Monsters in the Closet: Munchausen Syndrome by Proxy

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PRIME POINTS

- Munchausen syndrome by proxy (MSbP) is associated with a high incidence of recidivism, morbidity, and mortality.
- MSbP perpetrators are motivated to interact with health care providers to satisfy their own insatiable need for positive attention; abusers are willing to hurt their child in order to meet this emotional need.
- MSbP is child abuse. Health care providers are legally and morally obligated to report suspected abuse.

When you hear hoofbeats, think horses, not zebras.
—Old health care maxim

Eighteenth century German aristocrat Karl Friedrich Hieronymus Freiherr von Münchhausen was renowned for telling wildly exaggerated tales of travel and adventure.[1] In 1786, Rudolf Raspe published versions of the baron's imaginative tales in his book, *The Surprising Adventures of Baron Munchausen.* The medical profession has since borrowed the name of this famous raconteur to describe a group of individuals whose complaints are fabricated, but nonetheless so convincing that patients are subjected to needless hospitalizations, diagnostic tests, and even surgery.[2] British physician Richard Asher, who first described Munchausen syndrome in 1951, noted that "the most remarkable feature of the syndrome is the apparent senselessness of it. Becoming a patient is the purpose of the syndrome."[3]

CE Continuing Education

This article has been designated for CE credit. A closed-book, multiple-choice examination follows this article, which tests your knowledge of the following objectives:

1. Understand that Munchausen syndrome by proxy (MSbP) is probably an underrecognized and underreported condition
2. Describe red flags for MSbP
3. Recognize that MSbP is child abuse

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Definition

Munchausen syndrome is referred to by several different names, including Münchhausen syndrome, fabricated illness, and hospital addiction syndrome. The *Diagnostic and Statistical Manual* (DSM-IV) designates this condition as "factitious disorder."[2] The term "factitious" describes symptoms that are artificially produced rather than the result of a natural process.[4] Findings range from fabrication of subjective complaints to self-inflicted conditions and exaggeration or exacerbation of preexisting medical disorders.[5]

Motivations for this bizarre behavior continue to puzzle both medical and mental health professionals, but patients have in common a profound psychological need to assume the sick role and do so in the absence of external incentives for the behavior, such as economic

gain, access to narcotics, or a desire to avoid work or other unpleasant situations (ie, malingering).[2]

Typical Munchausen Syndrome Patients

More men than women are affected by Munchausen syndrome,[6] and onset generally occurs in early adulthood, often after hospitalization for true physical illness. Patients demonstrate uncontrollable, pathologic lying (*pseudologia fantastica*) and will describe their history or symptoms with great dramatic flair, yet findings are classically vague, inconsistent, unwitnessed, and difficult to either substantiate or disprove. When presented with evidence of their factitious symptoms, these individuals become angry, deny allegations of fabrication, and rapidly discharge themselves from the hospital only to present themselves to another facility or provider.[6,7] Sadly, this disorder is not benign. Multiple hospitalizations and procedures frequently lead to iatrogenically induced physical conditions[8] such as formation of scar tissue, adverse reactions to drugs, and abscesses due to numerous injections.

Munchausen Syndrome by Proxy

In 1977, physician Roy Meadow coined the term Munchausen syndrome by proxy (MSbP) when he described 2 cases in which the apparent symptoms of Munchausen syndrome were projected onto dependent children by mothers who fabricated signs of nonexistent illness. One woman introduced her own blood into her baby's urine sample and the other poisoned her toddler with excessive quantities of salt.[9]

As with Munchausen syndrome, many terms are used to describe the phenomenon including Münchausen by proxy syndrome, Munchausen by proxy, illness induction syndrome,[10] and pediatric symptom falsification. The DSM-IV applies the label "factitious disorder by proxy" and the American Professional Society on the Abuse of Children uses the designation "pediatric condition falsification" (for the child) and "factitious disorder by proxy" (for the perpetrator). Other authors have simply described MSbP as child abuse that occurs in a medical setting.[2,8]

Definitions: There Are Many

In addition to the lack of consensus regarding terminology, there is likewise no standardized definition of the disorder. MSbP is a strange combination of physical abuse, medical neglect, and psychological mistreatment that occurs with the active involvement of the medical profession.[8] Carter et al[11] described the disorder as

> an often misdiagnosed form of child abuse in which a parent or caregiver, usually the mother, intentionally creates or feigns an illness in order to keep the child (and therefore the adult) in prolonged contact with health providers.

