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

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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

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

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

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

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

Perhaps the association with the eponymous German aristocrat, caricatured as a figure of fun for his farfetched storytelling, means that MSbP is not treated with the gravity that it deserves. High profile

cases of reported miscarriages of justice related to diagnoses of MSbP in children heightened awareness of the condition, but unbalanced media reporting highlighted its controversial nature and the potential difficulties and consequences of making the diagnosis. Hesitancy about accusing carers of fabrication in the absence of explicit evidence and the fear of the potential costs to the professional may mean that suspicions are not followed up. If clinicians have been duped over a long period, they may not wish their past gullibility to be scrutinized. In British law, MSbP is recognized only as a label to describe a range of behaviours rather than a distinct medical or psychiatric condition, with the suggestion that the term should be confined to the history books [6].

Nearly all the literature on MSbP relates to children [2,3] and fewer than one per cent of published case reports involve adults. In the recent comprehensive review of cases involving adult proxies [7], five of the 13 cases identified were elderly. Nearly always the recipient of the abuse lacked autonomy and was a passive recipient of medical care, with a history of various unexplained medical symptoms leading to repeated unnecessary investigations and hospital admissions. The perpetrator was usually female, tended to be over-involved and interested in medical details, often with a background in healthcare. Psychological assessments have identified perpetrators of MSbP in children as often having narcissistic or borderline personality disorders and a previous history of somatic or factitious disorders and of pathological lying [8,9].

Fabricated symptoms are likely to be more challenging to detect than induced illness. Improvement on separation may help to suggest the diagnosis. When MSbP is suspected, local procedures for protection of vulnerable adults should be followed and cases reported promptly to relevant services rather than immediately confronting the perpetrator. Confession is rare and there is a high risk of recurrence so it is important to ensure the patient is followed up and does not disappear to another part of the health service where the cycle of abuse can be repeated.

Clinicians are used to dealing with unsatisfied or over-zealous relatives who slightly exaggerate symptoms in order to assure that the patient gets the priority and treatment that they consider to be appropriate. At worst, any disadvantage to the patient is unintentional and the motivation of the carer has good intent. However, this can escalate to a demand for interventions beyond what is reasonable and this is then no longer in the patient's best interests. Full blown fabrication has no positive benefit for the recipient, but is for the gratification and reward of the perpetrator. In some cases, the health

care system and even clinicians themselves may be part of the problem [10], responding unquestioningly to carers' concerns rather than that of the patient, especially if cognitive impairment is present. An over-emphasis on risk management may encourage over-investigation and medical sub-specialization may make it more difficult to see the bigger picture. MSbP will be easily missed if there is not continuity of care. Caution may be justified before rushing to a diagnosis of MSbP, but when suspected it demands prompt and decisive action.

Conflict of interests. None

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