The Phenomena of Phantom Illness: A Discussion of Munchausen Syndrome by Proxy

by Devon Rocha

Abstract

Munchausen syndrome by proxy refers to a pattern of behavior in which a caregiver either makes his or her child sick or lies about symptoms the child is experiencing in order to present the child to physicians. Unnecessary medical tests and procedures are then undertaken in order to determine the cause of the illness. This becomes a cycle that sometimes results in the death of the child victim. Debates exist over whether Munchausen syndrome is a diagnosable mental health disorder of the perpetrator or if it should signify a type of child abuse that is being perpetrated. There is also substantial debate on the appropriateness of the term "Munchausen syndrome by proxy." These discussions are informative, but provide limited guidance to social work, child welfare, and medical professionals as to how to recognize that this pattern of behavior may put a child in danger. This article argues for the inclusion of Munchausen syndrome by proxy in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders as a diagnosis under the factitious disorder category. This inclusion would stimulate research into uncovering a concrete etiology, as well as the development of treatment approaches. Some of the current treatment ideas for recognizing and dealing with these cases are explored.

Introduction

Munchausen syndrome by proxy (MSBP) is a controversial topic, but one of which all social workers, child welfare professionals, and mental health practitioners should be aware. Much of the literature about MSBP attempts to solidify its definition. There is an ongoing debate by the social work, medical, legal, and law enforcement professions about what the term should encompass. Questions have surfaced as to whether Munchausen syndrome by proxy should be characterized as a psychiatric diagnosis or as a form of child abuse. Tied in with this discussion is a debate about what this phenomena should be called, as "Munchausen syndrome by proxy" is not a universally accepted term. It is the purpose of this article to bring out the major points in each of these debates, and to offer a central, defining view of the topic. Statistical information about known cases is cited to present a more complete picture of the dangers of MSBP. Some theoretical considerations are then explored in an effort to generate views on how to deal with cases involving MSBP in the most appropriate and therapeutic manner.

Munchausen Syndrome by Proxy Defined

"Munchausen syndrome by proxy" refers to a pattern of behaviors in which a parent fabricates an illness in his or her child, either by lying about symptoms the child is experiencing or physically inducing the symptoms. The parent repeatedly presents the child to doctors, who in turn attempt to find the source of the child's "illness." Some speculations on why people would do this include the need to be the sick person by proxy, the desire to attract a spouse's attention, or the need to be in the spotlight. In MSBP, the child is harmed both by the parent, who manipulates the child's health to make it appear as if the child were sick, and by the doctor(s), who perform often invasive and painful procedures to determine the nature of the illness.

MSBP is an elusive cause of abuse to children because it is difficult to spot, at least in part because it is difficult for people to suspect parents of child abuse when they present as vigilant and knowledgeable about their child's health. It is also difficult to prove, and therefore, it may not get reported, investigated, or substantiated. Chiczewski and Kelly (2003) point out that the Illinois Department of Children and Family Services (DCFS) receives very few allegations of MSBP because most suspected cases are not reported to (or accepted by) the Illinois Child Abuse Hotline due to insufficient evidence. Harm to victims can carry on for years if the doctors are not suspicious or if they do not report their suspicions to the authorities, sometimes culminating in the death of the child.

MSBP is included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2000) as a condition under consideration for inclusion in a future edition of the DSM. It is grouped under the factitious disorder umbrella, wherein a person feigns illness in him- or herself. The four features, as listed for factitious disorder by proxy

in Appendix B, Criteria Sets and Axes Provided for Further Study in DSM IV-TR, are:

A. Intentional production of symptoms in another person who is under the individual's care;
B. The motivation for the perpetrator is to assume the sick role by proxy;
C. Lack of external incentives;
D. An inability to account for the behavior by another mental disorder. (p. 783)

As Rogers (2000) points out, this definition is open to more than the parent-child by proxy fabrication. This is important because it opens up the diagnosis to any person who might manipulate someone's health in this manner. For example, a person with this disorder could act similarly with an ailing parent or a person with a disability in their care (Meadow, 1995). The overarching pattern seems to be the manipulation of a weaker person in hopes of manipulating a more powerful person to satisfy pathological needs (Schreier, 2002a).

