Journal of Child & Adolescent Behavior

ISSN: 2375-4494

Zaky, J Child Adolesc Behav 2015, 3:4
DOI: 10.4172/2375-4494.1000e106

Editorial Open Access

Factitious Disorder Imposed on Another (Munchausen Syndrome by Proxy), a Potentially Lethal Form of Child Abuse

Eman Ahmed Zaky*

Department of Pediatrics, Faculty of Medicine, Ain Shams University, Egypt

***Corresponding author:** Professor Eman Ahmed Zaky, Department of Pediatrics, Faculty of Medicine, Ain Shams University, Egypt, Tel: 00202-1062978734; E-mail: emanzaky@hotmail.com

Received date: August 19, 2015, **Accepted date:** August 21, 2015, **Published date:** August 26, 2015

Editorial

Abstract

Factitious Disorder Imposed on Another is a behavior pattern in which a caregiver fabricates, exaggerates, or induces mental or physical health problems in those who are in her or his care. With deception at its core, this behavior is an elusive, potentially lethal, and frequently misunderstood form of child abuse or medical neglect that has been difficult to define, detect, and confirm.

Symptoms of the syndrome are hard to identify but are most prevalent when the child only becomes sick in the presence of his or her mother. The mother maintains a dynamic relationship with the physician, as the whole disorder is centered upon her need for attention and compassion from the doctor to placate self-doubt in the sufferer.

The first concern in Factitious Disorder Imposed on Another is to raise the awareness about it in order not to miss it as it could be lethal and to ensure the safety and protection of any real or potential victims. This may require that the child be placed in the care of another. In fact, managing a case involving Factitious Disorder Imposed on Another often requires a team that includes a social worker, foster care organizations, and law enforcement, as well as doctors. Psychotherapy generally focuses on changing the thinking and behavior of the individual with the disorder and its goal in such disorder is to help the person identify the thoughts and feelings that are contributing to the behavior, and to learn to form relationships that are not associated with being ill.

Introduction

Factitious Disorder imposed by another or Munchausen by Proxy Syndrome (MBPS), is a relatively uncommon but not a rare condition that involves the exaggeration or fabrication of illnesses or symptoms by a primary caretaker; usually the mother. It is a covert and potentially lethal form of child abuse that is difficult to recognize and deal with [1,2]; hence the importance of increasing the awareness of health care professionals about it as unless you put it in mind, you will definitely miss it.

In Factitious Disorder imposed by another, an individual deliberately makes another person sick or convinces others that the person is sick. Usually the parent or caregiver misleads others into thinking that their preschool child has medical problems by lying and reporting fictitious episodes. He or she may exaggerate, fabricate, or induce symptoms. As a result, doctors usually order tests, try different types of medications, and may even hospitalize the child or perform surgery to determine the cause [3].

In 1951, Dr Richard Asher originally used the term Munchausen syndrome to describe adults who fabricated illnesses to get medical attention, with no secondary gain except to adopt the role of illness through unnecessary medical procedures and treatments. The term was used in reference to the 18th–century military mercenary Baron von Münchhausen, who was known for fictional and dramatic accounts of his travels. In 1977, Roy Meadow coined the term Munchausen syndrome by proxy to describe 2 mothers who fabricated, lied, and induced symptoms in their 2 children. One of the children had a history of prolonged and recurrent passing of purulent bloody urine, and the other had a history of recurrent hypernatremia. The first child, whose symptoms occurred only in her mother's presence, improved during psychiatric treatment of the mother for her abusive behavior. The second child's symptoms occurred only at home, and he died as a result of severe hypernatremia. Later, Meadow reported that the boy's mother admitted to her psychiatrist that she killed her son by salt poisoning [4-7].

In 1994 & 2000, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) and DSM IV TR [8,9] respectively, used the term factitious disorder by proxy (FDP) to describe a psychiatric illness of the perpetrator who fabricates or inflicts illnesses on her / his victims. In 2013, DSM 5 used the term "Factitious Disorder Imposed by Another" instead of MBPS [10].

