MUNCHAUSEN SYNDROME AND MUNCHAUSEN SYNDROME BY PROXY: AN INTEGRATIVE REVIEW ON DIAGNOSIS, MULTIPROFESSIONAL CARE AND CONTEMPORARY ASSISTANCE CHALLENGES

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Daiane Gonçalves de Sousa[1], Arthur Gomes Almeida[2], Nicolle Calheiros de Souza[3], Luiz Henrique Soares da Silva[4], Náthally Carvalho Dias Teixeira[5], Ana Beatriz da Silva Matos[6], Maria Clara Jacomini de Almeida[7], Enoghalliton de Abreu Arruda[8] and Monique Bessa de Oliveira Prucoli[9]

Abstract

Munchausen syndrome and Munchausen syndrome by proxy are complex psychopathological conditions characterized by the deliberate and repeated fabrication of signs, symptoms, or laboratory abnormalities without any evident secondary gain, as occurs in malingering. These clinical phenomena are difficult to identify and cause physical and psychological suffering either to the individuals themselves, in the self-imposed form, or to third parties under their care, generally young children, in the by-proxy form, now also referred to as factitious disorder imposed on another. This study aimed to conduct an up-to-date integrative review of Brazilian and international scientific literature published primarily over the past decade in order to discuss contemporary diagnostic criteria and the epidemiological, psychodynamic, ethical, and healthcare-related aspects of these conditions. Particular emphasis was placed on the role of the multiprofessional healthcare team as a central component of early diagnosis, therapeutic management, and victim protection, while also critically examining the historical undervaluation of these professionals

[1] Undergraduate Nursing Student – Centro Universitário UniFAMESC
[2] Undergraduate Nursing Student – Centro Universitário UniFAMESC
[3] Undergraduate Nursing Student – Centro Universitário UniFAMESC
[4] Undergraduate Nursing Student – Centro Universitário UniFAMESC
[5] Undergraduate Nursing Student – Centro Universitário UniFAMESC
[6] Undergraduate Nursing Student – Centro Universitário UniFAMESC
[7] Undergraduate Nursing Student – Centro Universitário UniFAMESC
[8] PhD in Education from the Universidade Católica de Petrópolis (UCP)
Professor at Centro Universitário UniFAMESC
E-mail: enoghalliton.arruda@hotmail.com
ORCID: https://orcid.org/0000-0001-5634-4724
[9] Doctoral Candidate in Cognition and Language UENF);
Master's Degree in Cognition and Language (UENF); Nurse (UFF)
Professor at Centro Universitário UniFAMESC
E-mail: moniquebessauff@yahoo.com.br
ORCID: https://orcid.org/0000-0002-8197-8312

within care pathways. Electronic databases were searched, and the findings were synthesized qualitatively. The results indicate that, despite the classificatory advances introduced by the fifth edition, text revision, of the Diagnostic and Statistical Manual of Mental Disorders and the eleventh revision of the International Classification of Diseases, significant gaps persist in the epidemiology, systematic screening, and interdisciplinary management of these syndromes, contributing to underdiagnosis, iatrogenic harm, and victims' prolonged exposure to maltreatment. It is concluded that addressing these conditions requires investment in continuing education, stronger communication protocols across specialties, and effective institutional recognition of the work performed by nursing, psychology, social work, occupational therapy, and the other professional groups involved in healthcare, which have historically been relegated to a supporting role in these decision-making processes.

Keywords: Factitious disorder, Interprofessional relations, Munchausen syndrome, Munchausen syndrome by proxy.

INTRODUCTION

The deliberate production of illness, whether self-imposed or imposed on another, constitutes one of the most intriguing yet neglected areas of contemporary psychopathology. Originally described by Asher in 1951 after observing patients who traveled from one hospital to another recounting dramatic and often inconsistent medical histories, apparently seeking to assume the sick role, Munchausen syndrome was named after Baron Münchhausen, a historical figure known for recounting fantastical and exaggerated exploits (Asher, 1951; Bass; Halligan, 2014).

