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DENIAL IN MUNCHAUSEN SYNDROME BY PROXY: THE CONSULTING PSYCHIATRIST'S DILEMMA

MARC D. FELDMAN, M.D.
University of Alabama Medical Center, Birmingham

ABSTRACT

Objective: The purpose of this review, which also includes the report of a new case, is to discuss the pervasive denial of responsibility among individuals who have engaged in Munchausen syndrome by proxy (MSBP) behavior. In MSBP, a caretaker (almost always the mother) fabricates or induces illness in her child; she then presents the child for medical treatment, disclaiming knowledge of the etiology of the illness. *Method:* Literature searches of several computer databases were performed, and ninety-two citations dealing with MSBP, culled from medical, legal, and lay publications, were examined for descriptions of caretakers' responses to being confronted with the allegation of MSBP. Thirty-four citations contained relevant material, which was combined with observations from cases in which the author has served as a consultant. *Results:* Caretakers engaging in MSBP consistently deny any role in the dissimulation, even when confronted with compelling evidence. This denial complicates management, though intervention must focus on ensuring the safety of the child regardless of the caregiver's response. *Conclusions:* Techniques sometimes advocated in factitious disorders in general may be useful in stopping the abusive behavior; however, no consistently effective strategy for overcoming denial in MSBP has yet been described.
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Key Words: Munchausen by proxy; factitious disorders; Munchausen syndrome; child abuse; consultation-liaison psychiatry; forensic psychiatry; factitious disorder by proxy

INTRODUCTION

Case 1

A thirty-year-old unemployed nurse was criminally charged with repeatedly suffocating her two-year-old son so she could then resuscitate him and receive accolades as a "heroine." The child had been hospitalized twenty times during

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> his life, and the mother had made continual rescue calls to paramedics. No medical etiology was ever identified, and the child had been free of medical problems since placement in foster care. A daughter had died of unexplained apnea four years earlier. Another child for whom the woman had cared had also suffered apnea while alone with her, and the woman had received a "Good Neighbor Award" and laudatory newspaper coverage for "keeping her head" in that case. The woman refused a plea bargain on the current child endangerment charge, insisting throughout the trial that she had never engaged in any abusive behavior. Nonetheless, she was convicted and incarcerated. Despite the evidence against her and the fact that, as a precondition to early release, the parole board has sought her acknowledgment that she had induced apnea, she continues to deny that any abuse occurred [1, 2].

The term "Munchausen syndrome by proxy" (MSBP) was coined by Dr. Roy Meadow [3] to refer to cases in which a caretaker, usually the mother, falsifies illness in her child through the simulation and/or production of illness. She then presents the child for medical treatment while disclaiming knowledge of the origin of the problem [4]. Risks to the health of these children stem from diagnostic maneuvers and treatments as well as actual illnesses induced by the parent through behaviors such as suffocation or injections with contaminants. The alarming consequences of MSBP have been summarized by Rosenberg, who reports a short-term morbidity rate of 100 percent, long-term morbidity rate of 8 percent, and mortality rate of 9 percent [4].

Researchers have recognized that individuals engaging in MSBP almost invariably deny having engaged in this behavior even when confronted with incontrovertible evidence. MEDLINE, CATLINE, AVLINE, LEXUS, and NEXUS searches from 1977 (with Dr. Meadow's first use of the term) to the present uncovered no articles, books, or other items dealing principally with the role of denial in MSBP. Similarly, a computer search for the years 1966 to 1977 was unrevealing; during this time, there were professional papers recognizing parental induction of illness in children but these earlier publications did not use the term "MSBP" and also did not comment on the so-called "denial response." This article will focus on this pervasive denial of responsibility and its implications, describing a previously-unreported case of Munchausen syndrome by proxy as well.

Authors differ in their initial approaches to MSBP once it has been detected. The intensity with which confrontation of the offending parent has occurred and the amount of supporting evidence produced have varied considerably from case to case. Whether a gentle suggestion has been made [5], previously-concealed medications or medical equipment discovered and displayed [6], or definitive evidence from video surveillance presented [7], categorical denial is extremely common [8]. Severe agitation, psychosis, or suicidal reactions in response to direct confrontation have been reported in selected cases [7, 9]. However, as Waller states, typically:

> [t]he initial reaction on the part of the parent is angrily to deny any wrongdoing. In the case we studied, this denial by the mother was so convincing that for a moment the physicians involved in the case wondered if their laboratory tests were accurate [10, p. 83].

