



CLINICAL REPORT

Beyond Munchausen Syndrome by Proxy: Identification and Treatment of Child Abuse in a Medical Setting

John Stirling, Jr, MD, and the Committee on Child Abuse and Neglect

Guidance for the Clinician in Rendering
Pediatric Care

ABSTRACT

The condition widely known as Munchausen syndrome by proxy comprises both physical abuse and medical neglect and is also a form of psychological maltreatment. Although it is a relatively rare form of child abuse, pediatricians need to have a high index of suspicion when faced with seemingly inexplicable findings or treatment failures. The fabrication of a pediatric illness is a form of child abuse and not merely a mental health disorder, and there is a possibility of an extremely poor prognosis if the child is left in the home. In this statement, factors are identified that may help the physician recognize this insidious type of child abuse that occurs in a medical setting, and recommendations are provided for physicians regarding when to report a case to their state's child protective service agency.

INTRODUCTION

In the oft-quoted paraphrase of Hippocrates, the physician is admonished to “first, do no harm,”¹ and not without good reason. Even when necessary, diagnostic tests are at best inconvenient and frequently invasive or painful. Therapy is not without risk either, because it often involves hospitalization, drugs, or surgery. When the diagnosis is elusive and diagnostic efforts become more aggressive, the physician must always weigh risks to the patient against the benefits of an accurate diagnosis. Nowhere does this calculation become more important than in the rare circumstance in which the patient's caregiver fabricates the signs or symptoms of the disease in question, in what has traditionally been called Munchausen syndrome by proxy.

DESCRIPTION

The fictitious Baron von Munchausen was an extravagant raconteur, whose fanciful narrations of his imagined exploits made his name in literature. Physicians have borrowed his name to describe a group of patients whose complaints are fabricated but so convincing that they are subjected to needless hospitalizations, laboratory tests, and even surgery. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* refers to Munchausen syndrome as “factitious disorder” (300.19),² and motivations for this bizarre behavior continue to puzzle both medical and mental health professionals.

In 1977, Meadow first described cases in which the apparent symptoms of Munchausen syndrome were instead projected onto a dependent child as a parent fabricated symptoms and even signs of a nonexistent illness.³ When the fabrica-

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The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Key Words

child abuse, Munchausen syndrome, Munchausen syndrome by proxy, factitious disorder, factitious disorder by proxy, multidisciplinary team, covert surveillance, poisoning, SIDS, sudden infant death syndrome

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tions involved a dependent individual like this, the condition was likened to Munchausen syndrome experienced “by proxy,” and the diagnosis of Munchausen syndrome by proxy entered the medical lexicon. In the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, the condition is proposed as a new category called “factitious disorder by proxy.”⁴

There is no typical presentation for this condition. Suspicions may arise when parents misinterpret or exaggerate normal behaviors, and true cases range from apparent fabrication of reported symptoms to outright fabrication of signs of disease. Caregivers may report signs and symptoms that are undetectable to the medical observer, or the child may demonstrate signs that defy medical interpretation. In case reports, a wide variety of situations have been called, appropriately or inappropriately, Munchausen syndrome by proxy, including the following examples:

- A mother takes her child to the doctor for frequent evaluations for sexual abuse, even in the absence of objective evidence or history of abuse.⁵
- Mothers insist their children be treated for attention-deficit/hyperactivity disorder although there is no evidence to make the diagnosis.⁶
- A parent starves her child because she wrongly believes he has multiple food allergies.⁷
- Physicians suspect an unusual hematologic disorder after a mother repeatedly and secretly bruises her child with a hammer.⁸
- A parent purposely suffocates her child and kills him during a hospitalization for “apnea.”⁹

It is difficult to imagine how such varied conditions can be included in the definition of a syndrome. In some cases, the caregiver has merely exaggerated the child’s symptoms; in others, the caregiver has imagined them. In the worst cases, the signs and symptoms of illness have been induced by the caregiver’s intentional actions. In some patients, the consequences are minor; in others, the consequences are fatal. Indeed, the only things common to the presentations catalogued above are the caregivers’ insistence that something was wrong, an absence of pathologic findings sufficient to explain the described signs or symptoms, and consequent harm to the child.

TERMINOLOGY

Use of the term “Munchausen syndrome by proxy” has led to much confusion in the literature. For example, some experts insist that the term be applied only when the parent is seeking medical care because they are somehow personally compelled to relate to the medical care system,^{10,11} whereas others say the parent’s motivation is not important.^{5,12} Although the original description referred to harmful medical care, subsequent au-

thors have extended the appellation “Munchausen syndrome by proxy” to cases in which the only harm arose from medical neglect or noncompliance^{13,14} or even educational interference.⁶ In addition, there remains confusion about who should make the diagnosis of Munchausen syndrome by proxy: a psychiatrist or pediatrician? Is it a diagnosis applied to the parent or the child? Is it a pediatric or a mental health diagnosis? These ambiguities become especially important when medical personnel present their diagnosis to other professionals or to juries in seeking to protect a child victim.

