

Effects of Munchausen Syndrome by Proxy on the Victim

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The perpetrators of Munchausen Syndrome by Proxy (MSBP) produce symptoms that often result in multiple doctor visits, hospitalizations, incorrect diagnoses, and unnecessary procedures for the victim. Immediate physical harm exists for all sufferers of MSBP. However, growing research suggests that there are lasting adverse physical, psychological, and social effects for individual victims of MSBP. The mortality rate and risk of further abuse for children who are returned home after they receive a diagnosis of MSBP suggests greater consideration should be given before allowing a child to continue living with the perpetrator. Studies show that MSBP is not culturally dependent. The difficulty in diagnosing cases of MSBP indicates the prevalence rate may be underestimated.

The term Munchausen Syndrome (MS) was first described by Asher (1951), who suggests that the main goal of individuals with MS was to trick healthcare professionals with false illnesses and to gain attention and care from providers. The deceptiveness of those with MS, in part, has caused a delay in the identification of the disorder; it was not classified until the 1950s. Twenty-six years after Asher coined the term Munchausen Syndrome, Meadow (1977) introduced the term Munchausen Syndrome by Proxy (MSBP).

The two conditions are categorized in the Diagnostic and Statistical Manual of Mental Disorders IV-TR as factitious disorders (American Psychiatric Association, 2000). The subcategory Factitious Disorder Not Otherwise Specified is where MSBP, also known as Factitious Disorder by Proxy, is classified. MSBP is diagnosed in cases where a caretaker intentionally produces or feigns illness for another individual. The motive for inducing symptoms results from the desire for attention and sympathy. These cases typically involve, but are not limited to, a mother as the perpetrator and her child as the victim.

Due to the nature of the illness, the prevalence rates for MS and MSBP are difficult to determine. One study by Hamilton and Feldman (2006) reported a probable prevalence rate for MS of .2-1% for hospital inpatients, while another 2-year prospective study reported a prevalence rate of MSBP at .00075% for children under the age of 16 (McClure, Davis, Meadow & Sibert, 1996). The literature shows that the majority of individuals with MS tend to be white males between the ages of 30-50 years (Hamilton & Feldman, 2004). The majority of MSBP perpetrators tend to be white mothers of no specific age (Brannon & Carroll, 2008). Little other demographic data is available, and research examining whether or not religion and socioeconomic status may be significant predictors of MS and MSBP would be helpful.

Perpetrators of MSBP

Bools, Neale, and Meadow (1994) examined characteristics of MSBP perpetrators. The medical files of 62 families from the United Kingdom with a known history of MSBP were examined. Sufficient information on the mothers (the perpetrator of the MSBP cases) was gathered from 47 files and 19 mothers completed in-person interviews. The data showed that 19 of the 47 mothers had criminal records. A more detailed examination of mothers who completed in-person interviews found that 15 of the mothers reported childhood emotional neglect or abuse, 12 had a history of self-harm, and 8 reported a lifetime history of alcohol or drug problems. Also, 15 met the diagnostic criteria for somatizing disorder, eight for histrionic personality disorder, five for borderline personality disorder, two for dependent personality disorder, and one for avoidant personality disorder. On the whole, the data suggest that as a group, MSBP perpetrators face adverse childhood experiences and suffer from a range of psychological disorders.

Cases of MSBP

One of the first investigations of MSBP was conducted by Meadow (1982). Nineteen cases of MSBP occurring in England were examined. Data were gathered on 19 children (10 boys and 9 girls), under the age of 7, from 17 families. The mothers of these children consistently presented false clinical histories and fabricated symptoms that resulted in unnecessary harmful medical investigations, hospital admissions, and treatment. The data were derived from physician's medical records. The results showed that all of the children were subjected to hospitalizations. One subject missed 13 months of schooling, spent 5 months as an inpatient at a hospital, underwent 12 procedures, and was prescribed 27 medications. At the time of follow-up, which ranged from 1 to 4 years, two of the children in the study had died, and eight of the subjects were removed from their home environments. Records from two of the nine children

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who remained living with the perpetrator showed that frequent trips to doctors persisted. In seven of the 17 families with siblings, there were signs suggestive of similar practices with siblings. In one family, a sibling died under suspicious conditions. The findings of Meadow's 1982 study helped spark an increase in the amount of attention and research devoted to MSBP.

