PROBLEMATIZING MUNCHAUSEN BY PROXY

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ABSTRACT

The study critically examines the psychiatric phenomenon of Munchausen by Proxy/Factitious Disorder by Proxy. It provides a comprehensive examination of the literature, indicating the disagreements and lacunae. A critique of the literature is offered, with particular focus on the lack of attention to the historical and social predeterminations of Munchausen by Proxy, its diagnostic construction, its validity as a syndrome, the inadequacy of the clinical data, the recursivity of the literature and its concomitant lack of attention to contextual factors contributing to the emergence of the phenomenon. A case history is used to illustrate the dominant practices and discourses as well as the difficulties encountered in the clinical work. The study concludes with some questions raised by such cases and offers a few suggestions regarding the contribution of the clinical psychologist in addressing these questions.

CONTENTS

CHAPTER 1

INTRODUCTION: THE PATIENT, THE HISTORY, THE DEFINITION AND THE MAP

While it is still regarded as a relatively rare phenomenon in South Africa, Munchausen Syndrome by Proxy has recently become the topic of moral debates and legal battles in America and Britain, sparking various interest groups. In that respect it follows the path of Dissociative Identity Disorder and "false memory syndrome", both generating much controversy in the media. Apart from the well-publicized court cases,[1] Munchausen Syndrome by Proxy has been the topic of television documentaries and talk shows, has generated Internet websites and has even been the subject of a novel (Kellerman, 1992). Since its naming in 1977, the literature grew rapidly and ever more cases were identified. The current context is one where the following questions are being asked: Why has it only been foregrounded in the latter part of the twentieth century? Is it restricted to the "Western World"? Why are the perpetrators primarily women? Is it a diagnosable psychiatric disorder or is it merely another form of (child) abuse? Is it a "real" disorder or is it iatrogenic? Is it another modern-day witch hunt fuelled by sensationalist media? Has it become the first psychiatric scandal of the 21st century (Kenny, 1999)? Some of these questions will be addressed in this study.

The introduction comprises three sections. The first offers a case vignette which triggered the enquiry. This is placed in the context of the history of the Munchausen Syndrome by Proxy and its current definitional status. The second section is devoted to a synopsis of the dissertation, interwoven with the rationale and methodology of the study. The third section deals with technical aspects, namely my choice of terminology and the delimitations of the study.

1. THE PATIENT

Mrs X[2] was a 35-year-old, unemployed, Muslim woman who voluntarily admitted herself to Valkenberg psychiatric hospital 18 days before I was appointed as her case manager. She was transferred from the female psychotic unit to the (short-stay) assessment/crisis intervention ward where I had just begun my psychology internship.

Mrs X had been married and divorced twice under Muslim rites. She had three children, a 14-year-old daughter from her first marriage and two sons from her second marriage. The sons

were aged 11 and 9 respectively. I was informed that Mrs X presented with a "treatment-resistant depression with psychotic features" and my task was to assess her suitability for electro-convulsive therapy. She complained of depressed mood, initial and terminal insomnia accompanied by nightmares, lack of appetite, loss of weight, decreased energy, anxiety, tearfulness, restlessness and auditory hallucinations. According to her, the medication she was taking was not effective. At the time she was taking amitriptyline 150mg nocte, lithium 250mg mane, 500mg nocte (as augmentation) and chlorpromazine 50mg mane, 100mg nocte. (She had been taking amitriptyline and chlorpromazine for eight years. Lithium was added as augmentation three years ago). She was eager to receive electro-convulsive therapy. When asked how she understood the side-effects, she said she had been told that it might result in temporary amnesia. Her file history mentioned that she had given her youngest child anti-depressant medication for his headache, but because she expressed feelings of guilt and remorse, it was regarded as an isolated act of an overwhelmed mother to calm down her hyperactive child. During the first consultation Mrs X was drably dressed, sat slumped in her chair, was fidgety and made poor eye contact. She was tearful and appeared anxious and anhedonic. Mrs X offered no information about medicating her child. According to her, her children are her life. She reported being distraught after a phone call from them, during which they started crying, saying how much they miss her. She complained that her ex-husband was not allowing her sufficient access to them since her hospitalization. In an effort to facilitate more contact with her children, I tried to locate the social worker she had consulted at the local children's hospital.

Since I only had the social worker's first name and since she had subsequently moved to another institution, I had difficulty tracking her down. When I finally did, she informed me that Mrs X's youngest son had recently been hospitalized at the local children's hospital twice in three days, presenting with vomiting, headaches and a depressed level of consciousness. At the time Mrs X denied any knowledge of the aetiology of his symptoms. On the fourth day the boy deteriorated into an intermittent coma. A toxicology screen revealed high levels of tricyclics and opiates in his blood. A child psychiatrist was consulted and she diagnosed Munchausen by Proxy (Factitious Disorder by Proxy). The children were temporarily placed in the care of their grandparents and their father, and the case was referred to the Child Protection Unit. Initially Mrs X continued to deny any involvement, but 11 days later admitted having given her son one or two pills before his initial

hospital presentation. She persistently denied giving him any additional medication, claiming that he might have taken some himself. She also denied administering medication during his hospitalization. However, she admitted needing help and undertook to admit herself to a psychiatric hospital, which is where our paths crossed.

2. THE HISTORY

Before turning to the definition of Munchausen by Proxy, I will briefly situate this controversial phenomenon historically, with specific reference to its "predecessor", Munchausen Syndrome. Not only do the two phenomena share the eponymous name, but the conceptualisation of Munchausen Syndrome also influenced that of Munchausen by Proxy and therefore merits brief attention.

a) Munchausen Syndrome:

Hieronymus Karl Friederich Freiherr von Münchhausen (1720-1797) was a German officer and mercenary who was renowned for his fantastic tales of his peripatetic adventures. In 1785 Rudolph Eric Raspe, an exiled German writer and geologist, whose own life was almost equally eventful, anonymously published Baron Munchausen's Narrative of his Marvelous (sic) Travels and Campaigns in Russia (Bracy, 1963). [3]

Asher first used the Baron's name in 1951, in what is regarded as the first systematic documentation of (adult) Munchausen's Syndrome. Asher does not offer a definition *per se*, but describes these patients' multiple presentations at various hospitals with apparently acute illnesses, their dramatic histories consisting of falsehoods and their tendency to discharge themselves against advice (1951). He justifies his use of Baron von Munchausen's name as follows:

> The gentleman to whom I respectfully dedicated this syndrome originated as a real person - Karl Frederick Von Munchausen (sic) of Brunswick - who was wont to entertain his friends by recounting fabulous adventures of palpable absurdity. When Rudolph Raspe of Hanover anonymously published these stories without his permission, a gentlemanly old fellow with a gift for tall stories became the laughing stock of Europe and the eponymous representation of an incorrigible liar. It is to Raspe's fictitious Baron that my term refers; the patients resemble him in the dramatic nature of their stories, the wide extent of their travels and the untruthfulness of their tales (1959/1972, p.154).

Asher's article is characterized by a conflict between motive and lack of motive. He describes the "apparent senselessness" and lack of secondary gain, claiming that these patients lie from a "love

of falsehood" (1951, p.339). However, he then proceeds to list possible motives underlying the behaviour. These include a grudge against doctors and hospitals, a desire to become the centre of interest, to obtain free accommodation or drugs, or to escape from the police. He also concedes that most patients are hysterics, schizophrenics, masochists or psychopaths.

Asher's work formalized a phenomenon which had many labels, including "hospital addiction", "polysurgical addiction" (Menninger, 1934), "scalpellophilia" (Plassman, 1994), "professional patient syndrome", "Ahasuerus Syndrome" (Wingate, 1951) [4] and "factitious illness". Patients with this disorder have been called "hospital hoboes", "peregrinating (problem) patients" and "kopenickiades" [5] (Enoch & Trethowan, 1991; Parnell, 1998b). Many of the terms reflect a measure of devaluation (Plassman, 1994), which is also pervasive in the literature.[6] Throughout its history fabricated or self-inflicted illness had a distinct class association and as recently as the 1980s Munchausen patients were associated with unemployment, lack of achievement, alcohol abuse and criminal histories (Bhugra, 1997; Carney, 1980; Folks & Freeman, 1985).

Munchausen Syndrome still is believed to be more common among males (American Psychiatric Association (APA), 1994; Enoch & Trethowan, 1991; Folks & Freeman, 1985; Meadow, 1994). Whereas the terms "Munchausen Syndrome" and "Factitious Disorder" are frequently used interchangeably, some authors have attempted to reserve "Munchausen Syndrome" for those cases in which the factitious production is chronic, rather than episodic, and which - due to the patients' wandering - involve multiple physicians, towns and hospitals (Libow, 2000; Pankratz, 1999; Taylor & Hyler, 1993). When this distinction is made, the traditional gender ratio is modified: Munchausen Syndrome remains more common in men, but Factitious Disorder is more prevalent among women (Fink & Jensen, 1989; Sutherland & Rodin, 1990). It is not clear whether the more episodic Factitious Disorder is qualitatively different, or whether the episodic patient eventually evolves into the chronic Munchausen patient (Libow, 1998).

b) Munchausen by Proxy:

The documentation of parent-induced illness predates the 1977 baptismal article (Dine, 1965; Herzberg & Wolff, 1972; Lansky, 1974; Osborne, 1976; Pickering, Moncrieff & Etches, 1976; Rogers et al., 1976). The first use of the name "Munchausen by Proxy" appears in an article entitled "*Folie à Deux* in the Parents of Psychosocial Dwarfs" (Money & Werlwas, 1976). As the title suggests,

this use of "Munchausen by Proxy" refers to the presentation of parental-induced symptoms with both parents delusionally colluding in the falsification of the history.[7] In both the cited cases the mothers had a history of caring for sick or handicapped family members. In both families other siblings played the role of surrogate patients once the index patients improved or left the house.

The first systematic description of the phenomenon is credited to Meadow, a British paediatrician. His 1977 article was precipitated by two cases, one in which the mother systematically falsified her child's symptoms, tampered with urine specimens and interfered with hospital observations, and another in which a child was fatally poisoned with toxic doses of salt. Meadow based his choice of the term "Munchausen Syndrome by Proxy" on the similarities it showed with Munchausen Syndrome, particularly the fabrications and the extensive travelling to obtain treatment. He emphasized the falsification of symptoms and medical histories and the way these mothers seemed to use their children "to get themselves into the sheltered environment of a children's ward" (1977, p.345). He particularly noted how the mothers thrived on the attention of the staff.

As with most aspects of Munchausen by Proxy, the name has also been a site of contention. Subsequent to Meadow's article, many other names have been used, including "Munchausen by Proxy Syndrome" (Donald & Jureidini, 1996a; Hotchkiss, 1997; Lyons-Ruth, Kaufman, Masters & Wu, 1991; Parnell & Day, 1998; Schreier & Libow, 1993a; Siegel & Bryk, 1998; Sigal, Gelkopf & Meadow, 1989; Waller, 1983; Weston & Morelli, 1998), "Polle Syndrome" [8](Ackerman & Strobel, 1981; Burman & Stevens, 1977; Clark, Key, Rutherford & Bithoney, 1984; Leeder, 1990; Liston, Levine & Anderson, 1983; Mehl, Coble & Johnson, 1990; Verity, Winckworth, Burman, Stevens & White, 1979), "Meadow's Syndrome" (Lazoritz, 1987; Warner & Hathaway, 1984), "peregrinating paediatric patients" (Fialkov, 1984), "chemically abused children" (Shnaps, Frand, Rotem & Tirosh, 1981), "Factitious Illness by Proxy" or simply "child abuse". Lazoritz (1987) argued for the use of "Meadow's Syndrome", not only as a tribute to Meadow's work, but also because the Baron had suffered as a consequence of Raspe's fictionalizations and would never have harmed a child. Similarly Carek objects to the use of Munchausen's name, accusing Munchausen by Proxy proponents of debasing the noble Baron's name by introducing a "pathological or even malicious quality that is so foreign to the Baron's tales" (1995, p.261).

c) Relationship between Munchausen Syndrome and Munchausen by Proxy:

Differing views are held on the relationship between Munchausen Syndrome and Munchausen by Proxy. Munchausen by Proxy is commonly regarded as a variant or paediatric equivalent of (adult) Munchausen Syndrome, sharing essentially similar psychodynamics (Ackerman & Strobel, 1981; Enoch & Trethowan, 1991; Griffith, 1988; Lyons-Ruth et al., 1991; Mehl et al., 1990; Sigal, Carmel, Altmark & Silfen, 1988; Sigal et al., 1989). However, others contend that the similarities in name have led to confusion, that the one cannot be regarded as a variant of the other (Bhugra, 1997; Parnell, 1998b; Schreier & Libow, 1993a), and that the "etiologic commonality" suggested by earlier articles has not been borne out (Donald & Jureidini, 1996a, p.753). In this regard, Parnell argues that there seems to be a fundamental difference between the psychopathology of someone willing to make him/herself suffer and that of someone willing to create suffering in his/her own child. According to her, Munchausen by Proxy "is more a pathology of the parent-child relationship than a pathology of the self" (1998b, p.19).

3. DIAGNOSTIC CLASSIFICATION

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (henceforth DSM-IV) prefers the term "Factitious Disorder by Proxy" and it is commonly regarded to be interchangeable with "Munchausen by Proxy". While recognising that the varied terminology can be confusing, Parnell (1998b) maintains that the connection between the terms "Munchausen Syndrome by Proxy" (or "Munchausen by Proxy Syndrome") and "Factitious Disorder by Proxy" is clearly established in the research literature. However, she admits that problems with the disparate nomenclature still arise, citing a case in which a perpetrator's legal representative discredited a psychologist witness by arguing that Munchausen by Proxy does not even exist, because the specific term is not included in the DSM-IV.

The DSM-IV defines Factitious Disorder by Proxy as a form of abuse in which the essential feature is the "intentional production or feigning of physical or psychological symptoms in another person who is under the individual's care" [criterion A]. Typically the victim is a young child and the perpetrator is the child's mother. The motivation for the perpetrator's behaviour is presumed to be a psychological need "to assume the sick role by proxy" [criterion B]. "External incentives

for the behaviour, such as economic gain, are absent" [criterion C]. "The behavior is not better accounted for by another mental disorder" [criterion D] (APA, 1994, p.727). The perpetrator presents the proxy person for medical care and the latter is usually subjected to extensive hospitalizations and invasive and/or painful interventions. Victims often incur psychological and/or physical harm and may end up emotionally or physically damaged, disabled or dead. The perpetrator invariably disclaims any knowledge of the aetiology of the problem.

The phenomenon is currently listed in the DSM-IV as a subtype of the Factitious Disorders[9] and is included in an appendix as a concept or category "for further study" (APA, 1994, p.703). Technically it therefore falls under the broader diagnostic category of "Factitious Disorder Not Otherwise Specified". The latter has no specific criteria and Factitious Disorder by Proxy (as delineated by the suggested research criteria) is merely an example.

The tenth revision of the International Classification of Diseases (henceforth ICD-10) offers no discrete psychiatric diagnostic category or criteria for Munchausen by Proxy. In the section entitled "Injury, poisoning and certain other consequences of external causes", Munchausen by Proxy would be classified under "Other Maltreatment Syndromes" (T74.8), making it clear that it is not a psychiatric diagnosis (World Health Organisation (WHO), 1992).

Besides the DSM-IV definition, Rosenberg (1987) offers one of the most widely accepted and used definitions. She lists the following signs and symptoms as "constituting the syndrome cluster" (1987, p.548):

1) an illness is fabricated by the parent or someone *in loco parentis*
2) a child is presented for medical assessment and care, usually persistently
3) the perpetrator denies knowledge of the aetiology of the illness
4) acute symptoms abate when the child is separated from the perpetrator.

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4. THE MAP: SYNOPSIS AND RATIONALE

This study was prompted by the dilemmas encountered in my intervention with Mrs X. I turned to the literature for guidance regarding the establishment of a diagnosis, an understanding of what might underlie the behaviour and how to treat it. This literature, which is essentially empirically derived, is set out in chapter 2.[10] Unlike a conventional literature review, the literature is set out

in a detailed and comprehensive way, because: a) relatively little is known about Munchausen by Proxy, particularly in the field of psychology; b) a comprehensive examination of the literature is useful in an extremely difficult area of clinical work, and as such it provides an integral background for understanding the case material; c) it generates important questions about its construction, which in turn raises questions about the clinical work; and d) the field is rife with confusion, obfuscation and contradiction. Chapter 2 thus offers a relatively neutral inspection of the territory, while flagging some of the disagreements and lacunae within it.

After having examined the literature, many questions remained unanswered, and I therefore shifted my attention from the level of data collection to a conceptual one, thereby moving into a critical theory approach. Consequently chapter 3 is devoted to a critique of the literature, both from within its ranks and without. The critiques highlighted the inadequacy of the research, as well as the moral and ethical dilemmas presented by such a case. Chapter 4 returns to the abovementioned case, illustrating the material discussed in chapter 2. Remaining with the case study, chapter 5 critically examines the questions raised by the critiques. The moral judgement pertains to having to decide whether the behaviour constituted a crime or an act committed in a psychotic state, i.e. to what extent does a person like Mrs X belong in the psychiatric health system or in the legal system? Does the fact that someone behaves in an apparently wilful manner eliminate the possibility of her having a psychiatric disorder? If she does have a psychiatric disorder, what is our professional responsibility regarding treatment? Mrs X seemingly turned to the appropriate system for help, but we had very little to offer and therefore we pushed her into the legal system. These issues are addressed with specific focus on the way people like Mrs X are positioned, their absence of voice and the role psychologists can play in making these voices heard.

One of the difficulties in problematizing this phenomenon has been my own divided loyalties, which are reflected in the structuring of the dissertation. Chapters 2 and 4, the examination of the literature and the discussion of the case material, subscribe to the medical/psychiatric model as encountered in the public hospital system where I was placed as an intern. Whereas I recognize the power of this model and its usefulness in a country where psychological services to the disadvantaged are scarce, I am acutely aware of its inherent problems. Chapters 3 and 5 therefore critique both the literature and my case management as hegemonic practice, with the view to raising some critical

questions. These questions highlight a broader dilemma: How do we as clinical psychologists integrate our critical thinking with our clinical practice, especially when it involves multiple epistemologies? While there is no easy answer, I am reminded of two quotations pointing to the accommodation of two intersecting epistemologies. Turner (1992), a medical sociologist, premises that the body is socially constructed through various discourses (medical, moral, artistic, commercial, etc.). While he contends that such a position calls into question the claims of "expert" knowledge, he also acknowledges that "some things ('hysteria') may be more socially constructed than others ('gout')" and that topics which are "politically charged (such as 'black lung') are more likely to be regarded as socially constructed by sociologists than other conditions ('goitre')" (1992, p.26). Similarly, Wetherell and Potter, two social constructionists, defend their approach against charges of subjectivism with the following example: "New Zealand is no less real for being constituted discursively - you still die if your plane crashes into a hill whether you think that the hill is the product of a volcanic eruption or the solidified form of a mythical whale. However, material reality is no less discursive for being able to get into the way of planes" (1992, p.65).

Applying the above to Munchausen by Proxy, one is confronted by the material reality of children undergoing unnecessary medical interventions due to the behaviour of their parents. At the same time there is the discursive construction of a psychiatric disorder "Munchausen by Proxy", which is embedded in and reproduces patriarchal power relations, positions the subjects of its study as disordered, dangerous, deceitful, untreatable women, while simultaneously denying them a voice. As a clinical psychology intern faced with the "phenomenal reality" (Barrett, 1988) of a patient[11] with a diagnosis of Munchausen by Proxy, I had to examine my relationship with these two seemingly oppositional "givens".

In accordance with Turner, I want to argue for an "epistemological pragmatism" (1992, p.61). Since Munchausen by Proxy is a relatively uncharted territory for psychologists, it would be inappropriate to foreclose our conceptual options prematurely. This study therefore examines the field from both the hegemonic and the alternative perspectives without the presumption of providing answers, but endeavouring to explore the role of psychologists in a realm where they have heretofore been largely absent.

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5. TERMINOLOGY

My own use of terminology requires some clarification.