To alleviate confusion, the American Professional Society on the Abuse of Children has recently made a more explicit distinction between the abuse (pediatric condition falsification) and the presumed motive behind most such cases (factitious disorder by proxy).³ This distinction has the advantage of replacing an eponym with more descriptive nomenclature, a recent and welcome trend in medicine. Whatever it is called, it is important to remember that harm incurred when a caregiver exaggerates, fabricates, or induces symptoms of a medical condition may still simply be termed “child abuse, which happens to occur in a medical setting.” This appellation reminds us that the focus of our intervention should always be to identify and minimize harm to the child regardless of the motivation of the perpetrator.

DEFINITION

Whether it is called Munchausen syndrome by proxy, pediatric symptom falsification, or simply child abuse, what remains as the central issue of importance is that a caregiver causes injury to a child that involves unnecessary and harmful or potentially harmful medical care. To make the diagnosis, the physician must ask 3 questions:

1. Are the history, signs, and symptoms of disease credible?
2. Is the child receiving unnecessary and harmful or potentially harmful medical care?
3. If so, who is instigating the evaluations and treatment?

If the child receives excessive, unnecessary medical care merely because the physician is overly compulsive or, worse, incompetent, then abuse is not a consideration. If the child is getting the unnecessary medical care because the parent is systematically misrepresenting symptoms, purposefully making up symptoms, manipulating laboratory tests, or even purposefully harming the child to create symptoms (eg, by poisoning or suffocation), then continued medical care itself may become abusive. The medical staff, in pursuing an ever-more-elusive organic diagnosis, may lose sight of its ultimate implausibility. One needs 2 circumstances to make the diagnosis in this form of abuse: harm or potential harm

to the child involving medical care and a caregiver who is causing it to happen.

The motive of the caregiver, although useful to the therapist, is unimportant in making the diagnosis of abuse. In no other form of child abuse do we include the perpetrator's motives as a diagnostic criterion. For example, a man can sexually abuse a child for a variety of reasons, but his motivation is irrelevant; the child still carries the diagnosis of sexual child abuse. A mother might violently physically assault her infant because she is fed up with the child crying, she is intoxicated or drugged, or she earnestly thinks that is the way to get the infant to behave and start eating, but it is still called physical child abuse.

Child abuse is a pediatric diagnosis, one that describes what is happening to the child. Motivation of the perpetrator often becomes an issue when society considers incarceration, treatment, or reunification but not when the physician makes the medical diagnosis of child abuse.

DIAGNOSIS

Diagnosis of fabricated disease can be especially difficult, because the signs and symptoms are undetectable (when they are being exaggerated or imagined) or inconsistent (when they are induced or fabricated). Researchers may differentiate between exaggeration and fabrication or induction of symptoms, but action taken by the clinician must be determined by the perception of harm or potential harm to the child.

Regardless of the exact nature of the duplicity, health care professionals can be seduced into prescribing diagnostic tests and therapies that are potentially injurious. This is easier than one might think. After all, absolute certainty is a rare thing in medical diagnosis, and physicians have all known empirical therapy to be effective. On occasion, though, the well-meaning but misguided pursuit of an ever-more-elusive diagnosis or effective treatment can lead medical staff into an ethical dilemma. Potentially harmful medical care can range from a diagnostic search that subtly encourages and enables a caregiver's delusion through a full spectrum of invasive tests and medical or even surgical interventions. Alternatively, a child may present to the doctor with a common diagnosis but one that seems resistant to an increasingly aggressive array of treatment regimens. The common factor in all is the failure to consider factitious disease in the differential diagnosis, although it is often more likely than the arcane diagnoses being pursued so assiduously.

Child abuse is not a diagnosis of exclusion. On the contrary, when a clinician suspects that a disease has been falsified, this hypothesis must be pursued vigorously and the diagnosis must be confirmed if the child is to be spared further harm. In seeking to determine if signs and symptoms of a disease have been fabricated,

the physician should make every effort to gather information from all those involved and make other professionals aware of the concerns. Care of children who are victims of factitious disorder by proxy often involves a variety of medical personnel, from primary care physicians and medical subspecialty consultants to dietitians, physical therapists, and social service workers, and each has a unique perspective. Nursing and support staff can frequently contribute to making the correct diagnosis by reporting their observations of, and experiences with, the child and family to the supervising physician. It should be stressed, however, that the falsification of a medical condition is a medical diagnosis. Although multidisciplinary input can be very helpful in diagnosis and essential in treatment, psychologists, social workers, and others are not in a position to make or confirm this diagnosis.

Occasionally, more information about the maltreatment is needed before a diagnosis can be reached. When it is suspected that no true disease exists and it is felt that harm to the child is imminent, the use of covert videotape surveillance has been recommended.¹⁵⁻¹⁷ Such surveillance may capture a parent's misbehavior, as when a child is being physically abused in the hospital. It may fail to confirm reported symptoms when they are being exaggerated or exonerate a suspected caregiver when a disease truly exists. In any event, video surveillance cannot be considered a gold standard or held as the only way of diagnosing this insidious form of child abuse. When videotaping is used, adequate safeguards such as continuous surveillance and a well-understood plan of action must be present to prevent further injury.

