Annals of Pediatrics & Child Health

Review Article

Munchausen by Proxy: Five Core Principles

Brenda Bursch*

Department of Psychiatry & Behavioral Sciences, and Pediatrics, David Geffen School of Medicine at UCLA, USA

Abstract

To effectively identify, assess and manage suspected cases of Munchausen by Proxy abuse, clinicians, legal professionals and the public need to incorporate five core principles into their understanding of this life-threatening form of maltreatment. To successfully protect a MBP victim requires a focus on the presence of harmful deception, regardless of underlying health status. It requires appreciation for of the web of individuals who support the ongoing abuse by failing to recognize it and, sometimes, by participating in the false story of illness or impairment. It requires knowledge of the ways in which clinicians can be successfully misled and pressured to provide unneeded assessment and interventions, especially given the limitations of existing diagnostic tools. Finally, it requires understanding that this behavior is compulsive and addictive, likely to require clinical and social assistance for the abuser to refrain from engaging in their harmful behaviors and to become a safe caregiver. Health providers, legal professionals and family members who grasp these principles will be better able to use the available guidelines effectively to identify and protect victims, and to facilitate appropriate treatment of abusers.

***Corresponding author**

Brenda Bursch, Department of Psychiatry & Behavioral Sciences, and Pediatrics, David Geffen School of Medicine at UCLA, 760 Westwood Plaza, Semel 48-241, Los Angeles, CA, 90024-1759, USA, Tel: 310-206-4985; Email: bbursch@mednet.ucla.edu

Submitted: 09 March 2020

Accepted: 24 March 2020

Published: 27 March 2020

ISSN: 2373-9312

Keywords

- Child maltreatment
- Munchausen by proxy
- Factitious disorder imposed on another

ABBREVIATIONS

MBP: Munchausen by proxy; FDIA: Factitious Disorder Imposed on Another; APSAC: American Professional Society on the Abuse of Children

INTRODUCTION

Munchausen by Proxy: Five Core Principles

Although Munchausen by proxy (MBP) abuse has been recognized in the academic literature for over 40 years, confusion about this form of abuse remains common among health providers, legal professionals and the public. Those who engage in MBP abuse have complex and typically unacknowledged motivations for engaging in this behavior that often includes the desire for positive attention from others. Most clinicians lack the training and guidance needed to professionally, ethically and skillfully protect victims of MBP.

What is Munchausen by proxy?

MBP is a form of abuse/neglect in which an individual abusively and compulsively exaggerates and/or falsifies physical, psychiatric or developmental disorders in a child or adult victim in order to satisfy a psychological need.

MBP abusers engage in a range of deceptive behaviors. For example, verbal history and symptom reports to clinicians may be inaccurate due to intentional lying; symptoms might be created via nonadherence or induction of symptoms; diagnostic tests might be tampered with; and photos or other medical documentation may be falsified.

MBP behavior serves the psychological needs of the perpetrator, which can include various motivations such as the desire to be seen as a good caregiver, to receive positive attention and care from others, to outsmart the clinicians, and/or to be viewed as a martyr or victim.

The MBP perpetrator's psychopathology is labeled *Factitious Disorder Imposed on Another* in the Diagnostic and Statistical Manual of Mental Disorders, 5th ed.[1].

The *American Professional Society on the Abuse of Children* (APSAC) Munchausen by Proxy Practice Guidelines was created with input from nationally/internationally recognized MBP experts within the field of child maltreatment [2]. These guidelines are accessible to all at no cost on APSAC's website (https://www.apsac.org/guidelines) and provide clinicians with detailed instructions about how to identify, evaluate and manage families in which there is suspicion of MBP abuse. The guidelines were also printed within a special issue of *The APSAC Advisor*, along with six other papers written to support health and legal professionals [3]. The year after that publication, Sanders & Bursch published guidance on psychotherapy for perpetrators, victims and other impacted individuals [4].

The purpose of this paper is to describe five core principles

that are essential for professionals to appreciate in order to effectively identify, assess and/or manage cases of suspected MBP. Although these principles are integrated into the available guidelines, they are easily overlooked among those professionals seeking a checklist approach to care. Thus, this paper goes into more depth than the guidelines and highlights the need to incorporate these five principles into all aspects of care when considering suspected cases of MBP.

