Richtlijn
Kindermishandeling door Falsificatie (KMdF)
Fase 1

INITIATIEF
Nederlandse Vereniging voor Kindergeneeskunde
Vereniging voor Vertrouwensartsen Kindermishandeling en Huiselijk Geweld

IN SAMENWERKING MET
Nederlandse Vereniging voor Heelkunde
Nederlandse Vereniging voor Neurologie
Nederlandse Vereniging voor Psychiatrie
Nederlands Huisartsen Genootschap
Stichting Kind en Ziekenhuis
Verpleegkundigen & Verzorgenden Nederland
Jeugdartsen Nederland

MET ONDERSTEUNING VAN
Kennisinstituut van de Federatie Medische Specialisten

FINANCIERING
De richtlijnontwikkeling werd gefinancierd uit de Stichting Kwaliteitsgelden Medisch Specialisten (SKMS).

Colofon

RICHTLIJN KINDERMISHANDELING DOOR FALSIFICATIE (KMdF): voorheen PEDIACTRIC CONDITION FALSIFICATION (PCF))

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Algemene inleiding

Aanleiding voor het maken van de richtlijn
Kindermishandeling door Falsificatie (KMdF) is een vorm van kindermishandeling waarbij somatische of psychische symptomen bij een kind worden gefingeerd, gefalsificeerd of toegebracht door de ouder of verzorger. De ouder of verzorger presenteert het kind met deze signalen en symptomen in de gezondheidszorg. Vaak duurt het lang voor aan de diagnose KMdF wordt gedacht, en wordt het vermoeden door iemand anders dan de hoofdbehandelaar naar voren gebracht. Daarom richt deze richtlijn zich op het signaleren van KMdF en de samenwerking tussen de verschillende professionals die daarbij een rol spelen. Voorheen werd de term Pediatric Condition Falsification (PCF) gebruikt voor Kindermishandeling door Falsificatie. De richtlijn beoogt weer te geven wat volgens de huidige maatstaven de beste zorg is voor kinderen bij wie een vermoeden van KMdF speelt. De complexiteit van deze problematiek vraagt om een richtlijn. Een richtlijn bevordert het uniform handelen dat het herkennen van de problematiek verbetert (signalering) en de aanpak in het kader van onderzoek naar kindermishandeling structureert. Het eenduidig handelen bevordert de professionaliteit, maakt het handelen toetsbaar en maakt evaluatie en bijsturen van het proces mogelijk.

In 2007 is de eerste Nederlandse richtlijn over PCF gepubliceerd door de VVAK (VVAK, 2007). Deze richtlijn was aan herziening toe, onder andere door een veranderde werkwijze van Veilig Thuis, hernieuwde inzichten in de problematiek, veranderende naamgeving, toenemende juridisering en de toenemende samenwerking met justitie (Kwakman, 2017a; Kwakman, 2017b). Deze gaan over de termen Pediatric Condition Falsification en Factitious Disorder by Proxy, zowel qua definiëring als aanpak. In 2013 is het Medisch Handboek Kindermishandeling verschenen met een hoofdstuk over PCF (van de Putte, 2013).

Doel van de richtlijn
Op initiatief van de Nederlandse Vereniging voor Kindergeneeskunde (NVK) en de Vereniging Vertrouwensartsen Kindermishandeling en huiselijk geweld (VVAK) is vanaf april 2021 gestart met het opstellen van een vernieuwde richtlijn waarin beschreven wordt hoe te handelen bij een vermoeden van Kindermishandeling door Falsificatie. Kinderartsen werken in de praktijk intensief samen rond deze vorm van kindermishandeling; Kinderartsen vanuit een behandelsetting en vertrouwensartsen vanuit Veilig Thuis.

Afbakening van de richtlijn
De richtlijn baseert zich onder andere op de richtlijn van de Royal College of Paediatrics and Child Health (RCPCH, 2021), het Handelingsprotocol Veilig Thuis 2019 (Baeten, 2019), de Handreiking ‘Samenwerking bij strafbare kindermishandeling’ (Kwakman, 2017a) en de richtlijn voor de aanpak van PCF en FDP (VVAK, 2007)). Ook worden de uitgangspunten van de KNMG-meldcode kindermishandeling en huiselijk geweld (van Hoof, 2018) gebruikt, welke de professionele norm voor behandelend artsen vormt.
Voorliggend concept betreft de eerste 2 modules van de eerste fase van de richtlijn, welke gaan over een gezamenlijke visie over de definitie van KMdF en over samenwerking tussen verschillende partijen, waaronder kinderartsen en vertrouwensartsen. In de tweede fase van de richtlijn zal het diagnostisch traject, het doen van onderzoek en organiseren van veiligheid, verder worden beschreven en daarnaast zal de richtlijn ingaan op specifieke juridische en medisch ethische aspecten, communicatie met het kind en gezagdragenden.

Beoogde gebruikers van de richtlijn
De Richtlijn is bedoeld voor kinderartsen en andere zorgprofessionals werkzaam in de 0^{e}, 1^{e}, 2^{e} en 3^{e} lijn, en vertrouwensartsen en andere medewerkers werkzaam bij Veilig Thuis, Forensisch artsen 1^{e}-2^{e} lijn, Raad vd Kinderbescherming, Jeugdbescherming, Politie, OM en kinderrechters.

Afkortingen

ALK	Aanhoudende Lichamelijke Klachten
ALTE	Apparent Life Threatening Event
AMHK	Advies en Meldpunt Huiselijk Geweld en Kindermishandeling
AMK	Advies en Meldpunt Kindermishandeling
BRUE	Brief Resolved Unexplained Event
CBS	Centraal Bureau voor de Statistiek
CSG	Centrum Seksueel Geweld
DD	Differentiaaldiagnose
DBC	Diagnose Behandel Combinatie
DSM	Diagnostic and Statistical Manual of Mental Disorders
EFP	Expertisecentrum Forensische Psychiatrie
EMDR	Eye Movement Desensitization and Reprocessing
FA	Forensisch Arts
FDP	Factitious Disorder by Proxy
FDIA	Factitious Disorder imposed on Another
FII	Fabricated or Induced Illness
FMEK	Forensisch Medische Expertise voor Kinderen
FO	Forensische Opsporing
GGZ/JGGZ	Geestelijke Gezondheidszorg/jeugd-GGZ
HOV	Huis voor Onderzoek en Veiligheid (vervangt MDCK)
HV	Hulpverlening
IVRK	Internationaal Verdrag inzake de Rechten van het Kind
KA	Kinderarts
KJTC	Kinder- en Jeugd Traumacentrum
KMdF	Kindermishandeling door Falsificatie
LECK	Landelijk Expertisecentrum Kindermishandeling
MbPS	Münchausen by Proxy Syndrome
NFI	Nederlands Forensisch Instituut
NVK	Nederlandse Vereniging voor Kindergeneeskunde
OR	Omgangsregeling
PCF	Pediatric Condition Falsification
PGB	Persoons Gebonden Budget
PP	Perplexing Presentation
PTSS	Posttraumatische Stressstoornis
PvA	Plan van Aanpak
SOA	Seksueel Overdraagbare Aandoening
SOLK	Somatisch Onverklaarde lichamelijke klacht
TNO	Toegepast Natuurwetenschappelijk Onderzoek
VA	Vertrouwensarts
VNG	Vereniging van Nederlandse Gemeenten
VT	Veilig Thuis
VVAK	Vereniging Vertrouwensartsen Kindermishandeling en Huiselijk geweld
WLZ	Wet Langdurige Zorg
WMO	Wet Maatschappelijke Ondersteuning

Literatuur

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Kwakman, E. (2017a). Handreiking Samenwerken bij Strafbare Kindermishandeling [Guide to Collaboration in Criminal Child Abuse Cases].

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Royal College of Paediatrics and Child Health. (2021). Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in Children. RCPCH Guidance.

Verantwoording

Leeswijzer
Deze verantwoording zal op de Richtlijnendatabase (Richtlijnendatabase.nl) bij elk van de in deze richtlijn opgenomen modules worden geplaatst.

Autorisatie en geldigheid

Autorisatiedatum:	[datum]
Eerstvolgende beoordeling actualiteit	2027
Geautoriseerd door:	Nederlandse Vereniging voor Kindergeneeskunde, Vereniging voor Vertrouwensartsen Kindermishandeling en Huiselijk Geweld Nederlandse Vereniging voor Heelkunde Nederlandse Vereniging voor Neurologie Nederlandse Vereniging voor Psychiatrie Nederlands Huisartsen Genootschap Stichting Kind en Ziekenhuis Verpleegkundigen & Verzorgenden Nederland Jeugdartsen Nederland
Regiehouder(s):	NVK en VVAK

Algemene gegevens
De ontwikkeling/herziening van deze richtlijnmodule werd ondersteund door het Kennisinstituut van de Federatie Medisch Specialisten (www.demedischspecialist.nl/kennisinstituut) en werd gefinancierd uit de Kwaliteitsgelden Medisch Specialisten (SKMS) en de Vereniging voor Vertrouwensartsen Kindermishandeling en Huiselijk Geweld.
De financier heeft geen enkele invloed gehad op de inhoud van de richtlijnmodule.

Samenstelling werkgroep
Voor het ontwikkelen van de richtlijnmodule is in 2021 een multidisciplinaire werkgroep ingesteld, bestaande uit vertegenwoordigers van alle relevante specialismen (zie hiervoor de Samenstelling van de werkgroep) die betrokken zijn bij de zorg rondom KMdF.

Belangenverklaringen
De Code ter voorkoming van oneigenlijke beïnvloeding door belangenverstrengeling is gevolgd. Alle werkgroepleden hebben schriftelijk verklaard of zij in de laatste drie jaar directe financiële belangen (betrekking bij een commercieel bedrijf, persoonlijke financiële belangen, onderzoeksfinanciering) of indirecte belangen (persoonlijke relaties, reputatiemanagement) hebben gehad. Gedurende de ontwikkeling of herziening van een module worden wijzigingen in belangen aan de voorzitter doorgegeven. De belangenverklaring wordt opnieuw bevestigd tijdens de commentaarfase.
Een overzicht van de belangen van werkgroepleden en het oordeel over het omgaan met eventuele belangen vindt u in onderstaande tabel. De ondertekende belangenverklaringen zijn op te vragen bij het secretariaat van het Kennisinstituut van de Federatie Medisch Specialisten.

Werkgroeplid	Functie	Nevenfuncties	Gemelde belangen	Ondernomen actie
Teeuw*	Kinderarts sociale pediatrie Emma Kinderziekenhuis, Amsterdam UMC locatie AMC	Werkzaam als LECK kinderarts (Landelijk Expertise Centrum Kindermishandeling, www.leck.nu)	Geen	Geen actie

Schoonenberg*	Vertrouwensarts Veilig Thuis Amsterdam-Amstelland	Voorzitter VVAK (onbetaald)	Geen	Geen actie
Rippen	Directeur Stichting Kind en Ziekenhuis (32 uur) Eigenaar Fiduz management (8-12 uur) (strategie, advies en projectmanagement)	• Lid Raad van Toezicht MEEr-groep • Lid Adviesraad Medgezel • Coördinator European Association for Children in Hospital (EACH) • Bestuurslid College Perinatale zorg (CPZ) • AQUA De methodologische Advies- en expertgroep Leidraad voor Kwaliteitsstandaarden (AQUA) • Penningmeester Ervaringskenniscentrum Schouders • Voorzitter Landelijke Borstvoedingsraad • Voorzitter MKS Landelijke coördinatieteam Integrale Kindzorg • Voorzitter Expertiseraad Kenniscentrum kinderpalliatieve zorg • Lid Algemene Ledenvergadering VZVZ • Lid beoordelingscommissie KIDZ	Geen	Geen actie
Metting	Neuroloog/Kinderneuroloog Ommelander Ziekenhuis Groningen	Geen	Geen	Geen actie
Bakx	Kinderchirurg Amsterdam UMC	Voorzitter richtlijnencommissie NVvH Lid adviescommissie richtlijnen FMS secretaris bestuur Stichting Spoedeisende hulp bij kinderen Lid werkgroep ontwikkeling Nationaal Signaleringsinstrument Kindermishandeling	Geen	Geen actie
Jongbloets	Arts Maatschappij en Gezondheid profiel JGZ Stafarts JGZ Volksgezondheid Gemeente Utrecht	Gastdocent NSPOH, opleiding jeugdarts, betaald	Geen	Geen actie
Van Hoof	Praktijkeigenaar iMindU, praktijk voor (kinder- en jeugd)psychiatrie en psychotherapie (Kinder- en jeugd)psychiater; https://www.imindu.nl	Onbezoldigd: • onderzoeksaffiliatie met LUMC-Curium (oktober 2006 t/m juni 2021) en Amsterdam UMC (sinds november 2020) • bestuurslid afdeling psychotherapie Nederlandse Vereniging voor Psychiatrie (sinds september 2021) • bestuurslid Nederlandstalige Vereniging voor Psychotrauma, portefeuille psychotrauma kind en gezin (januari 2019-maart 2022) • voorzitter werkgroep Meldcode Kindermishandeling en Huiselijk Geweld Nederlandse Vereniging voor Psychiatrie (sinds november 2018 voorzitter; 2009-2012 en 2016-2018 lid; soms vacatiegeld) • voorzitter expertgroep Trauma en Kindermishandeling	iMindU richt zich o.a. op trauma (inclusief aanpak kindermishandeling en huiselijk geweld), gehechtheid, emotieregulatie/persoonlijkheidsontwikkeling van kinderen, jeugdigen en volwassenen. PCF komt zelden op het moment dat het gebeurt aan de oppervlakte, vaker is behandeling van gebeurtenissen achteraf nodig. Ideëel belang: implementatie van aandacht voor en	Geen actie

		Kenniscentrum Kinder- en Jeugdpsychiatrie (sinds 2007) • bestuurslid Project On Women Empowerment in Reproductive Health (2006-2022) • voorzitter Vrienden van het Willibrord gymnasium (2017-april 2022) • redactielid Kind en Adolescent Praktijk (sinds 2018) • redactielid Tijdschrift voor Psychotherapie (sinds februari 2022) • gevraagd als voorzitter organizing committee International Attachment Conference 2024 (SEAS)-(sinds juni 2021) • voorzitter Publieksdag 'Kapla' 6 juli 2022 in kader van Leiden 2022 European City of Science.	diagnostiek van gehechtheid naast diagnostiek van psychopathologie als transdiagnostische factor van belang zowel preventief, in diagnostisch arsenaal als in behandeling van kind en gezin.	
Van Mill	Kinderarts-MDL WKZ te Utrecht 0.8 FTE	Geen	Geen	Geen actie
Worm	Ik ben werkzaam als vertrouwensarts bij Veilig Thuis Gelderland zuid (32 uur). Veilig Thuis Gelderland zuid valt onder de GGD Gelderland zuid. Ik ben kinderarts en recent als kinderarts inzake PCF ge herregistreerd.	Ontwikkelen Praatboek voor kinderen in de jeugdbeschermingsketen in samenwerking en opdracht van het ministerie van VWS (periode december 2020-mei 2021) (Subsidie) Het geven van presentatie inz PCF voor Hogeschool Arnhem en Nijmegen, LVAK (betaald) vanuit eigen onderneming Medicus Vermino. Recent geregistreerd bij de Nationale Politie als landelijk deskundigheids makelaar op het gebied van PCF (betaling per advies)	Geen	Geen actie
Zwart	Intensive Care Kinderen Verpleegkundige Amsterdam UMC (AMC)	Werkgroep Kindermishandeling Werkgroep Voorbehouden Handelingen Valt beide onder werktijd.	Geen	Geen actie
Affourtit	Kinderarts-sociale pediatrie LECK kinderarts	WOKK instructeur, vacatiegeld, LECK bestuurder, vacatiegeld Erasmus MC	Partner in NSK onderzoek, financier 1: ZonMW: signaleren kindermishandeling. toename van eigen kennis als expert op gebied van kindermishandeling, kan van toepassing zijn in de patiëntenzorg en adviezen aan collega's	Geen actie

Inbreng patiëntenperspectief
Er werd aandacht besteed aan het patiëntenperspectief door afvaardiging van Stichting Kind & Ziekenhuis in de werkgroep.

Wkkgz & Kwalitatieve raming van mogelijke substantiële financiële gevolgen
Kwalitatieve raming van mogelijke financiële gevolgen in het kader van de Wkkgz
Bij de richtlijn is conform de Wet kwaliteit, klachten en geschillen zorg (Wkkgz) een kwalitatieve raming uitgevoerd of de aanbevelingen mogelijk leiden tot substantiële financiële gevolgen. Bij het uitvoeren van deze beoordeling zijn richtlijnmodules op verschillende domeinen getoetst (zie het stroomschema op de Richtlijnendatabase).

Uit de kwalitatieve raming blijkt dat er waarschijnlijk geen substantiële financiële gevolgen zijn, zie onderstaande tabel.

Module	Uitkomst raming	Toelichting
Module 1	geen financiële gevolgen	Hoewel uit de toetsing volgt dat de aanbeveling(en) breed toepasbaar zijn (5.000-40.000 patiënten), volgt ook uit de toetsing dat [het overgrote deel (±90%) van de zorgaanbieders en zorgverleners al aan de norm voldoet OF het geen nieuwe manier van zorgverlening of andere organisatie van zorgverlening betreft]. Er worden daarom geen financiële gevolgen verwacht.

Werkwijze
AGREE
Deze richtlijnmodule is opgesteld conform de eisen vermeld in het rapport Medisch Specialistische Richtlijnen 2.0 van de adviescommissie Richtlijnen van de Raad Kwaliteit. Dit rapport is gebaseerd op het AGREE II instrument (Appraisal of Guidelines for Research & Evaluation II; Brouwers, 2010).

Knelpuntenanalyse
Gedurende het ontwikkelproces van fase 1 heeft een eerste invitational conference plaatsgevonden, waarbij aan de hand van stellingen input is gevraagd van de aanwezigen op de eerste 2 modules van de richtlijn. Deze input is verwerkt in desbetreffende modules. Een verslag van de invitational is opgenomen onder aanverwante producten.

Methode literatuursamenvatting
Een uitgebreide beschrijving van de strategie voor zoeken en selecteren van literatuur is te vinden onder ‘Zoeken en selecteren’ onder Onderbouwing. De beoordeling van de kracht van het wetenschappelijke bewijs wordt hieronder toegelicht.

