Journal of Family Violence, Vol. 3, No. 2, 1988

Munchausen Syndrome by Proxy: Covert Child Abuse

Doris J. Manthei,[1] Robert L. Pierce,[2] Robert J. Rothbaum,[3] Uwe Manthei[4] and James P. Keating[3]

Munchausen syndrome by proxy has received considerable attention in the medical literature. These reports, however, usually focus on descriptions of the medical aspects of the often bizarre patterns of parent-child behaviors which characterize this syndrome. Despite the destructiveness of these behaviors, few attempts have been made to examine the syndrome from the perspective of a variant form of child maltreatment. In light of this, the authors will: (1) define and briefly summarize the history of the syndrome; (2) review the literature focusing particular attention on the definition of the syndrome, pinpointing its relationship to child abuse; (3) provide case studies of the syndrome to illuminate the interplay of medical and psychosocial aspects of the problem; and (4) suggest methods of intervention.

KEY WORDS: covert child abuse; factitious illness; Munchausen syndrome by proxy; social work intervention.

INTRODUCTION

Within the last 2 decades, the plight of maltreated children has become a topic of major concern. While statistics on the subject are, at best, sketchy, they do reveal that some parents and other trusted adults who care for our

[1]Department of Social Services, Children's Hospital at Washington University Medical Center, 400 S. Kingshighway, St. Louis, Missouri 63110.
[2]George Warren Brown School of Social Work, Washington University, St. Louis, Missouri 63130.
[3]The Edward Mallinckrodt Department of Pediatrics, Washington University School of Medicine and the Division of Gastroenterology and Nutrition, Children's Hospital, St. Louis, Missouri 63110.
[4]The Edward Mallinckrodt Department of Pediatrics, Washington University School of Medicine and the Division of Allergy and Immunology, Children's Hospital, St. Louis, Missouri 63110.

0885-7482/88/0600-0131$06.00/0

young are victimizing children in ways that sometimes go beyond one's imagination. These acts range from the most brutal of beatings that often cause serious injuries or death, to acts that are less abrupt, more covert, but are just as lethal. Kempe (1975) was able to identify eleven of these acts, labeling them "uncommon manifestations" of the battered child syndrome.

The purpose of this paper is to examine more closely, yet another uncommon parent-child interaction – Munchausen syndrome by proxy – whose characteristics resemble those of the battered child syndrome (Meadow, 1977). Although reports of Munchausen syndrome by proxy do appear in the medical literature (Rosen *et al.*, 1983; Meadow, 1985; Malatack *et al.*, 1985), few reports of the phenomenon appear in the literature of other helping professionals (see, for example, Jones, 1986). This omission is critical since case studies of Munchausen syndrome by proxy continuously reveal the interdisciplinary features of the problem. In light of this, the paper will define Munchausen syndrome by proxy; briefly discuss the historical context in which the parental behaviors occur; provide case illustrations to identify common features of the syndrome; and finally, using a social work perspective, several case management techniques will be offered.

THE DEFINITION AND HISTORY OF MUNCHAUSEN SYNDROME BY PROXY

The somewhat cumbersome title, Munchausen syndrome by proxy, derived its name from the original Munchausen syndrome, which was first described by Asher (1951). It can be defined as a phenomenon in which a person produces symptoms of an illness in oneself and fabricates evidence, including medical and social histories, in order to persuade health care personnel to perform a variety of medical interventions and procedures. The name, Munchausen syndrome, is borrowed from Baron von Munchhausen of Hannover, who in the 18th century became known as a great storyteller, traveling from place to place telling fantastic tales.

Munchausen syndrome by proxy was first described by Meadow (1977). An operational, rather than conceptual, definition of Munchausen syndrome by proxy allows for a clearer picture of what actually happens. This pediatric variant typically involves mothers who produce symptoms of illness in their children and then fabricate medical evidence in an attempt to prove that a disease actually exists. Social histories are fabricated or exaggerated, thus the connection to the storyteller Munchhausen.

