Munchausen Syndrome by Proxy in False Allegations of Child Sexual Abuse: Legal Implications

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A review of the literature regarding Munchausen syndrome by proxy in relation to allegations of child sexual abuse is presented. Problems in the diagnosis of Munchausen syndrome by proxy in these cases can be the result of a failure to consider that the allegations may be false, legal issues surrounding the child's testimony, and other biases in professional and legal attitudes towards allegations of sexual abuse. A proposal for a more stringent standard of care is made. Treatment of Munchausen syndrome by proxy is best effected by case management, with the person who made the diagnosis managing the case throughout the treatment. This person should act as liaison to relay information between all the parties involved.

Munchausen syndrome by proxy (MSP) is an uncommon disorder first described by Roy Meadow in 1977. It was so named because of its similarity to Munchausen syndrome, a factitious disorder in which a person intentionally produces or fabricates physical symptoms in him- or herself.[1] In MSP the symptoms are intentionally produced or fabricated in a child by a parent, usually the mother.

A complete description of the disorder was taken from Rosenberg.[2] She named four features of the disorder: (1) an illness in the child that is simulated and/or produced by a parent (or significant other); (2) the presentation of the child for medical assessment and care, usually persistently; (3) denial of knowledge by the perpetrator as to the etiology of the illness; and (4) acute symptoms and signs that abate when the child is separated from the perpetrator.

In addition to the basic description, there are some variables that have been found consistently in the description of the perpetrator. The perpetrator is usually female and usually the mother.[2-4] There is also some evidence of a greater incidence of personality disorders or factitious disorder in the perpetrator.[2, 5, 6] Mehl reported that 20 percent of MSP mothers could be diagnosed as having a factitious disorder. Samuels *et al.* found

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6 of the 14 MSP parents he studied had a history of factitious disorder.[7] He also reported that 9 of the 14 were abused as children, and 10 had a history of an eating disorder (obesity or anorexia).

The syndrome is usually seen in an intact family with a distanced father.[8] The perpetrator is often medically articulate, having had some medical training.[8] She seems to be highly devoted to the child and to thrive on the attention from the hospital staff.[2] Because the mother is so active and attentive, the staff may fail to consider MSP as a possible diagnosis.

There have been many hypotheses about the etiology of the disorder. Kahan and Crofts hypothesized that in MSP there is a lack of differentiation between the mother and child. They say this accounts for the powerful effects on the mother of the vicarious reinforcement of attention given to the child via the hospital testing and by staff.[9] Similarly, Waller theorized that the child's illness serves to express the parent's need for attention and help.[10] Eminson and Postlethwaite propose that MSP parents are impaired in their ability to distinguish their own needs from those of their children and will put their own needs first.[11] Others say there is significant pathology in the perpetrator, such as personality disorders or factitious disorders, that accounts for the way the perpetrator treats the child. Others think, because of the prevalence of female perpetrators, that MSP is a women's disorder tied to their expression of power and negative emotion within their social roles.[3] MSP has also been called a disorder of parental empathy for the child.[2] It has been proposed that MSP children have the tendency to experience somatic symptoms, possible histrionic traits, and a coexisting serious illness.[11] The children seem to learn that their parents will respond to their physical symptoms.

MSP has also been seen in the context of sexual abuse allegations. Deirdre Rand used the term contemporary type MSP to distinguish MSP cases involving fabricated sexual abuse.[12–14] She proposed that the contemporary type MSP is a subtype of the original disorder she referred to as classical MSP. She defines contemporary type MSP as a variation of MSP "in which a parent or other adult caretaker fabricates or induces the idea that a child has been abused and then gains recognition from professionals as the protector of the abused child."[13] She suggests that this will occur often in divorces, especially those with heated custody disputes. Because of the rise in divorce rates, she expects the incidence of contemporary type MSP to also rise.

