

# Anorexia by Proxy

Factitious disorder imposed on another, or child abuse? The case of anorexia nervosa.



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# Introduction

## Munchausen syndrome by proxy (MSBP)

- ▶ MSBP is a serious psychiatric disorder, with 4 features (Meadow, 2002):
- ▶ **The symptomology is fabricated or induced on another** – *fictitious information* about the child's physical state, or *directly producing symptoms* to him/her by mistreatment or poisoning.
- ▶ **The child is presented to the doctor.**
- ▶ **The illness is absent when the child is separated from the perpetrator.**
- ▶ **The perpetrator is acting out of a real need.**

# Diagnostics

## Factitious disorder imposed on another (FDIA)

- ▶ **Only the perpetrator receives the diagnosis** (APA, 2013).
- ▶ The DSM-5 classifies it within “**Somatic symptom and related disorders**”
- ▶ The ICD-10 suggests it as a „**Not otherwise specified form of child abuse**” (WHO, 2004).
- ▶ As the child can be harmed from the parental mistreatment or from unnecessary interventions, studies identify it as a deceptive form of child abuse (Gehlawat et al, 2015).

# Factitious disorder imposed on another – ICD 11

1. **Falsifying, or inducing medical, psychological, or behavioural signs, symptoms or injury in another person**, most commonly a child dependent, **associated with deception**.
2. **If a pre-existing disorder is present, the individual intentionally aggravates existing symptoms**, or falsifies or induces additional ones.
3. **The individual** seeks treatment, or **presents the victim as ill**, based on the falsified, or induced symptoms.
4. The behaviour is **not solely motivated by external rewards** (WHO, 2018).

## **Exclusions:**

- ▶ **Other mental disorders explain the symptoms**, e.g. malingering, delusional or another psychotic disorder.
- ▶ **Not just hidden motivations**, objective falsification of symptoms (APA, 2013).

# Can we speak about the case of „Anorexia by proxy syndrome” (ABPS)?

- ▶ Rare cases of comorbid AN, and Münchhausen's syndrome (Bulik et al. (1996).
- ▶ **The second most frequent disorder of the victims of MBPS were induced anorexia or feeding problems** (24.6% of all cases; Sheridan, 2003).

**A three-step algorithm for diagnosing ABPS** (Birmingham & Sidhu, 2007):

1. Is there a non-factitious disorder that can explain the anorexic symptoms?
  2. If no, **all previous medical reports shall be obtained**, hospital admissions, treatments, and surgeries. Therapist should clarify, whether the **parent's asked for discharge from the hospital against medical advice**.
  3. Are the child's symptoms are congruent with MSBP, e.g. **inconsistencies and behaviors?**
- ▶ **ABPS can be distinguished, based on the classical anorexic features, e.g. the intense fear of weight gain, body weight and shape misperceptions** (Birmingham & Sidhu, 2007).



# Method

- ▶ **Literature review**
- ▶ Key phrase: “anorexia by proxy”; keywords: “anorexia” and “Münchhausen” and „Munchausen”
- ▶ In the PubMed 24; in the Google Scholar 11 papers were relevant, until the end of 2020.
- ▶ Counting the duplicates, **14 papers matched the exact topic** in peer-reviewed journals, most of them were case studies.
- ▶ **Cases from our clinical practice** were also involved for a discussion.

# (Some) **former cases** on anorexia by proxy

- ▶ **Katz et al (1985)**: 17-year-old girl, BMI 15.6, with a severely underweight mother, who described her daughter as overweight. **The daughter was aware of her thinness. When the daughter improved in the therapy, her mother began to feel distress that herself would put on weight.** They described this as “anorexia by proxy”.
- ▶ **Honjo (1996)**: severely malnourished 2-year-old child, whose **mother complained about the child’s overeating periods since the first year of her baby.** She was afraid her child is going to put on overweight, **therefore applied feeding restrictions.**
- ▶ **Russell et al (1998)**: measured the weight and height of anorexic mother and their children – **out of the 14 children 9 suffered from food deprivation.**

# Former cases on anorexia by proxy 2

- ▶ **Zamora and de Ugarte (2007)**: 19-year old patient, BMI: 11.5, whose eating problems appeared at the age of 10. Her mother refused her to be weighed, and claimed, that her thinness was related to stress. **The daughter had no body image misperception, and gave her consent to the nutrition at the hospital.**
- ▶ **Birmingham and Sidhu (2007)**: 21-year-old, binge/purge AN. **Her mother advised her to reject the clinical treatment and enrolled her in a modelling school.** The patient recovered when she had moved out from the parental home.
- ▶ **Sadock and Sadock (2009)**: an anorexic mother, who restricted her child's nutrition due to her excessive fears of gaining weight.
- ▶ Most of these studies reveal: **hidden parental ED, coercion, and withdrawal from treatment.**



# Motivations

- ▶ **Internal motivations:** The child's disease gives chance **to demonstrate fake parental skills and affectionate care.**
- ▶ **Attention seeking and pseudo-superiority over other caregivers.**
- ▶ **Secondary gains:** drop-out from responsibilities, respect / reinforcement from the deceived professionals (Ali et al, 2015; APA, 2013; Meadow, 2002).
- ▶ As the disorder can have a homeostatic function, it is worthy to look on MSBP from a **systemic approach.**

# Characteristics of the families with FDIA

- ▶ **In 75% symptoms are produced by mothers** (Sheridan, 2013).
- ▶ **Parental rejection, lack of love or attention, early traumas**, sexual abuse of the mothers (Feldman, 2004).
- ▶ **Maternal anamnesis:** 80% psychiatric disorder, hystrionic or borderline personality disorders, 60% of them have tried to commit suicide (Bools at al, 1994).
- ▶ **Some cases begin after the child's hospitalization.**
- ▶ **Children:** suffered from rejection, guilt, break of trust with the caregiver (Dye et al, 2013).
- ▶ **The parent uses the child as an ego-extension.** Can symptoms reflect a pathological enmeshment of the intra-familiar boundaries? Unconscious anger towards the child?