Five Core Principles

1. Deception is present in all cases of MBP/FDIA.
2. Individuals with underlying medical, psychiatric or developmental disorders may also be victims of MBP.
3. The identified MBP victim is not the only victim of those with FDIA.
4. Lay person beliefs about the nature of clinical decision-making can perpetuate MBP abuse.
5. It can be helpful to think of MBP abuse as an addiction.

DECEPTION

The fist core principle is that **deception is present in all cases of MBP/FDIA**. At the heart of MBP abuse is the misrepresentation of history and symptoms leading to over-treatment and unnecessary medical (or other clinical) procedures. Although simple, this one fact creates many challenges that health professionals are not trained to manage. Health professionals are trained to believe that the history and symptoms reported by a patient or caregiver are accurate. Health professionals behave with the assumption that their patients and caregivers wish to achieve a state of optimal health and well-being. Health professionals strive to meet the expectations of their patients and caregivers by alleviating suffering. And, health professionals generally do not recognize that they are not capable of detecting deception when speaking with a patient or caregiver. Finally, with some variation, MBP abusers often appear to be perfectly normal and cooperative during clinical encounters [5-9].Thus, it is extremely difficult for well-meaning and well-trained health professionals to recognize someone who does not provide accurate information and does not have a goal of optimal health and well-being. For this reason, health providers are at high risk for being successfully manipulated by a MBP abuser. If, despite all of these factors, a health provider suspects MBP abuse, a systematic evaluation is indicated.

To effectively assess and manage MBP/FDIA, identification of deception is the central goal. Unfortunately health professionals are not socialized to suspect the veracity of symptom reports presented to them, or trained to proactively evaluate patients for possible deception. The reality is that deception is a frequent, normal, and universal human behavior that occurs during health care appointments, with a quarter to half of individuals admitting that they have lied to their health provider [10]. While most are more likely to exaggerate or omit information, a subset has also admitted to completely making up a symptom. However, health professionals, including mental health professionals, are no better at detecting deception than the lay public [11]. They also hold inaccurate beliefs about detectable signs of deception. The Truth-Default Theory posits that human survival depends on efficient cooperation, coordination, and communication with others [12,13]. Truth-default, defined as the passive acceptance of incoming communication content, makes survival possible. Using this framework, suspicion, doubt, or disbelief requires an active trigger and deliberate consideration. Otherwise, people tend to passively believe others. All this is to say that it usually requires something surprising and significant to occur before anyone will question the premise of the problem. Such moments of doubt or epiphany for the clinician (or other concerned individual) might happen, for example, when the abuser reacts oddly negatively to good news or unexpectedly positively to bad news. It may happen when the abuser starts telling a particularly outlandish story or requests a particularly inappropriate clinical intervention. It might happen when the patient continues to get worse despite being provided treatments that are typically very effective.

It can also be helpful to consider possible motivations associated with the deceptive behavior in order to develop a comprehensive identification, assessment and treatment plan. In cases of MBP/FDIA, deception motivation reflects an internal drive to satisfy a psychological need. However, specific psychological needs can be complex, unconscious and vary from individual to individual. When someone with FDIA deceives a clinician in order to appear smart, that person might drop hints, create medical crises, and/or provide hypotheses about the problem. For example, "Do you think this could have been caused by opiate ingestion?" In such cases, clinicians are urged to listen to these hints and to conduct related assessments, such as a toxicology screen in this example, if indicated. If the person with FDIA wishes to elicit sympathy from others, that individual may share a range of stories that are designed to trigger a sympathy response. For example, in addition to having a sick family member, false stores related to relationship problems, employment or housing woes, and/or the impact of crimes and/or natural disasters on them may be part of the presentation. When there is a general desire for attention by the person with FDIA, this need can be met in a variety of ways. In addition to telling stories of tragedy, some share positive false stories of themselves, such as their success as a professional athlete or credentialing as a health professional. Some become advocates for those with illness and/or for those who have been accused of falsifying illness. Unsurprisingly, such individuals are sometimes attracted to the media and to online social media venues for their story telling, especially when they are challenged by health professionals or legal authorities.