Overwegingen (van bewijs naar aanbeveling)
Om te komen tot een aanbeveling zijn naast (de kwaliteit van) het wetenschappelijke bewijs ook andere aspecten belangrijk en worden meegewogen, zoals aanvullende argumenten uit bijvoorbeeld de biomechanica of fysiologie, waarden en voorkeuren van patiënten, kosten (middelenbeslag), aanvaardbaarheid, haalbaarheid en implementatie. Deze aspecten zijn systematisch vermeld en

beoordeeld (gewogen) onder het kopje 'Overwegingen' en kunnen (mede) gebaseerd zijn op expert opinion. Hierbij is gebruik gemaakt van een gestructureerd format gebaseerd op het evidence-to-decision framework van de internationale GRADE Working Group (Alonso-Coello, 2016a; Alonso-Coello 2016b). Dit evidence-to-decision framework is een integraal onderdeel van de GRADE methodiek.

Formuleren van aanbevelingen

De aanbevelingen geven antwoord op de uitgangsvraag en zijn gebaseerd op het beschikbare wetenschappelijke bewijs en de belangrijkste overwegingen, en een weging van de gunstige en ongunstige effecten van de relevante interventies. De kracht van het wetenschappelijk bewijs en het gewicht dat door de werkgroep wordt toegekend aan de overwegingen, bepalen samen de sterkte van de aanbeveling. Conform de GRADE-methodiek sluit een lage bewijskracht van conclusies in de systematische literatuuranalyse een sterke aanbeveling niet a priori uit, en zijn bij een hoge bewijskracht ook zwakke aanbevelingen mogelijk (Agoritsas, 2017; Neumann, 2016). De sterkte van de aanbeveling wordt altijd bepaald door weging van alle relevante argumenten tezamen. De werkgroep heeft bij elke aanbeveling opgenomen hoe zij tot de richting en sterkte van de aanbeveling zijn gekomen.
In de GRADE-methodiek wordt onderscheid gemaakt tussen sterke en zwakke (of conditionele) aanbevelingen. De sterkte van een aanbeveling verwijst naar de mate van zekerheid dat de voordelen van de interventie opwegen tegen de nadelen (of vice versa), gezien over het hele spectrum van patiënten waarvoor de aanbeveling is bedoeld. De sterkte van een aanbeveling heeft duidelijke implicaties voor patiënten, behandelaars en beleidsmakers (zie onderstaande tabel). Een aanbeveling is geen dictaat, zelfs een sterke aanbeveling gebaseerd op bewijs van hoge kwaliteit (GRADE gradering HOOG) zal niet altijd van toepassing zijn, onder alle mogelijke omstandigheden en voor elke individuele patiënt.

Implicaties van sterke en zwakke aanbevelingen voor verschillende richtlijngebruikers		
	Sterke aanbeveling	*Zwakke (conditionele) aanbeveling*
Voor patiënten	De meeste patiënten zouden de aanbevolen interventie of aanpak kiezen en slechts een klein aantal niet.	Een aanzienlijk deel van de patiënten zouden de aanbevolen interventie of aanpak kiezen, maar veel patiënten ook niet.
Voor behandelaars	De meeste patiënten zouden de aanbevolen interventie of aanpak moeten ontvangen.	Er zijn meerdere geschikte interventies of aanpakken. De patiënt moet worden ondersteund bij de keuze voor de interventie of aanpak die het beste aansluit bij zijn of haar waarden en voorkeuren.
Voor beleidsmakers	De aanbevolen interventie of aanpak kan worden gezien als standaardbeleid.	Beleidsbepaling vereist uitvoerige discussie met betrokkenheid van veel stakeholders. Er is een grotere kans op lokale beleidsverschillen.

Commentaar- en autorisatiefase

De conceptrichtlijnmodule werd aan de betrokken (wetenschappelijke) verenigingen en (patiënt) organisaties en aan de genodigden van de invitational conference voorgelegd ter commentaar. De commentaren werden verzameld en besproken met de werkgroep. Naar aanleiding van de commentaren werd de conceptrichtlijnmodule aangepast en definitief vastgesteld door de werkgroep. De definitieve richtlijnmodule werd aan de deelnemende (wetenschappelijke) verenigingen en (patiënt) organisaties voorgelegd voor autorisatie en door hen geautoriseerd dan wel geaccordeerd.

Literatuur

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Module 1 Definities in de literatuur

Uitgangsvraag
Welke termen en definities zijn in de loop der tijd door professionals gebruikt (historisch perspectief) en welke term(en) en definitie(s) zijn het meest praktisch om te gebruiken door zorgprofessionals (m.n. door (kinder)artsen en vertrouwensartsen) in het proces rondom dit type casuïstiek?

Inleiding
Het doel van deze module is tweeledig:
1. Een historisch overzicht te geven van gebruikte termen en definities indien er een verdenking is op conditiefalsificatie bij kinderen. Aangezien er in de afgelopen jaren veel variaties zijn geweest in gebruikte termen en definiëring daarvan, wordt eerst een historisch overzicht gepresenteerd in het Engels waarbij in chronologische volgorde de verschillende benamingen en motivaties hiervoor aan bod komen.
2. Termen en definities te presenteren waarvan de werkgroep aanbeveelt ze te gebruiken met een motivatie voor deze keuze.

Search and select (Methods)
The databases Medline (via OVID) and Embase (via Embase.com) were searched with relevant search terms from the year 2000 until June 24th, 2021. The detailed search strategy is depicted under the tab Methods. The orientational literature search resulted in 186 unique hits. Studies were selected based on the following criteria:
- They should be a systematic review (SR) or a guideline;
- Published since the year 2000 until June 24th, 2021;
- And be in line with our research question.

A total of 25 publications were selected based on title and abstract screening. After reading the full text, 16 were selected and 9 were excluded (see the table with reasons for exclusion under the tab Methods). After scanning the reference lists of the included publications, 2 additional publications were added. In the end, 18 publications - 2 guidelines and 16 reviews - were included.

Summary of literature
<u>Historical overview of terminology and definitions: a review of reviews</u>
Since the introduction of the term “Münchausen (Syndrome) by proxy” (M[S]BP) by Meadow in 1977, there has been a lot of debate about what M(S)BP exactly entails (Meadow, 2002). The definition overall includes characteristics of the behavior and/or intentions of a perpetrator, mostly a parent or caretaker, and characteristics of the abuse suffered by the proxy, mostly a child (Ayoub, 2002). However, thus far, agreement on what characteristics define M(S)BP and where the focus should lie, on the perpetrator or on the abused victim, has not been reached. Over the last decades, new terminology has been introduced, with terms specifically addressing the diagnosis of the perpetrator and terms referring to the abuse. However, it remains difficult to come up with terminology and a definition that is practicable for all professionals that might encounter cases of M(S)BP, including medical and mental healthcare workers, and professionals working in the educational or legal justice system. As a result, terminology and definitions differ across countries and professional fields (Davis, 2019; Mart, 2004; Meadow, 2002). This lack of consensus with regard to definition and terminology impedes scientific research, effective recognition of cases of M(S)BP, constructive collaboration between all possible professionals involved in such cases, and ultimately it impedes the provision of the right care for both victim and perpetrator (Korpershoek, 2004; Mart, 2002).

In this module, we will provide an overview of the terminology and definitions coined over the decades since M(S)BP was introduced by Meadow.

Meadow (1977) first described M(S)BP, referring to mothers deliberately falsifying illness in their children. Meadow used the term to describe the combination of the abuse (and neglect) and the motivation of the caregiver. However, confusion arose whether the term should be applied to the child as a victim of abuse or to the abuser who intentionally falsifies illness, and whether the motivational component should be part of its definition or not (The American Professional Society on the Abuse of Children [APSAC], 2017; Mart, 2004). As a result, various definitions and new terminology have been introduced.

Rosenberg (1987) reviewed the literature on M(S)BP and identified a symptom cluster constituting one of the most widely accepted definitions used as a basis elaborated on in later definitions of M(S)BP (in Abdurrachid 2020; Frye, 2012; Korpershoek, 2004; Mart, 2004; Meadow, 2002; Rogers, 2004; Shaw, 2008; Sheridan 2003):

1. Illness in a child that is simulated (faked) 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; and
4. Acute symptoms and signs of the child abate when the child is separated from the perpetrator.

Rosenberg further specified the exclusion of cases in which children had incurred physical abuse only, sexual abuse only, and nonorganic failure to thrive only. Furthermore, Rosenberg rejected the idea that a psychiatric or motivational component should be part of the definition of M(S)BP, stating the difficulty in differentiating between M(S)BP and intentional poisoning, infanticide, pathological doctor shopping, extreme parental anxiety, or thought disorder, and considering the probability that the underlying psychology overlapped (Mart, 2004; Meadow, 2002).

Authors have argued that Rosenberg's definition is too broad for practical use. Symptoms two and tree (i.e. persistent presentations and denial of knowledge about etiology) have been considered too unspecific because these symptoms are likely to also be observed in non-abusing parents who are seeking treatment for unexplained symptoms (Rogers, 2004). Others have argued that leaving out the motivational component hampers the correct identification of cases and adequate management, including treatment choices for both victim and abuser, and possible legal steps to be taken (Frye, 2012; Korpershoek, 2004; Mart, 2004; Meadow, 2002; Roesler, 2018). Even though motivation is sometimes difficult to determine, these authors agree that the use of M(S)BP should be limited to the precise form of abuse in which active deception is involved and the primary motive of emotional gratification can be established (Meadow, 1995, and Rand and Feldman, 1999; in Frye, 2012). Emphasizing the importance of motivation, Meadow redefined the M(S)BP criteria, combining Rosenberg's criteria two and three and adding a new fourth criterium addressing the motivation of the perpetrator (Meadow, 2002):

1. Illness fabricated (faked or induced) by the parent or someone in loco parentis;
2. The child is presented to doctors, usually persistently; the perpetrator (initially) denies causing the child's illness;
3. The illness goes when the child is separated from the perpetrator;
4. The perpetrator is considered to be acting out of a need to assume the sick role by proxy or as another form of attention seeking behavior.

Getting attention for being the devoted parent of a child who is constantly sick is considered an important example of a possible incentive (Frye, 2012). Additionally, Meadow and others have stressed the importance of the active or passive implication of physicians and/or other medical staff in the abuse when defining M(S)BP (Ayoub, 2002; Galvin, 2005; Meadow, 2002; Roesler, 2018;

Schreier, 2002). Besides medical staff, the deception may also be targeted at other professionals of knowledge and influence such as school and mental healthcare personnel, and representatives of the law and justice system (Ayoub, 2002; Frye, 2012).

Although many authors consider the motivation of the perpetrator important in defining and identifying M(S)BP, authors differ in their opinion which motivations are associated with M(S)BP (hence pertaining to its definition). With their definition of M(S)BP, Kelly and Loader (1997; in Korpershoek, 2004) allowed for every possible motivation as long as exaggeration or fabrication of signs and symptoms in a child by a caregiver had taken place. They specified examples such as that of the excessively anxious parent exaggerating signs, the parent pursuing medical explanation to cover up child abuse, the parent in a custody battle inflicting an injury to a child attempting to make it appear that the other parent is responsible for the harm, and the misguided or delusional parent believing their child is genuinely ill and/or that medicalization is in the child's best interest.

This definition was criticized by Libow and Schreier (1998; in Korpershoek, 2004) for being too broad to be useful for diagnosis; a diagnosis should be more specific to be able to determine the type of treatment/response. Kelly and Loader (1998; in Korpershoek, 2004) responded to this criticisms made by Schreier and Libow (1998), arguing for subcategories of perpetrators of exaggeration or fabrication of signs and symptoms in a child, of which M(S)BP could be one, with each of the subcategories having different motivations and, therefore, different treatment/management strategies. In their turn, Libow and Schreier (1986; in Abdurrachid, 2020; and in Korpershoek, 2004) distinguished three categories of M(S)BP perpetrators based on their motivation:

1. *Active inducers* cause active and direct harm to their child, they appear as devoted, calm, trustworthy and co-operative until discovery, they have a mutually dependent relationship with their child, mechanisms of denial and projection are thought to dominate this picture together with being appreciated as a good parent, and they are very resistant to therapeutic interventions directed at them.
2. *Doctor addicts* are obsessed with the goal of obtaining medical treatment for non-existent illnesses in their children, their behavior is thought to be characterized by falsification of history and symptoms, they tend to over-react to the child's 'medical' condition, whilst under-reacting to the child's emotional state, they typically appear more suspicious, antagonistic, and paranoid, are thought to lack insight, and with the inability to acknowledge their behavior, they do not readily accept therapeutic interventions for themselves.
3. *Help seekers* use the fictitious child illness to communicate their own feelings of distress or inadequacy, their behavior is seen as more under their conscious control, less severe (as compared to active inducers) and open for correction as they usually readily accept psychotherapy.

They added that it is important to distinguish between M(S)BP parents and concerned or delusional parents. Later, Schreier (2002) further specified that "help seekers" should actually not be considered a M(S)BP category of perpetrators and neither all doctor addicts / doctor shoppers should be considered as M(S)BP perpetrators, because also anxious parents may doctor shop when they believe that their child is not being diagnosed or treated correctly; these parents may agree to letting their children get tested but inquire what the tests are for and are worried about possible negative consequences. According to Schreier (2002), this behavior distinguishes them from true M(S)BP perpetrators.

Attempts have been made to capture the motivational component in the diagnosis/description of the psychopathology of the perpetrator engaging in M(S)BP abuse. The Diagnostic and Statistical Manual of Mental Disorders (DSM) proposed the term Factitious Disorder By Proxy (FD[B]P) in 1994 (DSM-IV, American Psychiatric Association [APA], 1994) in the section "Criteria sets and axes provided for further study". It was initially not considered an official diagnosis because insufficient

information was available to warrant inclusion in the DSM (in Mart, 2004). The DSM-IV-TR (APA, 2000) research criteria for 'Factitious Disorder by Proxy' were listed as (in Meadow, 2002):

A. Intentional 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 to assume the sick role by proxy.
C. External incentives for the behavior, such as economic gain, are absent.
D. The behavior is not better accounted for by another mental disorder.

These proposed diagnostic criteria were criticized for being too vague and broad to be useful (Rogers, 2004), increasing the risk of a false positive diagnosis (i.e. overdiagnosis)(Mart, 2002). Criterium B was thought to be superficial and inadequate in explaining the complexities and dynamics involved by stating that the internal motivation only included "assuming the sick role by proxy" (Korpershoek, 2004; Meadow, 2002; Rogers, 2004; Schreier, 2002). In addition, with respect to criterium C, some considered the APA naïve in insisting that the presence of malingering by proxy (i.e. external incentives as motivation) excludes a FD(B)P diagnosis. According to these authors, external incentives may co-exist, but are secondary to the internal psychological motivation (Meadow, 2002; Rogers, 2004; Schreier, 2002). To help with the diagnosis of FD(B)P, Rogers (2004) proposed that the diagnosis could be characterized as "feigning by proxy", connecting it to the existing DSM-IV label "Factitious Disorders", organizing it in the same way with three categories of feigning: Malingering By Proxy, Factitious Disorder Psychological By Proxy (i.e. signs and symptoms are predominantly psychological in nature), and Factitious Disorder Medical By Proxy (i.e. signs and symptoms are predominantly physical in nature).

It was not until the fifth edition of the DSM (DSM-5, APA, 2013) that the diagnosis was officially included, now described by the term "Factitious Disorder Imposed on Another" (FDIA), and containing an altered set of criteria:

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
B. The individual presents another individual (victim) to others as ill, impaired, or injured.
C. The deceptive behavior is evident even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

In the new set of criteria, the APA seems to have taken to heart some of the previous critiques. Now they include falsification of psychological signs or symptoms, and allow for the possibility of the co-existence of malingering (by proxy) and other internal motivations than "to assume the sick role by proxy." While it must be clear that the psychological needs of the perpetrator have taken precedence over the needs of the victim to pave the way for them to harm their victim in order to have those needs met, specification of a certain type of internal motivation (attention, sick role, or other) is not required to diagnose FDIA. Compared with the previous version and in accordance with Meadow's definition (in Frye, 2012), the DSM-5 has increased the emphasis on deception (which is conscious, carefully planned and concealed) as the cornerstone of the disorder and subsequently, a need to identify deception as part of the FDIA evaluation process (APSAC, 2017).

Still, with its focus on deception, this definition of FDIA does not encompass all possible psychopathology and/or motivations caregivers may have, underlying their behavior of falsifying physical or psychological signs or symptoms in their children. Just as Kelly and Loader (1998; in Korpershoek, 2004), other authors have suggested that FDP/FDIA may represent only the extreme end of a spectrum of parental behavior and motivation underlying falsified conditions in children (Krener and Adelman, 1988, and Roth, 1990; in Shaw, 2008; Korpershoek, 2004).

Others criticize that by focusing on the perpetrator, half of the picture is neglected; the definition should also focus on the abuse and its victim (APSAC, 2017; Ayoub, 2002; Frye, 2012; Galvin, 2005), and many argue that the abuse should even be the primary focus (Mart, 2002; Mart, 2004; Davis, 2019; Glaser, 2019; RCPCH, 2021; Roesler, 2018). To address this issue, an APSAC taskforce introduced the term "Pediatric Condition Falsification" (PCF; Ayoub and Alexander, 1998; in Frye, 2012) to refer to a form of child maltreatment in which an adult falsifies physical or psychological signs or symptoms in a victim, causing the victim to be regarded as more ill or impaired than is objectively true (APSAC, 2017; Frye, 2012). To clarify that this term refers to child abuse and neglect, they later added the words "abuse by" (APCF; APSAC, 2017). (A)PCF refers to the child abuse regardless of motivation. Therefore, (A)PCF can exist without a parent being diagnosed with FDIA (Galvin, 2005). With the introduction of the term (A)PCF, combined with the diagnosis of the perpetrator (FD(B)P/FDIA), APSAC hoped to create better defined diagnostic criteria for M(S)BP (Galvin, 2005). However, neither M(S)BP nor (A)PCF is an official diagnosis. Thus far, FDIA is the only diagnosis specifically linked to M(S)BP cases, applied to the perpetrator, with ICD-10-CM code F68.A (6D51 in ICD-11). To the victim, the classification "child physical abuse, suspected" (T76.12XA) or "confirmed" (T74.12XA) can be applied.

