Lisa Blakemore-Brown says horrifying injustices take place in the name of Munchausen syndrome by proxy, illness induced or fabricated in a child.

**False illness in children - or simply false accusations?**

A YOUNG MOTHER took her son for one of the routine vaccinations of childhood. That night he developed a dangerously high temperature and soon afterwards started banging his head, sitting and gradually lost all of his language. His behaviour became erratic, he couldn't relate to others and he was difficult to control. Investigations followed which led to a diagnosis of Asperger's syndrome, a form of autism. Suspecting the vaccination might have been the cause, although nothing could be proven, the mother decided not to have her next three children vaccinated.

As time went on, she kept pestering the social services department for respite care, because she found the eldest boy so difficult to deal with. She came to be seen as a bit of a nuisance. It was suggested, despite the known diagnosis of Asperger's syndrome, that his symptoms might perhaps have been induced by the mother herself. An expert was called in and she was accused of Munchausen syndrome by proxy (MSPB) - deliberately harming her child. Her two youngest children were taken from her into foster care and the youngest was taken from the foster home against the mother's wishes to be vaccinated. Instantly and tragically, the child's behaviour deteriorated in the same way as her eldest brother's had done.

The foster mother had videotapes of the little girl's behaviour before and after the vaccination. Yet the younger children are now even being put up for adoption.

This is just one of many horrifyingly inappropriate instances of 'diagnosing' with MSPB. For what is supposed to be a very rare occurrence of a specific kind of children abuse - and there is no doubting that genuine cases occur - I have now seen details of many cases where children were wrongly taken from their families in the most heartrending of circumstances.

Where it all started

For a full understanding of what is going on, MSPB needs to be put in context. The term was coined by paediatrician Professor Roy Meadow in 1977 when he described the syndrome in the Lancet. Two decades before, physician Dr Richard Asher had introduced, also in the Lancet, the term Munchausen syndrome for people who induced dramatic illness in themselves, choosing the name because of the fabled German Baron Munchausen who told tall tales. Professor Meadow suggested the term Munchausen syndrome by proxy to describe the horrifying act of inducing illness in someone else - almost always in a child by the mother. (It is very, very clear that he considered MSPB a form of child abuse, not a psychiatric diagnosis that explained the behaviour. And he stressed that investigations should start with the child, regardless of suspicions.) So, if a child presented with pain in the stomach, the gastroenterologist should be called in. If an infant had breathing problems, a neonatologist should assess.

But times have passed and the climate that health and mental health professionals work in has dramatically changed. During the 1980s those at the sharp end - GPs, nurses, health visitors, social workers, psychologists, etc. - began finding themselves under enormous pressure. The resources were no longer there, and yet they were under pressure to produce results. Parents were better informed and laws were put in place to ensure that they had the right to demand whatever their child needed. When professionals said that they could not provide it, as it was too expensive.

Very many professionals worked in a climate of fear. They feared the loss of their jobs if they made recommendations which cost too much, at the same time knowing that it was being made easier for parents to sue them for negligence, for not making those recommendations. There was also the stress of knowing that, fundamentally, they were not doing the job they had trained for years to do.

Gradually professionals were being pitted against parents. Increasingly high profile cases of child abuse missed by professionals led to condemnation of many social services departments. Innocent children were openly abused within the families they trusted. It went against the most fundamental need of children - to feel safe within the home. The government demanded better detection of child abuse and the 1989 Children Act shifted the focus from prevention to protection.

Anyone who cared about children could not doubt the importance attached to exposing abuse. Around this time dramatic stories of cases of statutory abuse led to children being snatched at dawn, their parents accused of abusing them, only to be followed by public inquiries, such as the Reckitt Inquiry, in which social workers were severely criticised for a variety of methods which resulted in false accusations of abuse. Some were accused of putting words into children's mouths, for gross misinterpretation of events, for choosing to use information which suited their argument and leaving out information which did not.
A change of emphasis

What began as a medical model, where the concept was that it should stay, more and more often it has been to be psychiatric illness that was first called attention to the mother. There appears to be a struggle over whether psychiatric and pediatrics for professional ownership of M cb. Despite Meadon's insistence that he meant "unemployment" as a term to describe the child's mood. It is often seen as a child's problem, psychiatrists diagnose. Psychiatric disorders and psychiatric patients have been listed in DSM-III as the three major types of the American Psychiatric Association's diagnostic criteria for the purpose of child development. There are a few agreed diagnostic criteria relative to the concept of mental disorder, although these are not generally agreed upon by professionals and counties of development. This is very important as far as M cb is concerned.

