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Knowledge about Munchausen Syndrome by Proxy: research with healthcare professionals

Conhecimento sobre Síndrome de Munchausen por Procuração: uma pesquisa com profissionais de saúde

Sabrina Gomes[1]
Maritza Breder[1]
Alexsandra da Silva Souza[1]
Maria Aparecida Costa dos Anjos *(in memoriam)*[1]
Karen Cristina Alves Lamas[1]

[1]Universidade Salgado de Oliveira, Juiz de Fora, Minas Gerais, Brasil.

ABSTRACT RESUMO

Introduction: Munchausen Syndrome by Proxy, or Factitious Disorder Imposed on Another, is a psychiatric diagnosis in which an individual fabricates or induces illness in another person. It constitutes a form of abuse, most commonly occurring between mother and child, in which the perpetrator is diagnosed with the disorder and the victim is identified as having suffered abuse. The literature lacks sufficient studies on epidemiology, therapeutic management, and prognosis of this syndrome. **Objective:** To investigate the knowledge about Munchausen Syndrome by Proxy among health professionals with higher education degrees and nursing technicians, as well as final-year students of these programs, within the national territory. It also sought to identify the frequency of suspected and/or identified cases by professionals, the procedures to interrupt this form of violence, and the level of satisfaction regarding the sufficiency of information on the subject. **Material and Methods:** An empirical qualitative-quantitative study was conducted with 73 participants, recruited through non-probabilistic sampling, who answered an online form with sociodemographic questions and about familiarity with the topic. **Results:** Among the respondents, 68.5% reported working with children, 65.8% were not familiar with the syndrome, and 37% had encountered suspected cases. Knowledge of the syndrome was significantly higher among physicians, psychologists, and intensive care professionals, with Munchausen Syndrome by Proxy being the most frequently recognized term. The main management approaches included referrals to social services, child protection agencies, and psychological services. Most participants reported the need to increase educational initiatives. **Conclusion:** The findings corroborate studies indicating limited knowledge of the topic, highlighting the need for further investigations. There is no established criterion for diagnosis or evaluation protocol; therefore, a multidisciplinary team has been reported as the best approach, with lack of knowledge being an impediment to the identification of the syndrome and protection of the victim.

Palavras-chave: Munchausen Syndrome by Proxy; Factitious Disorder Imposed on Another; Child Abuse.

RESUMO

Introdução: A Síndrome de Munchausen por Procuração ou Transtorno Factício Imposto a Outro caracteriza um diagnóstico psiquiátrico no qual o indivíduo falsifica uma doença em outro. Trata-se de uma situação de violência, ocorrendo com mais frequência entre mãe e filho, em que a agressora é diagnosticada com o transtorno e a vítima recebe o diagnóstico de abuso. A literatura carece de estudos sobre epidemiologia, manejo terapêutico e prognóstico desta síndrome. **Objetivo:** Investigar o conhecimento sobre a Síndrome de Munchausen por Procuração por profissionais graduados no ensino superior na área da saúde e técnicos em enfermagem, além de estudantes do último ano destes cursos, no território nacional. Buscou-se identificar, também, a frequência de casos suspeitos e/ou identificados pelos profissionais, os procedimentos para interromper essa forma de violência e a satisfação quanto a suficiência de informação sobre o assunto. **Material e Métodos:** Realizou-se pesquisa empírica do tipo quali-quantitativa, com 73 participantes, recrutados de forma não probabilística, que responderam formulário on-line com questões sociodemográficas e sobre a familiaridade com o tema. **Resultados:** Verificou-se entre os respondentes que 68,5% atendem crianças, 65,8% não conhecem a síndrome e 37% já atenderam casos suspeitos. O relato de conhecimento foi significativamente maior por médicos, psicólogos e profissionais de terapia intensiva, sendo Síndrome de Munchausen por Procuração o termo conhecido com maior frequência. As principais abordagens de manejo foram encaminhamento para serviço social, conselho tutelar e serviço de psicologia. A maioria relatou necessidade de aumentar práticas educativas. **Conclusão:** Os achados corroboram com estudos que indicam haver pouco conhecimento sobre o tema, ressaltando a necessidade de mais investigações. Não há um critério para se estabelecer o diagnóstico ou um protocolo de avaliação, portanto, uma equipe multidisciplinar tem sido reportada como a melhor abordagem, sendo a falta de conhecimento um impedimento para a identificação da síndrome e proteção da vítima.