1) With regard to the pattern of abuse, I will follow Meadow's example and use the term "Munchausen by Proxy" (except when the context dictates otherwise, such as in quotations).[12] For the immediate purpose of the discussion "Munchausen by Proxy" will be regarded as interchangeable with "Factitious Disorder by Proxy", as defined by the DSM-IV.

2) Since the term initially denoted the form of abuse, and since its status as a psychiatric disorder is being disputed, I will refer to Munchausen by Proxy as a "phenomenon" (as opposed to a "disorder").

3) While it contains inherently problematic assumptions, I will adhere to the DSM-IV terminology in referring to the concerned parties as the "perpetrator" and the "victim", unless the context demands otherwise. The use of these gender-neutral terms is motivated by the fact that the behaviour is not confined to mothers only, and that attempts have been made to extend the definition to include similar abuse of adults and pets.

6. DELIMITATIONS

The study primarily focuses on issues surrounding the diagnosis and the perpetrator. Besides brief attention in the examination of the literature, matters concerning the child victim of this abuse are therefore excluded. Similarly, the covert video surveillance debate, the social work, legal and forensic aspects will only be addressed to the extent that they intersect with my broader argument.

CHAPTER 2

THE LITERATURE: INSPECTING THE TERRITORY

Due to Munchausen by Proxy's recent inclusion in the DSM-IV, its status as a category "for further study" (APA, 1994, p. 703), and its relative rarity, both in clinical practice and psychological writing, this chapter is devoted to an inspection of the territory as it presents itself in the literature. As the study is concerned with the psychiatric diagnosis and treatment of the adult "perpetrator", the discussion is primarily confined to these areas. Following some observations regarding the distribution of the literature, the chapter examines the literature on victims, perpetrators, aetiological factors, prevalence, definitional and conceptual developments and debates, and management. Although the study excludes forensic and legal matters, a short section on covert video surveillance is included, as it is increasingly regarded as an indispensable part of the diagnostic process.

1. THE DISTRIBUTION OF THE LITERATURE

The existing literature on Munchausen by Proxy generally emanates from paediatrics and is published primarily in paediatric, general medical or child abuse journals (Fisher, 1995b; Gray & Bentovim 1996; Griffith, 1988; Lyons-Ruth et al., 1991; Ostfeld & Feldman, 1996; Schreier & Libow, 1994a, 1994b; Sigal, Altmark & Carmel, 1986). Schreier and Libow (1994a; 1994b) specifically note the scant attention being paid to Munchausen by Proxy in the psychiatric literature. In an extensive search conducted in 1994, they located 178 papers of which 143 were published in medical journals and only 19 in the psychological and psychiatric literature (1993b). This distribution is corroborated by Ostfeld and Feldman (1996). The even greater lack of information in social work literature is noted by Gray and Bentovim (1996), Mercer and Perdue (1993), and Ostfeld and Feldman (1996).

A few implications of the above distribution are

- a primary focus on identification and the child victim, with little discussion of either the perpetrator or management or psychological treatment strategies other than confronting the parents and removing the child (Lyons-Ruth et al., 1991; Sigal et al., 1986);
- social workers and psychologists are at a distinct disadvantage regarding recognition and knowledge of Munchausen by Proxy (Ostfeld & Feldman, 1996);
- a lack of dynamic understanding (Schreier & Libow, 1994b).

The literature also appears to concentrate on dramatic cases of observed induction of symptoms during in-patient stays (Meadow, 1990), with less attention being paid to cases in which the perpetrator's involvement is more subtle or cannot be proved beyond a doubt (Lyons-Ruth et al., 1991).

2. VICTIMS

Since this study focuses primarily on perpetrators, the literature regarding victims is only attended to in brief, mainly because it sheds light on the case study that follows in chapter 4.

While the victims are typically young or preschool children, with the abuse most commonly starting in the first year of life, children of all ages and even adults have been abused in this way. The youngest presentations involved foetuses subjected to prenatal fabrication (Goodlin, 1985; Goss & McDougall, 1992).[13] Most of the illness simulation and production takes place while the children are in hospital. Males and females seem to be equally victimized (McClure, Davis, Meadow & Sibert, 1996; Palmer & Yoshimura, 1984; Rosenberg, 1987). Birth order also does not seem to play any significant role (Libow, 1998).

Although the presentation of symptoms and signs covers a broad spectrum, the majority of induced and simulated conditions involve the gastrointestinal, the genitourinary and the central nervous systems (APA, 1994). The most common presentations are bleeding, seizures, central nervous system depression, apnoea, diarrhoea, vomiting, fever and rash (Rosenberg, 1987). Various physical complaints may be presented simultaneously (Eminson & Postlethwaite, 1992; Sullivan, Francis, Bain & Hartz, 1991). (For more detail on manifestations, see Levin and Sheridan (1995) and Schreier and Libow (1993a)). Common methods of fabrication include poisoning,[14] suffocation, scratching, painting or applying caustics to the skin, dietary manipulations, exogenous blood application, falsifying temperature, contamination of blood and urine samples, symptom coaching and lying.

The victim's illnesses are characteristically atypical in their presentation, course and response to treatment. Signs and symptoms are often unverifiable and occur only in the presence of the primary caregiver. The victims usually require extensive medical attention, entailing invasive medical procedures, surgery, intravenous medicines and multiple X-rays. With older children (and adults) there may not only be compliance or passive collusion, but collaboration with the perpetrating caregiver in the production of signs and symptoms (APA, 1994; McClure et al., 1996; Meadow, 1984; Sanders,

1995; Schreier & Libow, 1993a; Sigal et al., 1989; Stone, 1989; Woolcott, Aceto, Rutt, Bloom & Glick, 1982). [15]

Consequences:

Obvious physical consequences for the victims of this type of abuse are needless and harmful investigations and treatments, inducing of a genuine disease due to the perpetrator's actions, disfigurement, sudden death as a result of the perpetrator misjudging the degree of insult and development of chronic invalidism (Meadow, 1989a, 1994; Rosenberg, 1995). Due to a lack of comprehensive follow-up, information about long-term (physical) morbidity is scant. The two available systematic studies (Bools, Neale & Meadow, 1993; Davis et al., 1998) suggest that many victims suffer long-term physical consequences and are at risk for further fabrication.

Despite being widely stated, psychiatric and psychological sequelae are poorly described due to limited follow-up. The only systematic follow-up study reported "unacceptable" outcomes for half the 54 children studied (Bools et al., 1993). Problems include feeding disorders, withdrawal, hyperactivity, conduct disorders, interference with the capacity to relate, retreat into illness under stress, fears of permanent damage, development of Munchausen Syndrome/Factitious Disorder and scholastic problems due to absenteeism (Berg & Jones, 1999; Bools et al., 1993; Conway & Pond, 1995; Croft & Jervis, 1989; Dowling, 1998; McGuire & Feldman, 1989; Sigal et al., 1989). For a victim's account of growing up with Munchausen by Proxy, see Bryk and Siegel (1997).

Co-morbidity figures vary greatly and include physical and sexual abuse, failure to thrive, neglect and inappropriate medication (Bools, Neale & Meadow, 1992; Gray & Bentovim, 1996; Rosenberg, 1987). Similarly, statistics about mortality rates show considerable variation. Among the larger studies ($n \geq 23 \leq 117$), the figure varies from 9% (Rosenberg, 1987), to 22% (Waller, 1983) and 33% (Meadow, 1990). It is hypothesized that the mortality rates are inflated, as it is invariably the more serious cases that find their way into the literature (Meadow, 1990; Schreier & Libow, 1993a). For a more detailed analysis, see Parnell (1998c).

Siblings:

Frequently Munchausen by Proxy involves siblings of the index patient in the same or similar manner. A follow-up study found sibling abuse to be more common than re-abuse of index children (Davis et al., 1998). Estimates of sibling Munchausen by Proxy abuse range from 25%-33% (Alexander,

Smith & Stevenson, 1990; Schreier & Libow, 1993b). The only systematic sibling study (Bools et al., 1992) reported fabricated illness in 39% of siblings and death with no identifiable cause in 11%. These morbidity rates are hypothesized to be an underestimate.

Apart from the morbidity associated with being victims themselves, the emotional impact of witnessing Munchausen by Proxy behaviour and of having the nuclear family break up after discovery has not yet been studied (Alexander, 1995). What does seem to be consistent in the literature, is that only one child is the target of Munchausen by Proxy at any given time (Alexander et al., 1990; Sigal et al., 1989).[16] Alexander et al. (1990) suggest that perpetrators who engage in serial Munchausen by Proxy may have more serious and overt psychopathology and children are more likely to be killed.

3. PERPETRATORS

a) Gender:

Munchausen by Proxy is primarily perpetrated by females. The biological mother is the perpetrator in 90% to 100% of cases (McClure et al., 1996; Meadow, 1994; 1995; Perdue, 1988; Rosenberg, 1987). Other female perpetrators include adoptive mothers (Rosenberg, 1987), baby-sitters (Richardson, 1987) and grandmothers (Samuels, McClaughlin, Jacobson, Poets & Southall, 1992). These mother-perpetrators may appear medically knowledgeable and a significant proportion are involved in medical or caretaking fields (Gray & Bentovim, 1996; Meadow, 1982a, 1990a; Rosenberg, 1987; Schreier & Libow, 1993a; Skau & Mouridsen, 1995).

In 1995 Meadow estimated that 5% of perpetrators were male. Parnell notes that by 1998 13 cases of father-perpetrators had been discussed in the literature (Jones, Badgett, Minella & Schuschke, 1993; Makar & Squier, 1990; for a full list of citations, see Parnell, 1998c). In the same year, Meadow published a review of 15 cases involving male perpetrators, all dating from the previous ten years. According to Meadow, this increase in male perpetrators may be due to the general increase in identification of the phenomenon. He also hypothesizes that the literature's exclusive focus on mother-perpetrators may have dissuaded medical professionals from identifying male perpetrators (Meadow, 1998). Jones et al. (1993) suggest that the increase in male perpetrators may be related to the growing numbers of fathers taking up primary caretaking roles. This role shift may leave them open to the same stresses of caregiving that lead to Munchausen by Proxy behaviour in females. Jones et al.'s

hypothesis is given credence by the fact that all but one of the 17 fathers in the three aforementioned studies were unemployed (Jones et al., 1993; Makar & Squier, 1990; Meadow, 1998).

Little is known about father-perpetrators. Meadow described them as very similar to female perpetrators, except that fathers are generally not well liked by hospital staff and are perceived as being overdemanding, overbearing and unreasonable (1995a; 1998). Father-perpetrators are also more likely to incur criminal prosecution and receive more punitive sentences than mothers (Meadow, 1998; Samuels et al., 1992; Schreier & Libow, 1994b). Regarding the characterological profile of male perpetrators, Meadow's experience differs from that of Schreier and Libow (1993a). The latter suggest that father-perpetrators are a more overtly pathological group, exhibiting bizarre behaviour or symptoms reports with possible psychosis. Due to the small case numbers and varied presentations, inferences remain provisional.

b) Prototypical presentation:

The prototypical presentation of mother-perpetrators is of attentive, self-sacrificing carers, who impress as good parents enjoying close (if enmeshed) relationships with their children. They rarely leave their children's bedside and since they are invariably actively involved with the in-house care of the children, they are well liked by medical staff and seen as an invaluable help (Meadow, 1982; Nicol & Eccles, 1985). They often play the role of adviser and comforter to other parents on the ward and have been noted even to comfort staff (Meadow, 1984; Skau & Mouridsen, 1995). Contrary to the public show of attentiveness, video surveillance has shown that these mothers often react indifferently to their children when no observers are present (Samuels et al., 1992; Zitelli, Seltman & Shannon, 1987). They often demand new interventions and are rarely wary of medical procedures, even when these are invasive and pose a significant risk to the child. Munchausen by Proxy perpetrators frequently appear inappropriate in their expression of affect: they are either overly calm in proportion to the gravity of the reported problem, show an inappropriate level of satisfaction with the child's medical problems or display excitement when the child's life hangs in the balance (McGuire & Feldman, 1989; Palmer & Yoshimura, 1984; Schreier, 1992; Schreier & Libow 1993a). They invariably thrive in a medical environment, particularly on the attention of staff (Meadow, 1977; Mehl et al., 1990). "The striking quality of the presentation lies in the glaring contrast between the external cooperativeness and the covert abuse" (Lyons-Ruth et al., 1991, p.311). Perpetrators may switch doctors frequently,

especially when there is a risk of being exposed. When confronted, most perpetrators persistently deny the accusations. Some become depressed and suicidal, others become angry with the health care professionals and attempt to remove the child from hospital against medical advice.

Perpetrators may give confusing, complex medical histories - both their own and that of the child (McGuire & Feldman, 1989; Meadow, 1977; 1982a; 1989a; Parnell, 1998c). These histories are often presented with dramatic flair and perpetrators may exhibit pseudologia fantastica. They commonly report having had an illness similar to that of the child (Meadow, 1982a; Parnell, 1998c; Schreier & Libow, 1993a). Many have complicated obstetric histories or histories of multiple pregnancies (Feldman, Christopher & Opheim, 1989; Griffith, 1988; Meadow, 1977; Parnell, 1998c; Polledri, 1996; Sullivan et al., 1991). Jureidini (1993) suggests that obstetric complications can contribute to the genesis of Munchausen by Proxy through unresolved grief secondary to perinatal bereavement, or through the production of a damaged child, which disrupts the mother-child bond and provides an external illness focus for the mother. He also suggests that pregnancy and childbirth can facilitate transition from self-focused hostile behaviour of Munchausen Syndrome to externally focused Munchausen by Proxy.

c) Psychopathological issues:

Most of the literature in this regard is based on single case reports or on small case numbers. The only systematic study is that of Bools, Neale and Meadow (1994), who reported on 47 mothers. 72% of the mothers were regarded as having a history of "Somatizing Disorder" (an umbrella term covering somatoform disorders and factitious disorders). In 73% of these cases, the most probable diagnosis was "Factitious Disorder with physical symptoms". In order to compare these findings with others, I confine myself to two other large studies. Meadow reports that of the 300 families he has seen, 20-30% of perpetrators have "marked somatisation disorders" (1994, p.335). Rosenberg's 1987 meta-analysis of 117 cases found that 10% of mothers had Munchausen Syndrome and 14% had features of Munchausen Syndrome. (Some studies with small case numbers report an incidence of up to 100%.)

Due to the idiosyncratic use of diagnostic nomenclature and a reported range too wide to be meaningful, it is not clear whether mother-perpetrators generally present with Munchausen Syndrome, Factitious Disorder or Somatization Disorder. However, three positions are discernible: a) the generally

accepted view in the literature is that Factitious Disorder/Munchausen Syndrome only manifests in a minority of perpetrators; b) the only systematic study (that of Bools et al., 1994) found that it manifests in a majority (between 52.5% and 72%); c) the DSM-IV work group on Factitious Disorder by Proxy perceives the latter as being on a continuum with Factitious Disorder, hence the similarity in diagnostic criteria. According to one of its members there is "sufficient information to suggest that perpetrators may have been victims of Factitious Disorder by Proxy in childhood, often have Factitious Disorder prior to the by-proxy abuse perpetration, and frequently manifest Factitious Disorder again after confrontation and removal of their child-victims" (Fagan, personal communication, 1996, in Parnell, 1998b, p.45).

Bools et al. (1994) reported forensic histories in 19% of mothers, histories of self-harm in 53% and substance misuse in 21%. Personality assessment of 19 mothers showed that the majority (±89%) were judged to have a personality disorder, often of a severe nature at the time of fabrication. Most subjects met the criteria for more than one category of personality disorder. Histrionic and Borderline personality disorders were most common, particularly among active inducers. Dependent and Avoidant personality disorders were also identified. These results do not fully correspond with Rosenberg's, who reported that "hysterical" personality disorder was noted "several times", as opposed to Borderline, Narcissistic and unspecified personality disorder noted "very occasionally" (1987, p.556). However, due to Rosenberg's lack of specificity, true comparisons are not possible.

In accordance with other authors (Parnell, 1998d; Rosen et al., 1983; Schreier 1996; Schreier & Libow, 1994a;1994b), Bools et al. (1994) found that none of the mothers were psychotic at the time of the fabrications. Only 15% of the interviewed mothers had well-defined Axis I disorders, including depression and an eating disorder. While the small percentage of clear Axis I disorders corresponds with the findings of Libow (1994) and Sigal et al. (1989), it differs from those of Gray and Bentovim (1996), who reported psychiatric problems in 49% of 37 mothers, with 43% having a history of depression.[17] It is, however, important to take note of both Gray and Bentovim's (1996) and Parnell's (1998d) observations, namely that the presence or visibility of Axis I disorders is contingent upon the time and circumstances of the evaluation. Most perpetrators initially mask or deny the presence of psychiatric problems and these usually only emerge later (e.g. during therapy).

Samuels et al. (1992) called attention to the presence of eating disorders in Munchausen

by Proxy mothers, following their observation that 71% of 14 perpetrators (of imposed upper airway obstruction) had eating and/or weight problems (which they speculated to be a form of self-harm). [18]

d) Psychological testing:

Psychological test data are mainly alluded to in a few individual case studies, but the data is generally incomplete (Griffith, 1988; Moszkowicz & Bjørnholm, 1989; Palmer & Yoshimura, 1984; Rosen et al., 1983; Schreier, 1992; Sigal et al., 1986; Sigal et al.,1988; Stone, 1989). In an attempt to draw up a profile of Munchausen by Proxy perpetrators, Schreier and Libow (1993a) obtained psychological testing protocols on 12 mother-perpetrators. However, the validity of their conclusions is undermined by the small sample size, the testing conditions (some mothers were court-ordered to undergo assessments) and their own admission that the clinicians were generally operating without a theoretical model or test profile, and the selection of test instruments were based on personal preference and familiarity. In a similar exercise, Parnell (1998d) reports on the MMPI-2 protocols of 15 mother-perpetrators. Again the sample size remains small and testing conditions are problematic, as 13 of these involved court-ordered evaluations. Given these problems, their findings can at best be regarded as exploratory descriptive information. However, two points deserve mention. 1) The protocols generally substantiate previous reports of little gross psychopathology and reveal no particular group profile. 2) Once therapy commences, the protocols are modified. Parnell notes that the retest MMPI-2 protocols "generally show the individual perpetrator's psychopathology along with the anxiety and depression that emerge during the uncovering therapeutic process. A protocol obtained even later in therapy usually shows less defensiveness than the first protocol and has lower clinical scales than the second protocol, with perhaps a more realistic picture of the perpetrator's personality structure" (1998d, p.144). For a critique of psychological testing of Munchausen by Proxy perpetrators, see Allison and Roberts (1998).

4. AETIOLOGY

Theories of aetiology are limited by the difficulty in obtaining accurate and detailed histories from the reluctant and often court-ordered parents. There seems to be agreement in the literature that the illness-inducing behaviour is usually triggered by life stresses, especially pregnancy, marital conflict or some form of real or fantasized abandonment (Fisher, 1995; Meadow, 1994; Polledri,

1996). Despite having a compulsive quality to it, the behaviour seems to be under conscious control, but the motivation is regarded as largely unconscious and transference-rooted (Nicol & Eccles, 1985; Parnell, 1998b; Schreier, 1996; Schreier & Libow 1993a).

a) Psychodynamic factors:

Multiple cursory explanations for the behaviour have been offered. It is seen as a form of projective identification from an over-involved somatizing mother (Bools, 1996; Palmer & Yoshimura, 1984); a projection of parents' hatred and despair with each other onto the child(-'s body) (Dowling, 1998); masochism externalized/converted to sadism (with direct identification with the physician as aggressor) (Sigal et al., 1988), a form of sacrifice serving to expiate and atone for the parent's own self-perceived sin (Money, 1989); or a form of pathological play (Jureidini, 1999). It may serve the following functions: providing an emotional buffer to or respite from stressful home environments or dysfunctional marriages by placing the perpetrators in the containing, nurturing atmosphere of the hospital and bringing them in contact with other parents (Griffith, 1988; Meadow, 1989; Mercer & Perdue, 1993; Rosen et al., 1983); generating support from relatives (Meadow, 1994); meeting unfulfilled dependency needs (Chan, Salcedo, Atkins & Ruley, 1986; Leeder, 1990); altering the habits of absent partners (Gray & Bentovim, 1996; Meadow, 1989); avoiding other physically abusive actions while maintaining an idealized perception of themselves as parents (Gray & Bentovim, 1996); maintaining the validity of family myths (Richtsmeier & Waters, 1984); distracting family attention from its unresolved grief over a loss (Richtsmeier & Waters, 1984), enabling the perpetrators to assert their hostility through gaining a sense of exhilaration and control in taking on and deceiving the medical system.