In distinguishing contemporary type MSP from the classical type, it may be helpful to present some of the similarities and differences between the two. Contemporary type MSP is similar to the classical type in that the child is used as a pawn to meet the needs of the parent. It is also similar in respect to the incidence of personality disorders present in the parent. Wakefield and Underwager noted that the incidence of personality disorders for parents who had made false accusations in divorce/custody disputes was found to be very high—around 75 percent.[14] This finding

is consistent with reports of personality disorders in classical type MSP.

The two types of MSP differ in that classical type cases emphasize the actual physical abuse that occurs, but Rand describes the emotional abuse as predominant in contemporary type MSP. This does not preclude the production of physical symptoms, but Rand reported that this is to be expected in only a small number of contemporary type MSP cases.[14] Meadow noted another difference between the two types. He claimed that in classical type MSP the abuse seems to begin in the first year of life, whereas in contemporary type MSP the children are typically older. Therefore, an integral part of contemporary type MSP is the indoctrination of the child into the "story."[15]

Contemporary type MSP, as defined by Rand, could be seen as encompassing a wide incidence of false allegations of sexual abuse. The question then follows: when do false allegations fit the description of MSP, and when do they not? Libow and Schreier asked the same question about what Rand termed classical MSP.[16] They noted three types of behaviors operating in the perpetrator, which they classified in three categories: *help seekers*, *doctor addicts*, and *active inducers*. With help seekers, the production of symptoms in the child is seen infrequently, usually in response to stresses on the mother such as depression, anxiety, and exhaustion. These stresses overwhelm the mother and affect her parenting skills. With doctor addicts, the mother seems personally convinced that her child is ill, and this belief approaches delusional intensity. Libow and Schreier noticed that these mothers tended to have paranoid and suspicious beliefs, suggesting possible personality disorders. The active inducers are the parents who commit the dramatic physical assaults, characterized by extreme denial and projection and also dissociation of affect. These are the most characteristic of the MSP perpetrators.

Libow and Schrierer suggested that the doctor addicts and the active inducers were the types that would be most validly described as having MSP.[16] In these two types the perpetrators were driven more by unconscious needs than by conscious needs and secondary gains. They offered that this characteristic is what separates MSP from other simulated illnesses such as malingering.

Others have taken a more stringent approach and have defined MSP as occurring only when physical symptoms are procured. They equated the mere exaggeration of symptoms with a generalized factitious disorder.[11]

We have agreed with Libow and Schreier's categorization, because it preserves the integrity of the diagnosis as we have understood it from the literature. The application of this categorization of contemporary type MSP would mean that the label would be applicable only in situations in which the abuse was fabricated because the mother was actually convinced it occurred or when the mother induced actual physical symptoms in the child. In discussions of divorce and custody battles false allegations of sexual abuse would not be considered as MSP when the parent's

motives were conscious (i.e., purposefully meant to taint the reputation of the other parent), unless the accusing parent either truly believed the abuse had occurred or produced physical symptoms in the child. We think that this description of contemporary type MSP is most consistent with the classical literature.

Divorce May Facilitate Contemporary Type MSP

In divorce the parents are often so distressed that their parenting skills and awareness of the needs of their children are decreased. Factors such as ongoing parental conflict, parental adjustment, and contact with the noncustodial parent have been shown to have significant effects on the adjustment of the child.[17] Parental conflict has clearly been shown to have adverse effects on the adjustment of the child. The child very often feels in the middle of the conflict and wants to prevent being abandoned by the parents. To insure the love and security of one parent, the child might go along with accusations of abuse by the other parent.

Thoennes and Tjaden found some meager support (their results did not reach statistical significance) for the premise that with increased levels of anger between divorcing parents, the validity of the accusation of sexual abuse decreases.[18] In their study the validity of the accusation (as perceived by the custody evaluator and/or the caseworker) tended to decrease with higher levels of anger between parents; however, this trend was not significant. Supposing this were the case, it is difficult to know whether this decrease in validity is due to increased incidence of MSP in a divorce/custody dispute (unconscious action taken by emotionally compromised parent) or efforts by one parent to taint the image of the accused parent (angry and resentful action).

