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CHILD ABUSE IN THE MEDICAL GUISE:

MUNCHAUSEN SYNDROME BY PROXY

by

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A dissertation submitted to the Graduate Faculty in
Criminal Justice in partial fulfillment of the
requirements of the degree of Doctor of Philosophy,
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ABSTRACT

Child abuse in the medical guise (CAMG) has been identified as Munchausen Syndrome by Proxy (MSBP). It involves the interaction of a parent who willfully distorts the medical condition of a child, presenting him/her for treatment with factitious symptomatology and a pediatrician who is coopted into providing (or making referrals to other providers for) excessive and unnecessary invasive diagnostic and treatment protocols for the child.

This study was designed to investigate the role of the pediatrician in CAMG.

It was hypothesized that: (1) pediatricians will be unable to differentiate sophisticated MSBP child abusers from pathetic non-abusing Help Seekers (HS) and aggressive non-abusing Health Care Addicts (HCA); and that: (2) pediatricians will be unwilling to report incidents of CAMG to the appropriate authorities within the criminal justice system because they perceive the CAMG perpetrators as "good" and well-intentioned people.

438 practicing pediatricians responded to one of 6 randomly selected case vignettes (about low intensity HS, HCA and CAMG/MSBP cases and about high intensity HS, HCA and CAMG/MSBP cases) involving parents/mothers who brought their infants to the hospital for emergency care. The Questionnaire provided for the objective diagnosis of each case and included a checklist of potential medical, mental

health and criminal justice referrals. Ss subjective responses to parents/mothers and babies were measured on seven-step Semantic Differential scales.

Support for these hypotheses was generated at both levels of intensity:

The three low intensity cases generated similar numbers of medical referrals. Ss did not make the excessive medical referrals for the CAMG/MSBP baby that would have resulted in her abuse in the medical guise. Yet, Ss did not effectively differentiate the criminal nature of the CAMG/MSBP case from the non-criminal HS and HCA cases by making sufficient criminal justice referrals for the CAMG/MSBP case. Mental health referrals replaced and/or accompanied criminal justice referrals. The CAMG/MSBP parent/mother was essentially perceived as being as "good" a mother as all of the other mothers.

The high intensity HS and HCA cases generated medical referrals that were similar to the 3 low intensity cases. However, the high intensity CAMG/MSBP case generated more than twice the number of medical referrals. These medical referrals were unnecessary and somewhat disturbing in light of the fact that Ss rated the CAMG/MSBP baby as being as potent (healthy) as all of the other babies. Ss did not differentiate between the CAMG/MSBP case and the pathetic (non-criminal) HS case. Both parents/mothers received similar numbers of mental health referrals. The pathetic HS parent/mother received more criminal justice referrals than

the criminal CAMG/MSBP parent/mother. The most intense and sophisticated child abuser in the medical guise and the least intense, pathetic Help Seeker were perceived as the "best" parents.

Two separate forms of adult behavior may produce the same types of CAMG outcomes. The first involves homicide, or the desire of an adult to maim and/or kill a child by means that are sufficiently exotic to avoid detection and apprehension. The second involves suicide, or the desire of an adult to test out a death-producing method on a child before applying it to him/herself.

Pediatricians have been described as the linchpins of the child protection system because it is the combination of their diagnostic skills and expert medical testimony that can produce meaningful reporting and effective prosecution.

In order to redress existing cases of CAMG and in order to deter parents from inflicting such abuse in the future, the author recommends that pediatricians receive more meaningful training and continuing medical education designed to both help them better identify cases of CAMG and to encourage them to be more willing to report such cases to appropriate agencies within the criminal justice system.

ACKNOWLEDGEMENT

The term "Child Abuse in the Medical Guise" was first suggested by Dr. Charles Bahn of John Jay College of Criminal Justice in 1992, as a more meaningful description of incidents of child abuse that have been reported as "Munchausen Syndrome by Proxy."

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Introduction

Child abuse represents a malum prohibitum, or an act that we (may or may not approve of, but that we) do not condone because it has been prohibited by law. Children who are abused and the adults who abuse them have become important contemporary concerns of the criminal justice system.

There are many ways to abuse a child. Some methods are relatively simple, while others are quite complex. Some involve familiar routines, while others have been described as "weird and extravagant" (Meadow, 1977). Children may experience the fruits of impulse, or they may be harmed by methods that involve varying degrees of premeditation.

Adults may act individually or through the agency of others. Couples or groups of adults may interact in a variety of ways in order to abuse a child. One or both parents and/or others may participate.

The legal prohibition against the abuse of children is augmented by measures that the criminal justice system can take to deter adults from abusing their children and by measures enacted to redress abuse that has already been perpetrated.

The enforcement of the legal prohibition against the abuse of children is essentially predicated upon the effective interaction of the pediatrician with the criminal justice system. Pediatricians are expected to expertly

observe and to diagnose cases of actual child abuse and then report their findings to the appropriate agencies within the criminal justice system. Fear of the pediatrician's detection is thus intended as a strong deterrent against adults acting out their potentially abusive impulses. The certainty of the pediatrician's report insures that the criminal justice system will have access to the cases of child abuse which it must redress.

From a historical perspective, pediatricians have been very tolerant of the variety of parent-child interactions that they have observed within our society. They have been reluctant to usurp the privilege of the parent to rear the child as s/he sees fit.

In the contemporary context of law enforcement, pediatricians have been required to complete continuing medical education programs in order to enhance their child abuse recognition and reporting skills.

Pediatricians who do make good faith reports of the child abuse cases they recognize, enjoy statutory protection from criminal prosecution in the event that their report(s) had been made in error. However, civil suits and charges of medical malpractice have been filed against increasing numbers of reporting pediatricians.

In some cases, pediatricians are able to quickly recognize that a child has been abused. In other cases,

pathognogmosis is unspecific. There are more exotic cases where the pediatrician may actually join the parent as a participant in the abuse of he child.

This study will investigate the interaction of the pediatrician with the criminal justice system. Examining the general history of this interaction as well as the contemporary issues that impact upon it, the author will explore the impact that mandatory reporting has had on two categories of parents: those who may act impulsively, but don't really want to harm their children and those who actually intend to inflict varying degrees of abuse upon their children.

The author will demonstrate that public knowledge that pediatricians are mandated to report recognized cases of child abuse has unintentionally deterred some parents (who fear detection) from providing their abused children with appropriate medical care.

Adults who lack strong behavioral controls may impulsively abuse without premeditation and without any clear intention or goal of permanently disfiguring or eliminating the child. They may lash out at a child and inflict wounds with an electrical cord or with a hot iron. As the abuse is being inflicted, there is little, if any concern with detection. Later, however, as calmness prevails and the impact of the adult's actions may become

clear, the child's medical needs may be abdicated in favor of the preservation of the adult's reputation as a "good" parent.

For adults who are less impulsive and more in control of their actions, mandatory reporting does serve as a powerful deterrent against inflicting any physical harm upon a child. Considering the wish to harm the child alongside of the knowledge that electrical cords, hot irons and caustic substances leave easily identifiable stigmata, causes these adults to seriously analyze the costs and benefits of abuse. Many will consciously refrain from abuse that will inevitably lead to their own apprehension.

For highly controlled adults who genuinely wish to disfigure or to eliminate their children, mandatory reporting has provided the impetus for the careful research and planning of some more sophisticated and detection-proof forms of abuse. Understanding that the conventional methods of abuse may be unsuccessful and even dangerous to themselves, these adults will consult medical texts in order to create more "fool proof" methods. Some will even perfect their techniques of abuse by first inflicting them upon their household pets in a manner that is somewhat analogous to the animal trials that pharmaceutical companies conduct before administering their products to human subjects. Once the technique has

had the desired effect on the household pet, the adult will inflict it upon the child.

"Child abuse in the medical guise" represents the highly sophisticated and carefully premeditated actions of a parent (or other adult who has comprehensive access to a child). This parent first researches and then either physically produces or emphatically claims to have observed complex medical symptomatology in a child who was actually healthy. The parent makes mendacious reports of the child's medical history to a pediatrician (or other health care provider). Unless the parent is apprehended, the child will be subjected to unnecessary invasive medical procedures designed to diagnose and/or to treat his/her parentally induced condition.

Child abuse in the medical guise begins with a parent who premeditates the abuse of a child. Its progress is facilitated by a pediatrician (or other health care provider) who is coopted into unwittingly subjecting the child to pernicious abuse in the medical guise.

Child abuse in the medical guise has been referred to as "Munchausen Syndrome by Proxy." The most recent edition of The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (1994) utilizes the term "Factitious Disorder by Proxy."

The empirical component of this study investigates the

interaction of the pediatrician with the criminal justice system in cases of child abuse in the medical guise. It seeks to determine whether pediatricians will recognize "Munchausen Syndrome by Proxy," i.e., whether they will be able to differentiate it from several alternative disorders in which the pediatrician is asked to play a role in questionable parent-child interactions. It then investigates the reporting behavior of pediatricians, i.e., whether pediatricians will be willing to report to the criminal justice system those cases of child abuse in the medical guise that they have actually recognized.

The text of this study is divided into 4 parts. Part I examines the way in which pediatricians have become intrinsically linked with legislative efforts to curb child abuse. It explores the ways in which pediatricians have been educated to fulfill their mandated roles and some of the problems inherent in doing so.

Part I consists of 6 chapters. Chapter 1 presents an overview of the history of the criminalization of child abuse. Chapter 2 discussed mandatory reporting and the pediatricians' response to it. Chapter 3 discusses the education that pediatricians receive in order to fulfill their roles as mandated reporters. Chapter 4 introduces "child abuse in the medical guise" and the new sophistication in child abuse methodologies. Chapter 5

describes the impact of contemporary medical malpractice litigation issues on child abuse reporting. Chapter 6 then discusses the issues related to the criminal justice system's effective response to child abuse in the medical guise/ Munchausen Syndrome By Proxy.

Part II presents a review of the Munchausen Syndrome By Proxy literature. It consists of 5 chapters. Chapter 7 examines the social stigmatization of the child victim and examines the "urgent need" that existed for child protection statutes. Chapter 8 examines the profile of the Munchausen Syndrome By Proxy abuser and provides several case histories. Chapter 9 provides information on the differential diagnosis of Munchausen Syndrome By Proxy. It differentiates between three categories of parent-child interactions (Help Seeking, Health Care Addiction and Munchausen Syndrome By Proxy) that involve the pediatrician's participation in an interactional triangle. Chapter 10 examines the child's involvement in the Munchausen Syndrome By Proxy triangle. Chapter 11 explores the antecedents of the term "Munchausen Syndrome By Proxy" and its derivation from a condition known as "Munchausen Syndrome."

Part III includes the empirical component of the study. It consists of 4 chapters. Chapter 12 presents the experimental hypotheses. Chapter 13 discusses the research

methodology. Chapter 14 describes the collection of data. Chapter 15 provides an analysis of this data.

Part IV presents a discussion of the findings of the empirical component of the study and examines the social as well as criminal justice implications of these findings. It consists of 4 chapters. Chapter 16 presents the conclusions of the experiment. Chapter 17 examines child abuse in the medical guise/ Munchausen Syndrome by Proxy as a feminist issue. Chapter 18 places child abuse in the medical guise within the larger context of other forms of abuse in the medical guise. Then, Chapter 19 concludes with future implications of these issues for the criminal justice system.

Part I

The Criminalization of Child Abuse

Chapter 1:

The History of the Criminalization of Child Abuse.

In societies where the doctrine of parens patriae promoted paternal supremacy, the starving, pernicious exposure, beating, maiming, ritual sacrifice and mundane killing of children was not considered a malum in se. Instead, it has been suggested that the acts which we have come to refer to as "criminal child abuse and neglect" in the more developed regions of the world during the final decades of the twentieth century, (Horowitz & Davidson, 1984) have been historically normative (deMause 1974, 1975).

In ancient times children were for the most part non-entities who lived or died at the behest of their fathers. The father's authority was generally analogous to a "royal prerogative" which could be asserted against the child without question. According to Radbil (Helfer & Kempe, 1987) the Roman Empire was the first to modify the father's authority with regard to infanticide in 450 B.C.E.. Then, some five centuries later, the early Christian church fathers read the Judaic commandment of "Though shalt not kill" to equate infanticide with murder.

Due to the historically "intermittent nature of public concern" with infanticide (Parton, 1985) an uneven

succession of imperial, judicial, legislative and religious edicts were pronounced over the next 1800 years. The practice of infanticide slowly became a malum prohibitum and formal sanctions were prescribed for its perpetrators.

The practice of infanticide abated significantly in countries where it was legally prohibited, but nevertheless continued. Historical records have indicated that in the pre-industrial as well as in the more modern urbanized and industrialized societies, courts were (and still are) very arbitrary and selective in their treatment of those who had committed infanticide. Some perpetrators have been severely punished, while others have been summarily excused.

Moreover, it is important to note that while church and state have both acted to at least officially guarantee the child's basic legal and moral right to life, the essential quality of the child's life was not at issue (Aries, 1962). Parents, industrial employers of young children and the child care staff at state run institutions were neither morally nor legally barred from regularly depriving children of food and necessities, nor from inflicted severe physical abuse and even deformity upon them. Acts that would be described today as the "active and cruel exploitation of children" were broadly considered "normative" at least until the end of the nineteenth century.

From the beginning of the nineteenth century when there

was some awakening awareness of the "needs" of children until the 1960s, some "child protective" legislation was introduced. These laws however, were not so much concerned with the protection of children from harm as they were concerned with protecting society from children who were "needy." They primarily focused on the control of delinquent youth, the prevention of crime, and the deterrence of delinquency and anti-social behaviors in children.

Indeed, there was little explicit public concern (except most notably in England and in the U.S.A. at the very end of the nineteenth century and in the period immediately following World War II) with taking emphatic legal measures to protect children from abuse or neglect.

In most American jurisdictions, few if any laws addressed "crimes against children." Beyond attempts at mitigating the pernicious effects of child labor, (Abbott, 1938) little was done to insure the physical safety and security of children from physical abuse. Moreover, members of the medical community were manifestly oblivious to the safety and security needs of their pediatric patients. Pediatricians who regularly treated the broken and battered bodies of living children and pathologists who autopsied the victims of infanticide generally appeared not to notice the trademarks of "abuse." Instead, physicians

in the nineteenth and early twentieth centuries appeared to be preoccupied with first creating and then preserving the myth that parents do not abuse their children.

During the period from 1925-1946, John Caffey, a New York radiologist who was also a pediatrician examined radiological evidence of pediatric long bone fractures. In 1946, Caffey published a paper in which he asserted that it may be possible to distinguish between trauma that is accidental and trauma that is parentally inflicted. Then, in the 1950s, Frederic N. Silverman and later Wooley and Evans extended Caffey's work and chastised the medical community for their reluctance to concede that many of the injuries that children had were willfully inflicted by their parents.

In fact, our entire modern conceptualization of "child abuse" is only about thirty years old. In 1962, C. Henry Kempe and his associates introduced the "battered child syndrome" in the Journal of the American Medical Association (7/7/62). Following a nationwide survey, Kempe et al. asserted that parents and foster parents do physically abuse their children and may therefore be responsible for the clinical pediatric conditions which cause childhood disability and death.

While the editors of the Journal (p. 130) called for "further intensive study" of the poorly understood

psychodynamics of the battered child syndrome, they also called upon "civilized society" to reevaluate state and local laws so that children who are too young to defend themselves from physical abuse may be adequately protected by the state in the future.

Physicians were then instructed to accept the difficult notion "that parents were instrumental in causing injury to their child." The editors of the Journal urged physicians to become involved "in good conscience" with the police, social agencies and legal authorities "to make certain that proper protection is given the child."

In 1962, the abuse and neglect of children was by no means a malum in se. Moreover, it was neither clearly legislated against in many jurisdictions nor did there even exist any effectual child abuse reporting laws. Yet, the American Medical Association called upon its members to recognize that a young child must no longer be considered "as a chattel of his parents" and that children must be protected from the physical abuse of their parents.

According to Radbil, (Helfer and Kempe, 1987) the 1962 conference at which Dr. Kempe presented the findings of his national survey generated the model child abuse law that was adopted by every American state within a five year period. Thus, by 1967, the broadly defined physical abuse and neglect of the child was a malum prohibitum in all

American jurisdictions.

Since the 1960s, there has been increasing recognition of child maltreatment as a "significant and devastating social problem." Numerous studies have been undertaken and articles and books have been published that examined many of the aspects of the problem. Tzeng (1992) has observed that despite our increased awareness and the myriad of efforts that have been undertaken in the arena of child protection, recent empirical studies have suggested that the extent and seriousness of the problem "has not wavered."

Infanticide--which was once an accepted parental norm and has been prohibited in most countries for many centuries--is still being selectively practiced.¹ The physical abuse of children--which was even more normative and which has not been prohibited in most countries until most recently--remains pervasive (Giovanni & Becerra, 1979; Ross, 1980).

Whether the practices of infanticide and the physical abuse of children represent mala in se or not remains an

1

For example, China's "population-control laws" require obstetricians to perform involuntary late third trimester abortions on women who already have one child. If the infant is born alive, they must kill it by injecting iodine or alcohol into the soft spot of its skull (Wong, 1995).

important issue for legal² and medical³ ethicists and philosophers to confront. That the practices of infanticide and the physical abuse of children are prohibited by modern laws creates an impetus for the criminal justice system to concern itself with both the enforcement of existing laws against criminal child abusers and the deterrence of future criminal acts perpetrated against children (Peters, 1989).

In 1963, the Children's Bureau of the Department of Health, Education and Welfare issued a document titled: "Principles and Suggested Language for Legislation on Reporting of the Physically Abused Child." According to Paulsen (Helfer & Kempe, 1968, p. 181-185,) this model legislation advocated that the mandatory reporting of child abuse be restricted to physicians. Unlike the numbers of teachers and social workers who had taken upon themselves the responsibility of reporting the instances of suspected

2

Societies that emphasize the social or communal worth of the child will be more likely to condone infanticide and abuse than societies where value is constituted by the individual human capacities of the child (personal communication with Professor John Kleinig, John Jay College of Criminal Justice, 5/16/95).

3

Gustafson (Shannon, 1976) on the limited rights of children in medical treatment: Physicians are routinely obliged to acquiesce to the desires of parents because we have accorded parents significant moral autonomy in decision making about the course of medical treatment for their children.

abuse which they had recognized, physicians seemed to be reluctant to "become involved" in proceedings which might require their appearance and testimony in court and/or which might create the danger of civil liability.

The Children's Bureau emphasized the physician's professional duty to report cases of discrepancy between the diagnosed physical state of the child and the caretaker's explanation of the course of events leading to medical treatment. Moreover, they sought "to establish that a doctor ought not, by remaining silent, assist those who mistreat children."

The American Medical Association argued that the Children's Bureau had "failed to come to grips with the entire problem" of child abuse reporting. It was their position that a much broader list of mandated reporters was necessary in order to blunt the publicity of reporting. Indeed, they explained that if only physicians were reporting, abusing parents and custodians would surely deprive their children of essential medical care in order to avoid detection.

In 1966, The American Humane Association drafted its own model for child abuse legislation. Although they asserted that "casefinding is a universal obligation of all responsible citizens and all community agencies," they emphasized the notion that "the great bulk of the most

serious cases" have generally come to the attention of physicians who have continually failed to report many of them. Thus, the American Humane Association essentially focused on the physician's moral and professional duty to report suspected cases of child abuse.

As the states began to formally legislate against the abuse of children and to mandate the reporting of suspected cases of child abuse, there was little uniformity in their procedures. Some states enacted "any person" laws which literally required any person with knowledge or suspicion of a case of child abuse to report this case to the appropriate authorities. Other states specifically required reporting by school teachers, school administrators and "those who might discover cases in the course of a health examination." Paulsen explained that six states which had enacted child abuse reporting laws did not specify who is required to report. A 1963 California mandatory reporting law even created a loophole for the physician which excused from mandatory reporting those cases in which "in his opinion it would not be consistent with the health, care or treatment of the minor" to report that the minor had been abused.

Chapter 2:

Mandatory Reporting: The Pediatricians' Response.

Pediatricians expressed varied attitudes on child abuse reporting issues (Krinsky & Kossan, 1979; Garbarino, 1985; Eisenberg, et. al., 1987; Brosig, 1992). Many physicians had personal objections (Thong, 1982) to mandatory reporting laws [such as reticence to intervene "in another man's affairs" (Beckelman, 1978) or a personal belief in corporal punishment (McCormick, 1992)]. Others objected to mandatory reporting laws on the grounds that these laws were disruptive of the professional relationship between pediatrician and parent, (i.e., parents would naturally become resentful and critical of the pediatrician in cases where formal reports of child abuse were made). The Committee on Infant and Pre-School Child of the American Academy of Pediatrics, however, asserted that mandatory reporting laws actually constituted important and supportive measures for pediatricians whose patients might criticize them for alerting the authorities. Indeed, they argued that "the widespread dissemination of the fact that the physician is legally mandated to report a case of suspected child abuse should also remove, or at least reduce the parents' resentment." The well-informed offending parent would come to view reporting as beyond the control of their pediatrician. The offending parent would thus be more

understanding and less likely to aggressively challenge and disrupt their existing relationship with the pediatrician.

The states which enacted mandatory reporting statutes differed in their approaches to penal sanctions for physicians who knowingly failed to make such reports. Almost one half of the states did not initially institute any penal sanctions. The state statutes that were written with penal sanctions ran the gamut from fines of "not more than \$25.00" (in the state of Vermont) to a fine "not exceeding \$500.00..." or a prison term "not exceeding one year or both" (in the state of Pennsylvania).

Physicians have argued that their "professional integrity" has been impugned by the mere suggestion that they require the threat of criminal sanctions in order to carry out their duties, yet Paulsen (Helfer & Kempe, 1968, p. 185) explained that this argument carried little force: "Prosecutors will be reluctant to act, especially since conviction will be difficult." Thus, criminal punishment is not so much intended to villify the physician as it is to emphasize "that parents will find a physician's action in reporting more palpable if it is required by law."

Mandatory reporting laws have indeed succeeded in forcing the physician to recognize and to report the most blatant cases of child abuse. They have also facilitated the creation of an important national data base for the

further study of reported incidents of child abuse.

Unfortunately, there is evidence to indicate that, beyond the wedge that reporting may place in the professional relationship between the pediatrician and the abusing parent, a more important consequence of mandatory reporting laws is that significant numbers of parents now fail to take their children to pediatricians and to hospitals because they fear reporting.

The "state of mind" of the individual who is aware of mandatory reporting laws and must decide whether or not to seek emergency medical care at the calculated risk of involvement with the criminal justice system has been the subject of analysis and contemplation. Important contrasts have been drawn between an individual's potential awareness and perception of laws designed to force physicians to report patients who seek care for unusual or suspicious injuries to themselves and the individual's potential awareness and perception of laws designed to force physicians to report parents who seek care for unusual or suspicious injuries to their children.

An example of the first case involves the mandatory reporting of gun shot wounds. It has been argued if physicians are required to report all cases of gunshot wounds, then the victims of such wounds who wish to avoid involuntary involvement with the criminal justice system

would be discouraged from seeking medical attention. Yet, it has been demonstrated that (with the exception of only the most stoic victims,) gunshot victims will regularly seek medical attention for themselves when the personal perception of extreme pain and/or the fear of death become overwhelming.

By contrast, however, mandatory reporting does pose a significant deterrent to a parent who is considering the option of medical care for their abused child. This is due to the fact that "parents are not presented with danger to their own persons," but to the bodies of children that they have already physically abused. Because they do not feel the pain of the (child's) injury in their own bodies, they will be much less likely than the gunshot victims to risk medical care which is involuntarily linked to reporting.

As early as 1966, a case appeared before the Supreme Court of the State of California (People v. Forbes, 44 Cal. Repr. 753, 755, 402, P.2d 825, 827 (1966)) in which the "defendant indicated to the police that she had not called the doctor because she feared that he might report her." While some such cases have been documented, Paulsen has asserted that "we do not know (and probably can never know) how many parents fail to take their children to hospitals because they fear reporting...."

The "state of mind" of the physician who is examining

a child who may have been abused has been explored as well. Paulsen (Helfer & Kempe, 1968, p. 187) explained that statutes have generally been written to require physicians to report all cases in which there may exist "reasonable grounds" or "reasonable cause" to "'believe' or 'suspect' that a reportable injury has occurred." Thus, whether or not the physician is certain that abuse has occurred, or whether or not the physician "holds the opinion" that abuse has occurred is almost irrelevant in these cases. As long as there may be some reasonable cause to believe that abuse may have taken place, these statutes actually require that the physician make an official report.

Two early forms of "physician backlash" to mandatory reporting statutes have been noted. The first involved the denial of the suspicion that parental abuse has actually occurred. The the second involved the denial that "criminal child abuse" is even an existing entity.

In the first case of denial, a pediatrician who had been told that a child has been physically (or sexually) abused may have chosen to believe that the child had lied to the authorities and that no actual abuse had taken place. Or, a pediatrician who examined a child and noted the existence of injuries which had been "probably caused" by abuse may have succeeded in rationalizing and documenting those injuries as "accidental" and therefore not subject to

mandatory reporting. However, as the technology of differential diagnosis progressed, a variety of manuals and atlases were published to explain, analyze and graphically depict photographic evidence of the injuries of abuse in contrast with photographic evidence of accidental injuries. Thus, most physicians are no longer able to simply excuse the injuries that they had excused in the past.

A case in point involves the large triangular burn marks of the torso that pediatricians have routinely observed for many years in children who have been abused with a hot iron: Whereas it had once been possible to assert (without much risk of formal challenge) that these marks had been the result of some accidental occurrence, physicians are currently expected not only to immediately recognize (Cameron & Rae, 1975) and report all such markings as the definitive signs of abuse with a hot iron, but may even be expected to recognize the brand name and the specific model of the iron that was used from the type of markings on the child's body.

The second form of physician backlash to the mandatory reporting of child abuse is couched in terms of:

a more enlightened conception of child abuse
from the one implied in the diagnosis of
'the battered child syndrome' to a more
humane view which focuses on the parent's

capacity to protect a particular child rather than any 'intent' he may have had to injure him (Newberger in Bourne & Newberger, 1979, p. 15).

In an article titled "The myth of the battered child syndrome" which first appeared in 1973, Newberger explained the movement to deny as "myth" that the abuse of children is a criminal act. Instead of criminality, Newberger proposed the notion that the abuse of children is one of the many symptoms of an "illness" that requires "vigorous" treatment.

Newberger reported that his colleagues at the Children's Hospital in Boston were so unwilling to conform to the requirements of mandatory reporting of child abuse that they alternatively formulated their very own "house euphemism" of "*trauma X*." Thus, in cases where "battered child syndrome" was the actual diagnosis, a notation of "*trauma X*" in the child's file facilitated a formalized evasion of the mandatory reporting laws.

The Massachusetts pediatricians were able to proceed with their program to essentially remove all family-related cases of child abuse from the purview of criminality because Governor Francis Sargent convened a special advisory council in the early 1970s in order to redefine the state's position on child abuse issues. This committee proposed that in

place of utilizing such pejorative terms as "the battered child syndrome" and "child abuse," the State of Massachusetts should consider the term: "a family crisis which threatens the physical or emotional survival of a child."

Thus, for all intents and purposes, in the 1970s, the State of Massachusetts came to view the physical abuse of children as neither a malum in se nor as a malum prohibitum. Instead, the physical abuse of children became part of the larger socio-psychological context of families in crisis.

Chapter 3:

Educating Pediatricians as Mandated Reporters.

The political and moral climate (Fesbach, 1979) that determines the way we treat child abusers and their victims continues to evolve. Many misconceptions (Bandman & Beavers, 1978) yet prevail about the nature and consequences of child abuse.

Many incongruous notions have influenced the attitudes of physicians (Chang & Oglesby, et. al., 1975; Young, 1976; Cathcart, 1989) and family violence specialists (Lipner, 1975; Gelles & Loseke, 1993). One approach asserted that child abuse has been with us since prehistoric times, but that we have only recently "rediscovered" its existence (Antler, 1976). An alternative approach held that child abuse is not a historical phenomenon, but represents a "'new' epidemic" (Whitworth, 1980).

Numerous articles and texts detailed the problems of "lost and found memories" (Terr, 1994) of physical and sexual abuse in childhood. The child protection community was informed that adults may suddenly discover repressed memories of childhood abuse that must now be remediated. Almost simultaneously, researchers (Wright, 1994; Yapko, 1994) began to question and challenge accounts of recovered memories.

Dr. Marsel Mesulam of Harvard University became the

foremost authority on the brain's "miscoding" mechanism. Dr. Elizabeth Loftus of the University of Washington offered expert testimony on how this "miscoding" (Goleman, 1994) is but one of several mechanisms that can lead to the "false memory syndrome." Thus, while being educated about the existence of repressed memories and the special problems of adults who recover these memories, many practitioners were/are also being informed that most, if not all of these memories are actually false.

Issues relating to "psychic terror" (Terr, 1990), the psychological maltreatment (Vondra & Kilar, et. al., 1992) and emotional abuse (Holm, 1986) of children as well as issues relating to the enduring stresses (Johnson & Cohn, undated), trauma (Sanford, 1990) and developmental defecits (Oates & Peacock, et. al., 1984) in abused children have been diluted by reports that many of these conditions were/are fabricated.