Keywords: Síndrome de Munchausen Causada por Terceiro; Transtornos Autoinduzidos; Maus-Tratos Infantis.

✉ **Sabrina Gomes**

Endereço: Av. dos Andradas, 731 - Morro da Glória, Juiz de Fora, MG.
CEP: 36036-000
sabrinapsigomes@gmail.com

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INTRODUCTION

Munchausen Syndrome by Proxy (MSbP) is a condition in which an individual uses deceptive tactics to fake illness or disability in another person, without any apparent external gain.[1] It is a type of abuse, usually committed by the mother in about 90% of cases, who simulates signs and symptoms in the child in order to attract attention to herself.[2] Victims, always excessively ill in the eyes of caregivers, are subjected to repeated hospitalizations, examinations and treatments that are often unnecessary and invasive, with a risk of physical and psychological sequelae and even death.[3,4]

Since 1980, MSbP has been introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) as a Factitious Disorder, which explains the production of false symptoms in children.[5] In its fifth edition,[6] it is called Factitious Disorder Imposed on Another (FDIA), being appended among the "Somatic Symptom and Related Disorders". In this condition, an individual falsifies a disease in another person, whether child, adult or even pets, and the victim is diagnosed with abuse.

Literature lacks consistent studies on the syndrome's epidemiology, therapeutic management, and prognosis.[1,7] Although often considered rare,[1,8] its true prevalence is unknown, and unreported cases are believed to exist.[9] It presents variable incidence considering 2–2.8/100,000 in children that are less than one year old and 0.4/100,000 in individuals that are less than 16 years old.[10] It should be noted that the syndrome does not concern children, but rather a psychiatric condition in adults, and although it is a disturbing clinical condition, the lack of studies in this area is justified by its complexity.

Due to the penalties involved and the deceptive behavior typical of factitious disorders, it is unlikely that abusers will report their actions in an honest way.[1] They often do not admit to the disorder and, when feeling suspicious, especially mothers, they may demand discharge and seek other hospitals, trying to hide their involvement.[5] This attitude makes treatment difficult, harms the child, raises costs and interferes with research on interventions with perpetrators.[11,7] Therefore, the suspicion of MSbP is essential to ensure adequate intervention.[12]

Since it is a specific and serious form of child abuse, it is essential that healthcare professionals are familiar with MSbP and its diagnostic criteria.[13,14] However, the lack of studies and the rarity of diagnosis contribute to the poor knowledge about the condition, hindering its management.

A systematic review has found that the reasons for the condition being underreported include: the healthcare professionals' misinformation about this syndrome, the lack of academic incentive towards the diagnosis, once it is a rare and difficult condition to evaluate; in addition to the insecurity and lack of confidence expressed by professionals in reporting.[14] However, some studies analyzed indicate increased knowledge by healthcare professionals in recent years.

No studies have been found on Brazilian professionals' knowledge about this syndrome. Therefore, it is assumed that healthcare professionals in Brazil still have limited knowledge of MSbP and face difficulties in identifying suspected cases, which compromises appropriate diagnosis and management. On that account, it is necessary to investigate knowledge to strengthen child protection and to reduce the impact on the victims by means of faster and more accurate identification.

Therefore, the general objective of the present study is to investigate the knowledge regarding MSbP among professionals graduated as HCP and nursing technicians, in addition to final-year students of related courses in the national territory. The specific objectives are to identify the frequency of suspected and/or identified cases by professionals, to understand the procedures adopted to interrupt this form of violence against children, and to reveal their perception of the adequacy of disseminating knowledge on the subject, as well as the relevance of disseminating knowledge about the syndrome.

MATERIALS AND METHODS

In order to achieve the proposed objectives, it was conducted an empirical exploratory study with a qualitative-quantitative approach, given that there are few scientific publications and instruments on the subject.[1,7] The sample consisted of 69 professionals from various healthcare fields and 4 students from unspecified healthcare courses, in a total of 73 participants (Table 1). This was a non-probabilistic sample, with healthcare professionals from any region of the country being invited to participate. The exclusion criterion was that the participants did not identify themselves as from the healthcare area.