Rosenberg (1987) performed an extensive review (1966 to 1987) of the existing literature on Munchausen Syndrome by Proxy. Rosenberg obtained 117 reported cases of MSBP and divided the symptoms of the victims into two categories: simulated or produced illness. Simulated illness was assigned to children when the mother did not directly cause harm to the child (e.g., infecting the child's urine sample with outside contaminants). In produced illness cases, the mother physically caused harm to the child, such as inducing bone fractures or subjecting the child to sunlamp exposure that resulted in severe burns. The method of symptom induction was available for 72 of the cases. The findings showed that 25% were simulated illness only, 50% were produced illness only, and 25% were a combination of the two.

Rosenberg further investigated the morbidity of MSBP by delineating short-term and long-term morbidity. Short-term MSBP morbidity was defined as discomfort and/or illness that once resolved did not have a negative lasting impression on the overall health and development of the child. Long-term MSBP morbidity was defined as permanent adverse effects that resulted from the pain and/or illness. All of the cases met the criteria for short-term morbidity and 8% of the living subjects were determined to be affected by long-term morbidity. Ten of the 117 children in the study died, resulting in a 9% mortality rate. Also, 10 siblings of the 117 MSBP victims died under unusual circumstances. Among the MSBP victims that died, 20% of the mothers were diagnosed with MSBP prior to the child's death. Despite knowledge of the mother's illness, these children were allowed to live with the mother, which resulted in the subsequent death of the child. Overall, 24% of the perpetrators were diagnosed with MS or possessed features of MS. Furthermore, 1% of the sample reported sexual abuse, and 1% reported physical abuse.

Similar to Rosenberg's review, Sheridan (2003) performed an extensive search for incidences of MSBP (1987-1999). The study showed that 57.2% of the cases involved physically produced symptoms. Sheridan also found a MSBP long-term morbidity rate of 7.3%, a 6% mortality rate, and a 25% mortality rate for siblings of MSBP victims. The data also showed that 61.3% of the siblings had documentations of suspicious illnesses or similar symptoms as the index subject. In 29.3% of the cases the perpetrator was diagnosed with MS or possessed features of MS; however, data on the number of perpetrators diagnosed with MSBP prior to the child's death was not provided. Furthermore, rates of sexual and physical abuse for the victims of MSBP were not documented.

Neither Rosenberg (1987) nor Sheridan (2003) examined whether the manner of fabrication significantly impacts the future well-being and adjustment of MSBP victims. Investigating such relationships would be an interesting area to explore.

Victims Becoming Perpetrators

According to Rosenberg (1987), it is possible that "child victims of MSBP grow into adults who perpetuate MSBP or who suffer from Munchausen syndrome or somatization" (p. 557). Incidence rates for the evolution of victims to MSBP becoming perpetrators of MSBP are not currently known; however, if Rosenberg's belief were true, one would expect most MSBP victims to be female given that the vast majority of MSBP perpetrators are female. In both Rosenberg's (1987) and Meadow's (1982) studies, all perpetrators were the mother of the child. In Sheridan's (2003) study, 76.5% of the perpetrators were mothers and only 6.7% were fathers. In Rosenberg's study, there were no significant gender differences among victims of MSBP (46% male, 45% female, and 9% unknown). In Meadow's study, there were 10 male and nine female victims. Sheridan showed similar gender rates among victims; 52% male and 48% female. This data suggests, that at least for males, being a victim of MSBP does not predispose the individual to become a perpetrator of MSBP later in life. More research is needed to determine whether or not a positive correlation between being a victim of MSBP and becoming a perpetrator of MSBP exists for females.