In divorce cases it used to be that the mother was almost always given custody of the children under the "tender years" doctrine.[17] Currently less importance is being placed on this doctrine, with the courts awarding joint custody of the children when it is possible. This switch, although welcomed by many fathers, could make mothers quite nervous. Gardner has written extensively about sex abuse issues and claimed that allegations of sexual abuse are one of women's most powerful weapons in custody disputes.[19] In fact, he reported that attorneys have been known to suggest to mothers that they claim abuse by the father for that purpose. This change in the legal attitude toward whom the child should be placed with and the increase in social concern about child abuse, Rand suggested, have opened the door to increasing opportunities for MSP. Again, this type of motivation for allegations of sexual abuse might not be classified as contemporary type MSP under the guidelines we have selected.

Problems in the Diagnosis of Contemporary Type MSP

Contemporary type MSP will first appear to a mental health professional in the context of a sexual abuse accusation or evaluation. A careful and thorough sexual abuse evaluation should uncover

MSP masquerading as sexual abuse. However, many experts in the field are critical of the adequacy with which these evaluations are being performed. Burton and Meyers, borrowing from Quinn, cited six factors that may lead to incorrect assessments and overdiagnosis of sexual abuse.[20] They are: (1) lack of professional resources and training; (2) lack of investigatory independence (i.e., alliance or interview with only one parent); (3) improper interview techniques (i.e., leading questions); (4) inadequate data base; (5) contamination by external influences (i.e., media coverage, communications between parents and children); and (6) failure to consider the possibility that the allegations may be false. Obviously these problems can contribute to a failure to discover MSP.

The failure to consider that the allegations may be false is a major problem in the diagnosis of contemporary type MSP. The issue of the validity and reliability of children's accusations/testimonies has been heatedly disputed. Professionals' opinions on the subject range from considering children's reports of sexual abuse as basically accurate to prone to substantial error. Either way, a critical approach to sexual abuse evaluations is certainly warranted. Gardner strongly argued this point.[19] He cited a study done by Lewis on three-year-old children. In this study, the children were left in a room and told not to peek at a toy. Ninety percent of the children peeked, and when questioned, 33 percent of these children admitted they peeked, 33 percent lied, and 33 percent didn't say, which was interpreted as a sign that they were learning to lie. He explained that children do not understand everything that is going on around them, and they are constantly guessing and construing to try to make sense of it. Adults are the authorities they look to, to correct their distortions. Thus the actions of the significant adults in the child's life can be quite influential in affecting the actions of the child.

Other problems that have contributed to the case of the MSP parent occur during the sexual abuse hearing and revolve around the acceptance of the testimony of the child. Legally children of any age can testify in all states.[21] In accusations of child sexual abuse, it is usually the child's word against the accused adult's. However many evaluators are hesitant to let the child testify because of additional suffering the child might incur from testifying in court. To protect the child from suffering additional trauma, many methods have been suggested, such as videotaping the child's statement, placing a screen between the child and the accused, or even allowing closed-circuit testimony. Eight states have passed statutes that would create a hearsay exception for videotaped statements of child sexual abuse.[21] The victim must be available for cross-examination. Twenty-seven states allow for closed-circuit testimony by the child.[20, 21]

These aforementioned problems can have serious implications in cases in which MSP is operating. First, the tendency to assume the child is telling the truth would not lead evaluators to even consider MSP. This leaves the real per-

petrator free to continue the abuse, and distances the child from the support and help of the other parent. Rosenberg stated that "the largest impediment to early discovery of MSP was omission of factitious illness from the differential diagnosis."[2] The lack of investigatory independence may prevent the observation of the child's interaction with the accused parent. This is an important source of information in determining false allegations and MSP. In fact, Gardner said that one of the most effective sources of information in sexual abuse accusations comes from observing both parents and the child together.[19] Often the child in a false allegation is quite comfortable with the accused parent, which Gardner purported is telling evidence.