The data collection instrument was an online form designed by the authors. This is a semi-structured questionnaire, via Google Forms, composed of three sections. The first dealt with the characterization of the participants, including data such as age, gender, profession, time of experience with infants and/or children and place of work. The second section addressed the knowledge around the terms MSbP and FDIA, aiming at verifying the professionals' familiarity with these concepts. The third one investigated previous experience with this type of aggression, including two open-ended questions regarding the conduct adopted in the face of suspicion and the participants' perception of the importance of awareness campaigns.

Data were obtained through the snowball sampling technique.[15] The invitation came from strategic initial contacts (seeds), such as urgent and emergency care services professionals, educational institutions and faculty councils, reaching Juiz de Fora (MG) and other locations through digital means. The disclosure also took place on social networks and WhatsApp, with a request for sharing to expand the scope of the research.

The current study was approved by the Research Ethics Committee, under opinion number 5.804.803. The professionals and students participated voluntarily, by accepting the Informed Consent Form, checking the option "I have read and agree to participate in the study".

Regarding data analysis, it should be noted that categorical variables were analyzed using descriptive statistical techniques, identifying absolute and relative frequencies, measures of central tendency (arithmetic mean), and measures of dispersion and variability (standard deviation, coefficient of variation). Cross-tabulation was made using Fisher's exact test, as more than 50% of the cells presented the expected frequencies of lower than five. A 5% level of significance was considered and the researchers sought to identify the association of the variables "Knowledge around the term FDIA" and "Knowledge around the term MSbP", with the variables "profession", "time of experience in the profession", "area of work", "assistance for infants/children", "time of experience with infants/children" and "place of assistance for infants/children".

Open questions about conduct in the face of suspected cases and the importance of disclosure were analyzed through Bardin's content analysis.[16] The method was structured in three phases: pre-analysis, for the organization of the material; exploration of the material, for the categorization of the registration units; and, finally, the treatment of the results, inference and interpretation, a stage that sought to assign meanings to the analyzed messages, in a systematic and coherent way.[17] Two researchers read the answers, identified similar excerpts and grouped them into categories, comparing and adjusting their analyses after individual evaluation.

RESULTS

Data from 81 participants were collected, and 8 were eliminated for not meeting the inclusion criteria. The final sample consisted of 73 participants, 64 (87.7%) females and 9 (12.3%) males, with a mean age of 38.8 years (SD = 9.34). Among these, 41 (56.2%) work in the public sector, 23 (31.5%) in the private sector, 5 (6.8%) work in both sectors, and 4 reported working in another sector (unspecified). Among the professional statuses, Nursing showed the highest frequency (26%) in the sample (Table 1).

Table 1: Distribution of professional status in the sample analyzed.

Professional status	N	%
Nurse	19	26.0
Nurse technician	14	19.2
Psychologist	12	16.4
Physical therapist	11	15.1
Physician	6	8.2
Dietitian	5	6.8
Speech therapist	1	1.45
Social worker	1	1.45
Students (unspecified)	4	6.8

Most professionals work with infants and/or children (68.5%), with 30.1% having worked with this population for more than ten years. In addition, 60.3% have ten years or more of experience in the profession (Figure 1).

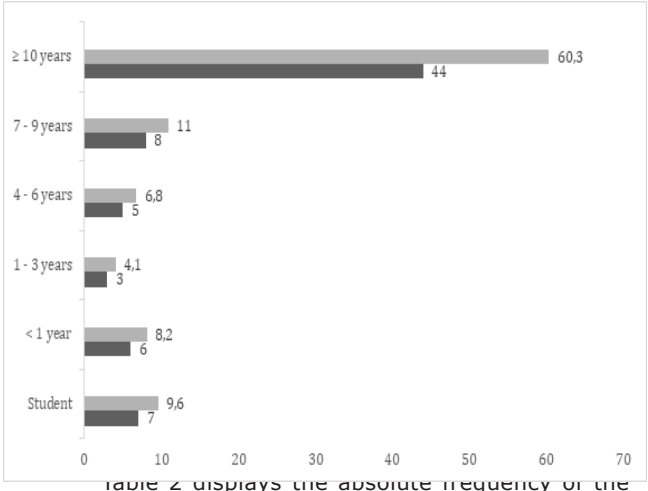

Figure 1: Time of professional experience.
Source: Author's own (2023)

Table 2 displays the absolute frequency of the variables about the knowledge of the syndrome and the experience in assisting suspected cases among the professionals.