It is important to highlight that MBP victims rarely alert clinicians to their victimization. Victims, even adult victims, may or may not be aware of ongoing MBP abuse. Abusers may encourage victims to (knowingly or unknowingly) participate in the deception by providing false information to clinicians [14,15]. They may convince the victim that he or she won't be believed if they share a suspicion with others, or that they are responsible for the abuse and could be punished for their role. The victim may care about or feel protective of the abuser or simply feel so dependent on them that the fear of separation outweighs the desire for rescue. Victims sometimes remain silent to protect others from upsetting information. Because victims may be rewarded for cooperating with the sick role, a victim might wish to maintain the status quo in order to receive emotional

or tangible rewards or to avoid retribution. In general, children are most commonly abused by their parents [16]. Importantly, children are biologically programmed to bond with their parents and to feel safe with them [17]. This biological process further limits their ability to detect and report parental abuse, and drives their desire for reunification even in the face of grave danger.

As is reviewed in detail in other papers, there are several ways to systematically detect MBP deception [2,4].

GENUINE DISEASE

The second core principle is that **individuals with underlying medical, psychiatric or developmental disorders may also be victims of MBP**. Some clinicians make the erroneous assumption that MBP must not be present if they have a patient with a confirmed diagnosis. Such clinicians cease to demonstrate curiosity or concern about potential MBP abuse if they obtain objective evidence of disease. In fact, it is important to remember that abusers discover that their psychological needs are met when they have a rewarding encounter with a health professional. The behavior may begin when they are appropriately seeking care for an illness or injury, but morph into inappropriate behavior over time as the abuser seeks to recreate and enhance the initially rewarding experience. Additionally, individuals with genuine medical, mental health or developmental impairments may be more dependent on their caregivers than healthy peers, causing them to be more vulnerable to victimization, less able to identify abuse, and less inclined to report it if they do suspect it [18]. In fact, it appears that nearly 75% of MBP victims also have a genuine illness [19].

Failing to recognize this important principle leads some health care teams to devise diagnostic approaches centered solely on evaluating the presence or absence of disease, rather than proactively assessing for deception regardless of underlying diseases status. The need to accurately diagnose genuine illness contributes to this confusion. For optimal health and functioning, victims of MBP must receive accurate diagnoses and be supported to function at their highest possible level with the fewest possible symptoms. For example, a child might genuinely have constipation predominate irritable bowel syndrome, but may also be over-medicalized such that he or she ends up experiencing excessive symptoms, surgeries and other treatments due to the mismanagement, misreporting and/or purposeful exacerbation of the problem by the abuser. As another example, the victim might have a benign genetic abnormality that is used to explain a wide range of otherwise unexplainable symptoms and disability. It is easy to get side tracked with false reassurance that genuine illness or disability rules out MBP abuse.

The take away message from this core principle is that recommended approaches to assessing suspected illness deception is the same, whether or not genuine underlying illness or other disorders are confirmed [2,4].

WEB OF VICTIMS

The third core principle is that **the identified MBP victim is not the only victim of those with FDIA**. MBP perpetrators typically create a web of deceit that that draws in at least one individual who is the direct target of over medicalization, but abuser deception success depends upon also misleading the victims' clinicians, teachers, family members and friends. All such individuals are victims of deception betrayal [20,21], and called upon by abusers to treat the MBP victim as excessively ill or impaired. This means that the MBP victim has no safe place to escape the abuse and that no one in the web is likely to recognize the deception or abuse. For the victims, it can be akin to living within a cult, with a false reality being constantly reinforced and shaping the victims' view of their health, abilities and potential future. For the professionals attempting to intervene to protect the child, it can mean that there are no trustworthy family members who can serve as foster parents or who can provide reliable information about family history. Spouses often continue to defend abusers after detection of the abuse, making them ineligible to serve as protectors of their children [22]. Adding to the family dynamic might be intergenerational abuse, meaning the abuser may have previously been similarly abused by the victim's grandparent. Among those family members who do recognize abuse, they may be ostracized by family members who have become tangled in the deception web. For family members, friends and professionals who have strong attachments to the abuser, they are at risk for feeling psychologically traumatized when they discover that they have been the victims of deceit. This realization may also trigger feelings of guilt, embarrassment, self-doubt, grief, anger or other natural emotional consequences to the interpersonal betrayal.

