

Persistent Problems With the Munchausen Syndrome by Proxy Label

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After nearly 30 years of clinical and legal experience, the definition of Munchausen syndrome by proxy remains controversial. As a result, mothers who present the problems of their children in ways perceived as unusual or problematic have become entangled in legal battles that should have been resolved clinically. Re-labeling the disorder as Pediatric Condition Falsification misdirects the focus onto mistakes and misunderstandings while avoiding the more crucial issue of intentions. Experts have enflamed the fears of harm by confusing warning signs with diagnostic signs and by citing retrospective studies instead of the more optimistic outcome studies. Accused mothers need the support of multidisciplinary teams but are often forced into contentious struggles with legal professionals and child protection services.

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Munchausen syndrome by proxy (MSBP), a form of child abuse played out in the medical setting, was originally described by English pediatrician Roy Meadow in 1977.¹ By 1995, to his surprise, MSBP had become so popular that Meadow admitted that the diagnosis had been overused and misunderstood by some social workers and legal professionals.² In his article, he reviewed a vast spectrum of problematic parenting behaviors that have sometimes been mistakenly considered MSBP. Meadow's published work was preceded by two other articles that also highlighted diagnostic misunderstandings and MSBP look-alikes.^{3,4} These papers were a clear sign that the MSBP label could be misapplied in many situations.

About seven years ago, an attorney asked me how much it would cost to assess a mother accused of MSBP. While reviewing the hours I had spent on previous cases, it struck me that I had confirmed the diagnosis of MSBP in only 2 of the 11 cases that I had evaluated up to that time. Two other cases involved tragic deaths, but I considered the Munchausen label

inappropriate for them because one mother was mentally retarded and the other harmed her child while in a delirium. Both went to prison, as did another mother for whom I considered MSBP appropriate. The rest of the mothers were well meaning but inappropriately concerned about the health of their children, or their behavior was problematic in other ways. They presented a variety of difficulties that should have been solved clinically, but the exotic label entangled them in a destructive web with no apparent escape.

My clinical experience with MSBP has convinced me that the problems with this diagnosis are far more extensive than the concerns I raised in my earlier writings.^{5,6} The medical literature on MSBP often mentions false accusations, or the possibility of false accusations, but does not convey the prevalence of these misunderstandings or the devastating consequences of a wrong diagnosis.

Defining the Disorder and the Confusion of Warning Signs

In case after case, experts disagree about how to define and confirm MSBP. Most commonly, some "warning signs" of MSBP are identified, and thus begins an irreversible process of gathering more

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signs, which ends in a presumptive MSBP diagnosis. To understand the misuse of warning signs, it is necessary to review the development of the disorder.

The profiling of MSBP mothers occurred as a reasonable response to Meadow's² distress about the excessive time it had taken him and other pediatricians to consider the parent as a source of the child's symptoms. He expressed sadness that in many cases the children were injured more by the doctors than by the parents. Obviously, some warning signs were needed to help clinicians identify these cases in a more timely way. Unfortunately, the number of suggested signs grew so rapidly that by 1996 over 100 had been identified.⁷ Some of these "red flags" are contradictory, and many can be commonly found in mothers with developmentally disabled children, making a huge pool of potential MSBP candidates. If the mother appears calm or distressed, charming or hostile, distant or overinvolved, either appearance can be described as characteristic of mothers with MSBP. These warning signs have repeatedly been substituted for diagnostic signs, which amounts to conviction by profiling.

Rosenberg⁸ defined MSBP as a cluster of four critical features: (1) a simulated illness that is (2) persistently presented for medical assessment in which (3) the mother denies knowledge of the etiology, and (4) the child's symptoms abate when the child is separated from the perpetrator. These are certainly important considerations, but they are merely warning signs that can easily entrap innocent mothers.³ In his 1995 article, Meadow² admitted that Rosenberg's criteria lacked sufficient specificity to be of value. With some reservations, he endorsed the diagnostic criteria provided by the DSM (DSM-IV),⁹ because it would "prevent the term being used for many forms of child abuse for which it is currently used inappropriately" (Ref. 9, p 536).