Meadow [11] downplays the role of anger but agrees with the tenacity of the denial, which the fathers tend to bolster [12]. Unless legal mechanisms to prevent it are in place, immediate discharge of the child against medical advice is common [13]. Despite her powerful denial, the mother may find that she has irretrievably lost the secondary gains associated with MSBP; further efforts by the parent to make the affected child appear ill may be met with disbelief rather than with nurturance and sympathy. This loss of secondary gain may prove potent enough for the behavior to cease. However, without definitive intervention the risk remains that the MSBP parent will relocate to an area where she is unknown and the dissimulations can be successfully repeated. If she remains in the same locale, a different risk may emerge: the child may not receive appropriate treatment for serendipitous illnesses due to the doubts of medical practitioners about their validity [14].

Only rarely have mothers readily acknowledged their role in MSBP, though some degree of admission may be likelier in cases in which the alleged abuse is comparatively mild [15-17]. Eventually, sometimes years after initial confrontation, they make indirect admissions with statements such as, "I guess I had a nervous breakdown" [11]. In many cases, the parent does not appear to be consciously lying while offering the denial. Instead, her thinking may best be characterized as "quasi-delusional" [18]; that is, while lacking a formal thought disorder, she may come to believe, at least intermittently, that her child has a primary, not induced, illness. In scattered cases, mothers will admit that they must have harmed their children based upon the compelling evidence but that they have no recollection of having behaved in this way [19]; these individuals may have had episodes of authentic dissociation. Other mothers will claim to have induced illness in the child "just this one time" [20], allegedly intending only that the staff heighten its vigilance to the child's medical status [9]; in these situations, the mother denies neither the evidence nor her culpability, but instead minimizes the seriousness of the possible consequences of the abuse. Additional responses to confrontation include attempting to change the subject; expressing utter perplexity about the allegations; attempting to disprove the charges by focusing on minor events the doctor cannot explain; offering implausible or inconsistent accountings; or wondering aloud, "What if I *had* done it?", perhaps tacitly acknowledging guilt [11, 12, 21].

Psychodynamic hypotheses about the "denial response" may inform the psychiatric consultation. One of these hypotheses would hold that, in deceiving health care professionals, the MSBP mother unconsciously accomplishes the primary task of deceiving herself into believing that the sympathy and attention are warranted. A second hypothesis involves projective identification. Through this defense mechanism, the mother projects onto her child her unconscious

longings for nurturance, then ensures—through her own indefatigable attention as well as that of caregivers and others—that the child receives the nurturance she herself so desperately craves. Third, in cases involving conscious deception, denial may be emphatic in an effort to block disclosure of motivations such as manipulating or exacting retribution from others.

It may seem surprising that even medical personnel sometimes resist the notion that the parent is the cause of the child's illness [10, 11]. As reported in one case,

> [t]here was great reluctance on the part of medical and nursing staff to accept that a parent could be so skillfully deceitful. Part of our reluctance stemmed from a wish to think well of this parent, especially when she appeared so attentive to her child [7, p. 222].

Skepticism and disbelief have also been common reactions within the legal system, as lawyers and judges struggle to understand how a parent could simultaneously make her child appear ill and seek the best possible medical care [10, 12]. This struggle and the tenacious parental denial are illustrated by the following recently-adjudicated case.

Case 2

By nine weeks of age, an infant had spent the majority of his life in the hospital for recurrent, idiopathic apnea. Extensive cardiac, pulmonary, gastroenterologic, neurologic, and infectious disease work-ups were unrevealing. The mother had been the only witness to the apparent apneic spells. This fact, combined with the mother's eagerness to have the child undergo invasive tests, led to a request for psychiatric consultation. Review of the records revealed that the mother's first son had died at eighteen months of age of aspiration pneumonia. This child had had numerous hospitalizations and emergency room presentations for "seizures" or "apnea" observed only by the mother. Phenobarbital had been prescribed empirically, but there were inexplicable variations in the blood level.

During informal conversation, the mother disclosed that she had been unable to realize her goal of becoming a paramedic, but often accompanied her mother, a nurse, to medical courses. She expressed her pride in having resuscitated her infant, but reported disappointment that his illness had not led her ex-husband to become close with her again. The ex-husband reported having seen bruises on his son's nose at times, and independently raised the question of MSBP after viewing television coverage of the phenomenon.

Based upon accumulated evidence, and despite the mother's emphatic denial and mobilization of legal resources, the Department of Human Resources placed the infant with a foster mother. The child remained well but, during the Shelter Care Hearing and Dependency Trial, the judge expressed consternation over several points. The judge viewed it as counterintuitive that an apparently-loving mother could produce illness in her child; that induced apnea could have

eluded detection in the past; that the diagnosis of MSBP could be made without a formal psychiatric evaluation of the mother; that there was no overt maternal history of antisocial behavior; and that there was no standard treatment for the disorder beyond physical protection of the child. Immediately following the testimony of the expert witness, however, and before a judgment was rendered, the mother's attorney agreed unilaterally to an award of temporary custody to the father. The child remained well during follow up. While continuing to deny any history of MSBP behavior, the mother stated she would "acquiesce to but not agree to" the father's receiving permanent custody.

