

*Personal practice***Management of Munchausen syndrome by proxy**

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The label of Munchausen syndrome by proxy may be applied to anyone who persistently fabricates symptoms on behalf of another so causing that person to be regarded as ill.¹ In paediatrics it is usually the mother who is the persistent fabricator of symptoms and signs so causing illness, danger, and unnecessary investigations and treatments for her child. There is considerable overlap with other forms of child abuse as well as with the usual behaviour of normal parents when a child is ill. Even though the fabrication of symptoms and signs may continue for several years and be gross, it can be most difficult to detect. Nevertheless effective management for the child and the family is even more difficult. In the past six years I have had unusual opportunities to learn about the condition, meet the families concerned, and be involved in the management. This article discusses some of the common and difficult management problems.

Background information

Since the 1982 article on Munchausen syndrome by proxy in this journal² many paediatricians have sent me detailed information of other cases. Of the 90 British cases for which I had details by the end of 1984, I had been involved personally with the families in just under half, either by virtue of the deception coming to light in my own region, the parents contacting me privately, or paediatric or social service colleagues in other parts of the country seeking my help. A further source of information has been colleagues from abroad who have written or telephoned to discuss similar problem families. It is relevant that only for a minority of cases—those which came to light locally or in which the parents contacted me directly—was I the paediatrician truly responsible for the continuing long term care of the child.

The clinical features of these families are similar to those described in the earlier review of 80 cases;³ but there has emerged a clearer picture of what

happens to these children if the deception is not uncovered and the fabrication continues. As the children become older, there is a tendency for them to participate in the deception and to become teenagers and adults with Munchausen syndrome. There is also a tendency for the children to grow up believing themselves disabled. (An example is the 22 year old confined to a wheelchair having been brought up in the belief that he has spina bifida and is unable to walk even though his legs and back are normal.) In addition to the fatalities mentioned in the earlier reports there have been three more deaths and another child who incurred severe brain damage resulting in spastic diplegia and mental subnormality; thus with increased numbers and follow up, the morbidity and mortality are greater than was apparent at first. An important association with cot death, particularly recurrent cot death within one family has emerged.

As management is easier if diagnosis is certain and speedy, it is appropriate to list the warning signals that may alert a paediatrician to the presence of factitious illness:

- (1) Illness which is unexplained, prolonged, and so extraordinary that it prompts experienced colleagues to remark that they 'have never seen anything like it before'.
- (2) Symptoms and signs that are inappropriate or incongruous, or are present only when the mother is present.
- (3) Treatments which are ineffective or poorly tolerated.
- (4) Children who are alleged to be allergic to a great variety of foods and drugs.
- (5) Mothers who are not as worried by the child's illness as the nurses and doctors, mothers who are constantly with their ill child in hospital (not even leaving the ward for brief outings), and those who are happily at ease on the children's ward and form unusually close relationships with the staff.
- (6) Families in which sudden unexplained infant deaths have occurred, and families containing many

members alleged to have different serious medical disorders.

Mild cases

Exaggeration and mild deception are part of everyday behaviour: for a parent to exaggerate her child's symptoms or to perceive problems that are not apparent to medical and nursing staff or even to others in the family is common. All paediatricians are accustomed to mothers who perceive problems in their children that are inconspicuous to others, and also to mothers who press for investigation and operations for states that others readily tolerate. Similarly, it is not rare for a parent occasionally to alter a temperature chart, tamper with a sample, or invent a seizure in order to get their child away from them for the night, into hospital, or to keep their child there longer. Paediatricians who are accustomed to this and to helping the mothers with their problems will not over react to this behaviour. It is part of outpatient practice to shepherd along such mothers with their children, to support them with their problems, and to prevent them from causing their child an abnormal life or referral for needless investigations and treatments. It is an important skill for the paediatrician to acquire because its absence will cause the mother to seek investigation and treatment elsewhere.