More than seven decades after its initial description, the subject remains surrounded by diagnostic, epidemiological, and healthcare-related uncertainties. This underscores the need for periodic reviews that incorporate classificatory advances, findings from behavioral neuroscience, and, most importantly, the transformations in healthcare models that have occurred in recent decades.

Within current nosology, Munchausen syndrome falls within the spectrum of factitious disorders, which are characterized by the intentional falsification of physical or psychological signs or symptoms or the induction of injury or disease associated with identified deception, even in the absence of an obvious external reward (American Psychiatric Association, 2023).

Unlike malingering, in which an individual consciously seeks an identifiable secondary gain, such as leave from work, social security benefits, or avoidance of legal responsibilities, the gain in Munchausen syndrome is predominantly psychological. It is associated with an unconscious need to assume the sick role and receive attention, care, and validation from the healthcare team (Yates; Bass, 2017; Krahn; Li; O'Connor, 2003).

Munchausen syndrome by proxy, currently also designated as factitious disorder imposed on another, refers to a situation in which a caregiver, in nearly all cases the child's mother or primary caregiver, produces, exaggerates, or fabricates signs and symptoms of illness in a child under their care, subjecting the child to invasive diagnostic investigations, recurrent hospitalizations, and unnecessary therapeutic interventions (Bass; Glaser, 2014).

This is a severe form of child maltreatment with the potential to cause permanent physical injury and, in extreme cases, death. It is internationally recognized as medical child abuse perpetrated through the healthcare system (Sheridan, 2003; Yates; Bass, 2017).

The social and academic relevance of this subject is undeniable. Studies indicate that children subjected to Munchausen syndrome by proxy may undergo multiple invasive procedures, on average, before diagnostic suspicion is raised, revealing systemic failures in early identification (Yates; Bass, 2017). From the perspective of healthcare services, both conditions generate high costs due to prolonged hospitalizations, repeated diagnostic tests, and unnecessary surgical procedures. They also expose the professionals involved to severe emotional strain, a phenomenon known in the psychoanalytic literature as negative countertransference (Feldman, 2004; Sanders; Bursch, 2002).

In recent decades, the understanding of these disorders has undergone significant reconfiguration, driven by the revision of diagnostic criteria in the fifth edition and subsequent text revision of the Diagnostic and Statistical Manual of Mental Disorders, as well as by the inclusion of a specific category in the eleventh revision of the International Classification of Diseases, developed by the World Health Organization (World Health Organization, 2022; American Psychiatric Association, 2023). These changes were intended to improve diagnostic precision and reduce the stigma previously associated with terms such as “Munchausen patient,” which is now understood more broadly within the spectrum of factitious disorders.

At the same time, there is growing recognition that these conditions cannot be adequately addressed without an interprofessional and interdisciplinary approach. Physicians, nurses, psychologists, social workers, occupational therapists, and other members of the multiprofessional healthcare team play an indispensable role in identifying clinical inconsistencies, coordinating protective networks, and providing longitudinal care in these cases (Peduzzi, 2001; Araújo; Rocha, 2010).

Historically, however, institutional recognition has been asymmetrical between the medical profession and other healthcare professions. The latter are frequently relegated to auxiliary functions, underpaid, and afforded little recognition in decision-making protocols, even though these professionals, particularly nurses and social workers, are often the first to identify suspicious behavioral patterns in either the caregiver or the patient (Costa et al., 2018; Peduzzi; Ciampone; Nicoletto, 2013).

Against this background, the present study aims to conduct a narrative and integrative review of the scientific literature on Munchausen syndrome and Munchausen syndrome by proxy, updating discussions from previous studies in light of recent classificatory and healthcare-related changes and critically examining, throughout the analysis, the role and persistent undervaluation of the multiprofessional healthcare team in identifying, managing, and preventing these conditions.