Studies have been conducted to determine whether or not physicians were able to recognize the clinical manifestations of sexual abuse (Ladson & Johnson, et. al., 1987). Then, as educational initiatives were undertaken to better prepare pediatricians and the entire child abuse community (LaFontaine, 1990) for their essential roles in dealing with such cases, a strong professional "backlash" movement (Myers, 1994) emerged. "Child abuse hysteria"

(Gardner, 1991) was described as a syndrome in which "some" children will fabricate, elaborate or exaggerate their allegations of sexual abuse.

In the broad field of child abuse, some have been concerned with the nature and extent of the actual injuries that children sustain (Blumberg in Parsonage, 1979), while others have been more concerned with the family dynamics (Kempe & Helfer, 1972) and the variety of social and psychological conditions involved in the abuse of children (Kempe & Helfer, 1972, 1980; Lenherr & Welch, 1990).

A variety of "disorders" were blamed for the abuse of children. The etiology of child abuse was discovered in the "multiple personality disorder" (Brown, 1993) as well as in the "development-ecological" disorders (Belsky, 1983) and in the "biosocial" disorders (Gelles & Lancaster, 1987). At the same time, it was asserted that child abuse probably does not represent a "disorder" in and of itself, but actually represents an integral component of our society's order.

The "violent society" theory (Blumberg, 1980) considered the violent abuse of children within the larger context of the acts of violence that are routinely perpetrated within our society. Children who are victimized or who will be victimized in the future are really no worse off than adults who are victimized. In the application of

this theory, the abusing parent is no longer given specific notice and the special needs and interests of abused children lose their significance.

An alternative approach asserted that our society is composed of "good" parents who maintain "good" homes in which our children are safe and secure. Children are only abused in our society under the most unusual or extenuating circumstances. Thus, while children who have been incarcerated (Wooden, 1976) may sustain physical and/or emotional abuse and children who come to the attention of child welfare authorities (King & Trowell, 1992) may in fact have been maltreated, children who live at home are to be considered safe and secure from abuse. As a corollary to this approach, children who are not cared for at home by "good" mothers, but who are delivered to day care facilities (Finkelhor & Williams, et. al., 1988) may suffer abuse as well.

Some have questioned the need to further open "Pandora's box" (Sugg & Inui, 1992) by engaging in more rigorous and detailed investigations of child abuse. Others have suggested that clinicians must now become aggressive "child advocates" (Wissow, 1990). Some researchers and practitioners have promoted the importance of better techniques of identification of existing cases of child abuse (Tuke, 1979), while others have advocated that we

emphasize efforts on behalf of future child abuse prevention (Blumenkrantz, 1992).

A broad variety of child abuse education strategies have been recommended for medical students (Hansen, 1979), residence staff (Krenk, 1984), nurses (Hopkins, 1970; Jolly, 1979; McKittrick, 1981), sociologists (Sokol, 1976), psychologists (Muehlman & Kimmons, 1981), dentists (Schmitt, 1986), pharmacists (Stewart & Roth, 1975) and members of the general public (Baade, 1980).

Sheppard (1982) noted that the impact of much of this child abuse education has been diluted through "individualistic approaches" that have fragmented the child protection community. Some approaches have led to confusion, while others have effectively discouraged mandated reporters from soberly recognizing and redressing the victimization of children through established channels within the criminal justice system.

Among the noted concerns, are: the difficulty in establishing interdisciplinary protocols for child abuse; the lack of two-way communication between medical and non-medical approaches to the abuse of children; and, the effects of the implementation of the social science model of child abuse on mandated reporting.

A broad variety of approaches address the recognition and understanding of child abuse (Butt, undated). Each

discipline has its own jargon as well as its own unique set of priorities. Definitions and goals of the various disciplines are incongruous, so that interdisciplinary dialogue and cooperation on behalf of victimized children are not easily facilitated.

The non-medical community has not adopted a medical frame of reference or medical terminology for its child abuse dialogue. Medical-legal protocols (Brown, 1971; DeAngelis, 1992) addressing specific clinical indicators of well-documented forms of child abuse are readily available. Published texts provide clear and detailed explanations of the medical aspects of child abuse for the non-medical researcher (Smith & Benton, et. al., 1989). Yet, anatomical and physiological terminology rarely appear within the social science lexicon.

Social science models such as the "hostage theory" of child abuse (Goddard & Stanley, 1994) are often very narrowly construed sociological approaches to broad interdisciplinary polemics. They are presented in terms that may be foreign and therefore uninviting to the medical practitioner.

It is interesting to note that apart from a lack of academic preparation in the natural sciences, non-medical child abuse specialists are deterred from anatomical and physiological awareness of child abuse injuries by a

continuing professional education system that either actually restricts this information to medical personnel or strongly recommends that non-medical personnel refrain from attending sessions in which such information is demonstrated¹ or discussed. In contrast with the education of non-medical personnel, medical practitioners are regularly exposed to and even required to attend and participate in "medical sociology" classes, professional conferences and continuing education symposia where social science approaches are promoted.

A cycle of "individualism" emerged where pediatricians who are legally mandated to recognize and to report cases of child abuse are for the most part being trained in child² abuse theory by non-medical social scientists.

1

The author has attended several professional child abuse conferences where non-medical personnel were discouraged or excluded from attending any presentations in which either graphic depictions of abused children or discussions of specific abuse-related physical pathologies were scheduled.

2

Some exceptions include physicians and nurses who no longer have any exposure to the physical aspects of medical practice due to early or recent affiliations with the mental health system or with a variety of academic or social service functions that have supplanted clinical practice.

These physicians and nurses will initially utilize a minimal amount of medical jargon in their presentations in order to identify themselves as "medical" practitioners. They will then abandon the medical model in favor of a social science approach to the topic at hand.

The social scientists who are responsible for the child abuse-specific training of pediatricians are essentially unfamiliar with medical terminology³ and unprepared to discuss the anatomical and physiological ramifications of child abuse. They are only prepared to educate pediatricians about a variety of social, psychological and historical "explanations" for adult-child interactions. While it has been asserted that this educational experience actually serves to "humanize" many pediatricians, it may also be asserted that this educational experience significantly detracts from the legislated role of the pediatrician as the expert reporter of child abuse.

It is important to note that child abuse legislation was not written to direct the pediatrician to evaluate a broad range of social, psychological and historical factors that might lend some obscure or latent meaning or causation to an episode of adult-child interaction. Instead, the intent of this legislation was and is to compel the pediatrician (as a noted expert at physical observation and medical diagnosis) to report to the criminal justice system any and all instances of child abuse that s/he observes regardless of these factors.

3

Texts describing the anatomy and physiology of child abuse in non-medical terminology (described above) may be utilized to compensate for any such deficiency.

In order to first develop and then to enhance their abilities and skills as child abuse reporters, pediatricians were required to participate in child abuse-specific continuing medical education. However, (due to the content of much of this continuing education,) even those pediatricians whose personal and political views encouraged them to report as mandated have been taught to relegate observable injuries and actual traumas to a less significant position than family constellations and the socio-psychological etiologies of intra-familial interactions.

Pediatricians who attend child abuse-specific continuing medical education programs seek clinical instruction in the definitive diagnosis of the various physical pathologies of abuse. As familiar manifestations of (impulsive) abuse are being replaced with more sophisticated and (well-researched) methods designed to evade detection, pediatricians need to access information that will enable them to effectively recognize and report new and unusual pediatric pathologies.

Chapter 4:

Child Abuse in the Medical Guise: What Pediatricians Learn About the New Sophistication in Child Abuse Methods.

In general terms, the sophistication of technology has been accompanied by a sophistication in the methodology of crime. Crimes that once involved simple preparation and basic skills may now require strategic planning and state of the art technology. For example, in order to break into a locked bank vault in the 1950s, a burglar might need only a floor plan and some special tools and equipment. In the 1990s, however, plans and tools are secondary to a very sophisticated understanding of computerized security systems. Moreover, while the departing burglar of the 1950s may have been careful not to leave clear fingerprints at the crime scene, the burglar of the 1990s evades hidden surveillance equipment, notes the presence of special money marking devices and guards against leaving behind any identifying microscopic traces of hair, saliva or fabric lint before escaping from the scene of the crime.

Child abuse was a relatively simple affair in the 1950s. Parents generally engaged in simple methods (such as beatings) and were rarely concerned with detection or its consequences. It has been suggested that child abuse in the 1990s has become a very sophisticated affair. An artifact resulting from the advancing technology of detection and the

implementation of mandatory reporting may be that parents may have been motivated to engage in strategic planning and state of the art technology in order to continue the undetected abuse of their children.

In recent years, pediatricians have examined children with a variety of bizarre "accidental" injuries (Lancet, 10/9/76) and illnesses. When presented with children who had been injured through a variety of unusual circumstances, pediatricians were reluctant to assume that they had "probable cause" to report a case of suspected child abuse. When presented with illnesses that they could not recognize, pediatricians have performed numerous tests and invasive procedures, accessed computerized diagnostic data bases and referred to colleagues for further evaluation. However, they have generally been reluctant to conclude that an "illness" might have been parentally induced with criminal intent.

On June 16, 1994 a letter appeared in the "Dear Abby" column of the New York Post. The writer complained that her brother in law had a vicious dog who threatened to attack her children (ages 9 months and 2 years) whenever the family visited. In a personal communication (February 15, 1995,) Professor Carl Wiedemann of John Jay College of Criminal Justice hypothesized that a vicious dog (who is kept at home and periodically allowed to "accidentally" maul young children) may provide abusing parents with a more advanced

and legally secure method of inflicting pediatric injury.

A variety of articles have appeared in the professional literature detailing the accounts of children who have been abused in the medical guise (Rosenberg 1987, 1988, 1992). These children have been the victims of sophisticated and well-researched plans through which they are made to experience severe medical symptoms [such as: simulated cystic fibrosis (Orenstein & Wasserman, 1986), brain damage (Meadow 1984b), severe head injuries (Ophoven, 1988), induced dwarfism (Money & Needleman, 1976), factitious bulimia (Feldman et al., 1989), and even simulated developmental disabilities (Stevenson & Alexander, 1990)] and then through factitious reporting, subjected to intensive and invasive diagnostic and treatment procedures.

Child abuse in the medical guise has been identified as "Munchausen Syndrome by Proxy." It has been referred to as a condition in which a parent will make mendacious reports of a child's illness in order to subject the child to unnecessary medical attention.

Since Roy Meadow (1977) initially appropriated the term "Munchausen Syndrome"¹ and applied it to the abuse of children, practitioners and researchers have published case

1

"Munchausen Syndrome" involves adults who make mendacious reports of their own illnesses in order to subject themselves to unnecessary medical attention.

reports, theoretical essays and specialized articles designed to introduce pediatricians to Munchausen Syndrome By Proxy. Updates on some of the more exotic manifestations of Munchausen Syndrome By Proxy (hereafter MSBP) as well as articles detailing the problems that pediatricians have faced in dealing with MSBP victims and perpetrators were presented in the academic pediatrics literature.

Specialized MSBP reports for the broader pediatrics community (Fulginiti, 1985), family physicians (Richardson, 1987), nurses (Hobbs, 1983; Kelly, 1988), child psychiatrists (Waller, 1983; Atoynatan, et. al., 1988; McGuire & Feldman, 1989), pediatric psychologists (Chan, et. al., 1986; Money, 1986), mental health professionals (Schrier & Libow, 1993b), family therapists (Griffith, 1988), behavioral science and law specialists (Kahan & Yorker, 1981), those concerned with issues of in-hospital electronic surveillance (Williams & Bevan, 1988), attorneys and legal advocates (Rand, 1993), parents' rights advocates (Kinscherff & Famularo, 1991), family violence professionals (Manthei, et. al., 1988; Ericson, 1993), child abuse professionals (Jones, et. al., 1986; Mian, 1991), social workers (Sheridan, 1989; Neale, et. al., 1991; Mercer & Perdue, 1993), social case workers (Stone, 1989), school health professionals (Kahan & Yorker, 1990), and pastoral counselors (Speed, 1990) have been presented at professional conferences and published in refereed journals.

Pediatricians and professionals involved in the care, protection and treatment of children have thus been educated about the existence of MSBP and about many of the problems inherent in the MSBP parent's act of "deception" (Naish, 1979).

Inherent in the knowledge that MSBP results in the disfigurement and even the death of its victims, is the notion that MSBP perpetrators join the ranks of other "life threatening parents" (Alexander, undated). Some MSBP victims will join the ranks of "child abuse fatalities" (Christoffel, 1986), while others become part of the international problem of child abuse (Taylor & Newberger, 1979).

American child protection statutes have not been written to specify all of the varied forms of abuse that may be perpetrated against children. Instead, some unusual or exotic forms of child abuse have been prosecuted as extensions of our prior conceptions of criminal adult-child interactions, while other exceptional cases have served as the impetus for legal amendment or reform. Thus, although no existing child abuse statute specifies MSBP by name, it might be asserted that child care professionals have been duly informed of yet another "syndrome" that they may be expected to recognize and to report as a form of child abuse.

Child care professionals learn what to report about

child abuse and how they should formally make such reports during the course of mandatory professional continuing education programs. The content and emphasis of MSBP-specific continuing medical education may therefore strongly influence the nature and frequency of MSBP reporting.

Pediatricians (as the deceived participants in these cases of child abuse in the medical guise), may be motivated to go beyond the required curriculum and enroll in special seminars or attend national and international conferences that offer advanced training or state of the art instruction in dealing with MSBP. They have joined nurses, mental health workers, child protection specialists, prosecutors and educators in specialized seminars and workshops dealing with MSBP issues. However, these seminars and workshops are rarely, if ever focused on the actual ramifications of the abuse of the child. Instead, participants are presented with an approach to MSBP that is essentially incongruous with both the medical model and the criminal justice aspects of child abuse reporting.

"Child abuse in the medical guise" involves a parent who has employed one of the more novel and sophisticated techniques of abuse in order to harm a child. Yet, the professionals attending specialized seminars and workshops have been continually instructed to almost completely ignore the child and the abuse that s/he has suffered in lieu of the notion that MSBP represents a "mothering disorder"

(Schrier & Libow, 1993a) that signifies some dysfunction in the "mother's" own perception of her relationship with a specific pediatrician.

One important example involves the 1995 San Diego Conference on Responding to Child Maltreatment that was attended by an interdisciplinary group of child abuse specialists from many American and international locations. There, on Tuesday, January 24, 1995, Catherine Ayoub, R.N., Ed.D. of the Harvard Graduate School of Education chaired an "open forum" on MSBP designed to offer an "overview of the current practice and research" in the field.

Dr. Ayoub began her presentation with some medical terminology and medical notation.² She then proceeded to explain that MSBP is a "disorder of mothers." Although several participants vocally protested the designation of MSBP as a "mother's problem," insisting that their caseloads³ consisted of large numbers of males/fathers, the presenter did not acknowledge this phenomenon.

2

Some of the non-medical participants were initially confused by lecture as well as audio-visual materials that employed medical transcription terminology such as "Hx" (for medical history) and "Dx" (for diagnosis), etc.

3

Several professionals energetically agreed with one participant who stated that at least one half of his Munchausen Syndrome by Proxy caseload involved the actions of fathers. When Dr. Ayoub did not address these comments, another participant asserted that her MSBP caseload probably consisted of fathers more than 70 percent of the time.

Dr. Ayoub proceeded to review some of the recent literature on MSBP and to explain some of the difficulties inherent in dealing with the disposition of MSBP children. She then invited the audience to present their own MSBP cases for discussion.

The tone of the forum was generally lighthearted. Participants actually laughed heartily at the details of a 10 year old boy whose mother reported that he had never had a bowel movement, as she sought the pediatrician's aid in subjecting the boy to invasive procedures. They were brought to laughter by several other accounts including that of a pediatrician in the audience who announced that he had⁴ seen over 76 cases of MSBP in his own practice.

The participants were never instructed that MSBP represents a form of child abuse. The issue of the⁵ mandatory reporting of MSBP was not discussed. Although two

4

The author has attended several San Diego Conferences on Responding to Child Maltreatment. The programs offered at these conferences have been conducted with the upmost professionalism, seriousness and sober concern for the children's issues being discussed. This MSBP session was exceptional for its lightheartedness and levity. The author discussed her concerns with several participants who noted that they had also experienced similar "jocularly" at the MSBP-specific presentations of other organizations.

5

Although Dr. Ayoub noted that child abuse cases tend to "drag on" as she mentioned her own role as an "expert witness" in such cases, she did not instruct forum participants in the recognition, reporting, or prosecution of MSBP cases.

separate questions were raised (from participants) about the potential for reporting and prosecution of MSBP cases, these were not addressed.

Child abuse in the medical guise was redefined as a form of "fetishism" in which the "mother" needs to "make contact with the physician" and the child becomes an accessory to that need. Thus, contradicting the position of Roy Meadow that MSBP parents intend to harm their children, Dr. Ayoub presented the view of Schreier and Libow that some mothers will almost inadvertantly harm their children in the course of fulfilling their own emotional needs.

Schreier and Libow (1993a) have asserted that when a mother experiences the "intense need to be in a relationship with doctors and/or hospitals," she may begin "imposturing." They define "imposturing" as a "clinical condition":

This clinical condition is a form of relating (here, to a physician) in which lying is the essential mode of interaction and represents a particular form of "character perversion" as described by Arlow (1971). The mother becomes a "perfect" mother in a perverse fantasized relationship with a symbolically powerful physician and the harm she does her child is but a by-product of that relationship (p. 84-85).

Schreier and Libow further explain that their use of

the term "perversion" is not intended in the sexual context, but, instead, implies a:

mode of mental functioning in which reality and fantasy coexist, though their distinction is blurred....

In the scenario enacted by a mother who brings her child for treatment and a physician who becomes implicated in the mother's fantasy, the infant serves as a fetishistic object [or "It"]..., much like the fetishistic objects in other forms of perversions (p. 85).

Schreier & Libow have asserted that this maternal "imposturing" is very distinct from "the various syndromes of child abuse." They explain that "the mother's relationship with her pediatrician is paramount in the development and continuance of" MSBP (p. 84).⁶

By promoting the notion of "institutional transference," Schreier and Libow ignore the clinical literature that describes numerous cases of parents who were

6

The author consistently refers to child abuse in the medical guise as "MSBP" in order to provide for uniform terminology throughout this text.

For the discussion of MSBP as a "mothering disorder," the author notes that Schreier and Libow (1993a) have now adopted the term "Munchausen By Proxy Syndrome" or "MBPS" in place of "Munchausen Syndrome By Proxy" or "MSBP".

clearly not fixated on or even remotely loyal to any one physician. They do not inform their readers that MSBP cases typically involve the transportation of children from physician to physician and from facility to facility so that parents can avoid detection as they continue to inflict unnecessary medical treatment upon those children.⁷

Roy Meadow personally communicated his disagreement with Schreier and Libow's approach. They included some of his comments as part of a footnote:

Meadow (personal communication, August, 1992) reports that the mothers he has questioned adamantly insist "that it has not been their fixation on a particular physician, nurse, or other person... that caused them to make their child ill....," (p. 85, note 2).

In spite of this criticism, Schreier and Libow add to the assertion that MSBP relates to the personal fantasies of the mother and further detract from the notion that the abuse of the child is of foremost concern. They replace an

7

Munchausen Syndrome By Proxy derives from Munchausen Syndrome because the latter refers to individuals who have generally transported themselves from physician to physician (without the necessity of any specialized fixation on any one physician) and from medical facility to medical facility, seeking to avoid detection as they continued to inflict abuse upon themselves in the medical guise.

earlier theory (Libow & Schreier, 1986) in which they had distinguished between "three categories of factitious illnesses in children." Blurring the earlier distinctions that they had proposed (between parents who as pathetic "Help Seekers" were utilizing the health care system in order to access vital services that were otherwise unavailable to them, "Doctor Addicts" who were demanding and belligerent in their abuse of health care professionals and manifestly good and compliant parents who were actually MSBP perpetrators,) Schreier and Libow (1993a) now treat all three distinct categories of dysfunctional parent-child relationships as one undifferentiated mass of MSBP description.

Their approach is noteworthy because in its practical application it serves to reinvent "*trauma X*" (Bourne & Newberger, 1979) and to apply the logic of the "myth of the battered child syndrome" to the treatment of MSBP cases. As the criminal nature of the parent's interaction with the child is supplanted with (the proposed dynamics of the fetishism inherent in) the mother-pediatrician bond, MSBP perpetrators may be protected from the concrete intervention of the criminal justice system and relegated instead, to an abstract psychoanalytic discourse that is essentially disinterested in the child-victim.

The MSBP perpetrator was understood to be a

sophisticated parent who intended to harm their child by well researched, unconventional means that were designed to avoid detection. The MSBP perpetrator joined the ranks of other sophisticated child abusers by employing exotic methods and coopting various agents (in this case the pediatrician) in order to facilitate the undetected/unredressed abuse of the child. Schreier and Libow now represent the MSBP perpetrator as a mother who is very simple and unsophisticated--except in her demonstrable knowledge of the history and dynamics of the feminist movement's battle and her own belligerent stance against the authority of the physician over the woman--and deeply needy of basking in the "glow" of the pediatrician's healing.

Schreier and Libow propose a series of ideas about the interaction between the MSBP mother and the pediatrician that do not comport with information published in the case reports of MSBP.⁸ Three non-child related dimensions are added to their MSBP schema:

1. The history and politics of women's interaction with the medical profession have been "complex and unsatisfying." "Power, authority and charisma [have been] attributed to the

⁸

These are reviewed in Chapters 7-11 of this text.

9
physician." While Schreier and Libow explain that this is
not the "foremost" consideration, they assert that the
MSBP mother will experience "complex feelings of competition
10
or resentment... toward medical professionals" that are
11
grounded in these historical phenomena (p. 118).

2. An "aggressive component" is noted in the mother's
relationship with the pediatrician. Her "need to control
12
and demonstrate superiority is prominent" (p. 131).

9
Several alternative "feminist" perspectives on MSBP are
discusses in Chapter 17.

10
The MSBP parent has been distinguished from the "Doctor
Addict" parent who may be belligerent, challenging and
resentful of health care personnel.

The classical MSBP parent is comfortable interacting with
the pediatrician. One rationale for this was described by
Roy Meadow (Schreier & Libow, 1993a, p.85, note 2). He
suggested that it is the "need to escape" from an unpleasant
or abusive home environment" that will motivate the MSBP
mother to abuse her child. She can then "escape into the
[comforts of the] hospital environment."

11
It is important to note that interviews of apprehended
MSBP parents have yielded evidence of intent to harm the
child rather than any motivation or intent to overcome the
"power of the pediatrician."

12
The MSBP parent will be differentiated from the "Health
Care Addict" or "HCA" (referred to as the "Doctor Addict" by
Libow & Schreier, 1986). The "Health Care Addict" has been
described as aggressive and controlling, while the MSBP
parent has been presented in the literature as a manifestly
compliant, deferential and congenial parent. The MSBP
parent (will surreptitiously control the health of his/her

3. An ironic complication of this theory is the need¹³ that the mother has to be nurtured by the pediatrician and to be part of the glow of "healing":

Furthermore, by virtue of the social prestige afforded to medical caregiving, a mother can at least bask in the glow of reflected glory when her pediatrician, with her help, succeeds¹⁴ in healing her child (p. 119).

Schreier and Libow have concluded that if a mother "feels neglected and hungers for" the appreciation of the

child, but) will be manifestly polite, agreeable and even considerate of the needs of medical personnel. S/he may even bring refreshments and do small chores in order to be of assistance to medical personnel. Chapters 8-9 of this text detail the difficulties inherent in the differential diagnosis of MSBP, including the difficulty that pediatricians have in believing that a parent who is so "good" and so prepared to comply with their instructions could possibly be abusing their child.

13

The MSBP parent will also be differentiated from the "Help Seeker" (Libow & Schreier) who may or may not actually harm the child (depending on the intensity of the case), but will make mendacious reports of the child's illness in order to obtain some form of "nurturance" such as an otherwise inaccessible referral for social services or home care.

14

By definition, the MSBP parent wishes to harm his/her child. Healing or remission of symptomatology do not produce a positive "glow." Instead, they have traditionally prompted Munchausen Syndrome as well as Munchausen Syndrome By Proxy perpetrators to seek alternative venues in which their symptoms could resurface and flourish.

pediatrician of her fixation, then:

she may gradually find herself taking steps
to remain in this exciting world, even at the
expense of her child and/or the "truth" (p. 119).

Child abuse in the medical guise has thus been transformed from a condition in which a parent will first inflict harm upon a child that mimics medical symptomatology and then seek to further harm the child by coopting the pediatrician into performing unnecessary invasive diagnostic and "therapeutic" measures that rarely result in anything other than the pernicious harm of the child. It has been redefined as a condition in which the emotionally needy and historically and politically astute mother of an authentically sick child (who is recovering under appropriate medical care,) decides to gradually prolong her child's illness so that she can remain within the "exciting world" of "medical drama."

Chapter 5:

The Impact of Medical Malpractice Litigation
on Child Abuse Reporting.

The "Child Abuse Prevention and Treatment Act" of 1974 (also referred to as "Public Law 93-247" and "The Mondale Act") provided federal funds to match state funding expended on behalf of a variety of child abuse education, prevention, protection, prosecution and treatment programs.

In order to be eligible for matching funds from the federal government, states were required to:

1. establish child abuse reporting protocols;
2. designate mandated reporters;
3. provide for penalties and criminal sanctions against mandated reporters who failed to report; and,
4. provide immunity from prosecution for all those who make reports of child abuse.

Each state legislated its own child abuse prevention and treatment act. Each state established its own abuse protocols and designated its own list of mandated reporters.

All 50 states now uniformly list pediatricians as mandated reporters and grant them immunity from criminal prosecution (similar to that of prosecutors and judges) in the event that an error would be made in their reporting of a case of child abuse. Pediatricians who believe that they

have recognized the physical manifestations of child abuse and make good faith reports to the appropriate authorities within the criminal justice system are thus theoretically immune from criminal prosecution if it is later discovered or demonstrated that the child(ren) involved had not actually been abused.

Although pediatricians acting in good faith have been indemnified against criminal prosecution for faulty child abuse reporting, they have not been indemnified against the variety of civil/ malpractice claims that may demand extensive commitments of time and significant amounts of money to litigate. Thus, before making a report of child abuse to the criminal justice system, pediatricians have considered the potential of personal and professional repercussions from parents who may claim that they have been wrongfully accused of abusing their child(ren).

In fact, an entire world-wide "backlash" movement appeared in response to the modern child protection movement. One example involves the group "VOCAL" or "Victims of Child Abuse Legislation" that challenges the entire scope of the child protection movement in the name of "family rights" (Myers, 1994).

Seeking to hold mandatory reporters liable for their (allegedly "numerous") errors, various outspoken professionals and active lobbying organizations have

undertaken serious efforts to repeal "the federal immunity clause" from state legislation. Ideally, however, they prefer to completely eliminate the concept of "mandatory reporting" from all of our child abuse legislation (Gardner, 1991, 1992).

In assessing the impact of the "backlash" movement, it is important to consider legislative as well as social and inter-personal agendas. While critics of our child abuse laws have become very vocal, they have not achieved any formal success in their legislative initiatives. There is no evidence to suggest that the federal government or state or local governments are preparing to modify or to repeal the concept of mandatory reporting in capitulation to the wishes of these groups. Socially, however, the "backlash" movement has attracted an important following. On the inter-personal level, this movement has effectively inhibited some pediatricians from making mandated child abuse reports.

The cases of child abuse that a pediatrician will observe in the course of clinical practice vary greatly in intensity and sophistication. Some children present with wounds that are mild and self remitting, while others bear injuries that may be severe and life threatening. Some children bear the clear and identifiable scars of serrated knives or hot irons, while other children bear unusual or apathognomonic sequelae. Some of these injuries are openly

displayed, while others have been obscured from the pediatrician's view.

Some parents behave in a belligerent, nasty or even threatening manner, suggesting to the pediatrician that they are probably capable of violence and abuse. Other parents behave in compliant, socially acceptable and even solicitous ways, suggesting to the pediatrician that they could never be capable of violence and abuse.

When evaluating a case of potential child abuse, the pediatrician is faced with two sets of dissonant concepts:

1. On the one hand, mandatory reporting laws compel her/him as an expert, to report what s/he has observed and even what s/he suspects to be incidents of child abuse. On the other hand, the influential inter-personal agendas of the "backlash" movement have challenged the expertise of the pediatrician and suggested that the pediatrician not report many of the cases that s/he initially considers to represent child abuse.

2. The pediatrician is encouraged to err on the side of protecting the child's physical safety and security (i.e., to report even those cases in which the abuse of the child is only suspected) by legislated safeguards against criminal prosecution for any errors in reporting. Yet, the pediatrician is simultaneously, keenly aware of the imperatives of protecting her/his own security as the threat

of civil/ malpractice litigation looms over her/his reports of even the most "obvious" and blatant cases of parental misconduct.

After grappling with these dissonant considerations, pediatricians are most likely to report only those cases in which the child's physical pathology is clearly evident and/or in which the allegedly abusing parent appears to be manifestly capable of violence and abuse¹ to the child. They are less likely to report cases involving varying degrees of speculation as to the nature and etiology of wounds. They are least likely to make reports against parents whom they judge to be "good" people regardless of the stigmata of abuse that may appear on the child's body.

As the abuse of children becomes a more premeditated and sophisticated undertaking, and as more and more medical syndromes are diagnosed that mimic child abuse or that bear essential similarities to cases of child abuse, the pediatrician is faced with a considerable dilemma: Should s/he follow the mandates of law or should s/he follow what s/he has been exposed to as the mandates of conscience?