As the medical staff works feverishly to disentangle the mother's story about the child's illness, the child may be put through a series of painful,

and even dangerous medical procedures and treatments. The staff does all it can to validate the mother's story and to find an illness, where none exists.

Observations from case studies of Munchausen syndrome by proxy reveal that there may well be common manifestations or symptoms of the syndrome (Guandolo, 1985; Meadow, 1985). For example, some of the most common symptoms induced in children by their mothers are bleeding, fever, vomiting, diarrhea, rashes, seizures, and lethargy (Fleisher and Ament, 1977; Meadow, 1977; Ackerman and Stroebel, 1981). At times, the presenting features of these illnesses can be life-threatening and may include cardiorespiratory arrest (Rosen *et al.*, 1983), near sudden infant death syndrome (Berger, 1979; Geelhoed and Pemberton, 1985), and profound hypoglycemia (Pickering, 1968). Because of the complicated nature of the symptoms, including their complex histories, it is often necessary to perform multiple laboratory tests, which often fail to elucidate the cause of the illness. In addition, laboratory specimens supposedly taken from the child, may be altered by the mother (Waller, 1983; Meadow, 1984). For example, mothers have been known to mix water, sugar, stool, or their own blood with the child's urine in order to fabricate the symptoms of an illness. In other situations, mothers may induce serious symptoms and laboratory abnormalities by administering medication by mouth or by injection to the child (Dine, 1966; Pickering *et al.*, 1976; Hvizdala and Gellady, 1978; Watson *et al.*, 1979); blood-letting from intravenous catheters (Malatack *et al.*, 1985); or, smothering a child until he/she passes out (Rosen *et al.*, 1983).

In spite of the variability of the presenting illness, and the complexity of their histories, the following common themes have emerged, which can be used to alert health professionals (Meadow, 1977, 1982):

1. unexplained persistent or recurrent illness in a young child;
2. discrepancies between clinical findings and histories provided by the mothers;
3. symptoms which are not explainable by experienced clinicians or specialists;
4. treatments that are not tolerated, such as intravenous infusions which keep coming out, or an inability to tolerate any prescribed drug;
5. diagnosis of a very rare disorder in a generally healthy appearing child;
6. seizures that do not respond to carefully administered anticonvulsants;
7. children who are alleged to be allergic to a great variety of foods and drugs;
8. symptoms which do not occur when the child is away from the mother;

9. any mother who is particularly, or noticeably attentive, and who refuses to leave the hospital;

10. any mother who, despite her child's fearful problems, does not seem quite as worried as the medical staff;

11. families in which sudden unexplained infant deaths have occurred;

12. families containing many members alleged to have different, serious medical disorders.

Based on clinical observations of the authors, another warning signal is:

13. the unexplained presence of pharmaceuticals in the child's blood, urine, stool, or stomach fluid.

Recognizing these characteristics is a difficult task and is often delayed because of the "concerned attitude" exhibited by the child's parent. Because of this presumed interest, the sign of a good mother, a trusting relationship begins to build between the medical staff and the parent. In fact, mothers perpetrating the hoax are often eager to communicate various facts about the illness, repeat histories, and easily engage the involved professionals in, what appears to be, an open and honest patient-physician relationship. Because the mother is so convincing, the physician uses his/her probing instinct to try and corroborate the patient's history with objective scientific data in order to confirm the presence of an illness.

