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**Munchausen syndrome by proxy – illness fabricated by another in older people**

Journal:	<i>Age and Ageing</i>
Manuscript ID	Draft
Manuscript Category:	Editorial
Keywords:	Munchausen syndrome by proxy, Fabricated illness by carers, Elder abuse
Keypoints:	Dependent patients are vulnerable to Munchausen syndrome by proxy, but few cases are reported involving adults, Identification in older frail patients is challenging given the atypical presentation and comorbidity common in this population, The usual motivation of the abuser is receipt of attention and gratification, rather than material gain, Inconsistent history, no diagnosis despite many investigations and improvement on separation from carer suggests the condition, When suspected, local procedures for protection of vulnerable adults should be followed

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3 Most elder abuse, whether physical, psychological, financial or sexual, remains undetected or ignored.  
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5 Munchausen syndrome by proxy (MSbP) – more formally called factitious disorder imposed on another  
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7 in the fifth edition of the Diagnostic and Statistical Manual of Disorders (DSM-V) [1] or fabricated or  
8  
9 induced illness by carers in the UK [2] - is no exception. Whilst most commonly identified in children [3],  
10  
11 it has also been reported in vulnerable older adults who are similarly dependent on another for their  
12  
13 care.

14  
15 MSbP is characterized by the abuser, usually the main carer, fabricating medical history or signs or even  
16  
17 inducing illness in the person in their care, and then purposely bringing their abuse to the attention of  
18  
19 health care providers who may unwittingly perpetuate the abuse by arranging unnecessary  
20  
21 investigations and treatments that can themselves be potentially harmful. Typically, the abused cannot  
22  
23 speak for themselves, although rarely they can be complicit in the deception. Clinicians may extend  
24  
25 considerable time on seeking an explanation for the unusual presentation and lack of an adequate  
26  
27 diagnosis, but eventually they recognize the true situation and retrospectively identify the factitious  
28  
29 nature of previous presentations. How many cases go unrecognized or remain unproven can only be  
30  
31 guessed at.

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33 The primary motivation in most cases of MSbP is considered to be that the perpetrator of the abuse  
34  
35 gains from the sympathy and attention given to them by health and social care staff, and sometimes  
36  
37 from other family members. Unlike conversion disorders, the deception is conscious and intentional, but  
38  
39 whereas the usual motivation for such malingering is external personal gain (often financial or other  
40  
41 material benefits), in MSbP it is generally internal, the benefit arising from the psychological reward of  
42  
43 presenting as a dedicated carer and receiving positive attention and support [4].

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45 As well as the avoidable morbidity associated with MSbP, there is likely to be a significant mortality. In  
46  
47 children this is reported to be 6% or more [5]. In adults the mortality rate is unknown, but a low index of  
48  
49 suspicion of MSbP in older frail patients in whom atypical presentation and multiple morbidity is  
50  
51 characteristic, together with their greater medical complexity and low physiological reserve is likely to  
52  
53 place them at similarly significant risk of adverse outcome and death.