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The possible exception being cases in which the pediatrician believes that s/he has reason to fear personal (physical) repercussions from reporting a particularly violent parent.

Should s/he be most concerned about the physical safety and security of the child, or, should s/he be most concerned about the financial security of her/his own professional practice?

Three additional factors influence the contemporary pediatrician's child abuse reporting decisions. These involve external constraints (about time and practice management) that have been either forced upon or strongly recommended to pediatricians:

1. The policies of the HMO to which s/he may belong. A recent exposé (New York Post, 5/18/95) described the ways in which physicians have generally compromised their medical ethics in favor of the financial concerns of the HMOs. Health Maintenance Organizations routinely dictate treatment protocols to pediatricians who must abide by these protocols (regardless of any resultant negative impact upon the patient) if they wish to be reimbursed for their services.

The HMO will in many cases dictate the amount of time or the nature of involvement that a pediatrician may devote to each child. Pediatricians who must see increasing numbers of children in order to maintain their anticipated levels of income, will be less likely to take the time to actually diagnose the more overt stigmata of abuse (and be even less likely to involve themselves in the more ambiguous cases of child abuse).

Parents who abuse their children by "ordinary" means may have less to fear in the future, because HMO pediatricians may not be able to take the time to (or may actually be directed to ignore rather than to) diagnose and report this abuse. Parents who abuse their children in the medical guise may have less access to the pediatrician and the variety of diagnostic and treatment options that could be employed in order to harm the child.

It is important to note, however, that parents who abuse their children in the medical guise may now be more successful in inflicting more severe and irreparable damage in larger increments than was ever possible before. HMOs that seek "quick" solutions to complex medical problems may authorize radical procedures in order to avoid the time and expense involved in intricate diagnostic procedures and
2
longer term protocols.

Pediatricians who wish to succeed in the environment

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The New York Post investigation (5/18/95) reported that an HMO was advocating the castration of men who suffer from cancer of the prostate as a more efficient alternative to continued (long term) effective treatment with injectable doses of medication.

In assessing the case of the 10 year old boy (described in the previous chapter) whose mother alleges that he has never had a bowel movement, it is possible to speculate that a radical procedure to "correct" this condition would be much more cost-effective than a protracted battery of invasive diagnostics that might ultimately reveal an ambiguous condition that would require long-term monitoring.

of managed care, must follow the dictates of their HMO's protocol. They may be expected to compromise medical ethics and legitimate patient needs in order to maintain their HMO relationships. In cases of child abuse, they may be discouraged from the diagnosis and reporting of child abuse not only by the constraints of billable time and resources, but by the fact that the HMO (currently) ³ shelters them from both criminal culpability for failing to report as mandated and from civil/ malpractice liability in the event that they either failed to act on behalf of the child or that they made an erroneous report of child abuse.

Under the auspices of the current managed care programs, only the most dedicated and self-sacrificing

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Child abuse statutes antedate the medical managed care programs. It may be argued that these statutes require all pediatricians, regardless of affiliation or locus of practice to diagnose and report all cases of child abuse. It may be alternatively argued that if the practice of the HMO pediatrician does not afford her/him the same access to patients as the pediatrician who practices independently, perhaps s/he loses some of the special qualities that provide for her/his designation as a mandated reporter.

Regardless of any revisions or reinterpretations in the child abuse statutes that may be recommended to either secure the role of the HMO pediatrician as a mandated reporter or to detract from that role in the future, pediatricians who are currently affiliated with HMOs (that restrict their time per patient and that maintain the written records of their patients) will be defended (by the HMO) against criminal sanctions in the event that it is alleged that they could have or should have diagnosed and reported a case of child abuse.

pediatricians will report as mandated. Others pediatricians may either fail to diagnose and report either because of alleged disadvantage or perceived advantage. They may assert that they do not have the requisite resources with which to recognize and report cases of child abuse. Alternatively, they may experience the "protected" environment of the HMO as indemnifying against any involvement with the legal system.

2. Pediatricians are being counseled to disregard symptoms in young children that were once considered cause for serious concern. Continuing education programs in pediatrics now advocate that pediatricians effectively ignore a variety of symptoms in children 3 months to 2 years of age. A case in point involves the diagnosis and treatment of fevers in children of this age group. Ipp and Jaffee (1993) have reported that pediatricians are now being advised not to necessarily regard high fevers in children of this age group with serious concern.

Fevers of unknown origin have been the focus of much medical investigation. They may represent the manifestations of any number of pernicious medical conditions including serious internal infections. They may represent the fruits of pernicious abuse (i.e., the exposure of a child to strong light or heat, etc.). Or, they may represent the response of the body to some unknown stimulus.

Because fevers may appear without other explicit symptomatology, pediatricians have traditionally investigated their etiologies. As pediatricians are being counseled to ignore their intuitive questions about the etiology of fevers in young children, they are also being deprived of valuable diagnostic and treatment opportunities. For, while it may be true that some fevers will remain "unexplained," it is also true that many fevers are important warning signals that the body issues to signify that it is in trouble. When these signals go unheeded, the potential for serious decline and even death is enhanced.

An additional concern for the pediatrician is the variety of poorly defined infant deaths that have been attributed to "Sudden Infant Death Syndrome." The term "SIDS" has been utilized to represent as yet "unexplained" cases of infant ("crib") death that may have actually involved one or a variety of demonstrable etiologies. When presented with a manifestly healthy baby who has suddenly died in its crib of "unexplained" circumstances, the pediatrician may diagnose "SIDS" or s/he may look for such factors as congenital breathing disorders that have not been diagnosed, the body's unanticipated response to one variety of the DPT vaccination, or several other minimally understood hormonal or neurological conditions. Alternatively, the pediatrician may investigate

the possibility that a child abuser in the medical guise has created a condition that may mimic (and produce the same outcome as) one of these disorders (Steinschneider, 1972).

The pediatrician may become involved with SIDS on two levels. The first, generally involves the disposition of an otherwise "healthy" infant from his/her practice who has suddenly died. The second, involves future children of the same parents who may be destined (with or without intervention) to suffer the same fate.

As pediatricians are being counseled to ignore some of the noted symptoms of disease in infancy and early childhood, they may actually be taught to overlook the very diagnostic criteria that would allow them to avoid the ambiguous post-mortem designation of "SIDS." They are inhibited from implementing proactive measures designed to either diagnose and (if possible) treat actual, defined medical conditions, or, to diagnose the cases of pernicious child abuse that threaten to mimic such defined medical conditions.

3. Some pediatricians have retained attorneys, either independently or through their insurance companies who are available to advise them on the legal issues that may impact upon their day-to-day practice of medicine. A pediatrician who is confronted with a potential SIDS case, may in fact consult this attorney before rendering a diagnosis and/or

before proceeding with any actions or statements relating to the deceased infant.

The pediatrician who consults an attorney is seeking advice about her/his own legal interests (which may or may not be congruous with the interests of the deceased infant). The pediatrician may be concerned with challenges to the care and treatment that s/he provided for the infant. S/he might wish to protect her/himself from questions relating to why s/he did not diagnose any condition or issue any warning that the death of the infant might be anticipated. If child⁴ abuse cannot be ruled out, the pediatrician may seek legal guidance on the pros and cons of reporting her/his⁵ suspicions of abuse.

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SIDS is a broadly utilized and poorly defined term for "unexplained" infant deaths. While many cases of infant morbidity that are labeled SIDS are actually the unanticipated and tragic consequences of poorly understood physiological phenomena (and therefore cause "good" parents shock and grief,) other cases that are labeled SIDS actually involve the sophisticated abuse of the infant in the medical guise.

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The pediatrician may seek counsel on whether to report her/his suspicions that the infant had been abused, or whether it would be more prudent to "leave well enough alone" because the infant was already dead.

The pediatrician who does decide to report, may also seek guidance on "what" to report, the appropriate language to use when making the report and/or how to insure that their post-report involvement in the case will be kept to a minimum.

Although legally mandated to report cases of child abuse, pediatricians have been deterred from reporting even the most "obvious" cases by the threat of civil/ malpractice litigation. Child abuse that manifests as SIDS is far from "obvious." SIDS parents generally present as "normal," "good" people who have just experienced a tragic misfortune. The fact that manifestly "good" parents have lost an otherwise "healthy" and well cared for infant places them (socially) apart from the manifestly "abusive" (Kempe & Silver, 1959) or "neglecting" (Polansky & Chalmers, 1981) parents who may have been responsible for the death of a baby (who may have had a history of being malnourished or repeatedly abused).

SIDS parents who are confronted with allegations of child abuse are more likely to formally join the backlash movement and much more likely to garner public (and jury) support against the accusing pediatrician than any other group of parents who are accused of child abuse.

Backlash organizations seek to solicit these parents⁶ because they appear to be "good" and therefore lend

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In fact, in order for a backlash organization to be effective, it must present itself as representing "good" parents who have been wrongfully accused of abusing their children. Providing resumes/ bios and photographs of these "good" parents is an important public relations tool for inter-personal, social and legislative agendas.

credibility to these organizations. Advertisements and notices soliciting the membership of these parents and offering them Networking, support and even pro bono legal counsel have appeared in "family" oriented publications.

The National Center on Women and Family Law has undertaken a program on behalf of women who have been accused of any form of child abuse in the medical guise. Seeking to attract experienced attorneys who are prepared to donate their time and energies to this undertaking, they issue the following notice in the 1993 Family Violence and Sexual Assault Bulletin:

Attorneys who represent parents in child abuse or child custody cases are now being faced with new allegations--that the client may suffer from "Munchausen Syndrome by Proxy." The parents are alleged to fabricate illness in their child.

...Officials have been advised to look for signs of this disorder in child abuse cases involving children with prolonged, extraordinary illnesses who undergo repeated hospitalizations and evaluations without definitive diagnosis, and parents or caretakers who show uneasiness as the child recovers or approaches discharge.

...there is a real danger that parents who are

free of ...[MSBP] and who are trying to care for children who have diseases or conditions that are difficult for doctors to diagnose or treat, will be falsely accused of child abuse. Legal Services attorneys and pro bono attorneys who have any experience representing clients accused of this syndrome are requested to contact... (p. 29).

Cases of child abuse in the medical guise have been notoriously difficult to prosecute because juries who look at the accused child abuser(s) do not perceive this defendant as a "criminal type." Moreover, the methodologies employed by the abusing parent(s) may be so bizarre that members of juries will not be able to comprehend them.

One example of a jury's performance in an MSBP case is the case of *People v. Phillips* (122 Cal.App.3d 69, 175 Cal.Reptr. 703 App., 1981) in which a mother was accused of poisoning her child with salt in order to produce medical symptomatology. The defense (unsuccessfully) appealed the mother's conviction on the grounds that it had discovered that the jury had been clandestinely sampling salt during the trial proceedings in order to attach some reality and meaning to what the mother had allegedly done.

In cases of alleged medical malpractice, where a pediatrician has been charged with falsely accusing a parent

of child abuse and of misrepresenting (and/or improperly treating) the symptoms of the child, the demeanor of the parent may be one of the most important factors in the outcome of the proceedings. A parent who appears to be aggressive, violent and abusive, readily fits our society's preconceived notion of a "child abuser." It is unlikely that a parent who appears to be passive, compliant and even cooperative will be perceived by a jury, a proceedings officer, or a judge as a pernicious abuser.

Thus, before a pediatrician will make a report of observed or suspected child abuse s/he may well consider the appearance and demeanor of the parent. The offending parent's public persona can impact upon the potential for the successful prosecution of the case. It can also reflect the dangers of subsequent civil/ malpractice litigation against the reporting pediatrician.

Child abusers in the medical guise are probably the most manifestly cooperative and compliant parents that any pediatrician will encounter. The pediatrician is likely to consider this public persona of the MSBP perpetrator in her/his reporting decisions.

Chapter 6:

The Problem: MSBP and the Criminal Justice System

One of the problems which the criminal justice system has confronted in representing the interests of children is that while all 50 states have broadly defined child abuse statutes, few of these statutes have been sufficiently updated to conform with the ever-evolving new definitions of the extent and scope of "child abuse." As less mundane and more exotic parental behaviors are observed and reported, the role of the criminal justice system becomes increasingly ambiguous and complex.

All child abuse statutes have been written to rely on the physician as the primary source of evaluation and reporting. Thus, the criminal justice system has come to rely heavily upon both the initial report of the physician that a case of child abuse has taken place and the expert diagnosis and testimony of the physician that cases already under consideration by the criminal justice system are in fact of intentional abuse rather than of accidental etiology.

This study will examine one of the more exotic, but nevertheless currently prevalent problems facing the criminal justice system in the 1990s. Technologically sophisticated and difficult to diagnose, "Child abuse in the

Medical Guise," or the factitious condition referred to as "Munchausen Syndrome by Proxy," is a "devil's waltz" (Kellerman, 1993) or a "web of deceit" (Rosenberg, 1987) in which the parent:

...falsifies illness in [the] child through simulation and/or production of illness, and presents the child for medical care, disclaiming knowledge as to etiology of the problem (Rosenberg, 1987, p. 547).

There is no current child abuse statute which recognizes Munchausen Syndrome by Proxy as a criminal act. Moreover, beyond the characteristic reticence of physicians to report exotic and poorly defined cases of suspected child abuse, Munchausen Syndrome by Proxy reporting is further impeded by the fact that by the time a definitive diagnosis has been made, the pediatrician him/herself may have unwittingly inflicted more harm upon the child in the course of diagnosis and treatment than the parent had inflicted in the course of fabricating the presenting symptomatology.

When child abuse is perpetrated in the medical guise, a myriad of new variables have been introduced into the doctor-patient relationship. The basic premise of the framers of existing child abuse legislation that the physician can and will reliably report as mandated must be reexamined.

Munchausen Syndrome By Proxy has been referred to as "the hinterland of child abuse," (Meadow, 1977).

Munchausen Syndrome by Proxy derives its name from the factitious disorder "Munchausen Syndrome" which involves "the deliberate seeking of repetitive hospitalizations through the use of simulated disease and the association of fantastic storytelling," (Ford, 1983). Adults suffering from Munchausen Syndrome will generally travel from hospital to hospital (to avoid discovery) and present themselves for medical treatment (Clark & Melnick, 1958) with manifestly acute (self-inflicted) medical conditions and with fictitious, but initially plausible and dramatic histories, (Asher, 1951). In many cases, before they have been accurately diagnosed, these adults will have undergone extensive evaluative and corrective procedures which are invasive, painful, debilitating and quite costly (Miller & Blancke, et. al., 1983).

"Munchausen Syndrome by Proxy" refers to a situation in which children are transported (Woolcott, et. al., 1983) from medical facility to medical facility (to avoid discovery) and presented for medical treatment with manifestly acute (parent or guardian inflicted) medical conditions and with fictitious, but initially plausible, dramatic and empathy evoking histories. In many cases, before these children have been accurately diagnosed, they, (like the above mentioned adults,) will have undergone

extensive evaluative and corrective procedures which are invasive, painful, debilitating and quite costly.

Physical abuse and the law: Modern statutory law is neither unanimous in its treatment of a substantial variety of self-inflicted injuries, nor in the specific classification of suicide as a crime (Grifis, 1975). Moreover, the legal status of physicians who have assisted in suicides, performed illegal abortions and provided unnecessary and even pernicious medical care varies from jurisdiction to jurisdiction.

Munchausen Syndrome involves the operational dyad of a consenting adult patient and a duly licensed physician. The adult patient is injured at his/her own request and with his/her express consent under conditions which would be manifestly legal in all jurisdictions. Thus, Munchausen Syndrome has received little if any attention from the criminal justice system. Physicians have not been held culpable for the unnecessary invasive procedures which they have performed and patients who were eventually discovered have been routinely referred to the mental health system and not the criminal justice system.

By contrast, Munchausen Syndrome by Proxy involves involves the operational triad (Sigal & Gelkopf, 1989) of a consenting adult parent or guardian, a duly licensed physician and a child who is the victim of severe parental abuse in the guise of necessary medical intervention.

Although "child abuse" is criminal in all 50 states and in many jurisdictions world wide, most relevant existing legislation antedates the first official report of MSBP (Meadow, 1977) and may therefore lack the provisions essential for the effective prosecution of these cases.

Psycho-social perspectives: Two important and contradictory developments are currently shaping our perspective on MSBP. While MSBP has achieved increasing recognition as a form of child abuse which merits the conscientious involvement of the criminal justice system, it has also been described as one of a variety of mothering disorders which ideally should be treated rather than punished (Rosenfeld & Newberger, 1976; Schrier, 1992; Schrier & Libow, 1993a).

The National Center for the Prosecution of Child Abuse (Peters, 1989) is among the organizations which have identified MSBP as a form of child abuse. It has officially called upon physicians to document and to report cases of MSBP to the appropriate agencies within the Criminal Justice System. It has further advocated that the criminal justice system vigorously prosecute MSBP offenders.

Some practitioners in the mental health community (while recognizing the need for some formal intervention in MSBP cases,) have advocated that MSBP should not be treated as a complex and sophisticated form of malicious child abuse. Instead, we are asked to recognize that it

represents some misguided manifestation of parental "love" and "devotion" which results in the parent injuring the child in the guise of medical intervention both because the parent loves the child and because the parent needs to be loved by the child (Schreier & Libow, 1993).

In the contemporary literature on the ritual mutilation of children, references have been made to the notion that parents/mothers have historically inflicted various forms of torture and permanent disability including foot binding and female genital excision upon their children with the assistance of both the "physician" and the community. It has been asserted that these parents acted out of love (albeit misguided) for their children as well as out of the desire that their children should love them in turn (by later appreciating the important social value of their disfigurement,) (Daly, 1978).

Is MSBP analogous to female genital excision or to the binding of female feet? Does the parent or guardian who enlists the services of the physician in the abuse of the child act within some predefined socially accepted milieu? Is the request for medical intervention for parentally inflicted hypoglycemia (Mayefsky & Sarnack, 1982,) apnea (Berger, 1979,) asphyxiation or cardiorespiratory arrest, (Rosen & Frost, et. al., 1986) a disguised or distorted expression for the parental expression of love? Do the

perpetrators of MSBP truly believe that they are acting in the best interests of the child, or are they actually attempting to harm or even to kill the child by evading more traditional methods of abuse which have been routinely apprehended by the criminal justice system?

It is a crime to abuse a child. In 1993, Pat Schroeder, congresswoman from Denver, Colorado initiated legislative efforts on the federal level and concerned state legislators (such as N.Y.S. Assemblywoman Barbara Clark of Queens) undertook efforts in state legislatures in order to criminalize the ritual mutilation of the genitals of a female child.

This study addresses the issues inherent in the criminalization of Munchausen Syndrome by Proxy as an official form of child abuse. While recognizing the need for empathy (and the provision of services) on behalf of parents and guardians who may be delusional, misguided, or incompetent in their parental roles, it considers the essential role of the government as the protector of the child who is clearly and in many cases permanently victimized by MSBP.

Establishing mens rea in cases of child abuse: Much of criminal justice is predicated upon the concept of mens rea, or evil intent. Acts are defined as criminal, but, effective prosecution of such acts entails the burden of proof of criminal intent.

In some cases (in which an act that is clearly and evidently covered by existing criminal statutes has occurred,) prosecution may be impeded because of difficulties inherent in establishing mens rea. The abusing parent may be regarded by the community as a "model citizen" and/or the abusing parent may initially impress law enforcement authorities with the image of a "concerned and nurturing parent." A 1994 case in which a manifestly "loving" parent restrained two children in their car seats and then pushed the car containing them into a muddy lake¹ may be covered by existing criminal statutes, but prosecutors must clearly establish that the parent acted willfully and intentionally in order to secure a conviction.

In other cases where mens rea may be clearly established, prosecutors may be impeded in proceeding against the parent because the specific actus reus may not be clearly covered by existing criminal statutes. A case (Rosen, et. al., 1983) in which a parent willfully and intentionally restrained two children in their cribs and induced potentially fatal episodes of apnea in order to then subject these children to invasive emergency pediatric care

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The October 25, 1994 South Carolina case of Susan Smith (outcome reported in "It's life for killer mom," New York Post, 7/29/95).

may not be covered by existing criminal statutes. In this case, prosecution may be problematic because, although we recognize the crime of asphyxiating children for the express purpose of killing them, there is no existing statute that recognizes the crime of asphyxiating children for the express purpose of exposing them to invasive medical treatment.

Thus, although there is evidence in the professional pediatric literature to suggest support for Meadow's (1977) view that:

When a parent induces life-threatening illness or fabricates an illness, resulting in invasive diagnostic, anesthetic, or surgical procedures for the child, the case becomes one of child abuse, (Rosen, et. al., 1983, p. 715).

we may currently lack the legal sophistication necessary to discover and to prosecute these MSBP cases.

Moreover, cases of MSBP routinely avoid detection because the issue of mens rea is unclear. It has been observed that in most cases of induced illness:

The parent is likely to be intelligent, medically sophisticated, supportive and appreciative of the medical care received, and to behave in a caring and concerned way toward the child, (Rosen, et. al., p. 720).

The very characteristics that have traditionally represented the absence of mens rea in legally recognized cases of child abuse, are now cited as the differential criteria for the presence of mens rea in cases of MSBP.

The parent or guardian in the Munchausen Syndrome by Proxy harms and may even kill the child in the guise of medical treatment. In New York City, The father of 4-year-old Leah O'Dougherty (March 10, 1994)² allegedly harmed and killed his daughter by administering his prescribed liquid methadone to her in order to keep her out of his way. The guardian of 2-year-old Ditaya Douglas (March 19, 1994)³ allegedly scalded her (and was responsible for her tragic death) so that she would learn not to wet her bed. Each act may have been done for its own manifest as well as latent purposes. Each act should be regarded, investigated and primarily prosecuted as a crime. Then, a court of law must determine whether the MSBP parent acted out of "love," whether Leah's father allegedly acted "while under the influence of controlled narcotic substances" or out of "concern for her" and whether Ditaya's guardian allegedly

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"Dad killed his tot with drug overdose: Cops," "Allegedly used dope to quiet her." (New York Post, 3/11/94).

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"Tot dies from burns in scalding bath: Child's aunt is charged with murder." (New York Post, 9/19/94).

acted "in the child's best interests."

The cases of Leah O'Dougherty and Ditaya Douglas appear to be well within the framework of existing child abuse legislation and appear to fall well within the purview of the Child Protection Services of the Human Resources Administration. Yet, Leah and Ditaya join 4-year-old Shayna⁴ Bryant (allegedly beaten to death at home on March 29, 1994) as the three young children who were victims of crimes that⁵ were already on the books in New York City, who had already been processed through the Human Resources Administration and who had all been killed by parents or

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"Tot's abuse death has Rudy fuming." (New York Post, 3/30/94).

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Responding to the death of Shayna Bryant and to the recent increase in child abuse fatalities, the New York Post (3/30/94) issued the following statement (in italics):

Infanticide is now the third-leading cause of death among children in this country.

We should all be ashamed that innocent youngsters suffer violence at the hands of adults.

This year, The Post will spotlight every case in which a child under 10 is murdered in the city.

We do this in the hope that we can learn from the tragedy.

Kids are our most important natural resource; they should not be forced to die for our mistakes.

The New York Post has indeed provided the most extensive (and in some cases the only) factual coverage of recent child abuse cases. It therefore became the newspaper of choice for child abuse researchers.

legal guardians who had open child abuse files.

Criminal justice concerns: Among the issues raised by New York State Senate and New York City investigators, are five important concerns:

1. that many child abusers are recidivists;
2. that many abused children are routinely and prematurely returned to the parents or guardians who have previously abused them, only to suffer repeated and often more severe abuse;
3. that caseworkers often neglect to take the necessary steps to intervene in these cases;
4. that existing confidentiality laws which were designed to protect the rights of abused children are frequently the cause of their repeated abuse; and,
5. that existing social service agencies are really not accountable and not held to public or governmental scrutiny.

Several important legislative initiatives have been proposed to address these concerns.

Vincent J. Fontana, director of the New York Founding Hospital and recognized authority in the field of child abuse has asserted that "child maltreatment in America now represents a national emergency." We are clearly losing the battle against child abuse, because:

Across the United States, child maltreatment continues undiminished as a result of bureaucratic incompetence, political hypocrisy and public indifference, (New York Post, 4/1/94).

If current legislation against child abuse and current social service policy and practice are inefficient in the defense of children and the prevention of child abuse recidivism, it may be argued that there would be little to gain by urging legislatures to add yet another burden to an overloaded and incompetent system. Yet, if Senator Roy Goodman in New York and his counterparts across the country are serious in their call for legislative reform, then this reform can and should include a section on child abuse in the medical guise/ Munchausen Syndrome by Proxy.

MSBP represents the hinterland of child abuse. MSBP occurs when the manifestly righteous and concerned perpetrator is secure from intervention by the system. It occurs when the pediatrician will not report child abuse because s/he has been coopted as an active participant in that abuse (or, as described in the previous chapter, because s/he fears civil/ malpractice litigation). It occurs when the abused child cannot be rescued and relieved by the criminal justice system or by social service agencies because those individuals most likely to make a report and

follow it through have either been wrongfully denied access to the child or have been "appropriately" reassured that the child's poor condition is the result of serious illness and not of victimization (Zitelli, et. al., 1987).

Thus, if an appropriate framework for legal and social service intervention in the extreme cases of MSBP can be formulated and implemented, it may serve as a constructive model for legal and social service intervention in less complex and more routine cases of child abuse (Yorker & Kahan, 1991; Kaufman, et. al., 1992).

In Part II, the role of the pediatrician and the role of the criminal justice system are complemented by the contemporary clinical understanding and social dimensions of the MSBP parent and the MSBP child. A review of the MSBP literature is presented.

Part II

Review of the Munchausen Syndrome By Proxy Literature

Chapter 7:

The Social Stigmatization of the Child Victim and the "Urgent Need" for Child Protection Statutes.

It has now become an open secret that people torture and kill their own children or children in their charge. But prior to recent publicity there was a virtual blackout, reaching far back into history, on the topic, (Bakan, 1971, p. 1).

In 1962, C.H. Kempe and his associates described "the battered child syndrome" in the Journal of the American Medical Association as "a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent." The Journal's editorial reinforced Kempe's call for recognition of this problem and then stated:

Despite the understandable hesitation of the physician in becoming involved in what may turn out to be a police action, the consequences of improper disposition are often so tragic that the physician must, in good conscience, call on social agencies and legal authorities to make certain that proper protection is given the child...., (181(1), p. 42).

The editors of the Journal then called for a reevaluation of "inadequate" or "lax" state and local laws regarding this problem and for "mandatory reporting."

In 1964 Vincent J. Fontana (of the New York Foundling Hospital) was joined by Douglas J. Besharov (who became the director of the United States National Center of Child Abuse and Neglect in Washington D.C.). Together, they undertook to:

bring out from hiding the types of abuse and neglect inflicted on children and the diagnostic criteria which can confirm the physician's suspicions, (Fontana & Besharov, 1979, p. xvii).

While demonstrating in the first edition of their text that there exists an "urgent need" for our society to recognize the parental abuse of children, Fontana and Besharov also asserted that the "disease" of child abuse could become a "rarity," if all suspected cases were reported by physicians and other involved professionals. In later editions of this text, the authors recognized that the abuse of children involved "complexities and variations" which cannot be solved "by any one single approach." The more realistic appraisal of the problem of child abuse which evolved, however, continued to view physician reporting as its linchpin.

The fourth edition of Fontana and Besharov's text focused on the Model Child Protection Act of 1974 which served as the prototype for federal legislation as well as (all 50) state child protection laws. Title II of this Act which outlines the procedure for reporting incidents of child abuse, includes "SECTION 5. Persons and Officials Required to Report Known and Suspected Child Abuse or Neglect,"¹ which states that:

(a) When the following professionals and officials know or have reasonable cause to suspect that a child known to them in their professional or official capacity is an abused or neglected child, they are required to report or cause a report to be made in accordance with this Act: any physician; resident; intern; hospital personnel engaged in the admission, examination, care or treatment of persons; nurse; osteopath; chiropractor; podiatrist; medical examiner or coroner; dentist; optometrist; or any other health or mental health professional;

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Pivotal to establishing the basis for including Munchausen Syndrome by Proxy in the official list of "reportable" crimes of child abuse, is an understanding of the history of mandatory reporting laws. Hence, the lengthy quotation for which I respectfully request the reader's indulgence.

Christian Science practitioner; religious healer; school teacher or other school official or pupil personnel; social worker, professional day care center or any other professional child care, foster care, residential, or institutional worker; or peace officer or other law enforcement official.

(b) Whenever a person is required to report under this Act in his capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, he shall immediately notify the person in charge, or his designated agent, who shall then become responsible to make this report or cause the report to be made, (p. 103-104).

The Model Child Protection Act advocates that each state establish a "statewide toll-free telephone number" for the initial reporting of child abuse cases occurring within that state. Section 13 states that "...all reports of known or suspected child abuse or neglect pursuant to this Act shall be made immediately by telephone" to the statewide toll-free number. Appropriate local agencies within each state are then to be designated to receive and to process reports transmitted through the toll-free number. Then:

All reports made pursuant to this Act shall be confirmed in writing to the appropriate

local child protective service on forms supplied by the state department within forty-eight hours of the initial telephone report, (p. 108).

The Act which is concerned with both the abuse and the neglect of children defines the child as "a person under the age of 18."