The relevance of this study is justified by the scarcity of Brazilian publications integrating these dimensions, the social importance of a subject associated with severe forms of domestic and institutional

violence, and the need to inform the development of more sensitive and effective care protocols within the Brazilian context.

METHODOLOGY

This is a qualitative, descriptive, and exploratory narrative literature review based on an integrative analysis of Brazilian and international scientific publications concerning Munchausen syndrome and Munchausen syndrome by proxy. Emphasis was placed on studies published between 2013 and 2025, a period deliberately chosen to encompass the publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders and its subsequent text revision, an important classificatory milestone in the field.

The narrative review model was chosen over a strictly systematic review because of the nature of the subject under investigation. The available scientific literature consists predominantly of case reports, case series, and qualitative reviews, with few randomized clinical trials or large-scale epidemiological studies, as previous reviews of the subject have already noted (Yates; Bass, 2017). Nevertheless, methodological rigor was sought in the source selection and analysis process through systematic stages of searching, screening, and synthesis.

The literature search was conducted in the following electronic databases: PubMed/MEDLINE, Scientific Electronic Library Online (SciELO), Latin American and Caribbean Health Sciences Literature (Literatura Latino-Americana e do Caribe em Ciências da Saúde, LILACS), PsycINFO, and the Virtual Health Library (Biblioteca Virtual em Saúde, BVS). The following descriptors in Portuguese, English, and Spanish were combined using the Boolean operators “AND” and “OR”: “síndrome de Munchausen,” “Munchausen syndrome,” “Munchausen syndrome by proxy,” “factitious disorder imposed on another,” “transtorno factício,” “maus-tratos infantis,” “child abuse,” “equipe multiprofissional,” “interprofessional team,” and “patient care team.”

The following inclusion criteria were established: (a) original articles, case reports, case series, systematic reviews, narrative reviews, and clinical guidelines published in indexed journals; (b) full texts available in Portuguese, English, or Spanish; (c) publications addressing diagnostic, epidemiological, psychodynamic, ethical, legal, or healthcare-related aspects of the syndromes under investigation; and (d) studies that directly or indirectly discussed the role of multiprofessional teams in managing these conditions. Non-peer-reviewed editorials, abstracts from scientific events for which no full text was available, and publications duplicated across more than one database were excluded.

The selection process was conducted in three successive stages: review of titles and abstracts, full-text review of preselected articles, and extraction and systematization of data relevant to the study objectives. To reduce selection bias, screening was conducted independently, followed by a consensus meeting to resolve any disagreements regarding study eligibility. This procedure was informed by methodological recommendations for health literature reviews (Souza; Silva; Carvalho, 2010).

In addition to literature specifically addressing Munchausen syndromes, theoretical references on multiprofessional teamwork and interprofessional healthcare practice, a well-established field in the Brazilian collective health literature, were incorporated as complementary material to support the cross-cutting discussion proposed in this study (Peduzzi, 2001; Araújo; Rocha, 2010; Peduzzi; Ciampone; Nicoletto, 2013).

The findings were thematically organized into analytical areas: history and conceptualization; contemporary diagnostic criteria; epidemiology and underreporting; psychodynamic aspects; impact on victims; the role and undervaluation of the multiprofessional team; ethical and legal aspects; and therapeutic perspectives. These areas provide the structure for the development section of this article.

Because this was a literature review involving no direct participation by human subjects, submission to a research ethics committee was not required. Nevertheless, the ethical principles of academic integrity were observed in attributing authorship to the sources consulted and ensuring the accuracy of the synthesis.