This core principle explains why traditional victim welfare policies and procedures may be insufficient and highly risky in cases of MBP. It also explains how health providers, legal professionals, and friends and family of the victim can also be coerced (and sometimes traumatized) by the behavior of the abuser. Professionals benefit from using a team-based approach using specific guidelines developed for cases of suspected MBP [2,4,23-25].

CLINICAL DECISION-MAKING

The fourth core principle is that basic **lay person beliefs about the nature of clinical decision-making can perpetuate MBP abuse** because they underestimate the fallibility of licensed health professionals, the availability of precise diagnostic tools, and the effectiveness of clinical interventions. Individuals often hold a fundamental belief that clinicians have tools to reliably and accurately diagnosis and treat the vast majority of presenting problems they encounter. Health professionals often start their clinical training holding similar beliefs. For example, a study of second year medical students revealed that most started medical school believing that any medical uncertainty they encounter in clinical practice would only be temporary [26].

Clinicians also vary in their practice patterns based on what they were taught, how much they keep up with recent research findings, and other barriers or incentives directing their behavior. Additionally, it takes an average of 17 years for research findings to be adopted into routine clinical intervention and guidance [27]. For an MBP abuser in search of a clinician who will accommodate their inappropriate requests, the abuser needs only to search for a clinician who is open to implementing caregiver suggestions, who strives to maintain caregiver satisfaction with care, who holds medical opinions desired by the MBP abuser, and/or

who does not feel constrained by the best available evidence. Such clinicians may provide excellent care for the vast majority of patients, but are also susceptible to manipulation by MBP abusers they encounter. A few clinicians become known for their nontraditional approach, typically via online caregiver venues, and unknowingly attract a number of MBP abusers into their practice.

The belief that medicine is an exact science with excellent diagnostic tools for most problems can create disbelief in a lay person who is confronted with a suspicion that someone they know could have misled a clinician to over-treat a victim. For example, a CPS worker, judge or family member of a victim might be shocked to hear that biopsy-confirmed tissue pathology is not required prior to bowel resection surgery or that MBP victims have even endured intestinal transplants [28].

This underlying lack of knowledge about the boundaries of medical knowledge, tools and clinical decision-making also impacts how the public interprets stories they hear in the media about families claiming to be falsely accused of this form of abuse. For example, within a frame of exact medicine, it is reasonable to ask, "How could a parent be held responsible for over-medicalization if it was the surgeon who conducted the surgery?" The answer to this question becomes clearer once one grasps the reality of clinical decision-making. Additionally, health professionals are rarely provided with legal releases by accused individuals so that they may publically share otherwise private health information that explains the concerns. Thus, one-sided inaccurate news stories and social media posts can contribute to the confusion of all involved.

The art of medicine refers to how professionals apply the scientific evidence to a specific patient. Evidence based algorithms are used solely as guidelines. These guidelines are shaped to meet the problems reported to clinicians who have the goal of optimally addressing complaints. Clinicians use their knowledge, training and experience to make educated hypotheses about a problem and to apply the best treatment plan available. When all diagnostic criteria are not met, clinicians do not routinely withhold treatment from a suffering patient. They try to help the best they can by trying out assessment and treatment approaches they believe might help. This clinical decision-making process is normally safe and effective. However, this process requires the clinician to possess fairly accurate reports about past medical history, previous evaluations and treatments, current symptoms and functional ability, and a host of other data provided by the patient and/or caregiver. This process also includes an assumption that patients/caregivers want clinical improvements to be achieved, are adhering to clinical recommendations, and not actively making the presenting problem worse.

A detailed example may best illustrate this important point. An unneeded surgery, for example, could include the tonsillectomy of a child based on the parent falsely reporting the child was treated for tonsillitis five times per year over recent years. Had a careful review of outside records been conducted, it would be clear that the child was repeatedly seen in the emergency department due to parental concerns of tonsillitis, but there were only two documented infections over the past five years and the child typically looked asymptomatic. The surgeon's high-level, quick review of the electronic record listing of presenting problem by the surgeon gave the false impression that the child truly had recurrent tonsillitis. And, the surgeon might reasonably wonder, "Why would a parent lie about that?" This example demonstrates how the insufficient time offered to clinicians for their clinical encounters discourages detailed record reviews and reinforces cursory attempts to confirm that the patient or parent provided history is accurate. However, lay people might not appreciate the many factors that culminate in the ease with whichone lie, such as the one in this example, can lead to a surgery.

