

Munchausen Syndrome by Proxy

How Could She Do That?

Definition

- 1 Illness in a child that is simulated (faked) and /or produced by a parent or someone who is in loco parentis;
- 2 Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures;
- 3 Denial of knowledge by the perpetrator of the etiology of the child's illness; and
- 4 Acute symptoms and signs in the child abate when the child is separated from the perpetrator.

Other Terms

- Polle Syndrome
- Meadow's Syndrome
- Medea Complex
- Chronic Nonaccidental Poisoning
- Factitious Disorder by Proxy
- Munchausen Syndrome by Proxy

Roy Meadows

- English pediatrician who reported first two cases
- Seminal paper in 1977

Meadow's First Case

- Six year old child with recurrent episodes of foul smelling bloody urine
- Caused by her mother adding her own urine or menstrual blood to the child's urine
- Resulted in 12 hospitalizations, 5 cystoscopies, 7 major X-ray procedures, many catheterizations, many other tests and multiple medications
- No urinary symptoms occurred when her mother was receiving psychiatric care

Meadow's Second Case

- Fourteen month old boy with recurrent attacks of vomiting and drowsiness with hypernatremia
- Determined to be caused by the mother giving the child salt, which did not occur when the mother was excluded from the hospital
- Child died while arrangements for his protection were being made

Factitious Disorder by Proxy

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

The Victim's Diagnosis

- Pediatric Condition Falsification
- Factitious Disorder by Proxy
- Munchausen by Proxy Syndrome/
Munchausen Syndrome by Proxy

Spectrum

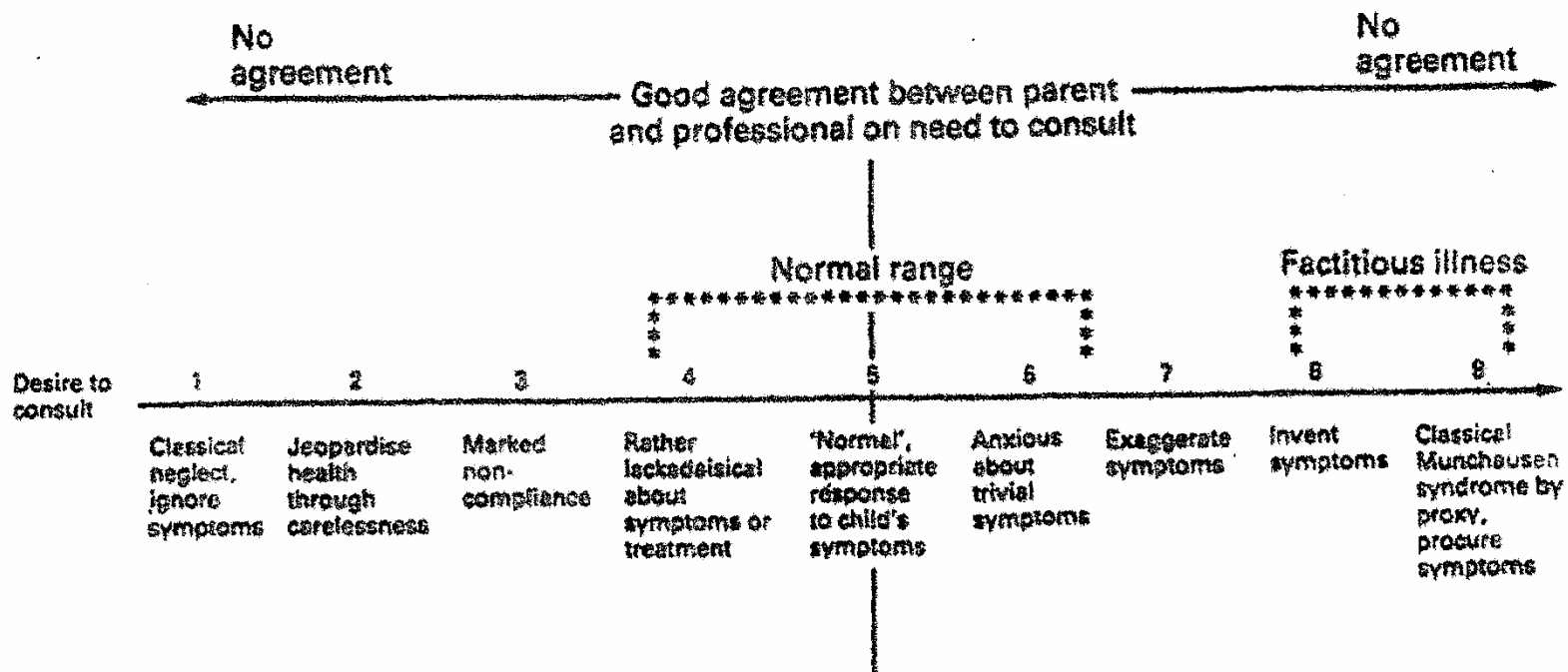


Figure 2.2. Parent's Desire to Consult for Their Child's Symptoms

SOURCE: D. M. Eminson and R. J. Postlethwaite, "Factitious Illness: Recognition and Management," *Archives of Disease in Childhood*, 1992, 67, 1511. Copyright 1992 by the BMJ Publishing Group. Used by permission.

