Medical Child Abuse & Munchausen by Proxy: When Child Abuse Happens in the Medical System

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History

Hieronymus Karl Friedrich Freiherr von Munchhausen

- was born May 11, 1720; died Feb 27,1797
- was from an old aristocratic family and was prominent in public affairs
- had a distinguished military career before he retired to manage the family estate near Hamlen (of Pied Piper fame)
- first marriage was happy, but childless
- was noted for his hospitality and his skill as a humorous raconteur
- after-dinner stories formed the basis for travel fantasies written by Rudolph Eric Raspe: *The Amazing Travels and Adventures of Baron Munchausen, The Surprising Adventures of Baron Munchausen.* NY: Peter Pauper, 1944.

Meadow & Lennert, Pediatrics 1984;74:554-556

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Terminology

- "Non-Accidental Poisoning" (Rogers, 1976)
- "Munchausen Syndrome by Proxy" (Meadow, 1977)
- "The Chemically Abused Child" (Schnaps, 1981)
- "Doctor Shopping with the Child as Proxy" (Woollcott 1982)
- "Polle Syndrome" (Liston, 1983)
- "The Peregrinating Pediatric Patient" (Fialkov, 1984)
- "Meadow's Syndrome" (Warner & Hathaway, 1984)
- "Outlandish Factitious Disorder" (Taylor, 1992)
- "The Persistent Parent" (Waring, 1992)
- "Imposed Upper Airways Obstruction" (Samuels, 1992)
- "Factitious Disorder by Proxy" (DSM-IV, 1994)
- "Pediatric Condition Falsification" (Alexander, 1998)
- "Medical Child Abuse" (Jenny & Roesler, 2008)

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Terminology

- In relation to children, the term (MSP) can be used if the following criteria are fulfilled:
  - the illness is fabricated by the parent or someone *in loco parentis*.
  - the child is presented to doctors, usually persistently.
  - the perpetrator (initially) denies causing the child's illness.
  - the illness clears up when the child is separated from the perpetrator.

Meadow R. J Roy Coll Phys Lond 1994:28;332-7

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Medical Child Abuse

- MCA is defined as "A child receiving unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker."
- "Knowing why the caretaker provides either too little or too much medical care, although important, is not required to determine that the child is being harmed."
- Roesler, T. Medical Child Abuse. In Jenny, C. 2011

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Classification

- Factitious Disorder by Proxy (FDP):
  - Previously used to describe overall case
  - Condition formerly called Munchausen Syndrome by Proxy (MSBP)

Alexander, 1998

- Pediatric Condition Falsification (PCF):
  - Subclass of Abuse by Condition Falsification
  - Applies to child victim
- Factitious Disorder by Proxy (FDP):
  - Factitious Disorder not Otherwise Specified (DSM-IV 300.19)
  - Applies to parent or caretaker perpetrator

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Terminology

- "MSP has mainly been used in relation to children, though it may happen to the elderly, mentally handicapped, and other dependent persons, and veterinary surgeons report that some people impose it upon their pets."

Meadow R. J Roy Coll Phys Lond 1994:28;332-7

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Terminology

- "The term Munchausen syndrome by proxy (MSP) is now being used to refer to a complex set of phenomena, apparently somewhat heterogeneous in nature."
- "In particular, there has been confusion between the proper use of the term MSP to describe a situation, and improper use as a (pseudo) psychiatric diagnosis applicable to the fabricator."

Bools C. British Journal of Psychiatry 1996;169:268-275.

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Terminology

- Morley (1995)
  - "Concern" about:
    - the label of Munchausen by proxy
    - the criteria for diagnosing MSP
    - the "indicators that presenting symptoms may be fabricated"
    - "exaggeration" being called MSP
    - inadequate history taking

Morley CJ. Archives of Disease in Childhood, 1995;72:528-538

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Terminology

- DSM IV "Criteria Sets and Axes Provided for Further Study" defines FDP as:
  - Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's control;
  - 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.