Regarding the place of work, the participants who declared to assist children work in clinical/outpatient services (n = 27, 37%), intensive care unit (n = 6, 8.2%), urgent and emergency care services (n = 3, 4.1%). The other persons claimed to work in two or more places, being clinical/outpatient services and intensive care unit (n = 5, 6.9%), urgent/emergency care services and outpatient services (n = 3, 4.1%) and urgent/emergency care services, clinical/outpatient services and intensive care unit (n = 1, 1.4%).

The variables "time of professional experience" and "time working with infants/children" showed data that deviated from normal distribution ($p < 0.05$), indicating a nonparametric sample. Cross-tabulation using Fisher's exact test identified a significant association between "knows the term FDIA" and "profession," with the $X^2 = 13.995$, $p = 0.036$, and between "knows the term MSbP" and "place of assistance for infants/children,"

Table 2: Knowledge about the syndrome and experience with suspected cases

Variables		N	%
Knows the term FDIA	Yes	14	19.2
	No	59	80.8
Knows the term MSbP	Yes	25	34.2
	No	48	65.8
Has assisted suspected cases	Yes	27	37.0
	No	46	63.0
Estimated frequency of cases identified in professional practice	0	46	63.0
	1 to 2	3	4.1
	3 to 5	15	20.5
	6 to 9	7	9.6
	10 or more	2	2.7
Has witnessed cases of suspected mothers that interrupted the treatment	Yes	16	21.9
	No	57	78.1

Source: Author's own (2023)

with $\chi^2 = 16.213$, p = 0.039 (Table 3). The Cramer's V obtained for these two associations was 0.483 and 0.492, respectively, indicating a moderate association between the variables. It is also noteworthy to obtain borderline significance between "knowing the term MSbP" and "profession - medicine" with p-value = 13.752, p = 0.051. For the analysis of cells that presented significance, those whose standardized residue (SR) presented values greater than ± 1.96 were considered. Medicine (SR = ±3.1) and psychology (SR = ± 2.2) were the professions significantly associated with knowing the term FDIA, while the intensive care

Table 3: Association between knowledge of terms and professional factors.

	Knows MSbP	Knows FDIA
Profession		
$\chi^2_{(8)}$	14.690	17.019
p-value	13.752	13.995
p	0.051	0.036*
Time of experience		
$\chi^2_{(5)}$	5.978	5.574
p-value	6.036	5.243
p	0.287	0.312
Area of expertise		
$\chi^2_{(3)}$	6.102	1.202
p-value	5.646	0.867
p	0.101	0.911
Works with infants and children		
$\chi^2_{(1)}$	2.333	1.142
p	0.185	0.754
Time assisting infants and children		
$\chi^2_{(5)}$	8.156	4.812
p-value	7.379	3.693
p	0.173	0.613
Place of care		
$\chi^2_{(10)}$	17.654	10.201
p-value	16.213	9.647
p	0.039*	0.424

Source: * p<0.05

units (SR = ± 2.6) were the place of care associated with knowing the term MSbP.

Following the same criteria, we intended to verify the association between the profession and: 1) reports of children's repeated hospitalizations with the same pattern without an identified cause; 2) reports of handling suspected cases; 3) frequency of cases handled throughout career; and 4) reports of treatment abandonment by mothers after suspicion raised by the healthcare team. Only the association with the report of handling suspected cases was significant, with $\chi 2$ (7) = 13.933; p-value = 12.944; p = 0.049 and Cramer's V = 0.44. Significance was found in relation to the medical profession, according to the analysis of standardized residue (SR = ± 2.5).

A significant association was identified between longer work experience with children/adolescents (10 years or more) and the reporting of 3 to 5 suspected cases (X^2 = 37.515; p = 0.000), with moderate association (Cramer's V = 0.37). The most frequent conduct regarding suspected cases included referral to social services (n=12), notification of the guardianship council (n=11), and contact with psychological services (n=8), as detailed in Table 4.