Schreier (1992) and Schreier and Libow (1993a) offer one of the more comprehensive psychodynamic explanations. They view the mother's behaviour as being rooted in early real or emotional abandonment and lack of recognition (particularly by the father). Becoming a mother gives her an *entrée* to the "theater of the 'patient'", where caring obstetricians, paediatricians and other staff provide an opportunity to repair the past trauma (Schreier, 1992, p.428). Since projections about the mother's own parents/father are transferred onto the medical staff, the doctor serves not only as a source of nurturance and an object of idealization, but also as a potentially punitive and rejecting figure. As the sadistic wishes against the abandoning parent are revived, the doctor becomes the focus of conscious or unconscious rage and fantasies of revenge. In this perverse [19]sadomasochistic

interaction the child is not the object of the process; it is dehumanized and serves as a regulatory fetishistic object to control the relationship. The mother becomes a "perfect" mother in a perverse, fantasized relationship with a symbolically powerful, nurturant physician. The physician, faced with a confusing clinical presentation, may become caught up in a projective identification, which makes him/her feel that s/he does not care enough, spurring him/her on to try harder at the cost of overlooking obvious clues. Schreier and Libow's aetiological thesis will be revisited in chapter 3.

Polledri (1996) and Hotchkiss (1997) also utilize the concept of perversion, as set out by Welldon (1988). Polledri (1996) describes the behaviour as being a perversion of the maternal instinct, manifested in the mistreatment of children or evidenced through multiple terminations of pregnancy. This perversion is the result of serial abuse or chronic infantile neglect involving more than one generation. Polledri argues that these mothers have experienced early and sustained maternal deprivation, as well as intrusive projective identifications from their mothers. This aspect of their relationship with their own mothers - probably experienced at a preverbal phase of development - becomes split off and encapsulated into a traumatic psychotic core (an "encapsulated containerlessness" (Gallwey, as cited in Polledri, 1996)). This split-off aspect of the self becomes reactivated when she becomes a parent or takes on a maternal role. The "good mother" who wants children is not integrated with the split-off, mother-infant childhood experience.

Hotchkiss, also drawing on the concept of perverse motherhood, traces the behaviour back to early rejection and points to the idealization of illness as a mechanism of unification or repair. The child has to be ill, so that the mother can prove herself as a healer and thus undo the internalized badness resulting from her own early relationships. "In projecting her own woundedness onto the child and then becoming the agent of the child's healing, she could heal herself over and over again" (1997, p.321). This process is conceptualized as a fetishistic ritual.

While Schreier and Libow, Polledri and Hotchkiss all theorize around the concept of perversion, they view the aim of the perverted act differently. According to Schreier and Libow (1993a), the Munchausen by Proxy behaviour is not primarily directed against the child, but against the physician, therefore distinguishing it from other forms of child abuse.

b) Family dynamics:

No large systematic study of family dynamics has been done up to date (Skau & Mouridsen, 1995).

Griffith (1988) evaluated two families using a systemic model and suggests that Munchausen by Proxy can be seen as a disorder maintained by the family system as a whole, not just by the autonomous behaviour of one parent. He highlights the following patterns: an enmeshment of parent-child relationships; "multigenerational themes of exploitative dominance/submission" in parent-child relationships (including physical and sexual abuse); "intense family group-loyalty" with no protective mechanisms for non-dominant family members/children; intergenerational patterns of illness behaviour around chronic medical/somatoform/factitious illness; and a "gender reversal of typical sex roles for power and caretaking within the parental couple" (the wife being more dominant and aggressive than the husband) (Griffith, 1988, p.434).

These findings are confirmed by McGuire and Feldman's 1989 study of 6 children and their families. In addition they found marital dysfunction in all families, paternal substance abuse and spousal abuse (both physical and sexual) in 3 out of 4 families. The role of marital conflict as a facilitating factor in the progression towards Munchausen by Proxy abuse is also stressed by Gray and Bentovim (1996) and Souid, Keith and Cunningham (1998). Although these findings are potentially significant, the case numbers are once again too small to draw definitive conclusions.

More commonly fathers have been described as physically absent, passive or emotionally uninvolved with the family or peripheral in some way. Fathers are generally regarded as oblivious of the abuse process, or in rare cases passively colluding with the mother. Alexander points out that mothers are normally the ones who take children to doctors or clinics, and if the mother has a medical background, it would be justifiable for the father to entrust the "medical details" to her (1995, p.63). However, he acknowledges that the passivity of these fathers transcends such understandable dynamics and recommends further study to determine whether this passivity contributes to the inception of Munchausen by Proxy, whether it is a conditioned response to a chronic situation, or whether it indicates a marital problem that some mothers attempt to resolve through their behaviour (Alexander, 1995).

While the literature concurs that most perpetrator mothers have suffered neglect, emotional abuse or deprivation in their childhoods (Bools et al., 1994; Gray & Bentovim, 1996; Meadow, 1990a; Schreier & Libow, 1993a; 1994b; Sigal et al., 1989), evidence regarding maternal childhood sexual and/or physical abuse is contradictory. Figures vary from no acknowledgement of sexual

abuse (Gray & Bentovim, 1996), to 50% incidence of sexual abuse (Samuels et al., 1992). Similar statistics apply to physical abuse (Bools et al., 1994; Meadow, 1990a; Rosenberg, 1987; Samuels et al., 1992; Schreier & Libow, 1994b; Sigal et al., 1989). Various factors may be responsible for these differences, most notably the perpetrator's penchant for fabrication and the quality of the history-taking process. Often maternal childhood histories are inadequate and collateral is absent. However, even competent collateral gathering might not yield any certainties, as most sexual abuse is perpetrated in secrecy. Parnell (1998d) states that in her experience mother-perpetrators rarely reveal abuse histories during the initial evaluation, and this information only emerges later during therapy.

Fisher (1995) points out that it is common for perpetrators of abuse to give histories of abuse themselves. Others may describe abusive experiences but may not consider their histories to have been abusive. Yet others will maintain - even in the face of evidence to the contrary - that they have not been abused. This denial could either represent an attempt to appear as "normal" as possible (so as not to be "discovered"), or an attempt to hold on to idealized constructions of their parents as a defence against recognizing that they were uncared for. Although Fisher shares the view that childhood physical and sexual abuse is common in the histories of Munchausen by Proxy perpetrators, he emphasizes that the emotional injury is the most destructive component of any abuse. Therefore he concludes that one can assume that many, if not most, perpetrators share the long-lasting feelings of deprivation, inadequacy, lack of trust and fragile self concept that are characteristic sequelae of early abuse.

The presence or absence of abuse and the severity thereof has significant aetiological repercussions. In contrast to the rest of the literature, Oppenoorth (1992) documented a case where the mother's actions were directly attributable to dissociation following childhood sexual trauma.

c) Social / Societal Factors:

The literature is characterized by an absence of attention to social/societal factors and their role in the production of Munchausen by Proxy. The exceptions are Schreier and Libow (1993a; 1994b), Day and Parnell (1998), Leeder (1990), Mercer and Perdue (1993), and Robins and Sesan (1991).

Schreier and Libow specify that their book Hurting for Love represents their attempt to "place this syndrome in the context of the destructive and unfulfilling roles assigned to women during the era of modern medicine" (1993a, p. xiii). They acknowledge the power imbalances in traditional

gender roles and argue that women's traditional socialization into caregiving roles mitigates against expression of their own needs and a sense of entitlement to make demands for themselves. In addition, other gender-based discrimination inside and outside the home may lead to feelings of powerlessness. They also recognize the less than critical attitude towards fathers who fail to fulfil their spousal or child caretaking roles as well as the mental health literature's neglect of research on the role of paternal psychopathology and its contribution to child maladjustment. With regard to women and the medical establishment, they briefly discuss the historical lack of gender equality in a largely male-dominated paternalistic profession.

Schreier and Libow therefore hypothesize that if ambivalent feelings towards caregiving roles are superimposed on childhood histories of neglect or lack of acknowledgement, women with developmentally difficult babies and little support from spouses might act out their own needs for recognition and power through a perversion of the caregiving role. The role of the devoted mother of a sick child not only guarantees approval, but also provides an opportunity to exercise power over the physician. While they recognize some of the important historical and social factors in which Munchausen by Proxy is embedded, they nonetheless deify the doctor. S/he is described as nurturing, sensitive, caring, kind, well-educated, powerful, important. Not only does the mother find "social stimulation and a sense of importance in this exciting world [the hospital]", but she can also "bask in the glow of reflected glory when her pediatrician, with her help, succeeds in healing her child" (1993a, pp.113,119).

In a 1994 article Schreier and Libow include a subsection, entitled "Society's role", in which they only focus on people's difficulty acknowledging that mothers can consciously harm their children in this way and the lenient treatment these mothers receive from the legal system. In this article society is therefore merely implicated in its lack of "belief", its lack of detection skills and its lack of appropriate punishment (1994b).

Outside of the Schreier and Libow "camp", there is little recognition of social/societal factors involved in the production of Munchausen by Proxy. Of the four sources cited, I confine the discussion to Robins and Sesan (1991), as the contributions of the others are limited.

Robins and Sesan (1991) address the aetiology of Munchausen by Proxy from three perspectives, namely a family systems theory, theories of women's psychological development and child abuse

theory. They identify the following contributing factors making women more vulnerable to these types of behaviours: intergenerational transmission of abuse and oppression; the chronic powerlessness related to traditional mother roles in a dominant patriarchal social order; the self-care-versus-other-care imbalance supported by Western culture, which produces feelings of deprivation and anger; the cultural condemnation of expression of anger by women, which leads them (particularly those who have been abused) to learn less direct means of expressing anger and frustration; and the culturally sanctioned obtaining of self care from the medical profession.

d) The role of health professionals:

Some proponents of Munchausen by Proxy acknowledge the role of health professionals in the production and perpetuation of the phenomenon, albeit rather superficially. Schreier and Libow refer to the doctor as the "complementary ingredient necessary for the establishment and maintenance of this extraordinary disorder" (1993a, p.101). Following Rosenberg's documentation that 75% of morbidity in published cases takes place at the hand of both the mothers and the doctors (1987), many articles acknowledge the medical staff's unwitting cooperation in the abuse in the form of invasive and painful procedures. However, few acknowledge the potential to induce iatrogenic disorders (Fialkov, 1984). One exception is Meadow, who calls the doctor the mother's "partner in the abuse", and states that it could be maintained that there is no such entity as Munchausen by Proxy and that it is "merely medical misdiagnosis and maltreatment" (1994, p.336).

Other authors regard the medical staff's reluctance to believe that ostensibly caring mothers perpetrate such acts, and their even greater reluctance to confront them, as reinforcing factors in the abuse (Schreier, 1992; Schreier & Libow, 1994a; 1994b; Sigal et al., 1989). Yet others suggest that the relationship of dependence and admiration between mothers and medical staff may be reciprocal, as the staff not only come to rely on the mothers' flattery and praise, but also on their help in caring for the children (Schreier, 1992; Sigal et al., 1989).

Meadow (1994) considers institutional factors in modern medical practice enabling or contributing to Munchausen by Proxy abuse. According to him, new policies of unrestricted visiting and resident parents have increased the opportunity for abuse. This is particularly pertinent given that most of the abuse is perpetrated during hospitalization. Meadow also questions the role of what he terms "an evolutionary culture which correctly believes home to be a safer and happier place than hospital

for most children and which seeks to admit fewer children for ever shorter periods" (1999, p.12). In a review of 81 "unnatural sudden infant deaths", he found that nearly half the children had brief admission to hospital within the preceding week and 15 died within 24 hours of being discharged (1999). These discharges were not due to a shortage of hospital beds or facilities. Meadow reiterates that children suffering from recurrent physical or Munchausen by Proxy abuse have multiple warning signals and hospital encounters before the event that finally maims or kills them, and cautions against discharging children without having taken the time to understand the reasons for their presentation.

In addition to the lack of contact between primary and secondary care doctors in modern medical practice, increasing specialization also increases the risk of Munchausen by Proxy. It facilitates a process of fragmented care with no individual physician reviewing the totality of the problems, considering the whole child in the context of the family or taking responsibility for the coordination of the child's treatment (Fialkov, 1984; Meadow, 1994; Rosenberg, 1995). Technological advances may also indirectly play a role in the process. "Some paediatricians are readier to order magnetic resonance imaging or a biopsy than to spend more time listening to the mother and dissuading her from yet further investigations of her child" (Meadow, 1994, p.336).[20]

Donald and Jureidini (1996a; 1996b) present the most emphatic argument for acknowledgement of the role of the medical system in the genesis of Munchausen by Proxy. According to them, Munchausen by Proxy "evolves as a product of the relationship between a parent, who has both the capacity for abuse and the potential to be gratified by the medical system and a medical system that is specialized, investigation-oriented, fascinated by rare conditions, often ignorant of abusive behaviours, and too accepting of reported histories"(1996a, p.754). They contend that poor history taking is central to the aetiology and that technological advances encourage more extensive and specialized investigations. To redress the exclusive focus on the perpetrator - which has allowed the medical profession to ignore their role in the development of Munchausen by Proxy - they propose that the central role of the physician should be included in the definitional criteria.

e) Role of the media:

Only Schreier and Libow (1993a) consider the role of the media in the evolution of Munchausen by Proxy. In addition to noting the dramatic increase in medical dramas on American television, they also comment on the highly idealized and intensely paternal representation of physicians in

television dramas. With regard to the discrepancy in roles for male and female doctor characters, they observe: "These programs mirrored the lessons of female upbringing and communicated to women that their problems could be solved not by becoming the active healer or problem solver themselves, but by being the passive recipient of a male physician's wisdom and authority" (1993a, p.60). According to them, it is not only isolated suburban women who are susceptible to the social messages embedded in these shows, but doctors too become "enamored with their own power and goodness" (1993a, p.60).

f) Ecological model:

Fisher (1995) offers one of the more comprehensive ecological models for understanding Munchausen by Proxy behaviour. Because he recognizes that it is not a unitary phenomenon and that different motivations may operate at various levels, he cautions against single factor theories and the illusions of integration offered by biopsychosocial formulations. Instead he argues for a "fluid dynamic conceptualization of the myriad interacting components" (1995, p.42). Consequently his model consists of constitutional factors (genetic or biological vulnerabilities and early experiences), cultural, psychosocial and family influences, psychodynamic factors and triggers. Although Fisher pays scant attention to the role of health care professionals, his model takes into consideration the interplay between predispositions to affective or anxiety disorders, childhood abuse, exposure to abnormal sick role behaviours, attachment problems, gender roles, poverty, societal perceptions of physicians, societal responses to single parents, et cetera.

5. PREVALENCE

a) An international phenomenon?

Although most studies of Munchausen by Proxy have emanated from Britain and the United States, there have been several articles from other countries, such as Australia and New Zealand (Donald & Jureidini, 1996a, 1996b; Goss & McDougall, 1992; Holborow, 1985), Belgium (Adriaenssens & Eggermont, 1991), Denmark (Moszkowicz & Bjørnholm, 1998), Germany (Plassman, 1994), Holland (Oppenoorth, 1992), Israel (Shnaps, Frand, Rotem & Tirosh, 1981; Sigal et al., 1988; Sigal, Gelkopf & Levertov, 1990), Nigeria (Ifere, Yakubu, Aikhionbare, Quaitey & Taqi, 1993), Oman (Manikoth, Subramanyan, Menon & Al Khusaiby, 1999), Singapore (Lim, Yap & Lim, 1991) and

Sweden (Carlson et al., 1994).[21] This list is not exhaustive: Various articles published in French, Spanish, Polish, German, Italian, Czech and Swedish were not accessible and/or obtainable.

The above distribution of case studies seems to suggest that Munchausen by Proxy might possibly be an international phenomenon (Meadow, 1994; Parnell, 1998c). Ifere et al. (1993) illustrate that Munchausen by Proxy does not only occur within a western medical paradigm, as the perpetrator in their case, despite being a trained nurse, also initially made use of traditional healers.[22] They point out that there is no referral system among these healers and children might be more at risk, because of the absence of documentation and the competitive relationship between traditional healers. In addition, poorly developed legal and social services and the stigma attached to psychiatric care in the society make management and intervention very difficult.

b) Complicating factors:

Although some estimates have been attempted, no reliable population-based prevalence data exist. This may be partly related to the lack of precise criteria in the literature, lack of awareness among primary care physicians and paediatric subspecialists (Kaufman, Coury, Pickrel & McCleery, 1989; Ostfeld & Feldman 1996), disagreement between professionals, the difficulty in obtaining sufficient proof and the acknowledged difficulties and delays in identification.

There is consensus in the literature that the available figures and published cases represent an underestimation. Reasons advanced for this underestimation include lack of sensitivity to the phenomenon, underdetection of more subtle cases, inadequate attention to the siblings of index patients, variability of cases and the tendency of the literature to represent the more severe cases and/or those that have been confirmed (Schreier & Libow, 1993a, 1993b). It has also been argued that the incidence may be increasing, "because psychosocial disorders are affected by changes in society and the structures in the family" (Jones et al., 1986).

c) Attempts:

Some attempts have been made to estimate incidence, both by obtaining estimates within specific paediatric settings and by polling professionals likely to have had contact with Munchausen by Proxy cases. Estimates within paediatric settings yielded percentages varying between 1% (Godding & Kruth, 1991) and 5% (Warner & Hathaway, 1984). Examples of surveys include those conducted by Kaufman et al. (1989), Perdue (1988) and Schreier and Libow (1993b). While both methods

provide interesting results, they cannot be regarded as valid estimates of prevalence.

The only study representing an attempt at reliable prevalence data, is that of McClure et al. (1996), who examined all cases in the United Kingdom and Ireland in a two-year period involving a child protection conference. They reported a combined annual incidence of Munchausen by Proxy, non accidental poisoning and non-accidental suffocation of 0.5 per 100 000 children under 16 (increasing to 2.8 per 100 000 children under one), but admitted that this may be an underestimate, because cases were only identified if they were reported and a child protection case conference was called. In addition, they hypothesize that paediatricians might have been hesitant to report due to lack of confidence regarding diagnosis and/or anxiety regarding legal aspects. Despite its clear biases and the fact that it combines three conditions, this study is significant in that it challenges two generally held assumptions, namely that Munchausen by Proxy is not as rare as previously thought and that the majority of perpetrators merely exaggerate symptoms or fabricate false histories, but do not actively inflict harm on their children. McClure et al. (1996) show that Munchausen by Proxy is in fact a rare phenomenon and that the majority of perpetrators do directly induce symptoms.

6. CLASS, RACE, CULTURE, RELIGION

Due to a distinct paucity in information on the class, race, culture and religion of Munchausen by Proxy perpetrators and victims, it is difficult to draw any conclusions in this respect - as in so many others.

According to some authors, Munchausen by Proxy occurs across social classes (Gray & Bentovim, 1996; Rosenberg, 1987; Sanders, 1995). Other studies report a bias towards well-educated, middle class perpetrators (Warner & Hathaway, 1984). Yet others report that perpetrators generally come from disadvantaged families with no regular income and/or receiving social support (Bools et al., 1994; Fisher, 1995; Light & Sheridan, 1990; Meadow, 1998; 1999).

With the exception of a few case studies indicating that the perpetrators and/or victims were white, black or Hispanic, information regarding race and culture is lacking. Gray and Bentovim (1996), Meadow (1990a; 1999) and Perdue (1988) report that virtually all their cases involved white families. However, these findings may not be significant as they merely reflect the demographics of the relevant countries. No local statistics are available.