Diagnostic and Statistical Manual, Fourth Edition, 1994

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Descriptive Categories

- Libow & Schreier (1986)
  - Help Seekers
  - Active Inducers
  - Doctor Addicts

"...the authors considered that the latter two are most validly identified as MSBP. Later, they concluded that the distinction between Active Inducers and Doctor Addicts was less clear" (C. Bools)

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Diagnostic Classification

- Behavior of the perpetrator
  - is this fabrication? add a descriptive classification of the type of fabrication
- Category of child abuse
  - physical, emotional abuse or neglect
- Psychiatric diagnosis applicable to the mother
  - according to DSM-IV and additional formulation of putative psychological processes.

Bools C. British Journal of Psychiatry 1996;169:268-275.

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Early Clinical Studies

- Rosenberg (1987); 116 children; literature review of cases identified in children
- Bools, Neale & Meadow (1993); 1-14 yr. follow-up
- Bools, Neale & Meadow (1994); 56 families, 47 mothers; 19 interviewed re: maternal psychopathology.
- Libow (1995); 10 adults; long-term psychological outcomes in adults identified by self-report
- Yorker (1996); review of legal cases: 4 before 1990, 11 during 1990-1994.
- Jones & Byrne (1996); 16 families were selected for inpatient treatment and reunification

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Facilitating Medical Environment

- EMR ("copy & paste")
- Barriers to accessing past medical info
- Increased reliance upon tests to make Dx
- Drive for patient (parent) satisfaction
- The internet
- Increased accessibility and exposure to specialists

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Epidemiology

- Over 700 cases reported from 52 countries
- UK: 2.8 /100,000 children under 1 year of age; 0.5/100,000 under 16 years
- Extrapolated to US: 625 cases annually
- 95+% of offenders are mothers
- Mean delay of 14 months to diagnosis
- McClure, Arch Dis Child, 1996

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Clinical Features

- Presentation & Descriptive Categories
- Psychopathologic Observations & Evaluation
- Multidisciplinary Team Involvement and Assessment
- Diagnostic Considerations & Making the Diagnosis
- Documentation & Reporting to Child Welfare Authorities

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Presentation

- Affects mainly young children who cannot speak for themselves.
- False illness may last from months to years.
- Any system may be affected, and multi-system disorders are often suspected.
- False diagnosis results mainly from the mother's story because we often have to base our diagnosis and management extensively on what she tells us.
- A proportion of mothers substantiate the diagnosis with false signs and a minority directly harm the child to cause signs of illness.
- Meadow R. J Roy Coll Phys Lond 1994:28;332-7

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- Common Presentations
  - Nervous System: seizures, apnea, drowsiness
  - gastrointestinal: vomiting, diarrhea, failure to thrive, hematemesis
  - Respiratory: apnea, breathlessness, hemoptysis, asthma
  - Renal: hematuria
  - Endocrine: glycosuria, biochemical abnormality
  - Allergy: rashes, diarrhea, wheezing

Meadow R. J Roy Coll Phys Lond 1994:28;332-7

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- Less Common Presentations
  - Educational: dyslexia, disability, special needs
  - Skin: dermatitis artefacta
  - Orthopedic: locked joints
  - Cardiovascular: sick sinus syndrome
  - Child Abuse: false allegations

Meadow R. J Roy Coll Phys Lond 1994:28;332-7

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"Warning Signals"

- Common fabrications (bleeding, neurologic, fevers, biochemical chaos, feculent vomiting, rashes, glycosuria)
- Unexplained persistent or recurrent illness
- Discrepancies between clinical findings and history; signs and symptoms do not make clinical sense.
- The working diagnosis is "a rare disorder."
- Experienced physician states "never seen a case like it before."

Guandolo. Pediatrics 1985:75;526-530

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"Warning Signals"

- Signs and symptoms do not occur in the mother's absence.
- Very attentive mother; refuses to leave child alone
- Child has frequent intolerance to all forms of treatment.
- Mother is less concerned with illness than medical professionals.
- Mother has previous medical or nursing experience.
- Mother has a history of illness similar to that of the child.