Table 4: Conduct adopted by participants who reported having attended to suspected cases

Conduct	Number of reports
Referral to social services/assistance	12
Notification to the guardianship council	11
Referral and/or contact with the psychology services	8
Discussion or referral to multidisciplinary team	4
Referral to primary care	2
Notification to the Juvenile Court	2
Reporting to the nursing staff	2
Mother's referral to psychiatry and/or medical referral	2
Referral to the general practitioner who requested examinations and specialized care	1
Contacting another family member in charge	1

Source: Author's own (2023)

Regarding the dissemination of knowledge on the subject, 55 participants (75.3%) did not consider it sufficient, 7 (9.6%) considered it sufficient and 11 (15.1%) did not know how to respond. Among the participants, 46 highlighted the importance and urgency of disseminating this kind of knowledge using the terms "a lot", "extremely", "quite", "urgent", "essential" and "indispensable".

The topics identified were: (i) lack of knowledge among professionals and the population; (ii) child protection; (iii) support for mothers and families; and (iv) reduced burden on healthcare services and better diagnoses through early detection. Professionals reported the importance of dissemination for both healthcare professionals and the population. Two participants suggested disseminating knowledge only to healthcare professionals.

Regarding the conduct followed by the professional in the face of suspected cases, the most frequent ones were: referral to social services/assistance (12 reports), notification to the guardianship council (11 reports) and referral and/or contact with the psychology services (8 reports). Other conduct were also identified, such as: discussion or referral to the multidisciplinary team (4 reports), referral to primary care (2 reports), notification to the Juvenile Court (2 reports), reporting to the nursing staff (2 reports), mother's referral to psychiatry and/or medical referral (2 reports), referral to the general practitioner who requested examinations and specialized care (1 report), and contacting another family member in charge (1 report).

DISCUSSION

The data obtained in this research bring light to the question of knowledge, since 80.8% of the participants reported not knowing the term FDIA and 65.8% did not know the MSbP, in a sample in which 68.5% of the respondents worked directly with children. Although no criteria were found in the literature on what can be considered low or satisfactory level of knowledge, the results show little familiarity with the terms among professionals. This is consistent with previous studies indicating that MSbP is poorly recognized among healthcare providers.[14] Although the sample does not represent all Brazilian professionals, it reveals a low level of knowledge on the topic, especially concerning the term FDIA, which is less recognized than MSbP. First used in 1977[8], the term appeared in diagnostic manuals in 1980 under factitious disorders,[5] but it was never formally included in official classifications, remaining, however, the most used term to describe abusive illnesses or fabricated conditions.[1] Greater recognition of MSbP may be related to its prevalence in scientific literature.

Physicians and psychologists demonstrated being more familiar with the subject, particularly

professionals in the intensive care unit (ICU). Physicians, especially pediatricians, are frequently the first to perceive suspected risk for children,[18] being essential to know the syndrome and how to identify it immediately.[19] Theoretically, hospitals and intensive care environment are ideal for identifying the disorder.[7] Thus, greater knowledge of MSbP by ICU professionals may be related to greater exposure to severe cases, favoring more attentive clinical observations and the recognition of suspected child abuse.

Despite this, MSbP poses challenges in management, requiring joint action with other professionals to establish a diagnosis. Factitious disorders are associated with several maternal mental illnesses, and there are no criteria for establishing the diagnosis or a confirmatory method, nor information that adequately guide health professionals in assessment and diagnostic closure.[1,9] Therefore, the involvement of a multidisciplinary team has been reported as the best approach for MSbP cases.[14,1,9]

Regarding the time of experience of the professionals who reported attending suspicious cases, the significant association found between professionals assisting children/adolescents for 10 years or more and reporting from 3 to 5 suspicious cases express a frequency of attending to suspicious cases of 0.3%-0.5% in 10 years or more, which can be considered low. Considering the diagnostic difficulty and the possibility of underreporting, it is important to train specialized teams to identify cases.[10] A study in a pediatric unit in Rome identified a prevalence of 0.53% of factitious disorders, higher than in previous studies, thanks to the work of an interdisciplinary team trained and coordinated by a MSbP specialist.[10] This reinforces that a low level of knowledge about the syndrome contributes to underreporting and reduced prevalence rates.[11,4]

Although the hospital environment favors the diagnosis of MSbP,[7] the syndrome presents varied signs, from moderate to severe[19] and even young children can be trained to simulate diseases.[1] The aggressors can adopt different patterns of behavior,[9] which makes the awareness among child health professionals essential, especially because mild forms of the syndrome are often underdiagnosed.