If the DSM were to include this as a full-fledged diagnosis, it might make sense to expand some of the criteria. The motivation of the perpetrator, instead of just to be sick by proxy, could possibly be opened up to include large-scale attention-seeking (Meadow, 1995). For example, when one woman who was eventually convicted of MSBP abuse became bogged down with hospital bills that insurance would not cover, she actually lobbied for healthcare reform, and ended up on a local news station with Hillary Clinton (Schreier, 2002a). Another DSM-IV-TR criterion that could be expanded is the fourth, "an inability to account for the behavior by another mental disorder." It seems possible that a contributing factor to MSBP in some people might be a personality disorder, such as Dependent Personality Disorder or Paranoid Personality Disorder, but the presence of another mental illness should not preclude an MSBP diagnosis if the defined patterns of behaviors exist. Donald and Jureidini (1996) stress the importance of including the medical professions' involvement in the abuse that occurs. A criterion to account for this could be simply, "Repetitive presentation of fabricated symptoms to medical personnel."

Data and Prevalence

Numerous case studies featuring MSBP have been published. Sheridan (2003) conducted a meta-analysis of 450 cases covered in 154 articles and generated statistics regarding MSBP. Most significantly, she found that 76.5% of the perpetrators were the biological mothers of the victims, and most had training in a health-related field. Victims were 52% male and 48% female. Most victims were 4 years of age or younger. Death of the victims occurred in 6% of the cases, 25% of the victims' siblings were known to be dead, and 61% of the siblings had illnesses similar to those of the current victims. Nearly one quarter of the perpetrators were described as having another psychiatric disorder, most often depression or a personality disorder. In 57% of cases, the perpetrators actively produced the symptoms, most often via suffocation, giving drugs to the victim, or poisoning. The most commonly reported medical problems of the victims of MSBP were apnea, anorexia, diarrhea, and seizures.

Prevalence rates are difficult to ascertain because the degree of awareness of MSBP among medical professionals is unknown. It could be that doctors are aware of the potential reality of MSBP, but are just not seeing it in their clients, or it could be that the doctors are simply unaware of the possibility that MSBP exists. As Eminson and Jureidini (2003) point out, MSBP can actually thrive in modern medical practice because contemporary medicine is investigation-oriented and also extremely litigious. Thus, there might be a tendency to over-test patients to guard against possible malpractice litigation due to not having run all diagnostic tests, and possibly missing the detection of something. Additionally, doctors (in hospital settings especially) are trained to investigate the origin of symptoms through various tests and procedures, and not to take social histories. Donald and Jureidini (1996), in analyzing the physicians' roles in cases of MSBP, note that incomplete or poor history taking is "central to its etiology."

Despite many case studies and detailed statistics regarding this phenomenon, there are some who attempt to refute the existence of MSBP. For example, Allison and Roberts (1998) liken MSBP to the social construction of witchcraft and then later, hysteria, as conditions afflicting women. An organization called Mothers Against Munchausen Syndrome by Proxy Allegations (M.A.M.A.) describes MSBP as a convenient way for doctors to avoid malpractice lawsuits or "rid themselves of a troublesome mom when unable to diagnose a child's condition" (www.msbp.com, para. 3). However, these analogies and explanations

are arguably a little too simplistic to account for the numerous MSBP cases found around the world. It may be that they feed off the lack of consensus regarding the classification of MSBP.

The Name Game

There are many terms used in the literature to describe this pathological phenomenon. These include "Munchausen syndrome by proxy," "Munchausen by proxy syndrome," "Factitious illness by proxy," and "Factitious disorder by proxy." One of the reasons this debate over semantics persists is because of the disagreement on how to classify it. While all are very similar, the fact that there is not consensus on what to call this condition becomes a weapon in the argument made by those who do not believe it actually exists. Additionally, some argue that MSBP and its derived names should be dropped altogether and, instead, a qualifier should be added to the child's presenting condition to designate it as fabricated.