To perpetuate the medical relationship, perpetrators systematically misrepresent symptoms, fabricate signs, manipulate laboratory tests, or even purposefully harm the child (eg, by poisoning, suffocation, infection). The goal of the perpetrator is to create symptoms or induce illness so that the child will receive unnecessary and potentially harmful medical care. In addition to inducing illness, abusers may withhold appropriately prescribed treatments. Unique to this form of child maltreatment is the role that health care providers play by actively, albeit unintentionally, enabling the abuse. By acceding to the wishes and demands of perpetrators, medical professionals are manipulated into a partnership of child maltreatment.

Incidence, Who Knows?

Although the condition is often characterized as "rare," lack of a standardized definition and centralized reporting repository make it difficult to quantify the incidence of MSbP.[4] Expert estimates range from 1 in a million children to 2.8 in 100 000 children.[12] In addition to numerous case reports in the medical literature, several descriptive studies have been done that examine the prevalence of MSbP within limited populations. For example, researchers reviewed the records and identified a total of 135 cases of MSbP diagnosed at Seattle Children's Hospital in a

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32-year period.[13] In a series of 250 Parisian children with a diagnosis of hyperinsulinemic hypoglycemia, 2 cases were found to be MSbP cases.[14] Surveys of pediatric neurologists and gastroenterologists suggest that the condition may be much more common than previously appreciated and that many cases probably go undiagnosed.[15]

An Escalating Disorder

The MSbP parent, usually a birth or foster mother, seeks health care for her child because she is somehow personally compelled to relate to the medical care system. The abuser's underlying psychiatric problems oblige her to gain positive attention from medical personnel, and she derives this attention by having a child with health problems. Thus compelled, perpetrators will do whatever it takes to satisfy their need. MSbP in its mildest form consists of simple fabrication of symptoms. However, if this fabrication does not garner sufficient interest from medical providers, abusers are driven to increase the stakes. Moderate MSbP is manifested by tampering with laboratory specimens, falsifying medical records, and so on. Those with severe disorders resort to actually inducing illness or injury in the child (Table 1).[2,16]

Popular Methods of Inducing Illness

A wide range of methods have been used to inflict factitious illness on children, but they fall into 4 general categories: poisoning, bleeding, infections, and injuries. MSbP case reports describe poisoning with substances such as ipecac, salt, insulin, laxatives, lorazepam, corrosives, diphenhydramine, amitriptyline, lamotrigine, and clonidine to name just a few.[11,14,17-22] Both hematuria and gastrointestinal bleeding can be simulated or produced by a variety of methods. Perpetrators either mix their own blood with a child's specimen or actively induce bleeding.[13,23] Infectious conditions are also readily simulated or induced. Reports that "my baby had a fever last night" are impossible to prove or disprove. Thermometers and temperature documentation are easily manipulated.[24] Cases of active infection induction include applying fecal matter to wounds, rubbing dirt and coffee grounds into orthopedic pin sites, injecting urine into the child, and spitting or introducing feces into intravenous catheters (Table 2).[25,26]

Injuries in the MSbP child are generally more subtle than those produced in typical cases of physical abuse and they differ from the usual pattern of injuries common to child maltreatment. Foreign bodies, osteomyelitis, nonhealing wounds, recurrent conjunctivitis, and fractures that fail to heal are all examples of injuries that do not blatantly suggest nonaccidental trauma. Suffocation is a particularly common form of symptom induction.[26-29]

Table 1 Severity of Munchausen syndrome by proxy

Disease severity	Examples
Mild, symptom fabrication	Claiming the child experienced symptoms such as apnea or ataxia
Moderate, evidence tampering	Manipulating laboratory specimens or falsifying medical records
Severe, symptom induction	Producing actual illness or injury including diarrhea, seizures, and sepsis