Potential Complications for Victims of MSBP

Psychological conditions have not been assessed in the majority of the MSBP subjects. Schreier and Libow (1993) noted that out of the 178 articles found on MSBP, 143 were located in medical journals, while only 19 were in psychiatric or psychological journals. However, Rosenberg (1987) noted three cases of psychological disturbances for MSBP victims. The symptoms included severe withdrawal, preoccupation with being poisoned, emotional disturbances specifically related to fear of blood and death, fixation with bodily integrity, and aggression. The lack of data on psychological disturbance and MSBP highlights the need for future work examining whether or not the onset of certain psychological disorders are positively correlated with MSBP victimization.

Schreier and Libow's (1993) study identified the mortality rates associated with MSBP. Questionnaires assessing for MSBP were mailed to 1,258 pediatric doctors (870 neurologists and 388 gastroenterologists). The response rates for the two groups were 22% and 32%, respectively. The results showed 273 confirmed and 192 highly suspected cases of MSBP. Furthermore, in 25.8% of the cases, siblings of the victim were also believed to have been subjected to MSBP. In total, the mortality rate was 9.7% for children suffering from MSBP and 4.8% for their siblings. These

studies showed the immediate consequences of MSBP and support the notion that more protection needs to be provided to victims of MSBP as well as other children living in the home.

Davis et al. (1998) conducted a follow-up study to McClure's 1996 study of the epidemiology of MSBP, non-accidental poisoning, and non-accidental suffocation. Questionnaires were sent to the pediatricians who participated in the earlier study to assess the outcome of the cases previously submitted to the British Paediatric Association Surveillance Unit (BPASU). The response rate for completion of the surveys was 93%. Excluding deaths, 91 cases of MSBP were identified. Physical harm was identified in 52 cases. Thirty of the 39 MSBP victims with no physical harm were returned to live at home. During the follow-up period, five cases of further abuse were reported, resulting in a 16.7% re-abuse rate. Two children suffered further instances of MSBP and three were victims of emotional abuse. Excluding cases involving suffocation or poisoning, 13 cases of MSBP with physical harm were documented. Nine of those children were returned home and one case of further mistreatment was found, which constitutes an 11.1% re-abuse rate. The 2-year prospective study combined with the 1-year follow-up study provides further support for harm associated with MSBP and the danger of returning victims to live with the perpetrator.

Few studies have specifically examined the impact MSBP has on its victims after receiving an MSBP diagnosis. A follow-up study conducted by Bools, Neale, and Meadow (1993) included a follow-up assessment of individuals diagnosed with MSBP. The initial study, which identified 56 MSBP cases occurring between 1976 and 1988, examined methods used to fabricate illnesses and the symptoms induced by the perpetrators were reported (Bools, Neale and Meadow, 1992). The follow-up study sample was comprised of 54 cases (26 males and 28 females). Two children died in the lapse between studies. The duration between detection of MSBP and follow-up ranged from 1-14 years with a sample mean of 5.6 years. Clinical interviews were conducted with the parent or current guardian of the victim if researchers determined that potential adverse effects for the child were minimal.

Upon follow-up, 30 of the 54 children remained living with the mother, who was also the perpetrator. In 10 cases the mother was still feigning sickness in the subject. No fabrication of illnesses was found in the children living with foster or adoptive parents. This data suggests the importance of permanently removing MSBP victims from the home environment.