Many premature babies, for instance, haven't had time for normal physical maturation and have been born prematurely. This is a major problem in terms of their medical disorders, including the medical problems premature babies have, such as heart problems and brain injuries, which increase risk of major brain damage and lead to hypertension and social communication problems.

Increasingly we are becoming aware of what I describe as a "spectrum" of developmental disorders, each presenting different ways to think about how their brains and cognitive abilities develop. These concepts are important to understand the complex and interrelated aspects of development and environment.

Lisa Blackburn's work has been instrumental in understanding these disorders in the context of child development. She has helped to identify various categories of disorders and has contributed to our understanding of the role of environment in the development of children with such disorders.
pauses to assimilate information. Combine the problems faced by the children and the mother's depression and you are increasing the risk factors for a difficult relationship. But we must understand that, even in the best families, children with such pre natal traumas and/or inherit neurodisorders are at risk for hyperactivity disorders and developmental delay in certain skills.

**Accusations of emotional abuse**

The shock about to descend on me personally was that MSBP experts were dismissing these disorders, instead accusing mothers of intentional emotional abuse to cause their children's difficult behaviour. Possibly because of the association with Allit, I have heard mothers described as potential murderers, probably psychopaths unable to change.

I first became aware of this dangerous interpretation when I was asked to see twins born so prematurely over 10 years previously that no one thought they would live. They went on to suffer massive head injuries through brain haemorrhages, so their survival was nothing short of miraculous. As expected, the twins did not develop normally. By the time I saw them, the social services were already involved and suspicion was being directed towards the mother. Because the children clearly had difficulties relating to others, this was regarded as arising from emotional abuse on the mother's part, rather than from the disorders they were suffering.

This mother had sought help for the twins' difficult and unpredictable behaviour for many years, to no avail. Now, in her desperation to prove she was not intentionally harming her children, she had offered to be videoed covertly in her home or to be taught new parenting skills if her own behaviours were to blame. After seeing a QED programme in which the Parent Child Game was featured, a means of improving parent-child interactions being used at the Maudsley Hospital at the time, she even contacted the Maudsley for help, but the hospital had been inundated with requests for support for their children and the Parent Child Game programme was closed shortly afterwards anyway. The twins' mother did, however, receive a very helpful letter suggesting investigation into hyperactivity disorders. But the local services interpreted her contact with the hospital as just another attention-seeking criterion for MSBP.

Many incidents were viewed with suspicion and the temperature between local services and the mother clearly rose. At one point, the mother threatened to sue if it was found that the social services had missed the real reason for her children's behaviour. In the end, one of her twins was taken into care and she fought passionately to get her back. Unfortunately all the natural instincts of a mother deprived of her young were interpreted as impulsivity and borderline behaviour. She was accused of MSBP and eventually lost all four of her children, the younger two of whom were perfectly normal.

So the evidence of a typical history of a child with the tapestry of developmental disorders threaded through with ADHD and coexisting with an autistic continuum disorder was totally dismissed, as were the professionals - myself and a paediatric specialist in ADDs - who had established the existence of these problems. Despite the appalling head injuries and prematurity of the twins, the mother was blamed for their behaviour in its entirety. When I asked how it was that her other two children had developed normally, I was told that they would also become like the twins.

**Why is this happening?**

I think it is partly because of the current climate of fear that cases like this are occurring. A child is brought to a GP or paediatrician with symptoms they do not recognize. Maybe the child is obsessive, has poor social skills, is very difficult to maintain, perhaps not toilet trained by age four or five. The mother may also appear to be very difficult (because there is a genetic component in some of these disorders and the mother may be mildly affected). So she brings everyone up all the time, describing all the awful things her child does, demanding action, making threats and, understandably, gets on everyone's nerves. Because of her anxiety and her own position and about potential negligence suits, the professional perhaps chooses to see clearly. Can she justify ordering expensive invasive investigations? But can she afford not to?