Table 2 Methods of inducing illness in Munchausen syndrome by proxy

Method	Examples
Poisoning	Ipecac, salt, insulin, laxatives, lorazepam, corrosives, diphenhydramine, amitriptyline, lamotrigine, clonidine
Bleeding	Hematuria, gastrointestinal bleeding, bruising
Infections	Applying fecal matter to wounds, rubbing dirt and coffee grounds into orthopedic pin sites, injecting urine into the child, spitting or introducing feces into intravenous catheters
Injuries	Suffocation, foreign bodies, osteomyelitis, nonhealing wounds, recurrent conjunctivitis, fractures that fail to heal

Symptoms

Multiple presenting complaints, either concurrently or serially, are the norm. Sheridan reviewed 451 MSbP cases reported in 154 articles and documented that the mean number of symptoms per victim was 3.25.[27] Although MSbP has no "typical" presentation, perpetrators almost always describe a history of signs and symptoms that are undetectable to the medical observer and are therefore both plausible and difficult to disprove.[2] One study

noted that approximately 50% of factitious illness cases involved diagnostically challenging central nervous system signs such as seizures, apnea, or other neurological events.[16] In a literature review, Rosenberg[30] analyzed the incidence of symptoms reported in MSbP patients: bleeding in 44%, seizures in 42%, central nervous system depression in 19%, apnea in 15%, diarrhea in 11%, vomiting in 10%, fever in 10%, and rash in 9%. Other stated disorders common to MSbP patients include allergies, behavioral problems, asthma, cyanosis, poor feeding, urinary issues, sexual abuse, and dermatologic conditions.[23,31,32] Feldman et al[13] documented that 25% of the children in their MSbP series manifested renal or urologic symptoms.

Many of these conditions lack clearly observable or diagnostic findings. For example, how do you disprove that a child had a seizure in the face of parental insistence? When abusers move beyond simply falsifying symptoms and start actually fabricating them, infection, bleeding, and urinary complaints can readily be induced. Gastrointestinal symptoms are easy to create with emetics, laxatives, and many other substances.[16] Seizures and apnea can be provoked with suffocation; fever and rash are initiated by inducing infection.

MSbP Victims

The incidence of MSbP victimization appears to be fairly equally distributed between the sexes.[27] Feldman and Brown[33] surveyed the medical literature from 24 countries and determined that MSbP is clearly not a phenomenon unique to Western or highly medicalized societies. MSbP occurs most commonly in children under the age of 5 years, but victimization may continue well into adolescence.[4] Older children can be coerced into feigning symptoms.[12] Tragically, child victims learn that they are most likely to receive the positive maternal attention they crave when they are playing the sick role in front of health care providers. Many case reports describe MSbP victims who grow into Munchausen syndrome patients or continue the pattern of abuse in their own children.[34] It appears that seeking and achieving personal gratification through illness (one's own or that of one's child) can be a lifelong and multigenerational disorder.[8,34,35]

Unfortunately, MSbP is difficult to detect, so the time from initial onset of symptoms to diagnosis is often lengthy. This delay can result in considerable psychiatric pathology. A review by Feldman and colleagues[13] documents a mean time to diagnosis of 4.5 years; Rosenberg[30] described mean time to diagnosis as 14.9 months (SD, 14 months), and Sheridan[27] reported a lapse of 21.8 months from symptom onset to diagnosis. Despite their variability, any of these intervals represent a very long time in the life of a young child.

Perpetrators: It's All About Me!

Unlike the typical physical child abuser, who seeks to release his or her own frustrations by striking out at a child, the motivations of the MSbP abuser are more complex. The goal of the MSbP perpetrator is to draw recognition and positive attention to herself; she has an insatiable need for social and emotional gain that must be fulfilled regardless of the harm to her child.[4] Mothers, and other women in a guardian role, are by far the most frequently reported perpetrators (93%),[31] but Sheridan's large scale review found that fathers were primarily responsible approximately 7% of the time.[27] Even when they are not actively involved in the abuse, several authors have described the fathers or male guardians of MSbP victims as being distant, emotionally disengaged, and powerless.[15,30,31] These men play a passive role in MSbP by being frequently absent from the home and rarely visiting the hospitalized child. Such men will vehemently deny the possibility of abuse, even in the face of overwhelming evidence or their child's pleas for help.[16,26,31,35] In 1 study, researchers reported that 40% of married MSbP parents had serious marital problems.[10]

