Factitious disorder by proxy: a call for the abandonment of an outmoded diagnosis

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Factitious disorder by proxy (also referred to as Munchausen's syndrome by proxy) is a controversial diagnosis that generally involves the induction, falsification or exaggeration of medical symptoms in a victim by a caretaker. The syndrome is recognized as generally, but not exclusively, involving a mother and child. The author suggests that syndromatic terms for this type of child abuse are outmoded and should be abandoned in favor of an exact description of the suspected abusive behaviors in child dependency courts. Should there be a finding of abuse, the offending parent should be evaluated in terms of the major dynamics of her medically abusive behavior. Such evaluations should be utilized in the dispositional phase of child abuse proceedings and not employed for the proof of the matter.

KEY WORDS: Munchausen's, factitious, syndrome, proxy, assessment, abuse.

Factitious disorder by proxy (FDBP) is an unusual diagnosis that has garnered increasing attention in recent years. The disorder was first identified by Sir Roy Meadow.¹ He referred
to it as Munchausen’s syndrome by proxy (MSBP), and this name is often used interchangeably with FDBP in the literature on the subject. In order to avoid confusion, the designation FDBP is be used throughout this article unless another term is specifically used by cited authors. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) the disorder is characterized by “intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual’s care” in order to assume the sick role by proxy (p. 726).²

Since FDBP was originally formulated as a diagnostic entity, it has been the focus of serious disagreement and controversy.³ The controversial nature of this diagnosis and the extent of its misapplication have become even more apparent in recent years, as an ever-increasing number of instances of false positive diagnoses has led to a series of high-profile cases in which women thought to have perpetrated this form of medical abuse have been incarcerated and subsequently exonerated in courts in the United Kingdom and the United States.⁴ This article explores the controversy and confusion surrounding this diagnosis and makes suggestions for the abandonment of FDBP, MSBP, and the related diagnosis of pediatric condition falsification (PCF) in favor of a descriptive rather than categorical approach. In this approach, the term FDBP would be replaced with an exact description of those acts or omissions by the caretaker that are thought to rise to the level of child abuse. If a finding of child abuse is made by a court, then the behavior of the perpetrating parent could be described in terms of a multiaxial continuum of dimensions of pathology.

**Definitions and diagnostic problems**

Indications of the controversial nature of FDBP can even be seen in the way it is approached by influential diagnostic systems. For example, FDBP is included in an appendix of
the *DSM-IV* titled "Criteria Sets and Axes Provided for Further Study" rather than in the main body of the volume. Proposed diagnoses are included in this particular appendix because an APA task force has determined that insufficient information was available to warrant inclusion as an official diagnosis. The *DSM-IV* indicates that the following conditions must be met for the diagnosis to apply:

1. Medical symptoms are induced, fabricated or exaggerated in a victim by a caretaker.
2. The behavior is designed to achieve the secondary gain associated with taking on the sick role by proxy.
3. Obvious external gain is not the motivating factor.
4. The behavior is not better explained by another diagnosis.

The *DSM-IV* cautions that this diagnosis must be differentiated from physical or sexual abuse that is not motivated by the goal of assuming the sick role by proxy, and also from malingering, which is predominantly motivated by external incentives. It should also be noted that although the victim of FDBP may be of any age (for example, an elderly incapacitated individual), the literature focuses almost entirely on children as the victims and mothers or female caretakers as the perpetrators.

**PCF/FDBP formulation of the American Professional Society on the Abuse of Children (APSAC)**

Controversy about FDBP has been seen in disagreement about the name of the disorder as well as the extent to which motivational issues figure in making the diagnosis. Most recently, the APSAC Taskforce on Munchausen by Proxy, Definitions Working Group, has attempted to develop a bifurcated approach to the disorder. The taskforce has proposed the use of the term pediatric condition falsification (PCF) for the diagnosis of child abuse through falsification of medical or psychiatric symptoms in a child by a caretaker.
The taskforce recommends that the *DSM-IV* diagnosis Child Abuse-61.21 be applied if the focus is on the victim, and Child Abuse-995.5 if the focus is on the perpetrator. In this diagnostic scheme, if MBP (FDBP/MSBP) is involved, the *DSM-IV* diagnosis Factitious Disorder Not Otherwise Specified-300.19 would be applied to the perpetrator.