Sufficient data to determine current psychological functioning of the individual was obtained for 38 children. Twenty-seven of these children were considered to have significant disorders and 10 of these subjects, although significantly impaired, were beginning to display signs of slight improvement. The children suffered from a range of symptoms that affected their physical, psychological, and social wellbeing, including: somatic symptoms, nocturnal

enuresis, developmental delay, irreversible brain damage leading to quadriplegia and severe learning disabilities, coordination issues, emotional problems, specific phobias, conduct disorder, hypochondriacal behavior, nightmares, concentration difficulties, social development delay, theft, school non-attendance, and school suspension. These studies indicate the short-term consequences of MSBP, while Bools, Neale, and Meadow (1992, 1993) also demonstrate that many victims continue to suffer even after a diagnosis of MSBP was determined.

Adult Survivors of MSBP

To research the lasting impact that MSBP has on child victims, Libow (1995) conducted a retrospective study that examined the adult lives of 10 MSBP survivors. The subjects completed a questionnaire and were offered an optional follow-up interview. The reports found that the perpetrator was the mother in nine cases and the father in one case. In response to a question regarding his or her childhood years, most participants reported emotional disturbances and two reported serious physiological problems. One respondent told of dramatic weight issues: being anorexic as a young child and 50 pounds overweight in her adolescence. Another suffered from significant growth problems, weighing 47 pounds and standing 47 inches tall as a freshman in high school. Half of the subjects reported suffering from a variety of depressive symptoms. Four individuals experienced difficulties in school that resulted from physical or psychological factors. One child missed 8 years of schooling due to the mother's insistence of her illnesses. Another reported difficulty concentrating in school due to the constant anxiety that her mother's abuse would recommence.

With regard to the victims' adult lives, two reported not being significantly affected by their childhood abuse; however, both of these subjects reported avoiding visits to doctors and ignoring health and medical issues. While these individuals did not consider their behaviors problematic, significant adverse consequences could result from ignoring potential health concerns and avoiding doctor appointments (e.g., early detection of cancer). The remaining subjects reported a range of lasting and damaging psychological symptoms, which included trouble sustaining relationships, inability to separate one's identity from that of being a victim, and difficulty distinguishing reality from fantasy especially regarding bodily symptoms and the need to seek medical attention. Furthermore, decreased feelings of self-worth, doubt, searching for maternal love, generalized rage toward family members, suicidal ideation, and feelings of anxiety and depression were all described as long-term consequences due to the MSBP abuse. Subjects were also given a 27-item questionnaire that screened for Posttraumatic Stress Disorder (PTSD). Nine adults completed the questionnaire and results found that six of the subjects had at least four symptoms of PTSD. Also, seven of the adults had received psychiatric or psychological counseling and one patient reported having a clinical

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diagnosis of Bipolar Disorder. These findings suggest that victims of MSBP can endure lasting negative psychological effects.

Out of the eight MSBP parents still alive at the time of the interview, only four participants reported having some contact with the parent. These adults expressed ongoing fear of the perpetrator. Furthermore, none of the eight parents admitted to the abuse, even when confronted by the participant. The direct effect of not receiving proper acknowledgement from the perpetrator cannot be determined from this study. However, in future studies it would be helpful to examine the parent-child relationship and the effect of proper acknowledgment of the abuse from the parent perpetrator.

Limitations

One limitation of MSBP research is the reliance on participants' retrospective memory of childhood. However, retrospective self-reports are used in the majority of research that examines the effects of childhood physical and sexual abuse on later life development (e.g., Libow, 1995). A study conducted by Bernstein et al. (1994) explored the validity and reliability of the Childhood Trauma Questionnaire (CTQ; Bernstein, 1995), a retrospective instrument used to assess childhood abuse. The results found an internal consistency ranging from .79 to .94 and a test-retest reliability of .88. The high validity and reliability of this measure supported Libow's decision to use the self-reporting method (1995).

