Medical Child Abuse
A New Perspective on Munchausen Syndrome by Proxy

Edited by Nichole Wallace, MD, FAAP
Outline

- Prevalence
- Historical Background
- Diagnostic Terminology
- Recognition and Management
- Perpetrator Motivation
- “Perpetrator Profiles”
- Sequelae
- Prevention
What is Munchausen Syndrome by Proxy?

- Traditionally defined as the fabrication or induction of illness in a child to gain attention.
- Results in needless medical intervention and treatment.
Prevalence

- Data on severe cases (mostly poisoning and suffocation) confirmed after investigation.
- Some studies suggest 0.5–2/100,000.
- Does not address other types that are far more common.
- Impossible to obtain accurate prevalence data.
Historical Background

- Baron von Munchausen—18th-century mercenary known for tall tales and exaggerations.
- Dr Richard Asher—defined adult Munchausen syndrome in 1951.
  - Described 3 case histories of patients who “hoodwinked” their physicians.
Historical Background

- Sir Roy Meadow—described Munchausen syndrome by proxy in 1977.
  - “Munchausen Syndrome by Proxy: The Hinterland of Child Abuse”
- Meadow’s original 2 cases
  - A child who died from salt poisoning
  - A child whose mother fabricated renal disease on laboratory tests
Hospital Practice

MUNCHAUSEN SYNDROME BY PROXY
THE HINTERLAND OF CHILD ABUSE

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Summary. Some patients consistently produce false stories and fabricate evidence, so causing themselves needless hospital investigations and operations. Here are described parents who, by falsification, caused their children innumerable harmful hospital procedures—a sort of Munchausen syndrome by proxy.

Introduction

Doctors dealing with young children rely on the parents’ recollection of the history. The doctor accepts that history, albeit sometimes with a pinch of salt, and it forms the cornerstone of subsequent investigation and management of the child.

A case is reported in which over a period of six years, the parents systematically provided fictitious information about their child’s symptoms, tampered with the urine specimens to produce false results and interfered with hospital observations. This caused the girl in-
Growing Awareness

- Moved from the “hinterland” to the mainstream of public awareness
- Now featured on television and in newspapers and other media
- Books and articles by victims
- Mothers Against Munchausen Allegations
  - msbp.com
  - one of the many voices against MSBP
Sickened

The Memoir of a Munchausen by Proxy Childhood

JULIE GREGORY

FOREWORD BY MARC D. FELDMAN, M.D.
My Mother Caused My Illness: The Story of a Survivor of Münchausen by Proxy Syndrome

Mary Bryk, RN, BSN* and Patricia T. Siegel, PhD‡

ABSTRACT. Objective. Münchausen by proxy syndrome (MBPS) is a form of child abuse in which a parent fabricates or produces illness in a child. Although the medical consequences of MBPS have been well described, there is no detailed published account of what it was like to grow up in a family where the mother systematically induced serious illness. This article describes one victim’s childhood experiences.

Methods. The medical history was obtained from a review of the original medical records, notes from the primary physician, discussions with two physicians who provided treatment, and several meetings with the victim and the victim’s therapist.

Results. This article chronicles the actual experiences of an MBPS victim through 8 years of medical abuse at the hands of her mother, reveals the victim’s account of what happened to her, describes what her family was like, details the long-term consequences on emotional and physical development, identifies the factors that influence recovery, and details the impact on family relationships.

Conclusions. Child maltreatment and MBPS need to be clearly distinguished. Although MBPS needs to be recognized, the child welfare system must also realize that abuse of this nature may require a different approach. Recent advances in the treatment of child abuse and psychiatric illness have implications for the management of MBPS and similar conditions.

Münchausen by proxy syndrome (MBPS), first described in 1977 by Professor R. Meadow, is a form of child abuse in which a parent, usually the mother, systematically fabricates information about their child’s health or intentionally makes the child ill. Some of these child victims die at the hands of their mothers. The majority suffer a degree of physical and psychological damage, either from outright harm or from painful procedures, unnecessary medications, or hospitalizations ordered from unwitting physicians. This form of abuse differs from other forms of child maltreatment in several ways: the perpetrator is almost always female and usually presents as a model parent, there is little or no indication of family discord, and the abusive behavior is clearly premeditated, not impulsive or in reaction to the child’s behavior.