With regard to the abuse by PCF, specifications have been made about the methods of falsification, the types of conditions falsified, and types of harm the victim may suffer.

Methods of falsification (APSAC 2017; Galvin, 2005):

- Providing false information about the child's current situation and history of symptoms, limitations, or treatments;
- Withholding information that would help explain the child's current presentation;
- Exaggerating symptoms or limitations, so that the child is seen as more severely ill or impaired than is true;
- Simulating symptoms by manipulating test procedures or results;
- Neglecting the child by withholding nutrition, or treatments;
- Inducing symptoms or impairments;
- Coaching / manipulating the victim or another person involved to answer questions in a way that substantiates and corroborates the false claims of the abuser.

Types of created, falsified, or exaggerated conditions (i.e. illness, disorder, disability, impairment or symptom; APSAC, 2017; Ayoub, 2002, Frye, 2012, Schreier, 2002; Sheridan, 2003):

- Physical: e.g. allergies, asthma, apnea, gastrointestinal problems, failure to thrive, fevers, infections, and seizures;
- Behavioral or psychiatric: e.g. falsely reporting symptoms consistent with a behavioral disorder, mental illness or disability;
- Educational: e.g. falsely reporting learning disabilities, attention deficit disorders, or autism; also labeled "Educational condition or disability Falsification (ECF).

Classical forms of child abuse and neglect may occur co-morbidly or may also be volitionally falsified.

Manners in which the child may be victimized/harmed by (A)PCF (APSAC, 2017; Ayoub, 2002; Parrish, 2004). Victims may suffer

- physical and/or mental harm by the abuser's fabrication or induction behaviors;
- physical and/or mental harm (i.e. iatrogenic harm) by undergoing unnecessary and invasive evaluations and interventions;
- psychosocial and/or developmental harm by being kept out of appropriate school settings, missing social and developmental opportunities, misperceiving themselves to be (excessively)

ill or disabled, and/or being exposed to considerable deception and secrecy on part of the abuser.

Examples of permanent physical harm are brain damage, loss of sight or hearing, scarring, loss of organs, and death. Examples of other forms of harm include the development of behavioral and emotional distortions (e.g. problems with attachment and social relationships, losing a positive self-image) and psychopathological disorders (e.g. disorders of psychotraumatic stress, anxiety, depression and/or somatization), including Factitious Disorder Imposed on Self.

However, APSAC has held on to the term M(S)BP as the umbrella term, with PCF defining the part of the abuse and FDIA the part of the psychopathology of the abuser. By applying this terminology, some have argued that the focus is still too much on the abuser and the implied psychopathology instead of the abused child, and the involvement of the third party, the health care professional, isn't addressed enough (RCPCH, 2021; Roesler, 2018). Furthermore, its categorical nature does not cover the full range of abuse and underlying motivations, but implies only the most severe forms of abuse and parental behavior and motivation (Mart, 2004). Therefore, the abandonment of these potential prejudicial labels has been suggested in favor of what is suggested to be a more general term: "medical child abuse" (MCA; Mart, 2004; Roesler, 2018).

Roesler (2018) states that MCA clearly labels the behavior as a form of abuse, not as a diagnosis, while explicitly stating the medical connection. Just as physical and sexual child abuse, it refers not to any medical condition that the child may have, but to an event or series of events in a child's life which may have medical consequences. Just as the other forms of abuse, it can be described as occurring on a continuum of severity form mild to moderate to severe. Roesler stresses that for healthcare providers their priority should not lie with the parent and the motivation behind the abuse, but with the child and ensuring that potentially harmful therapies are stopped (Roesler, 2018). Roesler's line of thinking concurs with the most recent view of the American Academy of Pediatrics (AAP), which coined another term with a definition that is focused on the abused child and not, or less on the motivation of the caregiver: Caregiver-fabricated illness in a child (CFIC; Flaherty, 2013; in APSAC, 2017). It is defined as maltreatment that occurs when a child has received unnecessary and (potentially) harmful medical care because of the caregiver's fabricated claims, or signs and symptoms induced by the caregiver.

From a legal point of view, Mart's 2004 paper is in agreement with Roesler's statements, but also warns that using the M(S)BP terminology of FDBP/FDIA/(A)PCF introduces bias in court by being associated with claims of more severe forms of intent and less correctable behavior without the proper evidence/research to back up these claims. Mart states that, because of this, courts tend to respond more strongly in alleged cases of M(S)BP/FDBP/FDIA/(A)PCF than in other abuse cases (Mart, 2002). Therefore, Mart proposes to refer to these types of cases as MCA and treat MCA in court as a multiaxial phenomenon for the purpose of disposition and child protection. According to Mart, courts would benefit from an objective description of the acts of abuse (i.e. the "guilty act" or actus reus) together with a description of the perpetrator's behavior in terms of a multiaxial continuum of the following dynamic variables establishing the "guilty mind" (i.e. mens rea):

- Secondary gain: Mart states that secondary gain is not unique to MCA cases; illnesses and injuries always have the potential to produce secondary gain which may be minor, in balance with, or outweigh the negative effects. Therefore, it is not merely present or absent, it is a dynamic variable that exists on a continuum because it depends on a complex interplay between (pre-existing) physical and/or psychological factors which also exist on a continuum;
- Severity of abuse: The abusive behavior also varies along a continuum of, for example, exaggeration, fabrication, and induction, and Mart stresses that it has not been proven that MCA is more likely to escalate than other forms of abuse;

- Psychopathology of the perpetrator: Mart says that no consistent pattern of psychopathology has been proven by research and therefore, also this variable is dynamic and varies in prognosis and choice of therapeutic modalities, and should be described as such.

Also beyond the legal context, Mart doubts that the FDBP/FDIA and PCF labels add anything useful in terms of diagnosis, prognosis or treatment (psychological and social management); he states that the impact on the child is better described in terms of the physical and emotional harm done by the specific abusive acts and the parental behavior is better conceptualized by the dynamic variables described above (Mart, 2004).

In line with objections made by Mart (2002 and 2004) and Roesler (2018), The Royal College of Paediatrics and Child Health (RCPCH) distanced themselves from M(S)BP and associated terminology and introduced their own terminology: the Perplexing Presentations (PP) and the Fabricated or Induced Illness (FII) spectrum (RCPCH, 2009; in Abdurrachid, 2020; RCPCH, 2021). This terminology describes a wide range of possible cases of falsification of injury or disease in a child, with cases ranging in severity of signs and symptoms, their impact on a child's quality of life and functioning, and in the health professional's certainty about if and how a parent may be involved in the causation of the reported or observed signs and symptoms. The RCPCH (2021) guideline consistently uses the term "parent" in their definitions, specifying that the mother is nearly always involved in PP/FII. Other's (e.g. Davis, 2019) prefer the more general terms "carer" or "caregiver."

- Perplexing Presentations (PP) encompass clinical situations where there are alerting signs of possible FII. The essence of these alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings. Furthermore, health professionals are alert to the possibility that there may be an unusual and potentially harmful parent-child interaction that is causing or perpetuating the presentation, observing that parents are reluctant to support a rehabilitative approach to the child and focus or insist on continued investigations. However, while an adequate and realistic medical explanation is absent and the actual state of the child's health is not yet clear, the extent and risk of immediate harm to the child is not (yet) perceived, the association between the possible harm to the child and parents' actions not (yet) established (Glaser, 2019; RCPCH, 2021).
- Fabricated or Induced Illness (FII) refers to clinical situations in which a child is, or is very likely, harmed due to actions of a parent, carried out in order to convince health professionals that the child's state of physical and/or mental health or neurodevelopment is impaired, or more impaired than is actually the case. FII is a form of child abuse and neglect, physical and/or emotional, that results from behaviors or beliefs of a parent and from subsequent responses of the health professional (i.e. iatrogenic harm; RCPCH, 2021).

A key aspect of the RCPCH terminology is that understanding the parents' motivation is not essential to establish (apply the labels) PP/FII in a child. This is important for pediatricians, because they are not expected to understand parental motivation, but simply to understand the cause of the child's presenting illness. Contrary to FDIA, where deception is an essential criterium for its diagnosis, in FII, when motivation is evident, the parent does not necessarily intend to deceive. The RCPCH (2021; also in Davis, 2019) distinguishes two possible types of parental motivations for FII:

1. Parents may experience a gain from the recognition and treatment of their child as unwell. The parent is thus using the child to fulfil their needs, disregarding the effects on the child. Gains can be psychosocial (e.g. a need for sympathetic attention, support, continued closeness of their child, and/or a need to deflect blame for parenting difficulties or child behavioral problems) and/or material (e.g. financial support for care, improved housing). Personality disorders and deception are more likely in parents with this type of motivation.
2. Parents may have an extreme concern and anxiety about their child's health and may develop, with the aid of the internet, erroneous beliefs about what their child needs (e.g. support,

treatment) based on a misinterpretation or misconstruction of aspects of their child's presentation and behavior. They then need these beliefs confirmed and acted upon to the detriment of their child. In rare cases, these beliefs about the child's health may become fixed or delusional. Anxiety disorders are more likely in parents with this type of motivation.

Just as the APSAC, the RCPCH (2021; also in Davis, 2019) describes the different ways in which parents may falsify signs and symptoms and persuade health professionals to investigate and treat their child:

1. The most common way is by "using their mouth", presenting and erroneously reporting of their child's symptoms, history, results of investigations, medical opinions, interventions and diagnoses. Motivation for these actions may vary.
2. A less common way is by "using their hands" falsifying documents, interfering with investigations, specimens, lines and drainage bags, and (most extreme) inducing illness in their child (e.g. by withholding food or medication from the child, poisoning, suffocation). These actions nearly always include an element of deception.

Lastly, the RCPCH (2021; Davis, 2019) specifies the many ways in which a child may be harmed by FII. Harm to the child may be brought about directly by actions of the parents, or indirectly by healthcare responses. FII may affect

1. the child's overall health due to
    a. the exposure to repeated (unnecessary) medical appointments, examinations, and investigations, which may cause physical and psychological discomfort or distress;
    b. genuine illness being overlooked;
    c. illness induced by their parent/s.
2. the child's development, daily life and (social) functioning due to
    a. having to assume the sick role;
    b. limitation of daily life activities;
    c. interrupted school attendance and education;
    d. social isolation.
3. the child's psychological well-being due to
    a. insecure attachment;
    b. being anxious and confused about their state of health;
    c. developing a false self-view as being sick and vulnerable;
    d. active collusion with the parent's illness deception;
    e. silent entrapment in falsification of illness;
    f. development of later psychiatric disorders and psychosocial difficulties.

Although the terminology coined by the RCPCH is intended for the use by health professionals to diagnose a child's condition, PP/FII are not official diagnostic terms. An adaptation from the ICD-11 "bodily distress disorder" has been proposed, called "child illness: carer distress disorder (Glaser, 2019). The intention is that this would then be an official ICD diagnosis for the presented illness in the child, not a label to refer to the carer. Suggested criteria are (Glaser, 2019):

- Presence of child symptoms that are distressing to the carer.
- The carer's response to the symptoms appears excessive and disproportionate in relation to the nature, impact and progression of the child's symptoms or any confirmed physical illness in the child.
- Excessive carer attention is focused on these symptoms, manifested by repeated contact with doctors, including tests and treatments that may be unnecessary and harmful to the child.
- The carers' excessive responses to the child's symptoms are not alleviated by appropriate examination of the child, reassurance, tests or treatments where needed (however, tests and treatments should not usually be carried out purely to provide reassurance to the carer).

- The child's symptoms (whether reported by the carer or observed due to induced illness) are persistent or relapsing and remitting, and lead to significant functional impairment. There is a risk of harm caused either directly by the carer or indirectly by the doctor.
- The symptoms may be multiple and may vary over time. On the resolution of one symptom another may appear. Different children in the same family may be presented at different times.
- There may or may not be evidence of the carer causing or creating the child's illness through apparently deliberate action (if present this would always require statutory intervention).
- The child may continue to exhibit emotional and physical consequences of the condition even after separation from the carer.

To this day, all these different terms and definitions, M(S)BP, FDIA, (A)PCF, MCA, CFIC, PP, FII exist and are in use alongside each other. It has yet to be decided which of these terms and definitions is/are the most adequate and practicable for continued use in the medical field and beyond, or if yet other terms and definitions are needed.

Overwegingen – van bewijs naar aanbeveling
Uit het historisch overzicht blijkt dat sinds de in 1977 bestaande beschrijving van het 'Munchhausen Syndrome by Proxy' (M[S]BP) als een vorm van kindermishandeling door Prof. dr. Roy Meadow er tal van ontwikkelingen hebben plaatsgevonden betreffende terminologie, definitie, prevalentie en behandeling. Enkele veelgebruikte beschrijvingen/definities in recente literatuur zijn o.a. Fabricated or Induced Illness (FII, RCPCH 2002, 2009), Medical Child Abuse (MCA), Caregiver-Fabricated illness in a Child (CFIC; AAP, 2013), Facticious Disorder Imposed on Another (FDIA, DSM V) en Pediatric Condition Falsification (PCF; APSAC 1998). In de eerdergenoemde VVAK-richtlijn PCF werd Münchausen Syndrome by Proxy gedefinieerd als PCF + FDP. Door deze variaties in terminologie is er onvoldoende duidelijkheid over waar de focus van de definitie zou moeten liggen. Moet de focus zich richten op de presentatie/klachten van het kind, of op de intenties/motivaties van de pleger? Wat is het meest praktisch?

<u>Rationale van de aanbeveling</u>
De beantwoording van het tweede deel van de uitgangsvraag "welke term(en) en definitie(s) zijn het meest passend en haalbaar om te gebruiken door zorgprofessionals (m.n. (kinder)artsen en vertrouwensartsen) in het proces rondom dit type casuïstiek?" is op basis van consensus tussen de werkgroepleden bepaald, met gebruik van informatie uit de literatuursamenvatting, m.n. de richtlijn Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children van The Royal College of Paediatrics and Child Health (RCPCH, 2021) en de artikelen van Davis et al. (2019) en Glaser & Davis (2019).

De werkgroep is van mening dat een werkzame definitie voor de gebruikers van deze richtlijn objectief zou moeten zijn waarbij de definitie tot een objectieve werkwijze zou moeten leiden. Het onderzoek naar motieven bij de pleger wordt door de vertrouwensarts gedaan binnen het kader van Veilig Thuis RT/JS Een zorgprofessional heeft ten slotte als taak te signaleren dat er bij een kind een vermoeden is van onverklaarde klachten welke mogelijk zouden kunnen passen in het kader van verwaarlozing dan wel mishandeling door een ouder/verzorger. Van de zorgprofessional die het kind behandelt wordt niet verwacht dat men zich bezighoudt met de intentie/motivatie van de pleger, dit is immers een taak van de GGZ, Veilig Thuis en Justitie. De werkgroep heeft er daarom voor gekozen om aan te sluiten bij de terminologie opgesteld door de RCPCH (2021) zoals die ook gebruikt wordt in de artikelen van Davis et al. (2014). Er wordt in deze artikelen een onderscheid gemaakt tussen 'Perplexing Presentations' (PP), en 'Fabricated or Induced Illness' (FII). Met deze Engelse termen wordt echter niet direct duidelijk dat het specifiek over kinderen gaat, en daarmee zou de patiënt ook een volwassene kunnen zijn. Ook wordt de overkoepelende en door de werkgroep als meer

duidelijk/herkenbaar beschouwde term “falsificatie” niet gehanteerd. Om deze reden heeft de werkgroep als Nederlandse vertalingen respectievelijk gekozen voor ‘inconsistente presentatie bij het kind,” en “kindermishandeling door falsificatie,” waarbij de laatste term eigenlijk een vertaling is van het Amerikaanse Pediatric Condition Falsification (PCF; APSAC, 1998), maar dan gedefinieerd zoals FII, waarbij falsificatie de overkoepelende term is voor de in FII benoemde fabricatie en inductie van symptomen. Deze term zal dan ook in het vervolg van deze richtlijn worden gebruikt.
Belangrijk is daarbij te benadrukken dat deze diagnose per inclusionem moet worden gesteld, en niet per exlusionem.

Inconsistente presentatie van het kind
De term “inconsistente presentatie van het kind” is overgenomen uit de RCPCH Richtlijn en wordt beschreven als de situatie(s) waarbij:

1. Alarmsignalen worden opgemerkt die kunnen passen bij falsificatie, met andere woorden, deze signalen zouden erop kunnen wijzen dat er sprake is van kindermishandeling door falsificatie. Alarmsignalen kunnen bestaan uit discrepanties tussen heteroanamnese en presentaties van het kind, discrepanties in onafhankelijke observaties van het kind, onwaarschijnlijke beschrijvingen, onverklaarde bevindingen, en/of bepaald gedrag van ouders/verzorgers.
2. Een inconsistente presentatie onderscheidt zich hierdoor van een presentatie met aanhoudende lichamelijke klachten waarvoor geen somatisch substraat wordt vastgesteld (ALK, voorheen SOLK), door deze opgemerkte alarmsignalen voor falsificatie.
3. Hierbij lijkt er bij een inconsistente presentatie nog geen significante schade bij het kind opgetreden, vastgesteld middels een gebruikelijke medische work-up, bestaande uit (hetero-) anamnese, lichamelijk onderzoek en eventueel aanvullende diagnostiek (denk aan schoolverzuim, staken sociale activiteiten, bedlegerigheid, gebruik hulpmiddelen etc.). De staat van het kind m.b.t. het lichamelijke, psychische en mentale welbevinden en de neurocognitieve ontwikkeling is nog niet geheel vastgesteld, maar er wordt ingeschat dat er geen direct ernstig risico bestaat op ernstige schade voor het welzijn van het kind.

   NB Bij een blijvend vermoeden op KMdF zal uiteindelijk de eventuele schade moeten worden beoordeeld conform de term schade zoals beschreven in de definitie Kindermishandeling in de Jeugdwet (2015).