Documented perpetrators also include foster parents, adoptive parents, and stepparents as well as other relatives or caretakers including nurses.[4,36] MSbP abusers are usually very knowledgeable about medical treatment options through experience as a patient, through training as a child care provider or health care provider, or through library and Internet research.[12] Hall et al[37] reported that in 85% of their 41 video-documented cases of MSbP, one or both parents had training in a field related to health care or in day care.

To the public, and to medical personnel, the offender appears ingratiating and extremely concerned about the child's well-being,[31] often refusing to leave the patient's bedside.[16] It is this feature of the disorder that makes MSbP difficult to detect as abuse. However, covert

videotapes have repeatedly recorded that these same parents generally ignore or even mistreat the child when convinced no one is there to observe their performance (Table 3).[12,31,37]

Motives

Many reasons for MSbP have been posited—and motivations no doubt vary among abusers—but falsifying a child's illness presents perpetrators with an opportunity to

- Gain sympathy, attention, respect, and public acclaim by playing the role of the loving, devoted mother, the only one capable of "rescuing" the child.
- Show off their medical knowledge. By baffling experts, manipulating and outwitting "important" people, abusers prove to themselves they really are in control.
- Escape other responsibilities in life. No one expects much else (eg, education, employment, household chores) from the devoted mother with a chronically ill child.
- Have a purpose, role, and self-image of doing good, important, and interesting things.
- Get back at a neglectful spouse or receive the support and concern of family members.
- Have a social life by being part of a hospital "family." Pediatric units in particular are full of sympathetic professionals, families of other children with whom to bond, fun activities, celebrity visits, unit parties and potlucks, charitable gifts, Ronald McDonald Houses, and more, all of which are more exciting than the life the perpetrator has at home.[16,31,36]

Table 3 Red flags for Munchausen syndrome by proxy

Characteristics of the child	Characteristics of the mother/caregiver
Is less than 5 years old at the time of symptom onset	Appears very caring and concerned, yet consistently pushes for further tests, procedures, surgeries, appointments, and hospitalizations
Has a history of frequent contacts with health care providers	Is comfortable in the medical setting, makes friends with staff members and other patients' families
Experiences objective symptoms that are witnessed only by the mother/caregiver	Exhibits a higher than average degree of medical savvy
Presents with multiple findings that are vague and confusing	Primarily views and describes the child as the sum of his or her medical record
Is not helped by standard treatments	Has an uncanny ability to dichotomize staff members' opinions of her
Has a dead sibling or a sibling with a complicated medical history	Becomes aggressively hostile when thwarted
Has an absent or emotionally distant father	
Deteriorates whenever discharge is planned	

Sometimes secondary gain also is significant: examples include food stamps, public housing, medications, financial aid, community support, media attention, and donations.[28] Perpetrators have a profound need to be seen in the role of "angel of mercy." Church and community groups routinely praise and reward these women for their selfless devotion to a sick child. However, to keep the attention coming, the lie must be perpetuated; thus, the child must continue to suffer. Because the perpetrator's self-concept revolves around this maternal image, if the child dies or becomes too old to be a target, perpetrators will transfer their attentions to a younger sibling or foster child. MSbP mothers become so good at this deception that, when caught in the act, family members, friends, and even health care providers will vehemently insist the abuser has been wrongly accused.[27]

MSbP Versus Typical Physical Child Abuse

The primary distinguishing feature that differentiates MSbP from garden variety physical child abuse is the degree of premeditation involved.[8] Whereas most physical abuse entails lashing out at a child in response to some behavior (eg, crying, bedwetting, spilling food), assaults on the MSbP victim tend to be unprovoked.[31] Both types of abuse, however, have certain features in common:

- The child usually has a long history of medical visits at multiple health care facilities ("doctor shopping").[31]
- Abusers become angry and hostile when confronted with their behavior.[8,12]
- Abusers do not accept responsibility for the child's health status.
- The child's condition quickly improves when separated from the abuser.[15]
- Abusers may abscond with the child if they detect suspicion.

