MUNCHHAUSEN SYNDROME
BY PROXY (PCF)

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MSBP:
CASE EXAMPLE
CASE

- 4 month old girl with apneic spells
- How do you proceed?
- Findings:
  - GE reflux
  - Central apnea
  - Seizure
- Referred to tertiary center
MUNCHAUSEN SYNDROME

• First described by Ascher in 1951
• Named after Baron Von Munchausen, a European teller of tall tales
• Children’s books exist in Europe based upon these fantastic confabulated tales
MUNCHHAUSEN SYNDROME

- Typically by adults – making up medical stories about themselves
- Fabricated stories about illness
- Production of symptoms/signs is common
- Multiple surgeries/hospitalizations often occur
Guinness Book of Records (1993)

- William McIloy (b. 1905)
- Cost $4,000,000 over 50 years
- 400 major and minor operations
- 22 aliases
- Longest out of hospital = 6 months
“In 1979 he hung up his bedpan for the last time, saying he was sick of hospitals, and retired to an old people’s home...where he died in 1983.”
MUNCHASEN SYNDROME vs. MUNCHAUSEN SYNDROME BY PROXY

• Munchausen syndrome
  – Victims/perpetrators: almost always adults
  – Make up things about themselves

• Munchausen syndrome by proxy
  – Victims: children almost always
  – Perpetrators: adults (almost always mom)
MUNCHAUSEN SYNDROME BY PROXY

- MSBP
- AKA:
  - Munchausen by proxy syndrome (MBP)
  - Pediatric Condition Falsification (PCF)
- Terms that are **not** synonymous:
  - Polle syndrome (not accepted and inaccurate)
  - Factitious disorder by proxy (FDP) - this refers to a possible psychiatric motivation
NEWEST TERMINOLOGY

- Pediatric Condition Falsification
  - The abuse
- Factitious Disorder by Proxy
  - A frequent motivation
- MSBP
  - Is the combination of PCF and FDP
MUNCHAUSEN SYNDROME BY PROXY

• First described by Meadow in 1977
• Over 1000 cases in the medical literature
• Thousands more cases known
• Crude estimate of 500 - 1500 cases in US population per year
SPECIFIC DEFINITION OF MSBP

- Apparent illness or health-related abnormality which the caretaker made up or produced
- Presentation of the child for medical treatment
- Failure of the perpetrator to acknowledge the deception
- Exclusion of simple child abuse/neglect and simple homicide
MSBP

• The caregiver (usually the mother) uses the child as a medical focus to meet her own needs
• The child is a pawn
• The inappropriate use of medical treatment, caused by the perpetrator, is medical neglect
• The first unnecessary needle poke = physical abuse
MSBP PRESENTATIONS

- Various symptoms, signs, and laboratory findings of:
  - Abdominal pain
  - Allergies
  - Anorexia (loss of appetite)
  - Apnea (cessation of breathing)
  - Arthralgia (painful joints)
  - Arthritis (swollen joints)
  - Ataxia (dyscoordination)
  - Bacteruria (bacteria in urine)
  - “Biochemical chaos”
MSBP PRESENTATIONS (Continued)

- Bleeding from ears
- Bleeding from other surgical sites (e.g. various tubes)
- Bleeding tendency
- Bleeding from upper respiratory tract
- Bradycardia (slow heartbeat)
- Cutaneous abscesses (skin infections)
- Cyanosis (turning blue)
- Cystic fibrosis
MSBP PRESENTATIONS (Continued)

- Dehydration
- Developmental disabilities
- Diabetes
- Diaphoresis (sweating)
- Diarrhea
- Easy bruising
- Eczema
- Edema (peripheral)
- Epistaxis (nosebleed)
MSBP PRESENTATIONS (Continued)

- Esophageal burns
- Feculent vomitus
- Fevers
- Food allergies
- Glycosuria (sugar in urine)
- Headache
- Hematemesis (vomiting blood)
- Hematochezia or melena (blood in stool)
- Hematuria (blood in urine)
MSBP PRESENTATIONS (Continued)

- Hemoptysis (coughing blood)
- Hyperactivity
- Hypernatremia (high blood sodium)
- Hypertension (high blood pressure)
- Hypoglycemia (low blood sugar)
- Hypokalemia (low blood potassium)
- Hyponatremia (low blood sodium)
- Hypothermia (low body temperature)
- Immunodeficiency
– Irritability
– Lethargy
– Leukopenia (low white blood cell count)
– Morning stiffness
– Nocturia (urinating at night)
– Nystagmus (jerking eye movements)
– Personality change
– Polydipsia (drinking a lot)
– Polymicrobial bacteremia (multiple germs in the blood)
Polyphagia (eating a lot)
Polyuria (urinating a lot)
Prolonged sleep
Pyuria (pus in urine)
Rash
Renal failure (acute)
Salt poisoning
Seizures
Septic arthritis (infected joint)
Shock
MSBP PRESENTATIONS (Continued)

- Unconsciousness
- Unimicrobial bacteremia
- Urination from umbilical micropenis
- Urine gravel
- Ventricular tachycardia (fast heart beat)
- Vomiting
- Weakness
- Weight loss

WHO DOES IT?