CHILD CHARACTERISTICS

It has been argued that victims of Munchausen syndrome by proxy are typically under nine years of age (Meadow, 1982; Jones, 1986). In all likelihood the syndrome would first be manifested in small children and infants; however, if the child has been affected for a long time, he/she may not be able to recognize the maternal manipulations as abnormal behavior. For this reason, and for the ones already discussed, recognition of the syndrome is often delayed. The desire to please their parents may make some children conscious or unconscious collaborators in their own abuse. This is similar to other forms of abuse where a child wants to remain with his/her parent no matter how abusive that parent may be. By adolescence, the patient involved in Munchausen syndrome by proxy is usually the main perpetrator of the hoax, changing the diagnosis to the more classical Munchausen syndrome. Thus, an intergenerational cycle may develop. As in physical child abuse, often only one child in a family is a victim. For example, Kempe and Helfer (1968) refer to the "special child" as being the most vulnerable to abuse. In the case of Munchausen syndrome by proxy, there is also a tendency for one child to carry the family's burden of pathology. Waller (1983) suggests that the child's fabricated illness is an expression of the parent's need to be sick.

Parental Characteristics

Although documented cases of Munchausen syndrome by proxy typically involve a mother as fabricator, it is clear, from a systems perspective, that all family members play a role (even of silence) in the deception. The fathers have consistently been found to have a low profile in the family. They often work long hours in a demanding job and are uninvolved in or unaware of the child's illness. This, in turn may have an effect on the marriage. For example, Meadow's (1977, 1985) and Waller's (1983) documented cases of the syndrome reveal troubled husband/wife relationships, including problematic family relations that tend to improve due to the distraction a child's illness creates.

Consistent characteristics of mothers involved in Munchausen syndrome by proxy include (Dine, 1966; Rogers *et al.*, 1976; Meadow, 1977, 1982, 1984; Fleisher and Ament, 1977; Guandolo, 1985):

1. histories of numerous illnesses, often consistent with a diagnosis of Munchausen's syndrome;
2. deception, lying, and denial when confronted with the facts of the child's illness;
3. overprotectiveness and devotion to the child;
4. close relationships to the hospital staff;
5. previous nursing training or medical sophistication.

Recognizing Munchausen syndrome by proxy as a form of child abuse is difficult since mother's caring and concerned appearance for her child is taken as an indication of a "good" parent. A caring mother, who presents her child voluntarily, is refreshing for a staff member to see when one spends a great deal of time with mothers who may not bring their children in voluntarily and who may not seem concerned, or appreciative, of the medical and social work staff.

Unlike the more common forms of child abuse, parents inflicting Munchausen syndrome by proxy on their children seem to be addicted to medical care and committed to outwitting the physician. Health care professionals are often thought of as caring and willing to provide attention to those seeking their services. These mothers often have a great desire to be cared for. Medical staff provide these apparently devoted mothers with attention and are responsive to concerns. Contrary to physically abusive parents, these mothers are initially viewed with admiration and respect for having cared for such an "ill" child. At the same time the perpetrators seem to get a vicarious thrill from being able to "stump" the physician. Meadow (1982) found that most mothers he studied had prior nurses' training, but usually failed to complete their training. It is possible that these mothers are trying to defeat the system that defeated them. In addition, there may be a close link between wanting to nurse and wanting to be nursed. One must wonder as the

general public becomes more medically sophisticated if this type of abuse will become more common.

CASE PRESENTATIONS

We will present four cases to illustrate the context of the syndrome. Examples of difficulties encountered by the health care professionals are provided.

Case 1: A 4-year-old previously healthy girl developed fever, vomiting, and diarrhea that persisted for a 4-month period. She also had a history of a seizure disorder that did not improve with administration of phenobarbital. In spite of the almost continual symptoms, she appeared generally well. During her eight hospital admissions, specialists in pediatrics, infectious disease, child neurology, rheumatology, and pediatric gastroenterology contributed to her evaluation. She underwent extensive testing, including blood drawing, lumbar puncture, X-ray studies, proctoscopy, and colonoscopy. A diagnosis of inflammatory bowel disease was made. She failed to improve on the usual treatment regimen of sulfasalazine and steroids and required long-term intravenous nutrition therapy. Four months into her illness, a specimen of gastric contents revealed the presence of syrup of Ipecac (an agent to induce emesis). Chronic administration of this agent could explain all of her symptoms.