DEVELOPMENT

HISTORY AND CONCEPTUALIZATION: FROM THE CLASSIC DESCRIPTION TO CONTEMPORARY UNDERSTANDING

Richard Asher's initial description, published in The Lancet in 1951, marked the emergence of a field of investigation that continues to challenge clinicians across different specialties. Asher observed that certain patients presented a clinical pattern characterized by dramatic and frequently untruthful accounts of their medical histories, visits to multiple hospitals, the use of false names, and an incessant pursuit of invasive procedures even when diagnostic test results were normal (Asher, 1951).

The reference to Baron Münchhausen, an eighteenth-century German nobleman known for fantastical tales of his own adventures, gave the syndrome its name. The designation was subsequently criticized for its pejorative nature, contributing to the progressive adoption of the term "factitious disorder" in official classification systems (Bass; Halligan, 2014).

The "by proxy" form was described later, in 1977, through the work of Roy Meadow, a British pediatrician who identified cases in which mothers produced or fabricated symptoms in their children and subjected them to unnecessary medical investigations (Meadow, 1977 apud Bass; Glaser, 2014). Meadow coined the term "Munchausen syndrome by proxy" to describe this pattern of parental behavior after reporting a series of cases in which children underwent invasive examinations, recurrent hospitalizations, and unnecessary surgical procedures because of symptoms fabricated or induced by their own mothers (Meadow, 1977 apud Bass; Glaser, 2014).

Meadow's work, also published in The Lancet, sparked intense debate within the medical community and, subsequently, in the legal field, particularly from the 1990s onward, when the author himself became involved in controversies relating to the use of his theory in legal proceedings concerning sudden infant death. For a time, this episode undermined the scientific credibility of the concept and highlighted the risks associated with the indiscriminate forensic use of psychopathological constructs that had not yet been firmly established (Bass; Glaser, 2014).

Over the following decades, the conceptual field underwent successive terminological revisions. In official classification systems, the expression “Munchausen syndrome by proxy” gave way to the designation “factitious disorder imposed on another.” This change sought to shift the diagnostic focus away from viewing the caregiver’s behavior as an autonomous syndrome and toward recognizing it as a mental disorder diagnosed in the perpetrator, with the child, or, less commonly, another dependent person, such as an older adult or a person with a disability under the perpetrator’s care, being the victim of factitious illness behavior (American Psychiatric Association, 2023). This terminological change is not merely semantic. It repositions the locus of clinical and legal responsibility by emphasizing that the diagnosis applies to the person fabricating the illness, not the person subjected to it.

CONTEMPORARY DIAGNOSTIC CRITERIA: DSM-5-TR AND ICD-11

The text revision of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders retains factitious disorders as a distinct category within the chapter on somatic symptom and related disorders, subdividing them into factitious disorder imposed on self and factitious disorder imposed on another (American Psychiatric Association, 2023).

The diagnostic criteria require the falsification of physical or psychological signs or symptoms or the induction of injury or disease associated with identified deceptive behavior, even in the absence of an obvious external reward; presenting oneself, or another person under one’s care, to others as ill, impaired, or injured; and determining that the behavior is not better explained by another mental disorder, such as a delusional disorder or another psychotic disorder.

It is important to emphasize that, in factitious disorder imposed on another, the formal diagnosis is assigned to the perpetrator, generally the caregiver, rather than to the victim. When necessary, the victim receives diagnoses corresponding to the physical conditions actually produced or to post-traumatic stress and other psychological harm resulting from the victimization (American Psychiatric Association, 2023; Bass; Glaser, 2014).

This nosological distinction is frequently misunderstood in publications intended for general audiences and even in some clinical records, reinforcing the need for continuing education among healthcare teams regarding correct diagnostic coding.

The eleventh revision of the International Classification of Diseases, developed by the World Health Organization and progressively adopted by Member States, incorporated a specific category for factitious disorders. It broadly aligns with the classificatory framework of the American manual, although there are nuances concerning the coding of subtypes and their interface with categories of maltreatment and neglect (World Health Organization, 2022). Convergence between the two primary international classification systems represents an important advance in diagnostic standardization and the comparability of epidemiological data across countries and healthcare systems, although the practical implementation of these categories in Brazilian electronic health records remains incipient.

