Munchausen Syndrome by Proxy

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In Brief

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Author Disclosure

Drs Brown, Tierney, and Serwint have disclosed no financial relationships relevant to this In Brief. This commentary does not contain a discussion of an unapproved/investigative use of a commercial product/device.

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The term Munchausen syndrome has long been recognized in adult patients who fabricate symptoms for the purpose of adopting the sick role and submitting themselves to unnecessary medical procedures. In pediatrics, this condition takes a different spin when a parent presents with a story of symptoms in his or her child, who then becomes the focus of medical investigation. Because the patient is not directing the signs and symptoms of the condition, the name of this condition is Munchausen syndrome by proxy (MSBP). MSBP was introduced in the medical literature in 1977 by British pediatrician Roy Meadow and has been labeled Meadow syndrome as well as Polle syndrome at various times.

MSBP is characterized by four features: 1) a parent or other caregiver fabricates an illness; 2) the child is presented persistently for medical assessment, often resulting in multiple procedures; 3) the perpetrator denies the cause of the child's illness; and 4) acute symptoms and signs of the illness stop when the child and perpetrator are separated. Although boys and girls are equally likely to be victims of MSBP, the condition is seen more commonly in younger children. The incidence is estimated to be 0.4 per 100,000 children younger than 16 years of age and 2 per 100,000 in children younger than 1 year of age. Fathers sometimes can be the perpetrators, but mothers have been identified as the sole perpetrators in 94% to 99% of cases. Many of the abusing mothers have a history of psychiatric illness, although such history often is not immediately apparent to the health-care team. The mothers characteristically are described as having friendly demeanors, often have some degree of training in the medical field, and generally appear very involved in the care of their children during hospitalization.

Common symptoms of MSBP can include recurrent sepsis from injecting fluids, chronic diarrhea from laxative abuse, false renal stones from placing pebbles in the urine, apparent "fever" from heating a thermometer, rashes from trauma, and false laboratory reports after sugar or blood is placed in the urine. Indeed, the variety of symptoms is one of the factors that makes MSBP so difficult to diagnose. To address this confusion, the American Professional Society on the Abuse of Children recently highlighted a distinction between the abuse (falsification of a pediatric condition) and the presumed motive behind the action, defining a condition termed factitious disorder by proxy (FDBP).

FDBP is recognized by the most recent text revision of *the American Psychiatric Association Diagnostic and Statistical Manual* (DSM-IV-TR, 2000), which determined that information was insufficient to warrant the inclusion of MSBP as an official category. Although the two terms seem interchangeable, the key distinction is that FDBP focuses on the psychiatric state of mind of the perpetrator, while MSBP describes a form of child abuse. The distinction is important because the motivation for abuse is not considered when diagnosing abuse in other circumstances. The hesitation that many clinicians feel in trying to determine the internal state of the parent should not distract them from recognizing the syndrome as a form of child abuse. When a clinician suspects that a disease has been falsified, the suspicion must be pursued.

Once MSBP is considered, the American Academy of Pediatrics Committee on Child Abuse and Neglect recommends working with a multidisciplinary child protection team, including state social service agencies and, ideally, a pediatrician who has expertise in child abuse to assess the case. As part of the assessment, physicians should ensure communication and cooperation among all treating physicians and review all

medical charts pertinent to the child's care, recognizing that abusing parents often seek medical care from a variety of sources and may change physicians frequently. It also is important to involve the entire family in treatment and address ongoing family issues to ensure the future safety of the affected child and other children in the home. Because children who have MSBP may exhibit significant ongoing psychological problems, it is important to consider the need for individual or family counseling as part of the treatment.

Comment: MSBP is one of the most challenging and perplexing diagnoses that pediatricians face, perhaps because of our inherent values of developing a trusting relationship with parents and respecting their viewpoints because they know their children best. This process leads to a fair degree of discomfort when such values are questioned. The need to seek proof also places us in a problematic situation. Yet, we must ensure the safety of the child because the consequences of MSBP can lead to significant morbidity and, in some cases, mortality. Our involvement in cases where the diagnosis is being considered is a great example of our advocacy role for children.

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