ADDICTION

The fifth core principle is that **it can be helpful to think of MBP abuse as an addiction** [2,29]. Similar to addiction to substances or other risky behavior, individuals with FDIA persistently seek interactions with health professionals despite potentially dangerous consequences or side effects. They often neglect or lose interest in activities that do not involve the harmful behavior. They may lash out at people who question their motives or problematic behavior. Even when faced with possible termination of parental rights or incarceration, some abusers are unable to cease or alter their problematic behavior. Deception is central to their abusive behavior. They do not alert anyone that they are exaggerating symptoms, providing false medical history, or inducing problems via nonadherence or assaultive behaviors. The behavior may escalate over time and/or under periods of increased stress. Using this same analogy, it is not surprising that most MBP abusers are ill equipped to stop their behavior simply upon confrontation by a clinician or family member.

Limited research supports the utility of the addiction model in cases of illness falsification. Individuals who self-identify as suffering from a factitious disorder often describe their illness fabrication behavior as similar to an addiction [30]. Persistence of the behavior is revealed by research that demonstrates 35%-50% of siblings are abused (sometimes fatally) before identification of MBP abuse in a subsequent victim[31,32]. Underscoring the risk for relapse, re-abuse rates for MBP have been found to range from 17% (mild cases) to 50% (moderate cases) [31,33]. In cases of severe MBP abuse, reunification may not even be attempted due to the inability of the abuser to cease their harmful behavior [2,31,34].Addiction to substances or other harmful compulsions are sometimes comorbid with FDIA among abusers [5,35]. Like substance abusers or compulsive gamblers, MBP abusers are most likely to recover from FDIA if they acknowledge they have a problem, commit themselves to learning effective coping skills and other relapse prevention strategies, are honest and open about their problem with their social support network (who they ask to assist and monitor them throughout their recovery), and are capable of experiencing empathy for those they harmed [4].

CONCLUSIONS

To effectively identify, assess and manage suspected cases of MBP abuse, clinicians, legal professionals and the public need to incorporate these five principles into their understanding of this life-threatening form of maltreatment. Those who successfully protect a MBP victim have placed their focus on the presence of harmful deception, regardless of underlying health status. They have likely encountered a web of (typically unsuspecting)

individuals who support the ongoing abuse by failing to recognize it and, sometimes, by participating in the false story of illness or impairment. They have appreciated the ways in which clinicians can be successfully misled and pressured to provide unneeded assessment and interventions, especially given the limitations of existing diagnostic tools. Finally successful protectors are aware this behavior is compulsive and addictive, likely to require clinical and social assistance for the individual with FDIA to refrain from engaging in their abusive behaviors and to become a safe caregiver. Health providers, legal professionals and family members who grasp these principles will be better able to use the available guidelines effectively to identify and protect victims, and to facilitate appropriate treatment of those with FDIA.