It becomes more difficult when the mother is imposing a special diet or restriction to activities and education because of the perceived illness. It becomes a matter of fine judgement whether the mother is abusing her child or not—child abuse varies from age to age and culture to culture. Essentially, a child is considered to be abused if the parents' behaviour is sufficiently deviant from that current in their locality at that time, and if the behaviour is harmful to the child's growth and development. But though a paediatrician might not agree with a parent who, for instance, puts her child on a strict vegan diet in order to stop the child's seizures (which no-one except the mother has observed and which probably do not occur), it is likely to be inappropriate to intervene too abruptly since the diet is unlikely to harm the child and if the mother believes it will stop the imagined seizures then it probably will do so. The paediatrician's role must surely be to continue seeing the child regularly and, as the symptoms recede, discussing with the mother any possible social disadvantages, for the child in having a rigid and difficult diet when attending school or visiting friends. Other impositions, however, that parents inflict on children for fictitious illness may amount to a lifestyle that is, in most people's opinion, unfair, unpleasant, or harm-

ful to the child—for instance the pseudo-allergic girl recounted by Warner⁴ who had to sleep each night on the back of an upturned wardrobe clad in aluminium foil and tissue paper in order to avoid contact with substances to which the mother considered her allergic. Similarly, the schoolgirl whose mother insisted she had osteogenesis imperfecta and who found herself being excluded from most activities, wheeled to school in a pushchair and round the shops in a supermarket trolley. Though those girls are not in immediate physical danger, most of us would consider them to be abused and intervention to be necessary.

As has been observed for adults with Munchausen syndrome the chief reinforcing factors for hospital addiction can be the medical and nursing personnel themselves rather than the medical and nursing procedures.⁵ Doctors and nurses feel compelled to act, to investigate, and to prescribe drugs when the patients may merely want concern and support. Therefore in our treatment of a potential Munchausen syndrome by proxy child we need to modify our own behaviour, for abuse to the child arises as a result of a *folie à deux* involving mother and doctors. Both parties need to act differently and we need to support without frenetic investigation of the child.

The suspected case

The realisation that a child's prolonged illness may have been fabricated tends to come slowly. The possibility may have been raised earlier but not explored energetically. There is understandable reluctance by medical and nursing staff to believe that a parent may have been deceiving. Part of this stems from a wish to think good of parents, and part from a wish to avoid facing the fact that all one's investigations and treatments have been both inappropriate and harmful, that one has been hoodwinked, and has made a completely wrong diagnosis up to that moment. When the possibility seems likely it is worth making every effort to establish with certainty that fabrication is taking place because without that certainty it is extraordinarily difficult to act helpfully. This at once poses problems because some of the illnesses being created by the mother are dangerous to the child and there is a worry that delay to accumulate more evidence may end in catastrophe for the child. This happened with one child who was suffering seizure/apnoeic spells caused by maternal suffocation; delay to prove that it was the mother causing these spells lead to disastrous suffocation for the child. On the other hand paediatricians are reluctant to intervene early for fear of being wrong in their accusation. Parents

for their part when later accused vary between those who say 'if you suspected it earlier why didn't you tell us so that it could have been stopped' to those who say 'it is outrageous that we should be accused of these things until there is definite proof'. The stage at which intervention will seem most appropriate is likely to depend on the degree of proof and also the degree of danger that the mother's actions may be creating for the child. Some parental actions have much more dangerous implications than others: for mothers who repeatedly poison their child, it only needs a small alteration in dose to kill; and those who are suffocating their child (either by hand, plastic bag, or carotid sinus pressure) need extend it only a small degree and the child is brain damaged or dead. It is clear from my records that children under the age of 5 years are most likely to have a sudden catastrophic end.

Establishing with certainty that the mother is fabricating the illness requires painstaking enquiry. The paediatrician is in the best position to do this because he is seen by the family as a helper and someone for whom the child's interests are paramount: he starts off with the confidence of the family. Far more detailed and inoffensive enquiry and access is possible for a paediatrician than for social services, police, or most other agencies.

Investigation follows several directions and those listed are not in priority order, they are concurrent:

(1) By studying the history it should be possible to decide which events were likely to be fabricated and which real. Whenever an event, whether it be a seizure or a nose bleed, is said to have taken place in the presence of someone other than the mother it should be possible to check with that person exactly what happened. Sometimes all that is needed is a few brief telephone calls to the school, the play group, or a neighbour. It is important to remember that there may be genuine illness within the fabricated illness, for instance a child who has mild epilepsy but whose mother multiplies the number of seizures by a factor of 20 or more. Therefore the fact that one episode of genuine illness is established does not rule out the possibility that many fabricated events are happening also. Several illness events should be investigated in detail.

(2) Look for a temporal association between illness events and the presence of the mother. One should also look for such an association with adults other than the mother but it is most unusual for the father to be a participant in the deception (I only know of two fathers who may have been involved and one other father who was definitely involved). In more than 95% of the cases it is the mother fabricating the illness, sometimes with the assistance of her child.

