*British Journal of Psychiatry* (1996), **169**, 268–275

***Review Article***

# Factitious Illness by Proxy
## Munchausen Syndrome by Proxy

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**Background.** Since 1977 a literature has grown describing examples of factitious illness by proxy (FIP).
**Method.** The literature in English was searched using MEDLINE and supplemented by a manual search. Extracted data focused on terminology of a spectrum of behaviours, clinical features and psychopathology of perpetrators.
**Results.** There has been difficulty with the use of terminology and classification of psychiatric disorders.
**Conclusions.** The spectrum of FIP is wide. Suggestions are made for the use of terminology and classification when FIP is identified.

In 1977 Meadow, a paediatrician, published "Munchausen Syndrome by Proxy: the hinterland of child abuse", in which he described two examples of the fabrication of illness in a child by the mother. Meadow drew attention to parallels with the adult Munchausen syndrome and hence referred to this behaviour as "a sort of Munchausen Syndrome by Proxy". In further reports a great variety of fabrications were described. In addition to the obvious physical dangers, including as a result of unnecessary medical intervention, later reports drew attention to the risk of serious psychological harm to the children involved (McGuire & Feldman, 1989; Bools *et al*, 1992, 1993; Schreier & Libow, 1993).

The creation of a name for this variety of illness fabrication served as a focus for the publication of further reports of similar behaviours. In 1987 a reviewer considered 116 examples of MSP that had been reported in the literature and described an additional three examples from the same family (Rosenberg, 1987). While a classical example of MSP/FIP presents little difficulty in the decision to use the term, there are difficulties at the edges of the spectrum.

The term Munchausen syndrome by proxy (MSP) is now being used to refer to a complex set of phenomena, apparently somewhat heterogeneous in nature. Confusion about terminology has arisen probably because of the heterogeneity and complexity, perhaps, combined with the involvement of the disciplines of physical medicine, psychiatry, social work and the legal system. In particular, there has been confusion between the proper use of the term MSP to describe a situation, and improper use as a (pseudo) psychiatric diagnosis applicable to the fabricator. One of the main purposes of this review is to present terminology that has been used for a spectrum of situations and to offer suggestions for appropriate nomenclature. The issue of psychiatric diagnosis relating to fabricators is looked at later as one of three elements necessary for detailed classification.

## Terminology and the spectrum of behaviours

### Other terminology

Doctors, mainly paediatricians, have given various names to a range of inappropriate consulting (health care seeking) behaviours by parents for their children. Woollcott *et al* (1982) used the phrase "doctor shopping with the child as proxy patient", Fialkov (1984) the "peregrinating paediatric patient", and Waring (1992) the "persistent parent".

Waring (1992) discussed four examples of paediatric presentations representing a spectrum of "persistent parents" and consulting situations, one of which, the most extreme, he considered to be MSP. Waring considered whether the parental persistence in the diagnosis and treatment of the child's illness was congruent with a physician's assessment of the child's morbidity. A "persistence algorithm" of pathways leading to a variety of second diagnoses is presented. In the algorithm, when falsification is present the second diagnoses include extreme illness exaggeration, malingering and MSP; if falsification is not present the second diagnoses include symptom overemphasis and a "vulnerable child syndrome" (Green & Solnit, 1964) (see below).



https://doi.org/10.1192/bjp.169.3.268 Published online by Cambridge University Press

In a paper looking at a spectrum of situations Eminson & Postlethwaite (1992) refer to what they have called "true Munchausen syndrome by proxy" when parents have actively procured symptoms. They suggest referring to the whole spectrum – including symptom procurement ('true MSP'), verbally invented histories and extreme exaggeration – as "factitious illness". Taylor (1992) put forward the term "outlandish factitious disorder" for a situation which he considers to straddle the two categories of MSP and hysteria, and may contain some elements of both.

### Forms (subtypes) of MSP/FIP?

The existence of three forms of MSP: "help seekers", "active inducers" and the "doctor addict", had been suggested by Libow & Schreier (1986). The authors considered that the latter two "are most validly identified as the Munchausen syndrome by proxy". Later these workers considered that the distinction between the active inducers and doctor addicts was less clear than had been originally suggested (Schreier & Libow, 1993).

### Choice of terminology

Schreier & Libow (1993) prefer the term "Munchausen by Proxy Syndrome" (MbPS) rather than Munchausen syndrome by proxy (MSP) to distinguish it more clearly from the adult Munchausen syndrome. Fisher & Mitchell (1992) in their review article prefer the non-eponymous term "Factitious Illness by Proxy" (FIP), as it is "descriptive, without aetiological assumptions". In this review the terms MSP, MbPS and FIP are used interchangeably.