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According to Section 4, it is concerned with the harm or threat of harm to the physical or mental health or welfare of the child that can occur when the parent or other person responsible for the child's welfare:

(i) Inflicts or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or

(ii) Commits, or allows to be committed, against the child, a sexual offense, as defined by state law....

The Act defines "a person responsible for the child's welfare" as:

the child's parent; guardian; foster parent;
an employee of a public or private residential

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I have quoted sections of the Act which are germane to "child abuse" and omitted those sections which define "child neglect."

home, institution or agency; or other person legally responsible for the child's welfare in a residential setting.

It defines "physical injury" as "death, or permanent or temporary disfigurement or impairment of any bodily organ."

It defines "mental injury" as:

injury to the intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in his ability to function within his normal range of performance and behavior, with due regard to his culture.

The Act mandates reporting of child abuse and neglect in instances when "probable cause" dictates such reporting. This refers to occasions when:

facts and circumstances based upon accurate and reliable information (including hearsay) that would justify a reasonable person to believe that a child subject to a report under this Act is abused or neglected. Such facts and circumstances may include evidence of an injury or injuries, if not satisfactorily explained, and the statements of a person worthy of belief, even if there is no present evidence of injury, (p. 102-103).

Child abuse: Although its operational definition has varied over time (Gelles, 1976, Smith, 1978, Lenherr, 1990,) the physical abuse of children is recognized as a crime in the United States of America as well as in many other countries.

Margaret A. Lynch (1985) reviews the historical literature on child abuse. She informs us that the leading medical figure Soranus' recorded reports of physical abuse of Greek children in the third century are remarkably analogous to twentieth century American reports of infant battery. Then from information in Rhaze's Persian pediatrics text (dated about 900,) Lynch asserts that:

early physicians seem to have been aware
that those caring for young children were
capable of physical abuse, rejection and
neglect, (p. 7).

In the middle of the seventeenth century, the Roman Dr. Zacchias described a variety of forms of punitive child abuse inflicted by parents and teachers which could cause severe injuries such as blindness or even death, yet would not result in any bleeding.

Then, in 1684, Dr. Bonet of Geneva published a book in Latin in which he described the abuse accidentally or purposely inflicted by "nurses" who cared for children (when their mothers were either unwilling or unable to do so).

In 1860, Tardieu, a French professor of legal medicine published a detailed treatise on the abuse of children which included 32 case histories. In his work, he recognized various manifestations of child abuse. Lynch noted that:

Diagnostic injuries, parental collusion, frozen watchfulness and response to removal from an abusive environment are all vividly described in this forgotten paper. Tardieu's plea for medical recognition and action had not been heard a hundred years later! (p. 9).

Indeed, it is a century that passes between the plea of Tardieu (1860) for official recognition of the abuse of children and the landmark article by Kempe et. al., (1962) which describes the "battered child syndrome" as the editors of the Journal of the American Medical Association in which it is published call for concrete action on behalf of battered children.

According to Masson, (1984) Tardieu was well aware of the horrors which abused children faced. He was aware:

that society at large, and medical practitioners in particular, preferred to deny the reality of what he observed. Participating in this denial, strangely enough was the victim, (p. 19).

Masson quotes from Tardieu (p. 361-362) as he explained that:

...finally, the most unbelievable thing of all, that the executioners of these children should more often than not be the very people who gave them life--this is one of the most terrifying problems that can trouble the heart of man, (Masson, p. 19).

Although Lynch makes no mention of this, Masson informs us that Tardieu discussed the sexual abuse of children. One of the 32 case studies in his 1860 book describes the victim of such abuse. Then, in subsequent editions Tardieu expands his discussion. In the 1878 edition, he clearly asserts (on p. 62) that "fathers often abused their daughters":

What is even sadder is to see that ties of blood, far from constituting a barrier to these impardonable allurements, serve only too frequently to favor them. Fathers abuse their daughters, brothers abuse their sisters. These facts have been coming to my attention in increasing numbers..., (Masson, p. 23).

Although Charcot was lecturing on the sexual abuse of children and treating them in his Paris clinic in the 1880's, and although Masson informs us that not only the

academic medical community, but Freud and his psychoanalytic community were clearly aware of this problem, we learn that it is only in the 1970s when the general child protection movement had gained post-Kempe momentum and the women's movement had spurred on greater concern, that we see any real awakening regarding the sexual abuse and exploitation of children (Finkelhor, 1984).

Although medical recognition and documentation of the various forms of child abuse was sorely lacking, the problem of child abuse was obviously becoming of important concern to some religious and social agencies. For example, in 1869, the Catholic Sisters of Charity of New York opened what was to later become The New York Foundling Hospital (Fontana, 1973) and by 1883, the first English Society for the Prevention of Cruelty was established in Liverpool (Lynch, 1985).

Bakan (1971) and Bourne and Newberger (1979) both refer to the industrial revolution as a further catalyst for the greater prevalence and public awareness of child abuse. Yet, even as young women who bore children out of wedlock attempted to "snuff them out," as children who were boarded with others either in "baby farms" or with families were victimized, as children were bearing the brunt of very severe "religious" upbringing and as neglected and abused children in industrialized areas came to the attention of

authorities, child abuse remained for the most part obscured from the public concern (Logan, 1979).

It is important to understand that among the reasons that child abuse was not effectively dealt with in the past--reasons that are viable even today--were both the assumption that it was the parent who was essentially responsible for the child and the assumption that the parent could do no wrong (Logan, 1980, Finkelhor & Strauss, 1987).

Reinforcing the traditions and religious doctrines (Mead & Balch, 1987) that establish the parent as the head of the household and as the authority over its members, was the concept that people were intrinsically good and well meaning. The notion that a parent could or would act with evil intent to inflict harm upon a child was both foreign and reprehensible.

Moreover, Freud's early reaction to the realization that parents could indeed (sexually) abuse their children is enlightening. In an 1897 letter to Wilhelm Fleiss, Freud writes:

Then the surprise that in all cases, the
father, not excluding my own, had to be
accused of being perverse...., (Masson,
1984, p. 108).

Freud is thus referring to the important principle that the recognition of child abuse in others must bring the practitioner to the realization that individuals, like

themselves are quite capable of this type of criminal behavior. It is important to appreciate that like Freud who ultimately suppressed his findings on child sexual abuse, many physicians confronted with the dissonance of recognizing the ramifications of the child abuse that was around them, chose to ignore what they saw. Thus, the victims of child abuse were not only physically harmed by their parents and guardians, but were, in many instances further harmed by either the indifference or the collusion of the medical profession.

The physician's reluctance: Ellerstein (1981) who edited a medical reference text on child abuse and neglect discussed the "multiple reasons" for physician's reluctance to become involved in cases of child abuse and neglect. These include seven basic categories:

1. the inadequacies of medical school training and the poor overall preparation that physicians receive in the diagnostic and interpersonal skills required to evaluate child abuse cases;

2. the lack of financial rewards associated with spending extra (unbillable) time on the investigation and resolution of these cases;

3. the lack of traditional "parental appreciation" that a physician has come to expect from his professional interaction with child and family;

4. The "negative emotional balance" or feelings of helplessness and emotional unreward associated with cases of child abuse;

5. the frustrations inherent with working with governmental and community-based services which are grossly inadequate;

6. the reluctance of the physician to become involved in protracted legal entanglements (which include legal proceedings, the potential for testimony and a fear of personal liability due to reporting error); and,

7. physician ignorance of the seriousness of the problem of child abuse.

Blaming the victim of child abuse:

Ellerstein (1981) also noted that:

some physicians refuse to believe that parents have injured their own child. This idea seems so abhorrent to the physician that he puts it out of his mind and, therefore feels that he does not have to deal with it. Once the physician acknowledges that abuse and neglect occur, he must maintain a high index of suspicion for cases of abuse and neglect, (p. 2).

Masson (1984) explored the antecedents of the physician's disbelief in parental abuse of children.

Moreover, he described the intense preoccupation of some physicians with the welfare of accused child abusers instead of with the welfare of the abused children. In one example cited from the 1880s, the French Dr. Alfred Fournier examined a child who had been molested and said of her abusing father (whom he had just met for the first time):

An excellent and perfectly honorable man,
father of a family, justly honored and
absolutely impeccable (I will gladly act as a
guarantor) of any ignominious action, allowed
himself to be caught up in a trap of this kind,
(p. 43).

An additional example from 1883 involves Paul Brouardel, dean of the French Faculty of Medicine, who asserted that children regularly lie about being abused. They will utilize their imaginations to "invent stories in which they are the hero." In describing the prototypical "victim" of child abuse, Brouardel explained:

...This child, to whom one ordinarily paid
only the most minor attention, finds an audience
that is willing to listen to her with a certain
solemnity and to take cognizance of the creations
of her imagination. She grows in her own esteem,
she herself becomes a personage, and nothing will
ever get her to admit that she deceived her family

and the first people who questioned her. Her lie will be all the more difficult to unmask since the child lies without troubling herself over the improbabilities which one finds in her account, (p. 45).

Masson documented the fact that Brouardel was familiar with the work of Tardieu. Moreover, he established the fact that Brouardel quoted a case in which Tardieu described a little girl who had been raped had received "seventeen knife wounds" during that rape. Masson questions how Brouardel can explain these 17 knife wounds , "surely they were not simulated psychosomatic wounds," (p. 47).

Brouardel was regarded as a consummate professional. He expressed significant interest in "*la psychologie de la victime*" and advised readers on protocol. It was his opinion that when medico-legal experts are consulted in cases of child abuse:

[they should] not [be] prohibited from acquainting the examining magistrate, from the very beginning with the very special psychology of the *victims* and the people around them, (p. 46).

Masson asserts that when Sigmund Freud joined the debate on child abuse, "he was clearly on the side of

Tardieu." Over time, however, Freud moved closer to the views held by Fournier as he asserted that descriptions of childhood abuse were fantasies. Freud added however that "the fantasies themselves had pathogenic psychological consequences."

Alice Miller (1986) noted that amongst the reasons that contemporary psychoanalysts in the Freudian tradition "do not address the real traumatizations of childhood," is the:

...factor that they have never even noticed
the posted prohibitions and have never doubted
the correctness of psychoanalytic dogma, (p. 7).

It is important to realize, however, that not only psychoanalysts, but physicians of all medical specialties have adopted some form of "blaming the victim" of child abuse. Masson discussed a paper on "Children Who Lie" which was delivered by Dr. C. E. Bourdin in 1882. Bourdin advised his colleagues that:

It is up to educators and particularly
medical doctors to destroy the myth of the
infallible sincerity of the child. This is a
meritorious task in every respect, (p. 48).

William Ryan (Drapkin & Viano, 1974) wrote about "the art of savage discovery" which refers to resolving dissonance about people who have in some way been neglected

or abused by suddenly "discovering" that they are "savages" or people who are most unlike ourselves. Ryan asserted that:

Discovering savages, ...is an essential component of, and prerequisite to, Blaming the Victim, and the art of Savage Discovery is a core skill that must be acquired by all aspiring Victim Blamers, (p. 152).

Among the categories that Ryan describes are "the ill." Thus, Victim Blamers must learn to conduct and interpret research that:

shows how "these people" think in different forms, act in different patterns, cling to different values, seek different goals, and learn different truths. Which is to say that they are strangers, barbarians, savages. This is how the distressed and disinherited are redefined in order to make it possible for us to look at society's problems and to attribute causation to the individuals affected, (p. 152-153).

In applying Ryan's theory to the abused child who is ill (or in need of medical intervention,) we note that the physician who is reticent to proceed as s/he is confronted with all of the problems inherent investigating and

reporting a case of child abuse (Ellerstein, 1981) may suddenly "discover" that the child is a "savage," i.e., that the child is "less than human."

Ryan confronts the challenge of reconciling the "progressive, charitable" and "humanitarian" nature of an individual with "his own self-interest." His theory offers the physician both an alternative to the repugnant "extreme" of completely ignoring the situation, and to the "more allergic" alternative of advocating on behalf of the child (and bringing the offending parent to the attention of the criminal justice system).

Thus, the physician is able to "in the words of an old Yiddish proverb, ...dance at two weddings." S/he is able to effect "a brilliant compromise" wherein the abused child is blamed in her/his pre-victimized state and then rehabilitated in her/his post-victimized state. Thus Ryan explains that "Victim Blamers":

...want to bind up wounds, inject penicillin, administer morphine, and evacuate the wounded for rehabilitation. They explain what's wrong with the victim in terms of social experiences *in the past*, experiences that have left wounds, defects, paralysis, and disability. And they take the cure of these wounds and the reduction of these disabilities as the first order of

business. They want to make the victims less vulnerable, send them back into battle with better weapons, thicker armor, a higher level of morale, (Drapkin & Viano, 1974, p. 155).

In this way, Ryan explains:

They are all unconsciously passing judgment on themselves and bringing in a unanimous verdict of Not Guilty, (p. 156).

Social stigmatization of the victims of child abuse:

Thomas Szasz (1977) explained that children have been traditionally perceived as "possessing a diminished human stature," (p. 88).

Bard and Sangrey (1979) in a chapter titled "Nobody likes you when you're down and out" have asserted that:

It is especially difficult for Americans to deal with the reality that good people can suffer serious misfortune. Innocent victims belie the American dream, which is our national version of the just-world theory.

McDonald (1976) examined the "just-world theory" postulated by Lerner (1971) and asserted that people have a basic need to believe that there is justice in the world:

--not only in the legal sense but in a more basic sense. Good things happen to good people

and bad things happen to those who deserve it, including among the latter, people who are unwilling to avoid suffering or who are in some way blameworthy, (McDonald, 1976, p. 41).

Thus, if the observer happens to come upon an "innocent" victim who is "suffering," and the observer believes that s/he is powerless to do anything to alleviate the suffering, then McDonald explains that:

the observer will make himself more comfortable by deciding that the victim is not innocent after all. In this way the observer is able to maintain his view that justice prevails in the world; he simply condemns the victim as undesirable, bad, or deserving of his fate, (p. 41).

Synthesizing the Szaszian argument that (even non-abused) children are perceived with diminished social stature with the notion that "nobody likes you when you're down and out," helps to clarify the socially tainted position of the child who has been abused. Add the dimensions of Lerner's just-world theory, and we begin to understand that children who are abused may be perceived as somehow deserving of their fate.

As the empirical component of my masters thesis in

forensic psychology (unpublished, 1978,) I demonstrated that a pronounced "stigma" or "the reduction in our minds from a whole and usual person to a tainted, discounted one" (Goffman, 1961, p. 3) is attributed to the adult victims of violent crime. Based upon the review of the child abuse literature, it is now possible to propose that an analogous stigma or "defect" (Hill, 1975) is attributed to the child victims of violent crime.

Public and professional perceptions of MSBP: The recognition of MSBP as a form of pernicious child abuse is dependent upon the perceptions of the pediatrician as a person as well as a professional. The remainder of Part II reviews (the clinical literature related to) the polemics of the differential diagnosis of MSBP.

In Chapter 8, our society's routine perceptions of child abusers are compared and contrasted with the diagnostic profile of the MSBP abuser. Two case histories illustrate the nature of the MSBP abuser.

Chapter 9 examines some of the professional issues that have impacted upon the differential diagnosis of MSBP. Two psychological syndromes that have been confused with MSBP are operationally defined and distinguished from MSBP.

Chapter 10 examines issues relating to the child's involvement in the MSBP triangle. The potential collusion of the child in her/his own MSBP abuse is examined. The

MSBP child is differentiated from children who exhibit conversion behaviors and children who exhibit psychiatric disorders.

Chapter 11 examines social perceptions of the name "Munchausen." The author describes the effects of these perceptions on the professional treatment of the medical mutilation of the self (MS) and the professional polemics of the medical mutilation of children (MSBP).

Chapter 8:

The Munchausen Syndrome By Proxy Abuser: Case Histories.

The child abuser: Today, in spite of the fact that many members of our society have been innundated with exposure to the actions of serial killers such as the notorious Jeffrey Dahmer; in spite of the appalling reports of sexual abuse within the day care system, etc. we are still quite reticent to believe that people are capable of such horrendous abuse of one another (Summit, 1992). We are even more reticent to accept the notion that a parent or guardian would abuse a child. For most of us, whether we have children of our own or not, the idea seems both reprehensible and bizarre.

Thus on June 11, 1974 when the blood of the two youngest Michulski children splattered their "neatly kept" lawn, (Rich, 1976, 1986) or when the underground chamber in which John Esposito had imprisoned Katie Beers on December 28, 1992¹ was discovered, we tended to view Joanne Michulski and John Esposito as extremely "other" than ourselves. These were individuals who had committed acts which we had to believe ourselves incapable of. These child abusers must be other, different, extreme, bizarre.

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John Esposito, an adult friend of Katie Beer's (temporary custodian) godmother took her to the Spaceplex Family Center in Nesconset, Long Island for her tenth birthday. He

Then, when a seemingly concerned parent or guardian who is not only "normal" in appearance, but is also in many cases capable of intelligent and technical communication of symptomatology presents with a child who is "ill," the physician or health care provider is psychologically unprepared to suspect this "nice person" of criminal intent.

Yet an important literature of anecdotal evidence clearly demonstrates that parents and guardians who look normal and appear to be deeply concerned with the welfare and well-being of their children, have actually undertaken the often potentially fatal abuse of their "beloved" children even as they have attempted to or succeeded in enlisting the full cooperation and facilitation of the medical profession in the process.

Blix and Brack (1988, p. 402-403) explain that

claimed that Katie had been abducted from the amusement center. When questioned by police, Esposito said that "his main concern is to see that Katie is safe and sound and back home." ("Abducted girl's kin fight to keep hope on her birthday." New York Post, 12/31/94).

It was later discovered that John Esposito (who was a building contractor) had imprisoned and enslaved Katie Beers for 16 days in an underground dungeon that he had built on to his house. Esposito was subsequently convicted of his crimes as was Sal Inghilleri who had sexually abused Katie on other occasions. ("Second suspect convicted in Katie Beers case." New York Daily News. 7/6/94).

pediatricians traditionally exhibit "extreme trust" in the parents of their patients. Thus, "in all forms of child abuse, disbelief" in the notion that the parent may have willfully injured the child "is paramount."

Diagnosing the more complex cases of child abuse may raise complex emotional issues and controversial considerations for health care providers. When "ideal" parents (who are perceived as "caring and attentive") create or feign illness in their children and then present them as "sick," they effectively "dupe" pediatricians into abusing their children for them.

Blix and Brack note that the diagnosis of MSBP is more complex than the diagnosis of simpler methods of child abuse. In both cases the pediatrician must come to terms with the fact that the parent is capable of abusing the child. In the case of MSBP, however, the pediatrician must come to terms with the fact that s/he has actually been "fooled" in order to make this abuse possible.

Profile of the MSBP abuser: Munchausen Syndrome by Proxy is a form of child abuse which is generally perpetrated by parents or guardians who do not fit our society's perception of the bizarre or show the demeanor of the demented. Instead, Blix and Brack (1988) describe the potential profile of this abuser as:

...an overly caring and dependent mother,
...and a mother exhibiting less anxiety than
medical staff regarding the inability to
diagnose the cause [of the child's illness].
Special attention is warranted when mother
has medical or nursing training and/or has
presented similar symptoms herself, (p. 402).

Sample case histories: The two case histories which
follow were selected from the literature because they
demonstrate not only the nature and consequences of the MSBP
abuse of the child, but also present an instructive profile
of the parent/perpetrator.

case 1. Epstein and Markowitz, et. al., (1986)
reported the case of an 18-month-old white boy who was
hospitalized for the second time with intractable diarrhea
which was severe and of unknown etiology. On both occasions
he required transfer to Yale-New Haven Hospital for further
evaluation. (An earlier incident of diarrhea on day 2 of
life is reported but not discussed).

Epstein and Markowitz, et. al., describe the child's
hospitalization for "treatment of diarrhea" at age 3 months:

His bowel was rested and parenteral
nutrition was begun. Subsequently, he
underwent extensive and costly bacteriologic,

radiologic, endocrinologic, and metabolic studies, results of which were all normal. After 2 months in the hospital, the diarrhea ceased rather abruptly and he was discharged home on an elemental formula, (p. 220).

Over the next 6 months the boy improved. He grew and gained weight and was tolerating an unrestricted diet. Of particular interest is the fact that:

During this time, the gastroenterologists received from the mother various cards, poems, and gifts expressing her thanks for their care of her child, (p. 220).

At the age of 18 months the boy was readmitted to the hospital with unremitting green mucoid diarrhea "following a long course of multiple antibiotics for an 'unresponsive' otitis media." He was again subjected to multiple and costly invasive procedures which yielded no cause for the diarrhea. The boy was then "fasted and received total parenteral nutrition through a surgically placed central catheter...."

After some time, a review of the "stooling pattern" was conducted. This indicated a peculiar pattern in which the boy was only experiencing diarrhea when awake, but not when asleep or involved in diagnostic procedures. At this time,

the mother who had been continually present at the boy's bedside and "cheerfully participated in his care" was "persuaded to spend some time at home." Reports indicated that "the diarrhea ceased when she left and resumed when she returned a few days later."

In the ensuing investigation (which included the continuous observation of the boy via concealed video monitor,) the mother was observed:

...emptying the contents of a syringe into the child's mouth... on two separate occasions during a 30-minute period. She was immediately confronted by members of the staff and a security officer. The room was searched and oily syringes, castor oil, milk of magnesia, phenobarbitol, amytriptyline, oral hypoglycemics, and other unidentified pills were found..., (p. 221).

This "ideal mother" who was "observed to be happy and at ease, often befriending the nursing staff," had actually been administering combinations of potent medications to her son at regular intervals during the day to the extent that she caused him to suffer from an extremely unusual condition in which:

Despite apparent losses of up to 80% of body weight in stool per day, the child maintained

normal serum electrolyte values and a normal state of hydration, (p. 222).

Physicians had performed numerous invasive procedures and could find no apparent physiological etiology for this disorder.

case 2. In presenting a case of MSBP in the outpatient setting, Guandolo (1984) notes that physicians rely upon the veracity of the patient's story as the foundation of medical treatment. He asks: "What happens when the gullible and conscientious physician meets the mendacious historian?"

In the case of a "5-year-old boy with a voluminous medical chart that belied his usual state of good health," the mother is the mendacious historian who regularly requested that her son be treated by one of a group of four pediatricians:

The medical encounter of physician, parent, and patient developed into a familiar scenario. In frantic telephone calls to the physician's office, the mother claimed that her child had intractable ear pain, persistent vomiting, respiratory distress, or multiple seizures; the calls resulted in immediate appointments. The lethargic patient was brought into the office wrapped in a blanket. In the waiting room, the mother would discuss her child's medical problems

with other parents. The mother would also socialized with the medical office staff with whom she was on a first-name basis. Gifts of homemade baked goods were often brought by the mother at the time of the office visits. Findings on physical examinations and screening tests were invariably normal; no specific treatment was prescribed; the patient could be easily aroused, (p. 526-527).

Guandolo described incidents at 18, 27, 38, and 40 months, when the mother reported a variety of conditions including upper respiratory difficulites, allergic reactions, chronic spontaneous orthopedic disorders, headaches and prolonged vomiting. Some of these disorders were brought to the atttention of the selected pediatrician in the group practice, while others were described as having been treated elsewhere:

Frequently, the mother called to inform the staff of the pediatric office that a physician neighbor or doctor at an emergency room had diagnosed and treated a specific problem. Requests were made for antibiotics, broncho-dilators, decongestants, or antiemetics that had been recommended by one of these physicians. In many instances, the requests were granted.

Follow-up visits failed to confirm the telephone history of the illness, (p. 527).

The "most significant and bewildering medical problem" which was reported by the mother was "afebrile generalized seizures." Here, as with many of the other problems for which a manifestly relevant familial medical history was suddenly produced, the mother first reported "no family history of seizures," and later indicated that "[h]er late father had suffered from epilepsy."

From the age of 27 months when "the mother provided a description of convulsions," until his hospitalization at age 4 years 9 months, the child was being evaluated and treated by neurologists for a seizure disorder:

By this time, the patient had been receiving phenobarbital for 35 months, phenytoin for 27 months, and propranolol for 19 months without a significant impact on the incidence of reported seizures or episodes of migraine. Preliminary evaluation prior to the planned hospitalization included a neurologic examination, EEG, and a noncontrast computed tomographic scan of the head. All results were normal. The mother subsequently refused to allow her son to be hospitalized, claiming that the staff was not sympathetic to his condition, (p. 527).

Apart from the information which the mother provided about her son, she offered a mendacious history of her own accomplishments, which included completion of the bar examination, completion of a Master's degree in Russian history and then a faculty appointment in Russian history with a local university. She also maintained that her husband traveled extensively and could not be reached by medical personnel.

Medical personnel attempted and successfully contacted the child's father who was available to meet with the pediatrician. The father revealed that while some of the information provided by the mother about herself and the child was true for the father, little if any of it was true for the mother or the child. The father asserted that:

the mother was "obsessed with medicine," and possessed an old copy of the Physician's Desk Reference. He also told the pediatrician that his wife had been employed in hospitals and in a doctor's office, (p. 528).

When the child was 5 years old, the pediatrician enlisted the cooperation of the local children's medical center in confronting the mother. She then admitted that she had "lied about the seizures." She exhibited only "transient" remorse "over the exposure of her prevarications," as she continued "to lodge false reports of

sickness in her son."

Following hospitalization of the child, all of his previously treated conditions were dismissed, all of his medications were terminated and he was successfully given a normal diet.

In reporting this case of "connivance" Guandolo has presented the details of yet another case of the "disturbing form of child abuse" in which parents deliberately involve their progeny in a "fraudulent game of medical 'hide and seek'" in order to imperil them.

Mendacious reporting: The MSBP case histories presented, serve to illustrate the fact that parents who seem to be normal may deliberately make false reports of a child's medical condition. These reports are similar (in nature and consequence) to the self-reports of the seemingly normal Munchausen Syndrome patient.

The unique qualities of the Factitious Disorders: The diagnostic criteria for MSBP have been established along side of the diagnostic criteria for Munchausen Syndrome (hereafter MS). Both are presented as related factitious disorders. (In the DSM-IV, MS is presented as the Factitious Disorder, and MSBP as the Factitious Disorder By Proxy). Thus, if either MS or MSBP are misrepresented as extensions of some other (unrelated) psychiatric disorders or psycho-social conditions, then the unique relationship

between MS and MSBP will be (improperly) eliminated.

Chapter 9 presents two challenges to the uniqueness of the "Munchausen" diagnosis. Both represent (erroneous) reappraisals of the adult's behavior. First, MS is misrepresented as part of a dissociative psychosis. Then, MSBP is (improperly) construed as part of a continuum of Malingering and Hypochondriacal behaviors.

Then, Chapter 10 analyzes the role of the child in MSBP and the problems inherent in confusing the Factitious Disorder By Proxy with conversion behaviors and delusional psychoses.

Chapter 9:

The Differential Diagnosis of Munchausen Syndrome By Proxy: Help Seeking and Health Care Addiction Contrast with MSBP.

MSBP has been presented as an extension of Munchausen Syndrome (Guandolo, 1984). Munchausen Syndrome and MSBP have both been described as "Factitious Disorders" that present as the seeking of unnecessary medical care for oneself (MS) or as the seeking of unnecessary medical care for another (MSBP).

The relationship between MS and MSBP has been challenged by two distinct (and manifestly unrelated) theoretical approaches. Attempts have been made to link the manifestations of MS with a variety of profound psychiatric disorders, as (unrelated) contrasting attempts have been made to link MSBP with a variety of milder and less pernicious forms of (maternal-child) relationship disorders.

Munchausen Syndrome v. psychosis: Several theories have attempted to link MS with the Multiple Personality Disorder (now referred to as the Dissociative Identity Disorder or DID)¹. Some have represented MS as a facet of the DID.

1

In order to provide consistent terminology, (the professional diagnostic term)"DID" replaces the (popular) term "Multiple Personality Disorder" throughout this chapter.

Others have presented MS as potentially coexisting with the DID (Toth & Baggaley, 1991).² These theories do not comport with the DSM-IV³ (1994) instructions that "[DID] must be distinguished... from Factitious Disorder..." (p. 487).

In fact, the MS patient does not present with any of the symptoms of DID⁴s. The MS patient is an individual (of manifestly intact personality) who controls her/his own behavior and is able to recall (or factitiously reproduce) memories and "facts" relating to her/his medical condition.

2

Although the author refers to "DID," Toth and Baggaley (1991) use the term "Multiple Personality Disorder" (see note 1, above).

3

The abbreviation "DSM" will refer to the Diagnostic and statistical manual of mental disorders of the American Psychiatric Association.

DSM-III refers to the third edition of this manual.

DSM-III-R refers to the revised third edition of this manual.

DSM-IV refers to the fourth (current) edition of this manual.

The American Psychiatric Association also published a Desk Reference to the Diagnostic Criteria from the various editions of the manual. These will be referred to as the "Desk Reference" of the relevant edition.

4

The one possible (although unlikely) exception would be the case of the MS patient who pretends to suffer from DID and requests treatment. In this case, a simple psychiatric evaluation would rule out the DID.

In contrast with MS, DID's are noted for their lack of control and for memory that is so poor, that it may border on amnesia. Indeed, unlike MS, DID's are characterized by:

...the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness, (DSM-IV, 1994, p. 477).