(3) Check the details of the personal, social, and family history that the mother has given. It is common to find a host of fabrication within it and unless one knows the truth it is impossible to help. Fabrication may extend to the number of pregnancies, family numbers and relationships, details of financial circumstances, the home, and the mother's previous work and training. Case conferences are not a reliable source of information about families. Although there may be 15 or 20 different people at the case conference each of whom is meant to know some particular aspect of the child or family, it is common for each to recite more or less the same story which has been given them by the mother so that sometimes the whole group has been deceived on such elementary details as numbers within the family, whether the mother has a job, whether there are any grandparents nearby, and how many people live at home. The solution is for the paediatrician to go to the home without invitation. Once there it is not difficult to find an excuse to meet everyone and to visit all the rooms in the home. Moreover, there is an obvious difference between the sort of look a surprised parent gives you when you arrive unexpectedly on their doorstep and they are embarrassed because they have not washed up the supper things, and the look they give you when they are devastated by realising that you are about to find out that all the interpersonal and home information they gave you is false and that there is not a bedridden grandmother living with them, and that their living room is littered with empty bottles of alcohol. If the door is literally shut in one's face and access denied, that itself shows a great deal. On the rare occasions that it has happened I have said words to the effect 'I know what you are doing; I understand and I have come to help'; they eventually let one in.

(4) Making contact with other family members is vital. Though the mothers may have been ever present with their child at the hospital, the husbands may have been seen little or not at all. Talking with them about the child's illness and their home life can reveal many discrepancies. One mother who made much of her previous nursing qualifications and who enjoyed teaching nursing techniques to trainee nurses on the wards had said that she met her husband when she was taking her final nursing exams. In casual, if deliberate, conversation with the husband he told me how he had met his wife when she was a cleaner in the canteen of the factory in which he worked: she had never been a nurse. Grandparents have been a potent source of information and sometimes have had far more insight into what their daughters might be doing to their children than anyone else. Sometimes the information from them has been breathtaking in its revela-

tion. One grandmother said to me of her daughter 'she was always a strange girl I think she would really have done nurse training if she had been able to, she used to spend all her money buying these big medical books. I have been wondering for a long time if she has been causing his illnesses but I didn't like to say so and the doctors never spoke to me'.

(5) Discuss with the family doctor the illness episodes within the family. In about 20% of cases it becomes clear that the mother has Munchausen syndrome herself or at least multiple unexplained illnesses. Sharing one's worries with the general practitioner and enrolling his active help is extremely useful but unfortunately some are unwilling to become involved, perhaps feeling that they must keep complete confidence with the mother, and are unwilling to consider the suggestion that there may be fabrication.

(6) Look for a motive for the behaviour. The reasons mothers behave in this way have been discussed extensively elsewhere;^{3, 6-8} there is usually an element of gain in terms of status for the mother (the child's illness giving her status and friendship in hospital and in her neighbourhood), improved family relationships perhaps with husband or in-laws, and also direct and indirect financial benefit. One mother whose child was having a prolonged fabricated illness investigated in different hospitals received during a six month illness £57.00 collected by the local church (following a service in which prayers had been offered on behalf of the child); a new pushchair, refrigerator and washing machine from social services department; and £250.00 collected by other parents whose children were admitted to the same ward. Find out exactly how the mother behaved when resident, or visiting her child in hospital, for it is those who have formed very close relationships with the hospital staff, who go to the disco with the nurses in the evening or cook meals for the resident doctors at night, who are enjoying the hospital most—and unnaturally.

Establishing motives helps us to understand the mother and help the family better. For those mothers with whom I have had continued contact I have come to understand, and at times sympathise, with their extraordinary actions; the group whom I do not understand are the minority who have Munchausen syndrome themselves or who categorically claim and cling to facts that are demonstrably false.

If the child is in hospital further manoeuvres are needed.

(7) Ensure that all charts and records are not altered by the mother. Remember that many nursing observation records (for instance of seizure

frequency, feeding, and input/output fluid balance) are often a record of what the mother tells the nurse who then records.⁹ A system must be devised whereby items which are verified by the nurse, for example her seeing the child vomit or start to have a seizure, are identified separately from those recorded from the mother's account. Such detailed record keeping will sometimes quickly show that all illness events and abnormalities are perceived only by the mother and occur only in her presence.

