Munchausen Syndrome By Proxy

What is it?

The term 'Munchausen Syndrome', was coined by a British Physician, Richard Asher, in 1951 to describe individuals who manufacture sicknesses and put themselves through potentially harmful medical procedures (Karlin, 1995 as cited in Thomas, 2003). He named the syndrome after Baron von Munchausen, a soldier, born in 1720 who used to produce false tales of unbelievable travels and military feats.

Professor Roy Meadow adapted the term in 1977 to include Munchausen Syndrome by Proxy (MSBP). MSBP has been established as a form of child abuse (Sussman, Joan & Joseph, 1992, as cited in Yasamy, Parvaresh, Fekri, Gudarzi & Malekzadeh, n.d). Thomas (2003, p.174) asserts ' In this type of child abuse, the perpetrator is usually the parent and caregiver who intentionally falsifies information concerning their child's medical history or presenting signs or symptoms to meet his or her own self serving psychological needs.' According to Alexander, Smith & Stevenson (as cited in Yasamy et al, n.d), this usually results in the child experiencing frequent hospitalisations and unnecessary medical investigations, which are sometimes harmful.

In the DSM IV, Munchausen Syndrome (MS) is classified as a Factitious Disorder. MS refers to the most severe and chronic form of this disorder. It does not distinguish between MS and MSBP in the DSM-IV.

The Diagnostic Criteria for Factitious Disorder includes;

1) Intentional production or feigning of physical or psychological signs or symptoms.
2) The motivation for the behaviour is to assume the sick role.
3) External incentives for the behaviour (such as economic gain, improving physical well being) are absent (American Psychiatric Association, 1994 p.517).

Aetiology

MSBP is a very difficult disorder to detect. The guardian, who is often the mother of the child is so clever in deceiving the medical profession, that she often gains the support of medical practitioners, who view her as an extremely loving, dedicated and caring mother (Thomas, 2003). Being masters of deceit, the guardians make it often very difficult to track their child's true medical history, as they tend to visit different doctors and hospitals. Probably the most important aspect of this syndrome is the ability of the mother to fool and manipulate doctors and physicians.

The perpetrator, usually the mother of the child, often has psychological problems or a mental illness. Thomas (2003) asserts that researchers have found that 90% of the perpetrators are the biological mothers. According to Thomas (2003), 80% of the perpetrators have a history of mental illness and 80% were themselves victims of MSBP.

According to Schreier & Libow (as cited in Schrier & Libow, 1994), female perpetrators represent more than 98% of MBPS cases.

MSBP perpetrators are found in all socio-economic classes. Paulk's (2001, as cited in Thomas 2003) research found that 71% of the perpetrators had eating disorders, were married and had marital discord within their marriages. Furthermore, fathers were emotionally absent and 50% of the mothers had some form of health training (Thomas, 2003).

Research studies that have been conducted into the reasons for this abuse indicate that the mothers often suffered emotional abuse and neglect and usually felt unwanted as children (Paulk, 2001 as cited in Thomas, 2003). Furthermore, Thomas (2003, pp.175) asserts 'Many mothers claimed to hate their children because they were jealous of their children's happy childhoods because their own childhood had been so miserable.'

The victims are generally children between the ages of fifteen months and six years of age (Smith-Alnimer, & Papas-Kavalis, 2003). Dowdell & Foster (2001), assert that for many of the child victims, they are diagnosed with MSBP after one of their siblings has died as a result of causes attributed to MSBP. According to Alexander et al (as cited in Yasamy et al, n.d), approximately 10% of cases are fatal and more than 25% involve more than one child.

Incidence

Denny, Grant & Pinnock (2001) asserted that Mclure et al reported a combined annual incidence for the UK and Ireland of MSBP as at least 0.5/100 000 in one of the only prospective studies reported to date.

Typical symptoms of MSBP

- Bleeding from warfarin poisoning, phenolpthalein poisoning, exogenous blood exsanguination of child and use of coloured substances;
- Seizures;
- Poisoning with phenothiazines, salt and imipramine;
- Apnoea via carotid sinus pressure and suffocation;
- CNS depression via drugs (eg. insulin, chloral hydrate, barbiturates, aspirin, tricyclic antidepressants, hydrocarbons);
- Diarrhoea and vomiting secondary to ipecac, laxatives and salt administration;
- Fever via falsification of chart records or actual temperature;
- Rash from drug poisoning, scratching or skin painting;

The most common fabrications or modes of symptom inducement involve seizures, failure to thrive, vomiting and diarrhoea, asthma, allergies and infections.