Low prevalences may also be related to the aggressor's behavior. Perpetrators can leave the hospital without formal discharge when confronted with suspiciousness.[7] A striking feature of factitious disorders is deceptive, dissimulated behavior, characterized by the improbability of abusers providing honest and direct accounts of their behavior,[1] which may delay or prevent diagnosis.

Professionals' beliefs should also be considered. In general, it is believed that a mother would be the last person capable of harming her children. The answers by two professionals illustrate this perspective: "you do not expect such behavior from a mother" (S55, psychologist) and "(...) culturally it is not acceptable and often goes unnoticed by professionals" (S8, physical therapist). Despite the syndrome being characterized by the conscious production of false and intentional information about the symptoms,[1] the professional tends not to accept this reality: "(...) the mother may have not realized that she is inducing these symptoms in the child" (S33, physical therapist). The aggressors usually present themselves as worried mothers, making it difficult to suspect that they are responsible for the child's illness.[8] That said, the ignorance associated with this belief will be an impediment for professionals to consider that it is the mother who has some type of disorder.

Given these factors, it is necessary to disseminate knowledge about this type of child violence, according to what several professionals have pointed out: "It is a must so that the consequences can be minimized" (S27, nursing technician); "It's really necessary, both to protect the victim and also to treat the mother" (S20, physical therapist); "It's a must to preserve the child's physical and emotional health" (S58, nurse); "So valid! It spares the child suffering and even reduces expenses with exams and procedures" (S10, psychologist); "It's necessary because of the impact on the child's physical and mental health. Overburdening of health services... Why would a mother do this? Mental health support for the mother and family is needed." (S65, nurse).

The answers emphasize the child's protection and the reduction of suffering as the main reasons for disclosing the syndrome, highlighting that greater knowledge favors early detection and protection of victims.[20] Research focuses on victims.[9] Direct aggression is generally associated with higher probabilities of treatment failure and even death,[14] and professionals' and researchers' perception of the seriousness of the condition likely leads them to focus first on the victim. Despite this, the importance of adequate care for the mother and family has also been mentioned, in addition to concerns about the overburden and costs of healthcare services in attempting to discover the causes of the symptoms, which are also highlighted in the literature.[7]

Focusing on the mother suggests an inclusive stance aimed at promoting effective therapeutic approaches with the perpetrators, for whom care is also needed.[13] However, little is known about perpetrators, since there are not many studies with a larger sample.[8] A systematic review of the reports about cases and occurrences produced a sample totalling 796 perpetrators. The results showed that the perpetrators were females (97.6%); they were the victim's mother (95.6%); the majority were married (75.8%); their mean age was 27.6 years old. They were also frequently reported to have health-related professions (45.6%), obstetric complications (23.5%), and a history of childhood abuse (30%). The most commonly identified psychiatric diagnoses were factitious disorder imposed

on self (30.9%), personality disorder (18.6%), and depression (14.2%). Despite the presence of psychiatric disorders, there are also cases motivated by financial benefits.

The lack of systematic studies on the psychological management of factitious disorders may be linked to the perpetrators' refusal to admit the diagnosis or participate in treatment and research. The literature is dominated by case reports and reviews, limiting the advancement of therapeutic approaches. Thus, there are still no biological or psychological therapies considered effective and based on scientific evidence for this condition.[7]

Given the above, the need for awareness on the topic becomes evident, emphasizing the importance of promoting knowledge among both professionals and the general population. However, three answers suggested that educational programs should be more geared toward healthcare professionals: "I consider the knowledge of healthcare professionals on the subject important, but not the dissemination among lay people (...) the mother could create more ways to avoid being discovered" (S7, nurse); "I do not know to what extent it would be beneficial to carry out campaigns, but I believe it would be interesting to work on the subject in healthcare professionals' training" (S53, nurse); "awareness should be raised among professionals, I do not believe that the outcome can be changed if it's shared with the general population" (S57, physician).