Thus, it is important to note that MS and DID have nothing, whatsoever in common. In fact, apart from the very rare case(s) ⁵ in which one of the personalities of the DID patient may have exhibited Munchausen Syndrome-like qualities, (i.e., that one personality appears to be seeking medical treatments for mendaciously reported symptoms, it is not anticipated that physicians who treat DID's will diagnose

5

DID has been popularized in the 1990s. According to the DSM-IV (1994, p. 486) there has been a "sharp rise in reported cases" which may either be attributed to the "greater awareness" of mental health professionals or to "overdiagnosis in individuals who are highly suggestible."

Toth and Baggaley's (1991) case of "coexisting" MSBP and DID represents an artifact in the MS literature. A five year follow up of this case would be very instructive for both MS and DID concerns.

the coexistence of MS. DIDs patients who engage in curious quests for medical care are probably incapable of maintaining the affect, symmetry and coordination of memory necessary for presenting and maintaining Munchausen Syndrome.

MS (a factitious disorder) has been differentiated from the DID (a form of psychosis). It is also possible to differentiate (the factitious) MSBP from two milder conditions that are related to Malingering and Hypochondriasis.

MSBP vs. other forms of disease fabrication: Libow and Schreier (1986) reported about the difficulties inherent in the differential diagnosis of Munchausen Syndrome By Proxy. They noted that the professional literature contained a broad variety of cases ranging "from child victims of a few weeks of age to late adolescents." The medical "falsifications" in these cases ranged "from mendacious history-giving to life threatening assaults," (p. 604).

While early reports focused upon the pleasant and cooperative and devoted nature of the parents in these cases, later reports seem to have included a variety of cases of child abuse involving medical intervention, which may or may not be appropriately diagnosed as MSBP cases:

As the literature expanded, there was less
homogeneity of symptomatology or of maternal

or child descriptions. In fact, the range of cases which have been described as Munchausen syndrome by proxy has highlighted the need to clarify the relationship between this phenomenon and conversion behavior, child abuse, hypochondriasis, maternal anxiety, and child psychopathology, (p. 604).

Libow and Schreier then present a "Munchausen syndrome by proxy spectrum" in which they offer a "tripartite classification" which helps to "differentiate true proxy behavior from other kinds of disease fabrication." Included in the spectrum are the categories of "Help Seekers, Doctor Addicts, and Active Inducers."

1. "Help Seekers": Although initially presenting with parentally induced medical conditions which superficially resemble MSBP:

...even in cases involving active and conscious deception... [they] are differentiated [from MSBP] by our ability to identify the primary motivation, which often involves a realistic need for outside intervention, (p. 605).

The case of the 18-year old black single mother who had poured cranberry juice into her 2-year old son's diaper and

then reported that he had had a bloody stool is instructive. Here, rather than being duped (by sophisticated parental fabrications) into instigating a prolonged and fruitless investigation for some exotic form of disease, physicians were quickly able to determine the etiology of the diaper stains. Then, rather than resist attempts at intervention, the mother readily revealed upon confrontation:

that she was feeling quite overwhelmed and burdened by caretaking responsibilities for her child... and was quite receptive to the idea of ongoing therapy and plans for daytime child care relief, (p. 605).

Thus, "Help Seekers" are parents or guardians who articulate their needs for personal assistance through their children. Their mendacious reports are generally simple and unsophisticated. Their inappropriate calls for personal help are generally met with swift and reassuring response. The children who have been utilized in this scheme are rarely in danger of either being harmed by the perpetrator or through excess medical intervention.

2. "Doctor Addicts": Parents who are "obsessed with the goal of obtaining medical treatment for nonexistent illnesses in their children," have been described as "Doctor Addicts." However, these individuals are more appropriately

referred to as "Health Care Addicts" or "HCAs" because-- apart from those who would be motivated by a psychological "transference" relationship with the physician--there are other parents to whom the "doctor" is not the central figure in accessing a variety of health care modalities.

Libow and Schreier report that these cases often involve parents whose children are older than the children of the "Active Inducers." Moreover, whereas the "Active Inducers" are generally reporting children's symptoms in order to access help for themselves, "HCAs" have somehow come to believe that it is the child who needs help and that it is their mission to access that help for the child.

Some "HCAs" are obsessed with the notion that their child suffers from "allergies." Others, armed with the knowledge that a child in remission from leukemia or other life-threatening diseases may relapse, become obsessed with the notion that the child has indeed relapsed, but the doctors are as yet unaware of this development.

Jessica, a 5-year old Hispanic girl had been sexually abused by a female relative at the age of 2 years. Although the child had been examined and had no physical findings to corroborate either vaginal or urinary disfigurement or disease, her mother became obsessed with the notion that Jessica was having repeated episodes of painful urination and vaginal irritation. Over a 3 year period, the mother

brought Jessica to the hospital emergency room on several occasions, (without physical findings) and then consulted a new private physician:

With some misleading clinical data she convinced this pediatrician to do a vaginal examination of the child under anesthesia and two 24-hour observations in the hospital. There were no significant findings and ...this physician [later] expressed frustration and outrage at having been tricked by the mother, (p. 607).

Unlike the "Help Seekers," these "HCAs" will often behave in a beligerent, argumentative and even paranoid manner with the medical staff:

The distrustful, angry style of these mothers toward their physicians, compared with the helpful, pleasant style of prototypical proxy patients, may result from greater defensiveness and fear of exposure, (p. 607).

"HCAs" may be suffering from some type of maternal attachment disorder (Klaus, et. al., 1982) in which they have an inappropriate perception of the needs of their children. Some of these parents will become "anxious, sometimes to the point of panic, fearing possible dire consequences" for their children. They are thus:

neither significantly reassured nor encouraged by the absence of biological abnormalities but continu[e] their efforts to help their children through an anxious, pessimistic pursuit of medical solutions, (Libow & Schreier, 1986, p. 609).

Children who are victimized by "HCAs" are therefore more likely to be subjected to repeated invasive diagnostic procedures than the children of "Help Seekers." They are, however, less likely than the children of "Active Inducers" to be victimized by extensive medical treatment.

3. "Active Inducers": These are the prototypical cases of Munchausen Syndrome by Proxy in which a child becomes the victim of intentional child abuse in the medical guise.

They are characterized by:

active and direct efforts of the parent to induce dramatic symptoms of illness in the ...child, (p. 606).

Blood and urine samples are purposely falsified.

Children are injected with hazardous substances or human or animal wastes. Suffocation, irritation and infusion with laxatives, emetics, prescription drugs and poisons are among the methods of abuse which have been reported.

Libow and Schreier note that:

These cases are noteworthy for a maternal style in the hospital which appears above suspicion; almost all the mothers have been described as cooperative, concerned, loving devoted, and trustworthy; many are nurses or other kinds of health professionals. Their child victims are usually infants or pre-school children who are too young to resist or serve as informants in the unraveling of their mysterious illnesses, (p. 606).

Thus, within the "spectrum" of factitious parental reports of their children's medical concerns, we observe two distinct phenomena: In the absence of demonstrable mens rea, the unsophisticated "Help Seekers" and "HCAs" are in fact inappropriately/hysterically agonizing over and projecting their own unhappy conditions upon their children as they (impoverished of an alternative mode of communication,) are either utilizing their children's bodies as vehicles to cry out for help for themselves, their children or both. With mens rea (i.e., the intent to abuse their children, the more sophisticated "Active Inducers" will make repeated "dramatic and life threatening assaults" Libow & Schreier, p.609) upon their children as they induce the medical profession to join them in educated and premeditated acts of potential disfigurement and death.

A review of this literature raises the important

question: Should the unfortunate and misguided parents who become "Help Seekers" or "HCAs" be lumped together in theory and in practice/disposition with the "Active Inducers" of premeditated child abuse?

The differential diagnosis of Munchausen Syndrome by Proxy: The "spectrum" of MSBP presented by Libow and Schreier does not represent a potential progression wherein "Help Seekers" who had evaded detection and treatment might then evolve into "Health Care Addicts," who, in a worst case scenario, might then become "Active Inducers."

Libow and Schreier are operating from within a liberal/feminist framework⁶ which ideologically approaches child abuse in the context of disorders of "mothering." The notion that "mothering disorders" should be removed from the purview of the criminal justice system and instead relegated to the protective umbrella of social justice and/or mental health concerns may offer some insight into the construction of their MSBP "spectrum."

On its own, the category of "Active Inducer," complete with mens rea, sophistication and premeditation, generates

6

Feminist perspectives on MSBP will be discussed in Chapter 17.

little public sympathy for the parent or guardian who would so perniciously abuse a child. Yet, if this well-differentiated syndrome is linked together with the often pathetic cases of the "Help Seekers" and the "HCAs," it may be possible to obscure or at least to relegate to secondary concern the criminal justice issues raised by the "Active Inducer" in favor of a more liberal/feminist social justice/mental health approach.

The DSM-IV, (1994a) describes several disorders which may be utilized to inform the differential diagnosis of MSBP. These include "Malingering," and "Hypochondriasis."

1. Malingering:

The essential feature of Malingering is intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, obtaining drugs or securing better living conditions....

Malingering should be strongly suspected [when noting] marked discrepancy between the person's claimed stress or disability and the objective findings..., (Desk Reference, 1994b, p. 296-297).

We are further instructed that:

Malingering differs from Factitious Disorder in that the motivation for the symptom production in Malingering is an external incentive, whereas in Factitious Disorder external incentives are absent, (p. 297).

Thus, a diagnosis of Factitious Disorder excludes a diagnosis of Malingering.

The essential incompatibility of the profile of the "Help Seekers" with the profile of Munchausen Syndrome by Proxy can be clearly demonstrated:

MSBP is a Factitious Disorder in which there is a marked "absence of external incentives" for the abuse of the child. By contrast, the definition of the "Help Seekers" as individuals whose behavior "often involves a realistic need for outside intervention," (Libow & Schreier, 1986, p. 605) clearly demonstrates that "Help Seekers" are in fact seeking "external incentives" through their behavior. "Help Seekers" are therefore to be classified in the category of Malingering and not in the category of Factitious Disorders. "Help Seekers" cannot be legitimately considered within a MSBP "continuum."

In fact, "Help Seekers" may belong to an alternative "continuum" of parents who will use/abuse their children in varying degrees for "external incentives."

Vincent Fontana (1980) described the unfortunate abuse of children:

In past civilizations and in various countries --some not long past or far away--children have time and again been deliberately mutilated by their parents, their eyes put out or their hands chopped off, so that they might better inspire sympathy and thus be more successful in their enforced role as youthful beggars, (p. 4).

Thus, the pitiful parent who stains the child's diaper with cranberry juice in order to access "relief," more appropriately represents the milder and non-criminal beginnings of a "continuum" of acts which parents in need of financial and social services have traditionally been prepared to undertake at the expense of their children.

As the MSBP parent does not seek to access any such services, the MSBP child is suffering from adult behavior whose motivation and form are neither related to Malingering, nor to the "continuum" of pathological/criminal parental behaviors which may evolve if the Malingering behavior proves insufficient to access the desired "external" goals.

2. Hypochondriasis:

The diagnosis of Hypochondriasis is rendered when a person is chronically preoccupied for at least 6 months and

"despite medical reassurance" with the fear or belief that s/he has "a serious disease, based on the person's misinterpretation of bodily symptoms....," (DSM-IV, p. 465).

And when:

[a]ppropriate physical evaluation does not support the diagnosis of any physical disorder that can account for [reported] physical signs or sensations or the person's unwarranted interpretation of them, and the symptoms ...are not just symptoms of panic attacks.

And, the symptoms are presented in a manner which is "not of delusional intensity," so that at some point:

...the person can acknowledge the possibility that his or her fear of having, or belief that he or she has, a serious disease is unfounded, (DSM-III-R Desk Reference, 1987, p. 152).

Libow and Schreier (1986) have described the "HCAs" as "obsessed with the goal of obtaining medical treatment for nonexistent illnesses in their children." These parents are "neither significantly reassured nor encouraged by the absence of biological abnormalities but continu[e] their efforts to help their children," (p.606- 607).

These parents have been presented as overly concerned and potentially "belligerent" rather than as "delusional." Unlike the MSBP parent who will create the physical symptomatology required to present to a physician, however,

the "HCAs," will exaggerate or inflate symptoms which either already exist or have existed in authentic illnesses in the past. Thus, while the MSBP parent will administer a toxic substance in order to elicit a particular symptom which would not/could not naturally appear in the child, the "HCA" will point to a mild rash or episode of sneezing s/he has not induced in the child as evidence that the child has either contracted a new illness or relapsed from a previous one.

"HCAs" are not delusional. They may include those new mothers who exhibit the simple "maternal anxiety" which requires concerted reassurance from the pediatrician. They may be persistent and often quite beligerent, but they all maintain their (often exaggerated) claims to the child's illness within a functional framework of reality. In fact, "HCAs" are sometimes exonerated. Libow and Schreier explain:

...every pediatrician is aware of a good number of cases in which a parent's intuition or insistence on continued workups of their child, despite the physician's initial assurances, have resulted in correct diagnoses of real and serious illnesses, (p. 609).

"HCAs" (who have become preoccupied with the "physical signs or symptoms" appearing in their children) are thus either understood as "Hypochondriacs by Proxy" with varying

degrees of intensity and beligerence or exonerated as concerned parents who have successfully persevered in the face of medical incompetence.

By contrast, the perpetrators of MSBP who have not observed "physical signs or sensations," but have instead caused them can neither be correctly considered "Hypochondriachal" nor eventually deemed exonerated. Moreover, instead of the prototypical beligerence and dedication to treatment and "cure" of the "HCAs," the MSBP perpetrator traditionally exhibits a pleasant and cooperative demeanor which serves to mask his/her true dedication to the harm and disfigurement of the child. Thus, it may be demonstrated that the "HCAs" would not belong in the "continuum" of MSBP behaviors.

Help Seeking, Health Care Addiction and Munchausen Syndrome By Proxy are thus understood as three distinct conditions in which a parent, a child and a pediatrician may interact. While Help Seeking and Health Care Addiction do not necessarily imply any intent to harm the child, MSBP is understood as a pernicious form of child abuse.

Chapter 9 presented the adult disorders that have been confused with the parent's role in MSBP. Chapter 10 will describe two peditric psychiatric disorders of that have been confused with the child's role in MSBP.

Chapter 10:

The Child's Involvement in the MSBP Triangle.

The child who is involved in the MSBP triangle may or may not be aware of the nature and consequences of her/his parent's actions. In addition to feminist and social justice attempts (described in the previous chapter) to remove the notion of criminal intent from the consideration of the mother, attempts to insulate the abusing parent from criminal prosecution have represented the child as collusive, or as a willing and able participant in her/his own abuse.

Just as Hypochondriasis and Malingering have been confused with MSBP, so attempts have been made to (inappropriately) link the Conversion Reactions and Shared Psychotic Disorders (that have been observed in the pediatric population) with MSBP. The differential diagnosis of MSBP implies that the pediatrician or pediatric psychiatrist has been able to rule out both of these conditions in a child whose symptoms have been manifestly fabricated.

1. Conversion Reactions: Children who exhibit "conversion behaviors" present symptoms that have been fabricated. Libow and Schreier (1986) have noted that the relationship between MSBP and conversion behavior in

children should be clarified (p. 604).

Ford (1983) noted that a broad variety of "conversion phenomena" such as "pseudoseizures, 'hysterical mutism' and tunnel vision" have been recognized since antiquity. Conversion phenomena are operationally defined as the "symbolic representations of physical conflict in terms of motor or sensory manifestations."

Ford explained that conversion phenomena may be differentiated from Malingering and from the Psychophysiological Reactions. They differ from Malingering "in that the patient does not have conscious control over the symptom," and may therefore not even be aware of its existence. They differ from Psychophysiologic Reactions in that conversion phenomena produce "no demonstrable anatomic or patho-physiologic abnormalit[ies]."

Although conversion reactions have been described in adults, Ford explained that they occur and "appear to be fairly common" in children. Moreover, while conversion reactions may or may not remit in adults, Ford explained that:

The symptoms of most children with conversion reactions remit within a relatively short period of time, with or without psychotherapy..., (p. 52-53).

Although it may be tempting to attribute MSBP to a

collusive relationship between a parent and a child, the "conversion reaction" does not provide appropriate grounds with which to accomplish this. Two examples serve to illustrate the incompatibility of the childhood "conversion reaction" with the diagnostic criteria of MSBP.

1. In the first case, the parent may suggest that the child is suffering from a particular illness. The child may then (under "the power of suggestion") assert that s/he is suffering from this illness. While the potential for a MSBP case may exist here, by virtue of the fact that the suggestion of the illness has come from the parent and not from the child him/herself, we do not have an authentic case of "conversion reaction."

2. In the second case, a child may exhibit an authentic conversion reaction. S/he may exhibit a symptom over which s/he "does not have conscious control." The parent (who may be acting within the "continuum" of "HCA" behaviors) may then seize upon the symptom and inflate its significance. While this case of childhood "conversion reaction" may be authenticated, it would not be possible to attribute MSBP here, because the "illness" is manifested by the child and not fabricated by the parent.

The dimension of time is also relevant here. While conversion reactions will generally "remit within a relatively short period of time," (Ford, 1983, p. 53) MSBP is generally a protracted syndrome which may not end until

the child experiences permanent disfigurement or death, or even until all children of the abusing parent have reached adulthood.

In Munchausen Syndrome By Proxy, the parent creates and perpetuates a factitious disorder in the child. Many of the case reports in the literature involve the pernicious abuse of helpless infants (Kurlandsky, et. al., 1979; Berkner, et. al., 1988; Lyons-Ruth, et. al., 1991) and very young children (Malatack, et. al., 1985; Chan, et. al., 1986; de Toni, et. al., 1987) who are obviously too young to be involved in any form of collusive behavior. However, the publication of several cases involving older and more sophisticated children (who are not mentally retarded,) serves to illustrate the necessity of considering the point at which a case of MSBP may become a folie a deux (Masterson, et. al., 1988; Griffith & Slovik, 1989; Money, 1989, 1992; Fisher, et. al., 1993) or a case of actual unfacilitated or unassisted Munchausen Syndrome in a young person (Raymond, 1987).

In his seminal report on MSBP, Roy Meadow described "Kay," a 6 year old girl from Leeds, England whose mother had reported recurrent illnesses, "in which [Kay] passed foul-smelling bloody urine," (1977, p. 347). The impurities in Kay's urine were ultimately attributed to her mother's menstrual blood and a variety of bacterial

organisms which had been added only to the specimens to which her mother had access.

Kay was described as "a healthy girl who was growing normally" (p. 347). The rigorous process of specimen collection which the hospital had adopted and the fact that her mother was not permitted to access her urine specimens could not have escaped Kay's awareness. Moreover, on the occasions when her mother was able to tamper with her urine specimens, Kay was apparently present.

During the course of her urinary "condition," Kay was subjected to:

...12 hospital admissions, 7 major X-ray procedures (including intravenous urograms, cystograms, barium enema, vaginogram, and urethrogram), 6 examinations under anaesthetic, 5 cystoscopies, unpleasant treatment with toxic drugs and eight antibiotics, catheterisations, vaginal pessaries, and bactericidal, fungicidal, and oestrogen creams; the laboratory had cultured her urine more than 150 times and had done many other tests; sixteen consultants had been involved in her care, (p. 344).

Kay's mother had to elicit some form of cooperation from her both to perpetrate the illusion of urinary infection and to insure compliance with the regimen of

invasive diagnostic and "therapeutic" measures which this 6 year old child endured. Yet, Meadow does not pursue the question of whether Kay's mother had so "murdered her soul"¹ (Shengold, 1989) that she was no longer able to identify with her own physical needs of self preservation or whether Kay and her mother were actually involved in some form of "Induced Psychotic Disorder" or folie a deux.

The "Induced Psychotic Disorder" described in the DSM-III-R is renamed the "Shared Psychotic Disorder" in the DSM-IV:

A delusion develops (in a second person) in the context of a close relationship with another person(s), who has an already established delusion [the primary case]. (DSM-IV Desk Reference, 1994b, p. 155-156).

The delusion in the second person is similar in content to that in the primary case.

1

Leonard Shengold, M.D., (Clinical Professor of Psychiatry at the New York University School of Medicine) has employed the term "soul murder" for child abuse that is so severe and emotionally challenging that the child must engage in autohypnosis and denial in order to survive it.

Shengold (1989, p. 2) defined soul murder as a "dramatic term for circumstances that eventuate in crime--the deliberate attempt to eradicate or compromise the separate identity of another person."

It is important to note that in order for MSBP-abuse to occur on an ongoing basis (such as in the case of Kay discussed above or the case of the 13 year old boy discussed below,) the (non-psychotic) child will either be subjected to "soul murder" or, will rebel against the her/his abuser.

Immediately before the onset of the induced delusion, the second person did not have a psychotic disorder or the prodromal symptoms of Schizophrenia, (DSM-III-R Desk Reference, 1987, p. 123).

A more complex case of a 13 year old boy who suffered from "recurrent left otalgia" is presented by Gilbert and Pierse, et. al., (1987) of Toronto, Canada.

Although he had no history of recurrent ear problems, and although audiometric and tympanometric studies were normal, the boy's "ear infection" did not respond to "appropriate medical management." When symptoms persisted: he was admitted to hospital for further investigation. While in hospital he was noted to have repeated low-grade temperatures. A complete blood count was normal as were his serum electrolytes and blood sugar. Because of a suspicion of subacute or chronic mastoiditis, mastoid films, technetium and gallium scans and a CT scan of the temporal bones were performed, all being normal. Consultation was sought from the neurology service, which noted decreased sensation in the region supplied by the ophthalmic division of the trigeminal nerve.

Because of persisting pain, low-grade

temperatures and the trigeminal nerve findings suggestive of petrous apicitis, the patient underwent a left cortical mastoidectomy. At surgery no abnormalities were noted....., (p. 231).

The boy was discharged after seven days. Four weeks later, he was seen by another otolaryngologist after complaining of "persisting pain in the operated ear and a blood-tinged ear discharge." He then underwent "revision mastoidectomy" surgery, but because of "persisting signs and symptoms" he "was referred back to the original hospital for further opinion," (p. 231).

When the boy returned to the original hospital, his mother:

...most notably brought along a plastic bag filled with paper towels soaked with what appeared to be blood-tinged [cerebrospinal fluid].

The patient was admitted and a patch was applied to the left ear. The nursing staff reported that the patch became soaked every three to four hours with the same pink fluid that had been noted on the paper towels, (p. 232).

Following a consultation with the neurologists, it was determined that the boy was probably suffering from "an iatrogenic CSF leak, and a temporal craniotomy was recommended" and scheduled (p. 232).

Two days prior to the scheduled cranial surgery, a vial "containing pink fluid that appeared similar to that discharging from the patient's ear," was found in his bedside table. When confronted, the boy asserted that "he had been collecting it to show the doctors." When the boy's mother was:

...presented with the suspicion that her son was placing this material in his ear, [she] responded with shock and dismay, after which she requested the immediate discharge of her son from the hospital. She was encouraged, with some difficulty, to keep her son in hospital until a psychiatric opinion could be obtained, (p. 232).

Forensic analysis of the pink fluid from the vial indicated that it was "beet-root juice." The boy then: admitted that he had been placing the material in his ear and stated he had not really been bothered by the surgical procedures, but became somewhat worried when a craniotomy was recommended.

A profile of the boy's mother indicates that she exhibited classic MSBP behavior throughout the course of his "illness." She had been:

domineering in the handling of her son and spent a great deal of time at his bedside. Also, the patient's mother had been very supportive of all

the hospital staff, frequently complimenting them on the quality of care her child was receiving. The mother had previously been employed in health care, but at the time was not working in that capacity..., (p. 232).

Most notably however, the authors advance the argument that although "[t]he suspicion of her involvement was never proven," the mother must have been involved in initiating and perpetrating the boy's "illness," because:

It seemed unlikely that a 13-year-old would have the medical sophistication to simulate a CSF leak or comprehend the significance such a sign would have for the attending surgeons, (p. 232).

Gilbert and Pierse, et. al., do not present this 13 year old boy as a definitive case of MSBP. Instead, they title their case report "Cryptic otalgia: a case of Munchausen syndrome in a pediatric patient." While they recognize the unlikelihood of a 13-year-old boy possessing the knowledge and sophistication necessary to perpetrate this type of medically knowledgable mendacity on his own, they also recognize the fact that no actual proof exists of the involvement of the patently MSBP-profile mother in the preparation or administration of the beet-root juice. Moreover, no mention is made of the potential involvement of

any other significant adult(s) who might have played a role in the child's fabricated illness.

Gilbert and Pierse, et. al., thus leave the door open for the assumption that this case may in fact represent a precocious case of Munchausen Syndrome in the boy (which would make it the one and only case of this type in the literature) and not of MSBP with a folie a deux.

An obvious artifact of MSBP is that it cannot, by definition involve the complicity of its youngest and most common victims. These newborns and infants are clearly unaware of the nature and consequences of their victimization, as they are unable to respond to it.

Toddlers and older children may or may not be aware of the mendacious behaviors of their parent or guardian. Indeed, having been "treated" by the doctors and nurses for most of their lives, they may have already reconciled themselves to this "norm" of "illness."

Some older children may be more sophisticated and aware (in varying degrees) of what is transpiring to and about them. Yet, it would be difficult to attribute the mechanism of psychosis (folie a deux) in these cases. Instead, children who become aware of what their parents are doing to them may choose to "play along" for a variety of "external incentives." For, barring the excruciating realities of "cranial surgery," they themselves may have come to prefer the non-judgmental calm of the hospital room to the

unremitting tensions of the school room, or perhaps, they may have come to prefer the tenderly administered intravenous infusions of the nurses to the metal buckles and hot irons² of the parental punishments.

2

These conclusions are based upon the following:

a. Donovan (1991, p. 172) has documented the "hesitancy on the part of the so-called helping professions to see human cruelty and human suffering as they are." Thus, in the case of "Esther," (a woman in her mid-fifties whose current clothing mimicked the clothing that she had been forced to wear when tethered to a pole as a child...,) health professionals did not even consider the possibility that she could have been physically abused as a child and that now, in a state of confusion, she was mimicking (in her current dress) the (perhaps) least offensive aspects of this abuse.

Similarly, health professionals who treat MSBP cases are unprepared to question whether other forms of child abuse may have preceeded this MSBP episode. To further complicate matters, even if a health professional were to receive appropriate training and be prepared to look for mens rea and to explore for a prior history of the more generic forms of child abuse, they would be hampered in their investigation by the "Privacy Act," which effectively seals off this information (American Academy of Pediatrics, 1988) from scrutiny.

b. In her own clinical experience with MSBP cases (and in professional consultation with pediatricians,) the author has observed and/or reviewed (at least 11) instances of clearly documented child abuse which later evolved into MSBP behavior.

In one such case, a mother had repeatedly punished her 11 month old son for "climbing" by placing him in the exposed dummy space between the kitchen cabinets and the ceiling, leaving him there in a state of hysteria and panic for up to 2 hours at a time. When caught and warned of the potential criminal consequences of her actions, the mother desisted. After several months, the young son began to have "problems" with his ears which required extensive evaluation and treatment. He then mysteriously developed food allergies, an asthmatic condition and a rare dermatological

Pediatricians are concerned with the role of the mother and the role of the child in MSBP. It is important to note that perceptions associated with the name "Munchausen" have also influenced the recognition and reporting of MSBP. The ramifications of the label "Munchausen" (for children who have been abused) are examined in Chapter 11.

disorder, all of which required intensive medical intervention. Pediatricians who had no access to the mother's history of abusing the child have been impressed with the great concern she exhibits for the welfare of her son and with her willingness to go to great lengths on his behalf.

By age 7, the child had clearly become an unwitting participant in the MSBP cycle by helping to report his "symptoms" to the pediatrician. The child reported that he did not mind being taken to various doctor's offices, because eventhough they sometimes hurt him, he gets days off from school, gets to ride the trains and buses and is always treated very nicely by the nurses who give him "lots of prizes."

In a second case, a father who had been beating his daughter and subjecting her to brutal punishments with a hot iron was threatened by members of his extended family and desisted in abusing the child. One year later, the child was being "treated" for a rare disease and relatives were impressed with the father's complete devotion to her medical care.

Thus, while I have searched and found no literature that documents the evolution of MSBP from other more well known forms of child abuse, based on the combination of: 1. an evolving awareness of the mens rea inherent in the MSBP abuse of the child; 2. a growing recognition that child abuse may represent a continuum of acts that may involve trials with animals to guage the nature and impact of particular methods of abuse (Arkow, 1994); and, 3. the actual case reports that I have described, I believe that future research will produce this documentation as the field of MSBP expands.

Chapter 11:

MS and MSBP:

Emulating the "Jolly Baron" vs. Attempting Self-Mutilation.

When Richard Asher first described "Munchausen Syndrome" in 1951, he noted that:

the most remarkable feature... is the apparent senselessness of it. Unlike the malingerer, who may gain a definite end, these patients often seem to gain nothing except the discomfiture of unnecessary investigations or operations..., (p. 339).

Munchausen Syndrome is rarely diagnosed proactively. Instead, the multiple scars of numerous medical deceptions which have been spread across many locations may ultimately lead the physician to a retroactive diagnosis. The literature on Munchausen Syndrome is replete with anecdotal evidence of individuals who have traveled extensively (and like the hospitable and humorous German raconteur Baron Hieronymus Karl Friedrich Freiherr von Munchhausen for whom the syndrome is named,) presented with mendacious reports of outrageous personal experiences.