The Prevalence of False Allegations of Child Sexual Abuse and Munchausen Syndrome by Proxy

The present sentiments about sexual abuse have been likened to hysteria.[19] Some evaluators have suggested that the allegations of sexual abuse are unfounded in as many as 65 percent of all cases.[22] However other examiners claim the prevalence of false allegations is actually quite small, anywhere from 2 to 20 percent of all cases, and possibly as high as 50 percent in heated custody disputes.[19, 23] To determine whether the idea that heated custody disputes foster sexual abuse allegations, McIntosh and Prinz looked at all of the divorce or child custody cases in 1987 that occurred in a small southeastern city.[24] Of the 603 cases, allegations of any abuse occurred in three percent of the cases, and sexual abuse allegations were present in less than one percent—only five cases! Other sources have indicated substantially higher rates. Underwager *et al.* reported that 51 of their 127 cases involving reported sexual abuse occurred during divorce and custody cases.[25] Thoennes and Tjaden used information from mail and telephone surveys, interviews with legal and mental health professionals who deal with child abuse cases, and empirical data gathered from 12 domestic relations courts throughout the United States. They found that slightly less than two percent of the cases involving custody and visitation disputes also involved sexual abuse allegations (range was from less than 1% to 8%). They also suggested that many of the high estimates in the literature come from research selectively drawn from the professionals' own caseloads. This information seems to indicate that concern about the rise in false allegations with the rise in divorce may be unsubstantiated.

MSP itself is rarely seen. Rosenberg said that the literature makes mention of 117 cases since it was first described 15 years ago.[2] Another review, similar to that done by Rosenberg, studied 56 children and 82 of their 102 siblings. These authors found that 64 percent of the index children had more than one illness fabricated, and 29 percent had a history of nonaccidental injury. Findings also showed that 11 percent of the siblings studied had died, and 34 percent had illnesses fabricated by their mothers.[26] Godding and Kruth found that

among the 1,648 asthmatic patients they saw during consultation over the course of three years, 17 families (about 1%) were identified as having MSP.[27] According to these studies, it appears that MSP may occur rarely, but when it does the safety of not only the index child but other family members needs to be considered.

There is evidence to suggest that MSP is simply not well known and consequently not diagnosed by professionals. A study by Kaufman *et al.* found that only 50 percent of their participants had heard of it.[28] Their 86 participants identified 77 cases of MSP they had seen in the past year. That is a rough average of one to two cases per year. In a survey of apnea-monitoring centers, 0.27 percent of parents with a child in treatment were strongly suspected of MSP.[29] In a more recent article by Schreier and Libow, results of surveys sent to 870 pediatric neurologists and 388 pediatric gastroenterologists were discussed.[30] With respective return rates of 22 percent and 32 percent, a combined total of 465 cases of Munchausen syndrome by proxy were reported. Of those cases, 273 were confirmed and 192 were seriously suspected. Although this information does not lead to an estimate of prevalence, it does indicate that this syndrome is more common (and possibly more well known) than the prevalence rates show.

The Identification of Contemporary Type Munchausen Syndrome by Proxy and Legal Issues

MSP is a problem that is distinctly different from false allegations of sexual abuse and the differentiation should be addressed. MSP is a reportable form of child abuse because it entails potential emotional and physical abuse, whereas false allegations are not.[12] By using the more conservative definition of contemporary type MSP proposed in this article, the seriousness of the syndrome is less likely to be deemphasized and the actions of the mother passed off simply as a way of getting back at a spouse.

Obviously, the first step in identifying contemporary type MSP is to try to discern whether the allegations are true or false, which, of course, is no easy task. This article will not attempt to discuss this very complex issue; the reader is referred to Green for a discussion of symptomatology of children who have been sexually abused and to Jenkins and Howell for a methodological discussion concerning sexual abuse interviewing.[23, 31]

Meadow, from work with families with contemporary type MSP, noted several characteristics of these families that help to differentiate MSP.[15] Prolonged investigations revealed a lack of appropriate language and detail in the allegations; the children did not express feelings which would have accompanied the alleged abuse. The mothers were the most active in repeating the story and insisting on further assessment. These mothers also showed inappropriate empathy and concern.