TREATMENT

By recognizing that this problem is a form of child abuse taking place in a medical setting, a clear role is delineated for the system that is currently in place in our states to protect children. Child protective services agencies are mandated to keep children who are abused—sexually, physically, or psychologically—safe regardless of whether the abuse occurs in the home or the hospital.

When considering treatment for child abuse taking place in a medical setting, the basic principles used in any other type of child abuse case should be applied:

1. Make sure the child is safe.
2. Make sure the child's future safety is also assured.
3. Allow treatment to occur in the least restrictive setting possible.

For example, if an overanxious mother who has insisted on too much medical care for her child is willing to cooperate with the physician and learn when it is appropriate to seek care, the child can safely be treated within his or her family setting. In contrast, if a mother has repeatedly suffocated her child, the "least restrictive

setting” that would guarantee the child’s safety would most likely be permanent out-of-home placement.

If the parent’s care-seeking is harming the child but the parent refuses to cooperate with the physician in limiting the amount of medical care to an appropriate level, the state child protective services agency should be informed. If the parent persists in harming the child, medical child abuse should be reported in the same way as physical and sexual child abuse. Any time that a dependent child is being hurt by an adult’s action, child protective services should become involved.

A list of possible interventions follows, from the least restrictive to the most restrictive. Some of these options require action by outside agencies (child protective services, private counselors, law enforcement, etc).

1. Use individual and/or family therapy while depending on a primary care physician to be “gatekeeper” for future medical care utilization.
2. Monitor ongoing medical care usage by involving people or institutions outside the medical practice to alert the physician gatekeeper about health care issues. For example, in the event of a child protective services investigation, or with the parent’s consent, the insurance provider can be alerted to inform the primary care physician or medical home about visits to other professionals. Another example would be having the parent authorize the school to call the physician any time the child is absent or have school officials agree not to excuse any absence without the physician’s approval.
3. Admit the child to an inpatient hospital setting or a partial hospital program, where his or her actual signs and symptoms can be monitored (as opposed to the signs and symptoms reported by the parent). This admission is a very important resource if the parent tends to exaggerate or lie about the child’s pain or disability. A program that treats the whole family can then work to define the child as normal in the parents’ eyes.
4. Involve child protective services to obtain dependency, either in or out of the home, to control overuse of medical resources and gradually reintroduce the child to the caregiver’s home while monitoring the child’s safety.
5. Place the child in another family setting permanently.
6. Prosecute the offending parent and incarcerate him or her, thus eliminating access to the child.

The physician’s role in options 4 through 6 would be to report the case to the appropriate authorities, carefully document the abuse, and, if needed, testify on the child’s behalf in courts of law. Obviously, options 3 through 6 will be required only in the most extreme or persistent cases of medical abuse.

CLINICAL ADVICE

When physicians diagnose and manage cases of child abuse in the medical setting, the following clinical advice will help ensure a more successful outcome of the case:

1. Whenever possible, have a pediatrician with experience and expertise in child abuse consult on the case, if not lead the team. This may help to reduce “false-positive” misdiagnosis and better identify actual cases.
2. Review all the medical charts pertinent to these complicated cases. Abusing parents often seek medical care from a variety of sources and may change physicians frequently. It is important to involve all the treating physicians in the process. Primary care and subspecialty physicians should work together to identify parents who seek excessive medical care. They should communicate regularly about the degree of medical care utilization and reach consensus on management. Cooperation of all the involved physicians is not only critical to good patient care, but it can also keep the parent from becoming confused or deliberately playing one doctor against another.
3. Work with a hospital- or community-based multidisciplinary child protection team. Such teams bring a variety of skills and viewpoints to the treatment process and provide expert consultation for the primary care physician in child maltreatment and child protection.
4. When a “more restrictive” response is needed, do not hesitate to involve the state social service agency responsible for protecting children from abuse. If the physician has access to a multidisciplinary child protection team, the team can help coordinate efforts to protect the child and facilitate communication with the state child protection agency.
5. Involve the whole family in the treatment. Their entire view of illness and health in their lives has to be adjusted. Ongoing family issues must be addressed to guarantee the future safety of the victim and any other children in the home. Therapists may use effective behavioral management techniques to change the child’s dysfunctional behaviors, when appropriate.

SUMMARY

What has been known as Munchausen syndrome by proxy may be better described as pediatric condition falsification or simply child abuse that occurs in a medical setting. In aggressively seeking an elusive diagnosis, physicians can sometimes cause harm to their patient and must remain aware of this possibility. The pediatrician who suspects that signs or symptoms of a disease are in fact being fabricated should concentrate on the harm or potential harm to the child caused by the actions of that caregiver and the efforts of the medical personnel to

diagnose and treat a nonexistent disease. Proper diagnosis of fabricated disease involves thorough evaluation of medical charts, clear communication among medical professionals, and, often, a multidisciplinary approach. A focus on the motives of the caregiver, although useful in therapy, is unnecessary for the diagnosis of this form of child abuse.

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