This approach has certain advantages over previous diagnostic formulations. There has always been some confusion about whether the child victim or the perpetrator of FDBP carries the diagnosis. This new formulation would create a diagnosis with two sets of criteria analogous to the two components that comprise the definition of a crime: *actus reus* (prohibited act) and *mens rea* (guilty mind). PCF would correspond to the *actus reus*, which refers to the action component of the crime, while FDBP would correspond to the *mens rea*, which refers to the intentional nature of the act. Accordingly, under the proposed APSAC criteria, PCF might be diagnosed in the absence of FDBP, but FDBP could not be diagnosed without a corresponding diagnosis of PCF.

Despite this approach, considerable problems remain with the diagnostic formulation of FDBP. For example, the aforementioned APSAC position paper indicates that although the absence of external incentives, such as economic gain, is one of the diagnostic criteria for FDBP, “it is clear from the work of people in the field (Meadow, 1995) that external incentives such as economic gain, escaping difficult life circumstances, and/or wresting attention or custody from an inattentive or abandoning spouse may be present.” Although this may very well be true, it blurs FDBP diagnostic criteria, leaving the clinician to determine which motivation is primary.

This ambiguity inevitably leads to difficulties in making the diagnosis of FDBP. For example, a parent who persistently fabricates allegations of sexual abuse of a child by a spouse in order to obtain custody would not be diagnosed with FDBP, nor would a paranoid mother who persistently makes
unfounded allegations of abuse, nor would a parent who is overanxious and fabricates symptoms in order to obtain the attention that she believes her sick child needs. However, a person who committed the identical acts of falsification and/or exaggeration would be diagnosed with FDBP if elements of attention seeking or secondary gain appeared to be present; this distinction is left for the clinician to make on the basis of extremely subjective criteria.

In addition, the following question arises: If the PCF diagnosis has been accurately applied, does the FDBP diagnosis add anything useful in terms of diagnosis, prognosis or treatment? For example, let us imagine two cases. In one, a parent induces illness in a child to collect disability payments; in another, the parent engages in the identical abusive behavior for purposes of secondary gain. The former would qualify as PCF but not FDBP, while the latter would meet the diagnostic criteria for both disorders. It is fair to ask whether this system of differentiating subtypes of medical child abuse adds anything to the treatment or management of such behavior. This concern is expressed succinctly by Eminson and Jureidini, whose comments reflecting their view of the MSBP label are equally applicable to the PCF/FDBP scheme. The authors state that “categorization of the parent as a perpetrator of MSBP or the child as a victim of MSBP provides the clinician with little further guidance as to what psychological and social management is appropriate for this particular child. The impact on the child is better described in terms of the physical and emotional harm done by the specific abusive acts than by a single term or label. Similarly, there are better ways of conceptualizing parental behavior” (p. 416).7

**Rosenberg’s diagnostic criteria**

It should also be noted that although APSAC and its Definitions Working Group are influential in the field of child
abuse and FDBP, no organization or group "owns" medical and psychiatric diagnosis, and other groups and authors present different conceptualizations of FDBP that have equal claims to serious consideration. For example, although the recent APSAC definition suggests a differentiation between PCF and FDBP, a more recent article by no less an authority than Donna Rosenberg rejects this conceptualization. In her article "Munchausen Syndrome by Proxy: Medical Diagnostic Criteria," Rosenberg uses the term MSBP to describe this form of child abuse and makes no reference to FDBP or PCF. She also categorically rejects the idea that there is a psychiatric or motivational component in the diagnosis of MSBP. Rosenberg's original conceptualization (1987) of MSBP is as follows:

1. Illness in a child which is simulated (faked) and/or produced by a parent or someone who is in loco parentis.
2. Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures.
3. Denial of knowledge by the perpetrator as to the etiology of the child's illness (at least before the deception is discovered).
4. Acute symptoms and signs in the child of illness which abate when the child is separated from the perpetrator.