There is a distinct absence of attention to culture in the Munchausen by Proxy literature. Besides the aforementioned arguments about gender role stereotypes within a patriarchal Western culture (Day &Parnell, 1998; Leeder, 1990; Robins & Sesan, 1991; Schreier & Libow, 1993a), and Ifere et al.'s remarks about traditional healers and the stigma attached to psychiatric care in Nigerian society (1993), I found one unexplained and unreferenced comment by Eminson and Postlethwaite that "different cultural groups have been shown to vary in relation to frequency of presentation at clinics" (1992, p.1512). Similarly, no attention is paid to religion. A few single case reports mention that parents were religious and one found four perpetrators to be involved in fringe religions or spiritualism (Alexander et al., 1990; Nicol & Eccles, 1985; Schreier & Libow, 1993a; Warner & Hathaway, 1984).

7. DEFINITIONAL AND CONCEPTUAL DEVELOPMENTS AND DEBATES

As outlined in chapter 1, the confusion regarding nomenclature is accompanied by confusion concerning definition. Bools (1996) suggests that this confusion may not only be due to the complexity and heterogeneity of the phenomena, but might also be related to the involvement of the wide range of disciplines. It is not possible to represent these dialectics strictly chronologically. However, it seems important to first mention some of the earlier attempts at definition and conceptualisation, before the later adaptations and critiques can be considered.

a) Categories and continua:

One of the first attempts at conceptualising the phenomenon is that of Schreier and Libow (1986), who proposed a categorical model, consisting of three subtypes of Munchausen by Proxy, namely the Help-Seekers, the Doctor Addicts and the Active Inducers. Help-Seeker parents seem to be motivated by a need to convey distress, exhaustion or feelings of inadequacy in order to obtain help from the medical community. Since they usually respond receptively to supportive services or psychiatric intervention, they are not regarded as "true" Munchausen by Proxy abusers.

In contrast, the Active Inducers, who are designated as prototypical Munchausen by Proxy abusers, appear devoted, calm and cooperative, while inducing illness or injury in the child. They respond to confrontation with denial and anger and often flee before intervention can take place. The most consistent characterization of Active Inducers includes lack of differentiation between

mother and child, anxiety, depression, extreme degrees of denial, dissociation of affect and paranoid projection. Their secondary gain appears to be the staff's appreciation of them as exceptional caretakers, as well as the enactment of a controlling relationship with the physicians.

Doctor Addicts fall between the above two types and are obsessed with obtaining medical treatment for nonexistent illnesses in their children. Because their child victims are usually older and thus more capable of resisting or reporting dramatic assaults, their deception does not generally extend beyond false reporting of history and symptoms. Unlike the prototypical perpetrators, they present as distrustful and antagonistic towards the medical personnel. However, the two groups are alike in their overattached, symbiotic relationship with their children, their insistence on unnecessary tests and treatments and their response to confrontation. Schreier and Libow hypothesize that these Doctor Addicts may be more common than has been recognized, because presentations are more subtle.

While recognizing its value, Fisher and Mitchell (1995) criticize Schreier and Libow's categorical system, arguing that the groups appear very similar except for the primary motivation underlying the abuse. As such it may be impossible to distinguish between the three types when presented with a case. In a later work, Schreier and Libow concede that the distinction between Active Inducers and Doctor Addicts may be less clear than originally suggested (1993a).

In 1989 Meadow proposes another categorical model, outlining four ways in which Munchausen by Proxy abuse manifests, namely Perceived Illness, Doctor Shopping, Enforced Invalidism and Fabricated Illness. These categorisations will not be discussed in detail, since Meadow is not clear whether he regards the first three categories as abuse *per se* (or mere extensions of the usual parental response to illness). He also seemingly contradicts himself in later years by clearly excluding overanxious parents (similar to Perceived Illness), Doctor Shopping and mothers with delusional disorder,

Bools (1996) offers yet another categorical model, classifying six groups. He distinguishes these groups by method of fabrication (e.g. verbal fabrication, poisoning, smothering, withholding nutrients or medicine) and fabrication in special situations (including fabrication in pregnancy and fabrication in the presence of genuine illness).

As an alternative to these categorical models, Eminson and Postlethwaite (1992) advance a dimensional model, consisting of two dimensions: the appropriateness of the parents' desire to

consult and the ability of the parents to distinguish the child's needs from their own (see Figures 1 and 2).

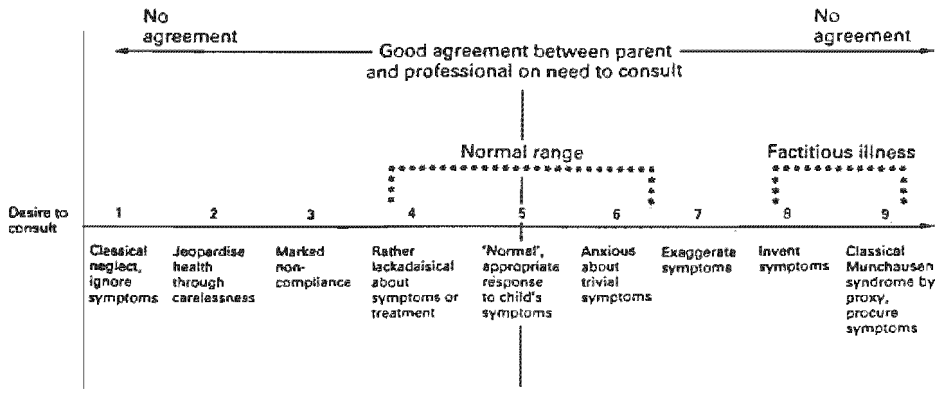

Figure 1: Parents' desire to consult for their child's symptoms

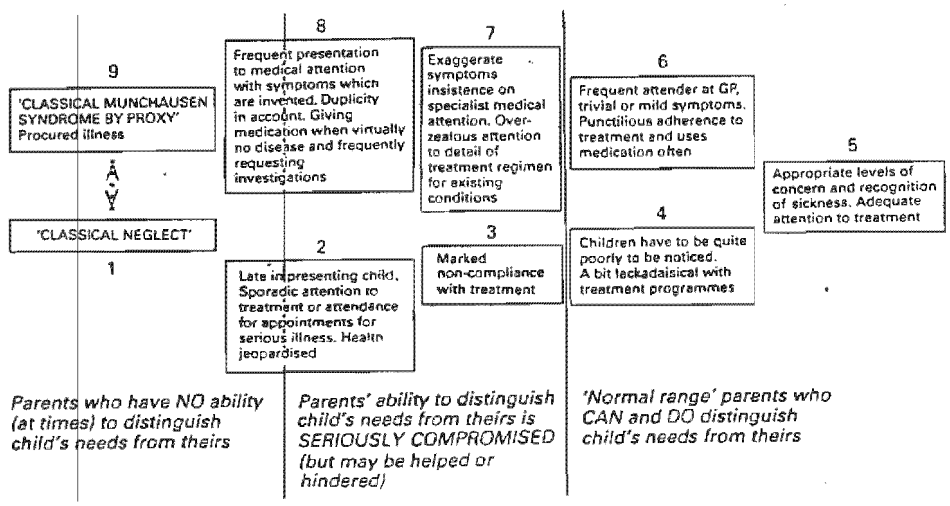

Figure 2: The spectrum of health care seeking by parents for their children

Eminson and Postlethwaite suggest referring to the whole spectrum - symptom procurement, verbally invented histories and extreme exaggeration - as "Factitious Illness", reserving "Munchausen by Proxy" for instances of procured symptoms only. On the second dimension, Munchausen by Proxy belongs in the range of parents unable to distinguish between their needs and their children's (as is the case in classical neglect). This model received mixed reactions. It was lauded for placing Munchausen by Proxy in the context of "better understood" forms of child abuse and allowing "flexibility in considering that the same case may present on different parts of the dimension at different times" (Fisher & Mitchell 1995, p.532). However, the latter claim is challenged by Donald and Jureidini

(1996b), who maintain that there is no empirical evidence to show that prototypical Munchausen by Proxy may have previously manifested as anxiety about symptoms, then symptom exaggeration and finally as symptom induction.

These attempts at conceptualising the phenomenon reflect the ongoing difficulty in subsuming a miscellany of presentations (in both victim and perpetrator) under a single rubric.

Eminson and Postlethwaite seem to be among the first proponents of the use of the term "Factitious Illness". The use of this label is followed shortly afterwards by the DSM-IV's inclusion of the phenomenon under the rubric of "Factitious Disorders". The introduction of this terminology seemed to open up renewed debates about the name/label and its definition. Before discussing these, I will briefly return to the DSM-IV criteria and the critiques thereof.

b) DSM-IV:

The DSM-IV prefers to use the term Factitious Disorder by Proxy and applies it to the perpetrator, rather than to the abuse. Several authors find this application of the label problematic (Davis & Sibert, 1996; Donald & Jureidini, 1996a; Meadow, 1995). Meadow argues that it might not only suggest a single cause and a single remedy for the behaviour, but it could lead to "authorities believing that such abuse of children could be diagnosed by psychiatrists or that an assessment of the perpetrating parent could overrule the clinical and forensic findings made by those involved with the child" (1995, p.538).

Criterion A, "the intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care" (APA, 1994, p.727), allows the term to be used in circumstances other than child abuse (e.g. causing false illness in the elderly or the handicapped). Parnell (1998b) takes issue with the inclusion of the fabrication and/or induction of psychological symptoms, citing the lack of support in the published literature for such inclusion.[23]

The key discriminator, according to Meadow, is criterion B, which concerns the motivation of the perpetrator, i.e. to assume the sick role by proxy. However, as various authors point out, a definition depending on motivation is problematic. Firstly, much would depend on the definition of the phrase "the sick role". Meadow (1995) suggests that it might be necessary to include different forms of attention-seeking behaviour in order to accommodate proposed expansions, such as false allegations of sexual abuse. Secondly, it may not be possible to determine the perpetrator's motive

at the time of the abuse. Unless there is direct disclosure, assessing the motive remains a subjective process (Davis & Sibert, 1996; Donald & Jureidini, 1996a, 1996b; Meadow, 1995). Donald and Jureidini caution that when the perpetrator's motive is not apparent, there is a risk that the abuse will be dismissed along with the Munchausen by Proxy diagnosis and the child will not be adequately protected. While there is anecdotal evidence that perpetrators derive a sense of importance, acknowledgement and nurturing from their interactions with medical staff (Goldfarb, 1998; "Kid Killers", 2000; Leeder, 1990; Nicol & Eccles, 1985), ascribing a single motivation to such complex behaviour seems simplistic (Meadow, 1995; Parnell, 1998b; Schreier, 1996). In addition, critics find this motivational assumption premature given the lack of detailed psychological and psychodynamic assessments of perpetrators (Donald & Jureidini, 1996a; Fisher, 1996).[24] According to Rosenberg "the intent of the perpetrator is diagnostically immaterial" and "cannot be added into the diagnostic equation" (1995, p.34).

The formulation of Criterion C - the absence of external incentives, such as monetary gain - has also been challenged. Meadow (1995) and Rosenberg (1995) both show that perpetrators may profit through litigation (e.g. suing the hospital or the physician for malpractice, or for malicious reporting of child abuse).[25] Other benefits may include support from social services, disability grants or other funding for families with chronically ill children (Meadow, 1984). Meadow suggests that this criterion needs altering to allow incentives such as economic gain to be present, provided that they are not the initial reason for the behaviour.

c) Other definitional criteria:

Parallel to the DSM-IV criteria are the criteria proposed by Rosenberg (1987), which have been guiding diagnoses both before and subsequent to the DSM-IV inclusion of the phenomenon. As previously indicated, these include fabrication or induction of illness by the caretaker, presentation of the proxy for medical attention, denial of responsibility for illness, and resolution of symptoms on separation. Although widely used, these criteria have been criticized for their general lack of specificity, for failing to specify the factitious nature of the presentation or the denial and for ignoring the role of the medical profession in the genesis and maintenance of Munchausen by Proxy (Donald & Jureidini, 1996a; Morley, 1995).[26] Both the DSM-IV and Rosenberg's criteria neglect the relational dimension of the phenomenon.

d) Expansion:

Various suggestions have been made to broaden the concept of Munchausen by Proxy to include the husband-wife dyad (Sigal, et al., 1986; Sigal et al., 1988), abuse of the elderly (Smith & Ardern, 1989),[27] false allegations of child sexual abuse to get attention from the child protection services (Meadow, 1993a; 1995; Schreier, 1996)[28] and fabrication and/or induction of illness in pets (Feldman, 1997; Finlay & Guiton, 1998). These extensions have been opposed by Jones (1996) and Donald and Jureidini (1996a). While these debates are significant insofar as they highlight the continuing efforts at definition and the disagreement between professionals, they are not directly relevant to my case discussion and will thus not be elaborated upon.

e) Restriction and current debate re nomenclature:

The abovementioned calls for expansion, the DSM-IV's changed nomenclature and the lack of specificity of its research criteria have given rise to various calls for restriction of the application of the labels and/or abandoning the term Munchausen by Proxy altogether.

Gray and Bentovim (1996) argue that due to the esoteric nature of the title "Munchausen by Proxy", paediatric professionals tend to be more aware of the syndrome than other child professionals. Its esoteric name also contributes to Munchausen by Proxy generally being seen as a medical or psychiatric problem rather than a broader child abuse problem. They suggest that the term be abandoned in favour of the more understandable "Factitious Illness by Proxy" or "Illness Induction" (Gray & Bentovim, 1996). Similarly, Davis and Sibert (1996) recommend that the term should be replaced by "Factitious Illness Spectrum Disorder of Childhood".

Another group of authors call for the abandonment of the term in favour of stating the exact nature of the problem, i.e. the condition of the child and, when possible, that of the perpetrator (Donald & Jureidini, 1996a; Fisher & Mitchell, 1995; Morley, 1995). Donald and Jureidini (1996a) maintain that the lack of clarity in the use of the term and the ambiguities in its definition lead to overinclusiveness, trivialization of abuse and lack of clarity about prognosis and long-term management. They propose that if the label is to be used, it should not refer to the perpetrator, but should describe "the complex transaction among at least 3 persons - a parent, her or his child, and the physician consulted by the parent on behalf of the child" (1996a, p.756).

One of the most comprehensive arguments for abandoning the term or restricting its use

is offered by Fisher and Mitchell (1995). According to them, the label "Munchausen Syndrome by Proxy" may imply that there is an "illness" with such a name, and may suggest that perpetrators have Munchausen Syndrome themselves and manifest their pathology via their child - which seems to be true only in a minority of cases. They assert that Munchausen by Proxy does not satisfy the criteria for acceptance as a discrete medical syndrome, because it is not a diagnosis in the traditional sense of the word, but an observational description. When making an observation that a fabrication has occurred, no diagnostic assumptions should be made about parental psychopathology. They further contend that it is not strictly speaking a syndrome either, as neither the victims nor the perpetrators have a specific collection of symptoms. Instead, as with child neglect, the victims present with a wide variety of symptoms and the perpetrators have various psychological, psychiatric and environmental pathways leading to their behaviour (this could include personality disorders, depression, severe family and social stressors). Fisher and Mitchell therefore recommend that paediatricians abandon making a diagnosis of Munchausen Syndrome by Proxy or Factitious Illness by Proxy, except in cases where the perpetrator clearly has Munchausen Syndrome *and* manifests this psychopathology via his or her child. Instead, paediatricians are called upon to diagnose or describe the specific fabricated or induced illness or conditions. Such a redefinition would be free of embedded assumptions, will ensure descriptive and obvious labels and will clarify the roles of paediatricians and psychiatrists.

Bools (1996) endorses a similar position, recommending that Factitious Illness by Proxy requires classification in three ways: the behaviour of the perpetrator (e.g. fabrication), the category of child abuse (i.e. physical or emotional) and any psychiatric diagnosis applicable to the perpetrator.

Another contentious point regarding the definitional parameters, concerns the intention or otherwise of the parent to kill the child. Although there is consensus that cases with clear infanticidal intent should not be regarded as Munchausen by Proxy (Feldman, 1994; Meadow, 1995; Morley, 1995; "Spying on Mothers", 1994), Parnell (1998c) maintains that some Munchausen by Proxy mothers do wish for or at least fantasize about the death of their children (including fantasizing about how to dress both themselves and the deceased child for the funeral).[29]

In an article entitled "What is, and what is not, Munchausen Syndrome by Proxy", Meadow attempts to address some of the definitional confusion (1995). Using the motivational criterion, namely to assume the sick role by proxy or other forms of attention-seeking behaviour, he excludes

the following phenomena: unrecognized physical abuse; failure to thrive; neglect; overanxious parents; mothers with delusional disorder; masquerade syndrome (where the intention is to keep the child dependent on the mother); hysteria by proxy (i.e. parents enforcing beliefs about their own illness onto children to make them invalids also); Doctor Shopping (since only a minority are doing it to assume the sick role for themselves); mothering to death (where parents evade medical services and are motivated by a need to adopt a perpetual mothering/nursing role, rather than a sick role); and "victor ludorum by proxy syndrome" (in which overambitious parents force their children to train exhaustively to achieve excellence in sport).

8. COVERT VIDEO SURVEILLANCE

Because of the delays in recognition, covert video surveillance has become one of the tools to confirm a diagnosis of Munchausen by Proxy. While this topic has generated heated debate, I will only summarise the main arguments briefly.

On the one hand, there are those paediatricians who assert that covert video surveillance is ethically justifiable. They cite as grounds that the predominant duty of care is owed to the child and as such, the protection of the child from life-threatening covert abuse takes moral priority over the moral obligation not to deceive or infringe upon the privacy of the parent (Gillon, 1995; Shinebourne, 1996). In addition, if the child is to be protected, definitive evidence is needed that will stand up in a court of law and covert video surveillance provides such evidence. Without it children may remain inadequately protected and suffer further abuse (Southall & Samuels, 1996). The legal system is further implicated in the justification process, as it is argued that judges often resist thinking ill of mothers when overt abuse is absent. Even when incontrovertible evidence of the syndrome has been presented, judges may hesitate to protect the children adequately without videotaped documentation (Feldman, 1994).

According to its proponents, the advantages of covert video surveillance include providing positive proof fairly quickly, thus expediting the provision of safety for the child and treatment for the family (Palusci & McHugh, 1996). It also eliminates having to make a diagnosis based on circumstantial evidence, risk factors and parental profiles, and it obviates the need to separate the parent from the child (either for diagnostic purposes or protection) on the basis of inadequate information

(Shinebourne, 1996). Proponents of covert video surveillance emphasize that it is used prudently - in one institution where 34 cases were monitored, 30 of them were confirmed (Samuels & Southall, 1994). In addition, advocates of covert video surveillance argue that it not only proves guilt, but also innocence ("Covert surveillance", 1994).

Those who oppose the current practices involving covert video surveillance, advance the following reasons: that it represents a breach of trust and an infringement of human rights (Morgan 1994; Tenney, 1994; Thomas 1996), that it threatens confidentiality ("Spying on Mothers",1994), that it carries the risk of falsely accusing others ("Spying on Mothers", 1994) and that it is very restrictive for both mother and child (as the infant is confined to his/her cot and the mother is confined to the particular room or cubicle in which the video camera is installed) (Tenney, 1994). In addition, opponents argue that obtaining videorecorded proof to justify confronting the mother or initiating criminal proceedings, smacks of vindictiveness ("Spying on Mothers", 1994).

9. MANAGEMENT AND TREATMENT

Management and treatment broadly consist of accurate diagnostic assessment, preventing the continued abuse of the child, care of the affected child and psychological/psychiatric help for the perpetrator. As indicated, the care of the child and the legal issues fall outside the ambit of this study.

Diagnostic assessment is the first and perhaps the most important step in the management process. This is reflected in Meadow's seminal article on management, in which he outlines procedures of investigation. These include a careful study of the child and family's history, gathering collateral from other family members and the family doctor, scrupulous record keeping, careful surveillance, ensuring that medical charts are not altered by the parents, retaining all blood and urine samples for poison analysis, searching parents' possessions, separating the parents from the child if necessary, convening multidisciplinary case conferences, informing social services and instituting other statutory procedures (1995). Similar guidelines are outlined by Eminson and Postlethwaite (1992), Light and Sheridan (1990), Parnell (1998c), Rosenberg (1987), Seibel and Parnell (1998), and Skau and Mouridsen (1995).