Guandolo. Pediatrics 1985:75;526-530

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Conditions that should arouse suspicion

- Illnesses that are…
  - puzzling or unexplained
    - "Never seen anything like this"
  - not responding to treatment
  - following an atypical course
  - manifested only in the mother's presence

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Maternal behaviors

- medically knowledgeable, educated
- may have worked in the health care field
- mother prefers to stay in the hospital rather than home
- uncharacteristically calm
- welcomes medical tests
- reluctant to leave hospital

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Maternal behaviors

- more interested in the medical procedures than in her child's welfare
- spends more time with hospital staff than with her child
- excessive praise for medical staff

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Histories that are suspicious

- Mother reports…
  - she had illnesses similar to her child's
  - other unusual family illnesses
  - unsubstantiated family illnesses
  - unexplained illnesses / deaths in siblings

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Bleeding

- Warfarin poisoning
- Phenolphthalein poisoning
- Exogenous blood applied
- Exsanguination
- Dyes

Seizures

- Poisons
  - Phenothiazine
  - Hydrocarbons
  - Salt
  - Imipramine
- Suffocation
- Carotid sinus pressure
- Lying

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Apnea

- Suffocation
- Poisoning
  - Imipramine
  - Hydrocarbons
- Lying

Infection

- Needle sticks
- Line contamination
- Catheterization

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Diarrhea

- Laxatives
  - Phenolphthalein
  - Ipecac
  - Others
- Salt poisoning

Vomiting

- Ipecac
- Lying

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Altered Mental Status

- Drugs
  - Insulin
  - Depressants
    - Chloral hydrate
    - Barbiturates
  - Anti-histamines
  - Tricyclics
- Suffocation

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Other Presentations

- Fever
  - Falsifying temp
  - Falsifying chart
- Vomiting
  - Ipecac
  - Lying
- Rash
  - Poisoning
  - Scratches
  - Caustics
  - Paint/Dye
- Cystic Fibrosis

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Exam / Lab findings that are suspicious

- highly unusual results
- discrepant with history
- inconsistent with examination
- clinically impossible

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Psychopathology

- Rosenberg (1987)
  - 117 cases from review of literature
  - associated sexual abuse 1%, physical abuse 1%, failure to thrive 14%
  - little information available on kids' psychopathology
  - perpetrators: mothers 98%, adoptive mothers 2%, fathers 2%
  - occupations: nursing training 27%
  - suicidal 12%, munchausen syndrome 10%, personality disorders, history of previous abuse, 2 with psychosis
  - themes of loneliness and isolation; absent / distant fathers

Rosenberg D. Child Abuse & Neglect 1987;11:547-563

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Psychopathology

- Bools (1994):
  - 47 mothers from 56 families (19 interviewed 1-15 yrs later)
  - 15/19 were abused or neglected (4 physical)
  - hypochondriasis 40%, psychosis 15%, eating disorders 11%
  - personality disorders (84%): histrionic 8/19, borderline 5/19, dependent 2/19. avoidant 1/19, none 3/19
  - somatizing disorder 72% (79%), self-harm 55% (63%), substance abuse 21% (37%)
    - smothering (self-harm>somatizing>substance abuse)
    - poisonings (somatizing>self-harm>substance abuse)
    - fabricated seizures (somatizing>self-harm>subs.abuse)
    - other fabrications (somatizing>self-harm>subs.abuse)

Bools, Neale & Meadow . Child Abuse & Neglect 1994;18:773-788

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Overlap between MSBP and the mother of an ill child

- The child's mother…
  - exaggerates child's symptoms
  - is intolerant of minor problem & demands work-up
  - is knowledgeable about child's illness
  - is calm about the child's illness
  - gets along well with hospital staff
  - brings child to MD frequently
  - describes an illness that seems unexplainable

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Overlap with normal illnesses

- MD's observations differ from mother's
- Symptoms observed only if mother is present
- Illness resolves after separation from mother

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Doctor Shopping / Perceived Illness

- Mother is obsessed with obtaining medical treatment for her well child.
- Child is subjected to repeated and unneeded testing.

- Evaluate degree of harm to child
- Not MSBP

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Enforced Invalidism

- Child has no disability but treated as if one exists
  - special diet, restricted activities
- Child has a disability
  - mother causes the disability to worsen or prevents the child from getting better

Child abuse if harmful to child

MSBP?

