# LETTERS TO THE EDITOR

## Munchausen syndrome by proxy

EDITOR,—Your recent series on Munchausen syndrome by proxy was a useful critique[1-3]; however we have points of disagreement with each of the articles.

Morley rightly criticises bad practice,[1] but he offers no alternative advice about dealing with those cases of severe child abuse generally classified as Munchausen syndrome by proxy. He seems more inclined to dismiss their existence on the basis of poor history taking. Medicine can err in overdiagnosis, but of more concern to us is the role of doctors in the *creation* of Munchausen syndrome by proxy. Morley misses this. His position seems to be overly defensive of both parents and doctors.

Fisher and Mitchell argue convincingly for distinguishing 'prototypical' Munchausen syndrome by proxy from other clinical situations incorrectly labelled as Munchausen syndrome by proxy.[2] They attempt to clarify classification by reference to the categorical model of Libow and Schreier, and the dimensional model of Eminson and Postlethwaite. Both of these models have contributed positively to the debate on this syndrome, but each has significant flaws. For example, Libow and Schreier suggest the 'active inducers' constitute prototypical Munchausen syndrome by proxy; however this formulation neglects the fact that without the ongoing involvement of the medical profession active illness induction does not result in the full range of prolonged morbidity characteristic of prototypical Munchausen syndrome by proxy.

With regard to the dimensional model, Fisher and Mitchell state 'the same case may present on different parts of the dimension at different times'. This implies that prototypical Munchausen syndrome by proxy may have previously manifested as anxiety about symptoms, then as symptom exaggeration, and finally as symptom induction. We are not aware of any empirical evidence to support this claim. Abuse/damage to the victim can coexist with any degree of parental 'desire to consult', and is not on a qualitative continuum with, say, overanxious parenting. Therefore damage to the child must be considered a separate dimension that determines the need for child protection.

Meadow regards cases of extreme induced illness as child abuse, but claims that they require different management.[3] We know of no empirical evidence that indicates that the application of standard child abuse management principles hampers the management of Munchausen syndrome by proxy.

Meadow's agreement with DSM IV that the diagnosis of Munchausen syndrome by proxy be applied to a perpetrator whose behaviour is motivated by 'the need to assume the sick role' is open to more criticism. While we respect Meadows unequalled experience, there is no research that demonstrates that such motivation is universal in this condition. Indeed, attempts to assess the motivation of the perpetrator are notoriously unrewarding, and potentially delay diagnosis, further increasing the risk to the victim.

We argue for (1) recognition of the critical role of the medical profession in the aetiology of Munchausen syndrome by proxy, (2) explicit attention to its abusive nature, (3) a standard approach to the management of any form of serious abuse, including Munchausen syndrome by proxy as defined in these articles, to ensure child safety and facilitate optimal treatment, and (4) restriction of the label Munchausen syndrome by proxy to apply to a *transaction* between doctor, perpetrator and victim, rather than to any one protagonist.[4]

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1 Morley CJ. Practical concerns about the diagnosis of Munchausen syndrome by proxy. *Arch Dis Child* 1995; **72**: 528–30.
2 Fisher GC, Mitchell I. Is Munchausen syndrome by proxy really a syndrome? *Arch Dis Child* 1995; **72**: 530–4.
3 Meadow R. What is, and what is not, 'Munchausen syndrome by proxy'? *Arch Dis Child* 1995; **72**: 534–8.
4 Donald T, Jureidini J. Munchausen by proxy syndrome: child abuse in the medical system. *Arch Dis Adolesc Med* (in press).

## Munchausen syndrome by proxy or factitious illness spectrum disorder of childhood

EDITOR,—Professor Roy Meadow's clarification of the criteria for diagnosing Munchausen syndrome by proxy was both refreshing and timely.[1] Those of us who have been involved in the clinical management of cases will have come across misconceptions among the legal and social services which have made this management much more difficult. Chief among these is the post-Allitt perception of Munchausen syndrome by proxy as a psychiatric condition of the perpetrator. We often have to remind other professionals that the term is intended to describe a form of child abuse.

We therefore have some difficulty in accepting the criterion suggested in DSM IV that 'The motivation for the perpetrator's behaviour is to assume the sick role by proxy'. We would prefer to use the term to refer to the abuse itself and the significant harm which it causes to the child, rather than the observer's perception of what was going through the mind of the abuser at the time.

Colin Morley's paper gives us a reminder of the dangers of overdiagnosing abuse.[2] We do not believe however that significant numbers of diagnoses of Munchausen syndrome by proxy are made on the basis of individual clinical features such as episodes which occur only in the presence of the child's mother, or which cease when the child is separated from his parents. Our own research, conducted jointly with Dr Rob McClure and Professor Meadow at Leeds, and presented at the 1995 BPA meeting, suggests the reverse, with 85% of paediatricians indicating that they were 'virtually certain' of the diagnosis before initiating child protection procedures.

Paediatricians make diagnosis of child abuse by taking into account the entire pattern of the clinical presentation. In attempting to protect children from abuse we should make diagnoses *on a balance of probabilities*. We should not delay in protecting a child in order to attempt to obtain confirmatory evidence of abuse *beyond reasonable doubt*. If paediatricians follow Colon Morley's criteria some children may not be protected from abuse and could even die as a result. The report of the BPA working party on imposed upper airway obstruction contains valuable guidance in this respect.

The nail in the coffin for the term Munchausen syndrome by proxy is undoubtedly, public perception. Just as other medical terms in the past, which have entered into public usage and changed their meaning (such as mongolism, idiocy, cretinism, etc), Munchausen syndrome by proxy has come to mean something else and has lost its value. We believe factitious illness spectrum disorder of childhood would be an appropriate substitute. We should always try and qualify this however by defining exactly what abuse was perpetrated and what the harm was to the child.

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1 Meadow R. What is, and what is not, 'Munchausen syndrome by proxy'? *Arch Dis Child* 1995; **72**: 534–8.
2 Morley JC. Practical concerns about the diagnosis of Munchausen syndrome by proxy. *Arch Dis Child* 1995; **72**: 528–30.

*Dr Fisher comments:*

We thank Dr Davis and Professor Sibert and Drs Donald and Jureidini for their interest in the recent articles on Munchausen syndrome by proxy.

Clearly, each of the correspondents has extensive experience in the management of these difficult child abuse cases. We would like to address a few points in summary. Both groups comment upon the DSM IV criteria about the motivation of the perpetrator's behaviour assumed to be 'the sick role by proxy'. We are not sure how true this is given that in our clinical experience we have met a number of perpetrators who have had a serious personality disorder, depression, and have even been using the child to manipulate obtaining services. We find the assumption that most perpetrators are assuming the sick role by proxy to be premature given the lack of detailed psychological and psychodynamic assessments of perpetrators in the spectrum of Munchausen syndrome by proxy.

We would agree that the label Munchausen syndrome by proxy should be used as no more than a description of a discovered situation. Obviously, if the label is used in this context then it is clear that there needs to be observations and research on the nature of the interaction between the perpetrator and physician.

Finally, Donald and Jureidini comment that in our paper we do not have any empirical evidence to support our claims. We agree that in the published literature to date there is no empirical evidence; however, in our clinical practice we have dealt with two cases in which there has been a complex mixture of longstanding parental anxieties about illness, with 'exacerbations' of this anxiety that has appeared to amount to falsification of history (and possibly more intrusive actions) that seem to correlate with periods of stress in the perpetrator's life. We hope to publish these two cases in due course.