Perhaps, if they are aware of MSBP, they will have heard that mothers often tell exciting or exaggerated stories and this parent is more agitated and excitable than most. Perhaps someone on staff has just seen a documentary or read something about MSBP. It seems easy and, incidentally, it's cheaper - to focus attention on the mother instead of the child. And so the crucial stage, assessment of the child by the appropriate medical person, is sidestepped. If a health professional calls in someone who has developed a reputation for expertise in MSBP, that expert will not, of course, even be looking for a disorder in the child.

After the case with the twins and through contact with other professionals, I began to hear of many other cases in which children had been taken from their mothers. (In some they were eventually returned to them after real causes had been exposed, in most cases treatable disorders.) When a case gets as far as a Family Court, even if specialists appear who testify to the existence of an organic disorder, the expert in MSBP may easily override them. The issue of child abuse is, naturally, an emotional one. But it is a straightforward neuropsychological phenomenon that, when emotion comes in the front door, rationality goes out the back.

**Other cases**

One child who was removed from his mother for years was eventually returned, at least recognized as suffering from a rare genetic disorder of the mitochondria affecting breathing and present from birth.

In another case a child who became highly allergic after vaccination was described as normal by an expert in MSBP. He wanted the child to be challenged by
to prove this, and said that, if the mother
she be taken into care. The child had
been subjected to challenges earlier in his life which
had sent him into anaphylactic shock. These reactions
had been witnessed at school and the GP, the school,
the social services and the local psychologist; all
disagreed with the MSBP diagnosis. The allergy
specialists in this case wrote about their great concerns
and their intention to report the
case to the GMC should a
challenge go ahead which could
kill the child.

In a few cases, a child has
begun to soil, throw tantrums
and head bang after MMR
vaccination (against mumps,
measles and rubella). Whilst in some cases the child
may have had subtle signs of autism prior to the
vaccination, there now appears to be some evidence
that a rare bowel disorder linked with autism may be
triggered in certain vulnerable children. The final
result to these families is to blame the mother for
creating the problem, with a charge of MSBP.

In yet another case, four puppies died from
starvation in a family home. The vet,
understandably concerned, called an MSBP expert,
as he had heard that if someone abused their pet they
were likely to go on to abuse their children. The
children were taken into care and the totally shocked
mother found herself facing the charge of strangling
the puppies and of MSBP. During the court case,
however, the father, an ex policeman who had suffered
from a nervous breakdown, stood up and admitted to
strangling the dogs. He was allowed to return home
with his wife and children (the family has since broken
up). But if the mother had been found guilty of the
crime, the children would have been removed and
the mother probably told she must admit to the abuse if
she wanted treatment. If she refused, her denial would
be seen as further evidence of MSBP and she would
be unlikely to get her children back.

I am aware that, in America, women have found
themselves in chains in prison and that currently two
women are facing the prospect of enforced sterilisation.
A child was recently removed from a hospital bed and
extradited to Britain.

In my opinion, we must ensure that very clear
methods are put into place before MSBP is
investigated, to avoid false allegations. Absolutely the
first requirement is to establish whether a disorder is
real or not. Shona Craig refers to this within the Delphi
project, an Auckland-based audit of research criteria
for MSBP. She states: “It is necessary to first eliminate
all possible possibilities of true physical illness so there
will not be a misdiagnosis of MSBP with irreversible
repercussions”. Meadow states in a letter to a refereee:
“In the diagnosis the essential step is to differentiate
between natural and genuine problems and artefactual
ones. One does not suggest fictitious disease without
excluding genuine disease. Therefore the most
important step in the diagnosis is in ensuring
that the child is assessed by a paediatric specialist who is
experienced and skilled in the particular disorder
which is being alleged. Although the mothers who
perpetuate this form of abuse may have certain
characteristic features and personalities, one does not
identify the abuse by examining the mother. It comes
from assessment of the child by an appropriate
expert.”