- Mother in nearly 95% of cases
- Other female caregiver in most of rest
- Rarely the father

- Compared to other forms of child abuse, the perpetrator of MSBP is the most gender specific
MSBP DIAGNOSIS

• Final common pathway: Mother uses a child in a cold calculated way to further her own ends
WHAT MOTHER WANTS YOU TO THINK
WHAT MOTHER REALLY IS
PROFILES

- Of no diagnostic value
- These are not medically or scientifically valid
- These are not legally valid
- One either commits the actions of MSBP or does not
- May be useful in understanding the group of who does this
GROUP CHARACTERISTICS OF MOTHERS

• May be hostile, friendly, or anything else
• Classic description of mothers:
  – Friendly, solicitous
  – The last person you would suspect
  – Often in constant attendance with child
  – Symptoms reduce or disappear when mother gone
GROUP CHARACTERISTICS OF MOTHERS (Continued)

– Common (30 to 40%?) to have a health background

– May be somewhat indifferent to the apparent serious nature of their child’s condition (an observation usually made only in retrospect)

– Psychological tests are usually normal
CAUTION!

- If the mother has Munchausen syndrome herself and commits MSBP, the risk of suicide is high once she is confronted.
- Have a game plan for her psychological help before you confront.
FATHERS

• Several have committed MSBP
• Non-perpetrators:
  – Disproportionately present?
  – Described as “distant”
    • But mothers often bring children for medical care
    • If mother is a health professional, fathers would defer
EXTENDED FAMILIES

• Intergenerational Munchausen syndrome and/or MSBP are known
• Families usually support the mother in such cases
COMMUNITY

- Doctor shopping until one is found who can be fooled
- May move between hospitals and communities to avoid detection
- Lawyers, legislators, media may be enlisted
MSBP: POSSIBLE MOTIVATIONS

• Desire to be in hospitals (ER syndrome?)
• Fooling physicians
• Escaping father
• Attracting father
• Respite care
DIAGNOSIS OF MSBP

• THIS IS A MEDICAL DIAGNOSIS
• Made by pediatricians and family practitioners primarily
• May be made by anyone licensed to practice medicine
• Confirmed by forensic pediatrician
MSBP: ROLE OF PSYCHIATRY/PSYCHOLOGY

• Psychiatrists can make a medical diagnosis of the medical acts/omissions
• Psychologists can not
• NOT the primary disciplines to diagnose MSBP
• Should test for co-existing disorders in mother
MSBP: PSYCHOLOGICAL TESTING

- No test for MSBP
- MSBP is an action, not a personality profile
- If a claim is made by a psychologist that psychological testing rules MSBP in or out -- refer to ethics board for professional sanctions
MSBP: FORMS OF ABUSE

- Always physical abuse
- Always medical neglect
- Almost always emotional abuse
SERIAL MSBP

- About 25 - 35% of cases involve other children in family
- Usually one child at a time
- May not start with first child
- Similar presentation for each child
- Case with multiple children are even more serious (Alexander et al., 1990)
TREATMENT OF MSBP

• Best strategy would probably be immediate termination of parental rights
• Nevertheless, courts often feel their case is different
• A few cases exist where much work may have resulted in an adequate outcome?
PROPOSED TREATMENT OF MSBP (mother)

• Admit all deceptions
• Identify antecedents of behaviors
• Correct antecedents (i.e. re-make into a new person)
• Review her own medical records and have her follow with one physician knowledgeable about Munchausen syndrome and MSBP
• Her therapist must not be fooled
PROPOSED TREATMENT OF MSBP (child)

- If returned home to perpetrator without extensive change by her, chances are about 100% for psychological disorders
- Use only one knowledgeable physician - mother should not be involved in any medical visits, treatment, or decisions
PROPOSED TREATMENT OF MSBP (child)

• Therapist who is knowledgeable about MSBP
• Child is the one who faces risk if returned
PROPOSED TREATMENT OF MSBP (family)