From the perspective of differential diagnosis, it is essential to distinguish factitious disorders from malingering, conversion disorder, somatoform disorders as such, and genuine medical conditions that are difficult to diagnose. Whereas malingering presupposes a conscious external secondary gain and somatoform disorders involve genuine suffering without any intention to fabricate symptoms, factitious disorder is characterized precisely by the intentional production of symptoms in the absence of an evident external gain, with the gain being predominantly psychological and relational (Krahn; Li; O'Connor, 2003; Yates; Bass, 2017). Although this distinction is clear in theoretical terms, it proves extremely challenging in everyday clinical practice, particularly in emergency departments and urgent care settings, where opportunities for longitudinal observation are limited.

EPIDEMIOLOGY AND UNDERREPORTING

One of the most problematic aspects of studying these syndromes is the scarcity of robust epidemiological data. Because these conditions are inherently characterized by deception and the

deliberate concealment of information, their identification depends largely on active clinical suspicion and thorough investigation, which contributes to substantial underdiagnosis (Yates; Bass, 2017).

Available international prevalence studies provide highly variable estimates, often based on hospital case series or records from child maltreatment referral centers. No representative population surveys are available to determine the true scale of the phenomenon (Sheridan, 2003).

The situation is even more critical in Brazil. Brazilian scientific literature is scarce and consists primarily of isolated case reports published by pediatric, psychiatric, and forensic medicine services. Furthermore, there are no specific reporting systems that would allow the epidemiological scale of Munchausen syndrome by proxy to be measured as a distinct form of domestic violence.

This gap is compounded by the absence of a specific category in the mandatory child maltreatment reporting systems currently used within the Brazilian Unified Health System (Sistema Único de Saúde, SUS). These systems tend to categorize such cases generically as neglect or physical abuse without distinguishing factitious fabrication of illness as the underlying etiological mechanism.

Underreporting also results from factors related to the dynamics of the phenomenon itself. Perpetrators often present themselves as exceptionally dedicated, cooperative, and highly involved caregivers, which paradoxically elicits admiration from the healthcare team and delays the formulation of alternative diagnostic hypotheses (Bass; Glaser, 2014; Feldman, 2004).

This is compounded by professionals' reluctance to express suspicions that could amount to a serious accusation against a caregiver. Such reluctance is heightened by fear of ethical, legal, and institutional repercussions if the suspicion is not confirmed, a phenomenon described in the literature as "diagnostic paralysis" in the presence of suspected cases (Yates; Bass, 2017).

PSYCHODYNAMIC AND ETIOLOGICAL ASPECTS

The psychodynamic understanding of Munchausen syndrome and its by-proxy form remains largely hypothetical and is based on case reports and theoretical formulations derived from

psychoanalysis and developmental psychology. Historically, the factitious production of symptoms has been associated with early experiences of neglect, abuse, or emotional deprivation that may have fostered the development of dysfunctional attachments to caregivers. Within these relationships, illness may come to serve as the primary, and sometimes only available, means of obtaining attention, protection, and recognition (Feldman, 2004; Sanders; Bursch, 2002).

In the specific case of Munchausen syndrome by proxy, or factitious disorder imposed on another, several authors have highlighted the frequent presence of personality disorders in perpetrators, particularly borderline and narcissistic traits, as well as personal histories of childhood victimization, suggesting a possible transgenerational pattern of reproducing suffering (Sanders; Bursch, 2002; Bass; Glaser, 2014). In this context, the child may occupy the position of a narcissistic extension of the caregiver and be instrumentalized as a means of gaining psychological benefits, including attention from the healthcare team, social recognition as a "dedicated and heroic mother," inclusion in support networks, and, occasionally, indirect material benefits.

