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# Parents' Reporting of Symptoms in Their Children: Physicians' Perceptions

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*Pediatricians and family practitioners were asked how accurately parents report young children's symptoms. They believe 5% conceal/fail to report, 8% minimize, 80% report accurately, 10% exaggerate, and 1% falsely report/induce symptoms. They report fewer puzzling cases in their own practices than these estimates would suggest. Health professionals should know the warning signs of Munchausen syndrome by proxy.*

## Introduction

Munchausen syndrome by proxy (MBP), or factitious disorder by proxy, is the non-accidental production or reporting by a caretaker of symptoms in a child, usually under 5 years old. It is a form of child abuse. MBP is not a diagnostic entity recognized in the *Diagnostic and Statistical Manual of Mental Disorders*,<sup>1</sup> but will be included in the new DSM IV (in press) as a variant of factitious disorder according to C. Jones of the American Psychiatric Association. It will have the following definition and criteria:

A. Production or feigning of physical signs or symptoms in another person who is under the individual's care.

B. The motivation for the perpetrator's behavior is a psychological need to assume the sick role (indirectly) as evidenced by the absence of external incentives for the behavior, such as financial gain.

MBP was first identified by S. Roy Meadow of Leeds, England.<sup>2-3</sup> Typically, a caregiver (most often the mother) repeatedly brings the victim to a doctor or hospital, reporting symptoms which cannot be ignored. In more malignant cases, the caretaker is inducing symptoms through mechanisms such as suffocation or poisoning, not simply making false reports. Over time a pattern emerges. Symptoms occur or are reported only in the presence of a single person, and they resolve when the victim is separated from that person. Recognizing MBP can be difficult, since diagnosis of true physical illness is not always

straightforward, and the prospect of falsely blaming a parent is daunting.

Health care professionals generally believe parents' reports, and MBP parents are often ingratiating and convincing. It can be easier for medical staff to pursue the possibility of a rare disorder than to believe that an apparently exemplary parent is, in fact, a child abuser. So the child continues to be tested and treated. For this reason, MBP has been called an interactive process between families and health care professionals.<sup>4</sup>

MBP is expensive to the health care and child protective communities and dangerous to children, although its full extent is unknown. Light and Sheridan<sup>5</sup> found that, among 24 infants with apnea that probably represented MBP, only one had not been rehospitalized. Five had been readmitted 5 times or more. Eight required 1 to 4 ambulance calls, and 7 had ambulance calls 5 or more times—a few almost daily. Eleven of 32 total patients in this study had been reported to child protective agencies, and 5 had at some point been placed in foster care. Three of the patients identified in this study were dead, and 1 had severe brain damage from abuse. Five of their siblings were known to be dead, supposedly the result of sudden infant death syndrome.

In his review of 27 well-substantiated MBP suffocations, Meadow<sup>6</sup> found that 9 of the index cases and 18 of their 33 siblings were dead. Bools et al<sup>7</sup> reported that 64% of 56 index children had more than one illness fabricated, and 29% had a history of failure to thrive, non-accidental injury, or neglect. Eleven percent of their siblings were dead, and 39% of their siblings also had fabricated illnesses. Even if symptoms are only reported and not induced, the children's lives revolve around a parent's need for them to be sick. There is some suggestion that they respond with behavioral and psychological pathology, perhaps eventually creating illness in themselves and their own children.<sup>8</sup>

Little is known about the epidemiology of MBP. Light and Sheridan estimated that 2.7/1000 infants on apnea monitors might be victims. Kaufman et al<sup>9</sup> found that 86 professionals attending a child abuse conference had seen 77 possible cases in the previous year. Schreier and Libow<sup>10</sup> surveyed 870 pediatric neurologists (22% response rate) and 388 pediatric gastroenterologists (32% response rate) and uncovered "465 cases, of which 273 were confirmed and 192 seriously suspected." They concluded, "there may be large numbers of Munchausen by proxy cases, and...many of them are not being diagnosed."

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No grant or other support for this project.