Any child lives in interlacing and intermingled circuits in which his family is the most close and intimate one followed by his community mainly the school environment, and then comes the society he and his family live in. The most important relation of all for any child is his relation with his mother. Such relation starts even before his birth and ends with his death not even with hers. This intimate and lengthy relation leaves deep imprints in his future life as an adult. If it is healthy, it will lead to the development of a healthy mature adult with self-actualization and multiple social, academic, and occupational achievements. Nevertheless, if this relation is negative and or abusive as in cases of Factitious Disorder Imposed by Another, it will lead

definitely to many adverse childhood experiences, social, environmental, and cognitive impairment, adoption of health risky behavior, with many possible diseases, disabilities, and social problems, and might even end with the victim child's early death.

Unfortunately, Factitious Disorder Imposed by Another is not as rare as previously thought as the reported cases in the literature reflect only the most severe cases and cases that have been substantiated. To show that it is not rare, it is worthy to mention that 1% of children with asthma, 5% of those with different food allergies, 22% of those with neurological disorders, and 32% of those with gastrointestinal problems had been proven to be victims of Factitious Disorder Imposed by Another in different reported series [11,12].

In more than 90% of cases of Factitious Disorder Imposed by Another, the mother is the perpetrator of the child's illnesses. The child's symptoms usually occur solely in her presence and subside in her absence. The mother's partner, other family members, and healthcare workers are sometimes called to witness symptoms or a physiologically normal event, such as mild discoloration with crying. The perpetrator later uses these witnessed events to substantiate an alleged illness of the child [13,14].

Perpetrators are frequently described as caring, attentive, and devoted individuals. However, not all perpetrators fit this impostor parent profile. Some can be hostile, emotionally labile, and obviously dishonest. Although they have no obvious psychopathology, perpetrators can be deceiving and manipulative. Their ability to convince others should not be underestimated. Their abuse is premeditated, calculated, and unprovoked [13,14].

The mother may have previous healthcare knowledge or training, and she is often fascinated with the medical field. Perpetrators aspire to establish close relationships with medical staff and frequently become a source of support for staff members or the families of other patients. The mother is usually calm in the face of the perplexing medical mysteries that her child is experiencing. She tends to pursue additional diagnostic and therapeutic options regardless of the pain and discomfort they may inflict on her child and almost always resists discharge orders and negative diagnostic findings. A physician's suspicion or reluctance to continue evaluations may encourage the mother to take the child to another facility for further consultation and workup [3-5,13,14] .

The perpetrators recognize their wrongful behavior but take great care to conceal their actions and rarely admit to their abusive activities. The perpetrator rarely has a severe mental illness (eg: schizophrenia), although several reports indicate that the presence of one or more personality disorders is common. She may also have a life history of an excessive drive to seek attention. The perpetrator's family history may reveal various types of abuse, unusual diseases in multiple family members, and family interactions that reward illness [15].

The mother's partner is often disengaged from the family and rarely plays an active role in the child's medical care. Trusting and unsuspecting partners may support the perpetrators and unknowingly become a passive perpetrator of the ongoing abuse. Other partners are abusive or uncommitted in their relationships with the mothers. In some cases, the abusing mother may be fabricating her child's symptoms to bring her partner back into the family. Approximately 10-25% of perpetrators also induce symptoms in themselves. The pattern of lying and fabrication may extend to other aspects of their lives, including employment, education, marital status, and previous illnesses. Few publications have reported fathers as the primary perpetrators in substantiated cases of Munchausen syndrome by proxy. In these situations, the fathers did not fit the devoted parent profile but were described as emotionally disturbed and mentally unstable. Other reported perpetrators have been stepparents, grandparents, foster parents, and caregivers (e.g , baby-sitters) [4,12-14,16,17].

Victim children usually present with an array of ailments in different organ systems. More than 100 symptoms have been reported. The most common symptoms include abdominal pain, vomiting, diarrhea, weight loss, seizures, apnea, SID (intentional suffocation), infections, fevers, bleeding, renal or urologic related issues, poisoning, and lethargy. Multiple unrelated manifestations may be reported as well [16,17].

Older children subjected to Munchausen syndrome by proxy often collude with their mothers by confirming even the most unlikely stories about their medical histories, sometimes out of fear of contradicting their mothers and other times because of their mothers' persuasion over time. Some of these children believe that they are ill with a mysterious disorder that the physicians cannot figure out [18,19].