In this case, and in other legal proceedings involving MSBP [22-24], parents generally have not been willing to admit to the dissimulations, even after their conviction or the removal of the child. In fact, in *In Re: S.R.* [24], the very refusal of the parents to concede that MSBP had occurred was a main reason for the termination of parental rights. In these legal cases, the intercession of law enforcement personnel, and sometimes media representatives, may intensify the denial because the mother can find no way to "save face"; she maintains her own version of events rather than be exposed as a "liar" or viewed by the public as mentally ill. As Meadow has written, "More mothers . . . have confessed to killing a previous child, or harming the child under investigation, to a doctor, social worker, or kindly probation officer than they have during formal police interrogation" [11, p. 390]. While there certainly is a need to prosecute MSBP, less adversarial models of confrontation may prove useful. For example, a consulting psychiatrist might explain reassuringly that he or she will work closely to help the parent emotionally though the behavior must still be reported to the authorities. However, the lack of an adequate explanation for the denial in most cases is mirrored in the absence of effective strategies for reversing it. MSBP is considered a form of child abuse [3, 12] and is not listed as a psychiatric diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-IIIR)* [25]. Despite its pending inclusion in the Appendix of *DSM-IV* as "Factitious Disorder by Proxy," currently MSBP is also not considered to be a psychiatric diagnosis by the Munchausen By Proxy Network of the National Association of Apnea Professionals [26], and the American Psychiatric Association's *Treatments of Psychiatric Disorders* [27] contains no entries on MSBP. Similarly, no authors describe consistently effective or specific treatment programs for the MSBP perpetrator herself, especially if an acknowledgment of involvement is not forthcoming. Psychological and psychiatric evaluations have been reported to be unrevealing or nonspecific [11]. The results of psychiatric intervention have seldom been published but are believed to be poor [8, 20]. Nonetheless, psychotherapy (individual and/or family) would seem to offer the best, and perhaps only hope for treatment of the MSBP perpetrator. The basic aim is to teach the MSBP parent adaptive ways to get her needs met, including expressing painful affects with words rather than abusive actions. This same goal

is a central component of treatment for patients with severe personality disorders, and, in fact, personality disorders seem generally to underlie the MSBP behavior [28]. It seems intuitive that parents admitting to the abusive behavior would be more likely to respond to treatment; an admission might facilitate identification of the causal factors underlying a given case of MSBP. However, Griffith and Slovik do report one case in which long-term family therapy appeared effective in quelling the behavior even without an admission of culpability [17]. In working with patients with factitious physical disorders, Eisendrath proposes other strategies that may assist in ending the behavior without mandating a confession [29]. Modifications of these approaches may be useful in MSBP; sample strategies include: 1) inexact interpretations of psychological defenses (i.e., offering psychodynamic hypotheses to the patient that encourage a change in behavior without declaring the disorder factitious), and 2) therapeutic use of a double bind (e.g., telling the patient that if the next therapeutic intervention fails, a diagnosis of factitious disorder will be proved). Finally, increased media attention and the publication of materials describing MSBP for general audiences [30] may attenuate the secrecy surrounding the disorder itself and thus the denial.

Overall, however, in view of the limits of treatment in most cases, the acuity of the risk of damage to the children, and the requirements for reporting abuse, management strategies have generally needed to focus on removal of the child from the home. In the majority of situations, the child must indeed be removed, if only temporarily; when the child has remained with the parents, mortality has been high, and siblings, including those yet to be born, are also at risk [14, 31-33]. One plan to keep a MSBP child with a parent was elaborated in *In the Matter of Jessica Z.* [34]. In this case, sometimes cited by other courts, the judge ordered consolidation of the child's medical care at a single center; long-term involvement by the physicians who diagnosed the syndrome; and maintenance of effective communication among all the individuals involved (including the child, parents, pediatricians, court officials, protective service workers, and other mental health professionals). Still, there is no evidence that strict monitoring consistently works well over the many years probably needed to follow such cases. As McGuire and Feldman state, "Parental psychologic and behavioral styles, family dynamics, and responses from legal and children's protective services systems make protection of the child [both physically and psychologically] within the home difficult, if not impossible" [35, p. 289]. Thus, management also needs to include on-going provision of education to legal authorities and medical professionals about MSBP and its warning signs to enhance early detection.

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Direct reprint requests to:

Marc D. Feldman, M.D.
421 CPM, 1713 Sixth Ave., South
UAB Station
Birmingham, AL 35294-0018