Munchausen by Proxy and Factitious Disorder Imposed on Another

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Why do you need to know about Munchausen by Proxy? Answers here.

More than a decade ago, an American Professional Society on the Abuse of Children taskforce recommended professionals separate the concepts of child maltreatment and psychopathology when discussing, evaluating, or treating Munchausen by proxy (MBP).\(^1\) Although not a formal medical or psychiatric diagnosis, MBP refers to abusive illness falsification that is due to factitious disorder imposed on another (FDIA) in the abuser. FDIA is the DSM-5 psychiatric disorder that describes individuals who persistently falsify illness in another even when there is little or nothing tangible for them to gain from the behavior. It is a compulsive behavior associated with a high degree of denial, akin to that of substance abuse behavior or an eating disorder.

**Why do I need to know about MBP?**

Victims of MBP may suffer from fear, pain, and loss of normal attachment, and from delayed development, growth, social functioning, and/or academic progression.\(^2\)\(^-\)\(^4\) They may develop physical and psychiatric problems due to being persistently regarded as ill; from deprivation; from unneeded assessments, medications, procedures, or surgeries; and/or from iatrogenic complications.

Some clinicians believe that they can avoid legal action and conflict by simply believing or avoiding parents who regularly present them with false information. It is important to note that clinicians who failed to file a mandated report for suspected illness falsification have been civilly sued for medical negligence and failure to report suspected child abuse.\(^5\) Some states, such as Texas and California, also have penal codes outlining criminal punishment for failing to report suspected child abuse.

**It would be difficult to fool me**

Can you tell if you are being lied to by a parent/caregiver? Research has consistently found that conscious assessments of veracity are only slightly more accurate than chance.\(^6\) Published case reports suggest that any disorder can be successfully falsified. One describes a case of factitious cystic fibrosis that included a falsified history, altered sweat tests and stool fat analyses, and sputum samples stolen from cystic fibrosis patients.\(^7\) Another describes a patient with factitious chronic intestinal pseudo-obstruction who received a small-bowel transplant.\(^8\) Falsified mental health problems have included learning disorders, attention deficit disorder, autism spectrum disorder, and bipolar disorder.\(^9\)\(^,\)\(^10\)

**Warning signs: induction not required**

Many individuals confirmed to have engaged in illness falsification (typically female caregivers) have the ability to appear normal as parents/caregivers.\(^11\) Formal psychiatric interview and psychological testing may suggest that no psychopathology is present. Others may be dramatic, aggressive, manipulative, and/or obvious in their lies. Between 30% and 70% of those who falsify illness in children also falsify illness in themselves.\(^12\)\(^-\)\(^14\)

Medical, psychiatric, and/or developmental disorders can be falsified in a variety of ways. Table 1 lists warning signs of possible illness falsification. While child victims of suffocation, poisoning, or other forms of induction are at highest risk for death, symptom exaggeration or medical noncompliance in a child with a genuine medical disorder can be sufficient to place the child in lethal danger.\(^11\)

**Assessment**

Clinicians are required to report child abuse suspicions to authorities. As with physical or sexual abuse, the determination of whether abusive illness falsification has occurred is normally based on careful data analysis—it is rare to directly observe an abusive act. In the case of a suspicious fracture, for example, a skeletal survey may be performed along with a clinical interview. Because the core feature of illness falsification is deception, assessment requires evaluation of objective data and of collateral data.\(^10\)\(^,\)\(^15\) Table 2 lists some general assessment approaches for clinicians.
Medical record analysis can be more helpful than contacting past clinicians because clinical information recorded at the time of the health care visit is less subject to clinician recall bias and defensiveness. Chronologically summarizing each medical contact into a table reveals patterns of health care utilization and parent/caregiver behavior in a format that is easy to analyze. Each row describes a health care contact. Columns include date of contact, health care location, reported signs/symptoms as stated by caregiver, objective test results and observations of the health care provider, conclusions/diagnoses made along with the care plan, and other comments or observations.

Mistakes to avoid when conducting an analysis of the medical record include failing to identify who directly observed or reported the documented information, failing to review primary data (test results, rather than interpretation of test results), failing to determine whether diagnoses match objective data, failing to consider whether objective findings could have been falsified or induced, and failing to consider whether the medical record makes clinical sense.

**Psychiatric evaluation of suspected abuser**

A key feature of an individual with a factitious disorder is the impressive ability to successfully mislead clinicians, including mental health clinicians. With this in mind, a psychiatric interview of the suspected abuser can be helpful to rule out other forms of psychopathology that might account for the abusive behavior and to identify comorbid diagnoses that should be included in the treatment plan of the suspected abuser. Motivation cannot typically be assessed directly because of denial of having engaged in the behavior and/or poor insight. The diagnostic differential should minimally include the disorders listed in Table 3. Because of reporting of false personal history, collateral data collection is strongly recommended.

**Clinical management**

Illness falsification due to FDIA is unlikely to stop simply on exposure and confrontation. Although the abusive behaviors might temporarily stop, they normally resume over time without significant progress in psychotherapy. In fact, illness falsification can increase after confrontation in an attempt by the suspected abuser to prove that he or she is not to blame. While it is helpful to have one clinician serving as a gatekeeper for all health care, this safeguard is not sufficient to ensure safety in the home. Placement with the abuser is especially dangerous to the child in cases of illness induction, when caregivers can afford to pay cash for medical care, or when the parent-child dynamic is highly dysfunctional.

Clinicians caring for children with warning signs of or confirmed illness falsification provide a basic level of safety when they are conservative in prescribing practices and other treatment recommendations, as well as in their support for school accommodations. They take suspected parent reports of symptoms with a dose of skepticism and engage the other parent in the care of the child. Effective clinicians provide ongoing feedback to the suspected parent about problematic behavior they witness. They do not allow themselves to be pressured to provide unnecessary treatments or recommendations. They document clearly and with details, maintain professional boundaries with the family, and consult with colleagues and experts as needed.

Recommended interventions for the child maximize the child’s normal functioning (physical, social, academic, etc), support developmental milestones, and assist the child to develop a sense of self that is not based on medical problems. Some need permanent protection from the abuser. Common psychotherapy themes for victims include denial of abuse, anger, enmeshment, attachment, dominance versus self-efficacy in relationships, control over one’s body, sick-role behavior, iatrogenic PTSD, self-esteem, defining family relationships, and grief. Abusers who acknowledge illness falsification are more likely to benefit from psychotherapy. Treatment includes efforts to increase awareness and to reduce the risk of relapse. Indicators of successful treatment include the abuser admits to the abuse, including specific details; the abuser experiences an appropriate emotional response to the harm caused to the child; the abuser develops better coping skills; and the abuser demonstrates the ability to refrain from illness falsification over a significant period of time.
Table 3: Differential diagnosis for suspected abusers

Disclosures:
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