Several features distinguish the victims and perpetrators of MSbP from those involved in more typical physical abuse behaviors (Table 4).

Complications

MSbP must be viewed as a life-threatening condition associated with significant psychological,

behavioral, and iatrogenic complications.[15] It is a very serious form of child abuse with high recidivism and mortality rates.[31] Prognosis is extremely poor if the child is left in the home. The overall mortality of MSbP is difficult to calculate but has been reported in several studies to be between 6% and 10%. When poisoning or suffocation are involved, mortality may be as high as 33%.[12] Of particular note is the excessive rate of morbidity and mortality reported in siblings of MSbP children.

Meadow described 27 MSbP victims who were repeatedly suffocated by their mothers. Nine of the 27 died and one was severely brain damaged. These 27 cases had 15 live siblings and, astonishingly, 18 siblings who had died suddenly and unexpectedly in early life.[38] Sheridan's meta-analysis of 451 MSbP cases documented that, of 210 known siblings, 61% had experienced symptoms similar to those of victims and 25% of these siblings were dead.[27] In an era of very low childhood mortality, the death of a sibling (or a sibling with an equally complicated medical history) should be viewed as a red flag for MSbP. Those who survive beyond the period of acute victimization are still at risk. Approximately 8% of children will suffer long-term problems as a result of induced illnesses or complications of medical care.[39] Virtually all will experience serious psychological sequelae from the abuse.[31,35]

Making the Diagnosis

Diagnosis of fabricated disorders is especially difficult because clinical findings are undetectable when they are exaggerated or imagined and are inconsistent when fabricated.[2] Findings that defy simple medical explanations send health care providers down a path of "chasing zebras" in an attempt to uncover unusual conditions. Even without maternal prompting, medical professionals may be easily seduced into prescribing diagnostic tests and therapies that are at best uncomfortable and costly, and at worst potentially injurious to the child.[2] The common factor in delayed diagnosis is failure to consider factitious disease in the differential diagnosis, even when MSbP is far more probable than whatever arcane diagnosis is being pursued so assiduously.[2]

The symptoms of MSbP can be quite obvious, but medical personnel may be reluctant to consider the diagnosis because they simply do not want to believe that such an apparently caring mother could do this to her child.[11] The American Academy of Pediatrics' Committee on Child Abuse and Neglect has taken the position that

> 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. [Practitioners] must have a high index of suspicion [of MSbP] when faced with seemingly inexplicable findings or treatment failures.[2]

MSbP should be considered whenever a child presents with an unusual illness and has a negative workup or an atypical response to standard therapy.[12] Various diagnostic

Table 4 Distinguishing characteristics: typical physical child abuse and Munchausen syndrome by proxy

The typical physical child abuser . . .	The Munchausen syndrome by proxy abuser . . .
Is commonly the child's stepfather or mom's boyfriend.	Is almost always the child's mother or other female guardian.
Is reluctant to seek medical care.	Seeks medical care all the time.
Pushes for early release of the child from care.	Is reluctant for the child to leave health care and instead insists on more tests and treatments.
Is typically bullying, sullen, hostile, or threatening.	Is eager to impress providers with her medical knowledge and concern for her child.
Needs to be viewed as in charge; "don't mess with me."	Needs to be viewed as "the devoted mother."
Feels threatened by medical staff and is fearful of specialists.	Craves the attention and approval of medical staff; demands specialists.
Avoids contact with staff members.	Quickly becomes embroiled in unit/department happenings including the personal lives of staff members and other patients' families.
Typical victims of physical child abuse	**Victims of Munchausen syndrome by proxy**
Present with findings that are often specific, but the story is vague.	Present with findings that are often vague, but the story is specific.
Usually present with physical injuries or signs of neglect.	Usually present with an atypical illness.