It is interesting to note that if MSBP (FDBP) does not have a motivational component, criteria 2, 3 and 4 are superfluous; if criteria 1 is shown to be present, the others are not necessary to make the MSBP diagnosis. Rosenberg insists that the diagnosis of MSBP does not require a motivational component or a related psychiatric diagnosis. She points out that there is no reliable evidence that any discrete psychiatric disorder or group of disorders is associated with MSBP-related behavior. Rosenberg also makes it clear that the use of intent as part of the MSBP diagnostic formulation can lead to misdiagnosis, since in cases in which all four of her MSBP diagnostic criteria appear to be present but the underlying motivational component (secondary gain) cannot be clearly demonstrated, the MSBP diagnosis would not be met. It
should be noted that although Rosenberg’s assertion that the motivational component is unnecessary for the medical diagnosis of MSBP makes sense from a medical diagnostic standpoint, it also reflects a certain naïveté about the course of these cases in the real world. A positive medical diagnosis of MSBP almost inevitably leads to the case moving to a child dependency or criminal court proceeding. As previously mentioned, an essential component of a conviction in these venues (particularly criminal) is the mens rea (guilty mind), which brings us back to the issue of intent. Often in such a court proceeding a pediatrician, psychiatrist or psychologist would be required to provide evidence addressing not only whether the parent induced, fabricated or exaggerated illness in a child, but also whether she understood the wrongfulness of her actions and was able to conform her actions to the dictates of the law. In addition, experts in child dependency cases are almost invariably called upon to provide the court with guidance regarding the disposition of the case. Consequently, attempts to fully “medicalize” MSBP are likely doomed to failure due to the context in which these cases occur.

The effect of FDBP flaws and fallacies in court

As these examples demonstrate, considerable confusion still exists about the definition and diagnosis of FDBP over a quarter of a century after Meadow’s original (1977) recognition of MSBP. This issue would be less important if it were not for the fact that these diagnoses carry considerable baggage. For example, a number of prominent authors on the subject have indicated that the diagnosis is associated with high degrees of mortality as well as physical and psychological morbidity. As a consequence, courts tend to respond more strongly in alleged cases of FDBP than in cases involving more common forms of child abuse. This is of concern because there is no empirical evidence that the perpetrators of FDBP have, as a group, a higher level of psychopathology
than parents who are found guilty of more common forms of physical or sexual child abuse.

Some of the literature on FDBP also suggests that it is a multigenerational disorder and that the parents and siblings of the alleged perpetrator may somehow be involved in the genesis and perpetuation of the disorder. As a consequence, even though that most states have statutes mandating good-faith attempts to place children taken by the courts in the care of blood relatives, in FDBP cases prosecutors and child protection workers often object to such placements on the grounds that the child will be in danger because of FDBP family dynamics. It is of note that in cases where children are taken from parents with severe substance-abuse problems, there is no such tendency to avoid placement with relatives, even though substance abuse clearly has a familial/genetic component. In such cases, courts and CPS workers generally ascertain that no active substance-abuse problems are observed in the relatives, rather than deny placement on the basis of a vague suspicion that something in the family dynamics makes them unsuitable caretakers.

Much of the professional literature also suggests that the underlying psychopathology of FDBP parents is severe and refractory to treatment, and that reunification is therefore unlikely to be feasible. As a consequence, these cases often move toward termination of parental rights more quickly than is usual in other types of child abuse cases. For example, in their discussion of therapy for FDBP perpetrators and the issue of parental termination, Sanders and Burch state: "If partial or no progress has been made in therapy, reunification is not recommended. If it appears that progress is not being made in a timely manner (perhaps within 6 months), the court might consider a more rapid progression toward termination of parental rights as it may not be likely that the parent would be able to reunify with the child" (p. 122)."
A multiaxial approach

One of the major problems with the various diagnostic formulations of FDBP is that dynamics and characteristics that are continuous variables are treated in the bulk of the scholarly and scientific literature as though they were dichotomous. Put another way, although many of the characteristics associated with FDBP vary along a continuum, they are approached as though they were either present or absent. This has led to a tendency to lump a wide variety of behaviors of varying intensity and concern into one ill-fitting category. FDBP has become a Procrustean bed, with unfortunate results.