In the diagnosis of MSP, the classical and contemporary literature points to the usefulness of appointing one long-term case supervisor to see the case through to completion.[10, 32, 33] This is

crucial in MSP because the social, medical, and mental health services are used by the mother and can contribute to or further the abuse of the child. The typical MSP mother is one who will take the child from doctor to doctor, or from therapist to therapist, until she finds one who will validate her allegations.

Fortunately, the legal system has established through the Child Abuse and Prevention Treatment Act the provision of a guardian *ad litem*.[21] The role of this person is to focus solely on the best interest of the child. A guardian *ad litem* could be very helpful in the assessment and treatment of MSP cases, by insuring that the child's needs are heard and possibly by organizing and overseeing contact between the different agencies involved in the case.

In a few states, special units have been set up to deal specifically with abuse allegations. Rand discusses the Special Court Master Program in Marin County, California.[14] This program is ideal for cases in which contemporary type MSP is diagnosed in the context of child custody evaluations/divorce. Under this program, two divorcing parents who have been unable to cooperate on custody and visitation can appoint a Court Master to decide all the details. The parents have to agree on the appointment, the length of time the Court Master will be in service, and premature termination of the Court Master. The Court Master should have an understanding of MSP type abuse and would take the best interests of the child into account. In MSP situations, it would be difficult to get the mother to agree to the arrangement, and Rand suggested that it would probably have to be offered as the only condition under which she could have contact with her child or as an alternative to criminal prosecution.

When it is determined that MSP is operating, there are several possible courses of action. If physical abuse is occurring, it must be reported. Child maltreatment is both a criminal and civil offense in every state. Thus MSP is prosecutable in both criminal and civil courts. In criminal courts, the occurrence of the abuse and the abuser's identity must be proven beyond reasonable doubt. This can be difficult to prove in MSP cases because there are usually no witnesses. If the child admits that he or she was coached by the mother, the child's credibility may be questioned because the statement conflicts with the nature of the previous allegations. Thus the child's suggestibility becomes an issue.

The use of statements by professionals, or expert witnesses, is not always acceptable. In child sex abuse cases, in which the court is also dealing with a child witness, expert witnesses have usually been accepted under the following conditions: (1) refutations of the defense counsel's claims, when the defense's attacks on the child's credibility is challenged by an expert witness; and (2) expert testimony offered as direct evidence of sexual abuse. The type of expert witnessing that is generally not allowed in the courts is that of presenting common characteristics of the child abuser. "A prosecutor is not allowed to establish a person's guilt through evidence that

the person has a particular character trait or propensity."[34] Most courts believe that this type of testimony places an unfair prejudice on the defendant and so outweighs its usefulness. However this type of information may be useful in MSP trials, and the Colorado Court of Appeals has allowed such testimony on the grounds that such information was not available to the average juror.[20]

Because of violation of fourth and fifth amendment rights, videotaped evidence is usually illegal. Kahan and Crofts found an exception in the case of *Burdeau v. McDowell* where the United States Supreme Court held that evidence obtained illegally by a "private party" (one which is not acting under the direction of a law enforcement agency) is admissible.[9] They suggest that protective service workers may qualify, depending on local case law. Foreman and Farsides argued for the use of videotaping to assess classical MSP in cases where there is a reasonable suspicion of factitious illness.[35] They mentioned that videotaping has been very successful in diagnosing classical MSP and pointed to the article by Samuels *et al.*, in which 14 of 15 parents who were strongly suspected of MSP abuse were diagnosed within two days by use of videotaping.[7] If there is the possibility of MSP working in sex abuse allegations, perhaps it is a good idea to videotape the assessment sessions, in case there is evidence of coaching by the mother or other signs that MSP may be operating.