It is important to emphasize, however, that although these psychodynamic formulations are clinically relevant, they lack robust empirical validation and are derived primarily from qualitative studies and case series. More recent literature has adopted greater caution in attributing standardized psychological profiles, recognizing the phenomenological heterogeneity of these conditions and warning against the risk of hastily stigmatizing caregivers on the basis of superficial personality characteristics (Bass; Halligan, 2014).

IMPACT ON VICTIMS

The impact of Munchausen syndrome by proxy on child victims is devastating from every perspective. In addition to direct physical harm caused by unnecessary invasive procedures, which may include exploratory surgery, the insertion of tubes and catheters, the administration of inappropriate medication, and, in extreme cases, the deliberate induction of symptoms through asphyxiation, poisoning,

or the contamination of biological samples, these children experience enduring psychological harm. This harm is associated with the early internalization of the role of a chronically ill patient, disruption of the development of a healthy identity, and damage to relationships of trust with caregivers and with the healthcare system itself (Bass; Glaser, 2014; Sheridan, 2003).

Although limited in number, long-term follow-up studies indicate high rates of post-traumatic stress symptoms, anxiety disorders, socialization difficulties, and, in some cases, the subsequent development of self-imposed factitious disorders in adulthood, suggesting a troubling cycle of intergenerational psychopathological reproduction (Sheridan, 2003; Yates; Bass, 2017). Although the mortality associated with this form of maltreatment is difficult to determine statistically, it is considered significantly higher than that observed in other forms of violence against children. This reinforces the urgency that should guide the suspicion and diagnostic investigation of these cases.

THE ROLE, AND PERSISTENT UNDERVALUATION, OF THE MULTIPROFESSIONAL HEALTHCARE TEAM

If there is one relatively stable consensus in contemporary literature on Munchausen syndrome and its by-proxy form, it is that properly diagnosing and managing these conditions depends fundamentally on a collective, interprofessional, and longitudinal perspective that is incompatible with fragmented approaches or models centered exclusively on physicians (Peduzzi, 2001; Araújo; Rocha, 2010).

Because nurses maintain continuous, daily proximity to hospitalized patients, they are often the first professional group to identify inconsistencies between caregivers' accounts and the observed clinical course, discrepancies between reported symptoms and objective signs, or suggestive behavioral patterns such as manipulation of medical devices, excessive insistence on additional tests, and resistance to hospital discharge (Costa et al., 2018).

Social workers, in turn, play a central role in coordinating with the social protection network, assessing the family and socioeconomic dynamics involved, and mediating between the healthcare institution and child protection agencies, such as Guardianship Councils and Juvenile Courts, once suspicion of maltreatment becomes substantiated (Sheridan, 2003; Costa et al., 2018).

In addition to supporting the psychodynamic assessment of the caregiver and child, hospital psychologists provide essential support to the healthcare team itself, whose members frequently experience severe emotional strain and ambivalent reactions in these cases, a phenomenon widely described in the literature as negative countertransference (Feldman, 2004). Occupational therapists, dietitians, physical therapists, and other members of the expanded healthcare team also contribute, each through their specific expertise, to developing a more accurate clinical picture and ensuring the child's continued protection during and after hospitalization.

Despite this multidimensional contribution, which is widely recognized in the collective health literature, everyday institutional practice continues to be marked by a hierarchy that relegates nonmedical professions to a subordinate role in decision-making processes involving diagnostic suspicion and the reporting of maltreatment (Peduzzi; Ciampone; Nicoletto, 2013).

Nursing and social work professionals frequently report situations in which well-founded suspicions derived from direct and sustained observation of the caregiver-child dyad were minimized or disregarded by medical teams. This may occur because of reluctance to question the parenting abilities of apparently dedicated caregivers or because of power asymmetries historically embedded in the organizational culture of Brazilian hospitals (Araújo; Rocha, 2010; Costa et al., 2018).