Meadow concludes his article with a short section on the role of psychiatry, in which he formulates the ambivalence characteristic of the literature in general. He states that a child psychiatrist

is "likely to be as effective as anyone in helping", and that they could play a major role in the long term help for the family, "if only in the form of discussion and moral support [for the paediatrician]" (1995, p.393).[30] The role of psychiatry is therefore minimal, if not counterproductive: Not only does psychiatric evaluation (and psychological testing) of the perpetrator invariably find the perpetrator to be normal, but psychiatric reports expressing their incredulity that the parent could be guilty as charged are usually produced by defence lawyers (Meadow, 1995). Mian (1995) indirectly echoes Meadow's sentiments, outlining the role of the psychiatrist in the multidisciplinary team in a mere two sentences. This contrasts sharply with the essential role of the hospital security officer, to whom three times as much text space is given. In a subsequent chapter in the same book dedicated to the role of psychiatry, Fisher openly states that the "by far greatest barrier to the diagnosis and effective management is the attitude and knowledge of physicians, especially psychiatrists" (1995b, p.369).

Whereas the literature displays ambivalence about the role of the psychiatrist, the psychologist is virtually absent in recommendations about management and treatment. The major exceptions are Chan et al. (1986), who devote three paragraphs to the role of the paediatric psychologist, [31] and Day and Parnell (both psychologists) who dedicate a large part of their book to therapeutic intervention (1998). I will return to the latter text in due course.

The literature on the treatment of Munchausen by Proxy perpetrators is meagre and few perpetrators have been successfully treated. Schreier and Libow (1993a) reported four cases which include a description of the therapeutic process (Kravitz & Wilmott, 1990; Lansky & Erickson, 1974; Lyall, Stirling, Crofton & Kelnar, 1992; Nicol & Eccles, 1985). Their choice of these four references is curious. Lyall et al. (1992) merely mention that family psychotherapy was only partly successful and Kravitz and Wilmott (1990) only report that the mother was hospitalized for a psychiatric evaluation and treated with anti-psychotic medication. In addition, Schreier and Libow omit six other articles that also refer to therapeutic interventions - all predating their book.[32] Subsequent to their book there have been a few additional reports of psychotherapy (Berg & Jones, 1999; Coombe, 1995; Fisher et al.,1993; Hotchkiss, 1997; Polledri, 1996; Sanders, 1995).

The literature is in agreement that Munchausen by Proxy abuse is associated with a poor prognosis. Schreier and Libow (1993a) outline the obstacles in the way of successful therapeutic treatment of perpetrators. According to them, the nature of the syndrome requires such a profound

level of deception and denial that engaging parents psychologically or helping them to understand the process of treatment is exceptionally difficult. Most perpetrators are unwilling to seek therapeutic help, and when referred either default or flee to another physician. In cases where psychotherapy is mandatory, perpetrators often only attend to regain custody of their children without being committed to the process. Additional barriers to successful treatment are the perpetrators' "unwillingness" to "use words rather than physical symptoms to express their pain, and to achieve the insight and skills necessary to discard Munchausen behaviors" (1993a, pp. 149-150). Similar views have been expressed by Jones (1994), Lyons-Ruth et al. (1991), and Skau and Mouridsen (1995). Polledri (1996) identified another potential barrier, namely the constraints upon the customary code of confidentiality where evidence relating to criminal activity or intention is involved. She acknowledges that it could render the process null and void, but argues that this need not happen if the client understands that the therapist is committed to his/her healing.

Because of these difficulties, the traditional psychodynamic out-patient therapy format has not yielded much success, except in the case reported by Nicol and Eccles, where the perpetrating mother was intelligent, well socialized, not beset with family and social problems and motivated to understand her behaviour. Coombe reports an 18-month multimodal milieu therapy of both mother and child and notes that the support of a strong and containing institution is a "basic prerequisite" for such treatment (1995, p.206).[33] Similarly Oppenoorth reports a successful outcome following long-term in-patient family milieu therapy, which included hypnotherapy for the mother, who had a dissociative disorder. Lyons-Ruth et al. (1991) suggest that because the mother is not immediately suitable for a traditional therapy format, and because her psychopathology is expressed in her relationship with her child, it is preferable to treat the mother-child relationship. They also argue for a psychodynamically informed supportive ("non-pathology based") approach, because the serious psychopathology manifested by these mothers is accompanied by an extremely unstable sense of self-esteem (1991, p.317). The therapist should therefore demonstrate to the client that her precarious defences and damaged self-esteem will not be further devastated. They recommend that the therapy be focused on the identification of the client's needs, limit setting and provision of more appropriate sources of attention and care. In addition, emergency room visits could be forestalled by home visits and regular appointments with a responsive paediatrician, who is skilled in sympathetic psychosocial

management.

The most comprehensive account of individual therapeutic work with perpetrators is given by Day and Parnell (1998), who incorporate cognitive-behavioural techniques and object relations theory. Framework parameters include the immediate establishment of the boundaries of the role (e.g. evaluator and/or therapist) with both the referral source and the client, the clarification of the limits of confidentiality, the clarification of financial issues in a written contract, and the use of a co-therapist to ensure support for the primary therapist and continuity for the client in case of vacation breaks. Since it is advisable that other professionals remain involved with the family during the treatment, it is necessary to obtain the client's permission to communicate with these professionals at regular intervals. In order to remain focused throughout a process with many potential pitfalls, they recommend the establishment of a treatment plan. In contrast to other authors, Day and Parnell recommend that the first stage of treatment should consist of individual therapy only, and that other modalities should be added only once the dynamics are understood and the treatment process warrants a change. Day and Parnell discuss three stages of the therapeutic process: the initial stage which revolves around trust, the middle phase which focuses on secrets, and the last phase which is primarily concerned with identity reformation. They recommend useful strategies that can be employed in the different stages.

While the literature endorses family therapy, there are only a few cursory case reviews, lacking guidelines and/or treatment models. Day and Ojeda-Castro (1998) ascribe the lack of long-term therapy to the dysfunction and lack of motivation present in Munchausen by Proxy families. Sanders (1995), who supports the view that factitious illness is co-authored by family members, recommends the use of a narrative approach for more cooperative families (where both parents are willing to commit to the process). The goal is to challenge the family's story of illness and help them develop an alternative story and alternative means of coping. Robins and Sesan (1991) present a multimodal treatment approach utilizing family, marital and/or group therapy incorporating feminist therapy theory, a socio-cultural perspective and treatment models that have been developed for adult survivors of abuse. However, Day and Ojeda-Castro (1998) caution against family therapy models that lack emphasis on perpetrator responsibility and victim empathy, as it could carry the risk of symptom substitution.

CHAPTER 3

THE CRITIQUE: A "MAP THAT PRECEDES THE TERRITORY"? [34]

I now turn to the critique of the literature, outlining both the dissent from within its own ranks and summarizing the most prominent critical text published thus far. The chapter will conclude with a discussion, including a few of my own observations.

1. DISSENT FROM WITHIN

While the Munchausen by Proxy literature superficially appears to portray a relatively homogeneous picture, closer examination reveals that the various proponents differ about virtually every aspect of the phenomenon. The most notable areas of difference include the nomenclature (including whether it can be regarded as a syndrome or not), whether Munchausen by Proxy is a variant of (adult) Munchausen Syndrome, the aetiology and prevalence, the victim morbidity and mortality statistics, the socio-economic backgrounds of the families involved, the abuse histories and psychopathological profiles of perpetrators, whether most perpetrators merely fabricate false histories or actually induce illness in their children, whether it is primarily a paediatric or a psychiatric diagnosis, whether extensions are justified or not, whether physicians are merely unwitting players or active co-perpetrators, whether covert video surveillance is justified, and most pertinently, whether perpetrators are treatable or not, and if so, what constitutes the most desired treatment modality.

Occasionally these differences and lacunae are acknowledged. Pankratz (1999) mentions the ongoing debate regarding the dimensions of the diagnosis. Rosenberg (1995) admits to having limited data, little understanding of the psychological problems of perpetrators, no large studies of comparative interventions and insufficient knowledge of the long-term harm suffered by victims. Similarly, Levin and Sheridan (1995) acknowledge that even the most basic questions regarding frequency, underlying dynamics and prevention remain unanswered. While they attempt to present the "state of knowledge" about Munchausen by Proxy, they grant that "one could easily call it the state of ignorance" (1995, p.xi). [35]

In addition to the disagreements listed above and detailed in chapter 2, the divisions within the ranks are illustrated by the criticisms among the major players, namely Meadow, Rosenberg

and Schreier and Libow. Meadow, who is regarded as the "father" of the phenomenon, criticizes Rosenberg's landmark 117-case meta-analysis (1987). He advises that extreme caution should be applied to the quantitative aspects of her meta-analysis, as overlaps occur, with the same cases being reported in different articles without cross-referencing. "Adding up these cases gives false information, and since it is also inevitable that isolated case reports highlight the more serious cases and those with worst outcome, the overall picture in relation to morbidity and mortality becomes even more false" (Meadow, 1990). Schreier and Libow's Hurting for Love - generally viewed as the "handbook" of Munchausen by Proxy - also elicited some criticism from Meadow. These two psychiatrists asked Meadow to write a preface to their text. However, he only refers to the authors in three sentences in the course of four pages. At a meeting three years after publication, Meadow acknowledged that he was critical of their hypothesis, but that they had edited out his criticisms, leaving only the praise (1995, as cited in Allison & Roberts, 1998). Rosenberg also diplomatically notes her disagreement with Schreier and Libow, albeit in an otherwise glowing review of Hurting for Love. She disagrees with their aetiological hypothesis and admits to feeling "a slight fatigue" upon reading about the relationship of Munchausen by Proxy and the disenfranchisement of women in society (1994, p. 1085).

Another crucial element within the disputes is the underlying power play between the paediatricians and the psychiatrists about who is qualified to make the diagnosis. As mentioned before, Bools (1996) partly attributes the confusion to the involvement of the different disciplines. Although the diagnosis is not of the child, but of the adult perpetrator, Rosenberg (1995) states unequivocally that it is a paediatric diagnosis, not a psychiatric one, as there exists no psychiatric or psychological test or interview technique to confirm or exclude it. Her assertion that reports by mental health professionals are often implausible and that they mistake conjecture for medical diagnosis, clearly illustrates the underlying territorial dispute. Fisher (1995) - a psychiatrist himself - agrees that it is not a psychiatric diagnosis and criticizes psychiatrists for their obstructive role. He also notes the power issues and status dynamics that may emerge around the question about who is qualified to make the diagnosis. According to him, a suspicion of Munchausen by Proxy raised by a psychiatrist or a non-physician is often met with resistance or opposition from paediatric staff.

2. DISORDERED MOTHER OR DISORDERED DIAGNOSIS?

By far the most vociferous criticism of the literature emanates from Allison and Roberts' *Disordered Mother or Disordered Diagnosis* (1998). While these two philosophers do not clearly place their approach in a context of contemporary theoretical methodologies, they periodically refer to Foucault and address issues through what can - at least in part - be regarded as a Foucauldian or deconstructionist historical analysis. More specifically, it can be likened to a Foucauldian archeology of knowledge, as they trace the layers of discursive sedimentation which have contributed to the emergence of Munchausen by Proxy (Foucault, 1972). More recent psychological proponents of this critical school of analysis include Parker, Burman and Fairclough, who all draw on Foucault's understanding of the profound relationship between power, ideology and discourse. This approach views discourse as a constitutive process in which subjects are positioned, identities are produced and power relations are sustained or restructured by warranting or refusing voice (Burman & Parker, 1993; Fairclough, 1992; Parker, 1989; 1992).

Allison and Roberts deconstruct the concept of Munchausen by Proxy by showing that it is a diagnostic construction produced by "a set of historically evolved discourses and operations that stem from particular medical institutions and individuals" and which "reflect and embody institutionalized medical power"(1998, pp.xx, xxii); a spurious syndrome that could result in miscarriages of justice involving the separation of mothers from their children and criminal prosecution of innocent caregivers.

Ignoring Meadow's assertion that one should not dwell on the past (1995a), Allison and Roberts maintain that Munchausen by Proxy (and other "disorders") harbour deep historical and social predeterminations underlying their appearance as "new" disorders. To illustrate the characteristic motivations underlying the formation of Munchausen by Proxy and to show how beliefs (irrespective of their truth value) become embedded in certain discourses and social practices, they draw on two "historically antecedent disorders", namely witchcraft and hysteria (pp.xxiii-xxiv). They argue that witchcraft and hysteria anticipate a similar pattern of dynamic construction in that both targeted women, their "evil" or "madness", and were perceived as a threat to the familial, social and institutional status quo. "With both witchcraft and hysteria, the fundamental expression of a cultural and psychological fear of women is magnified into a complex, necessary, and pressing social and political need" (p.xxiv).

Like Munchausen by Proxy, witchcraft also supposes a subject and a victim, a wide range of signs and symptoms inflicted on the victim, and a characteristic set of signs distinguishing the agent (recognized by a third party). The parallels extend even further: Witches also allegedly made use of drug powders, ointments and venoms to induce suffering, illness (particularly convulsions or fits) or death in others (often children); they too used fetishes such as cats, rats, insects; they were regarded as being inclined to sexual perversions such as promiscuity or erotomania; they were either single women or were unfaithful to or estranged from their husbands. Allison and Roberts show how the "continually repeated body of indications for witchcraft and demonic possession was, as with MBPS [Munchausen by Proxy] today, 'revealed', verified, and perpetuated by the various institutions that controlled the social, political, economic, and discursive practices of the time" (1998, p.8). Although witchcraft was an entirely invented "disorder", it assumed the legitimacy of a dangerous public threat, which, in turn, produced a whole set of procedures to contain it. It provided a "legitimating activity...for those who needed a subordinate other, an imminent but completely manageable danger, to oppose" (1998, p.21). The construction of witchcraft vindicated the authority of those who already possessed it or of those who sought to attain it.

Turning to hysteria, Allison and Roberts show that an analogous construction occurred, but in this instance the authority/power to determine personal and cultural "normalcy" was transferred to a medical model. They trace the history of hysteria showing how the medical profession - from Egyptian instruction, through Hippocrates, Galen, the Renaissance medical historians, to the 19th and 20th century physicians, therapists and clinics - produced various constructions in their attempts to appease and eliminate the outbursts of nonconforming and emotionally threatening conduct of women.[36] Hysteria was bound up with the moral restraint of women's sexuality and medically it was a rationalization of the symptoms produced by women's repression. Allison and Roberts illustrate how this behaviour, equated with madness, threatened the stable family unit and, by extension, the patriarchal social model. Constructed as an illness, its remediation was entrusted to medical authorities, who produced a large body of literature confirming the existence of a disorder. Medicine proceeded through a succession of impasses, each of which would be "resolved" by continually expanding the medical model itself, until the construction of hysteria was eventually "rescued" by Freud's theory of the unconscious (and psychoneurosis), which shifted the focus from "an organic model of degeneration

to one of psychic determination" (Allison & Roberts, 1998, p.42). To accommodate the 19th and 20th century psychodynamic theories, psychiatry extended its area of application to the determination and control of many traditionally nonmedical behaviours. In the process these behaviours were divorced from their social, family, economic and environmental contexts. These extensions were ultimately confirmed and given the appearance of reliability and validity in nosological manuals such as the DSM and the ICD. Allison and Roberts argue that Munchausen by Proxy's classification as a "disorder" follows the path of other aberrant, unusual or socially unacceptable behaviours such as Inadequate Personality (APA, 1968), Homosexuality (APA, 1968), Intermittent Explosive Disorder, Disorder of Written Expression, Premenstrual Dysphoric Disorder and so forth (APA,1994). [37]

Subsequently Allison and Roberts turn their attention to the historical antecedents of factitious disorders in particular. They examine the work of Cheyne (1733/1991), Gavin (1838), Brodie (1837), Charcot (1890), Freud (1894/1962, 1915/1958, 1926/1959), Menninger (1934), Asher (1951), Chapman (1957) and others, showing that the appearance of symptomatological and aetiological continuity is no more than an appearance and that personal, practical and punitive interests played a significant role in the motivation to diagnose factitious disorders. The underlying discourse essentially concerns the maintenance of power relations, involving financial interests, social control, questions of legal and professional responsibility and status, and the coherence of medical models.

Since Asher's "Lancet" article forms the *locus classicus* of all subsequent research on factitious disorders, Allison and Roberts' critique of his work warrants brief attention. They take issue with the way in which Asher subjectively and summarily determines the phenomenon as a syndrome, based on three disparate cases. According to them, he introduces Munchausen Syndrome as a *fait accompli*, simply declares it a syndrome in the first line of his article and assumes that most professionals would be in agreement. "Munchausen's is, then, a syndrome collectively conceived in the mind of a single observer" (Allison & Roberts, 1998, p.143). Following a review of a number of prominent cases, they conclude that virtually every Munchausen patient mentioned in the literature

> had a panoply of already existing physical, behavioral, and psychological disorders, not to mention that many were driven to seek hospitalization and shelter for reasons having to do with drug dependency, substance abuse, homelessness, poverty, or quite simply, intense personal pain and suffering. That is to say, what at first glance appears to be a unitary syndrome defining a factitious disorder... at closer inspection turns

> out to be a veritable grab-bag designation of patients with a wide variety of very real and very severe troubles. Moreover, such patients would never be classified together outside of the putative logic of the superordinate description entailed in the adult Munchausen's syndrome (1998, p.xxix).

In addition, Allison and Roberts comment on the punitive and surveillant terms of Asher's paper, excluding patients who, according to his own judgment, may suffer from medically and psychiatrically significant disorders. In addition, they criticize his lack of contextualization of the cited cases. They emanate from post-World War II Britain, which was characterized by dislocation, severe effects of economic and physical reconstruction, rationing, housing shortages and concomitant homelessness, unemployment and significantly increased divorce rates. Allison and Roberts thus conclude that it would not have been unusual for those suffering from the dislocation, stress, abandonment and grief resulting from the war, to seek comfort, housing, food and shelter within the newly formed National Health Care system, which provided free medical treatment.

Turning to Munchausen by Proxy, Allison and Roberts illustrate how Meadow's 1977 article reproduces Asher's *modus operandi*, in that he advances no substantive diagnosis, aetiology or treatment for the new "Munchausen by Proxy Syndrome", but identifies it by way of the "fabulations, impostures and deceit presented by certain types of parents....What Meadow effectively did was to take two perplexing cases of alleged child abuse, interweave them with the preexisting Munchausen 'lore' - its set of profiles, predetermining categories, apparent lack of etiological specificity, and so on ... - and arrive at a variant of the syndrome" (1998, p.136). As with Munchausen Syndrome, they question whether it can indeed be regarded as a syndrome. While they credit Rosenberg for attempting to define what constitutes a syndrome, they show how, in an attempt to cover a whole range of disparate signs and symptoms, the value of the definition is undermined by its breadth. They also highlight the weakness of the evidence reviewed, e.g. half the reviewed cases do not mention the age of the patient, one in ten fails to mention the sex of the child, 45 cases out of 117 fail to provide information on the primary criterion for the identification of the syndrome, namely the simulation or production of illness in the child. Since Rosenberg does not exclude these cases, the accuracy of her morbidity and mortality rates is (as Meadow has argued) questionable. Out of 97 mothers, 3 are described as having psychiatric or psychological disorders, but Rosenberg nonetheless concludes that the overall

behaviour of these mothers is "biologically abnormal" and that they have an "occult psychopathology" which warrants court-ordered long-term psychiatric evaluation (1987, pp.557, 560). Allison and Roberts also criticize Rosenberg's aetiological formulation as being of "lamentable generality" (1998, p.149). They conclude that the only way for Rosenberg to unite the "morass of conflicting information, multiple etiologies, incomplete case studies and histories, huge gaps in relevant information, no long-term analysis of either 'perpetrators' or 'victims', and a disparate array of symptoms and signs into a valid and diagnosable disorder" is to define it as a syndrome (1998, pp.150-151).