De werkgroep vindt het belangrijk dat er, naast/voorafgaand aan kindermishandeling door falsificatie, een term wordt gebruikt met een definitie, die aansluit bij een open, onderzoekende houding en die, doordat er nog geen concreet vermoeden van kindermishandeling is, nog opening biedt tot het aangaan van een dialoog met de ouders/verzorgers. De werkgroep is van mening dat “inconsistente presentatie bij het kind” hiervoor een geschikte term is.
Waar termen als Münchausen by Proxy en kindermishandeling door falsificatie insinueren dat het kind schade wordt berokkend door een andere partij (i.e. hier een ouder/verzorger), insinueert de term “inconsistente presentatie bij het kind” dat niet. Als er een gesprek met ouders kan worden aangegaan over de klachten van het kind, biedt dat mogelijk meer informatie.

De term inconsistente presentatie is een beschrijvende term waarbij verder onderzoek nodig is naar de oorzaak ervan. Kindermishandeling door falsificatie is een (werk)diagnose, die onderbouwd moet kunnen worden met alle punten die in de onderzoeksfase (inconsistente presentatie) zijn onderzocht. Dit wordt beschreven in module 5.

Kindermishandeling door falsificatie (KMdF)
In het vervolg zal deze term worden gebruikt.

De term “kindermishandeling door falsificatie” (KMdF, voorheen aangeduid als PCF) beschrijft klinische situaties waarin een kind (mogelijk) wordt geschaad door gedrag van een ouder/verzorger. Doel van dit gedrag is om zorgprofessionals te overtuigen van het verstoorde welzijn (of meer verstoorde welzijn dan in werkelijkheid het geval is) van het kind op lichamelijk, psychisch of mentaal vlak, dan wel betreffende de neurocognitieve ontwikkeling. Kindermishandeling door falsificatie is een direct gevolg van handelingen, gedrag of overtuiging van ouder(s) of verzorger(s), en de respons van dokters hierop; het kind wordt daarbij op fysiek en/of psychosociaal vlak geschaad. Het is daarbij van belang om op te merken dat volgens de door de RCPCH gehanteerde definitie, de ouders/verzorgers niet noodzakelijk de intentie hebben om te bedriegen, en dat hun motief niet altijd duidelijk is.

Wat kindermishandeling door falsificatie onderscheidt van inconsistente presentatie, is de reactie van ouders/verzorgers op een voorstel om van de medische onderzoeksfase over te gaan naar de fase gericht op herstel van het kind. Wanneer er sprake is van KMdF dan kan door de behandelaar opgemerkt worden dat ouders/verzorgers persisteren in hun zoektocht om meer onderzoeken en diagnoses te overwegen, dat zij meerdere medische meningen/second opinion van specialisten zoeken, en/of dat zij niet participeren in het herstelproces van het kind. Ook kan gezien worden dat ouders/verzorgers het moeilijk vinden als het kind beter om kan gaan met gezondheidsproblemen. Bij KMdF zijn de bij inconsistente presentaties beschreven discrepanties persisterend en onopgelost, kan het verwachte herstelproces staken en loopt het kind hierdoor schade op. Wat KMdF onderscheid van medische verwaarlozing bij niet participeren in het plan voor herstel is het feit dat de arts meent dat er aanwijzingen zijn die kunnen passen bij falsificatie.

Aanbevelingen

Rationale van de aanbeveling

De werkgroep beschouwt de volgende terminologie en definities het meest praktisch hanteerbaar voor zorgprofessionals wanneer er sprake is van een vermoeden van kindermishandeling door falsificatie.

- De term ‘Inconsistente presentatie van het kind’ biedt nog een opening tot dialoog met de ouders om meer informatie in te winnen en mogelijke escalatie te voorkomen.
- De term ‘Kindermishandeling door falsificatie’ en de gehanteerde definitie is kindgericht, benadrukt dat falsificatie het gedrag van de ouder typeert, dat het kind daardoor direct schade wordt toegebracht of indirect door de respons van de zorgprofessional op dat gedrag/het gepresenteerde beeld, en deze definitie maakt het mogelijk een open blik op het mogelijke motief van de ouder/verzorger te behouden, zonder de noodzaak dit motief direct vast te stellen, hetgeen ook in de meeste gevallen voor de behandelend zorgprofessional niet goed mogelijk is.

Om deze redenen is dit is de terminologie die verder in deze richtlijn gehanteerd zal worden.

Gebruik de term **Inconsistente presentatie van het kind** (Perplexing Presentation; PP) in een klinische situatie waarbij signalen worden opgemerkt die verklaard kunnen worden door meerdere oorzaken waaronder kindermishandeling door falsificatie. Bij een inconsistente presentatie wordt significante schade aan het kind na een gebruikelijke medische work op nog niet vermoed en/of er is nog geen sprake van daadwerkelijke significante schade. (stap 1 van de Meldcode)

Gebruik de term **Kindermishandeling door falsificatie** (KMdF) in een klinische situatie waarin een kind wordt geschaad, nu of in de toekomst, door falsificerend gedrag van een ouder/verzorger betreffende het verstoorde welzijn van het kind op lichamelijk of psychisch vlak, mentaal welbevinden dan wel neurocognitieve ontwikkeling. (stap 2 van de Meldcode)

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Bijlagen bij module 1

Evidence table for review of review (summary of literature)

	Umbrella terminology; Terms encompassing the other terminology, focusing on both the parent / abuser and the child / victim	**Terms focusing on the parent / abuser / their psychopathology, their behaviour and motivation**	**Terms focusing on the child / the victim / the abuse, the harm that is done to them**
Terminology **Source**	**Munchhausen Syndrome by Proxy (MSBP) / Münchausen by proxy (MBP)** **Fabricated or induced Illness (FII)**	**Factitious Disorder by Proxy (FDP)**; older term, replaced by the APA (DSM-5) term: **Factitious Disorder imposed on another (FDIA / FDIoA)**; behaviour is associated with identified deception FDP and FDIA/FDIoA include **obstetric factitious disorder** DSM-5 V-code: **Malingering**, which can be "**by Proxy" (MAL-BP)**	**Medical Child Abuse (MCA)** **Pediatric Condition Falsification (PCF) / Abuse by PCF (APCF),** including **Educational Condition or disability Falsification (ECF)**. **Caregiver-fabricated illness in a child (CFIC) / Parent-Fabricated Illness in a Child (PFIC)** **Perplexing Presentations (PP)** **Child illness: Carer distress disorder** (adapted from ICD-11 bodily distress disorder; proposed term in Glaser 2019)
Abdurrachid, 2020, Systematic review	**MSBP should be used to define the abuse itself.** APSAC guidelines (2017) define MSBP as "abuse by paediatric condition falsification, caregiver-fabricated illness in a child, or medical child abuse that occurs due to a specific form of psychopathology in the abuser called factitious disorder imposed on another." Not a formal diagnosis in the DSM or ICD. The Royal College of Paediatrics and Child Health (2009) considers the term MSBP "inappropriate" as it may imply a psychiatric diagnosis and furthermore takes the focus away from the victim, suggesting the term "fabricated or induced illness spectrum," with a more detailed description focused on the type of falsification in the abuse. The victims are mostly children.	**The psychopathology of the perpetrator is referred to as FDIA.** FDIA is a psychiatric condition of the perpetrator, who deceives to portray the victim as ill, impaired, or injured, even when there are no clear external rewards. The perpetrators put their psychological needs over the needs of the victim, resulting in the abuse. Contrary to the ICD-10, the ICD 11, which is already online but will be only in effect by 2022, delineates the difference between FDIS (factitious disorder imposed on self) (6D50) and FDIA (6D51). Certain characteristics are common between most perpetrators. They are predominantly female, and, in cases where the victim is a child, the perpetrator is usually the mother. She is articulate, socially adept, and manipulative; she spends plenty of time in the hospital and is familiar with medical terminology; she may have had prior training in the medical field (nurse, medical	Abdurrachid mostly uses the term MSBP, but mentions **MCA and PCF as the appropriate terms when addressing the abuse, centering the problem in the victim.** Children may be directly harmed by the abuser's falsifications or indirectly harmed by undergoing unnecessary evaluations and invasive medical interventions. For children, missing developmental opportunities and being kept out of the school setting are also part of the abuse. The victims often consider themselves as ill and may reveal anxieties about their diagnosis. In older children or adults, FDIS might be comorbid. The difficulty lies in differentiating between genuine and fabricated illness. In fact, the two can coexist, as people with FDIA might exploit genuine illness of their victims.

	Any illness could be the subject of falsification, even psychiatric disorders. Common medical conditions that are induced include: allergies, asthma, diarrhea, seizures, fever, or failure to thrive. Cases of MSBP may present as an acute situation in the hospital. However, they often have a chronic evolution, with frequent exacerbations of fabrications in a wide variety of clinical situations. Types of Falsification in MSBP (APSAC 2017): • False information: Providing false information about current symptoms and limitations in the child; the child's medical history; prior findings, recommendations, or treatments. • Withholding information: Failing to provide information that would help explain the child's current presentation. • Exaggeration: Exaggeration of a symptom of limitation, so that the child is seen as more severely ill or impaired than is true. • Simulation: Altering biological specimens or medical test procedures to yield abnormal results. • Neglect: Withholding medications, nutrition, or treatments to exacerbate symptoms. • Induction: Directly creating symptoms or impairments. • Coaching: Manipulating another to answer questions by clinicians and others in a manner that substantiates and corroborates the false claims of the abuser. Rosenberg (1987) described the characteristics which should be met in a case of MSBP: (1) illness in a child produced by a parent or someone in loco parentis; (2) persistent presentation of the child for medical assessment and care, resulting in multiple medical procedures; (3) denial of knowledge by the perpetrator regarding the aetiology of the child's illness; and (4) symptoms and signs stop when the child is separated from the perpetrator.	technician, social worker, etc.); she may have a history of similar symptoms as the current fabrication in the victim; she is friendly toward the staff; she may act devout and portray the victim as being dependent on her; she may have a history of abuse as a child, substance abuse, or self-destructive behavior; she may have a coexisting personality disorder (usually DSM IV Cluster B: Antisocial, Borderline, Histrionic, and Narcissistic) but does not necessarily have a psychiatric diagnosis. Rand proposed a behavioral model based on a perpetrator who causes harm to discharge dysphoric affects such as anger or anxiety (drive). This behavior is accessible because the perpetrators depersonalize their victims (breakdown of internal inhibitions), and manipulate healthcare workers through their deception, thus avoiding the consequences of their abuse (neutralization of external inhibitions). Libow and Schreier describe three categories of perpetrators based on their motivation: *Help seekers* use the factitious illness to communicate their own feelings of distress and usually readily accept psychotherapy; *doctor addicts* are obsessed with the goal of obtaining medical treatment and are typically more suspicious, antagonistic, and paranoid; *active inducers* cause active and direct harm and are very resistant to therapeutic interventions. It is difficult to place a perpetrator in one of these categories, as their motivations are often undisclosed. An essential criterion in the DSM 5 for the diagnosis of FDIA is identified deception, which is conscious, carefully planned, and well concealed. Unlike malingering, tertiary gains in FDIA usually have no monetary reward. **Factitious disorders during pregnancy (obstetric factitious disorder):** • The endangerment of the foetus is done through self-harm, thus putting at risk the mother's health as well. • Pregnancy can be a catalyst to shift between FDIS and future FDIA	The strange clinical presentation of the victim leads to intensive and often invasive diagnostic work-up, which facilitates the manipulation by the perpetrator and feeds their psychological needs, and can cause complications such as infections, which further harm the victim.

	The distinction between abuse in MSBP and other situations lies in the intention of the perpetrator. In MSBP, the falsification provides gains to the perpetrator, unconscious motivations which fulfil psychological needs of solitude, attachment, family status, or love. Unlike malingering, tertiary gains in FDIA usually have no monetary reward. Falsification alone is not enough to constitute MSBP, as other unspecified abuse also causes caregivers to falsify symptoms in the victim, in order to hide their abuse.		
APSAC, 2017, Guideline	**The MSBP/MBP definition encapsulates both the psychopathology of the abuser and the abuse of the victim.** MSBP/MBP was never a formal International Classification of Disease (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis (American Psychiatric Association, 2013). It is a term that has historically been used (and still is often used) to describe situations in which an individual diagnosed with factitious disorder imposed on another (FDIA) engages in falsifying a condition or illness in another. The victims of this form of abuse span the age range and may include animals (American Psychiatric Association, 2013). Dr. Roy Meadow (1977) first described MSBP in the literature when he coined the term to refer to mothers deliberately falsifying illness in their children. Meadow used the term to describe the combination of the abuse (and neglect) and the motivation of the caregiver. Due to confusion surrounding whether the term should be applied to the child as a victim of abuse or to the abuser who intentionally falsifies illness, several other terms have been proposed. Falsification of illness may take many forms and may occur along a broad spectrum of severity (list with types of falsification; see Abdurrachid 2020). Falsification *always includes a caregiver giving or producing false information or withholding information* in order to deceive.	**Term Describing the Abuser's Psychopathology and Actions:** **Factitious disorder imposed on another (FDIA):** FDIA is a DSM-5 psychiatric diagnosis (American Psychiatric Association, 2013). It is used to describe the psychopathology of some APCF, CFIC, or MCA abusers. Individuals with this diagnosis have falsified or induced physical, psychological, or developmental signs or symptoms in another individual. Intentional deception is associated with this behavior, differentiating it from a delusional or other psychiatric disorder. The deceptive falsification behavior persists even when there are no evident external rewards for the behavior such as money, child custody, or access to drugs, although these motivations may co-exist. The victim of this behavior is presented to others as ill, impaired, or injured. Compared with the previous version, the primary DSM changes include (1) an increased emphasis on deception as the cornerstone of the disorder (and subsequently, a need to identify deception as part of the FDIA evaluation process); (2) the fact that malingering (by proxy) may be a co-morbidity; (3) a simplified approach to motivation by requiring evidence only of internal motivation (primary gain) and not needing to determine a specific motivation (attention, sick role, or other); and (4) the ability to diagnose after a single episode of illness or condition falsification if the criteria are met. A diagnosis of FDIA does not indicate decreased responsibility for harm or freedom from legal liability; however, the abuser's intention is generally not to torture or kill the child, though this may occur. This diagnosis may be similar to making a diagnosis	**Terms Describing the Abuse and Neglect:** • **Pediatric condition falsification (PCF):** The 1996 APSAC task force to more clearly define this type of abuse and neglect (Ayoub et al., 2002, 2004) coined the term pediatric condition (illness, impairment, or symptom) falsification (PCF) to refer to a form of child maltreatment in which an adult falsifies physical or psychological signs or symptoms in a victim, causing the victim to be regarded as more ill or impaired than is objectively true. • **Abuse by pediatric condition falsification (APCF):** The words abuse by have been added to make it very clear that this term refers to child abuse and neglect. • **Caregiver-fabricated illness in a child:** A manifestation of child maltreatment (CFIC), it is the most recent term recommended by the American Academy of Pediatrics to describe this type of abuse and neglect of the child victim (Flaherty & MacMillan, 2013). • **Medical child abuse (MCA):** a term used by many medical providers to describe when a child receives unnecessary and harmful, or potentially harmful, medical care at the instigation of a caregiver (Roesler & Jenny, 2009). This term substantially overlaps with APCF and CFIC. APCF includes MCA and also false or induced problems presented to non-medical providers.

	The abuser may also e*xaggerate symptoms, simulate symptoms, and withhold medications, nutrition, or treatments* to exacerbate symptoms or induce illness. Abusers may *coach others*, even very young victims, to collaborate with them or corroborate false claims. Corroborating parties may or may not be aware of the fabrications. Due to the *persistent and often escalating nature* of this form of abuse and neglect, even seemingly mild presentations that are solely based on false reports of symptoms have the potential to lead to death. The abuse and neglect typically *extends far beyond the clinical setting*. Abusers typically maintain the false story and behave accordingly in all settings and with all friends, family, and professionals. It is clear from reports of abusers and hidden video surveillance that the *deceptions are conscious and often carefully planned, and that efforts are exerted to conceal the deception*. This form of abuse is *pervasive* and typically *includes emotional abuse and neglect*. Any medical condition can be created, falsified, or exaggerated (Levin & Sheridan, 1995). However, this form of abuse is not confined to medical conditions. Falsified symptoms may also be behavioral or psychiatric (e.g., falsely reporting the child is harming himself or others, or falsely reporting symptoms consistent with a mental illness or disability) (Schreier, 1997) or educational (e.g., falsely reporting learning disabilities, attention deficit disorders, or autism) (Ayoub et al., 2002; Frye & Feldman, 2012). Common medical conditions that are falsified or induced include the following: allergies, asthma, apnea, gastrointestinal problems, failure to thrive, fevers, infections, and seizures (Roesler & Jenny, 2009; Rosenberg, 1987; Sheridan, 2003). Clinicians and forensic experts have observed an increase in frequency of false reports of autism and mitochondrial disorders in recent years (diagnoses that encapsulate a large array of possible symptoms, evading detection of falsification or exaggeration). Finally, classical forms of child abuse and neglect may occur co-morbidly or may also be volitionally falsified (Schreier, 1996). If it is	of pedophilic disorder, with the primary goal of the behavior to satisfy a psychological need of the abuser. While secondary gain (malingering) may be present, it is not the driving force. Individuals with pedophilic disorder or FDIA ignore the needs and wellbeing of the victim in order to satisfy their own needs. Some individuals with FDIA target all children in their care and others serially focus on the youngest child, the most challenging child, the children with genuine underlying medical problems, or the children with whom they have disrupted attachments. Intergenerational abuse and neglect has been identified. There may be periods of time in which no abuse occurs for some time but then restarts. Based upon cases in which intent has been revealed or determined, APCF, CFIC, or MCA child abuse and neglect occurs when abusers' psychological needs take precedence over the needs of the child, paving the way for them to harm the child in order to have those needs met. Needs cited by those who have admitted to this behavior have included the need to receive care and attention; to be perceived as smart, caring, selfless, or in control; to manipulate and humiliate a powerful figure; to manipulate a spouse; or, for the excitement of being in a medical setting. Some who have admitted to this behavior consider addiction to a substance to be an appropriate analogy to describe their persistence and single-mindedness in engaging in falsification behavior. Those who engage in this behavior often report a personal history of childhood abuse or domestic violence; however, when possible to verify this, these reports frequently turn out to be false. They may falsify or induce symptoms in themselves, and may themselves be victims of APCF, CFIC, or MCA. Individuals with FDIA are predominantly female and have typically been found to have a coexisting personality disorder, usually cluster B disorders (i.e., borderline, histrionic, sociopathic, or mixed) (Bass & Jones, 2011). Bools, Neale, and Meadow (1994) found that of 47 mothers who had induced illness in their children, 72% had personal histories of a somatic symptom disorder or factitious disorder imposed on self.	Victims may be directly harmed by the abuser's induction behaviors, frequently undergo unnecessary and invasive evaluations and interventions, be kept out of appropriate school settings, miss social and developmental opportunities, and misperceive themselves to be excessively ill or disabled. Iatrogenic medical conditions may arise from unnecessary interventions, and the child may become ill or permanently physically or mentally harmed as a result of well-intended diagnostic and treatment efforts. Permanent physical harm that has resulted from APCF, CFIC, or MCA child abuse and neglect includes blindness, altered gut function, brain damage, hearing loss, scarring, removal of organs, surgical alteration of anatomy, limps, and other sequela, including death. Children who survive this form of abuse and neglect are often left with severe psychological damage and significant confusion about their health and relationships. Psychological harm varies, but may include overly compliant or aggressive behavior, adoption of self-falsification or somatizing behaviors, loss of a positive self-image, posttraumatic stress disorder, and disordered eating. This form of abuse and neglect can permeate every aspect of the victim's life. Occasionally, children and teens may be aware of the abuse, but do not inform others of what is happening to them. More frequently, they vigorously defend the abuser and do not grasp what has happened to themselves. Clinicians should consider the possibility of APCF, CFIC, or MCA in children with highly unusual clinical presentations, when clinical findings are unexpectedly inconsistent with the reports of the caregiver, or when a child's response to standard treatments is surprising.