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Warning signs that are suggestive of MSBP

- Illness is multisystemic, prolonged, or rare;
- Symptoms are inappropriate or incongruent;
- Patient has multiple allergies;
- Symptoms disappear when parent or guardian is absent;
- In children, one parent, usually the father is absent during hospitalisation;
- History of sudden infant death syndrome in siblings is noted;
- Parent overly attached to the patient;
- Patient has poor tolerance of treatment (eg. frequent vomiting, rash);
- General health of patient clashes with results of laboratory tests;
- Parent shows inordinate concern for feelings of the medical staff;
- Seizure activity is unresponsive to anticonvulsants and is witnessed only by the parent or guardian;
- A parent who appears to be unusually calm in the face of serious difficulties in his or her child's health;
- A family history of similar sibling illness or unexplained sibling illness or death.

(Mason, 2001)

Management and Treatment of MSBP

The management of MSBP cases has concentrated on diagnostic issues, subsequent confrontation of parents, and child protection issues (Meadow, 1985 as cited in Eminson & Postlethwaite, 2000).

The child's immediate safety is the first consideration. This would involve the collaboration of different professional groups in order to reduce the risk of further harm to the child. According to Jones and Bools, 1999 (as cited in Eminson & Postlethwaite, 2000), in most cases the child would be separated from the perpetrator while prognosis and risk are being assessed.

The treatment process has been described as involving three distinct phases. The first being the initial acknowledgment phase, followed by an improvement in parental sensitivity and effective parenting skills. The final resolution phase would focus on either providing alternative care for the child or care within the family (Jones, 1997 as cited in Eminson & Postlethwaite, 2000)

Eminson & Postlethwaite (2000, p.279 & 281) states that " the main risk considerations will be: the type of abuse, the extent of other forms of child maltreatment, the level of parental acknowledgment, the potential for co-operation in treatment and social casework; whether a focus for psychological treatment work emerges; and whether there is the prospect of finding other families/friends who might be supportive and assist in the management of the case and reduction of risk.

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It is paramount to conduct a thorough risk assessment in order to ascertain whether or not the child would be safe in having contact with the perpetrator and whether there is a likelihood of change occurring. For some children, having contact with the perpetrator is too dangerous so they would need to be placed in alternative care.

Where can I get further information about this disorder?

Various websites refer to this disorder with useful references. A number of journals including; Journal of Pediatric Nursing, Lancet, Child Maltreatment, Child Abuse & Neglect have articles about **Munchausen Syndrome By Proxy.**

Websites

Reference for further reading on Munchausen Syndrome by proxy

http://www.bratetreat.ofg/btpr/v4nl.html
http://www.bcpl.net/~agravels/amm/notes.htm
http://gateway1.ovid.com/ovidweb.cgi

References

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edn. American Psychiatric Association.

Denny, S.J., Grant, C.C., & Pinnock, R. (2001). Epidemiology of Munchausen syndrome by proxy in New Zealand. *Journal of Pediatrics and Child Health*. 37 (3), 240-243.

Dowdell, E.B., & Foster, K.L. (2000). Munchausen Syndrome by Proxy:Recognising a Form of Child Abuse. *Nursing Spectrum Online*. Retrieved November 6, 2003, from http://nsweb.nursingspectrum.com/ce/ce209.htm.

Jones, D.P.H., Byrne, G., & Newbould, C. (2000). Management, treatment and outcomes. In M. Eminson & Postlethwaite, R.J. (Eds.). *Munchausen Syndrome by Proxy Abuse: A Practical Approach* (pp. 276-294). Oxford: Butterworth-Heinemann.

Mason, J.D. (2001, May 1). Munchausen Syndrome by Proxy. *Emedicine,* Topic 830. Retrieved November 6th 2003, from http://www.emedicine.com/EMERG/topic830.htm.

Schreier, H.A., & Libow, J. A.(1994, December). Munchausen by proxy syndrome: A modern pediatric challenge. *The Journal of Pediatrics Online,* 125 (6), Retrieved on September 4, 2003, from http://www2.us.elsevierhealth.com/scripts/om.dll/serve.

Smith-Alnimer, M, & Papas-Kavalis, H. (2003). Child Abuse by a Different Name: How to recognise Munchausen syndrome by proxy. *American Journal of Nursing,* 103 (6), 56F-56J.

Thomas, K. (2003). Munchausen Syndrome By Proxy:Identification and Diagnosis. *Journal of Pediatric Nursing,* 18 (3), 174-180.

Yasamy, M.T, Parvaresh, N., Fekri, A.R., Gudarzi, S., & Malekzadeh, M. (n.d) *Successful Treatment of Mixed Munchausen Syndrome and Munchausen Syndrome by Proxy: A Case Report.* Retrieved September 16th 2003, from
http://pearl.sums.ac.ir/AIM/0141/yasami0141.html