or deceive authority figures. External incentives may also be present. ***This diagnosis applies to the perpetrator and is coded as Factitious Disorder not Otherwise Specified 300.19*** (DSM-IV p.475). In official psychiatric nomenclature, FDP has replaced the term MBP (1994).

NOTE: "MBP" is used in this protocol as Pediatric Condition Falsification has not yet gained widespread recognition and use, however, use of PCF" when reporting is encouraged as it does not require that the pediatrician or other reporter identify the suspected perpetrator's intent of psychological/psychiatric difficulty or diagnosis.

Commonly Accepted Diagnostic Criteria

- A parent or caregiver fabricates symptoms of illness in a child
- The child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures and hospitalizations
- The perpetrator denies the etiology of the child's illness
- Symptoms of illness abate upon separation of the child from the perpetrator (Possible exceptions: when the child has suffered permanent damage as a result of the abuse; child is actively colluding with the parent; child has developed a psychiatric disorder)

Actual induction of illness is not required for a diagnosis of MBP or PCF. Severe harm or death could result from the caregiver's false reporting of symptoms alone.

MBP/PCF may include the deliberate withholding of medication or treatment from a child with a genuine illness, i.e. a child with a chronic condition such as asthma. In these situations medications or treatments are surreptitiously withheld with the purpose of exacerbating the child's condition. In these situations the perpetrator is fabricating compliance with the prescribed medical regimen.

The single biggest reason for failing to recognize MBP/PCF, is the failure to consider it in the differential diagnosis

The emphasis in the evaluation of children should be on assessing and articulating the harm to the child, not on the specific diagnosis of MBP or Factitious Disorder by Proxy. The label applied to the abuse is not the critical issue-articulating the harm the child has suffered and potentially may suffer, should be the focus. Mandated reporters are not required to determine the intent of the parent/caregiver (i.e. to kill the child, to receive financial gain, to gain recognition as an exceptionally caring parent) in reporting reasonable suspicion. The focus during assessment should be on the behavior of the perpetrator that results in harm to the child, rather than the intent. This is important because there continues to be discussion regarding the scope of what should be included in this disorder. Use of the term Pediatric Condition Falsification allows the reporter to identify the child's victimization without establishing the motivation(s) of the perpetrator. Intent is relevant when issues regarding treatment and reunification are addressed in dependency court and in the criminal justice setting.

Spectrum of Harm Experienced by Victims

Children who are victims of MBP/PCF suffer a spectrum of harm, whether the symptoms of illness are simulated or produced. Producing illness in a child, i.e. by administering poisons or, introducing feces into a catheter to produce infection, is obviously harmful. The risks associated with falsely reporting symptoms may not be as evident to those unfamiliar with this form of abuse. False reporting of symptoms or faking of an illness (i.e. placing one's own blood in a child's diaper and falsely reporting the child is passing bloody urine) can lead an unsuspecting health care provider to order unnecessary clinical studies, to prescribe unnecessary medications, and to perform procedures and surgeries that in retrospect are found to have been unnecessary. All of these medical treatments and procedures have associated risks, some more serious than others. Medical personnel unwittingly act as agents of harm. The psychological, developmental, and emotional harm child victims suffer can also be profound.

Children may suffer:

- Death
- Complications of surgery
- Side effects of drugs
- Side effects of medical tests
- Temporary and permanent disfigurement from medical procedures
- Temporary and permanent impairment from medical procedures
- Fear
- Pain and suffering
- Loss of normal attachment to parent/caregiver
- Loss of normal developmental experiences (i.e. kept out of school)
- Loss of normal social experiences

Presentation

Hundreds of cases have been reported in the medical literature. The most common symptom presentations have been:

- neurologic (seizures)
- hematologic (bleeding)
- respiratory (apnea)
- gastrointestinal (vomiting and diarrhea)
- fever
- rash

However, cases have been reported with a vast array of both presenting problems and methods by which caregivers may simulate or produce illness. Illnesses such as cystic fibrosis and cancer have been faked. No list of presentations should be considered complete.