The assessment of alleged medical abuse would be of more utility to courts and support personnel if the terms FDBP, MSBP and PCF were abandoned altogether in favor of a two-part approach that provides (1) a clear description of the specific acts of medical abuse, and (2) an analysis of the accused perpetrator’s behavior in terms of the central dynamic variables associated with FDBP-related behavior. The first component of this approach would provide the court with a bill of particulars, a plain and impartial account of the perpetrator’s alleged crime without recourse to prejudicial labels, while the second component would provide a multiaxial analysis of the abuse for the purpose of disposition and child protection.

The postulated central dynamic variables of FDBP-related behavior include secondary gain, severity of abuse, and psychopathology of the perpetrator. Of these, secondary gain through assumption of the sick role by proxy has traditionally differentiated FDBP from other forms of child abuse. However, secondary gain is not unique to FDBP; all illnesses and injuries have the potential to produce secondary gain. An incapacitating back injury may cause pain and distress, but it may also allow the sufferer to escape from an unpleasant job. The secondary gain may be minor and may be far outweighed
by the negative effects of the injury, the advantages and disadvantages of the injury may be closely balanced, or the benefits of being out of work may far outweigh the negative effects of the symptoms. In some cases, an individual with pre-existing hypochondriacal or somatizing tendencies may exhibit a complex interplay between psychological factors and the bona fide physical effects of injury. Those working in the area of rehabilitation are aware that these factors exist on a continuum, and they assess this issue carefully in every case so as to develop appropriate treatment plans and interventions.

This interplay between physical and psychological factors likewise occurs in individuals diagnosed with FDBP and in parents who are not perpetrating FDBP but have sick or handicapped children. For example, a mother with a chronically ill child may prefer the role of nurse and companion to the demands of competitive employment. If this desire is strong enough, it might lead to symptom exaggeration, fabrication or induction. But there is almost certainly a population of mothers who do not need to engage in these behaviors, because their children are ill enough to require them to assume the sick role by proxy without the necessity of engaging in FDBP. Other parents may exaggerate symptoms, perpetuating their involvement in the caretaker role so as to enjoy the secondary gain provided by the sick role by proxy, but lack sufficient motivation to engage in outright fabrication. The picture is further complicated by the issue of external incentives, which the APSAC definitional taskforce has suggested can play a role in the symptom picture and genesis of FDBP in combination with secondary gain through assumption of the sick role. The balance between secondary gain and external incentives is likely to vary from case to case rather than being an either/or situation, and both factors should be assessed as occurring along a continuum rather than as either present or absent.

The second variable that is central to our understanding of FDBP cases is severity of abuse. Clearly, the potential for harm
varies among different forms of child abuse: Physical abuse can range from overuse of spanking to severe attacks resulting in broken bones or death, while sexual abuse may range from inappropriate touching over clothing to genital intercourse. Although all of these acts have the potential for negative effects on children, society differentiates between mild and severe abuse through its courts, agencies and laws, and different remedies are applied depending on circumstances. Cases of milder child abuse are often dealt with through monitoring by CPS, parent training, and psychotherapy for both victims and perpetrators, whereas moderate levels of abuse may require the removal of children from their parents’ custody for varying lengths of time. The most severe cases often prompt initiation of termination of parental rights proceedings and eventual adoption of children by third parties.