Although the medical consequences of MBPS have been well described, there are few articles that describe the long-term psychological impact of MBPS on its victims. Only one article describes MBPS victims who have recovered. This article is written from the perspective of a mother who treated her daughter for 8 years and describes the psychological and emotional consequences for the child and the family. The historical context and the psychological and emotional consequences of MBPS are discussed.

Child maltreatment and MBPS need to be clearly distinguished. Although MBPS needs to be recognized, the child welfare system must also realize that abuse of this nature may require a different approach. Recent advances in the treatment of child abuse and psychiatric illness have implications for the management of MBPS and similar conditions.
Confusion

- Despite growing awareness in the public consciousness, the concept is still not well understood by medical professionals and laypeople.
Confusion

- Who **gets** the diagnosis?
  - Mother/caregiver?
  - Child?

- Who **makes** the diagnosis?
  - Primary care physician?
  - Child abuse pediatrician?
  - Psychiatrist?
Shifts in Terminology

- Over time, other areas in child maltreatment have undergone conceptual clarification.
- Battered child syndrome -> child physical abuse
- Shaken baby syndrome -> abusive head trauma
Efforts to Clarify MSBP

- Over time, efforts have been made to clarify the diagnosis of MSBP.
- First major effort by Rosenberg to make the diagnosis fulfill the definition of a syndrome.
- Focuses on the child victim.
- Intent of the perpetrator is not a consideration.
Diagnostic Criteria: Rosenberg’s Web of Deceit

- Illness in a child that is simulated (faked) and/or produced by a parent or someone who is in loco parentis
- Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures
- Denial of knowledge by the perpetrator as to the etiology of the child’s illness
- Acute symptoms and signs of the child abate when the child is separated from the perpetrator
Diagnostic Criteria: *DSM-IV* 
Factitious Disorder by Proxy

- FDP first appeared in the *DSM* in 1994.
- Motivation of the perpetrator is the central feature as this diagnosis is applied to the perpetrator.
- Tells you nothing about what happened to the child.
Diagnostic Criteria: DSM-IV
Factitious Disorder by Proxy

- Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual’s care.
- The motivation for the perpetrator’s behavior is to assume the sick role by proxy.
- External incentives for the behavior (such as economic gain) are absent.
- The behavior is not better accounted for by another mental disorder.
Confusion

- 2 distinct descriptions.
- 2 sets of diagnostic criteria.
- In the late 1990s there was an effort by the American Professional Society on the Abuse of Children (APSAC) to clarify by dividing the diagnosis into 2 components, one that addresses the child and one for the caregiver.
FDP + PCF = MSBP
What?!

Factitious Disorder by Proxy
(psychiatric diagnosis given to the caretaker)
+

Pediatric Condition Falsification
(medical diagnosis given to the child victim)
=

Munchausen Syndrome by Proxy
Confusion

- Despite this effort, the diagnosis remains complex.
- New concept described by Drs Thomas Roesler and Carole Jenny.
Medical Child Abuse

- Child receiving unnecessary and harmful or potentially harmful medical care at the instigation of a caregiver
Medical Child Abuse Defined

- Straightforward definition.
- Don’t need to determine the caregiver’s motivation to know that a child is being harmed.
- Don’t need to determine if symptoms resolve with separation from the caregiver.
Critical Point

- Easier diagnosis to make
- More inclusive of less severe cases that still warrant some type of intervention
- Logical diagnosis as the counterpart to medical neglect at the opposite end of the spectrum
Counterpart Diagnoses

- Physical abuse and physical neglect
  - Inflicting vs failing to protect from physical harm
- Emotional abuse and emotional neglect
  - Emotionally attacking vs ignoring a child
- Medical child abuse and medical neglect
  - Obtaining too much care that is harmful or potentially harmful vs failing to obtain needed medical care
Continuum of Severity

- Parental anxiety leading to frequent medical visits
- Exaggerating symptoms
- Fabricating symptoms
- Inducing symptoms
Continuum of Severity

- Continuum of severity, just like other types of child abuse.
- Most cases of MCA fall at the less severe end of the spectrum.
- More severe presentations gain most of the attention.
- Raises the obvious question of where to draw the line of needing to intervene.
The Numbers: MSBP Vs Medical Child Abuse

- 75 cases of possible medical child abuse referred to Dr Jenny for evaluation.
- 38% met the criteria for MSBP.
- 67%–89% met the criteria for medical child abuse.
- Medical child abuse is a far more inclusive diagnosis than MSBP.
Clinical Presentations

- Seizures
- Recurrent apnea/suffocation
- Polymicrobial sepsis
- Poisoning (ipecac, sedatives)
- Bleeding (from anywhere)
- Multiple organ system involvement
Less Severe Cases?