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Mother fabricates/causes illness

- lies to the doctor about the child's health
- fabricates symptoms or signs of illness
- actively induces symptoms
- alters medical records

Child abuse

MSBP

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"Child Abuse in the Medical System"

- "We believe that it is the parent's seeking of gratification from the interaction with the medical system that authors are trying to capture and highlight when they separate MSBP from other forms of child abuse. By focusing on the perpetrator, however, the medical profession fails to recognize its own contribution to the development of MSBP and ignores the victim's perspective. If we as medical professionals do not recognize the cause of symptoms as abuse, we contribute to the damage."

Donald & Jureidini. Arch Ped Adolesc Med 1996;150:753-758.

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The Medical Triad

"The mother's partner in the abuse of the children is the doctor. Some will say that there is no such entity as MSBP and that it is merely medical misdiagnosis and maltreatment. Some of the most painful experiences for the child result from the doctor rather than from any direct action by the mother. The mother provides false information but usually leaves others to harm the child."

Meadow R. J Roy Coll Phys Lond 1994:28;332-7

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Realization of possible MSBP

- staff reluctance to believe deceit
  - divided loyalties
  - difficult to believe that they've been lied to
- confusion between real & fictitious illness
  - continued unnecessary testing and procedures
- need to make diagnosis of MSBP with certainty
  - continuing or increasing risk to the child
  - difficult to act / stop abuse without "proof"

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Investigation

- Review each illness / diagnosis
  - comprehensive review of histories / symptoms
    - "Unlimited" possibilities for deception
    - conference with all involved caretakers/physicians
  - detailed investigation of reported events
    - temporal relationship: mother / symptoms
  - validation of past illnesses / mother's history
    - contact other family members / family physicians
- Psycho-social evaluation of mother
  - look for motive / gain

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Hospital Management

- Discretion
  - control number of involved staff
  - limited chart documentation / hallway rounds
  - limited chart and record access by mother
- Verification of symptoms
  - differentiate those observed by nurse vs mother
  - obtain fluids / materials for toxicologic analysis
  - if bleeding, test to differentiate child/mother/human
  - surveillance of mother and child (video or telemetry)
    - Southall David. Pediatrics 1997;100:735-760

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Hospital Management

- Removal of child from parent: diagnostic/protective
  - voluntary vs enforced
    - report to Child Protection Agency
  - careful planning: make the most of this time
- Confrontation with mother / family
  - explain the diagnosis
  - offer psychiatric care for the parent / patient
  - anticipate suicidal behavior or escalation of deception

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Making the Correct Diagnosis

- Establish which events are likely to fabricated and which are real.
- Look for temporal association between illness events and the presence of the mother.
- Check the details of the personal, social and family history that the mother has given.
- Make contact with other family members.
- Discuss the family illness history with the family doctor.

Meadow R. Arch Dis Child 1985;60:385-393.

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Making the Correct Diagnosis

- Look for a motive for the behavior.
- Protect medical records and lab specimens.
- Retain samples for toxicological analyses.
- Verify the source of bodily fluids (i.e. human vs. animal; adult vs. child)
- Carefully observe mother and child.
- Consider videotaping and searching belongings.
- Consider excluding the parents.

Meadow R. Arch Dis Child 1985;60:385-393.

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Record review

- Were the diagnoses made on objective evidence or only on maternal history or persistence?
- Has anyone else witnessed the symptoms described by the mother?
- Are there inconsistencies or overt lies revealed n the histories the mother has given over time?
- Fischer, H. Munchausen Syndrome by Proxy. In Palusci & Fischer, 2011

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Documentation

- "…objective measures such as apnea monitors with event recording and covert video surveillance give us the positive proof to quickly provide for the safety of the child and the treatment of the family."

Palusci & McHugh. Child Abuse & Neglect 1995;19:148-9

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Covert Video Surveillance (CVS)

- 39 children (2-44 months) at two UK hospitals
  - 46 controls with proven ALTE
- Suspicion of abuse:
  - 36 ALTE, 1 epilepsy, 1 FTT, 1 suspected strangulation
- CVS revealed abuse in 33:
  - 30 intentional suffocation, 1 poisoning, 1 fracture, 1 emotional abuse
- Siblings: 12 had SIDS (4 changed to suffocation); 1 salt poisoning, additional abuse in 15

Southall DP, Plunkett MCB, Banks MW, Falkov AF, Samuels MP. Pediatrics, 1997;100:735-760.