The child's parents were divorced and the father had limited visitation. The mother, a working registered nurse, had stayed with the child throughout her hospital course. She had not objected to any proposed procedure or test and never appeared frustrated at the physicians' inability to diagnose or effectively treat her child. When confronted with the finding of Ipecac in her daughter's stomach, the mother denied having administered it. Despite her nursing background, she denied knowing about syrup of Ipecac. Following this confrontation, and with separation from the mother, the child became entirely well. The child's gastrointestinal complaints disappeared, and she resumed a regular diet.

Case 2. A 4-year-old girl was admitted with diarrhea and dehydration ten times over a one year period. She underwent extensive evaluations including exploratory laparotomy, to discern the etiology of the diarrhea. On her final admission, she experienced life-threatening hypokalemia and muscle weakness. Phenolphthalein (a laxative) was detected in multiple urine samples from the time of her last admission and for the succeeding 3 days. When confronted with the findings, the mother denied any involvement; however, from that time on, the diarrhea resolved and never recurred over 2 years of follow-up care.

This child's caretakers were foster parents. The mother was a nursing supervisor, and the father was a farmer.

Case 3: Many children in this large family reportedly suffered from seizures. The mother was trained as a nurse but was not able to work due to "multiple sclerosis and gynecologic cancer." Direct communication with mother's physicians failed to substantiate either diagnosis. Seizures were reported in each child through letters written by the mother to the neurologist and delivered by the father or the mail. Five of seven children, aged 9 to 15, were evaluated by pediatric neurologists at two Children's Hospitals. All had been prescribed phenobarbital and dilantin; subtherapeutic serum concentrations were noted on several occasions. Extensive evaluations including blood and urine analyses, X-rays, electroencephalograms failed to document any underlying abnormalities. Medications were gradually withdrawn. The mother reported further seizures in her letters, but none were witnessed by medical professionals. The involved physicians expressed the opinion that the family maintained the guise of the seizure disorders to obtain medical benefits and disability support. The family changed their source of medical care when confronted with this charge.

Case 4: A 20-day-old white boy was brought to the emergency room by his mother because "he stopped breathing and had turned blue." Communication with the apparently deaf mother was established with the help of an interpreting social worker who had accompanied the mother to the hospital. Soon after the social worker left, the mother started to communicate with normal hearing and verbal skills. The history she gave included that two of the patient's three half-siblings had previously been evaluated for "near miss sudden infant death syndrome" (SIDS) in other hospitals and had required long term monitoring (16 months in one case). The admission examination of our patient revealed no abnormal findings. The subsequent evaluation documented no serious illness. During 6 days of observation, no episode of apnea was noted. The patient was discharged on a home monitoring device after an audiogram had confirmed normal hearing in the mother.

Twelve days later the patient was readmitted because the mother reported another episode of apnea with cyanosis. Emergency medical technicians called to the scene had found the infant to be mottled but with normal respiratory and heart rate and to respond readily to oxygen by mask. The physical examination upon hospital arrival again was normal. During the following eleven days of observation, no apneic spells were noted, and a more extensive evaluation failed to uncover an etiology for the reported episodes.

In cooperation with medical and social services from three states, the hospital staff gathered the following additional information: The mother had on many occasions presented the other three children to different hospitals with similar undocumented histories. Subsequent evaluations had neither con-

firmed the mother's accounts of the events nor shown any abnormalities which could cause SIDS. It was thought that all three children were endangered by the nomadic lifestyle of the mother and they were placed in permanent adoptive environments in different states. Confronted with these facts, the mother denied ever having manipulated the health of her children; however, she did agree to foster care placement of this, her youngest child since again her living conditions were an unacceptable discharge environment for the patient. Follow up after 14 months revealed that the now adopted child is doing well and had never had another episode of apnea.

IMPLICATIONS FOR TREATMENT

Because of the multiple medical and psychosocial dynamics of Munchausen syndrome by proxy, the authors believe it is important for health care professionals to recognize and respect the interdependency of professional roles that focus on health care. As Clarke *et al.* (1986) noted, this comprehensive approach to care recognizes the necessity of each discipline's "contribution to the bio-psychosocial framework" of the patient (p. 3).