In the DSM-IV, the Munchausen term was abandoned in favor of "factitious," which means that the symptoms arise outside of their natural course. (Factitious disorder by proxy is virtually unchanged in DSM-IV-TR.) The DSM-IV diagnostic criteria for factitious disorder by proxy require that the mother intentionally produces an illness, or the appearance of an illness, motivated by a desire to assume the sick role by proxy. Meadow² acknowledged that lies and deceptions, in themselves, were not sufficient for the diagnosis, but that the motivation was certainly im-

portant to assess. However, he had reservations about the DSM-IV criteria:

A major disadvantage of factitious disorder by proxy being applied to the perpetrator, rather than to the abuse, would be if it led to authorities believing that such abuse of children could be diagnosed by psychiatrists, or that an assessment of the perpetrating parent could overrule the clinical and forensic findings made by those involved with the child [Ref. 9, p 538].

I read this to imply that Meadow approved of including psychiatric considerations in making the diagnosis but only if the conclusion agreed with the pediatrician's assessment. However, the reliability of a diagnosis is dependent on convergent information.¹⁰

The DSM-IV definition makes it impossible to confirm the diagnosis without an evaluation of the intentions and motivations of the mother. Nevertheless, Rosenberg recently argued that "intent itself does not have the observable quality necessary to have it qualify as a diagnostic criterion" (Ref. 11, p 426); and, therefore, MSBP cannot be a psychiatric diagnosis. Despite Rosenberg's concern, intentions, motivations, and volition are commonly considered by mental health professionals and by courts around the world. Judging intentions is such a critical social skill of daily life that ordinary individuals develop complex cognitive strategies that serve them well in life and in the courtroom.¹²

Yet, intentions are often presumed. I am repeatedly amazed when experts who have not interviewed the mother conclude that she is receiving secondary gain by caring for her sick child.

Even the recordings of covert video surveillance are not sufficient to confirm MSBP. The ethics-related concerns and warnings of false accusations¹³ were easy to ignore when Samuels and Southall, who pioneered covert video surveillance in MSBP, stated that they had "confirmed severe child abuse in 32 of 36 cases in which it was undertaken" (Ref. 14, p 414). However, it was later convincingly argued that some of these tapes contained no evidence of MSBP, and in other cases the nature of what was happening was highly subjective and in dispute.^{15,16} In one of my cases, the hospital staff, child protective services, and the police all ignored, or failed to report, that the covert video had captured an ongoing context of spontaneous affection among family members for each other and the disabled child. This secret view into the private functioning of the family should

have created serious doubts that the ambiguous acts of the mother were intended to be harmful.

In my view, everyone wants to use the MSBP diagnosis, but most experts want the court to trust their personal judgment about confirming the diagnosis. I have rarely (perhaps never) seen a thoughtful assessment in which the DSM-IV criteria were used. When confronted about this, some MSBP experts have admitted that they are not qualified to make a psychiatric diagnosis of the mother. This hurdle is circumvented by proclaiming that MSBP is really a diagnosis of the child or by calling the problem “pediatric condition falsification” and then declaring it an equivalent of MSBP.

Pediatric Condition Falsification and the Assessment Process

The term pediatric condition falsification has been adopted by the American Professional Society on the Abuse of Children.¹⁷ At first glance, this avoids an assessment of the mother’s mental state or her intentions. Indeed, falsifications are worthy of attention, but usually a mother’s false statements do not create an imminent danger such that the physician should call child protective services. It has been known for some time that mothers give unreliable (false) information about their children’s medical history.¹⁸ During careful interviews, ordinary mothers provided information that was not consistent with the medical records of their children. The findings in this study suggested that mothers say what they believe at the time.