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Covert Video Surveillance (CVS)

- MSPB found in 23/41 patients after CVS
- CVS was required to make the diagnosis in 13 / 23, supportive in 5
  - 2/2 inducers; 8/10 fabricators; 3/11 both
- In 4 cases, CVS established innocence of caretakers (illness with medical cause)
- Caretakers characteristics were neither sensitive nor sufficiently compelling to make the diagnosis.

Hall DE et al. Pediatrics 2000;105:1305-1312

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Steps to make the correct diagnosis

- I (a). Is the consultation with the doctor inappropriate given the physical condition of the child? If yes, proceed to (b).
- I (b). Is it possible that there is mild misperception, exaggeration or overemphasis of physical changes related to overt anxiety, o is there malingering?

Bools C. British Journal of Psychiatry 1996;169:268-275.

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Diagnosis and confirmation is a major team undertaking!

Requires multidisciplinary involvement by team members who have experience with the diagnosis

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Steps to make the correct diagnosis

II. Consider the dimensions recognized by clinicians that are present to a greater or lesser degree.

- what is done:
  - impression that illness is fabricated
  - presentation for assessment
- aspects of the fabricator at presentation:
  - denies fabrication
  - motivation for sick role by proxy
  - unawareness to the harm caused to child

Bools C. British Journal of Psychiatry 1996;169:268-275.

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CPS Assessment Issues

- What is the imminent danger to the child's life or health if returned to the home?
- Has the offending caretaker(s) been psychologically/psychiatrically evaluated?
- Has there been an evaluation of the adult/child relationship?
- What is the safety of other children in the home?

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The Role of Psychiatry

- "Making the pediatric diagnosis as firmly as possible is the first step."
- "When child protection proceedings are commenced, a child psychiatrist may be able to contribute to the decision regarding the harm vs. the risk of harm to the child."

Bools C. British Journal of Psychiatry, 1996;169:268-275

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To prove MBP

- Need to prove BOTH FDP and PCF
- To prove PCF, need a physician familiar with MBP not involved in the child's medical care to do a meticulous medical record review to determine which diagnoses and conclusions were based on objective data separate from caretaker report
- To prove FDP, need a psychologist or psychiatrist familiar with MBP to evaluate caretaker, child and other family members to rule out other mental health diagnoses

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Management Difficulties

- abuser deceptiveness
- overcoming diagnostic difficulties
- abuser's personality problems and disorders
- fear induced in professionals by the diagnosis
- professional denial of severity
- overcoming splits and collusive allegiances between parts of the professional system

Jones DPH. ISPCAN 1996

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Harm to child

- Effects from invasive procedures
  - expected
  - complications
- Induction of genuine illness
- Death
- Chronic Invalidism/ vulnerable child
- Emotional, cognitive, school problems
- Factitious Disorder as adult

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Indices of high risk to the child

- Suffocation or poisoning
- Child under 5 years old
- Deaths of other children
- Lack of recognition by mother
- Mother with Munchausen Syndrome
- Persistence of fabrication after confrontation
- Family dysfunction, drug or alcoholism

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Outcomes

- Rosenberg (1987)
  - 117 cases, literature review
  - 46% male, 45% female, 9% not recorded
  - age: mean=39.8 +/- 32.1m; r=1-252
  - time to diagnosis: mean=14.9 +/- 14m, r=0-240
  - simulation 25%, production 50%, both 25%
  - signs: bleeding 44%, seizures 42%, GI 21%, CNS 19%, apnea 15%, fever 10%, rash 9%
  - morbidity: short-term 100%, long-term 8%, death 9%

Rosenberg D. Child Abuse & Neglect 1987;11:547-563

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Co-Morbidity

- MSP Patients (n=56)
  - other fabrication: 36 (64%)
  - failure to thrive: 16 (29%)
  - non-accidental injury / neglect: 16 (29%)
  - none of these: 15 (27%)
- Siblings (n=103, 43 families)
  - MSP: 40 (39%)
  - FTT / non-accidental injury / neglect: 18 (17%)
  - died ? cause: 11 (11%)
  - none of these: 59 (57%)