One obstacle to the diagnosis of MBP is failure of health care professionals to recognize it. This comes from 3 major sources:

1. Lack of knowledge about the syndrome.
2. The convincing presentation of illness by perpetrators.
3. Reluctance to confront child abuse and/or the fact that one has been deceived.

Since MBP was not recognized until 1977, has been considered rare, and has not received wide publicity until recently, many professionals have not had an opportunity to learn about it. Kaufman et al<sup>11</sup> surveyed 86 professionals attending a child abuse conference and found that only 50% overall had heard of MBP prior to attending the conference. (Eighty-six percent of those working in medical settings had heard of it, compared to only 24% of those working in community agencies.) Ostfeld et al<sup>12</sup> surveyed 92 professionals and found that, while 93% of pediatric residents were aware of the disorder, only 44% of family practitioners and 43% of social workers knew about it.

### Methods

In 1992, pediatricians and family practitioners were surveyed to determine how accurately they believed parents reported symptoms in their young children, and whether they had any patients "who have recurrent or prolonged symptoms of illness which, after extensive testing, remain puzzling." Young children (defined as under age 5) were targeted because the literature suggests that MBP is more frequent in this age group, since they cannot as easily contradict their parents' reports. The survey focused on reporting of symptoms rather than MBP to avoid possible bias. It asked for a continuum of symptom reporting, from concealment through accuracy to exaggeration, because of the author's ongoing interest in this area<sup>13</sup> and because relatively little is known about under-reporting of symptoms.

The definition quoted was used as a basic screen for possible MBP. It is recognized that many cases *not* factitious in origin might fit that definition, either permanently or transiently. However, in the author's opinion, when looking for a pool of potential MBP cases, start with patients so described. In addition to the pre-printed questions, physicians were asked to add any comments they chose to the response form, and those who had patients who fit the screen for MBP were asked whether they would be willing to discuss these patients further "with proper protection for confidentiality." It was hoped that this would yield a group of patients appropriate for further study, in order to test out the brief definition.

The survey was mailed to 131 pediatricians and family practitioners (those listed in the Oahu Yellow Pages) accompanied by a postpaid return envelope. Forty-two responses were received (10 from family practitioners, 31 from pediatricians, and 1 that could not be identified), for an overall response rate of 32.8%.

### Results

The data on parental reporting of symptoms is shown in Table 1. In general, respondents believed that most parents report symptoms accurately. They agreed that parents are more likely to conceal relevant symptoms than to induce them or report falsely. Family practitioners appear more likely to take parents'

Accuracy	Total	Peds	Fam Prac
What percent of parents, for any reason:			
Do not report/ conceal symptoms which you feel are important	5%	6%	4%
Minimize or "play down" symptoms	8%	9%	5%
Exaggerate or over interpret	10%	14%	7%
Falsely report or induce symptoms	1%	2%	1%
Note: Responses do not total 100% because some respondents' answers did not total 100%.			

statements at face value than pediatricians, but this difference is not significant. Two respondents, both pediatricians, wrote comments. One pointed out that the quality of history-taking by the physician has a great influence on the information obtained. The other wrote a statement with which most physicians would probably agree: "Mothers who are insecure tend to exaggerate symptoms more. The ones who minimize symptoms are usually ignorant of the complications or sequelae of diseases and thus are *crisis oriented* and only seek help when it is absolutely necessary."

The physicians guessed that at least 1% of parents either falsely report symptoms or induce them—the essence of MBP. As part of the questionnaire's introduction, respondents were asked for an estimate of how many children under 5 years of age they cared for on a regular basis. The pediatricians averaged 852 young patients and the family practitioners 354. Extrapolating to all respondents, the total number of patients cared for by physicians answering the survey is estimated at 30,510.

However, there were only about 67,000 children under age 5 on Oahu in 1990, the latest year for which statistics are available, suggesting that physician practice estimates were inaccurate or that patients "doctor shop" more than physicians realize.<sup>14</sup> One percent of this number is 305, which could be taken as a gross estimate of patients about whom suspicions of MBP could be raised among this cohort of physicians. Yet, when asked in the next question, whether they had any patients with recurrent, puzzling symptoms, the physicians reported just over a tenth of this number (35). (Note that some respondents gave the response of "a few," which could not be quantified.) When those with such cases were asked if they would be willing to discuss them further, only 3/10 who admitted having such cases were interested in consultation. One additional pediatrician planned to send the child on to a specialist if the current therapeutic strategy was not successful.