Another major feature of the literature on Munchausen by Proxy is its recursivity ("a procedure in which all present cases are defined in terms of previously accrued and constantly reiterated cases" (Allison & Roberts, 1998, p.xxix)). After having examined the lack of specific data in the definitive texts, the uncritical and unreflective way in which ideas and opinions are accepted as fact, Allison and Roberts show how the literature reaffirms by reasserting, how repetitions and patterns based on invented or secondary characteristics receive legitimation by virtue of their own reinscription within the literature. They conclude that Munchausen by Proxy is "defined into existence by virtue of the enormous amount of material written about it: each professional paper, report, case history, and review thus serves to 'verify' the initial definition, to confirm the existence of subsequent 'cases', and to act as a warning that the disorder is far more widespread and pernicious than had been originally suspected" (1998, p.xxix).

The effect of such recursivity is that collateral empirical data is progressively eliminated and case studies emerge as abstract constructions, which correspond with equally vague earlier cases. This lack of attention to medical, psychiatric and personal histories, marital relations and socioeconomic conditions has contributed to the lack of sound aetiological formulations. If one returns to Meadow's initial article, this process is clearly illustrated. Meadow did pay some attention to the broader family context of his two patients. However, instead of locating the diagnosis and treatment in the psychosocial sphere, the subsequent literature absorbed all nonmedical elements of such cases into the medical mode, subordinating all other disciplines and social concerns to the "medicopsychiatric determination of the disorder" (Allison & Roberts, 1998, p.71). Consequently, other therapeutic approaches, social service interventions and family counselling were relegated to the status of "ancillary procedures, invoked as remedial aids to assist in the medically authorized treatment" (Allison & Roberts, 1998,

p.71). The primacy of the medical authority extends even further. Not only would the "disorder" be absorbed into the diagnostic nosology of psychiatry, with the physician alone being uniquely qualified to diagnose and treat it primarily within the medical environment, but s/he would also be the determining causative element - a far cry from Meadow's circumspect formulation: "...in these cases it was *as if* the parents were using their children to get themselves into the sheltered environment of a children's ward surrounded by friendly staff" (1971, p.345, italics added).

Allison and Roberts devote the latter part of their book to a critique of Schreier and Libow's Hurting for Love. Although Allison and Roberts criticize virtually all aspects of the text, their main concern is the proposed aetiology. The title of Schreier and Libow's volume implies that the doctor is the object of love, an idealized parental figure. As noted before, Schreier and Libow's aetiological construct rests on the premise of a virtually deified portrayal of the physician as a benign, caring, nurturing, powerful figure.[38] Allison and Roberts challenge the plausibility of this "mythical stereotype" (1998, p.173), arguing that historically and currently the treatment of women by doctors is far more problematic and strained than this view suggests. They draw attention to the large literature detailing the history of the relationship between women and the medical profession (Arms, 1975; Faludi, 1992; Hartmann, 1987; Janssen-Jurreit, 1982; Lawrence & Weinhouse, 1994; Oakley, 1980; Rich, 1976; Rothman, 1982; Tavris, 1992).[39] This history includes unnecessary gynaecological operations driven by gender biases and financial interest, the medicalization of childbirth and childrearing, the pathologizing of menopause, and the battle over reproduction rights (e.g. forced sterilization and anti-abortion campaigns which denigrate women, relegating them to mere vessels for carrying the child).

Allison and Roberts also criticize Schreier and Libow's research on the socio-economic background of Munchausen by Proxy mothers. They devote only two paragraphs (which include a discussion of religious affiliation, age, marital status) out of a 222-page text to these factors, clearly illustrating that they regard the broader contexts of these families as incidental. Allison and Roberts also challenge the claim that Munchausen by Proxy mothers are not distinguished by social, class, or economic backgrounds. Apart from the lack of demographic studies to verify the said claim, some surveys have found that the majority of suspected parents were from disadvantaged families with no regular income and/or receiving social support. While Allison and Roberts only mention the survey by Light

and Sheridan (1990), one could also add the findings of Bools et al. (1994) and Meadow (1998, 1999), as well as the observation by Fisher (1995) that virtually all his Munchausen by Proxy parents were single struggling mothers. Allison and Roberts argue that even if it were true that Munchausen by Proxy mothers came from the spectrum of different classes, it would not be true that they all receive the same kind of treatment. [American] Studies examining public health care for broad population samples show that poor, inner-city, and minority group parents routinely receive inferior medical care. For such women basic pre- or neonatal care is inaccessible, not to mention the "well baby home visits" that Schreier and Libow claim are part of standard practice. "Exciting and fascinating visits to gynecologists, obstetricians, and pediatricians, as well as intriguing hospital experiences, could also be largely ruled out" (Allison & Roberts, 1998, p.193). According to the authors, this disparity between the access to and quality of medical treatment for poor and minority women and middle and upper class women greatly undermines Schreier and Libow's notion of a common aetiology.

Allison and Roberts criticize Schreier and Libow's account of the role of the media. According to them, the notion that the image of the "good doctor" derives from television portrayals internalized by mothers fails to recognize the complexity involved in the transmission, apprehension and understanding of media-generated images. In addition, they question why doctors should be singled out in this process, and not other television figures invested with power, such as lawyers, sporting heroes, cowboys, corporate leaders, and the like. They further claim that Schreier and Libow's figures about increasing television shows featuring doctors as main characters can merely be ascribed to the general explosive growth of all television programmes.

Allison and Roberts further criticize Schreier and Libow's constructed aetiology for its unreflective, ill-defined and self-serving use of psychoanalytic terms such as "perversion", "transference", "sadomasochism" and "fetishism". I confine myself to two examples. A definition of perversion as a form of "unreal relating" is so broad as to be applicable to all forms of fantasy, psychosis or imposture. Allison and Roberts argue that despite their disclaimers, Schreier and Libow use the concept in the traditional Freudian sense (yet they deny its sexual nature). In addition, Schreier and Libow's claim that Munchausen by Proxy constitutes a perversion of mothering not only fails to explain the similar behaviour of fathers and abuse among unrelated adults, but it also presupposes a universally determined and accepted notion of "good mothering", thereby ignoring that the latter

is a complex socio-cultural construct. As with their use of "perversion", Schreier and Libow fail to define their central notion of the child as fetish, devoting only one sentence to it. Allison and Roberts maintain that it would be more accurate to describe this "perverse" relationship in which the child is used as a "fetish" to regulate the relationship with the physician as a sacrifice offered on the altar of the godlike physician in order to propitiate him and find affective fulfilment.

Despite their efforts to construct an aetiological explanation for the behaviour of Munchausen by Proxy perpetrators, Schreier and Libow fail to integrate it successfully into a therapeutic management plan. Although they acknowledge the absence of established therapeutic practices, they attribute the failure of therapy to the patient (as explained on p.39). Their suggested management strategies comprise guidelines for diagnosis and identification, guidelines for verification, ways of circumventing the legal safeguards and ramifications of covert video surveillance, national electronic medical networks, nationwide registries for convicted perpetrators and trained task forces. This prompts Allison and Roberts to conclude that the entire discussion of Munchausen by Proxy which sought to distinguish it as a distinctive disorder - the aetiology, diagnostic apparatus, treatment and therapy - essentially becomes secondary to preventive and punitive concerns, effectively criminalizing the behaviour. [40] The criminal aspect of Munchausen by Proxy is heightened by the dissemination of information in the media as well as on the Internet (Allison & Roberts, 1998). [41]

The last chapter of Allison and Roberts' book is devoted to the examination of a few prominent cases in which Munchausen by Proxy has been alleged, but in which this aetiology remains dubious and the crime itself unproven. They conclude that the danger of Munchausen by Proxy does not primarily lie, as Schreier and Libow would have it, in the disorder itself, but in the way in which hypothetical speculation based on inadequate and inconsistent data is used to advance a tendentious aetiology, which in turn establishes complete medical hegemony over women and their behaviour and casts the net of suspicion and surveillance ever more widely.

3. DISCUSSION

Allison and Roberts do not deny that stressed parents - especially those with dysfunctional family backgrounds, socio-economic problems, histories of personal and family illness or substance abuse histories - may harm their children, may seek medical help for transient or minor illnesses or may

use medication or medical instruments to abuse their children. They do, however, contest the assumption that such behaviour constitutes a specific illness or a rampant mental disorder. Their text is not above criticism. It is often repetitive and in their polemical ardour they tend to "rhetorical overkill" (Kenny, 1999). In addition they do not adequately situate their approach theoretically, they review the literature selectively [42] and neglect the valid critiques from "within" advanced by authors such as Donald and Jureidini, Fisher and Mitchell, and Morley (merely mentioning Fisher, Mitchell and Morley in a footnote). However, they do make a valuable contribution in situating the debate historically, pointing to the thinly veiled gender prejudice and power relations embedded in the construction process, and raising pertinent questions about the scientific basis and ontological status of Factitious Disorders in general and Munchausen by Proxy in particular. One might ask to what extent the diagnostic apparatus and virtual criminalization of the behaviour are a means of reasserting control over - if not punishing - people who not only overturn universalized notions of mothering, but subvert medical authority, an authority which is increasingly challenged by alternative healing practices? In this regard Allison and Roberts show that Schreier and Libow's "affabulated etiology" (1998, p.277) not only deftly reclaims power and authority for physicians, but amplifies it.

Examining the literature, I too was impressed by the dissention, the inadequacy of the research, its recursivity and the consequences thereof. A majority of articles seem to have been produced according to a "template", starting with similar historical frames, virtually identical definitions, followed by case studies which prioritize medical detail and individual pathology at the expense of structural or contextual issues. Most articles conclude with an injunction to professionals to educate themselves and be on the alert. A small but amusing illustration of the uncritical reproduction of earlier views concerns the use of the term "Polle Syndrome". According to Burman and Stevens (1977), Polle was the son of Baron von Münchhausen's (much younger) second wife. Polle's paternity was suspect and he died a year after birth. This information was uncritically utilized by subsequent authors, while a few even suggested that the Baron might have been implicated in Polle's early demise (Ackerman & Strobel, 1981; Mehl et al., 1990). It was therefore suggested that "Polle Syndrome" be used when there is evidence that the parent presents with Munchausen Syndrome: "a child of Munchausen whose life expectancy is liable to be short" (Burman & Stevens, 1977, p.456; Leeder, 1990; Verity et al., 1979). However, seven years later it was discovered that the child in question was in fact

a girl named Maria Wilhelmina and that she was almost certainly not the Baron's daughter. Maria Wilhelmina died of seizures and no influence of the Baron on her death has ever been recorded. Polle was the town in which she was born and baptized (Meadow & Lennert, 1984; Strassburg & Peuckert, 1984).

In his review of Disordered Mother or Disordered Diagnosis, Kenny criticizes Allison and Roberts for not mentioning Hacking's Rewriting the Soul: Multiple Personality and the Sciences of Memory (1995a), which parallels their approach and includes an extensive discussion of the "mystical power of statistics, the fallacies of measurement and the social power of expert knowledge" (1999, p.593). It is pertinent briefly to examine some of Hacking's ideas regarding the prevalence of Dissociative Identity Disorder among women, as it sheds light on the Munchausen by Proxy debate as well.

Hacking (1995a, 1995b) points to the strong association between early and repeated child abuse and Dissociative Identity Disorder, and shows how the gender ratio of abuse correlates with the gender ratio of Dissociative Identity Disorder. While the prevalence of childhood sexual abuse in Munchausen by Proxy perpetrators is disputed, there is consensus about a shared history of emotional abuse. Therefore, the role of childhood abuse in the emergence of Munchausen by Proxy abuse - and the role of dissociation - is one that deserves further research.[43] Consideration of the role of child abuse also sheds light on the question as to why Munchausen by Proxy has only emerged in the 1970s. Hacking shows how the feminist movement provided a political atmosphere in which child abuse could be drawn to public and medical attention in the 1960s (citing Helfer and Kempe's The Battered Child (1968) as the landmark text). [44]

Hacking argues that people "choose" culturally available and clinically reinforced ways to express distress. These are mediated by gender stereotypes. During the previous two centuries men often expressed distress through alcoholism, whereas women in the 19th century expressed distress through hysteria. Hacking argues that now women often express their distress through dissociative symptoms. Although it can merely be hypothesized that Munchausen by Proxy behaviour involves dissociative elements (as shown by Oppenoorth (1992)), it could be argued that the increased medicalization of women and children[45] enables the emergence of Munchausen by Proxy as a culturally sanctioned way of expressing distress and obtaining help. This neither means that it is culturally or socially "acceptable" to abuse children in this way, nor that it can be singled out as the sole explanation

for predominance of female perpetrators. However, it does provide a set of meanings within which the interaction between client and clinician is intelligible. As Rosenberg (1995) states, Munchausen by Proxy, "like a tango, cannot be done alone" (1995, p.36). Its defining feature is the response of the medical system. It is also not conceivable without the history of medicalization of women's bodies, childbirth and childrearing, a discourse which not only pathologizes natural bodily functions (such as menstruation, birth, menopause, ageing), but also positions women in a help-seeking role as primary consumers of medical services.[46] This discourse positions the physician (the general practitioner, the gynaecologist, the obstetrician, the paediatrician, and increasingly the plastic surgeon) as the provider, the authority, the arbiter of health and illness. Given that women are traditionally more involved in the daily care and illnesses of their children and that they occupy powerful positions of control over their children, it is a small step to conceiving the emergence of Munchausen by Proxy behaviour.

CHAPTER 4

THE PATIENT AGAIN: CASE DISCUSSION

1. PREFACE

I now return in more detail to the case of Mrs X, in order to illustrate the material in chapter 2. The reader is reminded that the integrity of Mrs X's history cannot be entirely vouched for, due to the following reasons:

1) Mrs X was a poor historian, whose history was characterized by vagueness and discrepancies.

2) I was appointed as her case manager at a relatively late stage, which meant that I had to rely partially on previous case records (which already "defined" her to some extent).

3) While I was not aware of it during our first meeting, Mrs X had already been informed that the case had been referred to the Child Protection Unit. This would undoubtedly have influenced the way she presented herself and her history.

When the evidence of her abusive behaviour towards her child became known, the emphasis shifted to accelerating the legal proceedings. The recommendation of the multidisciplinary team on the ward was to expedite her arrest, so that she could be transferred to the Lentegeur forensic unit for observation. My role thus consisted of confronting her with what we knew, preparing her for her possible arrest and coordinating the communication between the Child Protection Unit, the social worker of the children's hospital and the community social services.

2. COLLATERAL

a) Ward:

After my first interview with Mrs X, I started gathering collateral. Observation in the ward yielded inconsistencies between her report and her behaviour. Nursing reports contradicted her complaints of severe insomnia. Her interactions in the ward did not validate a clinical picture of depression: As mentioned, she would dress drably for the interview, be slumped, looking sad and anhedonic, but in the recreation area she would be dressed up in bright clothes, appear to be in good spirits and make jokes with fellow in-patients. During an in-patient therapy group which I co-facilitated later that day, Mrs X addressed herself exclusively to me, blaming her family for all her problems and adopting a justificatory tone (although she did not refer to medicating her son). My co-facilitator

felt that her tearfulness was not genuine.

b) Social worker:

Not realising the seriousness of her actions (due to lack of background information), I offered to find out whether she could have more contact with her children. When I finally reached the children's hospital's social worker, she provided me with the details precipitating Mrs X's admission.

Mrs X's youngest son, Rashied, was admitted to a local children's hospital on the 28th of December 1998 with vomiting, headaches and drowsiness. He was discharged the next day, but readmitted a day later with the same symptoms. Mrs X denied any knowledge about the aetiology of the symptoms. On December 31 Rashied deteriorated into an intermittent coma for a period of four days. Mrs X offered to bring a plant from home, which she claimed he might have ingested. A toxicology screen revealed high levels of tricyclic anti-depressants and opiates in his blood. While he was being fed a milk feed through a nasogastric tube, his stomach contents again showed renewed evidence of tricyclics. For this reason, it was suspected that Mrs X had been adding tricyclics to his milk feed while in hospital. On the 6th of January 1999 a child psychiatrist was consulted. She interviewed both mother and child. Mrs X denied any involvement, claiming that she had not been taking any medication for her "mood problem" for the last three years. Rashied told the psychiatrist that his mother gave him medication to make him sleep well. He also said she gave him milk she bought from the chemist. Munchausen by Proxy was diagnosed. With the help of Mrs X's sister, the children were temporarily placed in care of Mrs X's ex-husband, his parents and a maternal aunt.

Mrs X continued to deny any involvement and only on the 15th of January she admitted having given Rashied one or two pills prior to his first admission. She denied giving him any additional medication, saying that since he knew where she kept her medicine, he might have taken some himself. She persistently denied giving him any medication during his hospitalization. Her sister later told me Mrs X had given Rashied the medication in hospital to cover up her actions - i.e. trying to create the impression that he was being medicated by hospital staff. Mrs X said she realized she needed help and was going to admit herself to Valkenberg.[47] The children's hospital reported the case to the Child Protection Unit.

Rashied's hospital records reflected seven admissions since birth, mostly with similar symptoms. In 1995 he also presented with seizures and a toxicology screen showed chlorpromazine ingestion.

Staff accepted Mrs X's explanation that he had obtained it while visiting the neighbours. He also once presented with a head injury and was admitted to the trauma unit. The files repeatedly note a suspicious scar on his chest. Over the years he had had various procedures, including lumbar punctures, computed tomography (CT) scans, electroencephalograms (EEGs) and multiple blood tests.

Mrs X's elder son, Suleiman (11), frequently presented at the children's hospital's Neurology clinic with epilepsy. He was reported to have two seizures per week and was attending a school for epileptics. At the time Mrs X admitted to injecting anti-epileptic medication into his penis to stop the seizures. Rashied confirmed that he saw her do it. When questioned, she insisted that she was following doctor's orders. There was never any suspicion that Suleiman's seizures may have been induced. It is however noteworthy to consider that seizures are one of the most common manifestations in Munchausen by Proxy abuse and that chlorpromazine (and to a lesser extent amitriptyline) can be epileptogenic. During a follow-up contact with social services eight months later, it transpired that Suleiman had not had any seizures since being in the care of his father.

While little is known about Mrs X's 14-year-old-daughter, Farieda, she is reported to attend the Allergy clinic at the hospital, presenting with chronic allergies and asthma.

c) Family:

It transpired that before her meeting with me, Mrs X had told her family that she had already received electro-convulsive therapy. I started suspecting that she was planning to use the "amnesia" she believed to be induced by it as a defence in the event of a trial. Her sister reported that Mrs X was deceitful and aggressive. Her mother confirmed the deceitfulness and refused to allow Mrs X back into their home. The family described her as having a "split personality" (their words to describe the caring mother versus the abuser).

3. PERSONAL AND FAMILY HISTORY

Mrs X is the fourth of seven children. In contrast with her brothers and sisters who are professional people, Mrs X only reached standard eight. On leaving school she trained as a dental assistant. She worked as a dental assistant and what she termed "an oral hygienist". According to Mrs X, she gave up her work after ten years of employment to care for the people at home (on another occasion she claimed she lost the job due to tremulousness). She experienced the dentist she worked for as

"very caring". At the time of admission she was receiving a disability grant.

She reported that her parents regarded her as "backward", "mad" and "stupid" and therefore treated her badly. She always felt rejected by her family. Mrs X described her 61-year-old retired father as having been abusive, particularly towards the children. She did not report any sexual abuse. According to Mrs X, her father complained about her visits to the clinic and the hospital, saying she did not do enough for the household. She also reported to have a poor relationship with her 59-year-old diabetic mother, who, following severe gangrenous pain, had had a leg amputation the previous year. Her mother also received medication for hypertension and depression. Mrs X was in charge of collecting her mother's medication from the local community clinic.