Relationships among the mother, the child, and the primary physician may be long term and complex. Such involvement may hinder the physician from considering Factitious Disorder Imposed by Another as a differential diagnosis but several warning signs have been proposed to alert healthcare workers to the possibility of disorder. These include extraordinary, prolonged, and unexplained, extraordinary, and multiple symptoms that start or occur only in the presence of the perpetrator; ineffective or poorly tolerated treatments; and allergy to a wide variety of foods and medications. Patients usually have normal or negative results on laboratory tests, and their illnesses do not respond to known medical treatments. Siblings may receive the same abuse the patient receives from the same parent Finally, clinicians should remember that the presence of a real illness does not preclude Factitious Disorder Imposed on Another [11,12,16,17].

According to the American Academy of Pediatrics Committee on Child Abuse and Neglect, the health care worker must substantiate the credibility of the signs and symptoms, determine the necessity and benefits of the medical care, and question who is the instigator of the evaluations and treatments. To make the diagnosis, the presence of the following 2 factors must be established: Harm or potential harm to the child from excessive intervention and a caregiver who is fabricating illness or pursuing unnecessary treatment. The latency between the start of abuse and its discovery can be relatively long. The motivation of the perpetrator is not important in diagnosing the abuse [20,21].

Many barriers could hinder the diagnosis of Factitious Disorder Imposed on Another. These include the lack of certainty in differentiating parental anxiety or concerns from a pathologic seeking of healthcare, the tendency of the physician to believe the medical history the mother provides, the ability of the mother to present a highly persuasive and compelling medical history, the involvement of several physicians, often in different hospitals and sometimes numerous cities and states, fear of making a false accusation and its subsequent legal repercussions, lack of collaboration between medical, legal, and child-protection agencies, and the reluctance to separate the child from the family to evaluate the child's medical condition without the mother's involvement [22].

Before settling the diagnosis of Factitious Disorder Imposed on Another and during hospitalization and under close observation, obtain the necessary body-fluid samples for toxicology screens and any

other relevant investigations first to exclude organicity and second to second substantiate the evidence for your diagnosis. Finally, many institutions with court of law orders have used hidden cameras to video record the child in the hospital to confirm the diagnosis of this misleading disorder [23-25].

Several authors agree that a timely diagnosis is best achieved if a multidisciplinary team composed of physicians, psychologists, child protection worker, and juvenile court representative is involved. The role of the physician is to establish the pathologic healthcare-seeking behaviors that have led to medical abuse. The role of the psychologist is to evaluate the mother-child relationship, the mother's psychiatric condition, and the family's psychosocial functioning. The role of the child-protection worker is to ensure the child's immediate and long-term safety. The role of the juvenile court is to protect the child by making a strong commitment to the child's long-term supervision and to intervention that the family cannot refuse [22-24,26].

The long-term prognosis for these children depends on the degree of damage created by the perpetrator and the amount of time it takes to recognize and diagnose Factitious Disorder Imposed on Another. Some extreme cases have been reported in which children developed destructive skeletal changes, limps, intellectual disability, brain damage, and blindness from symptoms caused by the parent or caregiver. Often, these children require multiple surgeries, each with the risk for future medical problems. If the child lives to be old enough to comprehend what's happening, the psychological damage can be significant. The child may come to feel that he or she will only be loved when ill and may, therefore, help the parent try to deceive doctors, using self-abuse to avoid being abandoned. Most often, abusive Factitious Disorder Imposed on Another cases are resolved in one of three ways: the perpetrator is apprehended, the perpetrator moves on to a younger child when the original victim gets old enough to "tell", and the child dies [13,14,26,27].

To get help, the parent or caregiver must admit to the abuse and seek psychological treatment but if the perpetrator doesn't admit to the wrongdoing, psychological treatment has little chance of alleviating the situation. Psychotherapy depends on truth, and Factitious Disorder Imposed on Another perpetrators generally live in denial [26].

To summarize, investigating and reporting Factitious Disorder Imposed on Another can be both challenging and risky to caregivers. This is an emotional subject that incites interesting debate in the courts and in media outlets. A multidisciplinary team approach is mandatory to confirm its diagnosis and protect the child. Long-term psychiatric follow-up treatment of both the child and the perpetrator is needed. Lastly, but by no means least, educating physicians, social workers, and other healthcare professionals about Munchausen syndrome by proxy and establishing local task forces may facilitate timely diagnosis and management of the disorder.