Clearly, the physician has the responsibility and the knowledge base to make the final diagnosis of Munchausen syndrome by proxy. A physician may include this disorder in the differential diagnosis, but he/she will traditionally strive to rule out true somatic disorders beyond the shadow of a doubt. Parallel to that effort, an in-depth social history and assessment of relationships between family members, performed by a social worker knowledgeable of this particular syndrome, can identify personality and family patterns consistent with Munchausen syndrome by proxy.

The strategy of close collaboration has the dual advantage of: (1) gathering a wider knowledge base about the patient's circumstances, and (2) facilitating decisions about patient care that "take into account what other providers can realistically do" to facilitate the patient's recovery (Nason, 1983, p. 27). For example, a diagnosis of Munchausen syndrome by proxy without the social worker's psychosocial history of the patient's and/or mother's experiences in and outside of the hospital setting poses several problems. A crucial aspect of the syndrome is the manipulative behavior of the child's mother. Interviewing the mother and focusing on issues beyond hospitalization of her child should reveal clues to her behavior. Exploring with the mother issues related to her perceptions of her self as "mother," "wife," "friend," and "community member" would help determine the degree of isolation she is experiencing. Moreover, a social worker's social history and assessment would be helpful in the event a decision must be reached about whether or not to pursue action to have the child removed from the home.

Given the examples above, there is no doubt that any attempt to generate a set of widely accepted case management strategies will be just as difficult

to develop as a diagnosis. Answering questions about how, when and where to intervene beyond the medical arena have not been fully explored. However, because the syndrome is a recognized form of child abuse, case management strategies must flow from established reporting laws. Thus, the authors propose that the following recommendations be viewed as a guide for case management.

1. Following diagnosis, a hotline call must be made, and the case should be closely monitored throughout the patient's stay in the hospital.
2. While monitoring, if the child's life is endangered further, steps should be initiated to temporarily remove the child from his/her home.
3. If the child is removed from the home the mother's access to the child must be monitored. There should be no unsupervised visits between the mother and the child.
4. A strong appeal should be made to the particular state agency involved in child abuse reporting and case management to allow the medical social worker to serve as a consultant to the primary caseworker. This is necessary to help minimize the chances that the mother will continue to abuse the child and seek help from another medical environment.
5. Because of the medical aspects of these cases, involving an organization such as the Visiting Nurse Association may prove beneficial since a registered nurse could follow up on medical recommendations made by the hospital and monitor the situation. In addition, a nurse could also provide the mother with the nurturance she is seeking from the medical environment.
6. Services extended to the family should include education, parenting skills, and therapy (individual and family) for the duration of the crisis.
7. All children in the family should be continually monitored since inducing an illness in another child is quite likely.

Jones et al. (1986) suggest that the removal of the child from the home is optimal. Although this may be valid in some cases, the authors feel that to move in this direction may be premature. To pursue removal so quickly assumes that the mother cannot be reeducated and that the family system cannot learn healthy parenting techniques under closely supervised conditions. On the contrary, a number of studies have shown success in training abusive parents in child-rearing skills (Peed *et al.*, 1977; Denicola and Sandler, 1980; Wolfe and Sandler, 1981).

In our anger and frustration about the occurrence of such abuse, let us not forget that the mother and entire family system needs treatment, and it is our responsibility to make that treatment, not punishment, available.

REFERENCES

Ackerman, N., and Stroebel, C. (1981). Polle syndrome: Chronic diarrhea in Munchausen's child. *Gastroenterology,* 81(6): 1140-1142.