(8) At the time of any unexplained coma, gastrointestinal upset, or other major event retain any samples that may be useful for poisons analysis. These should include vomit, urine, and a blood sample. These samples are precious; the laboratory should store them carefully until the best plan for analysis has been worked out. Toxicological screening is very difficult in that most hospital laboratories and poisons centres can only search for the few drugs that are most likely to have been given, and one may not be able to suggest which until one has consulted with the general practitioner and the family. In the absence of this information a general screen for poisons is needed. In Britain the fullest screening is likely to be done either by the public analysts' laboratory (who are reluctant to take on work from hospitals which is not directly related to their public health and hygiene responsibility) or by the police forensic laboratories who are meant to accept work only from police officers. Since 'comprehensive screening' of a blood sample costs about £800 and even then does not include many unusual drugs (for example, several cytotoxic drugs), problems abound. The paediatrician is likely to get the best advice by contacting the regional home office pathologist—his name will be available from the coroner's office or from the police station—who should be able to advise how the sample can be analysed best.

(9) If there is haematuria, haematemesis, or other bleeding, various manoeuvres may be used to check that the blood is human (and not from raw meat) and is the child's rather than another person's.¹⁰ The local pathology laboratory may be able to help but it is likely that the police forensic laboratory will have more sophisticated techniques involving detailed blood grouping or red cell enzyme assay. When there is doubt about the origin of an abnormal urine specimen the child can be given an oral marker, for example regular vitamin C, which is easily detectable using Ames dipstix C. If the urine does not contain vitamin C it means that the urine sample is not from the child.¹¹ Though if it does contain vitamin C, it does not rule out the possibility that the mother has added chemicals or other contaminants to it.

(10) More careful surveillance of mother and child has to be arranged and this can be difficult not only because of staff shortages and a busy paediatric ward but because of reluctance by ward staff to accept the possibility that the mother may be harming her child. Even when ward meetings to discuss such plans have been arranged with care and tact, the senior nurse may burst into tears, refuse to take part in the surveillance, or accuse the paediatrician of uncaring outrageous behaviour. This is understandable when, as has happened, the mother has been living in the paediatric unit from the first few months of the child's life and formed such attachments with the staff that they have been made the child's godparents, the child has been named after one of the junior doctors, and the child's teddy bear named after another doctor. Careful surveillance is extraordinarily difficult in a modern children's ward in which mothers are resident and parents are welcome at any time. It is necessary to enrol the help of a few key members of the staff whom one can rely on to be obsessional. Sometimes one is let down even then, for instance by a most reliable person who did not admit she had stopped surveillance for a critical one hour meal time period when a massive fabrication occurred, and who subsequently told me that it was not that she was too lazy to continue the surveillance but that she knew the mother very well and could not believe that she would ever do anything harmful to her child—'it was all too incredible'. Giving the staff reprints about the condition is helpful, particularly if they contain explanations for the mother's behaviour; the staff become more readily prepared to identify that behaviour in others. Surveillance by video has been used¹² and may provide the sort of conclusive proof that many would welcome—for instance of a mother suffocating her infant with her hand,¹² a mother injecting contaminated solution into an intravenous line,^{13 14} and a mother who, after her child had been fed, took a nasogastric tube out of her pocket and with a syringe aspirated the milk from her baby's stomach (the baby was being investigated for failure to thrive). Setting up video surveillance is not too difficult technically because in most areas the police will have a specific surveillance unit and will be prepared to use it without demanding the right to prosecute subsequently. They can do it unobtrusively even in a busy hospital. For most paediatricians the problem will be an ethical one and before embarking on surveillance it is important to discuss with the hospital administration and the appropriate social services or child protection agency exactly how this information is likely to be used. For the paediatrician the legal admissibility of filmed evidence is not the issue: the great benefit is that as a

result of a film the paediatrician may become *certain* for the first time that the mother is harming the child directly.

(11) It is relatively easy to find out from doctors and relatives what poisons or substances might be being administered to the child, but it is much more difficult to consider searching a mother or her possessions for such agents. At times it has to be done and a particular problem is that though a consultant paediatrician might be willing to do it, he may be in a poor position to do so inconspicuously. Mothers do leave the lockers in their rooms and their bags unattended for brief periods. For a junior doctor to check that there is no drug or poison can be done speedily and without upset. I am reluctant to ask my juniors to do it and would prefer to do it myself if it is needed but acknowledge that I would be less likely to do it inconspicuously. My practice is to discuss it with the junior staff and to work out a plan that is acceptable to all of us, though whatever happens the final responsibility is the consultant's. I do not know of either junior or senior doctors who have been discovered searching through a mother's possessions. If I were discovered I would explain to the mother why I was doing it; that it was because I knew of other children who had been poisoned by their parents, who had seemed to me to be loving caring people; and that I had not wanted to upset her by suggesting this possibility but for her child's sake was anxious to exclude it.