Varying degrees of severity are also seen in cases of abuse through FDBP. At the severe end of the spectrum are cases in which parents engage in the active induction of symptoms. Unfortunately, this can be done in ways that have the potential to kill; cases of intentional suffocation have been observed through covert video surveillance, and there are well-documented cases of intentional poisoning with salt, emetics and laxatives. Other cases do not involve active induction of symptoms; instead, parents give physicians false reports of seizures, persistent vomiting, headaches, episodes of apnea, non-specific pain, and other complaints that do not lend themselves to immediate objective medical verification. Although such fabrications are not as immediately dangerous as symptom induction, they can lead to the use of potentially dangerous and unnecessary medications, treatments, and surgical procedures. Finally, in some cases FDBP perpetrators exaggerate their victims’ bona fide symptoms by overstating their frequency, severity and duration.

Clearly, the severity of the medically related abuse that forms the actus reus of FDBP varies along a continuum; nevertheless, there is a tendency to lump all such presentations together as
though they all posed the same degree of risk to the victim. Although there may be cases in which parents escalate their behavior, progressing from exaggeration to fabrication to active induction, the inevitability of such a progression has not been established through any empirical methodology. The existing literature relies on a few anecdotal case studies, some of which focus on selected cases in order to illustrate a particular perspective. One of the few empirical studies that actually focused on parents found guilty of more severe forms of FDBP indicated that parents generally did not escalate or persist in these behaviors after detection. Consequently, in the disposition of these cases the courts should consider the severity of the abusive behaviors and the potential for further harm, rather than automatically assuming that all FDBP cases are fatalities waiting to happen. This assumption of a high potential for fatality is not seen in the approach of mental health professionals or child protection agencies to physical abuse cases, and it should not be the point of departure in cases of medical child abuse.

The third variable that should be considered in FDBP cases is the psychopathology of the perpetrator. Although some preliminary studies of FDBP mothers have examined the psychopathology of these perpetrators, no consistent pattern has emerged, and the existing research has demonstrated that those identified as FDBP perpetrators vary widely in their level and type of psychopathology. Some research suggests that many, but by no means all, of these perpetrators have suffered from factitious disorder or other forms of unusual illness-related behavior. Some have histories of abuse; some do not. Personality disorders are seen with some frequency but are not universal. Some of the mothers in these studies have severe forms of mental illness, but this is the exception rather than the rule. There are several reasons why conclusions drawn from these studies are of limited utility in supplying information for the purpose of establishing a profile of FDBP perpetrators or creating treatment protocols. First, as far as personality dynamics are concerned, the only real pattern that
emerges is that there is no pattern. The second issue relates to the base-rate problem; those trends that have emerged in studies of the personalities of FDBP perpetrators have a high base rate in many other clinical groups that do not engage in such behaviors. The characteristics seen in the studies of Bools, Neale and Meadow, such as a history of physical or sexual abuse, characterological problems, somatizing disorders, drug and/or alcohol abuse, and self-harm, are commonly seen in patients suffering from PTSD and eating disorders, as well as in custody litigants and a variety of other clinical groups.\textsuperscript{15}

Construing the psychopathology of FDBP perpetrators as a dynamic factor would not only help provide a more accurate reflection of the true state of affairs, but also would assist professionals and courts in determining appropriate interventions on a case-by-case basis. For example, individuals with high levels of psychopathy are unlikely to benefit from psychotherapeutic treatment, and any danger to children arising from such pathology is unlikely to be ameliorated through psychotherapy. Individuals with other types of personality disorders, as well as anxiety disorders or depression, may be more amenable to treatment. Individuals who have been found to have medically abused their children might receive diagnostic psychological evaluations to assist in the assessment of prognosis and in the choice of therapeutic modalities, such as psychopharmacological treatment, cognitive behavior therapy, parenting classes, and a host of other therapeutic modalities commonly used with parents who engage in more common forms of child maltreatment.

The argument for change

The initial conceptualization of MSBP (FDBP) by Meadow might be compared to Kempe's identification of battered child syndrome. Kempe's term was useful in that it created
awareness of the physical abuse of children, but the term "battered child syndrome" has now been abandoned in favor of the more generally descriptive term "child abuse." Cases of child abuse are now prosecuted by providing the court with an exact description of the abusive acts alleged, and there is no need for recourse to a syndrome label or diagnosis.