criteria have been suggested,[30,40] but the American Academy of Pediatrics' Committee on Child Abuse and Neglect maintains that only 2 circumstances need be present in order to diagnose MSbP: (1) harm or potential harm to the child involving medical care, and (2) a caregiver who is causing the harm or potential harm to happen.[2]

Perpetrators and Providers: Partners in Crime

Several controversies cloud the diagnosis of MSbP. For example, does the term MSbP apply to the child or the perpetrator? Is MSbP a pediatric or a mental health disorder?[5] And who should make the diagnosis? A pediatrician or a psychiatrist? Regardless of these distinctions, MSbP is chiefly differentiated from other forms of child maltreatment by the active involvement of the medical profession in the production of morbidity; MSbP is abuse, and the medical system is critical to its genesis.[2,8]

In the much publicized case of Kathy Bush, a Florida woman accused of MSbP, her daughter underwent some 200 hospitalizations, 40 surgical procedures, experienced dozens of serious (and suspicious) infections, and suffered multiple poisonings. On the day of Ms Bush's arrest, the child was removed to an out-of-state hospital where she immediately improved and has been essentially totally physically well ever since.[31,41] How was it possible for dozens of altruistic and well-intentioned health care providers to be drawn into such a web of child torture?

Rosenberg[30] noted that, in many cases, as much morbidity is caused by medical staff as by perpetrators. In a meta-analysis of published cases, 75% of the morbidity occurred in hospitals and at the hands of the child's physician. Some children have undergone as many as 100 operations to treat nonexistent conditions,[31] including such invasive procedures as tracheostomy, feeding tube placement, insertion of a central catheter, pancreatectomy, orthopedic procedures, skin biopsy, laparotomy, endoscopy, and ear surgery.[14,25,26,28,29,42]

How can this happen? Valentine et al[22] describe MSbP as "a curious triad [that] develops among perpetrator, victim, and medical staff based upon abuse of the child and deception of the physician." Some MSbP mothers appear to have an uncanny ability as imposters, capable of simulating someone a health care provider will fall for, an ability akin to that of a psychopath.[31,43] Dedicated professionals are intellectually stimulated by challenging cases and may pursue unusual or rare diagnoses with intense interest, thus allotting even more time and attention to the child and the abuser.[8]

The "curious triad" between perpetrator, victim, and medical professional is strongly influenced by characteristics of the adults involved. All parents present somewhere on a continuum of medical neediness. This ranges from medical neglect of a child (at one end of the spectrum), to normal levels of worry or even hypervigilance. Parents, especially inexperienced ones, readily misinterpret or exaggerate normal behaviors with no ill intent, but at the extreme end of the neediness spectrum is illness fabrication.

Likewise health care professionals also fall along a spectrum of diagnostic thoroughness. At worst are those who are incompetent, followed by providers who do only the bare minimum, and then by those who are appropriately cautious. Some practitioners, however, are known for "going a little overboard," and (finally) there are those who are extremely hypervigilant. Unwitting medical collusion occurs because an MSbP parent will "doctor shop" until she finds a health care provider who is willing to meet her level of need. Our litigious society, laws related to the Emergency Medical Treatment and Active Labor Act, and the third-party payor system make it easy for MSbP parents to keep insisting that providers do more. In this manner, health professionals aid and abet the perpetrator by torturing the child with endless interventions. When further tests, drugs, procedures, surgeries, or specialists are denied, the MSbP abuser contrives to make the medical system appear as the bad guy for refusing to help her poor sick child and his selfless mother.

Monsters Among Us

Intuitively, one would assume that abuse would stop while the child was hospitalized, that fear of discovery would dissuade further harm. However, 70% of perpetrators who induce symptoms will continue to do so during hospitalization[16] because maintaining the child in the sick role is the only way to keep fulfilling the abuser's need. For example, in 2008 Amber Brewington was charged with attempted homicide for poisoning her infant son by repeatedly injecting salt water into his feeding tube (at least 5-6 times) while he was a patient in Tennessee and Pennsylvania

hospitals.[44] Covert, in-hospital video surveillance is one approach that has been used to distinguish fabricated events from actual health conditions. Placing hidden video cameras in patients' rooms is associated with serious legal, ethical, and moral issues, but in situations where this approach has been implemented, results have been nothing less than appalling.