## Clinical features

### Descriptive categories

For the purpose of this review the varieties of FIP are considered in three main groups by method of fabrication and in three special situations (Table 1). In groups 1 and 2 the child is not physically harmed directly by the fabricator. It is suggested that presentations in group 3 may be referred to as "illness induction syndromes". The groups are descriptive and the accounts given illustrate that mixed forms of fabrication are common.

*Categories by method of fabrication*

*1a. Verbal fabrications of seizures and apnoea.* Meadow (1991) considers that epilepsy is the most common illness invented by mothers for their children. Meadow includes under this statement seizures fabricated by all means, including by smothering and poisoning.

Table 1
Varieties of FIP by method of fabrication (1–3) and in special situations (4–6)

| | |
|---|---|
| 1a | Verbal fabrication of seizures or apnoea |
| 1b | Other verbal fabrications |
| 2 | Verbal fabrications plus the falsification of specimens or charts |
| 3a | Fabrication associated with poisoning to produce signs |
| 3b | Fabrication associated with smothering to produce signs |
| 3c | The production of signs by other means |
| 3d | Withholding nutrients and medicines to produce signs |
| 4 | Fabrication of psychiatric disorder |
| 5 | Factitious disorder in pregnancy |
| 6 | Fabrication in the presence of genuine physical illness |

*1b. Other verbal fabrications.* The most reported varieties of fabrication have been of allergies (18 examples), haematuria (6 examples), breathing problems (5 examples), bleeding (5 examples) and vomiting (4). Less common fabrications have included hearing impairment, spina bifida, and osteogenesis imperfecta.

*2. Falsification of specimens and charts.* There are a number of reports of fabrications of chronic illnesses that required considerable knowledge and persistence by the mother. In the report by Orenstein & Wasserman (1986) the mother of a 5-year-old boy falsified a history of cystic fibrosis. The mother altered sweat tests and stool fat analyses, and stole sputum from patients with the genuine illness.

*3a. Poisoning.* Fifty-four papers report 91 examples of poisoning believed to be non-accidental. From the information given in the papers it appears that 66 examples involved illness fabrication, although others may have done so. The most common group of drugs used were laxatives (24 examples), and tranquillisers (19 examples). Other substances used were non-opiate analgesics, drugs for diabetes, common salt, antidepressants, opiates and non-medicinal poisons. Ten children had been poisoned with more than one substance. The most common presentations, as may be deduced from the effects of the above substances, were diarrhoea and alterations in the state of consciousness.

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*3b. Smothering* Fifteen papers described smothering as part of the fabrication of illness. Samuels *et al* (1992) used the term "imposed upper airway obstruction" for their report of 14 examples of smothering. In all 14 examples the children presented with recurrent and severe cyanotic episodes.

In the report by Meadow (1990) of 27 examples of suffocation the certainty, or near certainty, of suffocation was based on reliable observation or recording of the suffocation, maternal confession, or successful prosecution in a criminal court. Meadow presented a comparison of selected features of the 27 suffocated children and of children considered to have died from "sudden infant death syndrome" (SIDS) who had been reported in the literature. There were major differences between the two groups of families in the incidence of previous apnoea, previous unexplained disorder, and a deceased sibling. In addition SIDS occurred less frequently after the age of 6 months.

*3c. Production of symptoms by other direct means.* Of the 22 examples reported in the literature 11 involved the introduction of infectious material directly into the child, via an intravenous line in eight cases.

*3d. Production of symptoms by withholding nutrients and medicines.* General dietary restriction and specific restriction such as of iron containing foods have been reported. Cantwell (1984) reported two children who had genuine diabetes and in both examples the mother had mismanaged the diabetes seemingly in a deliberate manner to cause illness. Important elements of the difficulties presented by one of the mothers included failing to keep appointments, withholding insulin to the point of endangering the child's life and lying about the family physician caring for the child. Cantwell suggested that some aspects of MSP were present in both these cases because the mismanagement of the diabetes was not as a result of a lack of understanding of the condition and was not pure neglect.

*Categories in special situations*

*4. Fabrication of psychiatric disorder.* A mother insisted that her 10-year-old son was psychotic with a history of hallucinations, bizarre behaviour and allergies (Fisher *et al*, 1993). For the first four years of life the boy was fed a strict vegetarian diet because of alleged multiple allergies. Throughout various consultations with doctors the mother always described the boy's symptoms and eventually a diagnosis of paranoid schizophrenia was made and medication prescribed to the boy. Later the boy was presented at an emergency room. When admitted to an in-patient psychiatric unit, the boy's mental state was entirely normal. Medications were discontinued and over six weeks no evidence of psychosis was observed. The boy was discharged home with child protection supervision and the mother engaged in intensive psychotherapy. The case is unusual in the literature in that (psychotherapeutic) psychiatric treatment was accepted and resulted in substantial positive changes.