Asher, R. (1951). Munchausen's syndrome. *Lancet* i: 339-341.
Berger, D. (1979). Child abuse simulating "near-miss" sudden infant death syndrome. *J. Pediatr.* 95(4): 554-556.
Clarke, S., Neuwirth, L., and Bernstein, R. (1986). An expanded social work role in a university hospital–based group practice: Service provider, physician educator, and organizational consultant. *Social Work Health Care* 11: 1-17.
Denicola, J., and Sandler, J. (1980). Training abusive parents in child management and self-control skills. *Behav. Ther.* 11: 263-270.
Dine, M. (1966). Tranquilizer poisoning: An example of child abuse. *Pediatrics* 36(5): 782-785.
Fleisher, D., and Ament, M. (1977). Diarrhea, red diapers, and child abuse. *Clin. Pediatr.* 17(9): 820-824.
Geelhoed, G., and Pemberton, P. (1985). SIDS, seizures, or esophageal reflux? Another manifestation of munchausen syndrome by proxy. *Med. J. Austr.* 143: 357-358.
Guandolo, V. (1985). Munchausen syndrome by proxy: An outpatient challenge. *Pediatrics* 75(3): 526-530.
Hvizdala, E., and Gellady, A. (1978). Intentional poisoning of two siblings by prescription drugs. *Clin. Pediatr.* 17(6): 480-482.
Jones, J., Butler, H., Hamilton, B., Perdue, J., Stern, H., and Woody, R. (1986). Munchausen syndrome by proxy. *Child Abuse Neglect* 10: 33-40.
Kempe, C. (1975). Uncommon manifestations of the battered child syndrome. *Am. J. Dis. Child.* 129: 1265.
Kempe, C., and Helfer, R. (1968). *Helping the Battered Child and His Family,* J. B. Lippincott, Philadelphia.
Malatack, J., Wiener, E., Gartner, J., Zitelli, B., and Brunetti, E. (1985). Munchausen syndrome by proxy: A new complication of central venous catherization. *Pediatrics* 75(3): 523-525.
Meadow, R. (1977). Munchausen syndrome by proxy: The hinterland of child abuse. *Lancet* ii: 343-345.
Meadow, R. (1982). Munchausen syndrome by proxy. *Arch. Dis. Child.* 57: 92-98.
Meadow, R. (1984). Factitious illness—The hinterland of child abuse. In Meadow, R. (ed.), *Recent Advances in Pediatrics,* No. 7, Churchill Livingstone, Edinburg.
Meadow, R. (1985). Management of munchausen syndrome by proxy. *Arch. Dis. Child.* 60: 385-393.
Nason, F. (1983). Diagnosing the hospital team. *Social Work Health Care* 8: 25-45.
Peed, S., Roberts, M., and Forehand, R. (1977). Evaluation of the effectiveness of a standardized parent training program in altering the interaction of mothers and their noncompliant children. *Behav. Mod.* 1(3): 323-349.
Pickering, D. (1968). Neonatal hypoglycemia due to salicylate poisoning. *Proc. Roy. Soc. Med.* 61: 40.
Pickering, D., Moncrieff, M., and Etches, P. (1976). Non-accidental poisoning and child abuse. *Brit. Med. J.* 1: 1210-1211.
Rogers, D., Tripp, J., Bentovim, A., Robinson, A., Berry, D., and Goulding, R. (1976). Non-accidental poisoning: An extended syndrome of child abuse. *Brit. Med. J.* 1: 793-796.
Rosen, C., Frost, J., Bricker, T., Tarnow, J., Gillette, P., and Dunlavy, S. (1983). Two siblings with recurrent cardiorespiratory arrest: Munchausen syndrome by proxy or child abuse? *Pediatrics* 71(5): 715-720.
Waller, D. (1983). Obstacles to the treatment of munchausen by proxy syndrome. *J. Am. Acad. Child Psychiatr.* 22(1): 80-85.
Watson, J., Davies, J., and Hunter, J. (1979). Non-accidental poisoning in childhood. *Arch. Dis. Child.* 54: 142-151.
Wolfe, D., and Sandler, J. (1981). Training abusive parents in effective child management. *Behav. Mod.* 5(3): 320-335.