At the time she was living with her parents and her three children in the two-bedroomed parental home. She was supplementing her income by making and selling food. Mrs X reported that Rashied had scholastic and behavioural problems, was distractible and "hyperactive". His behaviour was a constant source of friction in the home and her parents often criticized her for not being able to control him. According to Mrs X, Rashied frequently threatened suicide, saying he wanted to throw himself under a car. She felt he did not like her, but did not know why as she showed so much care for him. Farieda was abusive towards Mrs X, accusing her of causing their problems and blaming her for the divorce.

Given Rashied's behavioural problems, her mother's illness and the poor familial relationships, the home circumstances were very stressful for Mrs X. She felt she needed to take care of everyone. When the situation became intolerable the previous year, she left, but returned because she did not want to hurt her family's feelings. She expressed her wish that her eldest sister, a civil engineer, would look after her. This sister reported that Mrs X could not cope with responsibility.

4. MARITAL HISTORY

Her history lacked information about the early stages of her psychosexual maturation and her first marriage. Her relationship with her first husband seemingly deteriorated shortly after the birth of their daughter. She married Mr X, a mechanic, and when her daughter was about three years old, her first son, Suleiman, was born. Two years later her third child, Rashied, was born. Her husband started to abuse drugs and alcohol and became abusive towards her. According to the family, Mrs

X started showing a change at this time. She felt ashamed of her husband's drug use, particularly since the family was rather class conscious. It would appear that the couple got divorced in 1992, although different dates were given at various times. Her ex-husband lived with his mother. Both of them claimed that he had not taken drugs for the last two years, but Mrs X did not believe it. During Rashied's hospitalization, Mrs X had tried to prevent her ex-husband from visiting, claiming she had an interdict against him. However, she could not produce it. She also initially attempted to prevent the children from being in his care.

5. PSYCHIATRIC HISTORY

Mrs X's psychiatric history includes two or three previous admissions to psychiatric facilities and three suicide attempts by overdose.

Mrs X reported an admission to Lentegeur psychiatric hospital in 1991 and two suicide attempts in 1994, overdosing on anti-depressants. She was admitted to the emergency psychiatric ward at Groote Schuur hospital in 1995, followed by an admission to Valkenberg hospital. According to her she had attempted suicide by overdosing on her child's anti-convulsant medication. (At the children's hospital she reported having never felt suicidal in her life.) However, the referral letter did not mention a suicide attempt, but stated the reason for referral as Conversion Disorder. She apparently had left and right weakness, resulting in falling. This presentation was queried at Valkenberg, as the falling was very slow, occurred without injury and she showed no unsteadiness when sitting up quickly. At the time she described symptoms of Major Depressive Disorder with psychotic features, but this too was queried. File notes recorded entries such as "able to switch off tears", "appears to think up answers when asked leading questions", "open-ended questions answered with extreme vagueness" and "patient tended to be manipulative at times". While a differential of personality disorder was considered, Mrs X managed to continue receiving her prescribed medications. At the time a nursing sister conducted a family study.

During her two-month stay at Valkenberg in 1995, Mrs X repeatedly reported being "happy" to be in the ward and returned early after weekends, saying she was "tired" of her children and that she found them "too much". She admitted displacing her hatred for her ex-husband onto her children and feared that she might lose them. She also reported a conflictual relationship with her mother,

coupled with feelings of rejection. In a family interview conducted at the time, both Mrs X and her mother denied any tension between them, blaming the children, in particular Farieda, for the difficulties at home. During her hospitalization, Mrs X had a relationship with a male patient on another ward, and when he expressed a lack of interest, she threatened to commit suicide, but denied it later. When staff felt that she was becoming dependent on the hospital and discussed discharge plans with her, she requested a prolonged stay. After being discharged, she was followed-up at the local community clinic where she collected her medication.

6. MEDICAL HISTORY

Mrs X's medical history is contradictory: The profile at Valkenberg hospital differed considerably from the one in the children's hospital's reports.

To me Mrs X disclosed that she had had an early head injury (age 2), which resulted in her having a shunt inserted in her brain. To the staff at the children's hospital she reported that she had been epileptic until the age of 15. According to her Valkenberg folder, she reported in 1995 that she had a leg operation and asthma, but denied having been epileptic. None of her previous records mentioned the head injury.

The only information available on her first two pregnancies was that both children were born by Caesarian section. Mrs X reported a complicated obstetric history with Rashied. He was an unplanned baby. The children's hospital folder mentioned that she reported renal failure during this pregnancy. She reportedly spent most of her pregnancy in hospital, requiring a blood transfusion for "anaemia" and having an operation five months into her pregnancy for her bladder and kidneys, during which "a pipe" was inserted into her bladder. At Valkenberg she reported that she was depressed during this pregnancy. Rashied was born by "emergency Caesarian section" at seven months, because his "heart went low". He was in an incubator for three months.

Mrs X reportedly suffered from headaches, "migraines" and tension, medicated herself with Stopayne for the headaches and took Augmentin (amoxycillin) for her "kidney problem". There was no mention of any of these in the Valkenberg folder or in my initial interview. Blood tests revealed no abnormalities. (The omission of the "kidney problem" was particularly problematic, as lithium can affect the kidneys).

7. MENTAL STATUS EXAMINATION

Mrs X presented as a corpulent, casually but drably dressed woman, who sat slumped in her chair, was fidgety, made poor eye contact and mostly stared at the ground. Her affect was tearful and anxious and she described her mood as "terrible" and "depressed". Her speech was somewhat slow, but normal in tone and volume. Her thoughts were normal in flow and form and there was no evidence of possession of thought or delusions. She reported auditory hallucinations: to me she said that it consisted of a single male voice telling her she was a failure. To a previous case manager she reported hearing multiple voices telling her to kill herself. She also reported a drilling noise in her ears, but could not describe it with any precision. At the time the team questioned the authenticity of these hallucinations.

In terms of her cognitive functioning, she exhibited poor abstract thought, and a subjective evaluation suggested low average intelligence. Her insight was poor and her judgement was impaired.

8. SPECIAL INVESTIGATIONS

Special investigations included a full blood count, lithium levels, biochemical investigations and thyroid functioning. All these tests showed no abnormalities.

9. MULTIAXIAL EVALUATION

The report received from the children's hospital and our own clinical observations, led us to confirm the diagnosis of Factitious Disorder not Otherwise Specified (otherwise known as Munchausen by Proxy). Initially depression was considered as a differential diagnosis. However, during her stay all her medication was gradually stopped and she did not present with any clear features of depression. She appeared euthymic and apsychotic. It seemed as if her symptoms disappeared when there was no secondary gain. It was therefore hypothesized that her psychological symptoms were factitious. Malingering was considered as an additional differential, as her presentation at the hospital and her wanting to receive electro-convulsive therapy seemed partially motivated by a wish to evade prosecution.

On Axis 2 Personality Disorder Not Otherwise Specified was noted. Regarding Axis 3, examination and blood tests revealed no abnormalities. While she had at different times reported to have had

asthma, epilepsy, renal failure and migraines, she omitted or denied these on other occasions. If considered in conjunction with the seemingly factitious psychological/psychiatric symptoms, it could be concluded that Mrs X also presented with Factitious Disorder with combined physical and psychological signs and symptoms.

Axis 4 included "Problems with primary support group", in particular the intrafamilial conflict, the spousal physical and substance abuse, the divorces, Rashied's behavioural problems and the parental health problems. It also included "Occupational problems", specifically her unemployment and the concomitant loss of income and status.

On Axis 5 it was noted that both her interpersonal and occupational functioning were poor. While her social functioning in the ward seemed fair, she seemingly had no friends.

10. MANAGEMENT

The management plan was formulated in conjunction with my placement supervisor and the multidisciplinary team. It was recommended that Mrs X be charged with a criminal act, arrested and sent for psychiatric observation to the female forensic unit at Lentegeur hospital. The psychiatric consultant recommended that she should not receive electro-convulsive therapy, as both her depressive symptoms and her auditory hallucinations did not appear to be authentic. It was also initially decided to change her medication to a selective serotonin re-uptake inhibitor (SSRI), as it was less toxic and thus safer. Eventually all her medication was terminated, as she did not exhibit any features of depression.

My task was to inform Mrs X of the medication changes, confront her with the evidence at our disposal and inform her of the repercussions, that is obligatory reporting, possible arrest and forensic observation. The Child Protection Unit was contacted and informed of our recommendation. Although they were familiar with the case, they had not taken any steps as they claimed not to have received the children's hospital's reports. I obtained the reports and faxed them to the Unit. I liaised with the community social services, recommending that they conduct a comprehensive psychosocial investigation into the circumstances of the case, the needs of the family and how the children would be best accommodated in the event of the mother's arrest. They too claimed not to have received any reports. After I had faxed the reports to them, the case was still batted to and fro between the

district agencies before it was allocated, because Mrs X and her ex-husband resided in different districts. Multiple phone calls were required before a home visit was made.

I informed the family of the management plan and tried to get their cooperation in terms of supervised visitations. I further liaised with the children's hospital's social worker to ensure counselling and follow-up for the children (particularly Rashied) and support for the family. The father was contacted and two appointments were made for him and the children, but he never attended. I also informed the community psychiatric clinic of our assessment, management plan and termination of medication. However, Mrs X attended the clinic a few hours before my call, without disclosing that she was in hospital or that her medication had been stopped. Since the ward is an open ward, she had obtained leave from the nursing staff, ostensibly to collect her disability grant. (This episode took place a few days before discharge, which would not have altered our assessment of her psychiatric state off medication).

The Child Protection Unit undertook to arrest Mrs X in a way that would be least upsetting to the other in-patients and refer her under section 79(2) of the Criminal Procedures Act 51 of 1977 for a period of 30 days forensic observation and assessment. Despite numerous phone calls to the investigating officer and many assurances from her, no action was taken. She maintained that they only had circumstantial evidence and because they had no witnesses, they were unable to prove that Rashied did not take the medicine himself at home and that no-one else could have administered the medication in hospital. Eventually the team decided that Mrs X had to be discharged. All the relevant parties were informed of her pending discharge and urged to cooperate regarding supervision of visits to the children, until more permanent arrangements could be made with the help of social services.

Despite having been given sufficient notification of the date of her discharge and being very angry with me for confronting her, Mrs X nonetheless requested to stay another day. She claimed that the friend she would be staying with could only fetch her at a particular time on a particular day. Both Mrs X and the nursing staff were informed that she was not to be discharged without leaving contact details. However, Mrs X surreptitiously discharged herself before breakfast without leaving any contact details. No-one was seen to have fetched her. A few days later Mrs X returned, trying to convince one of the sickest and most heavily medicated male patients on the ward to move

in with her. She again returned a few weeks later, this time leaving contact phone numbers. She claimed to have resumed her work as an "oral hygienist", but when this was investigated, it turned out to be false. She probably would have returned again, but the nursing staff felt her presence was disruptive and forbade these visits. Some weeks later she phoned again, alleging that she had received a message from me to contact the ward.

Some months later a follow-up call was made to the community social services. They reported that her ex-husband was in the process of taking legal action to obtain sole custody of his sons, and her daughter was living with relatives. The father had decided to allow Mrs X telephonic contact with the children. According to the case worker, the father reported that both boys were symptom free. He was considering removing Suleiman from the school for epileptics, as he had had no seizures since he left his mother's care. Although social services had had no contact with Mrs X, they heard via the family that she had found employment and was involved in another relationship.

11. DISCUSSION

Mrs X conforms to the prototypical descriptions of Munchausen by Proxy abusers represented in chapter 2. Given the tenuous nature of the history, one can merely hypothesize about the determinants of her behaviour.[48] She is a psychiatrically vulnerable woman who seems to have experienced loss and rejection through paternal abuse, childhood illness and divorce. She is presently under considerable stress within her family, is unable to express her distress to them and finds herself struggling to remain with them, yet not able to leave the home. In a paradoxical effort to meet her dependency needs, she has taken on the role of caring for family members, while her unconscious wish is to be cared for herself. It is hypothesized that the hospital becomes a symbolic representative of home and provides the caring and recognition she did not receive. By presenting her child as sick, she can legitimately connect to the nurturant image of the doctor (who in fantasy can repair early trauma) and simultaneously earn the respect of others for being a concerned and attentive mother.

Given her childhood history, it is likely that Mrs X has internalized a sense of being defective or bad. She might therefore have developed low self-esteem, particularly since her siblings were achievers. She might feel that her present role as a caregiver is not valued to the same extent as her previous role as a professional's assistant. She could thus be using a misguided means of regaining

her "professional role" by medicating others - particularly Rashied. Identifying herself with the doctor also serves as a defence against the "loss" of the parent. It further enables her to release some of the primary aggressive impulses related to the rejection (Sigal et al., 1998).

Mrs X's behaviour seems to be perpetuated by Rashied's conduct. As he was an unplanned baby and it was reportedly a difficult pregnancy, it is hypothesized that there may have been bonding difficulties between mother and infant. Because his behaviour causes friction at home and Mrs X feels criticized by her parents for not "managing" him, sedating him or putting him to sleep may be giving her a way to control his behaviour.

The documented difficulty in identifying the abuse was evident in this case too: Rashied had six previous hospital presentations and Mrs X had been receiving psychiatric treatment for at least eight years, without anyone raising any suspicion. The delay in diagnosis seems to be due to various factors, particularly the lack of familiarity with this type of abuse and the lack of communication between the various treatment agencies. In addition, it is hypothesized that the increasing lack of resources and staff shortages contribute to the delay in recognition, as often inexperienced staff (such as interns and psychiatric or paediatric registrars) have to deal with large patient numbers. These conditions can result in lack of time to spend with the patient, lack of time to gather adequate collateral and lack of opportunity to observe parent-child interaction during hospitalization. The hesitance of the legal system to act concurred with reports in the international literature.

Mrs X persistently denied responsibility, except for the admission that she once gave Rashied one or two tablets to help him sleep. According to Meadow (1990a) such partial admission is quite common. She exhibited the prototypical deceitfulness attributed to these mothers. She saw the child psychiatrist visit the ward to deliver her report and although there was no definite proof of Mrs X's involvement, the report disappeared from the file a few days later.

Working with Mrs X was frustrating in many respects. Since she was the first patient assigned to me in my first internship placement, I was unprepared for a case such as this. I conceived my role as that of being an empathic, caring helper. Instead, my role turned out to be - at least in part - that of a detective. In addition, I had to abandon one of the basic elements of my relationship with my patient, namely being able to accept the truthfulness of her statements. I found it very difficult to have to assist in having my first hospital patient arrested. My feelings vacillated between guilt

at having to play this role and the classic countertransference documented in such cases (Chan et al., 1986; Schreier & Libow, 1993a; Szajnberg, Moilanen, Kanerva & Tolf, 1996), namely wanting to believe that she had only given Rashied one tablet to calm him down. Even when I gathered the collateral, I still had difficulty realising the full extent of what I had heard. Confronting her was equally difficult. (Even though she had been confronted with her behaviour at the children's hospital, she had been in Valkenberg for 18 days without anyone knowing the details of what had happened.) On the one hand I felt a need to apologize to her and at the same time I was afraid of how she might react. Would she be murderously angry with me? Would she try to commit suicide? Would she abscond and gain access to the children before I had time to ensure their safety? Would she become truly psychotic due to the stress of having to face possible incarceration?

Confronting her turned out to be the easier part. Once I did confront her, and despite my best efforts to remain empathic, she started turning other patients against me. I once overheard her lashing out against me. I became increasingly concerned about the reaction of the other patients if Mrs X were to be arrested. How would that affect the therapeutic relationship with my other patients? (Surprisingly, once she surmised that she might not be arrested, Mrs X very soon accepted the arrangements, saying that while she would have to get used to "not being a mother anymore", her children understood that she also deserved a chance at happiness.)

The staff situation in the ward did not make my task any easier. Because the ward social worker only functioned in a part-time consultative capacity, she was not available to assist in dealing with the Child Protection Unit and the community social services. Similarly, the only other case manager, the psychiatric registrar, had too large a caseload to discuss the medication changes with Mrs X. Therefore, because of staff shortages and lack of role definition in a ward where there are at the best of times only two case managers, I had to manage all aspects of the case. Given my multiple roles, the therapeutic relationship became too contaminated for us to establish an alliance in such a short time.

CHAPTER 5

DISCUSSION AND CONCLUSION

Whereas chapter 3 dealt primarily with an historical and conceptual critique of the literature, this chapter will problematize the case of Mrs X and raise some questions regarding the role of the psychologist. I therefore return to the intervention discussed in the previous chapter.

The decision to discharge Mrs X was made by the team, and while I understood the rationale, I also wondered whether it did not on an unconscious level reflect our anger at her deceitfulness and our anxiety about how to treat her. Our diagnosis of Munchausen by Proxy implicitly endorses its status as a psychiatric disorder, which raises the question of our responsibilities in terms of treatment. To what extent do we as mental health practitioners have the willingness and the resources to help the "perpetrators"?

Part of the problem in any attempt to address these questions resides in the terminology itself. In this dissertation I have been using the term "perpetrators" à la DSM-IV, not only because it is a gender-neutral term which would not exclude male perpetrators as happens in Schreier and Libow (1993a), but because my initial examination of the literature was one which emanated from the same psychiatric discourse. However, such a view implies equally simplistic assumptions as the stereotype of the "venerable doctor". In order to move towards a more complex understanding of the positionings involved, it might be useful to draw on Spivak's concept of the "subaltern"(1988). This concept is adapted from its post-colonial use by Spivak, on premises established by Said (1991) in his definition of the Other as a category of persons of whom Marx has said that, "they cannot represent themselves, they must be represented" (Marx, as cited in Said, 1991, p.xiii). The knowledge contained within such subalterns is described by Foucault as "a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy beneath the required level of cognition of scientificity" (1980, p.82). Swartz demonstrates how the term subaltern can be transposed from Spivak's post-colonial context to that of clinical psychology, thus exploring a new functioning for the construct: "...the clinical patient, and sometimes the clinical trainee, is our subaltern. This assertion posits the clinical patient, by virtue of her relationship to the clinician-elite, as bereft of speech in certain critical respects" (2000, p.5). In the context of Munchausen by Proxy, the subaltern would function as a construct

by the diagnostician, readily marginalized in any enquiry simply by denying or overlooking his/her subjectivity by directing the focus elsewhere, namely towards the victim, the "case", or the location of the remedy sought. In the case of Mrs X, she is "pre-positioned" as a subaltern by virtue of being a woman, being a Muslim woman, being economically disadvantaged and not being white - and is therefore denied the "permission to narrate" (Said, 1984). (Aitken points out how black women have been largely "edited out" or subsumed within the concerns of black men or white feminists, are least likely to have their needs met in relation to mental health issues, and are "'officially' invisible" as users of clinical psychology services (1996, p.77)).

Were we to return to the case of Mrs X in the light of the above, the question arises whether we were treating this differently from other cases of child abuse? If she had been arrested, declared competent to stand trial and deemed to have criminal responsibility, she would presumably have been sentenced. Would therapy have formed part of the conditions of the sentence, in which case at least an attempt would have been made to address her status as subaltern? Yet even if this were to have happened, the prognosis would be poor. Not only would one have to deal with the classical issues such as persistent denial, but additional indicators of a poor prognosis included late detection, lack of support structures plus social and economic problems. Moreover, the literature documenting the lack of treatment success originates from countries with far greater mental health resources than South Africa. As it was, it was quite a task to ensure the involvement of the community social services.

There are no easy answers to these questions. After having reviewed the literature and the critiques, the following constructions or positionings of the "perpetrator" emerge: that she is a disturbed, deceitful, dangerous person who needs to be controlled in some way, or that she is a victim of a powerful patriarchal social and medical hegemony. Both "explanations" deprive the women of agency.[49] More recent writings in the field of medicalization illustrate that women are not necessarily passive targets of a patriarchal process of discursive positioning, but that they often actively contribute to the process and appropriate it for their own gain (Litt, 1996; Riessman, 1983). A similar process is alluded to in the Munchausen by Proxy literature when it is suggested that some of these women experience exhilaration by taking on and deceiving "the best specialists and the best hospitals" (Meadow, 1982a), i.e. that they are "rebels" who gain pleasure - if not power - by subverting medical authority as the ultimate representative of patriarchal society.