*5. Factitious disorders in pregnancy.* Jureidini (1993) presents five cases of factitious disorders in pregnancy which progressed to MSP after the birth. These included probable feigned premature labour, factitious bleeding and bruised abdomen consistent with foetal abuse. Jureidini concludes that obstetric complications are common in the histories of MSP, and pregnancy and childbirth can facilitate the transition from self-focused hostile behaviour of Munchausen syndrome to the externally focused MSP.

This interesting formulation, however, may simplify a more complex phenomenon when one considers the postulated abnormal psychological boundary between mother and the child after delivery and into childhood (see below for a discussion of the process of differentiation). An interesting question is – to what degree is the foetus perceived by the mother as being separate from herself?

*6. Fabrication in the presence of genuine physical illness.* Masterson *et al* (1988) discuss the situation in which a child has a genuine medical disorder and there is "extreme parental exaggeration of disease severity" and suggest that it constitutes a variant of MSP. Two cases of mild asthma are given as examples.

In the paper "Parent salvage and sabotage" Krener & Adelman (1988) consider a range of behaviours displayed by parents who have a chronically sick child. They identify five features that they consider are typical ways in which the parents behave in order to adjust to their child's chronic illness in order "to salvage development against the corrosion of chronic illness'. The features draw attention to the need for particular

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care when considering the possibility of fabrication in such chronically stressful situations.

## Psychopathology of mothers

### Observed behaviour of the mother with the child

Many authors report a picture of the fabricating mother rarely leaving the side of the child on the paediatric ward (Meadow, 1982; Nicol & Eccles, 1985; Southall *et al*, 1987). Rosen *et al* (1986) reported that an apparent strong loving bond between mother and baby had been noted over a long period when the mother was intermittently smothering the baby while on the ward. The picture of a caring mother who is close to her child, albeit unusually close, may be considered the "classical', behaviour of the mother in MSP. Sometimes, however, the mother had not remained on the ward with the child and on occasions staff had voiced concerns about the quality of care given to the child or the relationship between mother and child (Nicol & Eccles, 1985).

A number of the mothers had been noted to be surprisingly calm and trusting of the doctors despite the seriousness of their child's condition (Southall *et al*, 1987). Other mothers, however, were highly critical of the doctors (Woollcott *et al*, 1982; Warner & Hathaway, 1984). Masterson *et al* (1988) describe how an initial good rapport between doctor and mother changed into conflict with staff as organic causes for the illness were eliminated.

### The relationship with the child

Accompanying the frequent observation that, in 'classical MSP', the mother remains unusually close (geographically) to her child, is the notion that the mother is psychologically over-involved with, and over-dependent on, her child. Waller (1983) referred to this as "the rather startling tie that exists between parent and child".

Possible origins of the over-involvement may be related to external factors as described in the "vulnerable child syndrome" (Green & Solnit, 1964; Waller, 1983), and/or to long-term psychiatric difficulties of the mother. Green & Solnit discuss the situation in which parent (s) may perceive their child as being especially 'vulnerable', leading to altered perceptions of the state of health of the child and overprotective behaviour with separation difficulties. In consequence the child may have difficulties in maturing and in relation to school attendance and achievements.

The psychological mechanism of projective identification may be a helpful concept in understanding the over-involvement (Rogers *et al*, 1976; Nicol & Eccles, 1985). When a mother already suffering from a somatising disorder herself also has a disturbed psychological boundary with her child it is possible to conceive MSP, at least in part, as a "spill over" phenomenon of the mother's own somatising, as suggested by Meadow (1982). Warner & Hathaway (1984) writing about factitious allergy affecting 17 children noted that five (of the 11) mothers were on diets themselves without any obvious justification. A mother with an eating disorder poisoned her child with ipecacuanha, producing diarrhoea and failure to thrive (Feldman *et al*, 1989). The mother described by Jones (1983) produced skin lesions (dermatitis artefacta) in herself and her child.

The desire of the mother to see the child as being ill may be strong, with the presence of overvalued ideas. A mother who carried out a sophisticated fabrication of cystic fibrosis in her child was seen by a psychiatrist who concluded that "the mother seems to be obsessed with a diagnosis being made on her son and that that diagnosis be cystic fibrosis. She appears to be obsessed to the point that she would fabricate information with the irrational belief that her son would have a better chance of being treated and cured should the diagnosis, even an inappropriate one, be made" (Orenstein & Wasserman, 1986). The mother described by Pickford *et al* (1988) who had fabricated a series of illnesses demonstrated many overvalued ideas about her own and her children's bodies.