In a British study, 39 children with a reported history of 1 or more apparent life-threatening events were admitted to the hospital and monitored with covert video surveillance (CVS). Videotapes captured episodes of serious injury or illness induced by a family caregiver in 33 of 39 cases. Abuse included suffocation, poisoning, strangulation, and fractures. The 39 children involved had a total of 41 siblings, 12 of whom had died. Cause of death in each case was listed as sudden infant death syndrome. When confronted with these data, 4 parents admitted suffocating 8 of the 12 dead children. Authors of this study concluded that CVS was essential to making the MSbP diagnosis.[45]

In a similar study conducted in the United States, CVS helped establish a diagnosis of MSbP in 23 of 41 patients monitored. CVS was deemed essential to the diagnosis in 13 cases and supported the diagnosis in 5. Importantly, CVS was able to exonerate the parents of 4 children by establishing an organic cause of illness. As in Great Britain, researchers concluded that CVS is an essential tool for MSbP diagnosis.[37] Nevertheless, despite glowing endorsements by the medical community, the practice of CVS has generated a hue and cry from the legal community, the media, and privacy rights activists.[16,24,46]

Interventional Priorities

Both the diagnosis and the cure for the victim of MSbP is complete separation from the perpetrator, a total "parentectomy." Doing so not only ensures the child's immediate safety but leads to dramatic reversal of symptoms as well, confirming the diagnosis. The American Academy of Pediatrics' Committee on Child Abuse and Neglect recommends that treatment occur in the least restrictive setting possible in order to minimize the child's separation trauma.[2] However, ensuring a child's future safety is equally important. Cases in which perpetrators have been informed of pending separations (or when parental visits have been permitted) have sometimes ended disastrously for the child. A coordinated, multidisciplinary approach to the MSbP patient and perpetrator is essential.[4,12]

Crucial to preventing ongoing episodes of abuse is involving child welfare agencies. Regardless of the type of maltreatment—sexual, physical, or psychological—our legal and moral obligation as health care providers is to report any suspicion of abuse.[1] Likewise, child protective services agencies are mandated to keep abused children safe regardless of whether the abuse occurs in the home or in the hospital. Nurses and other health care providers who act in good faith are immune to prosecution and potential libel charges.

Although their care is beyond the scope of critical care nurses, perpetrators will need psychiatric evaluation and care. A history of previous psychiatric treatment has been reported in 80% of perpetrators.[1] Of particular importance is the presence of other young children in the home. With the target child removed, perpetrators may turn their sights and unfulfilled needs on a victim's sibling.

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The Impact of MSbP on a Health Care Team

MSbP expert Herbert Schreier[31] has described the disorder as "a baffling condition that can wreak havoc not only on the body and mind of a child but also on the professionals who encounter it." Schreier and Libow[15] describe the complex relationship with the MSbP abuser as "a perverse sadomasochistic relationship with the pediatrician, the infant serving as an object in the service of controlling the physician."

This characterization of the perpetrator-physician relationship can easily be extended to other health care providers (such as critical care nurses) who often have even more prolonged contact with abusers and their victims. As nurses, we routinely aid perpetrators in their torture of the child[4] by administering drugs and performing tests and procedures.

MSbP abusers have often been characterized as charming individuals who are comfortable in the hospital setting and eager to form friendships with professional staff members. As parents, they outwardly appear to be devoted and attentive to their ill child, behaviors we admire.[16] However, perpetrators quickly master the art of dividing the care team. One camp will see an exceptionally devoted and dedicated woman who should be canonized and declared mother-of-the-year, while the other camp sees a conniving, manipulative, two-faced, cold-hearted, sociopathic liar. These intense reactions to the same individual can polarize staff members, compromising working relationships.[4] Although many MSbP mothers can be quite ingratiating, they can also lash out aggressively if they fear losing the spotlight, if they are threatened with exposure, or if they clash with caregivers unwilling to do their bidding.[31,36] When health care personnel realize they have been duped, they feel foolish and angry.[8] The complex psychological dynamics of the situation make consultation with mental health professionals essential.[15]