If the case is to be tried in a family or juvenile court, the prosecutor only has to present the case by showing "clear and convincing evidence." Obviously this is easier to do than to prove beyond reasonable doubt. The two legal forums have different implications for case management. In criminal cases, the focus is on the punishment of the perpetrators, and they can be fined, incarcerated, or placed on probation. In civil cases, the focus is on the protection of the child. The court can remove the child from the home, order supervision, or order the family to seek treatment.[21]

There have been cases in eight different states in which the courts have upheld the position that a parent cannot poison the mind of the child against the other parent and that it is improper and illegal to do so.[32] Florida has the Shared Parental Responsibility Statute under which a judge can admonish the parent for causing or contributing to the alienation and can also change the primary residence of the child. Palmer suggested this course of action for cases of parental alienation syndrome, which occurs when children are obsessed by an exaggerated or unjustified hatred of a parent. This syndrome may fit within the framework of contemporary type MSP.[13]

Case Management-Treatment

Rand stated strongly that the key in MSP cases is management and not therapy.[13, 14] Most authors have advocated removing the child from the home, especially if severe physical abuse is occurring.[6, 33, 36] Classical MSP has a high mortality rate, nine percent based on Rosenberg's study.[2] The first issue then is the protection of the child. In cases of classical MSP or contemporary type

MSP in which there is severe physical abuse, any avenue that provides for separation of the child from the perpetrator and close monitoring of the relationship is probably advisable.

In cases of contemporary type MSP, Rand suggested that the first step is to obtain a court order preventing the mother from taking the child for further therapy or examinations.[14] She advocated separation of mother and child because the emotional abuse and accusations against the father will probably continue. The severe pathology working in MSP mothers is likely to be chronic, and they do not respond well to therapy. Rand reported that therapy for the mothers is one of the worst strategies for dealing with MSP, because they usually lack insight and motivation. They may even try to align with the therapist to perpetuate the allegations.

Here again Rand suggested the use of a case manager; the person who made the diagnosis should remain on the case throughout the treatment to relay information between the parties involved. MSP is a long-term disorder in the parent, and to protect the child, consistent awareness and prevention of the mother's abusive tendencies is crucial. Rosenberg found that 20 percent of the children who were killed by their classical MSP-type mothers had been removed from and then returned to the home.[2] The parents had been confronted and had not changed their behavior. Godding and Kruth studied 17 cases of parental mismanagement of asthma, many of which could have been classified as symptomatic of classical MSP.[27] In 10 families, the child was undertreated. The parents reportedly complied with treatment, but they frequently withheld medication even during an attack (70%). One of these children died during an episode. Seven of the 17 families overtreated—they falsified and exaggerated symptoms and had the patients undergo useless and potentially harmful investigations. These parents had been confronted about their behavior and continued to fabricate symptoms or withhold medication, which resulted in the death of one child.

The physical safety of the children in classical type MSP situations is certainly of concern. There is some evidence to suggest that we should also be concerned about the physical safety of children who present as contemporary type MSP victims. Meadow presented several contemporary type MSP cases that did not occur during divorce/custody disputes.[15] He found that 13 of the 14 children were also victims of classical type MSP. The fourteenth child had a sibling who was a classical type MSP victim.

The child in contemporary type MSP situations may also be in need of treatment. It is possible that the MSP can escalate and become a *folie à deux*, with the child believing the mother's story.[14] The child may internalize the allegations so completely that a false memory syndrome is produced, and the child is truly convinced of the guilt of the father. Psychotherapy and careful management would be necessary in this case, because removal of the child from the mother is necessary to put an end to the abuse. However, the child might be fearful

enough of the father to be uncomfortable living with him. In this case the child could stay with other relatives such as paternal grandparents.

In summary, contemporary type Munchausen syndrome by proxy is an uncommon disorder that merits attention because of its potential for harm to the child. Although it has been discussed mainly in the context of divorce or custody disputes, there seems to be good evidence that a better predictor may be the presence of classical type MSP symptoms. If these symptoms are present, the physical protection of the child also needs to be considered, given the dangerousness of the classical type MSP disorder.

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