The base rate for misinformation in the pediatric setting may be high, but this does not necessarily reflect evil intentions. Falsification can arise from simple mistakes or complex psychodynamic drives; clinicians must evaluate and minimize these risks. Yet, attorneys comb the massive records of chronically disabled children looking for the smallest discrepancies, which are then paraded before the court as falsifications. This has a powerful effect on the whole process because anything that the mother says thereafter in her own defense can be dismissed as a part of her pattern of lies.

Many articles on MSBP recommend comprehensive evaluations, but the diagnostic labels of pediatric condition falsification and MSBP often divert the assessment process and management planning into a contentious legal battle.¹⁹ The purpose of a multidis-

ciplinary team, of course, is to assess different domains of function and, one hopes, to avoid viewing the patient through a diagnostic peephole.

Once a problem is perceived as MSBP or pediatric condition falsification, the focus easily turns to simplistic blaming instead of assisting the mother in the management of her child. Most often, the planning sessions of child protective services result in the assignment of burdensome tasks for the parents to earn back their child even when there has not been evidence of harm.

Working With Mothers in Need

In many cases, I have seen mothers brought into court who simply needed assistance. For example, a primary-care pediatrician testified that he felt overwhelmed by the complexity he faced in the management of two siblings with congenital disorders. He described the mother as honest and forthright, and he had no concern about abuse, but he contacted child protective services to help support the family and the child. However, child protective services hired a psychiatrist to review the mother’s records after they discovered that MSBP had once been considered as a possibility. Without interviewing the mother, the psychiatrist told the judge that she was reckless, aggressive, and relentless. He said he would not be able to sleep at night unless these children were removed from their mother. The judge eventually cleared the mother, delivering some harsh words to the psychiatric expert, child protective services, and the primary-care pediatrician who failed to stand up on behalf of the mother. However, the process disrupted more than a year of the mother’s life, ended her marriage, and consumed over \$100,000 in attorney’s fees.

I have seen mothers accused of MSBP simply because physicians disagreed about the medical management of their child. For example, a pediatrician in a small community was distressed by the more aggressive professors at the state medical school where he had sent his young patient for consultation. Instead of telling the professors that they had usurped control of his patient or that he disagreed with their treatment, he accused the mother of providing excessive care. Despite the absurdity of his accusation, child protective services took custody of this mother’s only child for several months. In addition, mothers are often blamed for the tests, procedures, and

consultations even though this is common practice, especially in larger medical centers.²⁰

Risk and Harm

It is well known that experts have wildly overestimated future dangerousness,²¹ and this historical tradition has continued for MSBP mothers. For example, one pediatrician falsely described the mortality rate of MSBP victims as 25 percent. The mother subsequently lost permanent custody of her child, perhaps not solely on the basis of this testimony; however, whipping up fears about MSBP mothers is typical. For example, Schreier,²² who acknowledged an error in his estimation of the epidemiology of MSBP, also reported improperly high recidivism “as in the death rate of 6 percent.”²³ However, the article that Schreier cited for the six percent death rate contained no outcome information,²⁴ and the follow-up study of those mothers identified no deaths in those children or in their siblings.²⁵

Of the four MSBP outcome studies,^{25–28} only two deaths were reported, but the causes were complex and induced illness was not necessarily the cause. The latter two follow-up studies provided evidence of good outcomes, even for children who had been severely abused, when the cases were properly managed. Experts often tell the court all the terrible things that MSBP mothers have done to their children, confusing retrospective studies with outcome. These stories are almost always sufficient for a judge to order a child into protective custody, even without an assessment of the mother. And once in custody, it is extremely difficult for child protective services to return the child to the mother.