I would like to suggest that the Internet could offer
a cheap and efficient means of finding an appropriate
expert, whatever symptoms are presented. So, if a child
is brought into a surgery or clinic apparently suffering from
something which is completely unfamiliar to the doctor and he
can’t find an appropriate specialist, it should be possible
to tap into the Internet, describe the symptoms in
detail and ask if anyone else has come across a similar case.
It could be that someone in Greece has had three such
cases and can easily advise. Specialists could perhaps
also use this method to describe unusual symptoms
or cases that have an unusual pattern to them.

Reasons for accusing the mother
Another major concern I have relates to controversial
profiling of the MSBP mother, using particular criteria.
The use of predictive profiles for identifying abusive
parents has resulted in “unacceptably high false
positives and was a disaster” according to Howitt. Cambridges
pediatrician Dr Colin Merley clearly
outlined his concerns regarding MSBP in the Archives
of Disease in Childhood. He wrote that the criteria, if
fulfilled, which Meadow suggested warranted the use
of the term MSBP, are very non-specific and could be
misinterpreted. These are: illness fabricated by the
parent or carer; a child presented to doctors, usually
persistently; the perpetrator (initially) denying causing
the child’s illness; and the illness clearing up after
the child is separated from the perpetrator.

Merley also expressed concern about the additional
diagnostic pointers suggested by Southall and Samuel.
These include: inconsistent histories from
different observers (but consistency could depend
upon how the history was obtained and whether the
same questions were asked in the same way); parents
being unusually calm for the severity of illness (but
they could be suffering inner turmoil) and parents
fitting in contentedly with ward life and attention from
staff (but this is common in a ward where the child
is well known and the staff are caring and
compassionate).

He stated: “Great caution about some of the criteria
for this diagnosis and concern about the accuracy
sensitivity and ethics of some of the techniques being
used. I urge doctors to take detailed histories and talk
to the mothers in a caring way about their concerns.
It is important to protect a child who is being harmed
by his mother. It is equally important not to harm
the child by falsely accusing his mother of Munchausen
by proxy and thereby breaking up the family.”

Particularly deserving of caution in regard to MSBP
is the criterion that the illness clears up when the
child is away from the mother. “Outcome is an
important aspect of the epidemiology of a condition.”
In other words, after the children have been removed
from a mother, the ‘acid test’ is seen to be the
improvement of their children. But we have no robust
evidence of outcome as yet. Merley makes the point
that many of the childhood illnesses such as aprosopha
and vomiting which may lead to a child being taken
into care usually clear up at the end of the first year. If the child had remained with the mother the condition would have cleared up anyway. Instead the fact that it cleared up after removal from the mother is seen as proof that the mother was inducive to the illness.

In ADHD impulsive and hyperactive behaviours, as the child grows, particularly in girls, to the extent that we used to believe that it no longer existed once the child approached adolescence. We now know that it simply changes in its presentation. Lack of motivation is a strong feature whereas overtly impulsive behaviour prevails particularly pre-school.

It can be difficult, once children have been taken into care, to find out what has happened to their illnesses and behaviours. In one case, a mother undergoing an acrimonious divorce, after she found her husband had been unfaithful to her, was accused of MSBP as a tactic by her husband's lawyer, so that the husband could gain custody of the child. Her husband, it emerged, was only too willing to say that his child was no longer ill once away from his mother. In fact, he remained the same as he had been previously. In another well publicised case a child died of the undetected disorder whilst his parents were away from him in custody accused of MSBP.

"Child normal"
The criteria some experts use to determine outcome, since mother and child are parted, is unacceptably vague. For instance, in one case, the MSBP expert just stated "child normal." So the massive efforts that were involved in securing files of mothers and children stop, the case being magnified glass placed over the family before the children were taken is suddenly removed, the excitement is gone, and an unsubstanciated comment of "child normal" is insufficient to satisfy the criterion of the illness clearing up when mother and child are separated.

Meadow's original criteria for MSBP have now been added to quite considerably and there is no consensus about them. The Delphi project, in its questionnaire answered by international MSBP experts, found wide disagreement even about the basic criteria listed in DSMIV (meaning the four criteria offered in DSMIV are insufficient to be diagnostic criteria). These four were: the intentional feigning or production of physical or psychological symptoms in another person; the motivation for the behaviour by the perpetrator being to assume the sick role by proxy, no external incentives for the behaviour and the behaviour not better accounted for by another mental disorder. Only the first of these was generally agreed to.