The phrase "Munchausen syndrome by proxy" was first used by Roy Meadow because it seemed to be an offshoot of the preexisting condition known as Munchausen syndrome, in which a person feigns illness in him or herself (Bools, 1996). The 'by proxy' designation was added to signify that the person used someone else to feign the illness. "Munchausen by proxy syndrome" came into favor because the term differentiated it from Munchausen syndrome. As stated previously, MSBP is included in the research section of the DSM IV-TR as factitious disorder by proxy. Fisher and Mitchell (1995) see this as the DSM following a trend against the use of eponyms. Rogers (2004) believes that 'feigning disorder by proxy' is an appropriate diagnostic label, and could be sub-categorized in the DSM in a manner similar to the way in which factitious disorder is categorized with psychological signs and symptoms by proxy and medical signs by proxy. Fisher and Mitchell (1995) are proponents of eliminating the label altogether, and simply diagnosing the child with a 'factitious' or 'fabricated' qualifier.

"Munchausen syndrome by proxy," while possibly the most used, is probably not the most appropriate terminology. This is especially so given that there is no evidence that its namesake, Baron von Munchausen, known for his tall tales and adventurous stories, ever sought unnecessary medical treatment or even tried to deceive people (Zide & Gray, 2001). Since the DSM has already preliminarily included it as factitious disorder by proxy, this would seem to be an appropriate label. This is truly an interdisciplinary issue, affecting medical, social work, psychiatric, and legal professions that warrants more research and attention than semantic debates. Indeed, the focus of attention needs to shift to understanding how to protect the child victims and how to help them with the traumatic effects of MSBP. The first step in helping victims is learning to recognize when children are being abused by their parents in the disguise of medical care.

A Psychiatric Condition

There is much debate surrounding the classification of Munchausen syndrome by proxy. Should it be classified as a psychiatric diagnosis, or should it be considered a form of child abuse? To think of this solely as a form of child abuse would be to discount the unique manner in which the perpetrators use the medical profession to carry out at least some of the abuse. Donald and Jureidini (1996) cite three ways that MSBP has been regarded as different from child abuse. First, MSBP seems to be symptomatic of some "specific psychiatric disturbance in the perpetrator" (para. 3). The fact that this syndrome is seen around the world makes it a cross-cultural phenomena, and would seem to hint at some sort of common etiology. This type of psychopathology could be the need to be the sick person by proxy, or it could point to a pathological attention-seeking fixation. Neither phenomenon is associated with the common understanding of child abuse. Higher reported mortality rates and the observation that MSBP abuse seems to be premeditated, rather than motivated by frustration or rage toward the child, are also cited by Donald and Jureidini as characteristics of the condition that differentiates it from classic child abuse. Lastly, consistent with the point made above, the authors weigh heavily the involvement of the medical profession as a differentiating factor.

There is an advantage to formally naming MSBP as a psychiatric condition. Most importantly, it would stimulate the mental health profession in devising treatment approaches for these perpetrators and their victims. Currently, a preponderance of the research and published writing is devoted to the classification of MSBP, instead of its etiology or treatment.

Moving beyond classification would be productive in helping to recognize and stop the abuse, and in treating the perpetrators and victims.

Many professionals oppose classification of MSBP as a psychiatric disorder, however. Their arguments reflect broader concerns that accrue to the diagnosis of mental disorders in general and the specific system used for diagnoses found in the DSM. Chiczewski and Kelly (2003), for example, state that law enforcement personnel should treat MSBP as a form of child abuse and not as a psychiatric diagnosis. The classification of MSBP as child abuse by this profession is arguably an appropriate position because it is the duty of law enforcement personnel to protect society from criminal behavior regardless of its underlying cause. For example, if someone with bipolar disorder shoplifts, that person will be treated as a thief by law enforcement personnel, and only secondarily as a person with bipolar disorder. But this does not mean that other professions should not regard MSBP as a psychiatric condition. This just demonstrates the importance of knowing the implications of various psychiatric disorders. For MSBP, a major implication is child abuse, and that needs to be dealt with appropriately and in its own right.

From a psychiatric perspective, Eminson and Jureidini (2003) also state that MSBP should not be considered a diagnosis, in part because there is not a single or specific causal explanation for the behavior. They give an example of meningococcal bacteria as a specific cause for many different illnesses and diagnoses, all of which can be related back to that bacteria, and thus, can be reliably thought of as diagnoses. This analogy and argument overlook the fact that there can be several different contributing factors to the development of many psychiatric disorders. These factors may even differ for two people with the same psychiatric diagnosis.