However, all these discourses are interested in particular representations only and do not allow the subaltern as "perpetrator" a voice. On a primary level, this silence can be attributed to the lack of documented therapeutic intervention. Even where therapy has been attempted and documented, the representation of these encounters has been cursory and has been filtered through the biased lens of the literature, which portrays these women as deceitful, as having the ulterior agenda to regain custody of their children, as - in the words of Schreier and Libow - "unwilling" to commit themselves to the process, "unwilling" to "use words rather than physical symptoms to express their pain" and "unwilling" to achieve the insight and skills necessary to discard their behaviour (1993a, pp.149-150). When they do speak, their voice is either not listened to (because they are regarded *a priori* as untrustworthy) or it is appropriated into the discourses of child abuse, psychiatry, hospital management and law.

Essentially little is known about these people, which is the classical status of Spivak's subaltern. Their histories, where documented, provide little information. No clear picture emerges of the role of race, class, culture and religion. How does the behaviour relate to self-harm, self-esteem, marital relationships, sexual identity, intelligence, for example? Is this behaviour underpinned by a form of over-identification with the child or is it a disorder of attachment?

The template-like nature of the case studies - and of all psychiatric case histories - reduces the possibility of subaltern voices being heard (Swartz, 2000). Due to psychiatry's embeddedness in the administrative, professional and legal institutional structures, it demands that clinicians capture patients' private and personal mental experiences in "codified idioms". Instead of searching for meaning in "everything that is infrequent, atypical and silent", Terre Blanche shows how psychiatric discourse is used selectively, how it is often "governed by an insane circularity forever predicated upon itself, where admission explains readmission, where categories of madness are always already known, and where well-rehearsed symptom checklists are recited over and over again with no necessary relation to actuality" (1997, pp.156, 154). Swartz, in her study of colonialism and the production of psychiatric knowledge in the Cape in the late 19th and early 20th centuries, argues a similar point: that psychiatric histories and classifications fail to engage with the distinctive features of the social, cultural and interpersonal context, thereby erasing patients' "connection with their own histories" (1996, p.17). In addition (and despite our claims to the contrary), the structure of the case records

reproduces the mind-body split through categories like "physical examination" and "mental status examination" (with similar subdivisions within this category). Because these records are constituted as "organizationally produced secret, esoteric knowledge of irrationality and psychopathology", they are "invested with power to damage" (Barrett, 1988, p.267). [50]

The same applies to my interaction with Mrs X. Elements of her history became relevant in so far as they pointed towards the diagnosis. Her "hallucinations" confirmed our expectation that she was deceitful and had ulterior motives. As soon as the diagnosis was reached - a diagnosis that essentially rests on one symptom - we did not look further for meaning, but instead shifted the emphasis to the protection of the children, her discharge and arrest. One could argue that the institutional "deafness" (Swartz, 2000) to her voice originated even earlier: Since she was a "chronic"/"known" patient with the possible diagnosis of a personality disorder, little attention was paid to psychotherapeutic possibilities and responsibilities. Terre Blanche shows how psychiatric hospital records reflect the idea that previous encounters with psychiatry (similar to previous encounters with the law) virtually automatically and with certainty position patients in a diagnostic category and exclude further investigation. If that diagnosis involves a personality disorder, these patients are regarded as essentially "untreatable" within the hospital system; and because they cannot afford private psychotherapy, they are often discharged without adequate long-term follow-up. Similar to the case examined by Barrett (1988), our case records/clinical writing are crucial in the induction of Mrs X into a career of mental illness, but there is no corresponding writing process through which she was transformed back to health.

While Mrs X clearly had multiple socio-economic difficulties, the "problem" was located in her as an individual. This seemingly obviated the need to gather collateral. She had been in hospital for 18 days before I saw her and no attempt had been made to contact her family or the children's hospital where her child had been admitted. It was pure coincidence that I should have "stumbled" upon the broader context, in an attempt to help her gain more access to her children. Little attention was paid to her dire family circumstances - having to live on a disability grant with three children in a two-bedroomed house, shared by elderly and sickly parents. In fact, we discharged her, knowing that she would not have a place to stay, as her parents clearly articulated that she was no longer welcome in their home. (Were we indeed having the children's best interest at heart by turning their mother out onto the street?). To what extent did cultural and religious factors contribute to her feelings of

powerlessness? As a twice-divorced Muslim woman, what was her value in the family and the community? Given these factors, was it surprising that she reported hallucinations of a male voice telling her she was a failure? For eight years she had been prescribed psychotropic drugs: To what extent was her emotional pain viewed as a symptom of illness? To what extent was the medication used as a distancing strategy, a way of not listening? Did she learn during these eight years that the only way to obtain help was to present her very real problems to a psychiatric system in a way that suited their discourse? [51] As a disempowered individual who is part of a structurally disempowered group, she adopted a very powerful discourse.

As indicated, psychologists have been virtually absent from the Munchausen by Proxy discourse. As an intern clinical psychologist, it is appropriate for me to question what the discipline could contribute to the understanding of this phenomenon. Since psychological testing has thus far seemingly yielded meagre results, our primary role could perhaps be that of granting people like Mrs X a voice and enabling them to be heard. To achieve that goal, we should be sensitive to the factors that have contributed to their "muteness" and our own "deafness". As Swartz (2000) illustrates, this process demands an awareness of the historical discourses generating diagnostic categories and practices and their embedded assumptions. It requires "reading the dominant discourses...with a view to noting their resistances, repetitions and silences" (Swartz, 2000, p.7). In addition it calls for a willingness to grapple with both our own and the patients' cultural, class and gender positionings and their effects on what can be said and what can be heard. As I have illustrated, these processes require that we draw on what Swartz calls "a wide set of theoretical allies" (2000, p.12). Only if we are willing to broaden our theoretical horizons, suspend our biases, listen beyond the deception, hear what is articulated in the silences and offer an experience of feeling heard, can we contribute to the process of healing. Given the challenged resources of our public mental health system, this will not be an easy task, but it is one from which we should not shy away.

In conclusion, I want to return to the question I posed in the introduction: How do we as clinical psychologists integrate our critical thinking with our clinical practice, especially in a public health setting where we are members of a multi-disciplinary team? While the political transformation process in South Africa has begun, it is naive to envisage a dislodging of the current power practices, because they will invariably be replaced by another set of power relations. I would like to contend

that our training equips us with a capacity for reflection and that we should draw on this capacity to identify and challenge personal, professional, institutional and ideological assumptions and practices which produce subaltern positionings, and use what we have as morally as we can.

FOOTNOTES

1. For a discussion of three prominent cases, namely those of Ellen Storck, Kathy Bush and Yvonne Eldridge, see Allison and Roberts (1998). In 1988 Yvonne Eldridge was named national "Mother of the year" by Nancy Reagan.

2. Names and other details have been changed in the interest of confidentiality.

3. The literature yields many variations in the order of the Baron's first names and the spelling of both his name (Friederich/Friedrich/Freidrich/Frederick) and surname (Munnikhouson/Münchhausen/Münchausen/Munchausen). While it has been claimed that the eponym should have two "h"s, the single "h" has generally been accepted as appropriate, as it refers to the fictional, anglicized Baron, not the historical one (Rodin, 1989).

4. Wingate argued for the replacement of "Munchausen Syndrome" with "Ahasuerus Syndrome", because the real baron was "too wise a fool ever to have put himself in peril of having to undergo an abdominal operation" (1951, p.412). According to Wingate, Ahasuerus Syndrome (which refers to the "Wandering Jew") would emphasize the patients' "constant suffering, their lack of any fixed abode, their multiplicity of names and their apparent immortality" (1951, p.412). However, this name never gained popularity and Enoch and Trethowan (1991) felt it necessary to make it clear that Munchausen Syndrome does not seem prevalent in people of Jewish origin.

5. The term "Kopenickiades" refers to Der Hauptman von Köpenick (1931), a play by Carl Zuckmayer based on the life of a shoemaker and jailbird, Wilhelm Voigt, who impersonated an army officer and duped a detachment of soldiers into obeying his outrageous orders (Von Einsiedel et al., 1974).

6. For historical examples of the derision with which these patients have been described and the attendant practices of detection and punishment, see Allison and Roberts (1998). Pankratz and McCarthy (1986) offer a more recent example. Although they recognize the pejorative nature of the labels applied to such patients (one was described as "obese, obtuse, obstinate, obstreperous and obscene"), they perpetuate the tradition with descriptions such as "the queen of laparotomies" and "the appearance of a mental defective" (1986, pp.614, 615). Ostensibly in jest, they also reproduce the criminalization of these patients, by modelling their article on the FBI's most wanted list of criminals, calling it "The ten least wanted patients".

7. These parents were regarded as not merely falsifying histories to cover up malevolent child abuse, but as sharing delusions of righteous parenthood. Although current perspectives largely exclude the presence of psychotic disorders in perpetrators, dissociation has been noted (Oppenoorth, 1992).

8. The name "Polle" refers to a child of Baron Munchausen who died early in childhood. See also p.51.

9. Kenny observes that Factitious Disorders have an "anomalous residual status, textually if not conceptually sandwiched between the Somatoform and Dissociative Disorders" (1999, p.590). He remarks that each member of this triad contains elements of what used to be called hysteria.

10. Keyword searches for articles were performed on the PsycLIT, Medline/PubMed, Social Sciences Index and Dissertation Abstracts databases. The University of Cape Town library holdings as well as the Internet were scanned. In addition, reference lists of articles and books were scanned for further studies. Articles written in languages other than English and Dutch were excluded.

11. Whereas I usually prefer the term "client", I use "patient" to denote the context of her hospitalization.

12. My choice is determined by a wish to avoid the confusion encountered in the literature, as some authors prefer "Munchausen by Proxy Syndrome", whereas others prefer the more traditional "Munchausen Syndrome by Proxy". It is also in part due to the fact that its status as a syndrome is being questioned, a viewpoint that I endorse.

13. It is not clear whether this type of fabrication or symptom induction is a form of Munchausen Syndrome (i.e. harm directed at the self) or Munchausen by Proxy (harm directed at the foetus). Goodlin (1985) does not clarify his position either: He includes such a case in an article on Munchausen Syndrome, but identifies the particular case with a subheading of Munchausen by Proxy.

14. For a review of cases of abuse by poisoning, see Dine and McGovern, 1982.

15. Croft and Jervis (1989) describes a case in which a four-year-old child was taught by his mother that he was epileptic and was trained to feign seizures. Taylor and Hyler (1993) point out that children may have little choice but to participate actively to avoid punishment or abandonment, they may attempt to repair the failed parent-child bond by trying to please or engage the object in the only way they know, or they may be addicted to the behaviour. A 6-year-old victim poignantly described her clinging attachment to her mother, combined with her fear of her mother's hostility, as "poison glue" (Dowling, 1998). For a detailed discussion of factitious disorders, malingering and somatoform disorders in children, see Pankratz (1999).

16. Schreier and Libow (1993a) documented one of the rarer cases in which two children were abused simultaneously. Lee (1979) reported a case of simultaneous abuse of twins, but in my opinion this case does not represent true Munchausen by Proxy. The mother rarely visited the children during their hospitalization and her motive seems to have been to gain relief from caring for them.

17. Rosenberg (1987) found that "depression was noted most commonly", but provides no specific percentages or indications of assessment strategies.

18. The presence of eating disorders in Munchausen by Proxy perpetrators raises the issues of child abuse and the role of dissociation. According to Torem (1990), eating disorders are often consequences of child abuse and many women with eating disorders have latent multiple personalities.

19. Schreier and Libow (1993a) assert that their use of the concept of perversion is not the traditional psychoanalytic one, nor the common pejorative one. It refers to a mode of mental functioning in which reality and fantasy coexist with blurred distinction.

20. Schreier and Libow hypothesize that this behaviour may in part represent an attempt by the doctor to flee from the demands of an "engulfing" mother. Because she is so needy, the physician may avoid her or may intensify investigations to solve the problem (1993a, p.131). However, psychiatry is not exempt from the lack of listening. A "Newsweek" story reported that patients' average time spent with psychiatrists in some clinics is three minutes (Newsweek, 1994, cited in Karp, 1996).

21. Parnell (1998c) also lists a case from Japan, but the cited case considers Munchausen Syndrome in a 10-year-old female (Abe, Shinozima, Okuno, Abe & Ochi, 1984).

22. The literature yielded one other case in which alternative healers were consulted. Fisher et al. (1993) reported a case in which the mother turned to faith healers, priests and spiritual healers because of her dissatisfaction with the medical profession's treatment of her child's "allergies" and "hallucinations".

23. The inclusion of falsified psychological symptoms remains controversial. Apparently the DSM-IV's inclusion of such symptoms as the focus of feigning or induction "was a reasoned conclusion given the presence of such symptoms in factitious disorder, the lack of sharp demarcation between psychological and physical factitious disorder, and the knowledge of unpublished cases" (Parnell, 1998, p.45). Before Schreier's documentation of 14 cases (1997), only one case was reported (Fisher, 1993). A recent article illustrates how easily inadequate assessment can lead to false diagnosis of "psychiatric" Munchausen by Proxy (McNicholas, Slonims & Cas, 2000).

24. Apparently the reasoning behind the inclusion of this criterion was to convey the essence of the diagnosis and to help delineate the behaviour from malingering (Parnell, 1998b).

25. Meadow (1994) reports a case in which a mother who repeatedly smothered her son 10 years previously, sued the paediatrician for failing to diagnose Munchausen by Proxy timeously.

26. One of Morley's (1995) examples of the way in which these criteria can be misrepresented, is evidenced by a case study. He argues that what might appear to be illness fabrication, may merely be an exaggerating style of communication, or a hyperconcerned mother trying to obtain thorough investigations. Clayton, Counahan & Chantler (1978) document such a case, and despite the mother's confession that she merely wanted a thorough investigation and her relief at confrontation, they nonetheless diagnose Munchausen by Proxy.

27. Sheridan (1995) reports ten cases in which male and female nurses allegedly induced illness and death in their patients (the number of victims is estimated to total almost 200). However, she does not argue that these be included under the rubric of Munchausen by Proxy, but rather views them as analogs of Munchausen by Proxy, what she terms "Munchausen by Professional Proxy". Her examination includes cases of firefighters committing arson to gain attention or appear heroic and people who falsely confess to crimes they have not committed.

28. In a chapter entitled "Munchausen Syndrome by Proxy and Sexual Abuse: Common Ground", Finkel (1995) essentially examines the similarities and differential characteristics between the two phenomena. He does not, however, address the issue of whether false allegations of sexual abuse constitute a form of Munchausen by Proxy.

29. Schreier and Libow (1993a) offer an explanation for this behaviour as well as the lack of maternal panic when the child is gravely ill or dies. According to them, the mother's reaction can be explained by level of involvement of the doctors and staff: When the child is most ill, the mother enjoys optimal involvement with the medical staff. When the child dies, they continue to be attentive, perhaps more so. While she may therefore lose the fetishistic object, her primary need is still met (if only temporarily).

30. The limited value of enlisting psychiatric help had already been expressed by Meadow as early as 1982 (1982a).

31. According to Chan et al. (1986) the role of the paediatric psychologist includes addressing the psychological needs of the staff through therapy and psychoeducation.

32. The articles in question are: Ackerman & Strobel (1981), Clark, Key, Rutherford and Bithoney (1984), Guandolo (1985), Leeder (1990), Malatack, Wiener, Gartner, Zitelli and Brunetti (1985), and Oppenoorth (1992).

33. This case is also discussed by Flynn (1998), in an article that focuses on the mother-infant sessions.

34. The title refers to the words of Baudrillard (1983, p. 2).

35. The lack of sound psychological theories underlying the factitious disorders may in part be due to the general absence of what Pankratz calls a "psychology of deception" (1999, p.305).

36. Their sources include Breuer and Freud (1893/1955), Brodie (1837), Carter (cited in Veith, 1965), Charcot (1890), Freud (1905/1953), Galen (cited in Veith, 1965), Hippocrates (cited in Simon, 1978), Janet (cited in Veith, 1965) and Kraepelin (1907/1981).

37. Allison and Roberts cite the dramatic example of the diagnosis and treatment of drapetomania (or "running away" disorder): In 1850 Dr Cartwright determined through extensive scientific research that the desire of slaves to run away was caused by this dreaded disorder. Curing them involved treating them like children in order to keep them in the "submissive state which was intended for them to occupy" (Chorover,1974, cited in Allison & Roberts, 1998, pp.24-25). However, some slaves also suffered from dysethesia, an "imperfect atmospherization or vitalization of the blood" (Chorover,1974, cited in Allison & Roberts, 1998, pp.25). This made them insensitive to whipping. To decarbonize the blood, slaves had to be washed and anointed with oil. The oil had to be slapped into the skin with a broad leather strap. Following this treatment the patient had to be put to hard work, such as chopping wood, splitting rails, etc., in order to expand the lungs. Drapetomania was still included in the 1957 edition of *Dorland's Medical Dictionary*.

38. Albeit to a lesser extent, Meadow also supports this romanticized view of doctors and hospitals, calling the latter "centres of excellence" (1989, p.249).

39. To this list can be added the work of Barker-Benfield (1976), Daly (1978), Fisher (1988), Frankfurt (1972), Gordon (1976) and Riessman (1983).

40. Speaking from her own clinical experience, Pankratz endorses a similar view. She asserts that the "attraction to a faddish, exotic diagnosis" results in overdiagnosing and false accusations, with "complex clinical issues [being] thrown into the legal arena, diverting attention from difficult management responsibilities" (1999, p.315).

41.The sensational nature of Munchausen by Proxy has contributed to its popularization. It has been featured in magazines, television documentaries and talk shows, and apart from its inclusion in numerous Internet websites, there are five websites exclusively devoted to the phenomenon. Two include online bookstores and one is a survivors' network with instructions for people who suspect that they were victims in childhood. A counter-group calling themselves MAMA ("Mothers against Munchausen Syndrome by Proxy Allegations") also have a website.

42. Their bibliography includes approximately 30 titles on Munchausen by Proxy, whereas the Medline/Pubmed database lists more than 300 articles and books.

43. Recent research suggests that dissociation is a mediating mechanism between child abuse history and adult abuse potential (Narang & Contreras, 2000). Although two thirds of abused children do not become abusive, those who continue the abuse cycle show high levels of dissociation (Bernstein & Putnam, 1986). The descriptions of adult survivors of child abuse correspond strikingly with those of Munchausen by Proxy perpetrators. For example, Judith Lewis Herman describes these women's socially conforming "false selves", their psychosomatic symptoms, their hunger for care, their fear of abandonment, their seeking out and idealizing of authority figures who offer the promise of a caretaking relationship, their repeated enactment of dramas of rescue, their difficulty consciously and accurately to assess danger, the breakdown of defensive structures following marital problems, the birth of a child, the death of a parent, etc. (1998).

44. The term "the battered child" was proposed by Kempe at a symposium in 1961. This was followed by an article entitled "The battered-child syndrome" (Kempe, Silverman, Steele, Droegemueller & Silver, 1962).

45. Riessman (1983) notes how medical jurisdiction has expanded to cover more and more issues of childhood and speculates that such expansion might be the result of a declining birth rate coupled with an increase in supply of paediatricians.

46. For a discussion of gender differences in utilization of medical resources and rate of prescriptions, see Lisansky (1995) and Verbrugge and Steiner (1981).

47. Chan et al. (1986) also report a case where the mother voluntarily requested psychiatric hospitalization after having been exposed.

48. In this regard I draw in part on information supplied in the child psychiatrist's report.

49. Drawing on Spivak's discussion of the practice of *sati*, Swartz shows how similar processes function in the interpretation of historical records of institutionalized patients at the turn of the century (1996, 2000).

50. Barrett (1988) also illustrates how case records constitute a process of Othering, by implicitly defining the clinician in terms that are polar opposites of mental illness, i.e. as an objective, rational, decision-making professional who displays the controlled emotionality of empathy, rapport and care.

51. In an article entitled "Depressed in, Stressed out: PD Ward Patients at Tara Hospital", Terre Blanche (1993) shows that patients themselves generally invoke depression to account for their hospitalization (cited in Terre Blanche, 1997).

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