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55 Perhaps the association with the eponymous German aristocrat, caricatured as a figure of fun for his  
56  
57 farfetched storytelling, means that MSbP is not treated with the gravity that it deserves. High profile  
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3 cases of reported miscarriages of justice related to diagnoses of MSbP in children heightened awareness  
4 of the condition, but unbalanced media reporting highlighted its controversial nature and the potential  
5 difficulties and consequences of making the diagnosis. Hesitancy about accusing carers of fabrication in  
6 the absence of explicit evidence and the fear of the potential costs to the professional may mean that  
7 suspicions are not followed up. If clinicians have been duped over a long period, they may not wish their  
8 past gullibility to be scrutinized. In British law, MSbP is recognized only as a label to describe a range of  
9 behaviours rather than a distinct medical or psychiatric condition, with the suggestion that the term  
10 should be confined to the history books [6].  
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19 Nearly all the literature on MSbP relates to children [2,3] and fewer than one per cent of published case  
20 reports involve adults. In the recent comprehensive review of cases involving adult proxies [7], five of  
21 the 13 cases identified were elderly. Nearly always the recipient of the abuse lacked autonomy and was  
22 a passive recipient of medical care, with a history of various unexplained medical symptoms leading to  
23 repeated unnecessary investigations and hospital admissions. The perpetrator was usually female,  
24 tended to be over-involved and interested in medical details, often with a background in healthcare.  
25 Psychological assessments have identified perpetrators of MSbP in children as often having narcissistic  
26 or borderline personality disorders and a previous history of somatic or factitious disorders and of  
27 pathological lying [8,9].  
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37 Fabricated symptoms are likely to be more challenging to detect than induced illness. Improvement on  
38 separation may help to suggest the diagnosis. When MSbP is suspected, local procedures for protection  
39 of vulnerable adults should be followed and cases reported promptly to relevant services rather than  
40 immediately confronting the perpetrator. Confession is rare and there is a high risk of recurrence so it is  
41 important to ensure the patient is followed up and does not disappear to another part of the health  
42 service where the cycle of abuse can be repeated.  
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49 Clinicians are used to dealing with unsatisfied or over-zealous relatives who slightly exaggerate  
50 symptoms in order to assure that the patient gets the priority and treatment that they consider to be  
51 appropriate. At worst, any disadvantage to the patient is unintentional and the motivation of the carer  
52 has good intent. However, this can escalate to a demand for interventions beyond what is reasonable  
53 and this is then no longer in the patient's best interests. Full blown fabrication has no positive benefit  
54 for the recipient, but is for the gratification and reward of the perpetrator. In some cases, the health  
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3 care system and even clinicians themselves may be part of the problem [10], responding  
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5 unquestioningly to carers' concerns rather than that of the patient, especially if cognitive impairment is  
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7 present. An over-emphasis on risk management may encourage over-investigation and medical sub-  
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9 specialization may make it more difficult to see the bigger picture. MSbP will be easily missed if there is  
10  
11 not continuity of care. Caution may be justified before rushing to a diagnosis of MSbP, but when  
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13 suspected it demands prompt and decisive action.

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16 **Conflict of interests.** None

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19 **References**

- 20  
21  
22  
23 1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th edition.  
24 Washington DC, American Psychiatric Association 2013.  
25  
26 2. Royal College of Paediatrics and Child Health. Fabricated or induced illness by carers (FI): a practical  
27 guide for paediatricians. London, RCPCH 2009  
28  
29 3. Bass C, Glaser D. Early recognition and management of fabricated or induced illness in children.  
30 Lancet 2014; 383: 1412-21.  
31  
32 4. Bass C, Halligan P. Factitious disorders and malingering: challenges for clinical assessment and  
33 management. Lancet 2014; 383: 1422-32.  
34  
35 5. Pritchard C. Munchausen syndrome by proxy and sudden infant death. BMJ 2004; 328: 1309  
36  
37 6. <http://www.bailii.org/ew/cases/EWHC/Fam/2005/31.html>  
38  
39 7. Burton MC, Warren MB, Lapid MI, Bostwick M. Munchausen syndrome by adult proxy: A review of  
40 the literature. J Hosp Med. 2015; 10: 32-5.  
41  
42 8. Bools C, Neale B, Meadow R. Munchausen syndrome by proxy: a study of psychopathology. Child  
43 Abuse Negl. 1994; 18(9): 773-88.  
44  
45 9. Bass C, Jones D. Psychopathology of perpetrators of fabricated or induced illness in children: case  
46 series. Br J Psychiatry. 2011; 199(2): 113-8.  
47  
48 10. Jureidini JN, Shafer AT, Donald TG. "Munchausen by proxy syndrome": not only pathological  
49 parenting but also problematic doctoring? Med J Aust. 2003; 178(3): 130-2.  
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