	determined that false abuse and neglect allegations are the result of an abuser attempting to meet his or her own psychological needs, this would also meet criteria for FDIA.	Twenty-one percent had a history of substance misuse, 55% had histories of self-destructive behaviors, and 89% had a personality disorder. They discovered that five of the 19 women they interviewed (26%) had histories of learning problems.	Children with genuine underlying medical, psychological, or developmental problems are often the targets of this form of abuse and neglect.
APSAC 2017	**MSBP/MBP Warning Signs** 1. Reported symptoms or behaviors that are not congruent with observations. 2. Discrepancy between the abuser's reports of the child's medical history and the medical record. 3. Extensive medical assessments do not identify a medical explanation for the child's reported problems. 4. Unexplained worsening of symptoms or new symptoms that correlate with abuser's visitation or shortly thereafter. 5. Laboratory findings that do not make medical sense, are clinically impossible or implausible, or identify chemicals, medications, or contaminants that should not be present. 6. Symptoms resolve or improve when the child is separated and well protected from the influence and control of the abuser. 7. Other individuals in the home or the caregiver have or have had unusual or unexplained illnesses or conditions. 8. Animals in the home have unusual or unexplained illnesses or conditions—possibly similar to the child's presentation (e.g., seizure disorder). 9. Conditions or illnesses significantly improve or disappear in one child and then appear in another child, such as when another child is born and the new child begins to have similar or other unexplained symptoms. 10. Caregiver is reluctant to provide medical records, claims that past records are not available, or refuses to allow medical providers to discuss care with previous medical providers. 11. The abuser reports that the other parent is not involved, does not want to be involved, and is not reachable. 12. A parent, child, or other family member expresses concern about possible falsification or high-healthcare utilization. 13. Observations of clear falsification or induction by the caregiver. This may take the form of false recounting of past medical recommendations, test or exam results, conditions, or diagnoses.		
Ayoub, 2002, Case studies with review	**Münchausen by proxy (MBP)** is a disorder that involves the deliberate falsification of physical, psychological, or, in this case, educational symptoms in a child by a parent, usually the mother, for that parent to meet her own self-serving psychological needs. By definition, the disorder includes both a child victim and an adult perpetrator. However, MBP is more than an abusive interaction between mother and child: It is also a family system disorder. Spouses, grandparents, and relatives often support and participate in the deception that is at the core of the perpetrating parent's victimization of the child. In married couples, fathers frequently choose to stay loyal to their wives and support their beliefs that the child is ill or disabled rather than separate from their wives physically and emotionally and provide safety and support for their children. In contrast, fathers who are separated or divorced from their spouses have often been denied contact or involvement with their children, particularly	Despite the variety of pediatric conditions falsified in the child, there is an extraordinary consistency observed in the way the mothers present themselves; this holds true in children presenting with factitious educational and learning disabilities in school settings as well. The psychiatric disorder in the parent perpetrator is called **factitious disorder by proxy (FDP)** and describes the parent's clinical presentation and psychological motivation. Parental actions include intentionally falsifying history, signs, and/or symptoms of physical, psychological, or educational conditions or disabilities in the child to meet the parent's own self-serving psychological needs. Primary psychological needs met through impostoring as exceptionally interested and invested Parents may include the wish to have family and friends see the mother as a competent and self-sacrificing person.	The first component of MBP describes the child's victimization as a form of child abuse called **pediatric condition falsification (PCF).** Children are victimized by a variety of means including being inappropriately placed in the sick or disabled role and being subjected to unnecessary assessments, procedures, and treatment. Classically, physical illnesses are fabricated or induced. However, psychiatric conditions have also been identified as presentations of PCF. The purpose of this article is to describe one form of PCF: the situation in which the child's condition or disability is in large part related to their learning. We have identified the child component of the disorder as a form of abuse contained within PCF that we call **educational condition or disability falsification (ECF)**. In our experience, the children in question are most

	as it relates to the management of their child's stated disability (Schreier & Libow, 1993). Also professionals (doctors, and especially in the case of ECF, teachers, guidance counselors, and principals) frequently play a central role in contributing to the interactions in MBP.	Professionals in positions of authority are particularly susceptible to the impostoring of these parents; the professional-parent relationships are frequently intense and there is a blurring of the usual professional/parent boundaries (Schreier & Libow, 1993).	commonly diagnosed with attention deficit hyperactivity disorder (ADHD), learning disabilities, and/or some behavioral difficulties that affect their school performance. As is common with other forms of PCF, these signs and symptoms may be exaggerated, fabricated, and in some cases even induced; they tend to continue and frequently escalate over time. Survivors reported serious emotional problems in childhood including faulty reality testing, insecurity, avoidance difficulties, and post-traumatic stress symptoms that for most endured into adulthood (Ayoub et al., 2000; Libow, 1995). Emotional responses of the children to this form of victimization often involve critical disturbances in attachment and social relationships and the powerful pull to maintain or at least not expose the maternal system of deception.
Ayoub, 2002	**Guidelines for Suspecting and Identifying Münchausen by Proxy in an Educational Setting** **I. Aids in Identification of Pediatric Condition Falsification - Educational Disability Signs and Symptoms** • A child who has one or more educational/behavioral problems reported by mother that are not identifiable through assessments or teacher reports or appear more severe than reports consistently indicate. Symptoms reported do not follow the expected pattern for the disorder the child is reported to have. A child who does not respond to treatment or follows an unusual course that is persistent, puzzling, contradictory and/or unexplainable. • Educational, psychological, and/or physical findings that are highly unusual, discrepant with history, or physically or clinically impossible. Independent educational testing can be helpful to substantiate these findings. • The signs and symptoms of a child's disability do not occur in the parent's absence (careful observation and monitoring may be necessary to establish this causal relationship). **II. Some Common Presentations of Mothers With Factitious Disorder by Proxy** (NB Factitious disorder by proxy (FDP) is to be considered only in conjunction with reliable findings of pediatric condition falsification; these typical characteristics should not be considered diagnostic in and of themselves. They do not provide a "profile" but present some typical presentations of FDP.) • A parent (usually the mother) who appears to be educationally knowledgeable and/or fascinated with details of educational or learning disabilities, appears to enjoy the school environment, and often expresses interest in the details of other children with educational problems. • A highly attentive parent who is reluctant to leave her child in the care of the school and who herself seems to require constant attention. • A parent who appears to be unusually calm in the face of serious difficulties in her child's educational course while being highly supportive and encouraging of the professional staff, or one who is angry, devalues staff, and demands further intervention, more procedures, and the like. Often, there may be vacillation between being overdemanding and rejecting needed interventions. • The suspected parent may work in the field of education herself or profess interest in an education-related job, particularly those jobs that have to do with developmental or educational disabilities. • A family history of unusual or numerous medical/ psychological/educational ailments that have not been substantiated and raise questions about the reporter's veracity in regard to similar difficulties in other family members.		

	• A family history of similar sibling complaints or unexplained sibling educational or medical illness or disability. • Apparent with symptoms similar to her child's own educational problems or an illness history that itself is puzzling and unusual. • A suspected parent with an emotionally distant relationship with her spouse. The spouse often fails to be involved with the child's assessments and has little to contribute to the formulation of plans for intervention. In intact families, fathers tend to assume the values and beliefs of their wives. In divorced or separated couples, the fathers are often systematically excluded from contact with their children. • A parent who reports dramatic, negative events, often either fantastic in nature or suspicious in terms of causation, such as house fires, burglaries, car accidents, and the like, that affect her and her family while her child is undergoing treatment. • A parent who seems to have an insatiable need for adulation or who makes self-serving efforts to obtain public acknowledgment of her abilities. This may also include the need to be seen as an expert in the area of disability experienced by her child.		
Davis, 2019, narrative review	**Like the RCPH, in this paper, FII is used to encompass PCF, MCA, CFIC, FDP and FDIoA.** Authors note that, the DSM-5 diagnosis stipulates that the carer behaviour is associated with identified deception which excludes many carers involved in paediatric FII. With regard to the literature they note that, overall, the literature focuses on cases of illness induction which, in practice, are far less common than the cases which are brought about by erroneous reporting by the carer. FII inevitably involves the carer and the child. We use 'carer' to include any primary caregiver. Most cases involve mothers. Fathers or male carers are seldom solely involved. They may collude with or be sidelined by the 'expert' mother. Others may be absent, unaware of the abuse or they may become suspicious. The mother may be supported by grandparents or extended family. Unrelated caregivers are very rarely involved. Although intention to harm the child is not an essential part of FII, by definition, the child is harmed in the process. However, some of the harm is inadvertently caused by medical involvement. The varied terminology currently used reflects uncertainty as to whether the definition should focus on parental behaviour or motivation, or on the harm to the child. The latter position has been advocated by both RCPCH and the American Academy of Paediatrics 'to reflect emphasis on the child as the victim… rather than on the mental status or motivation of the caregiver who has caused the signs and/or symptoms'. This paper adopts this approach which could be described as equifinality—a given end state which can be reached by many	**FII specifics with regard to the carer's/abuser's motivations and behaviours:** There are two different starting points or carer motivations, which are necessary but not sufficient for FII to occur. Both are underpinned by the carer's need for their child to be recognised and treated as ill or more ill or disabled than the child is: 1. In the first, the child is being used to fulfil the carer's needs and gains. Rarely the carer shows a callous disregard for the child's suffering. There are different reasons underpinning the carer's needs. They include: — Fulfilment of the carer's unmet emotional needs for attention and status, for example in personality disorder.* — Financial or material gain (e.g., disability or carer benefits).* — Deflecting blame from the carer for parenting difficulties or a child's behavioural problems. — Maintaining closeness to child. — Negativity towards/disappointment with the child 'justified' by evidence of disorder in the child. *More likely to include deception. 2. The second includes a carer's erroneous beliefs, extreme anxiety and concern about the child's state of health, to the detriment of the child. Rarely, these beliefs are delusional or may be associated with a carer's autism spectrum disorder. These motivations rarely lead to deceptive carer behaviour. Many of the harmful carer behaviours serve to encourage or persuade doctors to investigate and treat the child, and provide	**FII specifics with regard to the abuse / harm done to the child:** There are three aspects to the harm, some brought about directly by the carers (C below) and some indirectly through medical responses (D below). 1. The child's health and experience of healthcare: — The child undergoes repeated (unnecessary) examinations, investigations, procedures and treatments (D), often with attendances at several medical settings (C). ((D)) — Genuine illness may be overlooked due to repeated presentations (cry wolf). (D) — The child may be deprived of food or medication by the carer. (C) — Illness may be induced by the carer. (C) 2. The child's daily life and functioning — Poor school attendance and education. (C) ((D)) — Restricted normal activities. (C) — Assuming a sick role and use of aids (e.g., wheelchairs). (C) ((D)) — Social isolation. (C) 3. The child's psychological and health-related well-being — Insecure attachment. (C) — Anxiety, confusion and preoccupation with their state of health and vulnerability. (C) ((D)) — Adopting carer's beliefs about their poor state of health. (C) — Collusion with the illness presentation or feeling trapped in a cycle of fabrication. (C)

	potential means, and in the case of FII, motivations and behaviours. Of particular importance to paediatricians (and possibly legal professionals) is the acceptance that FII may not involve deliberate deception and that the harmful effect on the child is very similar whether there is deception or not. For many paediatricians this will be a change of viewpoint that considerably broadens the concept of FII. The core feature from the paediatrician's point of view is that the child is presented as ill or disabled, but their assessment suggests that a genuine illness or condition is unlikely to explain this presentation. FII is recognised when there is evidence of harm to the child, brought about by carer behaviours or concerns, underpinned by these different motivations. Some of the carer behaviours cause harm to the child directly, while others lead to iatrogenic harm.	a diagnosis which will confirm the carer's position. This is done in either or both of two ways: 1. The common form is erroneous reporting of the child's history, symptoms and signs (i.e., 'using their mouth'), and sometimes 'recruiting' the child into their beliefs. There may be an insistent quest for a diagnosis. The carer may limit the child's daily activities including school attendance. By focusing on the child's ill-health, the carer will, sometimes inadvertently, convey this to the child who may become increasingly anxious about, or come to believe in their own ill-health. This direct harm to the child is a form of emotional abuse. Indirect harm is caused by the involvement of doctors. Erroneous reporting may or may not include deception. 2. The rarer physical actions ('using their hands') include interfering with reports, specimens, investigations, withholding medications or food, and inducing signs of illness in the child by direct harm such as poisoning (the 'classical' but rare MSbP). These actions serve to strengthen the carer's contention about the child's state of health. Illness induction is not intended primarily to harm the child but may show a callous disregard for the child's welfare. All of these actions include deception. They will cause both direct and indirect harm to the child. Carers often engage in repeated consultations and "doctor shopping", may fail to attend consultations, may resist medical attempts at direct observation of or conversation with the child, may interfere professionals working together, may act as conduits of information between professionals as a route for misinformation. They often seek emotional and material support in their (online) network and use the complaints process when their needs and wishes are not being fulfilled or if they are at risk of being exposed. The carers often have psychiatric disorders. However, the presence or absence of any of these is neither necessary nor sufficient for FII to be recognized, but if the child is 'the other' in FDIoA (DSM-5), FII will, by definition, be recognized.	— Developing somatic symptom disorder. (C)
Frye, 2012, narrative review	**Update and expansion of Ayoub et al. 2002.**	**Factitious disorder by proxy (FDP)** is a diagnosis applied to a caregivers (usually a mother) who intentionally feign, exaggerate, and/or induce illness, injury or impairment in a	In 1998, the APSAC task force's report recommended that the term **"pediatric condition falsification" (PCF)** be used when a parent or other caregiving adult "falsifies

	Rosenberg (1987) reviewed the available literature on **MBP** and identified a **four symptom cluster** that was common to all identified cases of MBP at the time. These symptoms were: 1. Illness in a child which is simulated (faked) and/or produced by a parent or someone in loco parentis 2. Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple procedures 3. Denial of knowledge by the perpetrator as to the etiology of the child's illness 4. Resolution of the acute symptoms and signs of the child when the child is separated from the perpetrator. Most of the definitions and explanations for MBP since 1987 have agreed with these four criteria and elaborated on them: 1. critical to the identification of FDP 2. "doctor shopping" or "hospital shopping" 3. denial is most commonly entrenched and unshaken, even when the illness fabrication is proven by video surveillance or other means 4. is noted consistently Rand and Feldman (1999) acknowledged the difficulty of deciding whether the term MBP should apply to the perpetrator who harms the child, to the child victim, or to the abusive situation. They agreed with Meadow (1995) that the use of MBP should be limited to the precise form of abuse in which "**active deception** is involved and the **primary motive of emotional gratification** can be established." Meadow (1995) examples of non-MBP included mothers with a delusional disorder who incorrectly believed that their child was ill, or mothers who took their children repeatedly to a physician to keep them out of school and dependent on the parent/caregiver. Meadow (1995) and Parrish and Perman (2004) emphasized that **the motivation for fabricating illness is important in diagnosing MBP**, even though it is sometimes difficult to determine.	child to get attention from health professionals and other influential professionals like school psychologists and teachers, garnering emotional satisfaction by the manipulation and attention (Schreier and Ayoub, 2002). **Educational FDP** include parents of children with real or fabricated physical disabilities who request excessive or unneeded school health services and parents who request extensive education-related evaluations for children who do not demonstrate any educational need. DSM-IV-Text Revision (DSM-IV-TR; American Psychiatric Association 2000) includes criteria for factitious disorder that specify three different subtypes—the first with primarily physical symptoms, the second with primarily psychological symptoms, and the third with both psychological and physical symptoms. In the work by Ayoub et al. (2002b), "educational symptoms" were included along with physical and psychological symptoms as conditions sometimes falsified by parents. ADHD, specific learning disabilities, and behavioral difficulties were listed as the primary problems falsely reported, exaggerated, or induced in their study. **Differential diagnosis:** - Cases of **malingering (by proxy)** require a primary external incentive for the behavior, such as benefiting financially or obtaining narcotics. - Other instances of parents' intentionally inducing illness in or injury to their children have occurred when parents are divorcing and **pursuing** full **custody** (Schreier 2002a; Parrish and Perman 2004). In these cases, one parent inflicts an injury to a child and attempts to make it appear that the other parent is responsible for the harm. There are primarily **two ways FDP can appear in educational settings**. - First, parents of children with genuine or falsified medical conditions and physical disabilities can request unneeded	physical and/or psychological signs and/or symptoms in a victim, causing the victim to be regarded as ill or impaired by others" (Ayoub and Alexander 1998). The task force believed that **only when perpetrators deliberately fabricate a medical history or symptoms in a child to satisfy their own psychological needs** should the **diagnosis of "MBP"** per se be made.