The possibility should be considered that a mother may wish to have her (well) child admitted to hospital for more straightforward reasons. This may be, for example, to help the mother cope without admitting that she was experiencing difficulties with the child. Alternatively fabricating illness could result in financial gain. In such situations an appropriate description term could be "malingering by proxy".

### General psychopathology

In a study of the psychopathology of 43 fabricating mothers, 19 of whom were interviewed (Bools *et al*, 1994) it was not easy, in retrospect and after referring to original medical case notes, to give a precise diagnosis to many of the psychiatric disorders discovered, so the term "somatising disorder" was used when the diagnosis may have been either a somatoform disorder or a factitious disorder (American Psychiatric Association, 1987).

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It was thought that the most probable diagnosis, at some time in their life, for 34 of the mothers had been "Factitious disorder with physical symptoms". There have been very many reports of "somatising disorders" in fabricating mothers.

It is of interest that, given the incidence of somatising disorders, a number of fabricating mothers had some level of training or experience in caring professions, mainly nursing (Meadow, 1982; Rosenberg, 1987). Others noted false claims that training had been completed.

In the study by Bools *et al* (1994) 26 of the 47 mothers had a history of self-harm and 10 of substance misuse. A history of self-harm by drug overdose has been reported by other authors (Palmer & Yoshimura, 1984). In addition, eight of the 13 mothers reported by Samuels *et al* (1992) had a history of self-harm, six by overdose. Alcohol dependence has been reported (Black, 1981) and the mother reported by Dershewitz *et al* (1976) suffered from both alcohol and heroin addiction.

A number of fabricating mothers have been reported to suffer from eating disorders. The mother reported by Feldman *et al* (1989) expressed the wish that her children should not become fat and gave them ipecacuanha to cause failure to thrive. The mother suffered from a serious eating disorder herself. Samuels *et al* (1992) noted that 10 of the mothers had suffered from an eating disorder; five from anorexia with weight loss, and five had been grossly overweight.

There have been very few examples of FIP associated with psychotic illness in the mother. One of the mothers described by Warner & Hathaway (1984), who treated her daughter as if she had very serious allergies, eventually had a "nervous breakdown" which was diagnosed as schizophrenia. One of the mothers described by Woollcott *et al* (1982) had a previous diagnosis of schizophrenia combined with multiple somatisations, although it is not clear whether the mother was actively ill with schizophrenia at the time of the fabrications. The mother described by Stone (1989) had received a diagnosis of chronic paranoid schizophrenia. Roger *et al* (1976) described a mother who had a severe depressive illness with retardation and depersonalisation. The mother reported by Hosch (1987) suffered from "severe depression". A number of workers have reported that the mothers suffered from varieties of depression (McGuire & Feldman, 1989), depression with character disorder (Watson *et al*, 1979), or depression with personality disorder (Fialkov, 1984).

In the study by Bools *et al* (1994) a number of the mothers had histories of antisocial behaviour; there were four convictions for theft, one for fraud, and three for arson. Another mother had been strongly suspected of arson while attending a psychiatric hospital. Other authors have noted antisocial behaviour. Alexander *et al* (1990), noted that there had been four fires in the home of a mother who poisoned her child with arsenic, strongly suggesting arson. The mother reported by Epstein *et al* (1987) who worked as a nurses aid had been dismissed for stealing medication from patients on a number of occasions. The mother reported by Jones *et al* (1986) robbed the person she was staying with. One of the mothers described by Samuels *et al* (1992), when she was 17-years-old and together with her sister, had abducted a baby.

### Personality disorder

A diagnosis of "personality disorder" was made for all 14 of the mothers described by Samuels *et al* (1992), although categories were not specified. In a study of 19 mothers (Bools *et al*, 1994) histrionic and borderline features were the most common and were the predominant personality disorder for eight and five mothers, respectively. This is in broad agreement with many individual case reports; however, a number of the mothers met the criteria for a number of co-existing personality disorders.

## Classification

### ICD and DSM classification

The fact that there is uncertainty regarding use of the term FIP (or MSP) is reflected by the present situation regarding classification in both DSM–IV (American Psychiatric Association, 1994) and ICD–10 (World Health Organization, 1992). In Appendix B of DSM–IV, titled "Criteria sets and axes provided for further study" there are "research criteria" for "Factitious Disorder by Proxy". In ICD–10 one is referred to a separate volume in the section titled "Injury, poisoning and certain other consequences of external causes" and MSP would be classified under "other maltreatment syndromes" (T74.8), thus making it clear that FIP is not a psychiatric diagnosis.