In this regard, the systematic review mentions that the pediatricians' awareness of the condition has improved following an increase in case reports and medical and lay literature,[14] including case series in the media. In this sense, one of the participants reported that, "despite the recent popularization through the series The Act, the topic is still little addressed. It is necessary that campaigns are widely disseminated to facilitate identification and treatment." (S13, nursing technician).

There are warnings that informing the population about suspicious signs can lead some mothers to be prepared to avoid identification, once the more they are informed, the less chances to make mistakes that reveal the situation.[21] Mothers with prior knowledge of health may also use this knowledge to induce symptoms in their children and convince the medical team.[22] Therefore, caution and further studies are necessary when proposing to disseminate the topic to the general public.

Lastly, the procedures reported by the professionals to interrupt this kind of violence against children in suspicious cases are discussed. Most of the time, social services/assistance was referred and/or the guardianship council was notified.

The Brazilian Child and Adolescent Statute (ECA)[23] deals with regulatory measures for parents and guardians of the child and contemplates, among others, mandatory psychiatric or psychological treatment for parents, loss of custody (Art. 129) and, in cases where child maltreatment is verified, the possibility of removing the aggressor from home (Art. 130). The Guardianship Council is a permanent, autonomous and non-jurisdictional body entrusted by society to ensure the enforcement of children and adolescents' rights. It is the Council's responsibility to comply with and apply measures to protect children and adolescents in cases of parents' or guardians' abuse, and to promote the execution of their actions (Art.136).

CRM/DF Resolution Nº 48/2018 guides the management of suspected cases of MSbP:

> [...] the Social Assistance sector of the Health Unit must be immediately contacted, which in turn will notify the Guardianship Council for the adoption of protective measures. The medical team should request the presence of the closest family members of the child, thus seeking involvement and responsibility for a shared conduct, especially at hospital discharge. Psychiatric treatment counseling of the perpetrator, usually the mother, is necessary. Finally, considering the child's vulnerability, the Juvenile Court must also be contacted for legal support in case the perpetrator needs to be removed from the child's coexistence for protection, better investigation and treatment.[24]

Children who are victims of child maltreatment must be immediately taken from their caregivers and monitored by a specialized team, while the caregivers must receive assistance directed to the management of mental disorders.[18] Most respondents' actions were consistent with these guidelines, although some opted for measures such as referral to primary care, nursing, or general practitioners. Although it is not possible to evaluate the appropriateness of these decisions, the importance of proper training for accurate referrals must be emphasized.

Only one answer ["notification to the Guardianship Council and to another family member" (S58, nurse)] indicated the notification to another family member. The perpetrating mothers usually have a childhood abuse story involving deprivation, negligence and traumas and there were also frequent cases of dysfunctional families, with the absence of the child's father.[11] Family factors, therefore, can represent one

more challenge for healthcare teams in suspected or confirmed cases of the syndrome.

CONCLUSIONS

MSbP or FDIA is a complex phenomenon which requires careful investigation, and primary diagnosis is essential to avoid severe or fatal consequences. The results of this study are related to healthcare professionals' lack of knowledge, highlighting the necessity for a broader dissemination about the subject in the academic environment, especially among those who work with children.

Professionals and students highlighted the importance of training on MSbP, which reinforces the need for specialized teams to provide early diagnosis. There was no consensus regarding public awareness as a form of prevention, raising the hypothesis that public dissemination may bring risks by providing information that helps the perpetrators. Therefore, future studies are suggested to evaluate the impacts of this diffusion. In the academic environment, the inclusion of the theme in lectures, educational materials and courses is encouraged in areas such as psychopathology and intrafamily violence.

One of the limitations of the study was the lack of data on the location of the participants, which made it difficult to geographically map the sample, although it is assumed that most of them are from Juiz de Fora and the region. Neither the academic background of student respondents was identified. In light of these issues and the small sample size, further research in diverse regional contexts is recommended.

We hope that this research brings more attention to the topic, increasing the debate and strengthening actions to protect children, who are victims of the most subtle and dangerous ways of abuse.

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