Fisher and Mitchell (1995) also state that it is not appropriate to say that someone 'has' MSBP. Their reasoning is that neither the perpetrators, nor their victims, have a specific set of symptoms. Perhaps all perpetrators do not engage in the same harmful behaviors with their victims (one parent might suffocate a child, one parent might use poison, for example), but the pattern is essentially the same. Whether or not these behaviors can be referred to as "symptoms" relate to Rosenberg's point of view. Rosenberg (2003) contends that MSBP should not be considered a diagnosis because it represents a collection of acts and not just the "predisposing state of mind" (p. 423). However, the diagnosis of conduct disorder, for example, is based largely on acting out behaviors as the symptom picture. Rosenberg also states that only observable criteria can be used in a diagnosis, and that the intent of the perpetrator, perhaps to garner attention or assume the sick role by proxy, cannot be observed. However, in the diagnosis of antisocial personality disorder, the individual's lack of guilt regarding his or her crimes is not directly observable either. Thus, some arguments against MSBP as a diagnosis do not hold up when compared with the nature of other currently accepted psychiatric disorders.

There is also concern that utilizing MSBP as a diagnosis of the perpetrator may result in diminished responsibility for the abuse that ensues. Rand and Feldman (1999) state that psychiatric diagnoses should have limited use in the court for this reason. However, it should be noted that an explanation of MSBP might actually convince a judge or jury to convict a parent of child abuse, even though they may not have hit, neglected, nor sexually abused their child. In cases where hospital surveillance tapes depicting a parent tampering with tests or with their child's health are not available, but other evidence for MSBP exists, the perpetrator could rightfully be held accountable.

Donald and Jureidini (1996) see MSBP as a label not for a diagnosis nor for a form of child abuse, but to describe a "complex transaction" among a parent, a child, and the doctor consulted by the parent in regards to the child's illness (How should MSBP be defined section, para. 6). Fisher and Mitchell (1995) advocate that MSBP not be "diagnosed" at all, and that pediatricians who observe fabricated illness in a child describe it as just that, for example, as factitious or induced apnea. This would presumably help guard against using a diagnosis such as MSBP to reduce blame for the perpetrator if prosecuted (as in, arguing that a person is not guilty of child abuse because he or she is mentally ill with MSBP), but it would also shift attention away from working to uncover the psychopathology of this condition. This is too important and dangerous an issue to ignore or minimize. It is the author's contention that MSBP should be recognized as a need for attention at the expense of a child's physical health and emotional well-being, and dealt with actively by child welfare professionals, therapists, law enforcement, and medical personnel.

Smith-Alnimer and Papas-Kavalis (2003) wrote about MSBP as both a psychological diagnosis and as a form of child abuse. This position is consistent with The American Professional Society on the Abuse of Children's (APSAC) two-element definition of MSBP: 1) A pediatric condition falsification evident in the child, and 2) A caretaker who has a diagnosis of factitious disorder by proxy, because he or she harms the child for self-serving psychological needs (Schreier, 2002a & 2002b). This definition seems to effectively connect the pediatric condition and psychiatric disorder labels into one definition. It also indicates the appropriateness of giving a psychiatric diagnosis to the perpetrator.

Theories of Etiology and Treatment

Scheper-Hughes (2002) weighs in on the existence of MSBP by detailing some of her anthropological studies undertaken in an economically disadvantaged region of Brazil. She observed mothers repeatedly taking their babies to doctors and receiving medications and food, but not administering them, effectively keeping the child sick, and necessitating further medical attention. She asserts that MSBP exists as an extreme pole along a continuum of maladaptive maternal behaviors that arise in response to prior unmet emotional and environmental needs of the mother. She conceptualized this behavior as the poor mothers' needing to feel connected to the social world, and using the child as an object of primary or secondary gain, which serves the mother's (and even the doctor's) narcissistic needs. This goes back to the idea of the parent's motivation being an attempt to maintain a relationship with "powerful" medical personnel. Scheper-Hughes also observed that the perpetrator could feel excited at having "tricked" doctors and hospitals. On the other side of the coin, the doctors might see the child victim as a frustrating, yet unique "challenge" to his practice.