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ders additional studies are required. Arteriography, phlebography and arthrography are not recommended for children and often do not provide adequate therapeutic information.<sup>26</sup> Noninvasive, painless techniques for evaluation of vascular anomalies include sonography, Doppler, color Doppler, CT scans and MRI. MRI studies in patients with suspected venous malformations are superior to other studies due to the clear delineation of skin, muscle, joint and bone involvement.<sup>26</sup> In addition, with use of Gadolinium-DTPA, flow rates throughout the malformation can be determined.

Prognosis and therapeutic intervention is different for the various forms of vascular anomalies and vascular syndromes. In this patient it was important to exclude Maffucci's syndrome because of the increased risk of developing chondrosarcomas.<sup>9</sup> Individuals with arteriovenous malformations can develop pseudo-Kaposi sarcomatous skin changes, skin ulcerations, increased cardiac output and even congestive heart failure.<sup>26</sup> Arteriovenous malformations usually are dormant during childhood.<sup>26</sup> Patients who have venous malformations involving a limb complain of pain and swelling often related to vascular thrombosis.<sup>26</sup> Joint effusions and hemarthrosis are a consequence of vascular infiltration. Massive intraosseous disease of long bones also results in decreased bone density and increased risk of fracture, as demonstrated by this case.

Treatment of venous malformations is difficult and often unsuccessful. External support through the use of custom-made elastic stockings or wraps is indispensable and should be encouraged on a lifelong basis. If well circumscribed the patient may experience some therapeutic benefit from percutaneous sclerotherapy under fluoroscopy and surgical excision of venous pouches.<sup>26</sup> If knee hemarthrosis is not treated with synovectomy and surgical removal, flexion contractures, leg muscle atrophy, equinus deformity of the foot and progressive ankylosis of the joint may ensue.<sup>26</sup> The increased risk of fracture in this patient required us to provide him with a molded orthoplast arm guard secured with velcro straps.

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## Discussion

This survey was not designed to establish definitively the incidence of accurate or inaccurate reporting among parents, but rather to tap the perceptions of those who work most closely with children's illnesses. Survey results suggest that physicians are aware of the potential for both under- and over-reporting, and believe in the abstract that these form a rough normal curve. However, they do not report an equivalent number of puzzling cases in their own practices. Perhaps they are aware of those parents within their practice who falsely report/induce symptoms, or perhaps they do not believe that parents in their practice are typical. Induction of symptoms, if not persistent false reporting, is clearly child abuse. It is noted by S. Choy, Director of the Multidisciplinary Child Protective Team at Kapiolani Medical Center for Women and Children that Hawaii Child Protective Services has received fewer than 5 total reports of MBP.

The reluctance of respondents to discuss their puzzling patients is unclear. Perhaps they simply did not wish to share these cases with the author, who is not a physician, or did not feel that confidentiality could be properly safeguarded in such a discussion. Perhaps, as one indicated, they have management strategies and resources already in place. It is also possible that they are reluctant to face the implications of MBP—a personally stressful process in addition to its legal implications.<sup>15</sup>

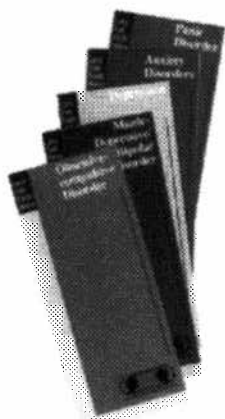
It is recommended that physicians, together with other health and social services professionals, be aware of MBP. Knowledge in the abstract, however, like awareness of other forms of child abuse, is not enough. By their own estimates, approximately 1% of respondents' patients may have parents who frankly lie about

or induce symptoms. Practitioners should make sure they are translating their theoretical knowledge into proper awareness and safeguards for young children.

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