Meadow's conceptualization of MSBP (FDBP) has likewise been useful in bringing attention to the phenomenon of medical child abuse, but there are significant arguments for its retirement, including calls in the literature for abandonment of the FDBP label. Authors such as Morley have raised objections to the diagnosis because of its high potential for overdiagnosis. The low base rate of the diagnosis, coupled with excessively broad diagnostic criteria and the misuse of profile data, ensures an unacceptable level of false-positive diagnoses of the condition, particularly in cases of alleged fabrication or symptom exaggeration, as identification of this phenomenon is quite subjective.

Events over the past ten years have borne out these concerns, and as matters stand, the FDBP label has become an obstacle to fair and effective intervention in cases of medical child abuse. The use of this label in court has opened the door to highly questionable testimony related to the presence or absence of the FDBP profile, which has no empirically derived discriminant validity. Although testimony about the supposed behavioral characteristics of FDBP mothers is frequently allowed in court, it would be unthinkable to allow testimony that an alleged child molester did or did not "fit the profile" of a sexual offender.

The right of the accused to a fair hearing is further undermined through the use of the FDBP label when, as often happens in such cases, accusations of FDBP substitute for specific charges. Alleged perpetrators are often faced with "moving target" prosecutions consisting of vague and shifting
allegations. When serious allegations such as active symptom induction cannot be substantiated, lesser and more easily proved allegations, such as fabrication or exaggeration, emerge to take their place. In addition, when the prosecution is permitted to use FDBP rather than specific allegations of abuse as the focus of its case, the adjudicatory process often becomes bogged down in an either/or debate about the presence or absence of FDBP. Such debates are irrelevant when it comes to deciding whether aspects of a parent’s behavior caused harm or placed a child at risk, nor do they help with the disposition of cases if the response to a finding of FDBP is invariably a prescription for long-term foster care or termination of parental rights.

Abandoning the term FDBP and treating medical child abuse as a multiaxial phenomenon would allow a more productive, flexible approach to such cases. Rather than attempting to decide whether a particular instance of medical child abuse meets or does not meet the diagnostic criteria of FDBP, courts and evaluators would be able to approach cases with an awareness of the individual characteristics and dynamics of the instant case. Although the alternative formulation for FDBP suggested by the APSAC taskforce (pediatric condition falsification and FDBP) attempts to address the problems inherent in the FDBP diagnosis, it only sidesteps the issue. The PCF component has a high potential for reification, yet it provides no advantages over a simple statement of allegations that a parent has exaggerated, fabricated or induced a child’s symptoms of illness, whereas the FDBP component perpetuates the use of an unproductive and outmoded diagnosis. A non-diagnostic, general term such as medical child abuse would provide a more accurate and useful replacement for the current diagnostic labels and divest such cases of the baggage that encumbers them, such as inflated mortality rates and inaccurate and negative prognostic statements. In addition, by requiring a bill of particulars, the two-part multiaxial approach would help prevent “moving target” prosecutions.
Overall, the use of the FDBP label has led to situations in which courts are forced to make important decisions about child protection based on highly subjective evidence of limited or nonexistent probative value. Courts sometimes give unwarranted weight to such evidence when child abuse is involved, reasoning that it is better to err on the side of child safety. However, it should be borne in mind that erring on the side of child safety is not as simple as it seems; many children suffer separation anxiety when precipitously removed from their families, and abuse is not unknown in foster care. The tragic effects of the unwarranted destruction of families incurring a false-positive diagnosis of FDBP would seem so obvious as to need no mention, but a perusal of the literature on this subject shows a surprising lack of concern or focus on this aspect of the problem.

With so much at stake, such issues should be decided without recourse to the highly questionable FDBP label. In the final analysis, there is much to be gained by abandoning FDBP and nothing to lose but the unfortunate and counterproductive effects of this diagnosis.

Notes

6. Ayoub et al., supra note 5, p. 108.