The literature on MS (and MSBP) contains references to suggestions by various practitioners that the name "Munchausen" was not appropriately selected and that the

the syndrome should be renamed. It is important to note that although Baron Munchhausen significantly exaggerated the reports of his travels (thereby casting so much doubt upon the factual details of his life that he may have been erroneously credited with having a daughter named "Polle"¹ (Meadow & Lennert, 1984, p. 554) who mysteriously died at the age of one year, hence "Polle Syndrome" or MSBP,) there is no factual evidence to suggest that his exaggerations were intended in order to inflict harm upon himself, his alleged daughter, or anyone else. Instead:

Munchausen was noted for his hospitality and his skill as a humorous raconteur. His after dinner stories later formed the basis for travel fantasies written in English language..., (Meadow & Lennert, 1984, p. 554).

Like the Baron von Munchhausen who traveled and talked, Munchausen patients and MSBP parents will frequently travel

1

As several new case presentations of MSBP were designated "Polle Syndrome" (Ackerman & Strobel, 1981; Leston, et. al., 1983; Clark & Key, et. al., 1984) Roy Meadow (1984c) responded by raising notion that a decision was in order: He asked practitioners to determine which was the correct term: "Munchausen Syndrome by Proxy" or "Polle Syndrome." In the interim, it was suggested (Lazoritz, 1993) that the term "Meadow Syndrome" was the most appropriate, honoring Roy Meadow for his role in promoting awareness of this problem.

from hospital to hospital and talk to anyone who will listen to them. It is apparent that a potentially problematic analogy has been created: Like the Baron who craved the limelight of social attention, these individuals are said to crave the spotlight of medical attention.

Two important issues hamper this analogy:

a. It is important to note, that the syndrome that bears the name "Munchausen" is anything but entertaining. Whether an individual presents fabricated and exaggerated accounts of his/her own "illness" or of the "illness" of a child, no laughter is generated. Another round of jolly drinks is not passed around by the individual and the audience is hardly moved by a spirit of jocularly. Instead, Munchausen patients and MSBP victims endure a life of debilitation and pain which is amusing to no one.

b. The presentation of Munchausen Syndrome or MSBP as a vehicle for obtaining social or medical attention or recognition introduces the concept of "external incentive" which violates the diagnostic criteria for a "factitious disorder." Thus, if the individual presents mendacious accounts of "illness" in him/herself or in a child for the purpose of seeking the external incentive of the spotlight of attention, then this individual may perhaps be represented somewhere along the continuum of the "Help Seeker," but could not be differentially diagnosed within

the category of the "factitious disorder."

An alternative view of "Munchausen Syndrome" and MSBP are possible within the framework of Alfred Adler's conception of suicidal behavior.

Ansbacher and Ansbacher (1979 ed.) explain that:
Early in his career, Adler... gave a bold interpretation of the dynamics of suicide as an "act of revenge," "to force [one's relatives] to appreciate what they have lost." Thus he in fact defines suicide as a form of communication, a view held quite generally today. [In] ...his final formulation of this thesis, [Adler describes] the suicidal individual as one who hurts others by dreaming himself into injuries or by administering them to himself, (p. 248).

Alfred Adler thus distinguishes between the "suicidal individual" and the individual who actually commits suicide. The individual who actually commits suicide (as for example in the case of Dr. Kevorkian's "patients,") will generally terminate his/her life and be done with it, while the "suicidal individual" will often be "saved" and thus persevere in his/her condition for some time.

Utilizing Adler's conception of "suicidal behavior" as a potentially recurring phenomenon, it is possible to

attribute Munchausen Syndrome behavior to a "continuum" of "suicidal behavior." MS may in fact represent a piecemeal and less controversial (for religious, social and legal reasons) method than overt suicidal behavior. Following this line of reasoning, MSBP can be portrayed as a piecemeal and less manifestly controvercial (for religious, social and legal reasons) method of infanticide.

The stigma of late abortion, the opprobrium of pernicious child abuse, the fact that even within the prisoner sub-culture the child killer will be marked,² all serve as a patent deterrent to the non-psychotic parent with some formalized medical sophistication who has been saddled with an "inconvenient" child.

A trip to the library, or perhaps, some research in the old textbooks on the book shelf at home will yield sufficient information for this parent to premeditate the abuse of the child which can be perpetrated in the medical guise and is thus devoid of stigma.

If Adler was correct in his theory of "suicidal behavior," then an individual who covets "external incentives" will actually hope to, act to, or prepare for

2

Bowker (1977) noted that child abusers represent an underclass of the prisoner subcultures that he studied. They often had to be segregated from the general prison population for their own safety.

rescue "before it's too late," while an individual who truly covets disfigurement, death (or both) will simply and quietly succeed in harming or killing him/herself without hope of or preparation for rescue. Thus we might expect that the mendacious reporter who was actually a "Help Seeker" might find some way around the most acute pain and/or pronounced disfigurement by opting for "elopement" or rescue/cure at the last moment, in contrast with the "Active Inducer" or true Munchausen case who would endure any and all pain and debilitation and only then, (as examples abound in the literature) escape prematurely from prescribed post-operative or follow-up care.

The primary difficulty inherent in the identification of the "Munchausen" with the syndrome is that Munchhausen himself sought personal attention and improvement rather than suffering. Moreover, (apart from the fact that he may have been somewhat long winded,) there is no evidence of his intent to harm others. Munchausen patients, on the other hand, do exhibit mens rea. They do intend to have harm inflicted upon themselves and in the case of MSBP inflicted upon others.

MSBP is thus a diagnostic category with a double disadvantage. In its inherent qualities of mens rea it can neither claim to have descended from the jolly (Schweitzer, 1969) Baron von Munchhausen, nor can it establish clear lineage from Munchausen Syndrome which has been repeatedly

misappropriated to define a broad variety of people, some of whom coveted attention and recognition and others who actually coveted pain and disfigurement.

Adult self-abuse and the dynamics of iatrogenesis and medical malpractice are not pleasant topics. The abuse of children by parents with the support or at least the indifference of pediatricians is even less palatable. Perhaps, the unwillingness of our society in general and the medical profession in particular to effectively deal with the prevalence and intensity of "child abuse in the medical guise" has been responsible for the disguise of this³ "hinterland of child abuse" in the outwardly jocular expanse of the illustrious Baron von Munchhausen.

3

For a discussion of the atmosphere of lightheartedness and levity that has been observed during professional presentations of MSBP materials, see Chapter 4, note 2.

Part III

The Study

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Chapter 12:

Hypotheses.

Pediatricians are for the most part either unable to recognize or unwilling to report Munchusen Syndrome by Proxy.

1. Pediatricians are for the most part unable to recognize MSBP because:

- a. the boundaries of three distinct categories of adults bringing children into the health care system have been so blurred by inefficient academic preparation and by unprofitable pre-professional training experience that pediatricians are for the most part unable to differentiate between the pathetic but unsophisticated help seeker, the demanding health care addict and the criminal abuser who induces and promotes illness in the child, often by employing highly sophisticated techniques.
- b. because of the reasons stated in part a of this hypothesis, MSBP will be perceived by pediatricians as a "mothering disorder," i.e. a misguided attempt by the mother to

take care of the child's needs, rather than as a serious crime. They will too easily assume that the MSBP offender has no conscious intent to harm the child.

2. Pediatricians are for the most part unwilling to report cases of MSBP because:

- a. pediatricians have a basic need to obliterate the realities of child abuse and to believe that the parents and guardians of their patients are for the most part "good" and well intentioned people.
- b. while pediatricians have been traditionally reluctant to report even those forms of child abuse in which the perpetrator overtly represented a "bad" person, they will be more unwilling to report cases of MSBP where the perpetrator presents as a manifestly "good" and well intentioned person.
- c. the pervasive terror of malpractice litigation has come to overshadow the differential diagnostic capabilities of pediatricians to the extent that they would rather over-test and over-prescribe in misguided attempts at

parental compliance than to challenge the credibility of the child's presenting symptoms.

- d. thus, instead of perceiving the MSBP offender as socially diminished and blameworthy, pediatricians will stigmatize the child victim of MSBP, by perceiving this child as inferior and as somehow deserving of her/his fate.

Chapter 13:

Methodology.

1.
1. Subjects: An available "convenience" sample of 751 currently practicing pediatricians.

a. Definition: A "Pediatrician" was defined as a licensed medical doctor who either (a) has designated the practice of "pediatrics" as his/her area of specialization or who (b) is currently enrolled in a pediatric residency program.

b. Access to subjects: Pediatricians are constantly being bombarded by non-patients who make demands upon their time and attention. These include a variety of

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A non-randomized convenience sample lacks external validity. It does not, however, suffer from the sui generis artifacts of "snowball" sampling.

"Snowballing" (Kalton & Anderson, 1986) is a method which has been utilized in the sampling of "rare" populations to which the researcher would not otherwise have access. For example: (1) a specialized criminal population of indoor marijuana growers (New York Times Magazine, 2/19/95) would only be accessible through a "snowballing" network of informants who are themselves marijuana growers. Or, (2) hospital personnel who have had some role in the treatment of a documented MSBP patient might only be accessible through the authors of published journal articles on MSBP.

In contrast with the snowballing technique, the Ss who will participate in this study do not represent some obscure or unreachable group. Each and every participating

mail solicitations, (survey questionnaires from many sources, "urgent" requests for information and large quantities of investment opportunity literature, etc.,) as well as numerous "walk-in" requests involving attempts by pharmaceutical salespeople, laboratory sales representatives and others who would "just like a few moments of the doctor's time."

Thus, the receptionist or (increasingly) the practice manager forms the first line of defense between the pediatrician and any non-patient soliciting her/his time and attention. Mail that is not germane to the actual pediatric practice is disposed of and "walk-ins" are sent away by the receptionist or practice manager, so that in many cases the pediatrician is not even aware of having been solicited.

Therefore, inherent in the process of conducting a research study involving the responses of pediatricians to questionnaires are the following difficulties:

(a) mail and telephone surveying techniques

pediatrician is already accessible to any researcher through published professional directories (such as the Directory of the American Academy of Pediatrics) as well as through telephone directories in which pediatricians are routinely listed by specialty.

The convenience sampling method has been adopted here, not for the purpose of "access," but for the purpose of facilitating a rate of pediatrician compliance that was be better than the abysmal standard. (See Appendix D).

(Dillman, 1978) will be ineffective because the researcher will be routinely denied access to the pediatrician by the receptionist or practice manager who will in all likelihood dispose of the mail questionnaire without even showing it to the pediatrician and/or effectively prevent the researcher from ever reaching the pediatrician by phone.

(b) for the reasons described above, (and for additional reasons described in Appendix D) any schema involving the randomized sampling of pediatricians will not be effective. Random "cold calling," mail solicitations, or personal visits will not yield a large enough number of Ss responses for analysis.

Thus, the Questionnaire was delivered to Ss obtained through (a) pediatricians who are familiar with the researcher's work and who facilitated contact with their colleagues; (b) professional colleagues who are physicians practicing in other medical specialties who facilitated contact with their colleagues who are pediatricians; (c) community health and mental health agencies which network with both the researcher and pediatricians who practice in the Tri-State Area; (d) medical school/ hospital pediatric residency programs with which the researcher's agency maintains professional contact; and (e) the American Professional Society for the Abuse of Children (where the researcher is a life charter

member) whose membership includes pediatricians.

These methods yielded an impressive (58%) rate of return which far exceeded the researcher's expectations.

Note: In order to control for bias in the sample, an additional question was appended to the Questionnaire: Ss were asked whether they have had any MSBP-specific training. Ss responses to the Questionnaire will be divided into two groups for comparison: Ss who have had MSBP-specific training and Ss who have not had MSBP-specific training.

c. Human Subject Assurance: Application has been made and approved by the Committee on the Protection of Human Subjects (see Appendix E) for "exempt status" under Category 2 exemptions because the Ss are free, mature and consenting adults who were asked to voluntarily complete a written questionnaire that involves no risk or harm. The anonymity of Ss will be assured.

2. Method of Inquiry:

a. Hypothesis 1: This hypothesis measures the "seriousness dimension" of the parental role in the MSBP triad of pediatrician, parent and child. The experimental hypothesis (H₁) states that pediatricians will be unable to operationally distinguish between parents who are pathetic help seekers, parents who are demanding health care addicts and parents who are criminal abusers.

1) Instrument: The "crime scenario" method has become a popular empirical tool for examining crime seriousness. Lynch and Danner (1993) have noted, however, that this method suffers from the potential dual limitations of: (a) the a priori bias of the researcher in slanting the vignette material to elicit the desired outcome, and (b) latitude in "filling in the blanks" and making judgments not assumed by the researchers, (e.g., imputing socio-economic deprivation where none was described or implied).

Hagan (1993, p. 92-93) asserted that the major disadvantage of this methodology is its "artificiality." He noted that:

...the very controls imposed by the researcher to control for rival causation factors internal to an experiment may create artificial conditions that impede the ability to extrapolate to larger populations which are subject to natural conditions....

A recommended improvement upon the crime scenario method has been garnered from econometrics. Borrowing from the human dimensions of housing price indexing, Lynch and Danner explain that an "actual crime event" (p. 312) may be more appropriate than a constructed scenario as the cue for evaluating the perceived seriousness of a crime.

The literature on MSBP provides a variety of "actual crime events" which may be utilized individually or in composite form as the cue for evaluating the perceived seriousness of the parent's behavior.

2) Design: A 2x3 factorial design was employed utilizing the variables of "intensity" and "sophistication." This is presented on Table 1, below.

Table 1

Factorial Design

<u>SOPHISTICATION</u>				
		<u>Pathetic</u>	<u>Demanding</u>	<u>Inducing</u>
I N T E N S I T Y	1 <u>Low</u>	a transparently mendacious	b with some history/ probable cause	c questionable symptom- atology totally induced
	2 <u>High</u>	a largely false	b no history	c sophisticated symptom- atology totally induced

This study is concerned with the typology of the MSBP abuser. The three distinct types of parental sophistication in the design correspond to the three distinct types of parental sophistication (the unsophisticated help seeker, the demanding health care addict and the criminal abuser) which have been detailed in the MSBP literature but which have been comingled in materials utilized for the continuing professional education of pediatricians². The variable of intensity will be discussed in connection with Hypothesis 2.

It was hypothesized that pediatricians' responses to the questionnaire will indicate that they are for the most part unable to differentiate between the three types of parental sophistication and thus unable to recognize MSBP abuse.

2

A case in point is the "Workshop on Munchausen Syndrome by Proxy" that was presented by Robert Reece, M.D. on Tuesday, January 25, 1994 at the San Diego Conference on Responding to Child Maltreatment.

Following the Workshop, the researcher participated in a group discussion with several pediatricians and other health care professionals about an actual case of MSBP that one of pediatricians had been treating in a hospital setting. The group's consensus appeared to the author to be, that if a child abuse specialist of Dr. Reece's renown was prepared to endorse Schreier and Libow's (1993a) approach to the mental health model of MSBP, then they would have to reconsider any inclinations to report the MSBP perpetrator to the criminal justice system and simply deal with hospital cases of MSBP through internal channels.

reported in the clinical literature. (See Appendix A). Each case cue began with the identical introduction of the parent and then provided the Ss with information representing one of the squares of parental-child interaction from within the factorial design.

Each Ss received a prepared booklet containing one of the six prepared case cues. The Ss were then asked to respond to a series of questions involving diagnosis, referrals to other agencies and their own professional opinions.

The score derived from this portion of the questionnaire will reflect:

- (1) the number of agencies referred to;
- (2) whether or not a criminal justice agency has been selected for referral; and,
- (3) the diagnosis: whether or not a determination of child abuse has been made.

b. Hypothesis 2: This hypothesis measures the willingness of the pediatrician to view the MSBP offender as a "bad" person and the child as an innocent victim of abuse. The experimental hypothesis (H_2) states that the pediatrician will view the child victim as a "bad" person and will thus stigmatize the child victim instead of the adult perpetrator.

1) Instrument: Same as for Hypothesis 1.

2) Design: Same as for Hypothesis 1.

3) Questionnaire: This utilizes the same booklet with case cue as for Hypothesis 1. Ss were asked to mark Semantic Differential Scales in order to measure:

(a) their attitudes toward the child, and (b) their attitudes toward the parent.

The semantic differential scales (Osgood, et. al., 1957) have been employed in order to assess Ss attitudes along the three underlying dimensions of evaluation (good vs. bad); potency (strong vs. weak); and activity (active vs. passive).

It was hypothesized that pediatricians' responses to the questionnaire on the semantic differential scales will indicate that:

(1) Pediatricians' attitudes toward the parent will not differ significantly by the type of case cues. The sophisticated abuser will not be given a more negative semantic differential rating than the demanding health care addict or the unsophisticated help seeker; and,

(2) In rating the child victims, a main effect is anticipated for the type of case cue where pediatricians

will attribute progressively more negative characteristics to children who have been victims of more sophisticated and more intense forms of abuse, thus most profoundly stigmatizing the most seriously afflicted children.

The variable of "intensity" has been introduced into this study because the more grotesque and florid modalities of MSBP abuse may be recognizable by even the "greenest" pediatric resident. However, in the absence of bizarre and exotic presentation, even a sophisticated clinician might be unable to render a differential diagnosis of pernicious abuse.

There has been an attempt to link the general principles of interactionist theory with the response of health care professionals to the abuse of children. O'Toole and O'Toole et. al., (1994) have hypothesized that:

...recognition and reporting of child abuse will vary by characteristics of the event, characteristics of the observer, and characteristics of the organization in which the process occurs..., (p. 194).

In a major study of over one thousand nurses which utilized their responses to more than 24,000 "vignettes where case characteristics were systematically manipulated,"

the authors who employed 162 correlations have concluded that none of these additional variables are actually valuable to our understanding of nurses' responses to child abuse. Indeed, as the authors clearly note:

Examination of the correlations among case characteristics provides evidence of their independence and orthogonality...., (note 3, p. 204).

A multitude of extra vignette variables (such as the gender, age and social class of the parent, child and health care professional in the case scenarios) have already been demonstrated to be independent of and orthogonal to the issues of "response" to and "reporting" of child abuse cases. Thus the present study of pediatricians' responses to child abuse was not encumbered by these variables.

Instead, this study was concerned with the varieties in the type of case cues which have informed the MSBP literature and (in order to insure that the case vignettes would not suffer from insufficiencies of grotesqueness and floridity which might compromise their utility,) with the added variable of "intensity."

It should be noted that care has been taken to request such demographic data about the responding pediatricians (see Appendix C) as age, gender, number of years in

practice, specialty training, etc. for potential analysis, even though O'Toole and O'Toole et. al. (1994) have found that these are of minimalistic impact (accounting for less than one half of one percent of the variance).

Chapter 14:

Distribution and Collection of Questionnaires.

864 Questionnaires were printed, assembled, placed in postage paid return envelopes and stacked for distribution in 16 numbered boxes. Each box contained 54 (9 each of cell versions 1a, 1b, 1c, 2a, 2b, 2c)¹ Questionnaires. The boxes were opened one at a time and in sequential order. Each pediatrician was issued the Questionnaire that was at the top of the pile in the box that was open when s/he was approached. (10 misprinted Questionnaires were discarded).

A total of 751 Questionnaires were distributed to pediatricians during the months of January, February and March, 1995 (by the methods described on p. 99).

The cut off date of March 29, 1995 was established for receipt and processing of returned Questionnaires.

438 Questionnaires (or 58% of those distributed) were returned by the cut off date. 313 Questionnaires (or 42% of those distributed) were outstanding.

Of the 438 Questionnaires that were returned, only 342² (or 46% of the 751 Questionnaires distributed) had been

¹
See Table 1 on page 162.

²
This rate still exceeded the expectations of the researcher. (See Appendix D).

sufficiently completed so that they could be utilized for³
this study. See Table 2 below.⁴

Table 2

Questionnaire Distribution and Return

<u>Distributed</u>	<u>1a</u>	<u>1b</u>	<u>1c</u>	<u>2a</u>	<u>2b</u>	<u>2c</u>
751	125	125	121	126	130	124
<u>Returned</u>						
438	55	71	82	79	69	82
<u>Percentage</u>						
0.58	0.44	0.57	0.68	0.63	0.53	0.66
<u>Usable</u>						
342	52	59	63	60	44	64
<u>Percentage of Returned</u>						
0.78	0.95	0.83	0.77	0.76	0.64	0.78
<u>Usable as Percentage of Distributed</u>						
0.46	0.42	0.47	0.52	0.48	0.34	0.52

3

Of the 438 Questionnaires returned, only 5 had been completely filled out. 342 of these returns, while incomplete, were utilized. Further information is provided in the "Analysis of Data" section.

4

No significant differences on table (chi sq.=7.1919, df=5).

The rate of return for Questionnaires varied by cell:

For cell 1a: 55 (or 44% of the 125 Questionnaires distributed) were returned. 52 of those Questionnaires (95% of the returns) were utilized.

For cell 1b: 71 (or 57% of the 125 Questionnaires distributed) were returned. 59 of those Questionnaires (83% of the returns) were utilized.

For cell 1c: 82 (or 68% of the 121 Questionnaires distributed) were returned. 63 (or 77% of the returns) were utilized.

For cell 2a: 79 (or 63% of the 126 Questionnaires distributed) were returned. 60 (or 76% of the returns) were utilized.

For cell 2b: 69 (or 53% of the 130 Questionnaires distributed) were returned. 44 (or 64% of the returns) were utilized.

For cell 2c: 82 (or 66% of the 124 Questionnaires distributed) were returned. 64 (or 78% of the returns) were utilized.

Although the rates of return and usability of Questionnaires manifestly differed, none of these differences were actually significant.

Returns: The rate of return for cell 1a (44%) was lower than the rate of return for all other cells. It is hypothesized that because the vignette for this cell

presented an "obvious" case of such low intensity and minimal sophistication, more than 50% of the pediatricians who read this vignette were neither challenged nor motivated to respond to the Questionnaire.

Usability: No significant differences were observed between the usability of Questionnaires from cells 1b, 1c, 2a, and 2c.⁵ Returns for cell 1a had the greatest number of usable Questionnaires (95%,) while returns for cell 2b had the lowest number of usable returns. Moreover, most of the respondents to 2b wrote comments (see page 174) in the margins of their Questionnaire forms.

The manifest differences in rates of usability may be explained as follows: It may be hypothesized that the "obvious" nature of the case presented in cell 1a facilitated an ease of Ss response to the Questionnaire. It may be further hypothesized that because the HCA (at higher level and greater sophistication) in cell 2b represents an imposing challenge to the pediatrician, s/he will be motivated to consider the case described in the vignette. However, s/he will also exhibit some reticence when responding to questions about her/his attitudes toward the demanding parent and the child in this case.

5

None of the manifest differences in usability were significant. This uphold the null hypothesis (that the rate of return would be flat, i.e., the same in each cell.

Chapter 15:

Analysis of Data.

(1)

In the original design of this study two hypotheses were to be tested as follows:

1. Hypothesis 1: This hypothesis stated that pediatricians will be unable to recognize MSBP. The dependent variable in this hypothesis is "recognition." Four parts of the Questionnaire were provided to measure pediatricians' recognition of MSBP (see Appendix B).

These were:

- a. the examination and treatment protocol,
- b. the pediatrician's referral checklist,
- c. a 4-item Likert-type inventory for the child, and
- d. a 5-item Likert-type inventory for the parent.

A coding system was developed for scoring responses to these sections of the Questionnaire.

Support for Hypothesis 1 would derive from the inability of pediatricians to "recognize" MSBP as evidenced by the analysis of the mean scores of their responses to these four sections of the Questionnaire. That is, (for the cells described on page 162):

1

Ho: $u2c = u1c = u2b = u1b = u2a = u1a$
H1: $u2c > u1c > u2b > u1b > u2a > u1a$

Of the 438 Questionnaires that were returned, only 5 consisted of fully completed examination and treatment protocols and child and parent Likert-type inventories. 6 other Questionnaire responses consisted of some partial attempts to complete items a, c, and d.

Many of the questionnaires (357) were returned with (often graphically and aggressively) scribbled comments indicating that the pediatrician either did not wish to complete the examination and treatment protocols and the Likert-type inventories or believed that s/he had insufficient information to do so. The remaining Questionnaires were returned with items a, c, and d left blank.

Thus, items a, c, and d were eliminated and Questionnaires were tentatively marked tentatively "usable" if they had a completed pediatrician's referral checklist.²

1

The author is aware that she is in the unusual position of believing in the null hypothesis here and will therefore be sensitive to issues of statistical power.

2

A return Questionnaire was actually designated "usable" when it also included responses on Hypothesis 2 measures.

The "recognition" of MSBP is thus defined by the physician's referral checklist, i.e., the number and type of the agencies that the pediatrician will refer to in each cell.

2. Hypothesis 2: This hypothesis stated that pediatricians will be unwilling to report MSBP because they will stigmatize the child victim instead of the adult perpetrator. That is, the more serious the case of MSBP, the greater the stigmatization of the child victim. And, that regardless of the seriousness of the case of MSBP, the attitude of the pediatrician toward the offending parent remains constant.

The dependent variable in this hypothesis is "attitude." Three parts of the questionnaire were designed to measure pediatricians' attitudes toward the parent and child (see Appendix B). These are:

- a. seven-step Semantic Differential scales for the child,
- b. seven-step Semantic Differential scales for the parent, and
- c. A series of Munchausen Syndrome by Proxy-specific questions.

Factor analysis of the Semantic Differential scales was proposed in order to recover mean responses on the three

dimensions of good vs. bad, strong vs. weak and active vs. passive.

A coding system was developed in order to evaluate mean responses to the MSBP-specific questions.

Support for Hypothesis 2 would derive from the observation that the more serious the case of MSBP, the greater the stigmatization (the more negative the mean Semantic Differential ratings on all three dimensions) of the child victim.³ Thus, (for the cells described on page 162):

$H_0: u_{2c} = u_{1c} = u_{2b} = u_{1b} = u_{2a} = u_{1a}$

$H_1: u_{2c} > u_{1c} > u_{2b} > u_{1b} > u_{2a} > u_{1a}$

The MSBP-specific section of the Questionnaire consisted of 14 questions (see Appendix C). These questions were not fully completed by any of the respondents. Cells 1a and 1b had no responses to these questions. Partial responses (ranging from one to six questions answered) were recorded for cells 1c, 2a, 2b and 2c. These were insufficient for comparison.

³

In this case, the author believes in the alternate H_1 and not the null hypothesis H_0

The final section of the Questionnaire consisted of a Demographic Survey. (See Appendix C). Although it has been demonstrated that demographic data have had minimalistic impact upon the "response" to and "reporting" of child abuse (O'Toole & O'Toole et. al., 1994) the researcher was particularly interested in the relationship between demographic variables and the pediatricians' attitudes toward the parent in the case vignettes.

No demographic data is available for analysis in this study, however, due to lack of Ss compliance. Of the 342 usable Questionnaires, only 5 contained fully completed Demographic Surveys. Most Survey forms were left blank. Some Ss completed several questions, and left the remainder of the Survey blank. Other respondents took umbrage at either individual questions or the very existence of the Demographic Survey, or both. Comments such as: "How can you claim that this is an anonymous survey, when you ask me these questions?" abounded.

There was insufficient response to the question about MSBP-specific training (see page 159) for comparison.

(2)

Analysis of the pediatricians' referral checklist, seven-step Semantic Differential scales for the child and seven-step Semantic Differential Scales for the parent proceeded as follows:

Appropriate mean scores and standard deviations were calculated and recorded in tabular form.

A 2x3 analysis of variance (ANOVA) was conducted on each of the 33 dependent measures. A two-tailed F-test was conducted at the 0.20 level of significance.

A regression analysis was then conducted in order to investigate the strength of the relationship (if any) between the variables and the dependent measures.

Note. The reason for conducting tests at the 0.20 level of significance is as follows:

The researcher in this study is in the unusual position of wishing to uphold the Null Hypotheses (H_0).

It is therefore important that the beta risk (or Type II error rate) as opposed to the alpha risk (or Type I error rate) be under control.

Setting $N=342$, $\alpha=0.20$ and specifying a small effect size yields a power of 0.6 (or 60%). That is: the researcher has about a better than even chance of

rejecting the null hypothesis if it is false.

Conventional wisdom would suggest that it would be much more desirable to achieve a power of 80% and a corresponding beta risk of 20%. This, however, would require an N per condition of 300, or a total N=900 which is considerably beyond the researcher's resources.

Achieving a power of 60% is thus viewed as the best possible compromise (Cohen, 1969).

(3)

1. Hypothesis 1: Essential to the facilitation of "child abuse in the medical guise" is the role of the pediatrician as the source of "referrals" to specialists who will perform invasive diagnostic and therapeutic procedures.³ This hypothesis stated that the pediatricians who participated in this study would be unable to "recognize" either the factitious symptomatology of MSBP or the role of the parent as abuser, and will thus unwittingly make numerous "referrals" for the MSBP cases provided. That is:

a. when presented with sophisticated cases of MSBP, pediatricians will make more medical referrals than they would make in the less sophisticated cases of Health Care Addicts or Help Seekers. Moreover, the greater the intensity of the MSBP case, the greater the number of anticipated medical referrals.

b. when presented with the most intense and sophisticated case of MSBP, pediatricians will respond by making mental health referrals rather than criminal justice referrals.

3

Thereby replicating the operational triad of parent, physician and child victim that represents "child abuse in the medical guise."