Features of Victim

- Persistent or recurrent unexplained illness despite extensive medical work up
- Diagnosis that is extremely rare or only describes symptoms
- Disease unresponsive to treatment
- Laboratory or physical findings inconsistent with provided history
- Physical findings and reported symptoms inconsistent with child's healthy appearance

Features of Victim

- Temporal relationship between symptoms and presence of mother
- Medical history that cannot be substantiated
- Presenting complaints include bleeding, seizures, unconsciousness, apnea, diarrhea, vomiting, fever, lethargy and urinary complaints
- Child may also have real chronic illness

Features of Mother

- Maternal caregiver of child
 - 85-98% biological or adoptive mothers
- Reluctance to leave the child in the hospital
- Development of close relationships with hospital staff
- Background in a medical field
- Unusual calm despite child's medical problems

Features of Mother

- Medical problems similar to child
- Fabrication of information about her life
- Seems to regard child as a possession used to meet mother's emotional needs

Features of Family

- Unexplained illness or death in another child in the mother's care
- Emotionally distant marital relationship
- Emotional, physical, or sexual abuse in mother's family of origin
- Pattern of illness behavior in mother's family of origin

Incidence

- Unknown, though estimates of 0.3 to 5% of ill children
- Many cases undetected
- Many cases unproven

Mortality

- Significant risk of death
- Estimated to be about 10%, though uncertain
- Mother may not intend to kill child

How does she pull it off?

- History
 - History
 - History
- Move to new doctor, hospital or area
- Appears to be “Mother of the Year”
- Forms close relationship with medical personnel

Reporters

- Medical personnel
- School personnel
- Relatives
- Social workers

Diagnosis

- Review of records
- Conversations with child's medical providers
- Hidden surveillance
- Discovery of events

Treatment of Victim Child

- Protection of child
 - Non-offending parent
 - Relative placement
 - Non-relative placement
 - Medical foster care
- Mental health services
- Determine “real” disorders and treat or discontinue treatment accordingly

Placement of Child

- Caretaker must accept and have understanding of the abuse that has occurred
- If caretaker will be supervisor of visits must understand conditions of supervision
- Without placement offender is not forced to acknowledge or complete treatment for her abusive behavior

Reunification

- No contact between child and parent until parent has acknowledged MBPS behavior and is involved in treatment
- Gradual decrease in supervision and increase in contact
- Continued therapy for mother and child
- During early contact parent should never be alone with child, nor should she bring food, drink or medicine for child

Reunificaton

- May require very long process
- Visitation progress should be based on therapeutic progress rather than the calendar
- Could be affected by incarceration
- Reports of continued abuse during treatment and reunification process

Visitation Sequence

- Supervised visitation outside of the therapists office
- Unsupervised but monitored visitation within the therapist's office
- Monitored access outside of the therapist's office
- Unsupervised visitation outside of the therapist's office for short periods
- Overnight visitation
- Reunification

Medical Care

- Before reunification parent should be reintegrated into child's medical care
- Medical providers should be aware of diagnosis
- Number of medical providers should be limited
- Primary care provider should coordinate care with specialists and must be alert to further abuse

Criteria for Reunification

- Victim child without serious real medical problems
- Parent should understand her MBPS behavior and use of child to meet her needs
- Parent should have developed some alternative coping strategies
- Family members should have accepted the abusing parent's MBPS and committed to protection of child

Criteria for Reunification

- Parent should have made progress in psychotherapy
- Parent should not exhibit additional serious psychopathology
- No evidence that parent continues to claim unsubstantiated medical problems or somaticize her own problems
- Parent should demonstrate adequate parenting and warmth for child

Criteria for Reunification

- The court should mandate that the child's medical providers be kept to a minimum and care be coordinated by one doctor committed to stopping the MBPS behavior
- Social services should provide long term follow-up (years) including communication with school and doctor
- Restriction of family's ability to move or transfer of long term follow-up

Termination of Parental Rights

- Necessary when offender cannot acknowledge abuse
- Necessary when psychological/psychiatric therapy is unsuccessful