Excluding the parents

If a parent is fabricating the illness, then the symptoms and signs should go when they are excluded. This is the ideal diagnostic test and in modern paediatrics it is a difficult one: unfortunately for children with Munchausen syndrome by proxy, it tends to be used as a last resort.

In Britain and America it seems that the child with prolonged Munchausen syndrome by proxy has usually suffered a vast number of blood tests, radiodiagnostic tests, examinations under anaesthetic, and biopsies before separation from the mother is used as a diagnostic test. I doubt if this is because we all believe that a brief period of separation is so harmful for the child: more likely it reflects our diffidence and inadequacy in persuading the parents not to visit the child. Lacking the courage of our convictions we must, nevertheless, act in the good sense of our suspicions. If the recurrent 'illnesses' are happening several times a day it should be possible to persuade the mother to be absent for an afternoon, evening or weekend 'to see the rest of the family at home', leaving her child in hospital. It is more difficult, however, if the

periodicity of the illness is so infrequent that one really needs the mother to be away for 10 days or more. I have not found a satisfactory method of excluding mothers. Sometimes I have talked in psychological terms about the need for them to have a break. Sometimes I have been more frank and said that their child has a very unusual illness, we are having to consider rare possibilities, and that the mother's presence may in some way be interacting harmfully with the child either through emotional or allergic factors or as a result of something that they are doing to each other. This is not necessarily seen as a direct accusation and is usually accepted by the parents. For many mothers it is a major event and support must be given during the difficult exclusion period by regular telephone contact and home visits by anyone who may be helpful to them.

Excluding parents from their ill child in hospital is upsetting for the child and parents and contrary to the beliefs of the staff, some of whom may suggest that it ought to be adequate merely to arrange more strict supervision when the mother is on the ward with the child. The degree of supervision required, however, is not one for which medical and nursing staff are trained; it is too easy for a crafty mother to outwit hospital staff. One mother for whom limited visiting had been arranged with strictly controlled observation by selected staff who were instructed never to be more than five yards away from her, arrived on the ward slightly early for her visit. It is thought that she went to the toilet and then when she arrived by her child's bed at the appointed time and met the escort smoke was seen to be coming from beneath a toilet door where there was a small fire of toilet paper. All staff including the escort rushed to help and the mother was left alone with her child despite the agreed plan that under no circumstances should this be allowed during the four weeks of restricted visiting. Therefore trial separation has to be total exclusion.

If a period of parental exclusion cannot be arranged by mutual agreement, it may need to be imposed statutorily. Though it is usual to allow parents to visit when their child is kept in hospital under a place of safety order, it is possible for the order to specify exclusion of the parents. Such legal sanctions involve a degree of confrontation with the parents and this raises many difficulties when definite proof of parental harm to the child may be lacking and the paediatrician is uncertain. Therefore, voluntary agreement is preferable. When the parents are excluded full use must be made of that trial period to ensure that there is no possibility of adverse effects on the child. Two or three specific members of the ward staff need to be allocated to take a particular mothering interest in that child,

and if there is any possibility of previous poisoning, anything in which the mother might have left behind a poison should be removed; thus sweets, drinks, toothpaste, paint box etc are best removed so that at the end of the trial period there is certainty that the child could not have been harmed by the parents directly or indirectly.

Child protection agencies

When child abuse is suspected it is customary in Britain to notify the social services department either through the hospital social work department or the department near the family home. The stage at which the social services department is contacted will depend on many factors. Sometimes the family will already be known to the social services department and there may be a social worker already involved. The responses of British social services departments to children suffering from Munchausen syndrome by proxy have varied. In the early years there was disbelief and some unwillingness to take action. With more publicity, however, the departments no longer disbelieve the possibility, though many have difficulty investigating it vigorously. There can be few more difficult cases of child abuse to deal with than a Munchausen by proxy family, because it is so difficult to disentangle truth from untruth, yet all too often the social worker designated to the case is rather young and inexperienced. (An important difference between medical practice and social services practice is that in medicine the most difficult case is dealt with by the most experienced clinician whereas in the social services the most experienced worker is involved only in administration and few do case work.) The police representatives at case conferences are rarely instigators of action but will respond helpfully to requests for help. Even they are unlikely, however, to devote a great deal of energy or time unless they think there may be a criminal prosecution. For most of the British cases there has been no active police involvement. In a minority there have been police investigations including what seems to be their standard three to four hour interrogation of the mother in the local police station and a search of the home for evidence. More mothers, however, 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.