Hypothesis 1 was measured by the "Pediatricians' Referral Checklist." After reading a case vignette, Ss were asked "Which referrals would you make in this case?" A checklist of 26 items plus 2 blank spaces marked "other" were provided and Ss were instructed to "Please utilize this checklist and feel free to add any other...." (See Appendix B).

As data from the usable Questionnaires was being tabulated, the researcher noted that the important criminal justice referral, "District Attorney" had not been checked off by any Ss. Several Ss added "Criminal Justice Services" or "In Hospital Child Protection Team" in the spaces provided for "other" referrals.⁴

Several general referrals (that had been added as filler in order to provide a broad range of referrals that may or may not be germane to the case) such as "Breast Feeding Support Group," "Dietician," and "Geriatrics" had not been checked off by any Ss. Other referrals, including "Primary Care Physician," "CT Scan-MRI," "WIC," "Insufficient Information" and "None"...,) had been added to the checklist.

⁴

The "Police" referral was initially discarded, but then reinstated because it was checked off by 7 Ss responding to case 2c (the highly intense and sophisticated MSBP case).

Thus, for the purpose of data analysis, only those referrals (hereafter REFERLs) that had been checked off or that had been added to the list of REFERLs) by at least one Ss were included.

REFERLs that had very few responses were grouped together with similar REFERLs. Thus, "Criminal Justice Services" and "In Hospital Child Protection Team" were grouped together with the "Child Abuse Hotline." Similarly, "Pathology" was combined with "Laboratory," "Neurology" was combined with "Neurosurgery," "Community Nursing" was combined with "Pediatric Nurse Practitioner" and "None" was combined with "Insufficient Information."

The number of working categories of referral (hereafter TOTREFER) was thereby reduced to 20, making the total score that each script could generate 20. Table 3 lists these referrals (on page 183 below).

Table 3

TOTREFER: List of Usable Referrals

REFERL1: Ambulatory Care

REFERL2: Admitting

REFERL3: Bureau of Child Welfare

REFERL4: Child Abuse Hotline/
Criminal Justice Services/
Child Protection Team-Hospital

REFERL5: Dermatology

REFERL6: Gynecology

REFERL7: Gastroenterology

REFERL8: Laboratory/
Pathology

REFERL9: Neurology/ Neurosurgery

REFERL10: Psychiatry

REFERL11: Social Services

REFERL12: Urology

REFERL13: X-Ray

REFERL14: None/
Insufficient Information

REFERL15: ENT

REFERL16: WIC

REFERL17: CT SCAN-MRI

REFERL18: Community Nursing/
Pediatric Nurse Practitioner

REFERL19: Primary Care M.D.

REFERL20: Police

The 20 REFERLs were then divided into 3 groups for further analysis. These included:

Medical Referrals (hereafter MEDREFER) which represented:

REFERLs 1, 2, 5, 6, 7, 8, 9, 12, 13, 15, 17, 18, 19;

Mental Health Referrals (hereafter MHREFER) which represented: REFERLs 10, 11, 16; and

Criminal Justice Referrals: (hereafter CRJREFER) which represented: REFERLs 3, 4, 20.

REFERL14: None/Insufficient Information was then eliminated from further analyses. Unlike Ss who made similar informal notations in the margins of the completed Questionnaire pages, these Ss utilized the spaces provided for "other" referrals to formally add this notation ("Insufficient Information") to their completed list of referrals.

The results for TOTREFER, MEDREFER, MHREFER and CRJREFER yielded significant interactions. Based upon Winer (1971), the author examined the results across each level⁵ of intensity, rather than emphasizing the main effects.

5

This concurs with many the position of many statisticians that in the presence of significant interactions, Independent Variables should be examined one level at a time.

Table 4

Analysis of Variance: TOTREFER

Dependent Variable: TOTREFER

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	416.06679808	83.21335962	31.54	0.0001
Error	336	886.41273409	2.63813314		
Corrected Total	341	1302.47953216			
	R-Square	C.V.	Root MSE	TOTREFER Mean	
	0.319442	61.44776	1.62423309	2.64327485	

Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	82.41385072	82.41385072	31.24	0.0001
SOPHIST	2	292.85042221	146.42521111	55.50	0.0001
LEVEL*SOPHIST	2	40.80252515	20.40126257	7.73	0.0005

Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	60.60316829	60.60316829	22.97	0.0001
SOPHIST	2	304.11650709	152.05825354	57.64	0.0001
LEVEL*SOPHIST	2	40.80252515	20.40126257	7.73	0.0005

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	1.7115	1.6610	3.0000	2.1609
High Level 2	2.6500	1.6136	4.6563	3.1429
	2.2142	1.6408	3.8347	2.6433

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

TOTREFER: Several significant differences emerge as can be seen on Table 4 (page 185):

High levels of intensity cause more referrals than low levels of intensity.

Greater degrees of sophistication cause greater numbers of referrals than lower degrees of sophistication.

Overall, level, sophistication and their interaction accounted for 31.94% of the variance in pediatricians' referrals. Sophistication accounted for a unique 23.94%. Level accounted for a unique 4.65%. And, the interaction accounted for 3.13%

The significant interaction of Level by Sophistication can be seen most clearly on the Figure 1, the TOTREFER Bar Chart (page 188).

At low intensity, differences between the total numbers of referrals are insignificant between cases 1a (Help Seekers or HS) and 1b (Health Care Addicts or HCAs). For (the most sophisticated) case 1c (MSBP) however, significantly greater numbers of referrals are noted than for the other two cases (See Appendix F for Tables of Significant Tests on Individual Means).

At high intensity, the HCA case 2b has the fewest number of referrals, the Help Seeker case 2a has more referrals and the MSBP case 2c has the greatest number of referrals. All of these differences are significant. (See Appendix F).

The essence of the interaction is explained as follows:
At low levels of intensity, the MSBP case receives more referrals than either the HS or the HCA, but these latter two do not differ from each other. At high levels of intensity, the MSBP case receives the greatest number of referrals, the HCA case receives the least number of referrals and the HS case becomes the clear intermediate.

These results are significant and salient. They provide support for the hypothesis that pediatricians will not recognize MSBP (i.e., that they will make the excessive number of referrals that differentially identify the case as "child abuse in the medical guise.")

An ancillary and unpredicted finding is that when the level of intensity is raised, pediatricians make more referrals for the MSBP and HS cases, but do not change their referrals for HCAs. In fact, if one examines the Bar Chart for TOTREFER (Figure 1, page 188) and ignores the HCAs (or both 'B' columns, (See Figure 2, page 189) it appears as though pediatricians are treating the cases of MSBP as higher level cases of HS (or in the alternative, that pediatricians are treating cases of HS as diminished versions of MSBP).

It is interesting to note that this observation follows the Libow and Schreier (1994) model of treating MSBP as an exaggerated form of Help Seeking.

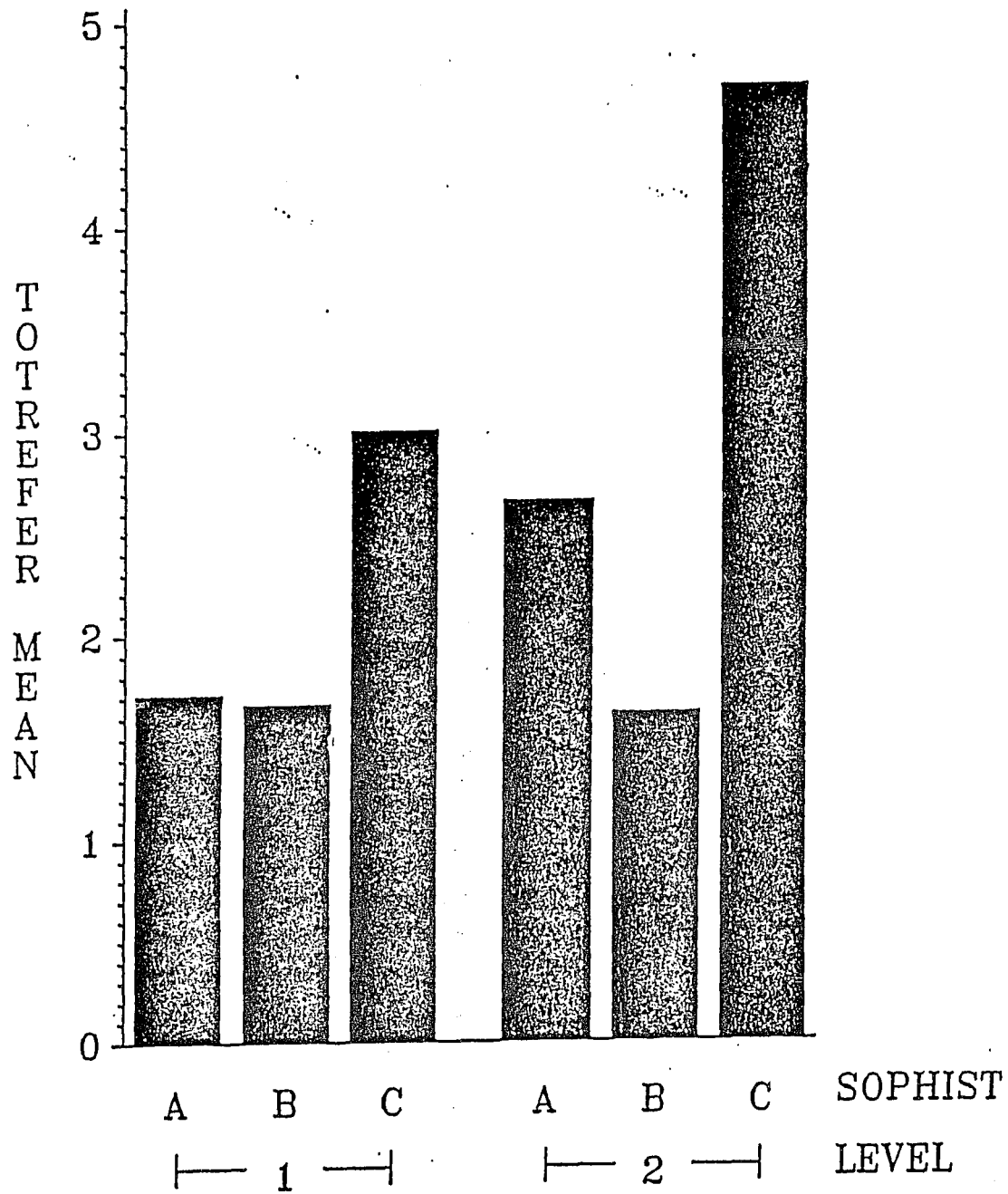


Figure 1. Bar Chart of TOTREFER by Sophist*Level

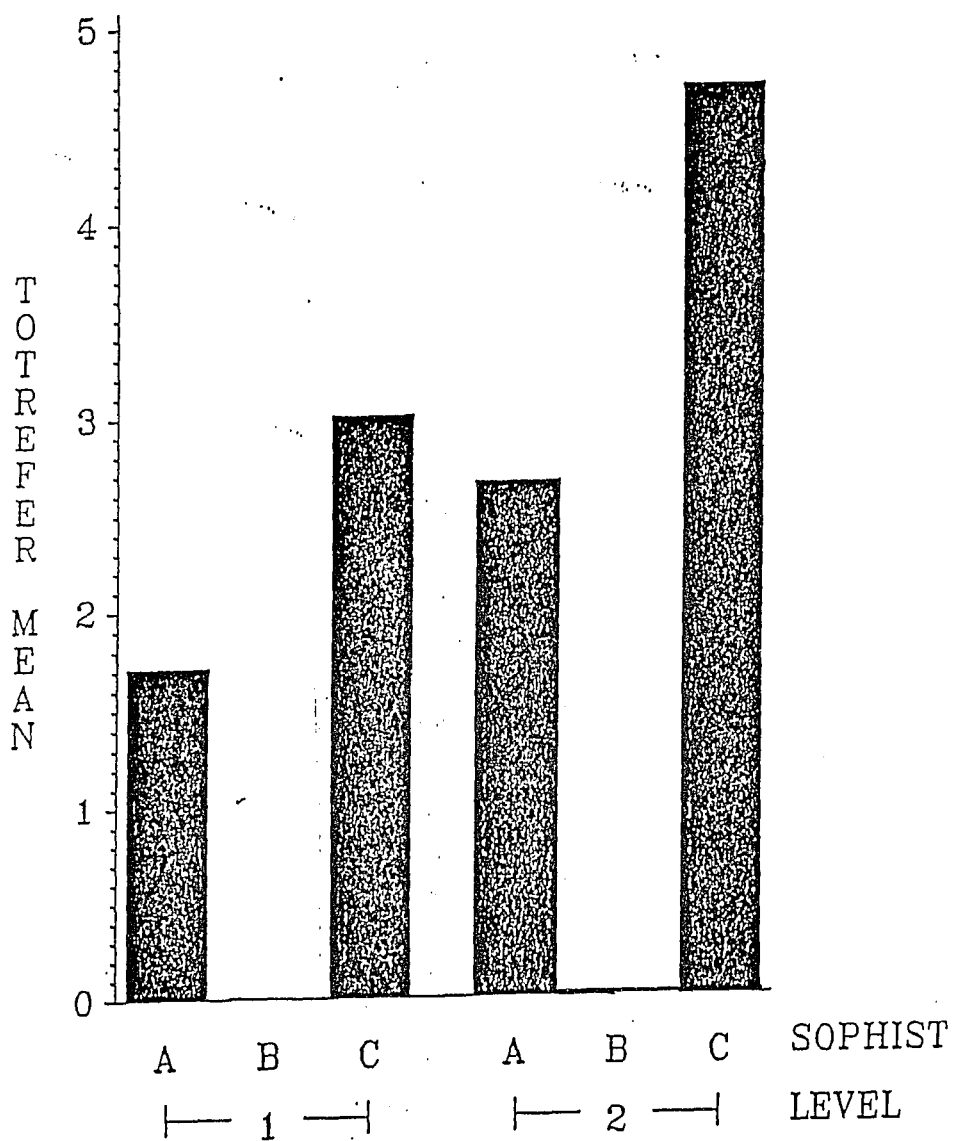


Figure 2. Bar Chart of TOTREFER by Sophist*Level with 'B' Values Removed

Table 5

Analysis of Variance: MEDREFER

Dependent Variable: MEDREFER

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	199.36288715	39.87257743	31.77	0.0001
Error	336	421.71606022	1.25510732		
Corrected Total	341	621.07894737			
	R-Square	C.V.	Root MSE	MEDREFER Mean	
	0.320994	76.47664	1.12031572	1.46491228	

Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	15.07402126	15.07402126	12.01	0.0006
SOPHIST	2	125.81940820	62.90970410	50.12	0.0001
LEVEL*SOPHIST	2	58.46945770	29.23472885	23.29	0.0001

Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	7.62358329	7.62358329	6.07	0.0142
SOPHIST	2	129.28643711	64.64321855	51.50	0.0001
LEVEL*SOPHIST	2	58.46945770	29.23472885	23.29	0.0001

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	1.3462	0.9153	1.5079	1.2586
High Level 2	1.0833	0.6364	2.9531	1.6786
	1.2054	0.7962	2.2271	1.4649

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

MEDREFER: Several significant differences in medical referrals emerge as can be seen on Table 5 (page 190).

High levels of intensity cause more medical referrals than low levels of intensity.

Greater degrees of sophistication cause greater numbers of medical referrals than lower degrees of sophistication.

Overall, level, sophistication and their interaction accounted for 32.10% of the variance in pediatricians' referrals. Sophistication accounted for a unique 20.80%. Level accounted for a unique 1.23%. The interaction accounted for 9.41%.

The significant interaction of Level by Sophistication can be seen most clearly on Figure 3, the MEDREFER Bar Chart (page 193).

At low intensity, differences between the total numbers of medical referrals are insignificant between the cases 1a (HS,) 1b (HCA) and 1c (MSBP).

At high intensity, the HCA case 2b has the fewest number of referrals, the HS case 2a has more referrals and the MSBP case 2c has the greatest number of referrals. While the differences between the HS case 2a and the HCA case 2b are not significant, the differences between the HS case 1a and the MSBP case 2c as well as the differences between the HCA case 2b and the MSBP case 2c are significant. (See Appendix F).

The essence of the interaction is explained as follows: At low levels of intensity, the MSBP receives more referrals than either the HS or the HCA, but the difference in referrals is not significant. At high levels of intensity, the MSBP case receives the greatest number of medical referrals, while the HS and the HCA do not differ significantly from one another.

Thus, the MEDREFER scores mirror the TOTREFER scores, yielding the same patterns of pediatrician referrals.

These results are significant and salient. They provide support for the hypothesis that pediatricians will not recognize MSBP (i.e., that they will make the excessive number of referrals that differentially identify the case as "child abuse in the medical guise.")

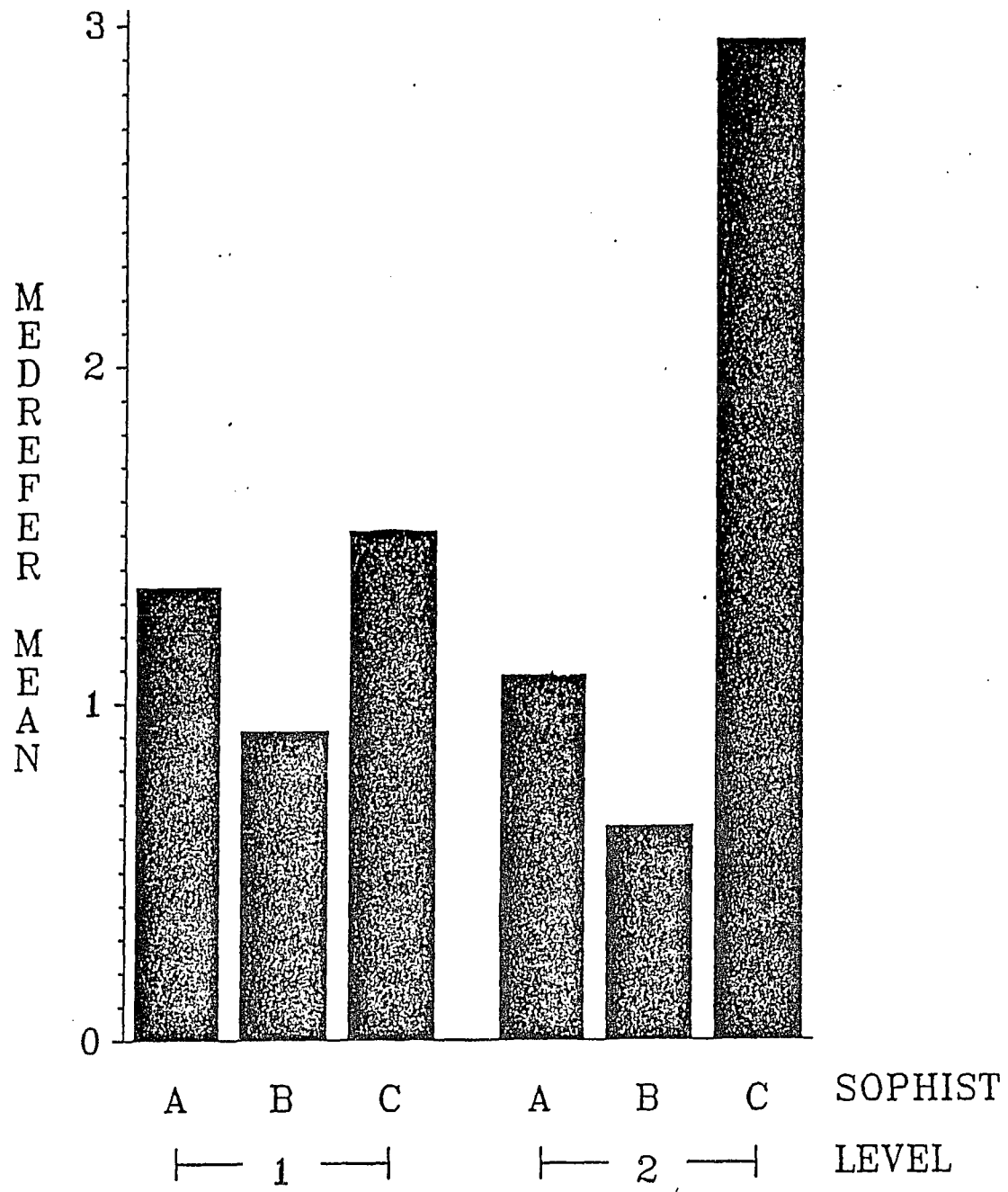


Figure 3. Bar Chart of MEDREFER by Sophist*Level

Table 6

Analysis of Variance: MHREFER

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	22.41428609	4.48285722	13.44	0.0001
Error	336	112.03015835	0.33342309		
Corrected Total	341	134.44444444			

R-Square	C.V.	Root MSE	MHREFER Mean
0.166718	103.9370	0.57742800	0.55555556

Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	11.00273673	11.00273673	33.00	0.0001
SOPHIST	2	7.69527091	3.84763546	11.54	0.0001
LEVEL*SOPHIST	2	3.71627845	1.85813923	5.57	0.0042

Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	10.59410853	10.59410853	31.77	0.0001
SOPHIST	2	7.92804631	3.96402316	11.89	0.0001
LEVEL*SOPHIST	2	3.71627845	1.85813923	5.57	0.0042

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	0.1731	0.2373	0.6825	0.3793
High Level 2	0.8000	0.5455	0.8125	0.7381
	0.5089	0.3690	0.7480	0.5555

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

MHREFER: Several significant differences in mental health referrals emerge as can be seen on Table 6 (page 194).

High levels of intensity cause more referrals than low levels of intensity.

Greater degrees of sophistication cause greater numbers of referrals than lower degrees of sophistication.

Overall, level, sophistication and their interaction accounted for 16.67% of the variance in pediatricians' mental health referrals. Level accounted for a unique 7.88%. Sophistication accounted for a unique 5.90%. The interaction accounted for 2.76%.

The significant interaction of Level by Sophistication can be seen most clearly on Figure 4, the MHREFER Bar Chart (page 198).

At low intensity, differences between the total number of mental health referrals are not significant between cases 1a (HS) and 1b (HCA). For (the most sophisticated MSBP) case 1c however, significantly greater numbers of mental health referrals are noted than for the other two cases (See Appendix F for Tables of Significant Tests on Individual Means).

At high intensity, no significant differences emerge between referrals. (See Appendix F).

The essence of the interaction is explained as follows:
At low levels of intensity, the MSBP case receives more

mental health referrals than either the HS or the HCA, but these latter two do not differ from each other. At high levels of intensity, there are no significant differences based upon the sophistication of the case.

Another way of looking at this interaction is that only the Help Seeker responds to an increase in level of intensity. In considering the fact that by definition the "Help Seeker" is the individual who is actually seeking help (i.e., mental health referrals that will provide her/him with relief and coping strategies,) the researcher notes that pediatricians have responded to the increased intensity of the call for "help" with a corresponding increase in
6
mental health referrals.

The Health Care Addict and the MSBP do not respond to changes in level of intensity. This can be seen most

6

In Chapter 16, an alternative (but undocumented) explanation will be offered for these HS artifacts. On pages 258-259, the idiographic personality traits of pediatricians are examined. Some pediatricians may be paternalistic/maternalistic and welcome the opportunity to nurture the Help Seeker. Other pediatricians may be intolerant of pathetic weaknesses and stigmatize the Help Seeker.

Although far exceeding the capacities of this study, it would be interesting to determine whether the unanticipated disparity in MHREFER results for HS cases 1a and 1b may have been caused by some (inadvertantly) shared personality characteristics in the pediatricians who responded to case 1a (and opposite shared characteristics in pediatricians responding to case 1b).

clearly on Figure 5 (page 199). When the results for the HS (1a and 1b) are removed, the results for the HCA and the MSBP cases are strikingly similar for levels 1 and 2.

These results are significant and salient. They provide partial support for the hypothesis that pediatricians will not recognize MSBP (i.e., they will fail to discriminate between high intensity cases of HS, HCA and MSBP as they perceive all three cases as "mothering disorders" that necessitate comparable mental health referrals).

The total number of mental health referrals for case 1c (low intensity MSBP) does not differ significantly from the total number of mental health referrals for the more intense 2a (HS,) 2b (HCA) or 2c (MSBP) cases. These results will be discussed in Chapter 16.

It is interesting to note that pediatricians are making similar mental health referrals for both levels of MSBP cases and for the more intense cases of Help Seekers and the Health Care Addicts. This observation follows the Libow and Schrier (1994) model of treating MSBP as a mothering disorder that should be treated by the mental health system.

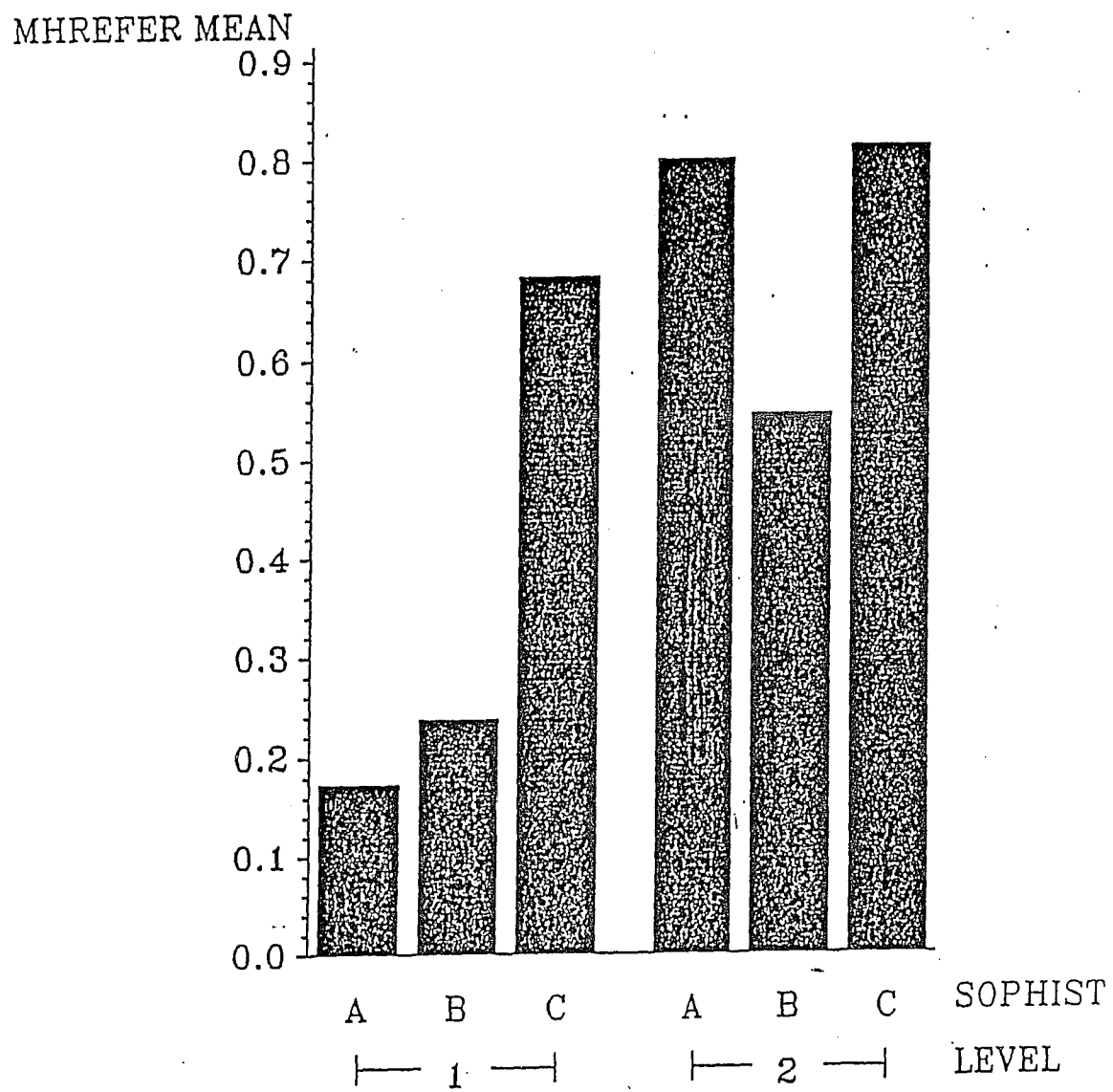


Figure 4. Bar Chart of MHREFER by Sophist*Level

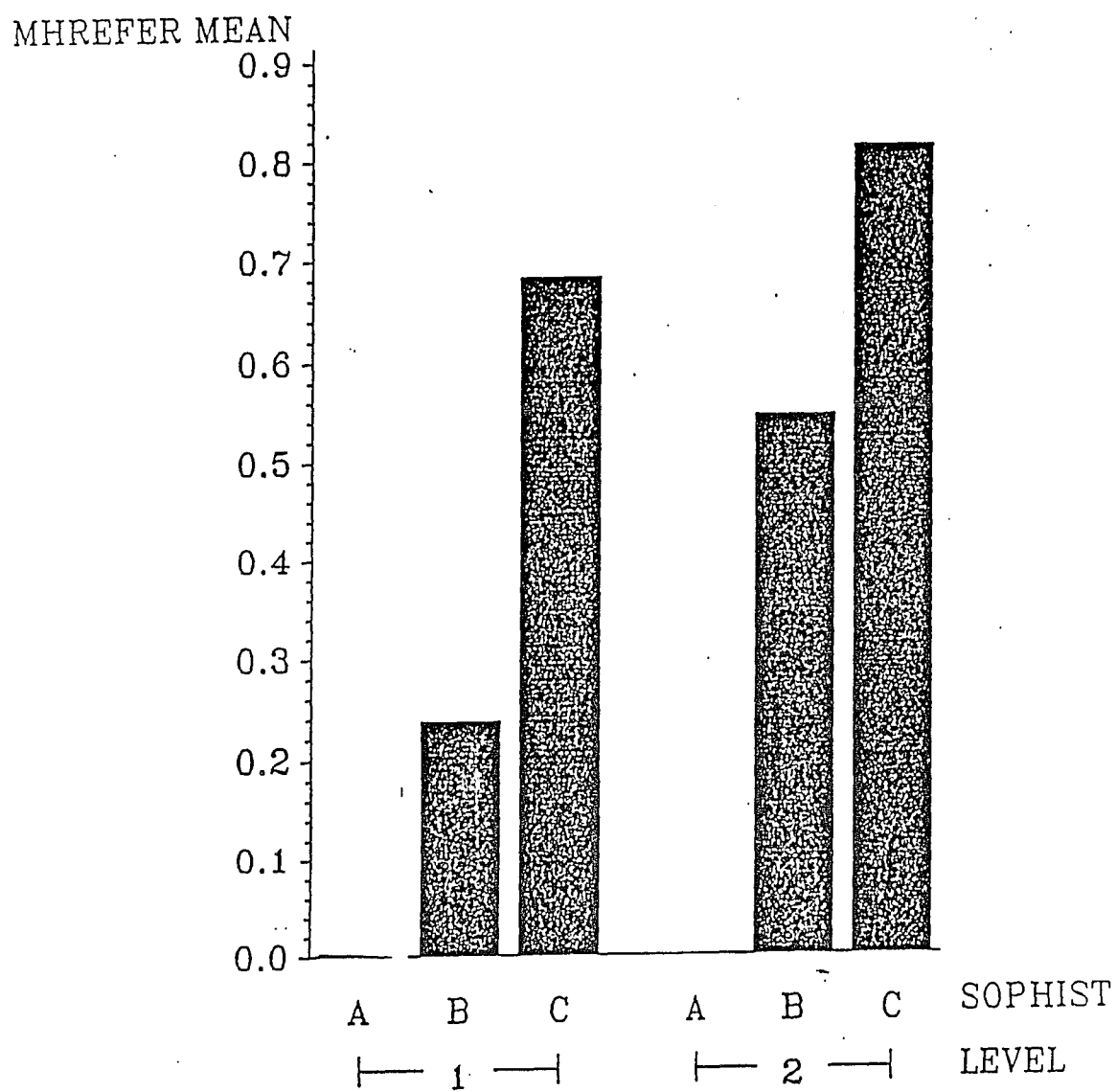


Figure 5. Bar Chart of MHREFER by Sophist*Level with 'A' Values Removed

Table 7

Analysis of Variance: CRJREFER

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	16.37383050	3.27476610	9.87	0.0001
Error	335	111.09831026	0.33163675		
Corrected Total	340	127.47214076			

R-Square	C.V.	Root MSE	CRJREFER Mean
0.128450	165.0208	0.57587911	0.34897361

Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	8.16017407	8.16017407	24.61	0.0001
SOPHIST	2	7.26737482	3.63368741	10.96	0.0001
LEVEL*SOPHIST	2	0.94628161	0.47314081	1.43	0.2416

Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	7.12617083	7.12617083	21.49	0.0001
SOPHIST	2	7.24270111	3.62135055	10.92	0.0001
LEVEL*SOPHIST	2	0.94628161	0.47314081	1.43	0.2416

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	0.1731	0.0000	0.4032	0.1965
High Level 2	0.6000	0.1165	0.4920	0.3490
	0.4018	0.1165	0.4920	0.3490

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

CRJREFER: Several significant differences emerge for the total number of criminal justice referrals as can be seen on Table 7 (Page 200).