This asymmetry is not merely symbolic. It produces concrete consequences for care by delaying the formal documentation of suspicions, prolonging the child's exposure to iatrogenic procedures, and undermining nonmedical professionals' confidence in their own clinical judgment. In some instances, this results in underreporting due to institutional discouragement.

The literature on interprofessional healthcare practice has repeatedly demonstrated that horizontal care models based on effective communication, attentive listening across professional groups, and equal recognition of the different forms of expertise involved produce better healthcare outcomes in contexts of high diagnostic complexity, such as the syndromes discussed here (Peduzzi, 2001; Peduzzi; Ciampone; Nicoletto, 2013).

Effectively addressing Munchausen syndrome by proxy therefore necessarily requires cultural reform within healthcare institutions. Such reform must provide institutional recognition, including in terms of remuneration, decision-making autonomy, and representation on child protection committees, for the central contributions of nursing, psychology, social work, and other professional groups that have historically been subordinated.

ETHICAL AND LEGAL ASPECTS

Managing Munchausen syndrome by proxy presents ethical and legal dilemmas of considerable complexity. On the one hand, there is an ethical and legal duty to protect the child, established in Brazilian legislation through the Statute of the Child and Adolescent (Estatuto da Criança e do Adolescente), which makes it mandatory for any healthcare professional to report suspected maltreatment, irrespective of definitive diagnostic confirmation. On the other hand, there is a genuine risk of unfounded accusations against caregivers, potentially causing irreparable harm to family relationships and to the reputations of individuals who may be innocent, particularly given the complexity of the differential diagnosis described above (Bass; Glaser, 2014; Yates; Bass, 2017).

This delicate balance requires diagnostic suspicion always to be developed collectively, documented systematically, and supported by objective evidence, such as discrepancies between reported symptoms and clinical findings, unexpected responses to treatment, or direct evidence of the manipulation of tests or medical devices, rather than by the isolated subjective impressions of a single professional. Where hospital-based child and adolescent protection committees exist, they play a fundamental role in

centralizing this information and assessing it collectively, thereby reducing both the risk of underreporting and that of premature accusations (Sheridan, 2003).

The historical controversy surrounding Roy Meadow himself, whose theoretical formulations were used problematically in legal proceedings concerning sudden infant death in the United Kingdom, is frequently cited as a warning about the risks of applying complex psychopathological constructs indiscriminately in forensic settings. It reinforces the need for any decision to separate children from their caregivers to be supported by a careful multiprofessional assessment rather than the isolated judgment of a single specialist, however experienced that specialist may be (Bass; Glaser, 2014).

THERAPEUTIC PERSPECTIVES

Treating Munchausen syndrome and its by-proxy form remains one of the most challenging aspects of this field because of the low levels of treatment adherence that characterize these conditions and the frequent denial, by either the perpetrator or the self-inflicting patient, of the factitious nature of the symptoms presented (Krahn; Li; O'Connor, 2003; Yates; Bass, 2017).

Unlike other mental disorders, in which recognition of psychological suffering encourages individuals to seek treatment actively, the preservation of the sick role in factitious disorders is, paradoxically, a central component of the psychopathological dynamics, significantly undermining motivation for change.

In cases of self-imposed Munchausen syndrome, psychodynamically oriented psychotherapy and cognitive behavioral interventions focusing on dysfunctional patterns of attention-seeking and emotional regulation have been described with varying outcomes. The prognosis is generally guarded, particularly in chronic and longstanding cases (Krahn; Li; O'Connor, 2003).

In the by-proxy form, the primary and urgent therapeutic intervention is the immediate protection of the child through removal from direct and unsupervised contact with the perpetrating caregiver. This measure must be implemented in close coordination with the justice system and child protection agencies.

Psychotherapeutic treatment of perpetrators who agree to engage in care has limited efficacy and an uncertain prognosis. The literature emphatically prioritizes the victim's safety over any expectation of rehabilitating the caregiver (Bass; Glaser, 2014).