	Two motivations for PCF that point to MBP/FDP appear consistently in the literature: - The first incentive is gaining attention for being the devoted parent of a child who is constantly sick (Atoynatan et al. 1988; Meadow 2000; Shaw et al. 2008). - The second is deceiving and manipulating physicians /medical staff/school personnel/judges, media representatives, and law enforcement personnel who are usually respected for their knowledge and influence (Ayoub and Alexander 1998; Ayoub et al. 2002b; Feldman 2004; Shaw et al. 2008).	assistance, such as individual nursing care or related services (such as counseling, occupational therapy, or physical therapy) as part of their children's individual education plan. - Second, parents of children with no educational need for special education services may refer their children for special education. This second category can include parents of children with genuine disabilities who request testing and services beyond those actually needed by the child.	
Galvin, 2005, narrative review	The American Professional Society on the Abuse of Children (APSAC) has taken the definition of **FDP** and **combined** it **with** a diagnosis pertaining to the abused child (**PCF**) to create better defined diagnostic criteria for **MBP**. The APSAC guidelines specify that both FDP and PCF must be present for a diagnosis of MBP to be made. PCF committed with intent other than fulfilling psychological needs is therefore not MBP, but should still, in most cases, be classified as child abuse. Recidivism rate in caretakers with FDP is very high, and these children are in much greater danger than those who are victims of factitious illness of different intent. MBP is 'a complex **transaction among at least three persons** – a **parent**, his or her **child** and the **physician**.' investigators have reported that 75% of the morbidity to the child 'occurred in hospitals and at the hands of the physician'.	In 1994, the DSM-IV introduced the term 'factitious disorder by proxy' (FDP) as a diagnostic label for the psychiatric disorder of a perpetrator who deliberately feigns or induces illness in a child for the purpose of fulfilling psychological needs. Caretakers may create false pediatric conditions for many reasons. In '**malingering by proxy**,' the primary motivation is some secondary gain, usually financial or material. **Other psychiatric illness** in the caretaker, such as psychosis, hypochondriasis, or an anxiety disorder may result in PCF. Finally, overwhelmed parents may fabricate or exaggerate symptoms as a means to **seek help in caring** for their child. Caretakers with any of these other motivations **do not meet criteria for FDP**. MBP perpetrators are mostly women/mothers, often have a history of training or involvement in some aspect of healthcare, often have a history of symptoms consistent with factitious disorder or a somatoform disorder, often present as genuinely caring and appropriate with their children in view of medical personnel, often seem particularly close with the medical staff, eliciting their sympathies, and may request or eagerly accept invasive testing for their child. Confronted with negative test results or discharge planning, they may become quite angry and when informed team's suspicions, they may become acutely suicidal or intensely rageful.	'**pediatric condition falsification' (PCF):** actions upon a child, regardless of motivation. Pediatric condition falsification can be carried out through **simulation** (i.e., false reporting of symptoms, chart falsification, or contaminating lab samples), **production of symptoms** (that is, any action that affects the child's body), or both. Apnea is a common presentation of PCF, usually caused by smothering, and can mimic an **acute life threatening event (ALTE)** or **sudden infant death syndrome (SIDS)**. However, the AAP states that apnea is not predictive of or a precursor to SIDS and the evidence indicates that there is no clear, unequivocal relationship between apnea and SIDS. PCF should always be included in the differential diagnosis for ALTE. Similarly, **child abuse** (whether PCF or another type of physical abuse) should always be included on the differential in cases of presumed SIDS. Schreier 2004 algorithm to evaluate the level of **suspicion for suffocation in ALTE** with cases that involve any of the following should incite a higher level of suspicion: multiple episodes of apnea or reported apnea, a child older than 6 months, a sibling with another major illness, a sibling who has died, a history of child protective services involvement for the child or a sibling,

		The actions taken to fabricate or induce illness are volitional and planned, can be brutal, and are spontaneous and do not seem to be reactions to a child's behavior.	blood in the nose and/or mouth, and events that occur only when the suspected caretaker is present. Reece 2001 has published a chart of criteria for **distinguishing SIDS from fatal child abuse** and other medical conditions. Although it is possible for two children in the same family to die of SIDS, the most current analyses estimate the probability as 1 in 8500 (Craft, 2004).
Glaser, 2019, narrative review	**Perplexing** medical **presentations (PP)** encompass many situations encountered by paediatricians, where a child is reported to have symptoms or disabilities that impact significantly on their everyday functioning, and yet thorough medical evaluation has not revealed an adequate and realistic medical explanation. Unlike in other medically unexplained symptoms (MUS), the parent(s) are reluctant to support a rehabilitative approach to the child and insist on continued investigations. The clinicians dealing with the child are, in addition, alert to the possibility that there may be an unusual and potentially harmful parent-child interaction that is causing or perpetuating the presentation. Authors note that there are many cases just below the FII threshold, where there is room for a rehabilitative approach to be attempted before considering a safeguarding approach. These are cases where harm to the child is predominantly iatrogenic and avoidable. There may be a potential for some of these cases to progress to 'True' FII over time but they are not at that stage.	**Child illness: carer distress disorder** (adapted from ICD-11 bodily distress disorder) ►Presence of child symptoms that are distressing to the carer. ►The carer's response to the symptoms appears excessive and disproportionate in relation to the nature, impact and progression of the child's symptoms or any confirmed physical illness in the child. ►Excessive carer attention is focused on these symptoms, manifested by repeated contact with doctors, including tests and treatments that may be unnecessary and harmful to the child. ►The carers' excessive responses to the child's symptoms are not alleviated by appropriate examination of the child, reassurance, tests or treatments where needed (however, tests and treatments should not usually be carried out purely to provide reassurance to the carer). ►The child's symptoms (whether reported by the carer or observed due to induced illness) are persistent or relapsing and remitting, and lead to significant functional impairment. There is a risk of harm caused either directly by the carer or indirectly by the doctor. ►The symptoms may be multiple and may vary over time. On the resolution of one symptom another may appear. Different children in the same family may be presented at different times. ►There may or may not be evidence of the carer causing or creating the child's illness through apparently deliberate action (if present this would always require statutory intervention). ►The child may continue to exhibit emotional and physical consequences of the condition even after separation from the carer. The intention is that **these would be paediatric** (or in some cases child psychiatric) **criteria focused on the presented illness in the child, not a label to refer to the carer.**	
Glaser, 2019	**Alerting signs** are **suggestive, not indicative of FII.** Their presence **should initially be regarded as PP**. It is the discrepancy between reports and observations, or presentations and requests for which there is not an obvious explanation, which suggests the possibility of PP or FII. Generally accepted alerting signs: ► Symptoms not observed independently in their reported context. ► Symptoms not corroborated by the child. ► Reported symptoms or observed signs not explained by child's known medical condition. ► Physical examination and results of investigations do not explain reported symptoms or signs. ► Inexplicably poor response to medication or procedures. ► Repeated reporting of new symptoms. ► Frequent presentations, seeking opinions from multiple doctors but often with paradoxically poor compliance with medical advice and multiple failed appointments.		

	► Carer(s) insistent on more, clinically unwarranted, investigations, referrals, continuation of or new treatments. ► Restriction of child's daily life and activities that is not justified by any known disorder, possibly including the use of wheelchairs and other aids.		
Korpershoek, 2004, systematic review	'Münchausen's Syndrome by Proxy' (MSP) **The ICD-10 (World Health Organization 1992)** provides a descriptive and a theoretical classification of MSP, **giving a clear description of the type of abuse** endured without coding the perpetrator's motivation for inducing the illness in the child. However, this makes it difficult to distinguish MSP abuse from other forms of behaviour, such as physical abuse or overanxious parenting, which require different forms of intervention from MSP. **Rosenberg (1987)** offers one of the most widely accepted definitions of MSP, with the following constituting the syndrome cluster: 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 aetiology of the child's illness; and 4.acute symptoms and signs of the child abate when the child is separated from the perpetrator. **This definition describes the behaviour of the perpetrator**, but does not specify the motivation, and may therefore be too broad and have negative implications for long-term management and prognostic factors. It would appear that a comprehensive understanding of MSP is best achieved by a **definition which includes both descriptive (outlining the nature of the child's health state) and motivational (outlining factors which could account for the perpetrators' behaviour) components.** Clear specification of the motivation for the perpetrators' behaviour allows for greater consistency in terms of understanding and management of MSP.	**Parnell and Day (1998)** offer a guideline for the identification of MSP which divides the framework into mother-perpetrator features, child–victim features and family features. **Parnell and Day (1998) Mother–perpetrator features** The perpetrators are generally women and usually the child's mother. **Libow and Schreier (1986)** identified three categories: active inducers, help seekers and doctor addicts: **'Active inducers'** actively induce an illness or injury in the child through suffocating, poisoning and injecting noxious foreign substances into the child's body. **The perpetrator is seen as being devoted, calm, trustworthy and co-operative.** They may respond with denial and anger if confronted with their behaviour and frequently abscond before any intervention can take place. The mother has a mutually dependent relationship with the child. Disturbed marital relations are common. The use of the **defensive mechanisms of denial and projection** predominates the picture. They argue that the behaviour may be motivated by the secondary gain of **being appreciated as a good mother** (Libow and Schreier 1986, Schreier and Libow 1993a, Schreier 1997, 2000). **'Help seekers'** present with fictitious child illness. They differ from the 'active inducers' in terms of the severity and the frequency of the symptom presentation and their motivation for the behaviour. Libow and Schreier (1986) describe their motivation as being related to **a need to communicate exhaustion, distress or feelings of inadequacy** whereas 'active inducers' may be trying to receive nurturance for themselves by presenting the child as sick. The mother's **behaviour is** thus seen as being **more under her conscious control** and usually falls away once the underlying need for outside involvement has been met. According to Libow and Schreier (1986) **'doctor addicts**' are seen as seeking treatment for non-existent illnesses in their children .	**Parnell and Day (1998) Child–victim features** The victim is usually the biological child of the perpetrator, mean age less than six years. There is no gender differential in the choice of victim. They present with baffling, unremitting illness which is undiagnosable and resistant to treatment, illness is multisystemic, prolonged, unusual or rare, signs and symptoms are inappropriate or incongruent, signs and or symptoms disappear when the parent is absent, the child shows a poor tolerance to treatment, the general health of the child clashes with the results of laboratory tests and the father is usually absent.

	The DSM-IV definition includes motivation for the behaviour in the diagnostic criteria, but under "disorder not otherwise specified." The lack of a distinctive diagnostic category for factitious disorder by proxy in the DSM-IV is a reflection of the lack of clarity that exists amongst researchers, clinicians and other professionals alike as to the particular diagnostic criteria to be included under this label. The DSM IV (APA 1994) definition: This category includes disorders with factitious symptoms that do not meet the criteria for Factitious Disorder. An example is factitious disorder by proxy: the intentional production or feigning of physical or psychological signs and symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role. Cases that involve over-anxious parents, noncompliant parents of chronically ill children and parents who attempt to gain benefits from the medical, social, educational or legal systems, do not reflect this diagnosis (Schreier 1997). The DSM-IV definition of MSP focuses purely on illness fabrication or induction, without any consideration of psychological or psychiatric presentations of the illness. The motivation of MSP as defined by the **DSM-IV to 'assume the sick role by proxy', has been criticised for being superficial and inadequate and not explaining the complexities** of the dynamics involved (Parnel and Day 1998, Rogers 2004). **Rogers (2004)** proposes that fabrication/ induction of symptoms in another person could also be characterized as **feigning by proxy** and recommends three separate categories to help with the diagnosis of MSP, namely: **Malingering** by Proxy; Factitious Disorder — **psychological** by proxy (signs and symptoms are predominantly psychological in nature) and Factitious Disorder — **medical** by proxy (signs and symptoms are predominantly physical in nature). **Kelly and Loader (1997)** define MSP as follows: 'the carer will have either exaggerated or fabricated symptoms, falsified investigations, or induced signs and in the process may have directly harmed the child herself'. The definition allows for the following motivating criteria to be included	They present with an inability to acknowledge their behaviour or their motivation even when help has been offered. They tend **to pursue diagnostic and medical procedures relentlessly**. Their behaviour is characterised by **falsifying history and symptoms**. They tend to **lack insight, refuse to accept contradictory medical evidence** and often appear to be **less co-operative and more angry and suspicious than the active inducers**. Confrontation of this behaviour will often result in anger and denial. The victims tend to be older and the mothers tend to over-react to the child's 'medical' condition, whilst under-reacting to the child's emotional state. It is important to **distinguish between a concerned parent, a delusional parent and MSP** as it will inform the treatment and intervention strategies Additional perpetrator characteristics: denial of any responsibility; medical experience or training, prevalence of personality disorders, particularly histrionic, borderline, narcissistic and paranoid personality disorders, history of self-harm and substance abuse, an absence of the mother's expression of concern for her child, details of the child's illnesses being copied from cases receiving media attention, over attachment on the part of the perpetrator on the medical system, hospital or, medical staff, the perpetrator having medical problems similar to those of the child, and fabrication of other aspects of the perpetrators life. (Bools 1996, Feldman 1994, Folks 1995, Jureidini 1999, Leonard and Farrel 1992, Marcus et al. 1995, Parnell and Day 1998, Polledri 1996, Schreier 1997, 2000, Sheridan 2003, Yorker and Kahan 1990). **Family features** The perpetrator may have: Emotional neglect and psychological abandonment in childhood, possibly active (sexual) abuse, unexplained and recurrent childhood illnesses, possibly a history of factitious or somatising disorders, an absent marital partner, marital discord, disturbed family relationships, and familial pattern of illness presentation => siblings of MSP victims are at greater risk for MSP, unexplained illness or death.	

	in the diagnosis: the parent is excessively anxious; the child has been abused and the parent is pursuing a medical explanation in order to avoid accusation; the mother believes that their child is genuinely organically ill; the behaviour is an attempt to antagonise somebody; the perpetrator has a misguided belief that medicalisation is in the child's best interests and there is extreme enmeshment of the parent/child relationship. **Schreier and Libow (1998)** dispute this redefinition stating that it '**renders the FDBP (Factitious Disorder By Proxy) diagnosis virtually useless** for the purposes of perpetrator treatment or child protection, by **further confusing categories of child abuse with parental psychopathology'**. Schreier and Libow (1998) argue that FDBP is a diagnosis of perpetrator psychopathology and not of child abuse, which has many differing motivations and parental psychopathologies. Furthermore, the specificity of diagnosis is essential in that treatment of an overanxious parent would certainly differ from a parent who has specifically induced an illness in her child. **Kelly and Loader (1998) responded to the criticisms made by Schreier and Libow (1998).** They argue for **subcategories of Factitious Disorder by Proxy, of which MSP could be one, with each of the subcategories having different motivations and, therefore, different treatment/management strategies.** There appears to be a **need to allow for** a greater understanding of the possibilities of **a continuum of factitious disorder spectrum diagnoses with specific psychopathological formulations for each** of the 'disorders' on the spectrum to avoid confusion and help ensure appropriate intervention strategies. A definition that allows for **both a descriptive account of the disorder** as well as an account that allows for **more specific psychopathological formulations of MSP behaviour** would appear to be the most comprehensive approach to this disorder.		
Mart, 2002, narrative review	This paper analyses if a testimony about FDBP meets the evidentiary standards for admissibility in court. The analysis	Mart states the DSM-IV criteria for FDBP and **questions the validity of FDBP as a syndrome** (a syndrome describes a range	

	suggest that it does not due to lack of consensus on the definition of FDBP with vague and broad criteria which are not grounded in / backed up by scientific research.	of signs and symptoms that are often, but not always, related to an underlying cause of a disease). In FDBP, a wide range of perpetrator behaviors and characteristics have been proposed as "**warning signs**" of parental involvement in the production or feigning of illness in a child. Unfortunately, these warning signs are often **confused** by clinicians **with confirming signs/diagnostic signs** instead of an indication that further investigation is required to confirm the presence of FDBP. Mart further states that because such a large number of warning signs has been proposed, **and** because these signs are **unsupported by research**, **this confusion undermines the valitdity of FDBP as a syndrome**. Mart states the Rosenberg 1987 criteria and further says: **The lack of consensus in the field regarding who carries the diagnosis, together with disagreement about the correct name and diagnostic criteria for the putative disorder**, is reflected in the studies that have been conducted to date, employing various labels for the disorder, and different criteria for its identification and diagnosis. Because the lack of consensus about what is being studied, it is difficult to set up controlled, replicable studies that might affirm or **undermine the scientific status of FDP**, and difficult to compare conclusions across studies. Studies on FDBP are likely to have limited generalizability until the definition on what constitutes a case of FDBP is clear. **Mart warns that because of the extremely low base rate of reported FDBP, coupled with the unclear definition of FDBP, with vague and broad criteria, there is a risk of a high error rate, especially false positives/overdiagnosis in the diagnosis of FDBP**; broad ranges of contradictory signs and symptoms are presented as evidence to support the diagnosis although none of the caregiver characteristics or behaviors described have been reliably related to the absence or presence of FDBP and a base rate of these behaviors in parents of chronically or seriously ill children where FDBP is not suspected has not been established.	