Differential Diagnosis

The differential diagnosis and assessment process takes into account the many possibilities for parental persistence regarding the child's illness:

- Other medical diseases
- Psychogenic illness
- Vulnerable Child Syndrome
- Malingering (by proxy)
- Overanxious parent/caregiver
- Doctor shopping
- Parent/caregiver with delusional disorder

Diagnostic Pointers for MBP/PCF

The overarching feature is a medical history and clinical picture that do not make sense. Discrepancies among the reported history, clinical findings, and the general health of the child should raise concern about MBP/PCF. Specific cues to be considered in the differential diagnosis include:

- * Inconsistent histories from different observers.
- Persistent or recurrent illness that cannot be explained, i.e. symptoms are illogical, improbable, or are inconsistent with known pathophysiology-the physical exam and results of investigations don't explain the child's symptoms
- Illness(s) are unresponsive to treatment-symptoms fail to respond to conventional, effective therapies
- Reporting of new symptoms upon resolution of previous problems
- Symptoms/signs are associated with the presence of the parent/caregiver
- Unusual or unexplained illness or death in other children
- History of unusual illness in parent/caregiver

Evaluation and Assessment of Possible MBP/PCF Cases

These cases present complex medical, psychological, social, and legal issues. An interdisciplinary approach to evaluation and case management is optimal. A coordinated, systematic approach to the evaluation is recommended. Assessment of possible MBP/PCF cases is often done during an inpatient stay. Components of an evaluation commonly include:

- Familiarity with this form of abuse by those involved in the evaluation
- Extensive review of previous medical records
- Baseline toxicology studies with repeats if sudden, unusual events
- Physiological recordings
- Interviews of parents/caregivers for medical and social history
- Interview of child
- Additional clinical studies when indicated, for differential diagnosis
- Observation of child under controlled circumstances (usually inpatient hospitalization or placement out of home)
- Interviews with collaterals (i.e. previous physicians and other health care providers, teachers, grandparents, day care provider, etc.) for external verification of history/symptoms

Assuring the safety of the child while the assessment is proceeding is critical. Contrary to other forms of abuse, children who are victims of pediatric condition falsification are at **significant risk during hospitalizations**. Rosenberg (1987) reported that in 70 % of cases involving produced illnesses, the inductions took place in hospitals.

Evaluations of these cases often require tremendous resources to collect and assimilate the data and to monitor the safety of the child during the process. A multidisciplinary team in a hospital setting may include a pediatrician, medical subspecialists, a hospital social worker, psychiatry team member, nursing, child development specialist, nutrition services, one or

more members of the hospital's child protection team, and others. Consultation with the hospital's risk management department, media relations representative, and attorney may also be helpful when dealing with issues such as covert video surveillance and threats by the suspected perpetrators to involve the media or file a civil action.

Physicians and hospital staff who are concerned that a child may be a victim should consult with a member of the hospital's child protection team or seek consultation with another pediatric facility or professional with expertise in this area.

In cases where concerns arise about possible illness fabrication and a comprehensive evaluation has not yet taken place, review of medical records by a knowledgeable professional may assist law enforcement and/or DCFS staff, or a physician, to determine if there is sufficient basis to undertake an inpatient evaluation and/or separation.

Special Issues for School Personnel

Teachers, school nurses, attendance personnel, social workers, and others in the school system are important sources of information about a child when an evaluation of possible illness fabrication is underway. Information about the child's attendance, school health records, parental reports of medical/health problems, educational testing, and staff observations of health and behavioral issues are relevant.

School personnel may raise concerns regarding illness fabrication if they observe discrepancies between the parent's reports of health problems in the child and their observations of the child's health. Contact with the child's health care provider to clarify the child's diagnosis, health status, and implications for school attendance and participation in school activities and to inform the provider of observations of the child in the school setting is recommended.

References

"Definitional Issues in Munchausen by Proxy", Cathernine C. Ayoub, Ed.D. and Randell Alexander, M.D., Ph.D., *The APSAC Advisor*, v.11 n. 1, 1998

Rosenberg, D.: *Web of deceit: A literature review of Munchausen syndrome by proxy*. *Child Abuse and Neglect*. 11:547, 1987