Bools, Neale & Meadow . Arch Dis Child 1992:67;77-9

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Long-term Outcomes

- 50% of adult victims recall active inducement / 50% fabrication.
- # hospitalizations, 0-23, mean=4.5 40% of abusing mothers had nursing training
- 80% "long-lasting and serious consequences"
- 20% "serious psychological problems"
  - 70% had Munchausen Syndrome at one point
  - childhood depression, anorexia
  - manic depression
  - post-traumatic stress syndrome
- Libow J. Child Abuse & Neglect 1995;19:1131-1142

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Follow-up of Victims

- 54 children studied 1-14 years later (mean=5.6)
  - 30 were living with their mothers:
    - further fabrications (10), other concerns (8)
  - 24 were not in their mother's care:
    - 14 had significant emotional disorders
- Features of better outcomes:
  - Continuous positive paternal / GP input (5)
  - Successful short-term foster care (5)
  - Long-term mother/Social worker relationship (3)
  - Successful remarriage (2)
  - Early adoption / Long-term placement (4)

Bools, Neale & Meadow.. Arch Dis Child 1993;69:625-630.

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Factors associated with poor outcomes

- Abuse that involved suffocation and poisoning
- Abuse of a child under age five
- Previous SIDS or unexplained deaths in siblings.
- A lack of understanding by the mother of what is happening and little feasibility of continued help to her and the family
- Mother has overt Munchausen syndrome.
- Major adverse social factors (drugs, EtOH)
- Persistence of fabrication after confrontation.

Meadow R. Arch Dis Child 1985;60:385-393.

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Legal Considerations

- Lack of legal foundation for diagnosis.
- Evidentiary patterns:
  - "introduced pattern"
    - criminal context, expert witnesses and juries
    - family / juvenile court, "need for assistance" and *res ipsa loquitor*
  - "other factors pattern"
    - instability, lack of services
    - failure to acknowledge the syndrome
- Other problems:
  - the DSM, differences among diagnostic categories

Hofstra Law Review 1993;22:495-520

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Outcomes

- Jones (1996)
  - multidisciplinary child psychiatric team, closely integrated with protective services
  - program was designed to promote reunification, with intensive services
  - 16 cases selected for inpatient treatment
    - 11 reunited, 5 to be discharged to alternative care
    - 1 child in each group was re-abused (alternative care recommendation not followed)

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Treatment of Medical Child Abuse

- Identify the abuse
- Stop the abuse
- Make sure the abuse does not recur
- Repair the physical and psychological damage experienced by the child
- Do all this in the least restrictive manner that ensures the safety of the child
- Roesler, T. Medical Child Abuse. In Jenny, C. 2011

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Issues in Treatment

- Acknowledgment
  - ABC of abusive act(s), other aspects of parenting and attachment failure, impact on child and family members
- Development of increased parental competence and sensitivity
  - meeting abuser's needs more healthfully
  - distinguishing abuser's over-concern from healthy affection
  - working on attachment difficulties
- Resolution
  - talking with sibs and telling, relapse prevention
  - interprofessional and system issues

Jones DPH. ISPCAN 1996

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Key Points

- This is a form of child abuse
- Fairly common: estimated 625 U.S. cases annually
- Both a pediatric and psychiatric entity
- A family disorder involving the health care team
- Physical, psychological and legal consequences

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Key Points

- Suspicion alone may not be enough to report to CPS
- If report is made without court order, the child may be place at greater risk
- Investigation by CPS is not the sane as other cases and requires experienced worker and supervisor with medical sophistication
- Unification is often not a realistic goal

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AAP (2007): Clinical Advice

- Whenever possible, have a pediatrician with child abuse expertise involved/ consult in the case
- Review all medical charts
- Work with a hospital or community-based child protection team
- Where a more restrictive response is needed, do not hesitate to consult with the local child protection agency
- Involve the whole family in treatment

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Conclusions

- Changing terminology
- Several difficulties in accurate diagnosis
- Need for Multidisciplinary team and protocols
- CVS and objective evidence
- Poor prognosis for reunification even with treatment

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