Other "pointers" suggested by some include tendency to complain, run away, approach lawyers or the media. Even if you commit suicide there will be no sympathy as this can be another sign of MSBP.

I am personally concerned about the way in which the only research criteria for MSBP for which there is most consensus can be used. The idea of "fabricating or inducing" the problem certainly covers most possibilities and ensures that, if a woman cannot be accused of the one, then she can be accused of the other. The mother in the previous MSBP case was accused of fabricating a story about a neighbour's baby which had died. It was claimed that she had invented the tale that the mother of the infant rushed hysterically into the street and pushed the baby which had already been dead for 12 hours, into her arms. What had happened was that, tragically, the baby had played with his head caught between the slats of a home-made cot and hanged. The mother, when she found the child in the morning, rushed screaming with it in her arms into the street, calling for help. The twins' mother ran out, as did many others, and the child was thrust into her arms, and then other women's arms in the hope they could resuscitate it. The woman hysterially refused to believe it could be dead.

When this was found to be a true story, it was claimed by the twins' mother's accusers that she had killed it. Fortunately the Coroner's office was able to confirm that the baby had been dead for 12 hours and the judge threw the accusation out. But when such information is written down and produced in court, relevant or not, it does have an effect on the nervous system of any normal person.

Many of us would run a mile
As the President of the Medico-Legal Society, His Honour Arthur Milbon QC, said to Professor Meadow after his talk in 1995, printed in The Therapist in 1996 (vol 3, no 3): "I find it a most appalling subject. I am glad there are chiefs like you who are prepared to do something about it. I think many of us would run a mile and prefer to do something else." He is right, we would. From my experience, when people are presented with the armoured detail of MSBP cases, all lined up in huge bundles, no matter how many of them with the most minute details, the mind red. They effectively do run a mile. Rational thinking desert them as they struggle to understand how a woman could possibly do such things to her children. Resistance sets in, defences go up and from that point on, the woman is damned.

But what if the details are wrong? What if the idea of MSBP was based on a rumour? Or on the focus on the mother? What if the expert who diagnosed a real disorder had been ignored? What if the MSBP experts had left out the bits which didn't fit their hypothesis and just left in those which did, possibly greatly embellished? In the same talk at the Medico-Legal Society, Professor Meadow was asked about the theories put forward in Hurting for Love, a book by Shroder and Libow. MSBP experts in America said: He said: "I know them and their book, and they actually invited me to write anything I wanted after I had read their manuscript, and I did so, and I was a bit critical of their hypothesis. They just abstracted the bits that praised their work and left out my critical bits from the book. I have never had that done to me before." Professor Meadow was clearly upset that he should be misrepresented, especially as it became the preface to the book, said the world over, and he was the man who had coined the term MSBP.
Selective evidence

I thought it was extremely that experts in child abuse can choose which information they want to leave in and which they want to take out, as the Rochdale Inquiry Judge exposed. In one case 13 witnesses speaking in favour of an accused woman were some of the left 'out' bits. In another: the fact that a child who was found to have ingested prescription medication had been left in her parents' care by a disturbed grandmother when he became drowsy, was missed out and the mother was accused of administering 'poison' to him - a deliberately emotive word in itself.

I fear that if one is aware of the diagnosis of MSBP has been placed on the shoulders of a woman, it cannot be removed. All exit routes are blocked and women find that, despite our so-called democracy, their democratic rights are curtailed. They are in a terrible Catch 22 situation. Denial is a usual feature in MSBP, so if they deny abuse, this may add to suspicions. If they believe that their doctor's real disorder has been missed, this may be claimed as another pointer to MSBP. If they decide to seek an alternative opinion, they will be accused of 'doctor shopping', another possible pointer to MSBP. If, in absolute desperation, they write letters of complaint or approach lawyers, this busy in litigation procedure is yet another pointer. During the period of the media is seen as a clear sign of MSBP. If they go to another country, this is a very bad sign, and they will be tracked down and extradited if possible or the systems in that country rapidly informed about this 'dangerous person'.