With regard to the multiprofessional team, it should be emphasized that follow-up care after the case has been uncovered, both for the child victim and, where applicable, for other children of the same caregiver who may be at similar risk, is a therapeutic stage frequently neglected by current care protocols.

At this stage, psychology and social work are particularly important in developing continuing care plans designed to help the child process the trauma, strengthen alternative protective bonds, whether with extended family members, foster families, or adoptive families, and provide the long-term psychosocial follow-up needed to mitigate the risks of the transgenerational repetition discussed above. Nursing, in turn, remains a vital link in the child's continued clinical monitoring during any subsequent hospitalizations or follow-up appointments, remaining alert to signs of inappropriate renewed contact with the original caregiver or the recurrence of factitious behavioral patterns, even within a new family arrangement (Bass; Glaser, 2014).

Finally, recent literature has advocated the development of formal institutional, multiprofessional protocols for suspected and confirmed factitious disorder imposed on another. Such protocols should include clear communication pathways among the different professional groups, objective criteria for documenting suspicions, and legal protections for professionals who submit reports. These measures would reduce both underreporting caused by institutional fear and the individual emotional burden placed on the professionals involved (Yates; Bass, 2017; Costa et al., 2018). The absence of such protocols in Brazil represents a significant gap in care that this study specifically seeks to highlight.

FINAL CONSIDERATIONS

This review demonstrated that, more than seventy years after Asher's original description and almost five decades after Meadow's first reports of the by-proxy form, Munchausen syndrome and

factitious disorder imposed on another remain clinical conditions characterized by delayed recognition, uncertain epidemiology, and fragmented healthcare management. This remains the case despite the classificatory advances introduced by the revised fifth edition of the Diagnostic and Statistical Manual of Mental Disorders and the eleventh edition of the International Classification of Diseases.

The concealed intentionality underlying the production of symptoms, combined with the absence of an evident external gain, makes these conditions particularly resistant to conventional diagnostic models, which generally presume that patients or caregivers are reporting information in good faith.

The findings of this review reinforce that the early diagnosis and safe management of these cases depend fundamentally on the coordinated and sustained work of a multiprofessional team capable of integrating longitudinal clinical observations, psychosocial assessments, and objective diagnostic test data.

In this regard, nursing, social work, psychology, occupational therapy, and the other healthcare professions should not be regarded as auxiliary to a diagnostic process conducted by physicians. Rather, they should be recognized as legitimate and indispensable protagonists in that process because of their privileged position in continuously observing the caregiver-patient dyad.

In light of the literature reviewed, the persistence of asymmetrical hierarchies within Brazilian healthcare institutions, which tend to undervalue the contributions of these professional groups in decision-making processes involving suspected maltreatment, constitutes a concrete, rather than merely symbolic, obstacle to the effective protection of victims.

The limitations of this study include the narrative nature of the review, which does not provide the methodological guarantees of comprehensiveness and reproducibility associated with systematic reviews, as well as the aforementioned scarcity of robust primary literature on the subject, particularly within Brazil.

Future studies should include Brazilian empirical research, both epidemiological and qualitative, investigating how different professional groups perceive their role in identifying these syndromes. The

development and validation of specific institutional multiprofessional protocols for the suspicion and management of factitious disorder imposed on another are also recommended. Such protocols could support the development of more effective child protection policies that are sensitive to the complexity of this phenomenon.

Finally, it is concluded that properly addressing Munchausen syndrome and its by-proxy form requires not only continuous scientific and technical improvement but also a cultural transformation within healthcare institutions aimed at recognizing, valuing, and institutionalizing collaborative and equitable work among the different professions involved in care. This is essential if the protection of victims, particularly children, who are the most vulnerable in this context, is no longer to depend on the good fortune of encountering individually vigilant professionals but instead to be guaranteed by robust, replicable, and permanent institutional pathways.

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