Another shortcoming associated with MSBP research relates to the complexity of uncovering MSBP cases. A 2-year prospective study looked to examine the epidemiology of MSBP, non-accidental poisoning, and non-accidental suffocation among children under the age of 16 (McClure et al., 1996). Pediatricians from the UK and the Republic of Ireland reported all diagnosed or suspected incidences of MSBP, non-accidental poisoning, and non-accidental suffocation that occurred from September 1992 through August 1994 to the BPASU. The results showed 97 cases involving MSBP (55 MSBP only; 26 MSBP and poisoning; 14 MSBP and suffocation; and 2 MSBP, poisoning, and suffocation). The Office of Population Census and Survey reported a population of 12,725,936 during the time period of the study. From these statistics the prevalence of MSBP was found to be .75/100,000; however, this percentage only included cases detected by the pediatricians.

Other factors help make determining the true prevalence of MSBP difficult. Meadow (1995) listed the following differential diagnoses for MSBP: unrecognized physical abuse, overanxious parents, mothers with delusional disorder, masquerade syndrome, hysteria by proxy, doctor shopping, and mothering to death. There have also been multiple instances when the victim had informed professionals of the perpetrators' production or simulation of the symptoms and the child was not believed (Libow, 1995). Another aspect that may make diagnosing cases of MSBP

even more challenging results from blended cases, which Libow (2002) described as the collusion of symptoms between caregiver and child. In these cases, the intentions of both parties coincide. Consequently intentional revealing of the deceit could make subsequent diagnosis more difficult for practitioners. Detecting and properly labeling cases of MSBP has been proven difficult. These challenges undermine accurate reporting of prevalence, and suggest that current rates of MSBP incidences are underestimated.

An International Look at MSBP

While most research of MSBP has been conducted in western societies, the universal presence of MSBP should not be ignored. Feldman and Brown (2002) searched multiple databases, articles, chapters, and books to investigate the existence of MSBP in countries excluding Australia, Canada, New Zealand, Ukraine, and the United States. The results found a total of 129 cases of MSBP from 24 different countries. Gender information was available for 81 cases (54% male and 46% female). In the 93 reports where the perpetrator was identified, 86% were the mother, 4% were the father, 4% were spouses unrelated to the child, 2% were the grandmother, and 4% were other. While information documenting the detrimental effects and mortality rate for the victims was not provided, the study did show that MSBP existed throughout developed, developing, and underdeveloped countries.

Another international study reported on cases of MSBP throughout Japan (Fujiwara, Okuyama, Kasahara, & Nakamura, 2008). In 2004, 11 leading Japanese physicians specializing in child abuse were asked to identify confirmed or suspected cases of MSBP they encountered from 1995 to 2004. Twenty one cases were reported, consisting of 10 male and 11 female victims. Incidences were categorized as either having predominantly physical or psychological symptoms (16 and 5, respectively). Eighteen of these cases were reported to the Child Guidance Center and eight of the children were returned home to live with the abuser. Two of the victims who returned home died; both of the victims were classified as having predominately physical symptoms. This study provides further proof that MSBP also occurs in non-western cultures, with similar negative outcomes for victims. The findings also note the risk of returning victims of MSBP to the home environment. Lastly, another avenue for future exploration may be potential differences between perpetrators who produce physical versus psychological symptoms in the child, and more specifically predictive outcomes based on the four types of symptom feigning (i.e., physical, psychological, simulated, and produced).

Conclusion

Significant literature and research has been conducted since the introduction of MSBP in the 1970's. However, more attention and study needs to be given to the disorder. The literature currently shows the damaging short-term and

long-term risks that may arise due to MSBP victimization. The harmful complications compounded by the mortality rate for victims and siblings suggest that more consideration needs to be given to removing children from homes when MSBP has been diagnosed. Future research should more thoroughly address psychological issues among those exposed to MSBP. An increase in knowledge surrounding psychological complications will help provide appropriate services to care for victims of MSBP. Furthermore, the prevalence of MSBP and its signs and symptoms need to be made more publically accessible across all countries and cultures. Greater awareness regarding MSBP will hopefully decrease the duration between the onset of MSBP and its diagnosis

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