Szajnberg and Moilanen (1996) discuss MSBP perpetrators as presenting a convincing "false self" to clinicians. This conceptualization came from the observations of clinicians who treated MSBP-perpetrating parents. Despite evidence to the contrary, these therapists described having an "uncanny, ego-dystonic, and uncomfortable sense of disbelief" that the parent had actually induced the child's sickness (para. 6). The idea of the false self is derived from Winnicott's view of object relations. In addition to the mother, it can also be applied to the child victim in these cases. According to Winnicott, the true self develops in the child out of a genuine and flexible attachment (presumably with the mother) (Berzoff, Flanagan, & Hertz, 2002). But when the child is brought up in a holding environment exclusively focused on the needs of the mother, an overly compliant false self will develop in the place of the true self (Berzoff, et al., 2002). In MSBP cases, it is out of his or her own needs that the parent seeks medical attention for the child. Accordingly, it is not only the physical and medical abuse that harms the child, but if he or she survives, he or she will likely continue in a pattern of being overly compliant, putting his or her needs last, if attending to them at all (Berzoff, et al, 2002).

Hotchkiss (1997) writes about the idea of the child as a fetishistic object. In referring to mothers, she notes that "in projecting her own woundedness onto her child and then becoming the agent of the child's healing, she could heal herself over and over again" (p. 321). The idea of MSBP behavior as a form of fetishistic ritual is an interesting idea which may illuminate some obsessional and compulsive features of this disorder. Haddad, et al. (2002) notes that often the mother has had a personal history of symptoms similar to the ones she induces or reports in the child. This is a more literal interpretation of the notion of the mother 'healing' herself, but it could be an interesting point of therapeutic exploration with the MSBP perpetrator.

Szajnberg and Moilanen (1996) indicate that MSBP perpetrators exhibit a disturbance in the capacity for valuing intimacy and emotional proximity. This points to individual psychotherapy as a recommended form of treatment. However, the literature that does touch on treating those with MSBP is inconclusive about success in working with this population. Additionally, there is not much literature regarding specific treatment approaches.

Along with concepts from object relations theory, self psychological concepts could be useful in understanding treatment with a client with MSBP because self psychology also speaks to the existence of a false self and a true self (Cooper & Lesser, 2002). From a self-psychological viewpoint, perhaps the mother uses her child as a selfobject. Through the fabrication of symptoms or inducing illness, her child mirrors her own feelings of being sick and requiring care.

While empathy in the therapeutic relationship is central to a self-psychology model of treatment (Cooper & Lesser, 2002), the therapist should keep in mind that it may be difficult to garner empathy for the MSBP client, given his or her actions and likely refusal of responsibility toward hurting his or her child. Lastly, cognitive therapy techniques might be explored with these clients by focusing on the cognitive distortions the patient may cling to that result in such abusive behavior toward their child.

The role of the medical profession in the treatment of MSBP is pivotal, since doctors themselves can unknowingly carry out much of the abuse of these children on behalf of the parent through various examinations and treatments. Donald and Jureidini (1996) offer several factors in particular that should raise physicians' suspicions about MSBP abuse, including medical problems that do not respond to treatment, implausible lab findings, and similar unexplained illnesses in siblings. There is discussion about the actions that doctors should take when suspicious of abuse. For example, Bryk and Seigel (1997) suggest getting more specific details about the patient's history, obtaining records from other hospitals, and restricting hospital visitation or having someone else present during visits with a suspicious parent. However, there is no research that examines the ability or likelihood of doctors to recognize these signs (or what signs they will actually respond to), and what will lead them to take action to protect the child

Summary

Munchausen syndrome by proxy is a frightening child welfare phenomenon that presents itself in the medical arena. The existing literature is informative, albeit preoccupied with how the disorder should be defined and what it should be called. Many disagree about the value of regarding MSBP as a psychiatric diagnosis of the perpetrating parent, and instead opt to think of it solely as a form of child abuse. This line of thinking seems to trivialize the unique nature in which these parents harm their children. Additionally, MSBP differs from what we conceptualize as child abuse in many ways. Classification of MSBP as a psychiatric diagnosis could help bring professionals together on the issue. Reaching such a consensus would allow us to focus on understanding the dynamics of the problem and how to effectually treat both the MSBP-diagnosed person and the victim.

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