At the case conference it is essential that the paediatrician or other doctor who has known the family a long time, and has identified that factitious illness and abuse are occurring, is present. This creates some difficulties since many of the decep-

tions first come to light in a specialist centre far away from the child's home. Initially I referred the child back to the medical and social services department of the home locality, sending them a written report. One or two tragedies have convinced me, however, that this is not the correct course. The paediatrician who has uncovered the deception is likely to know the family better than anyone else at that moment because he has been worrying about, investigating, and treating the child for a long time. He knows well all that has happened and has a close relationship with the parents and child. He will understand the dangers for the child and is more likely to be respected and trusted by the parents and relatives. Thus his presence at the case conference is vital and he is also likely to be the most appropriate person to deal directly with the parents in the difficult negotiations ahead. If the social services department do not seem prepared to take up the case actively an alternative child protection agency (for example the National Society for the Prevention of Cruelty to Children) may be approached. As a last resort a firmly worded letter from the paediatrician to the director of social services for the town or city concerned is likely to produce a speedy response.

Members of a case conference, rather like magistrates in a juvenile court or the officers in a higher court, do need to have the dangers of Munchausen syndrome by proxy explained to them clearly and categorically, that:

(1) There is a risk of permanent handicap or death.

(2) Hospital admissions, investigations, and treatments are unpleasant and dangerous for the child. Many of us have faced barristers in court who have remarked that 'my child rather enjoyed being in hospital when he was 4—I don't think it can really be considered unpleasant'. (Yet they would have no hesitation in condemning a mother who herself had stuck needles into the veins of a small child more than 200 times or who had given the child drugs that suppressed growth, that could render him sterile, and that caused seizures and serious gastrointestinal bleeding.)

(3) Children who have fabricated illness thrust upon them in early life acquiesce to it, and at older ages participate in it themselves, some adopting abnormal illness behaviour as an adult and retaining it for the rest of their lives. After early limitation of activity and school attendance they grow up to believe themselves incapable of employment, marriage, or normal life. They are disabled.

Confrontation

Telling a mother that you know she has been lying,

harming her child, or deceiving doctors is difficult. At the time one has to do it one may not be able to explain all the facets of the child's illness story and there may be areas of doubt; it is best to confine oneself to those areas in which one feels sure of the truth. Although many of us in ordinary practice may give important news about children to both parents together, this is one disorder where approach to the offending parent, the mother, should be made first. If one tries to talk to both parents together the father, who will know nothing about the deception, is likely to dominate the subsequent interview by anger or forceful denial. Talking to the mother one can approach it along the lines that one knows what she is doing, understands it, and that one is going to help the child and her. It is very rare for the mothers to become angry; usually their response is 'what a strange suggestion', or 'why should I be doing that', or 'you can never prove that'. It is useful to be able to present clearly the evidence for part of the deception. Usually they will not deny it but try to lead the interview on to another happening (which perhaps one cannot explain). One must not be side tracked but simply stick to the facts and the truths that one does know and say quite openly that other unsolved incidents are irrelevant.

The purpose of confrontation is not to prove that one is right and they are wrong. As in the handling of mothers who perceive symptoms in their child that are not observable to others, the aim is to understand and respect the meaning of the symptoms in order to help them. As Richtsmeier and Walters¹⁵ have written, there is no point in declaiming to them what is really going on when it becomes clear that the family is unable to hear it: explanations seldom change behaviours that are illogically derived, and direct challenge of the defence will usually only drive the patient away. Subsequently the aim is not so much to get the family to look back on what was really happening but to look forward to the future and feel good about the positive steps they are taking.

I am sure that the person who conducts this interview should be the paediatrician who has known the family and the child longest and who has uncovered the deception. I prefer these interviews to be private but accept that it is helpful for the social worker with subsequent responsibility for the family to hear all that goes on, though it may limit the amount of information that emerges. The task is to explain to the mother the way in which her actions are harming her child and the dangers these have for the child's future. An outline is given of the steps that are being taken for the care of the child and help for her and the family. I discuss with the mother what is to be told to the father, and likely

family reactions are anticipated. At this stage there is sometimes tacit admission by the mother of what has been going on; in other cases that only emerges later. For another group there is never direct admission, though a few years later they may come out with a comment such as 'I suppose I had a sort of nervous breakdown'. The doctor meanwhile is trying not to be hostile or condemnatory but to seem understanding and to act in a supportive way.¹⁶ It is a dangerous time and three mothers have made suicide attempts at this stage.