The physician most closely involved in the care of the child is often the one most taken in by the mother's account. Physicians have been known to defend a perpetrator even after referring the case to a specialist on the basis of their own suspicions. Physicians may angrily discharge consulting teams from the child's care when those suspicions are validated.[12,31] Nurses who suggest the possibility of MSbP may likewise come under fire from medical staff.[31]

Conclusion

MSbP, or pediatric condition falsification, is a serious form of child abuse associated with a high incidence of recidivism, morbidity, and mortality. The single most important intervention for critical care nurses is to simply consider a diagnosis of factitious illness in any unusual case. Follow standard abuse reporting protocols, observe suspect parents closely, and remember that perpetrators routinely play upon emotions to manipulate and coerce staff members in order to meet their own needs. The safety and well-being of the child must remain our paramount goals. For a truly harrowing and heartbreaking first-hand account of life as an MSbP victim, see "My Mother Caused My Illness" by Bryk and Siegle, in *Pediatrics*.[26] CCN

dotmore

To learn more about pediatric critical care, read "Medical End-of-Life Decisions: Experiences and Attitudes of Belgian Pediatric Intensive Care Nurses," by Inghelbrecht et al in the *American Journal of Critical Care,* 2009; 18:160-168. Available at **www.ajcconline.org**.

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None reported.

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CE Test

Test ID C106: Monsters in the Closet: Munchausen Syndrome by Proxy

Learning objectives 1. Understand that Munchausen syndrome by proxy (MSbP) is probably an underrecognized and underreported condition 2. Describe red flags for MSbP 3. Recognize that MSbP is child abuse

1. Which of the following is considered to be a primary gain for the Munchausen syndrome by proxy (MSbP) perpetrator?
a. Financial aid
b. Public housing
c. Escape from life responsibilities
d. Media attention

2. Which of the following do researchers consider to be an essential tool for MSbP diagnosis?
a. Covert video surveillance
b. A psychiatric evaluation
c. A focused physical assessment
d. Computed tomography

3. Which of the following is the cure for the MSbP victim?
a. Report the abuse to child welfare agencies
b. Complete separation from the perpetrator
c. Psychiatric care
d. Consult with mental health professionals

4. Which of the following is an example of moderate MSbP disease severity?
a. Claiming the child experienced apnea
b. Inducing seizures
c. Falsifying medical records
d. Inducing sepsis

5. Which of the following is a particularly common form of symptom induction in MSbP?
a. Laxative poisoning
b. Suffocation
c. Urine injection
d. Fecal matter application to wounds

6. Which of the following best describes the MSbP abuser?
a. Becomes aggressively hostile when thwarted
b. Exhibits a lower than average degree of medical savvy
c. Is uncomfortable in the medical setting
d. Avoids relationships with staff members

7. Which of the following best describes a victim of MSbP?
a. The child has a strong emotional bond with the father.
b. The child is older than 5 years at time of symptom onset.
c. The child is helped by standard treatments.
d. The child deteriorates whenever discharge is planned.

8. Which of the following relationships do most MSbP abusers have with the victim?
a. The victim's stepfather
b. The victim's mother's boyfriend
c. The victim's mother
d. The victim's father

9. Which of the following characteristics distinguishes the MSbP abuser from a typical physical child abuser?
a. The MSbP abuser avoids contact with staff members.
b. The MSbP abuser feels threatened by medical staff.
c. The MSbP abuser is reluctant to seek medical care.
d. The MSbP abuser demands specialists.

10. Which of the following characteristics distinguishes a victim of MSbP from a typical victim of physical child abuse?
a. An MSbP victim frequently presents with specific findings.
b. An MSbP victim usually presents with physical injuries.
c. An MSbP victim usually presents with signs of neglect.
d. An MSbP victim usually presents with an atypical illness.

Test answers: Mark only one box for your answer to each question. You may photocopy this form.

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
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❑c	❑c	❑c	❑c	❑c	❑c	❑c	❑c	❑c	❑c
❑d	❑d	❑d	❑d	❑d	❑d	❑d	❑d	❑d	❑d

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