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub. 2013.
2. APSAC Taskforce. APSAC Practice Guidelines: Munchausen by proxy: Clinical and Case Management Guidance. The APSAC Advisor. 2018; 30: 8-31.
3. APSAC Taskforce. The APSAC Advisor. 2018; 30.
4. Sanders M, Bursch B. Psychological Treatment of Factitious Disorder Imposed on Another/Munchausen by Proxy Abuse. J Clin Psychol Medical Settings. 2019; 27: 139-149.
5. Ayoub C. Advancements in Diagnosis & Co-Morbidities in Factitious Disorder by Proxy. In Brenda Bursch (Chair) Munchausen by Proxy: Forensic Issues. Symposium at the 41st Annual Meeting of the American Academy of Psychiatry and the Law, 2010. Tucson, Arizona
6. Palmer AJ, Yoshimura GJ. Munchausen syndrome by proxy. J Am Academy of Child Psychiatry. 1984; 23: 503-508.
7. Parnell TF, Day DO. editors. Munchausen by proxy syndrome: Misunderstood child abuse. Sage Publications. 1997.
8. Rosen CL, Frost JD, Bricker T, Tarnow JD, Gillette PC, Dunlavy S. Two siblings with recurrent cardiorespiratory arrest: Munchausen syndrome by proxy or child abuse? Pediatrics. 1983; 71: 715-720.
9. Schreier HA, Libow JA. Hurting for love: Munchausen by proxy syndrome. Guilford Press. 1993.
10. Irwin K. Patient deception of doctors: Industry View 2014. Software Advice.
11. tenBrinke L, Stimson D, Carney DR. Some evidence for unconscious lie detection. Psychological science. 2014; 25: 1098-1105.
12. Levine TR. Truth-default theory (TDT) a theory of human deception and deception detection. J Language and Social Psychol. 2014; 33: 378-392.
13. Levine TR. Duped: Truth-default theory and the social science of lying and deception. University Alabama Press. 2019.
14. Deimel G. "Munchausen syndrome by proxy with an adult victim: A case series" APA 2011. Abstract NR01-20.
15. Deimel GW, Burton MC, Raza SS, Lehman JS, Lapid MI. Munchausen syndrome by proxy: an adult dyad. Psychosomatics (Washington, DC). 2012; 53: 294-299.
16. https://www.nationalchildrensalliance.org/media-room/nca-digital-media-kit/national-statistics-on-child-abuse/
17. Sullivan R, Lasley EN. Fear in love: Attachment, abuse, and the developing brain. Cerebrum. 2010; 17.
18. Randall P, Parker J. Factitious disorder by proxy and the abuse of a child with autism. Educational Psychology in Practice. 1997; 13: 39-45.
19. Roesler TA, Jenny C. Medical child abuse: Beyond Munchausen syndrome by proxy. American Academy of Pediatrics. 2008.
20. Bursch B, Hurvitz S, Parikh M. Betrayal Trauma: Impact on in Health Professionals. Under review.
21. Lesnik-Oberstein M. Denial of reality: A form of emotional child abuse. Child abuse & neglect. 1983; 7: 471-472.
22. Sanders MJ, Ayoub C. Munchausen by Proxy: Risk Assessment, Support, and Treatment of Spouses and Other Family Caregivers. The APSAC Advisor. 2018; 30: 66-75.
23. Arizona Department of Child Safety. Investigating Munchausen by proxy: Policy and procedure manual. Chapter 2, Section 4.6. 2012.
24. Bursch B. Child protective services management of cases of suspected child abuse and neglect due to factitious disorder imposed on another. The APSAC Advisor. 2018; 30: 76-82.
25. Michigan Governor's Task Force on Child Abuse and Neglect. Medical child abuse: A collaborative approach to identification, investigation, assessment, and intervention. 2013.
26. Knight LV, Mattick K. 'When I first came here, I thought medicine was black and white': Making sense of medical students' ways of knowing. Social science & medicine. 2006; 63: 1084-1096.
27. Morris ZS, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. J Royal Society Medicine. 2011; 104: 510-520.
28. Sigurdsson L, Reyes J, Kocoshis SA, Mazariegos G, Abu-Elmagd KM, Bueno J, Di Lorenzo C. Intestinal transplantation in children with chronic intestinal pseudo-obstruction. Gut. 1999; 45: 570-574.
29. Libow JA, Schreier HA. Three forms of factitious illness in children: when is it Munchausen syndrome by proxy?. Am J Orthopsychiatry. 1986; 56: 602-611.
30. Lawlor A, Kirakowski J. When the lie is the truth: grounded theory analysis of an online support group for factitious disorder. Psychiatry Res. 2014; 218: 209-218.
31. Davis P, McClure RJ, Rolfe K, Chessman N, Pearson S, Sibert JR, et al. Procedures, placement, and risks of further abuse after Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation. Archives of disease in childhood. 1998; 78: 217-221.
32. Gray J, Bentovim A. Illness induction syndrome: paper I—a series of 41 children from 37 families identified at The Great Ormond Street Hospital for Children NHS Trust. Child abuse & neglect. 1996; 20: 655-673.
33. Bools CN, Neale BA, Meadow SR. Follow up of victims of fabricated illness (Munchausen syndrome by proxy). Archives of disease in childhood. 1993; 69: 625-630.
34. Jones DP. The untreatable family. Child Abuse & Neglect. 1987; 11: 409-420.
35. Bools C, Neale B, Meadow R. Munchausen syndrome by proxy: a study of psychopathology. Child abuse & neglect. 1994; 18: 773-788.

Cite this article

Bursch B (2020) Munchausen by Proxy: Five Core Principles. Ann Pediatr Child Health 8(2): 1171.