The long term therapeutic aim is to stop the abuse and protect the child and secondly to get the mother to understand the consequences of her actions, and to try and achieve motivation for continued treatment and help. Since most mothers have enjoyed some personal gain from their actions one tries to replace hospital care and child illness as the main source of satisfaction in their life with other things.

Statutory procedures

At a case conference the abused child and siblings are likely to be put on the 'at risk' register at once and the child at that stage may well be in the hospital children's ward under a place of safety order. The debate will centre on what should happen at the end of that temporary period. Many factors will be taken into account but those that are most worrying from a paediatric viewpoint and have been found to be most dangerous for the child include:

- (1) Abuse that has involved suffocation or poisoning.
- (2) Abuse of a child under the age of 5 years.
- (3) Previous 'cot deaths' or other sudden unexplained death of siblings.
- (4) A lack of understanding by the mother of what has been happening and little feasibility of continued help for her and the family.
- (5) Mothers who themselves have overt Munchausen syndrome; because rational conversation and management is impossible without truth.
- (6) Major adverse social factors such as drug dependency or alcoholism.
- (7) Persistence of fabrication even after some degree of confrontation with the mother.¹⁷

Statutory arrangements have usually been contested, in some cases only as a result of the husband being unable to accept the possibility of his wife's deception and demanding legal help. In Britain most child abuse cases come to the juvenile courts where they are considered by three lay magistrates, but Munchausen syndrome by proxy cases are likely to be inappropriate for that court. They can be incredibly complex and the degree of medical evidence and the length of the case together with

interposed adjournments means that they are best dealt with by higher courts. Applying for wardship (ward of court) for the child gives automatic access to a higher court. This procedure has been used increasingly in recent years for complicated cases of child abuse and may well be the ideal, even though it is expensive. For a child who is a ward of court the welfare of the child is paramount and matters relating to that child are dealt with by the family division of the high court. As in a juvenile court, proceedings will be held *in camera* (that is no proceedings can be reported in the press.) It is worth bearing in mind that in high court actions the local authority is compelled to disclose all documents at the court hearing, which is not so for juvenile courts. This means that any document one has written about the child will be available to all parties. The practical advantage of wardship over care proceedings at a juvenile court is the immediate recourse to the expertise of a high court. It has been noteworthy that the judges in the high courts have been quick to believe and understand the way in which mothers have behaved. They have not doubted the facts and they have understood clearly the dangers in a way that has not always happened in the lower court. They do appreciate being given reprints of articles about the condition that have been published in medical journals. Mitchels¹⁸ has pointed out that a further advantage of wardship is the way that it can be used in emergencies without the need to establish that any harm, mental, physical, or emotional has *already* been sustained by the child: it is sufficient if the court believes that there is a risk of such harm. If a paediatrician were in the unusual position where a social services department was unwilling or unable to act, he or she could, as could any private person, apply for wardship from the court registrar. Almost certainly before the full and costly hearings, the local social services department would have been stimulated into action.

Whatever arrangements are made for the child, the paediatrician must agree to continue to see the child for a long time. It is helpful to have this incorporated into the legal agreement. This is particularly important if the child has an additional genuine chronic illness, and important anyway because all children will have an occasional genuine illness. There have been some bizarre happenings when children, returned to the family home but still under supervision, have become ill. One child developed tonsillitis whereupon a conscientious social worker notified the police who searched the house from top to bottom for poisons (that might have caused the tonsillitis) and took the mother away to jail for the night. The paediatrician must liaise closely with the family doctor and agree with

him and the supervisory agency to adjudicate on the authenticity of any illness.