# Common features of cases seen in our unit

- ▶ **Less expressed body image concerns**
- ▶ **Extreme low body weight** with the direct life threatening status
- ▶ **Chronic clinical course**, the bad outcome
- ▶ **Family secrets**
- ▶ **„Silent daughters”** – children were reluctant to express any form of aggression as it would have meant the surrender from the relationship
- ▶ Parental marriages were charged with **marital and financial difficulties** – the value of food
- ▶ **External family boundaries were extreme rigid**
- ▶ Higher parental control and **destructive messages**
- ▶ **Ambivalent parental involvement** with deficient compliance
- ▶ **Arbitrary drop-outs** with the leading role of the parents

# Other relevant manifestations of FDIA

- ▶ **“Orthorexia by proxy”**: a one-year-old child in with life threatening condition (5 kilograms) was hospitalized – an inflexible vegan diet was imposed by the parents (Andreis, 2016).
- ▶ **„Feederism”**: the body fat becomes the object of sexual desire – the individual feeds his/her partner, to a harmful extent (Giovanelli and Peluso, 2006).
- ▶ **Fashion industry**: agents force strong diets and excessive exercises, with both internal ideals and financial interest in the background + often there's is a collusion with the parents „to make a successful child” (Bogár and Túry, 2019).

# AN or AN by proxy?

## „Regular” AN – indirect, unintentional contribution

- ▶ Parental weight and shape attitudes influence the child's eating and body concerns (Patel et al, 2002).
- ▶ Some mothers with eating pathology misperceived their infants' size (Stein et al, 1996).
- ▶ Parents with AN may wish their children to be thinner; and may force feeding or eating patterns congruent with their false beliefs (Russel et al, 1998).

## ABPS – direct, conscious influence of the child's physical/mental health

- ▶ **Criticizing the child for body weight and shape, or deprivation of normal food intake, exaggerating symptoms**, then taking him/her to doctors driven by internal incentives (Meadow, 2002).
- ▶ FDIA cases cannot be better explained by another mental disorder – **What about parental AN?**



# The spectrum of FDIA in eating disorders

## **Classical AN**

Family features unconsciously, unintentionally contribute to the onset and maintenance of symptoms.

## **The parent's eating and body image disorder with lacking insight**

contributes to a diet-centred atmosphere and perhaps to the misperception of the child's needs.

## **Direct contribution of parental needs**

when the parent refuses the child's treatment based on a symbiotic relationship or on his/her own needs.

## **The parent projects his/her own anorexic attitudes onto the child**

and criticize his/her body weight and shape even, when the child perceives them perfectly normal.

## **The parent make his/her child starve based on his/her body image disorder – an explicit case, which **corresponds most the criteria of FDIA****

## **Criminal abuse**

when the parent does not feed his/her child – e.g. as a punishment

# The treatment of FDIA

- ▶ **Involve the caregiver and the child, combining family therapy and hospital admissions** (Dye et al, 2013; Stirling, 2017).
- ▶ **Long term psychiatric admission of the child**, sometimes separation can be required (Sanders and Brush, 2002).
- ▶ Children may benefit from expressive therapies, discussion about rejection and guilt; **the mothers' eating disorder shall be monitored** (Russel et al, 1998).

## **Stirling's (2007) suggestions:**

- ▶ Review all medical charts, and provide **expert consultation**.
- ▶ Cooperate with each professional, **involve one with experience in child abuse** as well as **social service agencies**.
- ▶ **The whole family shall be involved in the treatment,**
- ▶ **Provided that the whole family can guarantee the safety of the victim in their home further on.**

# Conclusion

- ▶ Family therapy is the primary treatment of young patients with anorexia nervosa.
- ▶ Blaming the family as a cause is a pitfall, as family is the biggest resource of recovery.
- ▶ **In anorexia by proxy, a spectrum of parental involvement can be highlighted that spans between a *psychiatric disorder* and *child abuse*.**
- ▶ **When *direct parental purposefulness* can be observed, and *classical anorexic features are less apparent*, special attention shall be payed to:**
  - ▶ Previous medical reports,
  - ▶ Hidden parental features,
  - ▶ And to the possibility of FDIA mechanisms.

# Declaration of interest

- ▶ The authors declare that they have no conflict of interests.
- ▶ No financial support was received to conduct this manuscript.
- ▶ Ethical approval: Medical Research Council Scientific and Research Committee (5692-2/2015/EKU).
- ▶ The referred patients had given their written informed consent to be involved in the anonymous cases.

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