References

1. Kay J and Tasman A (2006) Essentials of psychiatry. John Wiley & Sons, Ltd pp: 680.
2. Lasher L (2011) "MBP Definitions, Maltreatment Behaviors, and Comments".
3. Sadock B J, Sadock VA (2000) Kaplan & Sadock's Comprehensive Textbook of Psychiatry (7th edn.) Lippincott Williams & Wilkins Publishers.
4. Schreier H A and Libow J A (1993) Hurting for Love: Munchausen by Proxy Syndrome. New York: The Guilford Press.
5. ASHER R (1951) Munchausen's syndrome. Lancet 1: 339-341.
6. Asher RAJ (1969) Obituary notice. British Medical Journal 2: 388.
7. Fisher JA (2006) Investigating the Barons: narrative and nomenclature in Munchausen syndrome. Perspect Biol Med 49: 250-262.
8. DSM IV (1994) American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, (4th edn), Washington, DC, American Psychiatric Association.
9. DSM IV TR (2000) American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, (4th edn), Text GH Revision. Washington, DC, American Psychiatric Association.
10. DSM 5 (2013) American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, (5th edn). Washington, DC, American Psychiatric Association.
11. Sheridan MS (2003) The deceit continues: an updated literature review of Munchausen Syndrome by Proxy. Child Abuse Negl 27: 431-451.
12. Christie-Smith D, Gartner C (2005) "Understanding Munchausen syndrome by proxy". Special Report: Highlights of the 2004 Institute on Psychiatric Services. Psychiatry.
13. Feldman M (2004) Playing sick? untangling the web of Münchausen syndrome, Münchausen by proxy, malingering & factitious disorder. Philadelphia: Brunner-Routledge.
14. Fisher JA (2006) "Playing patient, playing doctor: Münchausen syndrome, clinical S/M, and ruptures of medical power". J Med Humanit 27: 135-149.
15. Friedel RO. Borderline Personality Disorder Demystified, Münchausen syndrome.
16. Giannini AJ, Black H R, Goettsche R L (1978) Psychiatric, Psychogenic, and Somatopsychic Disorders Handbook. New Hyde Park, NY Medical Examination Publishing pp: 194-195.
17. Davidson G (2008) Abnormal Psychology (3rd edn). Mississauga: John Wiley & Sons Canada, Ltd. pp: 412.
18. Libow JA (1995) Munchausen by proxy victims in adulthood: a first look. Child Abuse Negl 19: 1131-1142.
19. McNicholas F, Slonims V, Cass H (2003) "Exaggeration of Symptoms or Psychiatric Munchausen's Syndrome by Proxy?". Child and Adolescent Mental Health 5: 69-75.
20. Stirling J (2007) American Academy of Pediatrics Committee on Child Abuse and Neglect Beyond Munchausen syndrome by proxy: identification and treatment of child abuse in a medical setting. Pediatrics 119: 1026-1030.
21. Flaherty EG, Macmillan HL (2013) Committee On Child Abuse And Neglect Caregiver-fabricated illness in a child: a manifestation of child maltreatment. Pediatrics 132: 590-597.
22. Bursztajn H, Feinbloom RI, Hamm RM, Brodsky A (1981) Medical Choices, medical chances: How patients, families and physicians can cope with uncertainty. New York Delacourte/Lawrence.
23. Johnson BR, Harrison JA (2000) Suspected Munchausen's syndrome and civil commitment. See comment in PubMed Commons below J Am Acad Psychiatry Law 28: 74-76.
24. Elder W, Coletsos IC, Bursztajn HJ (2010) Factitious Disorder/ Munchhausen Syndrome. The 5-Minute Clinical Consult Philadelphia.
25. Southall DP, Plunkett MC, Banks MW, Falkov AF, Samuels MP (1997) Covert video recordings of life-threatening child abuse: lessons for child protection. See comment in PubMed Commons below Pediatrics 100: 735-760.
26. Brown R, Feldman M (2001) Adshead, Gwen, Brooke, Deborah. International Perspectives on Munchausen Syndrome by Proxy. Munchausen's syndrome by proxy: current issues in assessment, treatment, and research. London: Imperial College Press pp: 13–37.
27. Feldman, Mark D (1998) Parenthood Betrayed: The Dilemma of Munchausen Syndrome by Proxy.