Role of psychiatry

Many mothers who have perpetrated Munchausen syndrome by proxy have been referred to psychiatrists, and many have had detailed psychological testing. Usually the tests are normal and no disorder is apparent to the psychiatrist. It is customary during court proceedings for the mother's legal representative to produce a document stating that she has been seen by a psychiatrist and a psychologist who have found her to be normal and who do not believe she could be acting in this way. This is not surprising because the mothers do seem normal (the exception being the small minority who have Munchausen syndrome themselves). Fewer mothers have been seen by child or family psychiatrists and this is a pity because an experienced child psychiatrist might well detect more. Nevertheless, quite a large number of British mothers have been seen by child psychiatrists who have not found any apparent disorder, and the psychiatrists themselves have written that they cannot believe the accusations that have been made against the mother. (Some have suggested one or two even rarer organic disorders as the reason for the child's illness!) This is understandable, since it is very difficult on meeting these mothers for the first time to envisage all that has happened, and certainly no specialist, however skilled, can understand as well as a doctor who has known the mother for several months, and on whom the deception has been practiced and gradually revealed. Additionally, in Britain, child psychiatrists have tended to contribute little to the care of families in which child abuse is occurring and have limited experience of it. This is not universal and there are many countries where psychiatrists play an important role in the management of child abuse.⁷ These psychiatrists are likely to be as effective as anyone in helping. Early involvement is preferable, if possible before and during the stressful confrontation period, so that they will have a stronger role and be more effective therapeutically. I can envisage a child psychiatrist taking on the major role in the long term help for the family. Even when it is more appropriate for that role to be taken by the paediatrician, there is little doubt that he would welcome help from the child psychiatrist, if only in the form of discussion and moral support, because these families are exceedingly difficult and stressful to manage.

Postscript

Many paediatricians, including myself, are critical sometimes of child protection and social services, case conferences and court procedures for children. But this should not deter us from using these proper procedures early. Within this series of cases are several in which experienced paediatricians suspected bizarre abuse for a long time but failed to request formally a case conference. Similarly, there are examples of case conferences failing to appreciate the gravity of the problem and failing to test the case legally in court. Both these omissions have caused the needless death and permanent handicap of children.

References

- Meadow R. Munchausen syndrome by proxy—the hinterland of child abuse. *Lancet* 1977;ii:343–5.
- Meadow R. Munchausen syndrome by proxy. *Arch Dis Child* 1982;57:92–8.
- Meadow R. Factitious illness—the hinterland of child abuse. In: Meadow R, ed. *Recent advances in paediatrics* No. 7. Edinburgh: Churchill Livingstone, 1984:217–32.
- Warner JO, Hathaway MJ. Allergic form of Meadow's syndrome (Munchausen by proxy). *Arch Dis Child* 1984;59:151–6.
- O'Shea B, McGennis A, Cahill M, McIlroy: some of the answers. *Irish Journal of Psychiatry* 1984;5:5–8.
- Rogers D, Tripp J, Bentovim A, Robinson A, Berry D, Goulding R. Non-accidental poisoning: an extended syndrome of child abuse. *Br Med J* 1976;i:793–6.
- Waller DA. Obstacles to the treatment of Munchausen by proxy syndrome. *J Am Acad Child Psychiatry* 1983;22:80–5.
- Lee DA. Munchausen syndrome by proxy in twins. *Arch Dis Child* 1979;54:646–7.
- Meadow R. Fictitious epilepsy. *Lancet* 1984;ii:25–8.
- Kurlandsky L, Lukoff JY, Zinkham WH, Brody JP, Kessler RW. Munchausen syndrome by proxy; definition of factitious bleeding in an infant by ⁵¹Cr labeling of erythrocytes. *Pediatrics* 1979;63:228–31.
- Nading JH, Duval-Arnould B. Factitious diabetes mellitus confirmed by ascorbic acid. *Arch Dis Child* 1984;59:166–7.
- Rosen CL, Frost JD, Bricker T, Tarnow JD, Gillette PC, Dunlavy S. Two siblings with recurrent cardiorespiratory arrest: Munchausen syndrome by proxy or child abuse? *Pediatrics* 1983;71:715–20.
- Liston TE, Levine PL, Anderson C. Polymicrobial bacteremia due to Polle syndrome: the child abuse variant of Munchausen by proxy. *Pediatrics* 1983;72:211–3.
- Halsey NA, Tucker TW, Redding J, Frentz JM, Sproles T, Daum RS. Recurrent nosocomial polymicrobial sepsis secondary to child abuse. *Lancet* 1983;ii:558–60.
- Richtsmeyer AJ, Walters DB. Somatic symptoms as a family myth. *Am J Dis Child* 1984;138:855–7.
- Bayliss RIS. The deceivers. *Br Med J* 1984;288:583–4.
- Palmer AJ, Yoshimura GJ. Munchausen syndrome by proxy. *J Am Acad Child Psychiatry* 1984;4:503–8.
- Mitchels B. Munchausen syndrome by proxy—protection or correction? *New Law Journal* 1983;133:165–8.

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