		Mart further quotes Fisher and Mitchell (1995) that medical staff assume the presence of an illness/FDBP in a parent when the label MSBP is applied, but **MSBP is not a diagnosis but an observational description with implications regarding cause.** They further state that the application of the term **"syndrome" is misleading because neither the victims nor the perpetrators have a specific collection of commonly associated signs or symptoms.** They concluded that FDBP does not meet the criteria for acceptance as a discrete medical syndrome and recommended that the diagnosis be abandoned in favor of simply diagnosing the fabricated or induced illnesses encountered.	
Mart, 2004, narrative review	Mart proposes the abandonment of the prejudicial labels FDBP, MSBP, and PCF in favor of a descriptive rather than categorical approach with a non-diagnostic, general term such as medical child abuse; these old terms 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. When child abuse is established in court, the behavior of the perpetrating parent could be described in terms of a multiaxial continuum of dimensions of pathology. About Rosenberg's article "Munchhausen Syndrome by Proxy: Medical Diagnostic Criteria", Mart mentions Rosenberg's original 1987 four criteria and says that Rosenberg categorically rejected the idea that there is a psychiatric or motivational component in the diagnosis of MSBP. However, Mart states that to fully "medicalize" MSBP, not recognizing the motivation/intent/mens rea doesn't work in the real world context in which the medical diagnosis MSBP leads to a court proceeding in which intent needs to be proven.	Mart sums up the criteria for FDBP which are included in an appendix of the DSM-IV: Criteria sets and axes provided for further study; insufficient information was available to warrant inclusion as an official diagnosis. Motivation is "sick role by proxy" and dd is malingering (external incentives as motivation) and physical and sexual abuse with other motivations. **According to Mart, the FDBP label has become an obstacle to fair and effective intervention in cases of medical child abuse.** Courts see FDBP cases as more severe than other child abuse cases, as fatalities waiting to happen, associating it with a specific, escalating pattern of behaviors and psychopathology unresponsive to treatment and with family/genetic patterns which may often not be present and if they are, they are not unique to medical child abuse associated with FDBP cases alone, but also present in other types of child abuse. Nevertheless, in cases of medical child abuse with FDBP courts (more) often proceed to termination of parental rights and long-term foster care on basis of these assumptions. Mart compares Meadow's conceptualization of MSBP (FDBP) with Kempe's identification of battered child syndrome, a term that was useful to raise awareness of physical child abuse, but which has been abandoned in favor of the more generally descriptive term "child abuse" and which requires an exact description of the abusive acts alleged in court and does not require a syndrome label or diagnosis. Likewise, the label MSBP	Mart explains the formulations by the APSAC Taskforce on Munchhausen by Proxy Definitions Working Group which proposed the term 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. If MBP (FDBP/MSBP) is involved, the DSM-IV diagnosis Factitious Disorder not otherwise specified-300.19 would be applied to the perpetrator. In this manner, **PCF corresponds to actus reus (prohibited act) and can be diagnosed in the absence of FDBP. FDBP corresponds to mens rea (guilty mind) and cannot be diagnosed without PCF.** It is clear from the work of people in the field that external incentives are often present in PCF cases, as well as custodial motivations (false allegations of sexual abuse of a child by ex-spouse), as PCF due to overanxious or paranoid mother. Then, FDBP would not apply. 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 associated with taking on the sick role by proxy appeared to be present; the distinction is left for

		has been useful to raise awareness of medical child abuse, but there are arguments for its retirement. **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. Thus, **Mart proposes a two-part approach that provides (1) a clear description of the specific acts of medical abuse, providing the court with an impartial account of the perpetrator's alleged crime, and (2) an analysis of the accused perpetrator's behavior in terms of the central dynamic variables associated with FDBP-related behavior - secondary gain, severity of abuse, and psychopathology -, providing a multiaxial analysis of the abuse for the purpose of disposition and child protection.** With regard to the postulated central dynamic variables of FDBP-related behavior, Mart states that **secondary gain** is not unique to FDBP; all illnesses and injuries have the potential to produce secondary gain next to negative effects, and the secondary gain may be minor, in balance with, or outweigh the negative effects. The secondary gain depends on a complex interplay between (pre-existing) physical and/or psychological factors which exist on a continuum. Therefore, secondary gain is not merely present or absent, it is a dynamic variable that **exists** and should be assessed **on a continuum**. External incentives may also be present and vary from case to case and should also be assessed as occurring along a continuum. Also, the **severity of the medically related abuse**, the actus reus of FDBP, **varies along a continuum (exaggeration, fabrication, induction)**, just as is recognized for other types of abuse, and does not have to escalate (not all FDBP cases are fatalities waiting to happen).	the clinician to make on the basis of extremely subjective criteria. (The APSAC definitional taskforce has suggested that external incentives can play a role in the symptom picture and genesis of FDBP in combination with secondary gain through assumption of the sick role.) Mart wonders if the FDBP diagnosis adds anything useful in terms of diagnosis, prognosis or treatment (psychological and social management) of the particular child when the PCF diagnosis has been accurately applied. 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 and there are better ways of conceptualizing parental behavior. Mart also says that although PCF has a high potential for reification, it provides no advantages over a simple statement of allegations that a parent has exaggerated, fabricated or induced a child's symptoms of illness.

		The third variable that should be considered in FDBP cases is the **psychopathology of the perpetrator**. According to Mart, research has proven that there is no consistent pattern of psychopathology behind FDBP/PCF cases; perpetrators vary widely in their level and type of psychopathology. Also this variable **is dynamic and varies in prognosis and choice of therapeutic modalities**.	
Meadow, 2002, narrative review	States the Rosenberg's 1987 definition of MSbP as a cluster syndrome of: 1. Illness in a child that is simulated (faked) 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; and 4. Acute symptoms and signs of the child abate when the child is separated from the perpetrator. Rosenberg specifically excluded children who had incurred physical abuse only, sexual abuse only, and nonorganic failure to thrive only. That list of exclusions was important, but in practice many found that it was not exclusive enough. Examples of child abuse, specifically smothering and nonaccidental poisoning, is often inappropriately labeled as MSbP. Problems have arisen from the overlap between MSbP and the commoner ways in which parents, by their unusual perceptions or care of an ill child, may cause harm: by doctor shopping, enforced invalidism, delusions about their child's ill health, and from maternal separation anxiety (Meadow, 1984). Rosenberg described the difficulty that she encountered in differentiating between MSbP and "intentional poisoning, infanticide, pathological doctor shopping, extreme parental anxiety, or thought disorder," and considered the probability that the underlying psychology overlapped (Rosenberg, 1987). The criteria for using the term MSbP have been discussed widely and remain open to debate. Inevitably, the widest	The DSM IV TR research criteria for 'Factitious Disorder by Proxy' are listed as: A. Intentional 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 to assume the sick role by proxy. C. External incentives for the behavior, such as economic gain, are absent. D. The behavior is not better accounted for by another mental disorder. The most important point to note is that **the term is being applied to the perpetrator** and **not to the abuse** (the constellation of features listed by Rosenberg). Meadow states that it is somewhat naïve to insist that "external incentives for the behavior, such as economic gain, are absent." DSM IV would have been wiser to suggest that external incentives for the behavior were not the prime reasons for behavior. Meadow stresses that "abnormal illness behavior," such as factitious disorder and somatoform disorder, is often present in the perpetrators of MSbP, and parents with these disorders are overrepresented in child abuse cases in general.	

	division lies between those (usually pediatricians) who use the term to describe certain forms of child abuse, and psychiatrists and psychologists who seek a diagnostic label for the perpetrator. **Meadow's 2002 criteria for MSbP abuse are:** 1. Illness fabricated (faked or induced) by the parent or someone in loco parentis; 2. The child is presented to doctors, usually persistently; the perpetrator (initially) denies causing the child's illness; 3. The illness goes when the child is separated from the perpetrator; 4. The perpetrator is considered to be acting out of a need to assume the sick role by proxy or as another form of attention seeking behavior. Meadow stresses the importance of criterion 2, the active or passive implication of doctors in the abuse. And stresses: we should not become too preoccupied with terminology. For the individual child who is being abused, our approach should follow the usual guidelines for the management of any serious child abuse.		
Parrish, 2004, narrative review	**Münchausen by Proxy**, entailing parents' deliberate falsification of children's medical circumstances (Meadow, 1977).	With **Factitious Disorder by Proxy (FDBP)**, a child's medical or psychiatric history and illness are intentionally fabricated, exaggerated, distorted or induced by the adult for the purposes of achieving a sick role vicariously or "by proxy." The motivation, which is a deep need to occupy a sick role, distinguishes Factitious Disorders from **Malingering** (which is a V-Code) in which financial or legal gains are typically relevant. The behavior is not better explained by any other mental disorder, such as a parent's Delusional Disorder (Somatic Type), or a Shared Psychotic Disorder. The condition enters the realm of **child maltreatment**, because it involves the deliberate distortion, exaggeration, or even production of a child's medical circumstances. The purposefulness of the behavior is central to the FDBP condition. The objective of the behavior is to attain a sick role	FDBP is a psychiatric condition, and applies to the perpetrator, rather than to the pediatric patient. For the child, issues of medical as well as emotional abuse apply. For documentation purposes, the use of **V-Codes to indicate physical, emotional, and/or medical abuse of the child** would be applied, rather than an Axis I condition being applied to the child. The majority of FDBP cases involving children entail symptoms of gastrointestinal or genitourinary illness, or central nervous system involvement (Folks, 1995, Ostfeld, Feldman, 1996). Among children, feigned psychiatric symptoms are more rare (APA, 2000). With younger children, especially infants, neurologically involved presentations involving seizures, and apnea-like symptoms appear common, as does cyanosis (blueness

		(by proxy) via the child's medical status (which includes risk to the child). The perpetrator's need for attention, sympathy or recognition is a driving force behind the condition, without regard for the risk to a child. Another hypothesized motivation is the perpetrator's need to deceive or somehow manipulate figures or systems perceived to be more powerful than themself (e.g., physicians, hospitals, law enforcement, social workers, etc.) (Ayoub, Alexander, 1998). **Important Distinctions of Presentations That Are Not Factitious Disorder by Proxy** • Psychotic or Delusional Disorders entailing somatic complaints • Overly anxious parents seeking medical attention for their child • Bitter, accusing parents embroiled in custody disputes (although this may co-occur with FDBP) • Presentations that are motivated by an identifiable external consequence (financial, legal, social, or academic) • Misrepresentations of a child's medical history provided as means of explaining results of child physical abuse or neglect • Children who have been over-medicated by parents trying to quiet them • Children whose "Failure to Thrive" presentations are better explained by various medical or situational variables • Children with poor school attendance better explained by school or social avoidance or phobias (of their own or their parents) The FDBP perpetrator is often quite articulate, with some educational as well as socio-economic advantages, often possess some level of child care, or nursing, medical, or other health-related training or experience, with familiarity with medical environments and equipment and fluency with medical or technical terminology (APA, 2000, Light, Sheridan, 1990, Ostfeld, Feldman, 1996). The perpetrator typically appears to be profoundly attached to the child while the non-perpetrating parent often appears somehow uninvolved, passive, "invisible," or may even be physically absent (APA, 2000, Light, Sheridan, 1990, Ostfeld, Feldman, 1996).	of the skin associated with severe respiratory difficulties). Patterns involving diarrhea, vomiting, inability to walk, and limb paralysis seem more likely to emerge during childhood (Folks, 1995). Children of FDBP perpetrators may have separation difficulties and other forms of delayed maturation for their age (Rand, 1996). Children may also be socially isolated by being overtly or covertly exposed to considerable deception and secrecy on the perpetrator's part, and a perpetrator's insistence upon missing school and other developmentally normal activities due to fabricated illnesses may have also prevented normal socialization experiences. A child's need for approval and attention are important factors in understanding the potential for collaboration and other behavioral and emotional distortions.

Parrish, 2004	**Warning Signs of Factitious Disorder by Proxy** • Persistent, recurrent illnesses which are unexplained or prolonged • Clinical signs that are incongruent with a child's general health status • Signs or symptoms that are extraordinarily rare, prompting such comments as "I've never seen anything quite like this before" from experienced professionals • Repeated hospitalizations and evaluations failing to provide a conclusive diagnosis or etiology of the symptoms • Histories of repeated hospital discharges "against medical advice" • Noteworthy signs and symptoms not recurring when perpetrator is absent • Perpetrator often hypervigilant, insisting on participating in procedures, or bringing food or medicine from home, often refusing to leave the hospital • Perpetrator appearing comfortable or at ease around medical procedures, and in a medical environment, sometimes forming unusually close alliances with various staff members • Perpetrator having child care, medical, nursing, or para-medical training, or describing experience with similarly rare medical conditions in the past • Perpetrator welcoming even invasive or painful diagnostic or surgical procedures for the child • Perpetrator's concern for prognosis incongruent with severity of symptoms • Clinical symptoms not responding to treatment as anticipated. • Families in which sudden deaths have occurred during childhood • The child's non-perpetrating parent rarely present during treatment • Perpetrator's level of anxiety increases with child's medical improvement • Prior medical records which could confirm or preclude diagnostic impressions either reported missing or somehow unavailable • Perpetrator becoming defensive or hostile if the information s/he provides is questioned or proven inaccurate		
RCPCH, 2021, guideline	**Fabricated or induced Illness (FII)** is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s') behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect, as a result of parental actions, behaviours or beliefs, and from doctors' responses to these (i.e. iatrogenic harm). The parent does not necessarily intend to deceive, and their motivations may not be initially evident. • The essence of FII is the parents' focus on engaging and convincing doctors about the parents' erroneous view of the child's state of health. • FII is based on the parent's underlying need for their child to be recognised and treated as ill or more unwell/more disabled than the child actually is (when the child has a verified disorder, as many of the children do). • FII may involve physical, and/or psychological health, neurodevelopmental disorders and cognitive disabilities. • Parental behaviour may or may not include deception.	**RCPH only report on FII, which is not a DSM or ICD diagnosis, but note with regard to the abuser:** **In FII,** the mother is nearly always involved or is the instigator of FII. **In FII,** one child (initially with a genuine illness) or more children within one household/family may be affected (and also animals and spouses). **In FII**, there are two possible, and very different, motivations underpinning the parent's need for their child to be recognised and treated as ill or more unwell/more disabled than the child actually is: (1) the parent experiencing a gain and (2) the parent's erroneous beliefs. (1) The parent experiences a gain from the recognition and treatment of their child as unwell. The parent is thus using the child to fulfil their needs, disregarding the effects on the child. Gains can be psychosocial (e.g. need for sympathetic attention, need for support, need to deflect blame for parenting difficulties or child behavioural problems, need	**RCPH report on FII; centering their definition on the clinical situation / abuse of the child.** The term **Perplexing Presentations (PP)** has been introduced to describe the commonly encountered situation when there are alerting signs of possible FII (NB: Alerting signs are not evidence of FII), when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life. If associated with possible harm to the child, they amount to general safeguarding concerns. The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour. **In FII,** there is often a confirmed co-existing physical or mental health condition in the child. **FII** can harm the child physically by

	• Parental behaviour may be motivated by anxiety and erroneous belief about the child's state of health and/or by gain for the parent/s. **Illness induction** is a form of physical abuse. In order for this physical abuse to be considered under FII, evidence will be required that the parent's motivation for harming the child is to convince doctors about the purported illness in the child and whether or not there are recurrent presentations to health and other professionals. **RCPH report on FII, but note with regard to MSBP:** Literature searches on this topic have identified that the term 'Münchausen Syndrome by Proxy' yields all relevant literature hits on Medline (an online literature database), with additional search terms not identifying any further papers. This could be explained in part, due to the covert and complex nature of such presentations, but particularly because a key focus within the literature is upon illness induction which, in practice, is far less common than the presentations which are brought about by erroneous reporting by parents. Münchausen by proxy by internet is reported as a new phenomenon in which caregivers present online considerable distortion of information received from doctors, describing escalation of the severity of their children's illnesses and consequent requests for online donations for their children's health needs.	continued closeness of their child) and/or material (e.g. financial support for care, improved housing). Personality disorders are most likely to be found in parents who derive a clear gain from having their child regarded as ill/more ill. (2) The second motivation is based on the parent's erroneous beliefs, extreme concern and anxiety about their child's health (e.g. nutrition, allergies, treatments). This can include a mistaken belief that their child needs additional support at school. The parent, aided by the internet, may be misinterpreting or misconstruing aspects of their child's presentation and behaviour. In the extreme (rare), parents may develop fixed or delusional beliefs about their child's state of health. The parent's need here is to have their beliefs confirmed and acted upon, but to the detriment of the child. Anxiety disorders may lead the parent to have unfounded anxieties about their child's health. Beliefs are more rarely underpinned by psychotic illness or autism spectrum disorder. RCPH note: Understanding the parents' motivation is not essential to the paediatric diagnosis of PP/FII in the child. This is important because a paediatrician is not expected to understand parental motivation, but simply to understand the cause of the child's presenting illness. Parents engage health professionals, in the following ways: (i) The most common form is by presenting and erroneously reporting the child's symptoms, history, results of investigations, medical opinions, interventions and diagnoses. There may be exaggeration, distortion, misconstruing of innocent phenomena in the child, or invention and deception. In their reports, the parents may not be actually intending to deceive, such as when they hold incorrect beliefs and are over-anxious, to the child's detriment. (ii) A less common way of engaging health professionals is by the parent's physical actions. These actions nearly always include an element of deception. They range from falsifying documents, through interfering with investigations and specimens, interfering with lines and drainage bags, and, at the extreme	• having to experience physical and psychological discomfort or distress due to repeated (unnecessary) medical appointments/examinations/investigations; • genuine illness being overlooked; • illness induced by their parent/s. **FII** can harm the child developmentally and socially by • having to assume the sick role; • limitation of daily life activities; • interrupted school attendance and education; • social isolation. **FII** can harm the child psychologically by • being anxious and confused about their state of health; • developing a false self-view as being sick and vulnerable; • active collusion with the parent's illness deception; • silent entrapment in falsification of illness; • development of later psychiatric disorders and psychosocial difficulties. In assessing the severity of the situation, it is important to focus on the harmful effects on the child, rather than gauge severity by what the parent is saying or doing. Although if there are clear deceptive parental actions or illness induction, it is likely that the harm to the child will be more severe.

		end, illness induction in the child (e.g. by withholding food or medication from the child, poisoning, suffocation). In **malingering and factitious disorder**, there is unacknowledged deception about the reported symptoms and signs. Both these are associated with gain for the person, the former material gain and the latter psychological or other gain.	
RCPH, 2021	**Alerting signs to possible FII** **In the child** • Reported physical, psychological or behavioural symptoms and signs not observed independently in their reported context • Unusual results of investigations (e.g. biochemical findings, unusual infective organisms) • Inexplicably poor response to prescribed treatment • Some characteristics of the child's illness may be physiologically impossible e.g. persistent negative fluid balance, large blood loss without drop in haemoglobin • Unexplained impairment of child's daily life, including school attendance, aids, social isolation. **Parent behaviour** • Parents' insistence on continued investigations instead of focusing on symptom alleviation when reported symptoms and signs not explained by any known medical condition in the child • Parents' insistence on continued investigations instead of focusing on symptom alleviation when results of examination and investigations have already not explained the reported symptoms or signs • Repeated reporting of new symptoms • Repeated presentations to and attendance at medical settings including Emergency Departments • Inappropriately seeking multiple medical opinions • Providing reports by doctors from abroad which are in conflict with UK medical practice • Child repeatedly not brought to some appointments, often due to cancellations • Not able to accept reassurance or recommended management, and insistence on more, clinically unwarranted, investigations, referrals, continuation of, or new treatments (sometimes based on internet searches) • Objection to communication between professionals • Frequent vexatious complaints about professionals • Not letting the child be seen on their own • Talking for the child / child repeatedly referring or deferring to the parent • Repeated or unexplained changes of school (including to home schooling), of GP or of paediatrician / health team • Factual discrepancies in statements that the parent makes to professionals or others about their child's illness • Parents pressing for irreversible or drastic treatment options where the clinical need for this is in doubt or based solely on parental reporting.		
Roesler, 2018, narrative review		For psychologists, terms like **factitious disorder by proxy (FDP), pediatric condition falsification (PCF), caregiver-fabricated illness in a child (CFIC), or factitious disorder imposed on another (FDIOA)** naturally direct them to focus on the adult perpetrator.	**Medical child abuse (MCA)** is defined as a child receiving unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker (Roesler, 2009). Contrary to other forms of child maltreatment in which physicians can separate themselves and objectively