- What about illness exaggeration and extreme parental anxiety?
- Don’t we all have patients like this?
- No room for these children with the old diagnostic criteria.
- In fact, exaggeration of existing symptoms is far more common than fabrication or induction.
  - 48% of Jenny’s 75 cases had symptom exaggeration only.
Less Severe Cases?

- Sometimes a mother seeks help for social needs by presenting her child for medical care.
- Usually presents for 1 to 2 visits and stops once she receives the social support she needs.
- Usually does not qualify as MCA.
Questions for Mother

- Have you ever worried that your child might not be normal or that you might lose him?
- Are you considered a worrywart by your family or friends?
- If yes, ask mother how much of the child’s symptoms result from her anxiety vs a medical problem.
Questions for Mother

- Ask mother to put herself on a spectrum of how much she worries about her child’s health.
- A mother who recognizes her own anxiety is far less worrisome and easier to work with than one who lacks insight.
Important Distinctions: Case Study

- 12-month-old child is repeatedly smothered by her mother until she stops breathing and turns blue.
- Is this medical child abuse?
Important Distinctions: Case Study

- No. This is a physical assault.
- Constitutes child physical abuse.
- But then...
Important Distinctions: Case Study

- After one of these episodes, mother calls EMS, who transports the child to the hospital.
- She has further apneic “episodes” in the hospital (when mother again smothered her).
- She gets a bronchoscopy and several other tests in an effort to diagnose the cause of her apnea.
- Is this medical child abuse?
Important Distinctions: Case Study

- Yes!
- This child is receiving unnecessary and harmful or potentially harmful medical care due to being smothered by her mother.
Important Distinctions: Case Study

- The mother of a 5-month-old adds salt to the baby’s formula. The infant becomes hypernatremic and dies.
- Is this medical child abuse?
Important Distinctions: Case Study

- No. This is homicide and physical abuse.
- Instead, what if...
Important Distinctions: Case Study

- This 5-month-old is admitted to the hospital and receives multiple tests (including blood draws) to evaluate his hypernatremia.
- Is this medical child abuse?
- YES!
Overview: Management of MCA

1. Recognize that abuse is occurring.
2. Stop the abuse.
3. Provide for ongoing safety of the child.
4. Treat the physical and psychological damage to the child.
5. Help maintain family integrity as much as possible.
Recognize Abuse Is Occurring

- Requires that physician reaches a tipping point.
- Shift from trusting the parent to questioning the parent’s honesty.
- More complex to recognize MCA than other types of abuse due to our role as physicians.
- Immediate response is often to examine our own actions and wonder how we got duped rather than focus on the abused child.
Recognize Abuse Is Occurring

- Extra step in history gathering.
  - Reflect on quality of the historian.
  - Document “mother reported that....”
- Physicians often emphasize that the diagnosis lies in the history and a mother is the best source of information about her child.
- Sometimes we must not trust to practice good medicine.

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Challenges to Recognizing Abuse

- Challenge to the primary care doctor
  - Long-standing relationship with family
  - Guilt regarding participation in care
- Challenge to the subspecialist
  - Brief history with the family
  - Goal of figuring out the puzzling cases, ordering esoteric tests, digging deeper
Challenges to Recognizing Abuse

- Defensive medicine
- Fear of malpractice
  - Sometimes physicians order tests to avoid missing a diagnosis that could result in a lawsuit.
  - What if this is something really rare and fatal and I miss it?
Recognizing Abuse

- Medical records review.
- Central feature of evaluation.
- Complicated and time-consuming.
- MUST GET ALL RECORDS!
  - Ask parent about all doctors, health departments, hospitalizations, ED visits, urgent care clinics, subspecialists.
  - Ask for a complete record (including nursing notes).
Recognizing Abuse