- Family therapy
- Family must genuinely accept the diagnosis
PROPOSED TREATMENT OF MSBP

• Very little data that mental health approach to this form of child abuse is appropriate or that it works
• Legal remedies frequently not sought
• If a case ever was to work out, quick admission by mother and fast reform would be a key requirement
• Would take several years at a minimum
WHEN YOU GET A CASE

• It is a black hole -- absorbing most or your energy and thoughts
• Warn your family you will not be as “available” for several weeks
• Clear your professional and social calendar as much as possible
• Work with a team -- you will have second doubts, frustrations, and at least some failures
STAFF RESPONSES

• Look after the mental health of your staff
• Give them time
• Have them talk about it later - perhaps give a lecture to others
TAKE CARE OF YOURSELF
INVESTIGATION AND PROSECUTION OF MSBP
MUNCHHAUSEN SYNDROME BY PROXY

- Attack is on the concept and the doctors making this diagnosis
- Attack is made by mental health defense witnesses - who usually are not entitled to make such a diagnosis
- Increasingly the hospitals and doctors are sued for making this diagnosis -- so far not successfully
COURTROOM ARGUMENTS

• **It’s not a real diagnosis**
  – It has different names
  – Does not meet legal standards for expert testimony

• **Doctors gone wild**
  – Doctors say MSBP when they don’t know what’s really wrong
  – If real, it is over-diagnosed

• **Videotape is the gold standard**
A REAL DIAGNOSIS?

• Formally described since 1977 (older than AIDS, Lyme disease)
• Hundreds of articles in literature
• Accepted under medical codes
• Accepted by medical organizations
• Accepted by most, if not all, states
• Accepted in federal court
A REAL DIAGNOSIS?

• Whether PCF, MSBP, or MBP -- physicians not confused that it is child abuse
• Reproducible - doctors know it when they see it (eventually)
• Probably under-called
• Not a diagnosis of exclusion
• Profiles not used by forensic pediatricians
DOCTORS GONE WILD?

• Claim: doctors say MSBP when they don’t know what’s really wrong
  – Not a diagnosis of exclusion
  – There are enough “negative” consequences to physicians in making this diagnosis that they would be reluctant to make it unless necessary

• Claim: If real, it is over diagnosed
  – Not a diagnosis of exclusion
  – Rare conditions in medicine are under diagnosed!

• Profiles not used by forensic pediatricians
VIDEOTAPE

• Useful in the minority of cases where conditions permit
  – Won’t demonstrate a lie
  – Might not perform on camera
  – Absence of performance may be argued as showing “innocence”
  – No stronger evidence than strong medical conclusions (e.g. symptoms improve when mother is gone; impossible coincidences, etc.)
VIDEOTAPE

• Check with hospital attorney first - may be liability issues
• Need constant monitoring lest a fatality occur
• If enough concern to use camera, does this meet the reporting statute? If clear about the diagnosis, who needs the camera?
• Good idea for large academic hospitals
COURTROOM

- The child’s welfare or the perpetrator, not MSBP, should be on trial
- Emphasize that it is child abuse - MSBP is only one form and helps us understand some of how this happens
- In cases where the MSBP diagnosis may be an awkward fit, it is best to deal with it as neglect
MSBP = PCF x FDP

• GOOD LUCK !!
MSBP:
ISSUES
SCOPE OF MSBP

• Educational MSBP?

• Over diagnosed?
PROACTIVE APPROACHES

• Insurance companies/Medicaid searches
• What can hospitals do proactively?
• Media’s role?
EDUCATION

- Educating judges
- Educating prosecutors
- Educating “high risk” physicians and nurses
LEGISLATION

• Combating Frye/Daubert challenges
• Immediate TPR?
MSBP QUIZ
QUIZ

• Which of the following is not a defining characteristic of MSBP?
  A. The perpetrator makes up a history of the child having a medical condition that is not true
  B. The child is brought in for medical care
  C. The deception continues to be told to the medical provider
  D. The symptoms cease when the child is taken away from the perpetrator
QUIZ

• Which of the following is FALSE?
  A. Females constitute at least 95% of the perpetrators of this mental health condition
  B. Most victims are preverbal
  C. The perpetrator tends to allege the same medical condition from the one child to the next
  D. Pediatric Condition Falsification (PCF) is the abuse portion of MSPB
QUIZ

• Which of the following is FALSE?
  A. MSPB is almost always a form of emotional abuse
  B. MSBP is rarely physical abuse by proxy
  C. MSBP is always medical neglect
  D. MSBP victims are nearly always psychologically abnormal if left with the perpetrator (even if the overt MSBP stops)
THANKS!
MORE ON THE INVESTIGATION OF MSBP
IMPORTANCE OF INVESTIGATION

• Pediatric Condition Falsification (PCF)
  – Occasionally, may have a “smoking gun” (e.g. poison)
  – Usually it is a pattern that does not make medical sense
  – May be seen across multiple children

• Factitious Disorder by Proxy
  – May have multiple motives
  – Pattern may illuminate the “why” of PCF
WHO DOES THE INVESTIGATION?