Some women have had their children removed and found themselves silenced by injunctions. In one case a child had a rare breathing disorder but the mother was accused of MSBP and all three of her children were taken into care. At the Appeal Court she was vindicated and six paediatricians backed up the diagnosis of the breathing disorder. Her children were returned but she and her entire family had had injunctions placed upon them to stop her speaking to the media. She was told by the judge that she could spend seven years in prison if she spoke out about her experience.

The classic witchhunt is with us again. If you drown you are innocent but if you float you are a witch and will be burned at the stake. Women are being demonised and demagogued, demonised and damned. I am appalled at the control which is threatening basic human freedoms and the extraordinary inhume treatment of women once they are accused of this disorder.

The court fiasco

Criminal proceedings are opted for "in most if not all cases of MSBP abuse." If only we had such a tight system for mass murderers, paedophiles, serial rapists, drug pushers, stalkers and fraudsters. It seems that resources in relation to MSBP are unlimited. Each case can involve numerous professionals - one woman faced 27 when she went to pick up her child in hospital. The court cases are breathtaking; the one in which I was involved cost over a quarter of a million pounds but there were no resources when the mother asked for help when the twins were little and the amount of paperwork is gargantuan.

It seems the more paperwork which can be created the more likely that we will assume guilt. I often wonder whether it all gets read. Let's face it, professionals do not have the time, we are overloaded and overworked. If we are faced with thousands of sheets of paper and a convincing argument from an MSBP expert, is it not just a little bit possible that we might not read every detail, finding ourselves overwhelmed, and take the line of least resistance - agreement? What happens to those who dare not agree once the machinery is rolling? They are likely to be maimed or dismissed out of hand, at the very least. If our reasoning affected by terrible stories of abuse apparently undertaken by the accused, confused by massed detail and the convincing argument, under pressure to conform to the prevailing thinking, we are faced with the prospect of possibly losing a child in an abusive situation, most of us would opt for removing the children.

It is interesting to reflect on the similarity between MSBP procedures and the effects which scatological acceptors are accused of creating to meet an apparent underlying need for attention. Once the first gossamer breath of a whisper of MSBP has been uttered, our systems can rapidly draw together many people, including the police, the FBI in America, vast amounts of material and, in cases of covert surveillance, cameras, ringing bells, flashing lights and police cars with flashing lights. A recent Primetime New York (November 1997) gave us a flavour of the behind the scenes activity. If I didn't have such concerns about the use of the MSBP label it would make me wonder if some of these who designed the procedures didn't have it. Only joking!

In my work with people with impulse disorders, obsessions and problems of empathy, I expect to find that they will have a fascination for certain types of stimuli and, indeed need this to trigger their apparatus. The case of one child I saw would run after ambulances and he already knew at age 10 that he wanted to work in an emergency ward when he left school. Another was fascinated by police cars and ended up being arrested for getting in and looking around. Another leapt into a builder's skip after dogs chased him and told his mom it was the most 'exciting night of his life'.

I would urge caution before making assumptions about the 'personalities' of women from the style in which they talk about their children's problems. It may well be that some, suffering from a mild form of their children's disorder themselves, have to tell a dramatic story in order to put their point across, as their cognitive processing prevents them from communicating effectively in any other way. In the case of others, many mothers feel anxious when with professionals and may feel they have to make their case strongly, in desperation for help for their child.

What now?

I have raised many issues of concern. Could I make a plea for openness, honesty and balance in the diagnosis of MSBP? I believe that specialists in particular disorders, MSBP experts, lawyers and politicians need to get together and thresh through these issues properly, to see exactly where there has been an incorrect diagnosis and how to move forward and put things right. I wrote to Princess Diana about this and was about to embark on discussions with her when she tragically died. Unless some equally powerful influence is brought to bear, I fear for the fates of wrongly accused mothers and their vulnerable children.

References

9. A talk. Munchausen syndrome by proxy. given by Professor John R. Meadow at a meeting of the Medical-Legal Society at the Royal Society of Medicine, 1 Wimpole Street, London W1 on Thursday, March 9, 1995.
10. As far as above.