### When to use the term FIP?

As can be seen from the above account the range of presentations of the FIP spectrum is broad. In addition, there are a number of situations that are closely related. In order to decide if the descriptive

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label FIP is appropriate, it is suggested that a two stage procedure is adopted (see Appendix). In the first stage two questions are asked and in the second a number of dimensions considered. In state one, input from an expert in physical medicine is required to decide if fabrication has occurred. In stage two the events (a) are separated from aspects of the fabricator (b) at the time of presentation.

All the five key elements of stage two are required to use the term FIP. Having decided that the FIP label is appropriate then the assessment may proceed in order to address the other two areas described below.

### Suggested overall classification

It is my recommendation that for completeness FIP requires classification in three ways:

(a) The behaviour of the perpetrator, i.e. is this fabrication (FIP)? – with a descriptive classification of the type of fabrication.
(b) The category of child abuse – determined by existing national and local guidelines and procedures i.e. physical abuse or emotional abuse.
(c) Any psychiatric diagnosis applicable to the mother – according to ICD–10 or DSM–IV – and additional formulation of putative psychological processes.

It is suggested that confusion has arisen as a result of the temptation to merge all three of these dimensions with each other.

### Limitations of the review

Most of the examples of FIP reviewed here are reports of single cases and often the results of detailed psychiatric assessment had not been published or not been completed. There is therefore a relative lack of information about mental states and how these might change, especially in response to psychiatric treatments as part of an overall management strategy, and in relation to the potential for successful resolution of child protection issues. In addition, there are few reports of detailed family assessments, which is important because treatments will usually need to include family as well as individual therapies. It is possible that the examples of FIP reported in the literature are biased towards the more physically harmful end of the spectrum.

## Conclusions

In this review I have attempted to present an overview of a literature from a wide range of sources while maintaining a focus for the psychiatrist of the core issue which is the psychiatric assessment of the perpetrator – as an individual, in relation to the child, and in the family system. Psychiatric assessment will address the possibilities for treatment of the perpetrator combined with the potential future risk to the child.

### Clinical implications

- Although FIP is not common, it is important because of the potential physical and/or psychological harm that may result for child victims.
- Psychiatric assessment of fabricators will usually be complicated by total denial and psychopathology that may be well concealed.
- Assessment of the fabricator and child will almost always take place within a child protection framework.

### Limitations

- Most published reports of FIP have been of single examples.
- Published reports are probably biased towards the more extreme examples of FIP.
- There are few reports of detailed psychiatric assessments at the time of the fabrications followed by psychiatric treatment.

## Appendix

### Stage One – Questions

Question 1:
Is the consultation with the doctor (health care seeking) inappropriate given the physical state (caused by natural processes) of the child? If so consider question 2.

Question 2:
Is it possible that there is **mild misperception, exaggeration** or **over-emphasis** of physical changes related to overt **anxiety**, or is there **malingering**? (There is inevitably a grey area concerning the degree of misperception, exaggeration and over-emphasis.) If so consider alternative descriptive terms. If not examine the dimensions in stage two.

### Stage Two – Dimensions

Consider the dimensions of MSP recognised by clinicians that are present to a greater or lesser degree. These are presented under two headings:

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*a) What is done*

1 The impression (or actuality) of illness in a child is created (fabricated) by a parent or someone in *loco parentis* (by a range of methods from verbal fabrication to illness induction).

2 The child is usually presented for medical assessment (often persistently).

*b) Aspects of the fabricator at the time of presentation*

3 The fabricator denies the fabrication of the impression of illness.

4 There is a strong motivation to get the child in to the sick role because of varying degrees of
(i) a desire to receive medical attention (by proxy)
(ii) (mis)belief that the child is suffering from an illness.

5 The fabricator is unaware (or insensitive) to the possible harm being caused to the child by the fabrication.

## Acknowledgement

The clinical study reported in the three papers referred to in this review article was carried out together with Dr Brenda Neale PhD (Sociology) under the guidance of Professor Roy Meadow in the Department of Paediatrics and Child Health, University of Leeds, between 1986–1990. Julie Peat started our computer data base of references. A grant from the Yorkshire Regional Health Authority supported the study. Dr David Jones of The Park Hospital, Oxford, made helpful comments upon a draft of the paper and provided substantial encouragement during revision.

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*(First received 12 June 1995, final revision 17 April 1996, accepted 19 April 1996)*

https://doi.org/10.1192/bjp.169.3.268 Published online by Cambridge University Press