Court Guidelines

Extensive negative publicity about MSBP in England has been associated with more court decisions, usually favoring plaintiffs in suits against those who originally made false accusations. In contrast, mothers in the United States have not fared well in such suits. For example, in *Yuille v. State of Washington*,²⁹ the plaintiff argued that the accusing pediatrician’s actions were outside the umbrella of protection afforded by child-abuse-reporting law, but the court disagreed. The court said that the plaintiff failed to show a malicious motive on the part of the defendant, and negligence was not sufficient be-

cause “as a matter of legislative policy, the immunity bar is set very high, and plaintiffs cannot overcome it” (Ref. 29, p 6). In a more far-reaching decision, a three-judge panel in the United Kingdom ruled that children, but not parents, can sue those who wrongly conclude they have been the victims of abuse.³⁰ Considerations barring claims of wrongful diagnosis were swept away by the European Union’s Human Rights Act of 2000.

In another case, the European Court of Human Rights ruled in favor of parents who brought suit because their child was taken at birth following a previous conviction of MSBP.³¹ The court concluded that removing an unharmed child from her mother was a “draconian step.” The child protection agency had provided no substantiation of their assertions of dangerousness other than the MSBP diagnostic label, and there was no explanation why the parents should not have continued contact with the child or why, in the worst case, an open adoption was not possible.

The European Court of Human Rights has also provided hospitals and physicians more specific guidelines about their responsibilities in the management of MSBP mothers. In *Venema v. The Netherlands*,³² the court concluded that those involved in an accusation against a mother had an obligation to discuss their concerns directly with the parents. The rapid removal of the child from her home was unjustified because any potential danger to her was not greater than the disadvantages of placement away from the family. The state had an obligation, according to the court’s decision, to be more creative in finding a solution that protected the parents’ interests. The state’s action was incompatible with the expectations of families in a democratic society.

In a recent ruling, an English judge in a Family Division Court³³ provided comprehensive opinions that follow the spirit of *Venema v. The Netherlands*. In this case, a mother continued to describe symptoms of diabetes in her child even after being told clearly that the child did not have diabetes, and she reported many false episodes of seizures and ataxia. However, the judge concluded that the mother’s reporting these symptoms was not malicious exaggeration; instead, her presentation was characteristic of her dramatic style. The child was born prematurely, and the physicians should have attended to the reasonableness of her fears. Although the developmental

problems of the child had resolved, the pediatricians should have appreciated her difficulty in managing the child at home. Instead of blaming her, they should have taken into account that she was not a reliable medical historian.

The court noted that the physicians failed to assist this mother but instead excluded the mother from her child as if she were dangerous. The police investigation supported these fears, but case workers should have understood the adversarial nature of the criminal procedure. The whole assessment process should have attended to wider concepts of social, emotional, ethical, and moral factors. The child protective agency had a responsibility to ensure that the mother was provided a multidisciplinary evaluation before removing the child or bringing the case to court. They should have challenged the opinions of the experts, no matter how well qualified or senior, reappraising the information from professionals. Instead, the label became everyone's way of understanding the mother and judging dangerousness.

Courts should be interested in factual descriptions of events and avoid substituting a diagnosis for a finding of guilt. An Australian court supported this idea by declaring that the introduction of MSBP diverted the jury from deciding whether the mother had intended to harm her child through unnecessary medical procedures.³⁴

Conclusions and Recommendations

When MSBP is suspected, the clinician should discuss the concerns directly with the mother so that a path of management can be established. If child protective services become involved, it is important to avoid needlessly enflaming fears so that an even-handed assessment can proceed. Separation of mother and child should be considered only with evidence of imminent danger, as many state laws direct. The intentions and motivations of the mother are not established by declaring the MSBP diagnosis, and future risk is not established by citing the evil deeds of other MSBP mothers. The MSBP diagnosis may have prevented abuse by the hands of parents and unsuspecting physicians, but its misuse has unnecessarily torn many families apart. These persistent problems with the Munchausen syndrome by proxy label must be honestly addressed in court, the medi-

cal literature, and ultimately in the next psychiatric diagnostic manual.

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