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

- 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