• Medical opinion is the bottom line
• Doctors are terrible at gathering all the records
• Significant help in obtaining records and putting them together:
  – CPS
  – Police
  – Nurse
  – Prosecutor’s office
FIRST CONTACT
FIRST CONTACT

• Call to CPS almost always comes from medical personnel
• Occasionally a family member may call
• Establish the who the caller is (unless anonymous) and what their specific concerns are:
  – What abuse are they seeing?
  – What makes them think MSBP?
FIRST CONTACT

• Find out who else has MSBP concerns and why
• Is this a suspicion or a diagnosis?
• Try to get the SPECIFICICS as to why PCF is suspected or diagnosed
ASSEMBLING THE TEAM

- Key members:
  - Physicians and other medical personnel who treated the patient
  - CPS. Sometimes a CPS specialist is available.
  - Police
  - Prosecution (from the beginning!)
  - Forensic pediatrician
ASSEMBLING THE TEAM

• Forensic Pediatrician
  – Experience with all forms of child abuse (PCF may have other forms of co-existing abuse)
  – Specific experience and expertise with PCF
  – Will need to review all the available medical records
  – May need to consult with other specialists
ORGANIZING:
INFORMING THE MOTHER

- DON’T
- Tipping off the mother may end cooperation needed to obtain records, etc.
- It may intensify the danger to the child
- The mother may flee
ORGANIZING: INFORMING THE MOTHER

- Conflict of CPS rules about informing the subjects of an investigation vs. police/prosecution imperatives to gather information before making an arrest/charge
- May need a special rule/court intervention for CPS
ORGANIZING: GETTING RECORDS

- Basically: try to get all medical records of the child
- Ask the mother for permission to contact original sources – don’t just accept her versions of the records
  - They may be selective
  - They may be edited
  - They may be forged
ORGANIZING:
GETTING RECORDS

• Try to obtain:
  – School records if the child is old enough
  – Mother’s own medical records

• Consider obtaining:
  – Veterinarian records for any pets
ACTIVE INTERVENTION: HOSPITAL SURVEILLANCE

• Check with hospital attorney, prosecutor

• Define:
  – goals
  – monitoring process
  – endpoint
  – possible complications and interventions
ACTIVE INTERVENTION: HOSPITAL SURVEILLANCE

- Requires a properly equipped room for covert surveillance
- Protocols are best
- Hospital admission form usually covers any intervention of this type – modify it if needed for future cases
ACTIVE INTERVENTION: HOSPITAL SURVEILLANCE

• Best only for academic hospitals
• Needs complete monitoring of the “public areas” (not the bathroom)
• Camera quality is usually poor
  – Multiple cameras?
  – Infrared camera?
ACTIVE INTERVENTION: HOSPITAL SURVEILLANCE

• Advantage:
  – May catch someone in the act (evidence enhancing)

• Disadvantages:
  – Numerous
TIMELINES

- Often the most important investigative tool
- Requires much work, much attention to detail
- Concentrate on raw data instead of just conclusions
- Often need medical review of the raw data – key medical issues may fail to be realized by non-medical investigators
TIMELINES

• Chronologically arrange columns for mother and child(ren). Look for unnatural incidence patterns.

• Example.
FINALIZING THE DIAGNOSIS

• Forensic pediatrician to review records and report to team
• On-going pursuit of additional records common, especially if child might have lived in other locations. This need not defer a sufficient diagnosis.
ESTABLISHING FACTITIOUS DISORDER BY PROXY

- There is an “unreasonable” need by professionals to discover a perpetrator’s motivation
- Failure to find a motivation does not change whether child abuse occurred
- May be multiple motivations other than attention seeking
ESTABLISHING FACTITIOUS DISORDER BY PROXY

- Team may have idea of motivation.
- Review of medical records by forensic pediatrician may establish a motivation.
- Psychological/psychiatric interviews of mother may suggest one or more motivations. However, mother may not cooperate.
INVESTIGATION: SUMMARY

• Be persistent
• Work with a team for help and emotional support
• Use timelines!
• Avoid conclusions in the medical records – concentrate on the data