- Organize the medical record into a table format.
- Look for patterns.
  - Multiple encounters on the same day?
  - Objective evidence to support complaints?
  - Treatment for the same problem in multiple places?
<table>
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<tr>
<th>Date</th>
<th>Age</th>
<th>Dr</th>
<th>PMH</th>
<th>HPI</th>
<th>Exam/Labs</th>
<th>Plan</th>
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Stop the Abuse

- Medical community must recognize and agree that harmful or potentially harmful medical care is taking place.
- Often need multidisciplinary team to agree on a plan of action.
Stop the Abuse

- Informing session.
- Invite parents, others closely involved.
- Need to have involvement of other parent and caregivers for this to be successful.
- In the past, this was often a “confrontation” where the child was then removed from mother’s custody.
Stop the Abuse

- Not a confrontation but a notification of a new treatment plan.
- Focus on the positive—“Your child is not sick.”
- “Now that we have a clear understanding of your child’s health, any further health care-seeking behavior would be harmful and would constitute abuse.”
- May need psychiatric care on standby.
Treatment

Minimum influence necessary

1. Education—least forceful.

2. Persuasion—“I know you may not agree with my advice, but I/we want you to follow it anyway.”

- Asking the person to change the behavior because you want her to only works if she wants to preserve the relationship with you.
Treatment

3. State possible consequences.
   - Not making a threat but outlining a course of action.
   - Must be willing and ready to follow through.

4. Initiate action that leads to the consequences.
   - Child welfare referral.
   - Multidisciplinary team is essential at this point.
Treatment

- Separation of mother and child has been considered necessary in many cases.
  - Presumption that abuse would worsen along the spectrum to induction of illness and possible death.
  - Still may be necessary in severe cases, but not a requirement.
Long-term Treatment

- How do we define treatment? Of whom?
- Child
- Mother
- Family

- How do we define success?
Perpetrator Motivation

- How could a mother do that to her child?
  - The question we all want answered in these cases
- Diagnostically irrelevant for MCA
- Prognostically very important
Treatment of Perpetrator

- Most important element is admission.
  - Significant increase in success of treatment
- Usually involves ascertaining motivation.
- Help perpetrator confront the reasons why she harmed her child and the results of her actions.
High Risk of Treatment Failure

- Persistence of fabrication after confrontation.
- Other family members believe mother.
- History of unexplained death of siblings.
- Symptom induction—poisoning, suffocation.
- Other psychiatric symptoms.
Perpetrator Motivation

- Many different theories have been described.
- Assume the sick role by proxy.
- Manipulate and outsmart the doctors.
- Use their child as an object.
Perpetrator Motivation

- Knows what she is doing but is unconscious of motivation.
- Versus malingering—conscious awareness of motivation.
  - Eg, claiming child is sick to obtain disability benefits.
“Perpetrator Profile”

- Interest or expertise in medicine.
- Life revolves around child’s illness.
- “Good parent” or martyr.
- Overly comfortable with medical staff.
- Does not appear relieved with normal test results.
- Promotes invasive tests and procedures.
- Enjoys being in the spotlight.
- May have personality disorder, Munchausen syndrome, or somatization disorder.
- Not really accurate or helpful in diagnosis.
Sequelae

- Attachment disorder
  - Betrayed trust between parent and child
- PTSD
  - Symptoms of depression and anxiety
Sequelae

- Cognitive and behavioral disorders
  - Children begin to see their reality as normal.
  - Interpret feelings with somatic symptoms.
  - Older children often begin to participate in illness behavior.
  - Normal response to being told you are sick is to feel sick.
  - Patients begin to think and act like a sick person.
MCA—Malpractice

- Medical care delivered in good faith.
- Meets the standards of practice generally agreed on by the medical community given the reported signs and symptoms.
- Care that would not be given if it were not for the improper actions of the caregiver.
Are We Vulnerable?

- Many of the qualities that make us good doctors for children may also render us vulnerable to MCA.
  - Trusting, sympathetic, compassionate.
  - Like working closely with parents.
  - Go the extra mile to find out what is wrong with a sick child.
  - Sensitive to the emotional needs of parent and child.
Prevention

- Keep MCA on your differential diagnosis.
- Search for objective evidence to confirm reported symptoms.
- Remember that historians sometimes are not truthful with physicians.
Resources