		The standard for psychiatric diagnoses is the Diagnostic and Statistical Manual - Fifth Edition (DSM-V). The 2013 revision included an entry for factitious disorder imposed on another (FDIOA) as distinct from factitious disorder imposed on self (FDIOS). Regrettably, the definition of this disorder carries us far afield from defining MCA as a form of child abuse. The primary feature of FDIOA is the intentional deception involved in the falsification of signs and symptoms of illness in another. The perpetrator's motivation is the key factor. Though creators of this diagnosis moved away from "wanting to assume the sick role by proxy," they still were compelled to describe a particular motivation in the perpetrator. Note that a child victim is not required to make the diagnosis. In fact, FDIOP has been described with adults or animals as the focus of the deception. It has even been invoked when only imaginary people or animals are lied about as in FDIOP over the Internet. Forensic psychiatrists are sometimes asked by courts if the perpetrator of MCA meets criteria for FDIOP. While undoubtedly some do, it seems more important to ascertain if a child has been harmed and what must be done to stop the abuse. For providers, the rationale behind why a parent lied in order to ensure their child would be subjected to potentially harmful therapies is less of a priority compared to the need for providers to stop harmful medical treatments.	evaluate what is happening to children, in MCA, physicians and the medical community are involved, and initially unknowingly, the diagnoses, associated evaluations, and therapies may contribute to harm inflicted on these children. Physicians may be compelled to come up with descriptive terms that, in effect, absolve them from responsibility. As medical providers coming to terms with our unwanted complicity, we may be tempted to focus on the prevarication rather than the harm to the child. In order to move past the feelings of having been lied to and instead focus on helping the children, we can/should simply call it medical child abuse. According to Roesler, the names people choose for this behavior reflect their primary interests. Those using medical child abuse emphasize the similarities MCA has with other forms of child maltreatment. Authors using pediatric condition falsification or other similar designations focus on characteristics of (e.g., lying) and treatments for abusers. Medical child abuse clearly labels the behavior as abuse and states the medical connection explicitly. It makes no more claim to a medical diagnosis than does other forms of abuse. Physical or sexual abuse are not medical diagnoses of a specific illness as much as events in the life of the child which can have medical consequences. The same is true for medical abuse. As an event or series of events, it can be described as occurring on a continuum of severity from mild (more common) to moderate to severe (less common). All forms of child maltreatment share this property. A mild presentation of MCA may involve an anxious mother who takes her child to the doctor on a weekly basis with few symptoms of illness. The child may undergo multiple exams, miss school, and might get unnecessary testing to treat the parent. The treatment for this type of abuse would require

			the medical treatment community to reorient the parent in a way to normalize the doctor/parent/patient relationship. Continuing to focus on the child, a moderate presentation of MCA may involve a child whose parent lies about witnessing seizures resulting in the child being placed on antiepileptic medication. The unnecessary prescribed medication and other seizure precautions may have a significant but not life threatening impact on the life of the child. In such a case, social services should be involved and a treatment plan would include close supervision of the family and discontinuation of potentially harmful medical treatment. At the severe end of the MCA spectrum are the children whose lives are put at risk by medical treatments such as unnecessary surgeries, indwelling lines, and treatments with potentially life-threatening side effects such as the administration of intravenous immunoglobulin. A mother who smothers a child to death has committed murder. If the child lives, the crime is assault or attempted murder. If the child lives but is subjected to numerous invasive medical treatments as a result of the behavior of the parent, in addition to the assault, he or she has also been medically abused.
Rogers, 2004, narrative review	This review also states the Rosenberg 1987 criteria (see Meadow 2002, and other articles), and states that only two criteria (first and last) address the fabrication/induction of symptoms. The other two (persistent presentations and denial of knowledge about etiology) are also likely to occur in non-abusing parents who are seeking treatment for unexplained symptoms.	This review states that the DSM-IV provisional criteria for FDBP are more encompassing than MSBP in allowing the **classification of persons other than parents**. However, it is more circumscribed in its delimitation of patients' putative motivation to the **adoption of a "sick role."** Meadow (1995) recommended broadening the motivation to include **attention-seeking behavior**. Schreier and Libow (1993e) underscore the importance of the FDBP **patients' relationships with medical staff**. Fisher and Mitchell (1995) questioned the underlying assumptions regarding either MSBP and FDBP as a disorder; they stated "Münchausen syndrome by proxy/factitious illness by proxy **is not a diagnosis in a traditional sense but an observational description with implications regarding cause".**	

		Invoking the classic Syndeham criteria, every disorder must have inclusion, exclusion, and outcome criteria. **The proposed inclusion criteria do not delineate symptoms for the person with FDBP**, **but rather the effects of apparent symptoms on others and the putative motivation for producing these effects.** In addition, the sole exclusion criterion ("not better accounted by another mental disorder"; American Psychiatric Association, 1994, p. 727) is simply too vague to be useful. Finally, studies of outcome criteria tend to focus on the child victims rather than the FDBP parents. The DSM-IV (American Psychiatric Association, 2000) nosology organizes feigning in three separate categories: (a) malingering; (b) Factitious Disorders with Predominantly Psychological Signs and Symptoms (hereinafter "FD-Psychological") and (c) Factitious Disorders with Predominantly Physical Signs and Symptoms (hereinafter "FD-Medical"). The fabrication/induction of symptoms in another person could easily be characterized as "feigning by proxy." As previously noted, the provisional designation of **FDBP** presupposes that the motivation is the vicarious adoption of a "sick role" with no other external incentives being present (Donald & Jureidini, 1996). However, the current constellation (MSBP/FDBP) is often stretched to accommodate deliberate feigning that extends beyond both parental roles and sick-role objectives. MSBP loses its diagnostic clarity if all forms of feigning are allowed. In keeping with the current diagnostic distinctions between factitious disorders and malingering, a second category must be considered: **malingering by proxy.** **A research priority is the establishment of symptoms and other characteristics that reliably differentiate FDBP from other disorders.** Before attempting large-scale known-groups comparisons, prototypical analysis (in which experts are asked to quantify the salience and representativeness of different criteria in relationship to the diagnosis of a specific disorder) is a useful method of **identifying core symptoms of FDBP that differentiate this disorder from (a) other forms of child abuse,**	

		(b) other types of dysfunctional parents, and (c) other genuine conditions that imitate FDBP. At this preliminary stage, the types of variables should not be arbitrarily constrained. **Three general categories ought to be included: FDBP clinical criteria, proxy-victim characteristics, and relationship (parent-victim and parent-physician) variables.** Rogers 2004 proposes that, while extensively researched models of FDBP are missing, explanatory models of malingering could be applied to FDBP: Rogers (1990a, 1990b, 1997a) tested three nonexclusive explanatory models of dissimulation found in the clinical literature: pathogenic, criminological, and adaptational. Rogers 2004 reviewed the FDBP literature and found that **explanations/descriptions of motivation for FDBP mostly fell in the Pathogenic category** (i.e. use of child as fetishistic object, penis envy towards doctor, rigid defensive style masking immaturity, terror at isolation and abandonment, episodes of dissociation, histrionic personality, over-attachment and symbiosis with the child, sadomasochistic relationship with doctor, intergenerational-Münchausen mothers, addicted to doctors and care, medea complex-regain husband's love, circumscribed disturbance of identity, overly submissive women fearing betrayal), and were mostly psychodynamic in nature, overlooking behavioral models of secondary gain and symptom production. Examples of **Criminological** nature: false claims about accomplishments, prior criminal convictions, psychopathy. Examples of **adaptational** nature: motivated by secondary gain, financial gain, seek legal redress for failurs, parent-child collaboration for disability, rewarding child for fake illness, resolve family conflicts.	
Schreier, 2002, narrative review	**APSAC / Ayoub 1998 / 2002** introduced a specific term to be used for the medical diagnosis in the child: "pediatric condition falsification" (PCF). But this approach recognizes that there are many serious forms of illness exaggeration or fabrication that pediatricians and others encounter that involve motivations other than those found in MBP. Factitious disorder by proxy (FDP) is the diagnostic category for the caretaker who harms her child though PCF for particular self-	In the case of FDP, there have been enough cases studied intensively that show commonalities that strongly suggest motivational needs that can be seen as quite distinct from those found in other forms of PCF and from the more common forms of child abuse.	The APSAC guidelines recognize that pediatricians will usually initially recognize and respond to the harm and abuse of their patient: PCF. Teasing out the motivation of the caretaker (possible FDP) may be more difficult and at times requires the skills and efforts of others. However, although the prognosis for caretaker's treatment will vary by her diagnosis, the responsibility of

	serving psychological needs. MBP then is retained as the name applied to the disorder that contains these 2 elements, a diagnosis in the child and a diagnosis in the caretaker. The APSAC group's definition recognized that the usual clinical presentation, motivation, and prognosis in MBP is such that distinguishing it from other forms (e.g. overwhelmed, anxious or delusional mothers) involving PCF is essential for the protection of the child. It has been demonstrated that the recidivism rate of mothers suffering from FDP is exceptionally high even in the moderately serious cases, as is the death rate of 6%. Besides the medical context, MDP has also been described in the context of the school system, where school psychologists have been the major "targets", and in the legal context of custodial disputes (i.e. allegations of sexual abuse with MDP motivation alongside the secondary motivation of obtaining custody). Schreier warns not to quickly label/diagnose difficult parents (because of personality problems) with FDP and says that also culturally specific practices and beliefs can be confused with PCF. Also some bona fide medical conditions can wrongfully raise suspicions of being caused by a parent.	The primary motivation seems to be an intense need for attention from, and manipulation of, powerful professionals, most frequently, but not exclusively a physician. This phenomenon almost always involves the participation of the child's physician, who at times might be the agent of harm to her child. Despite a very convincing presentation of deep caring for their children, these mothers do not relate or are directly cruel to their children. On separation from the mother, it becomes apparent that there is nothing medically wrong with the child. **It should be noted that contrary to Diagnostic and Statistical Manual of Mental Disorders, other motivations than those described here may co-exist in MBP, e.g. monetary gain or gaining custody, but in MBP such concerns are secondary to the dynamics described above.** **The "help-seeker" described by Libow and Schreier is not MBP.** There will be **overly anxious parents who "doctor-shop" because they believe that their child is not being diagnosed or treated correctly.** These parents may agree to tests, but usually will be anxious about them, want to know what they are for, and if there are risks. This is not typical of FDP mothers. **"Doctor shopping" per se, then, is not MBP. The "masquerade syndrome,"** in which a caretaker, to keep a child with her, will amplify or falsify an illness or go along with a child's doing so to keep her home from school, **is not FDP/MDP.** Also, a caretaker with the **delusional belief** that her child is ill**, is not FDP/MBP**	the pediatrician to report to protective services must be defined by the child's harm. There are **numerous conditions (PCF)** included in case presentations of MBP. In 1993, there were published case reports involving 105 different symptom presentations. GI, neurologic, infectious, dermatologic, and cardiopulmonary are the most common forms of fabrications. Younger children, particularly infants, are the most likely victims. However, when undiscovered, the problem can go on for years. Algorithms have been developed for the most common presentations, e.g., apnea, to help distinguish it from cases of suffocation, and for pseudo-bowel obstruction. Also psychiatric conditions have been described,18 and they include multiple personality disorder, bipolar disorder, psychosis, chronic fatigue syndrome, attention-deficit/hyperactivity disorder, and various psychological symptoms associated with severe allergies. **Parents who describe accidental injury to cover their own abuse of that child should not be categorized as PCF.**
Shaw, 2008, narrative review	Shaw 2008 states the definitions by Rosenberg 1987, APSAC definition of PCF, and the DSM-IV-TR criteria for FDP. All information is already available in the other (newer) reviews. Only with respect to differential diagnosis, they add something to the other reviews.	**Pediatric Condition Falsification: Differential Diagnosis** • Neglect and failure to thrive Caregiver cannot cope with child or fails to feed him/her. • Direct injury/abuse and lie Caregiver injures or abuses child directly and then lies about the circumstances. Usually becomes quickly apparent. • Dependent and home Child is missing school due to illness, but primary motivation of caretaker is to keep child dependent and at home. Child may participate in process. • Delusional caretaker There is generally no factitious disorder by proxy behavior and usually presents with older child.	

	Krener and Adelman (1988) have suggested that FDP represents the extreme end of a spectrum of parental behavior surrounding chronic illness of their children. There are numerous conditions other than FDP in which caretakers falsify physical or psychological symptoms in their children. Roth (1990), for example, used the term hypochondriasis by proxy to describe mild variants where maternal anxiety leads to an exaggerated perception of the child as sick. Since there is no standard psychological profile or diagnostic test, FDP is a diagnosis of exclusion.	• Help seekers Caretaker falsifies symptoms in context of being overwhelmed and needing to get assistance caring for child. These caretakers cooperate with, and are relieved to accept, psychotherapeutic services or out-of-home placement of their children by child protective service agencies. • Difficult caretaker Caretaker of child with chronic physical illness who is difficult because of psychological issues of his/her own or because he/she disagrees with the pediatric staff, and who is resistant to treatment. • Anxious caretaker Overanxious caretaker who is extremely distressed about child's health and may exaggerate child's problems in order to receive "proper care." • Factitious disorder by proxy Caretaker intentionally falsifies child's history, signs, or symptoms to meet their his/her own self-serving psychological needs.
Sheridan, 2003, systematic review of case studies	Sheridan follows the 1987 Rosenberg definition/ criteria of MBP, which focuses on the child maltreatment behavior of MBP instead of the motivation of the perpetrator (as is done in the DSM-IV FDBP research category): • Illness in a child which is simulated (faked) and/or produced by a parent or someone who is in loco parentis; • Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures; • Denial of knowledge by the perpetrator as to the etiology of the child's illness [at least before the deception is discovered]; and • Acute symptoms and signs of the child abate when the child is separated from the perpetrator. The definition specifically excludes physical abuse only, sexual abuse only, and nonorganic failure to thrive only. In total, 451 cases in 154 articles, published between 1972 and 1999, were analyzed in this review.	Sheridan presents tables with all symptoms found in the articles reviewed and presents victim and perpetrator characteristics (also mentioned in other/later reviews): Typical victims may be either males or females, usually 4 years of age or under. Victims averaged 21.8 months from onset of symptoms to diagnosis. Six percent of victims were dead, and 7.3% were judged to have suffered long-term or permanent injury. Twenty-five percent of victims' known siblings are dead, and 61.3% of siblings had illnesses similar to those of the victim or which raised suspicions of MBP. Mothers were perpetrators in 76.5% of cases, but as knowledge of MBP grows a wider range of perpetrators is identified. In a small number of cases, MBP was found to co-exist with secondary gain or other inflicted injury.

Table of excluded studies

Author and year	Reason for exclusion
Amlani, 2016	**Did not contain information adding to included reviews and guidelines**
Ayoub, 2010	**Book chapter (not containing information adding to included publications)**
Barros, 2016	**Case report**
Lieder, 2005	**Case report**
Maldonado, 2003	**Book chapter (not containing information adding to included publications)**
Schreier, 2010	**Book chapter (not containing information adding to included publications)**
Siegel, 2001	**Did not contain information adding to included reviews and guidelines**
Walters, 2020	**Did not contain information adding to included reviews and guidelines**
No authors listed, 2002	**Background article on the publication of some other articles**

Literature search strategy

Database	Zoektermen		
Embase	*No.*	*Query*	*Results*
	#1	'munchausen syndrome by proxy'/exp OR (((munchausen* OR munchhausen* OR muenchausen* OR muenchhausen* OR 'factitious disorder' OR 'factitious illness' OR malingering) NEAR/4 (child OR carer* OR caregiver* OR caretaker* OR proxy OR another OR paediatric OR pediatric)):ti,ab,kw) OR (((fabricat* OR induc*) NEAR/3 illness NEAR/3 (child OR carer* OR caregiver* OR caretaker* OR proxy OR another)):ti,ab,kw) OR 'active illness falsification':ti,ab,kw OR 'meadow* syndrome':ti,ab,kw OR (((paediatric OR pediatric) NEAR/3 'condition falsification'):ti,ab,kw) OR 'polle* syndrome':ti,ab,kw	1072
	#2	'practice guideline'/exp OR 'review'/exp OR guideline*:ti,ab,kw OR review*:ti,ab,kw	5245156
	#3	#1 AND #2 AND ([english]/lim OR [dutch]/lim) AND [2000-2021]/py NOT (('animal'/exp OR 'animal experiment'/exp OR 'animal model'/exp OR 'nonhuman'/exp) NOT 'human'/exp) NOT ('conference abstract'/it OR 'conference review'/it OR 'editorial'/it OR 'letter'/it OR 'note'/it)	139
PsycINFO (OVID)	1 exp Munchausen Syndrome by Proxy/ or (((munchausen* or munchhausen* or muenchausen* or muenchhausen* or 'factitious disorder' or 'factitious illness' or malingering) adj4 (child or carer* or caregiver* or caretaker* or proxy or another or paediatric or pediatric)) or ((fabricat* or induc*) adj3 illness adj3 (child or carer* or caregiver* or caretaker* or proxy or another)) or 'active illness falsification' or 'meadow* syndrome' or ((paediatric or pediatric) adj3 'condition falsification') or 'polle* syndrome').ti,ab. (434) 2 exp Treatment Guidelines/ or exp "Literature Review"/ or guideline*.ti,ab. or review*.ti,ab. (604398) 3 1 and 2 (119) 4 limit 3 to ((dutch or english) and yr="2000 -Current")(69)		