High levels of intensity cause more referrals than low levels of intensity.

The Help Seekers and the MSBP cases cause greater numbers of referrals than Health Care Addicts at both levels of intensity.

Overall, level, sophistication and their interaction accounted for 12.85% of the variance in pediatricians' referrals. Sophistication accounted for a unique 5.68%. Level accounted for a unique 5.59%. The interaction accounted for 0.74%.

At low intensity, there were no criminal justice referrals made for (the HCA) case 1b. Differences between case 1a (HS) and case 1c (MSBP) were not significant. (See Appendix F for Tables of Significant Tests on Individual Means).

At high intensity, the HCA case 2b has the fewest number of referrals. The HS case 2a and the MSBP case 2c have almost the same number of referrals. There are no significant differences in CRJREFERS for the more intense cases on level 2. (See Appendix F).

No significant interaction appears. However, if one examines the Bar Chart for CRJREFER (Figure 6, page 203) and

ignores the HCAs or 'B' columns (see Figure 7, page 204) an ancillary and unpredicted finding emerges. Pediatricians appear to be treating the Health Care Addict cases differently than the Help Seekers and the MSBP cases. It appears as though pediatricians are treating the HS and the MSBP cases as similar versions of the same syndrome, while treating the HCAs with some alternative measure, as was the case for both MEDREFER and TOTREFER.

These findings are contrasted with the findings for MHREFER, where pediatricians treated HCA and MSBP as variants of the same condition.

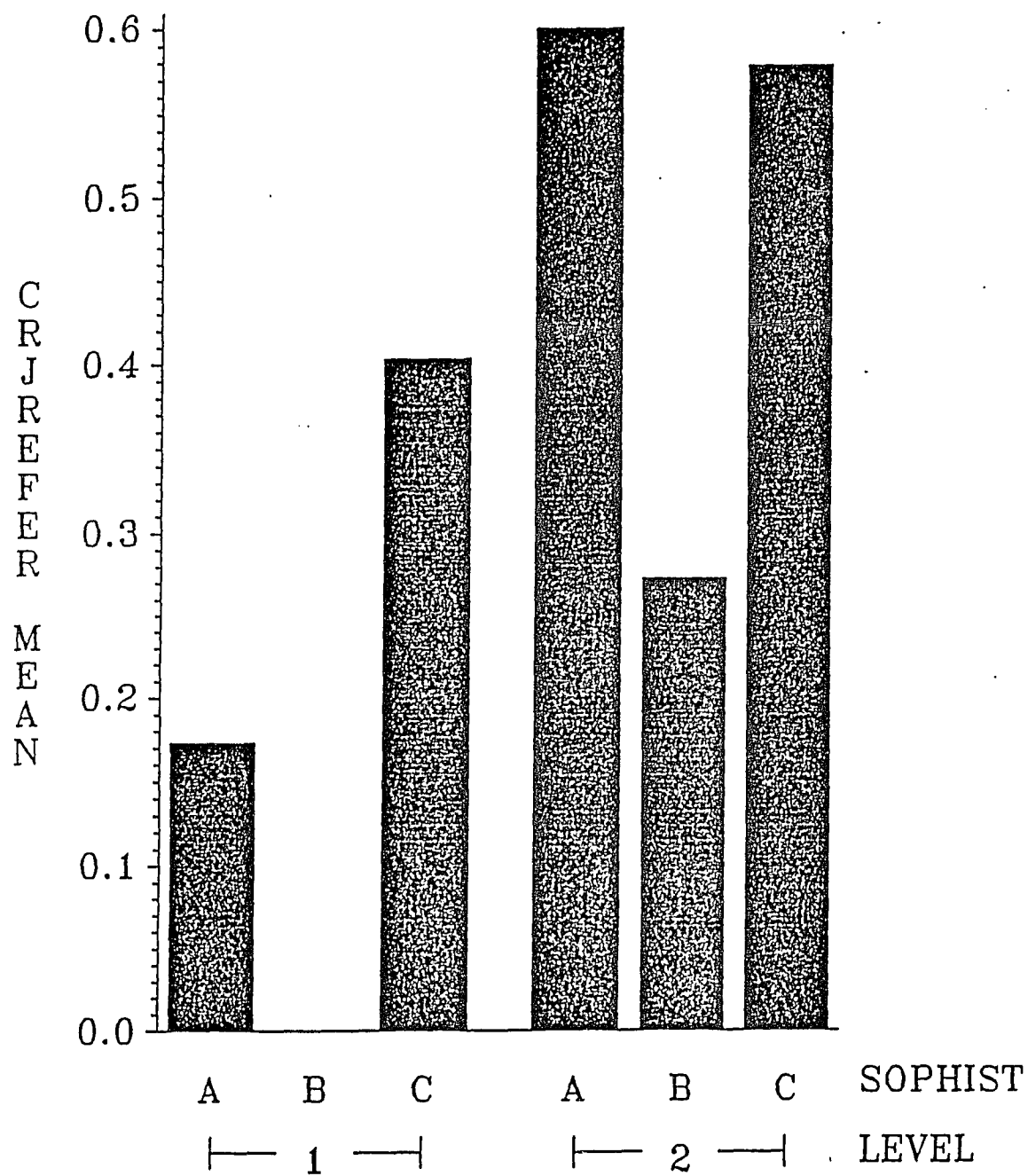


Figure 6. Bar Chart for CRJREFER by Sophist*Level

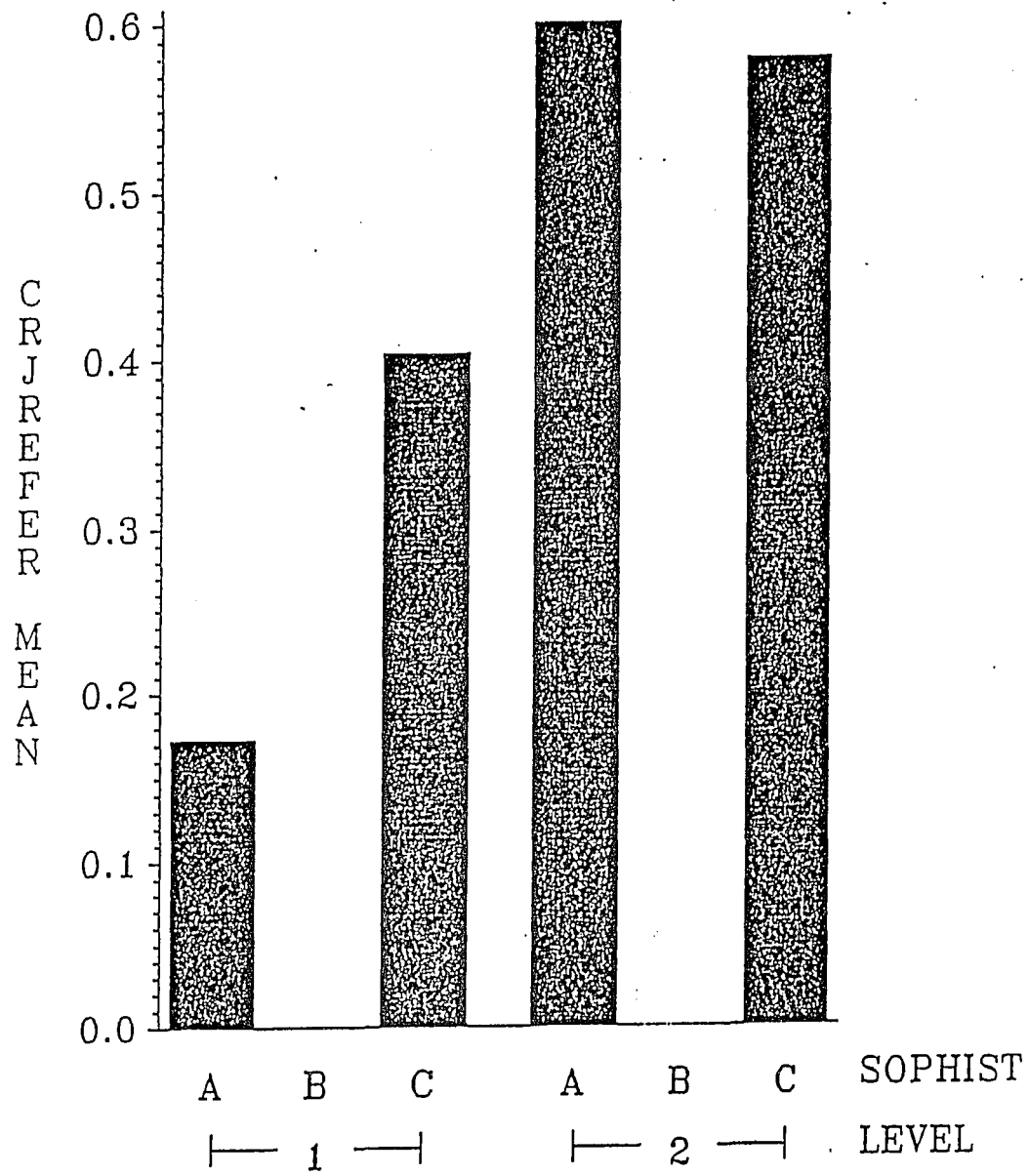


Figure 7. Bar Chart for CRJREFER by Sophist*Level with '2B' Removed

2. Hypothesis 2: The physical abuse of children has been defined as:

the intentional, nonaccidental use of physical force, ...on the part of a parent or other caretaker interacting with a child in his care, aimed at hurting, injuring or destroying that child, (Gil, 1973, p. 6).

With the case scenarios presented, (as well as with real-life cases,) in order for the pediatrician to make a mandated report of physical abuse, s/he must first decide whether or not the child presented to her/him is the victim of such intentional, nonaccidental abuse. Moreover, in cases where the pediatrician does decide that the child has been abused, s/he must also decide whether to report the parent as the alleged perpetrator of that abuse.

Hypothesis 2 states that pediatricians are for the most part unwilling to report cases of MSBP. Instead of perceiving the MSBP offender as socially diminished and blameworthy, pediatricians will stigmatize the child victim of MSBP by implying that this child is somehow deserving of his/her fate.

This study measured the "attitudes" of pediatricians toward the children and parents in the 6 case vignettes on seven-step Semantic Differential (hereafter SD) Scales. The 26 SD scales for the child (hereafter BABYSD) and the 25

SD scales (hereafter MOMYSD) for the mother (see Appendix B) were then analyzed along the three underlying dimensions of evaluation (good vs bad); potency (strong vs. weak); and activity (active vs. passive).

Variables for the pediatricians' attitudes on the BABYSDs were defined as BEVALUE for the dimension of evaluation; BPOTENT for the dimension of potency; and BACTIVE for the dimension of activity.

Variables for the pediatricians' attitudes on the MOMYSDs were defined as MEVALUE for the dimension of evaluation; MPOTENT for the dimension of potency; and MACTIVE for the dimension of activity.

1. The reader should keep in mind that for the value dimension (BEVALUE and MEVALUE) a higher number represents greater devaluation.

2. For the dimension of potency (BPOTENT and MPOTENT)⁷ a higher number represents less potency.

3. For the dimension of activity (BACTIVE and MACTIVE)⁸ a higher score represents more activity.

7

The child being evaluated by the pediatricians in this study is a six month old infant. High levels of potency would not be anticipated for an infant of this age.

8

For MACTIVE, the lower score represents activity and the higher score, passivity. For BACTIVE, the lower score represents activity and the higher score, lethargy.

Table 8

Analysis of Variance: BEVALUE

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	5079.71350519	1015.94270104	6.78	0.0001
Error	336	50350.66076382	149.85315704		
Corrected Total	341	55430.37426901			

R-Square	C.V.	Root MSE	BEVALUE Mean
0.091641	22.15589	12.24145241	55.25146199

Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	1526.76692089	1526.76692089	10.19	0.0015
SOPHIST	2	1020.41805598	510.20902799	3.40	0.0344
LEVEL*SOPHIST	2	2532.52852831	1266.26426416	8.45	0.0003

Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	1244.90997993	1244.90997993	8.31	0.0042
SOPHIST	2	1154.88329660	577.44164830	3.85	0.0222
LEVEL*SOPHIST	2	2532.52852831	1266.26426416	8.45	0.0003

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	51.4321	57.1525	62.3651	57.3280
High Level 2	54.1667	53.1818	52.0469	53.1010
	52.8970	55.4563	57.1654	55.2515

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

BEVALUE: Several significant differences emerge in the pediatricians' evaluations of the babies on the SD scales as can be seen on Table 8 (page 207).

Overall, level, sophistication and their interaction accounted for 9.16% of the variance in pediatricians' responses. Level accounted for a unique 2.25%. Sophistication accounted for a unique 2.08%. The interaction of level and sophistication accounted for 4.57%.

At low levels of intensity case 1a (HS) is different from case 1c (MSBP).

At high levels of intensity, no significant differences emerge between the Help Seeker, the Health Care Addict and the MSBP cases. (See Appendix F).

The nature of the interaction is that at low levels the baby is significantly more devalued in the (1c) MSBP case than in the (1a) HS case. The case of the HCA (1b) does not differ significantly from either the HS or the MSBP.

Significant differences are observed between the MSBP cases 1c and 2c. Indeed, for the MSBP scripts, the baby is more significantly devalued at the lower level of intensity than at the higher level of intensity. (See BEVALUE Bar Chart, Figure 8, page 210).

Paradoxically, support for the hypothesis comes at low levels of intensity where the baby is significantly

devalued. At higher levels, contrary to the researcher's predictions, there is no significant difference in the pediatricians' evaluations of babies 2a (HS), 2b (HCA) and 2c (MSBP).

The researcher has no ready explanation for the phenomenon of low level intensity exclusively producing the predicted distinction.

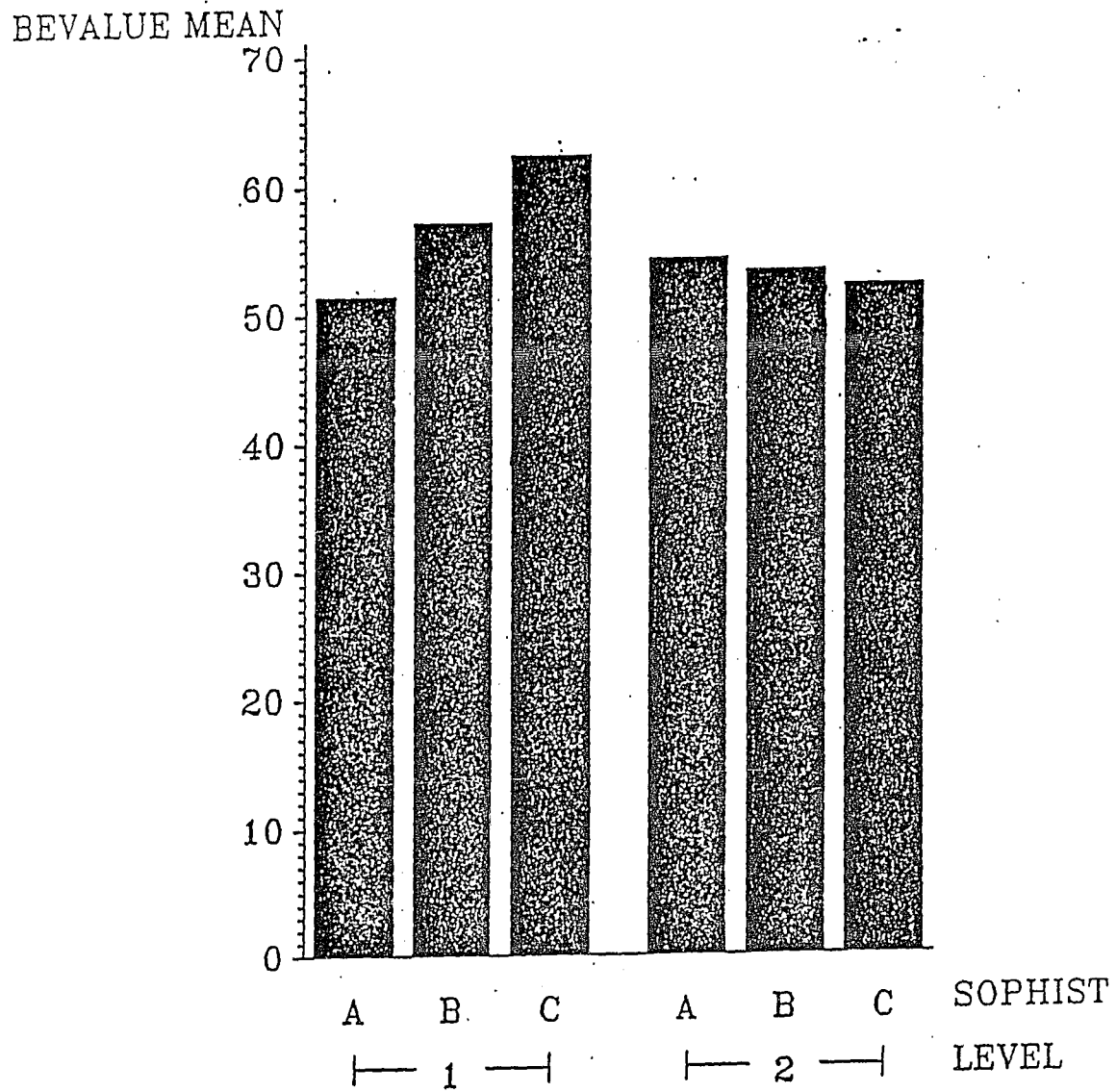


Figure 8. Bar Chart of BEVALUE by Sophist*Level

Table 9

Analysis of Variance: BPOTENT

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	134.07829223	26.81565845	3.95	0.0017
Error	336	2279.06790660	6.78294020		
Corrected Total	341	2413.14619883			
	R-Square	C.V.	Root MSE	BPOTENT Mean	
	0.055562	24.36290	2.60440784	10.69005848	
Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	31.55013972	31.55013972	4.65	0.0317
SOPHIST	2	92.40473928	46.20236964	6.81	0.0013
LEVEL*SOPHIST	2	10.12341323	5.06170661	0.75	0.4749
Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	22.24647090	22.24647090	3.28	0.0710
SOPHIST	2	93.93753353	46.96876677	6.92	0.0011
LEVEL*SOPHIST	2	10.12341323	5.06170661	0.75	0.4749

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	10.3269	11.1017	11.4286	10.9885
High Level 2	9.5667	11.0909	10.6563	10.3810
	9.9197	11.0971	11.0394	10.6901

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

BPOTENT: Several significant differences emerged in the pediatricians' SD ratings of the potency of the babies in the 6 cases as can be seen on Table 9 (page 211).

Overall, level, sophistication and their interaction accounted for 5.56% of the variance. Sophistication accounted for a unique 3.85%. Level accounted for a unique 0.92%. The interaction accounted for 0.42%.

Thus, while a significant effect is observed for level of intensity and a significant effect is observed for degree of sophistication, no significant effect is observed for the interaction. (See Appendix F).

At low levels of intensity, the baby is seen as less⁹ potent than at high levels of intensity. This is tantamount to stigmatizing the baby at higher levels of intensity and¹⁰ therefore supports the researcher's hypothesis.

Overall, however, the baby is seen as significantly more potent in the HS condition (1a and 2a) than in the HCA or the MSBP conditions. (See Bar Chart for BPOTENT, Figure 9, page 214).

9

For the dimension of potency, a higher number represents less potency (see page 206).

10

Babies are not generally perceived as being very potent. To attribute great potency to a 6 month old baby, is to stigmatize that baby.

Perhaps, this phenomenon may be understood in terms of the sympathy that the HS mother has evoked in the pediatricians. Having generated impressive numbers of MHREFERS for the HS cases, pediatricians may be attempting to attribute some measure of the blame for the unfortunate HS mother's plight on the "potency" of her baby (although they have not been given any information in the case vignette that would indicate that this was the case).

To ideally comport with the researcher's hypothesis, pediatricians SD ratings would have indicated that they attribute the most potency to the MSBP babies (cases 1c and 2c). In responding to the cases prepared for this study, however, pediatricians rated the HS babies (cases 1a and 2s) as the most potent.

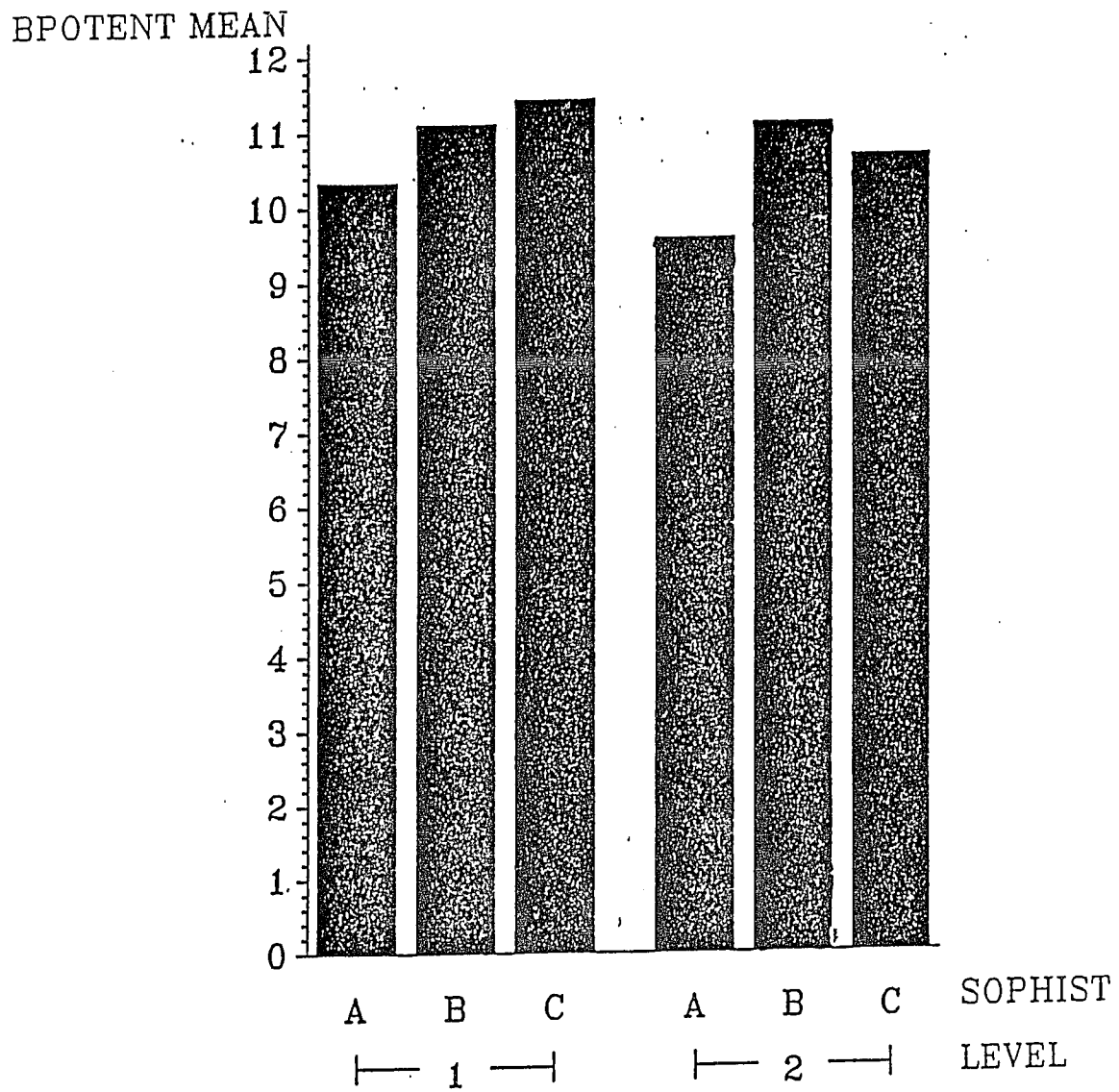


Figure 9. Bar Chart of BPOTENT by Sophist*Level

Table 10

Analysis of Variance: BACTIVE

Dependent Variable: BACTIVE

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	253.28252039	50.65650408	1.86	0.1009
Error	334	9097.47042079	27.23793539		
Corrected Total	339	9350.75294118			

R-Square	C.V.	Root MSE	BACTIVE Mean
0.027087	25.32048	5.21899755	20.61176471

Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	6.10399323	6.10399323	0.22	0.6362
SOPHIST	2	231.85477608	115.92738804	4.26	0.0150
LEVEL*SOPHIST	2	15.32375108	7.66187554	0.28	0.7550

Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	4.51392111	4.51392111	0.17	0.6842
SOPHIST	2	224.84092881	112.42046441	4.13	0.0170
LEVEL*SOPHIST	2	15.32375108	7.66187554	0.28	0.7550

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	20.0000	20.6102	21.4839	20.7442
High Level 2	19.1667	20.6364	21.5938	20.4762
	19.3750	20.6214	21.3702	20.6118

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

BACTIVE: No significant differences emerged in pediatricians' SD ratings for the babies on this dimension, i.e., the percent variance accounted for was only 2.70%. See Table 10 (page 215) for the Analysis of Variance and Appendix F for the Significance Tests on Individual Means.

²
Although the overall R is not significant, it is derived entirely from the dynamic of Sophistication (which is significant on its own).

This is reported because the results are consistent with the researcher's hypothesis, i.e., the baby is seen as most active in the MSBP condition, regardless of level. See the Bar Chart for BACTIVE (Figure 10, page 217).

These results are important because the baby presented to pediatricians in each of the case vignettes is 6 months old. For this stage of infancy, we might have anticipated a flat or near flat BACTIVE Bar Chart, yet both MSBP babies (cases 1c and 2c) are perceived by pediatricians as being somewhat more active than the HS babies and the HCA babies of the same age.

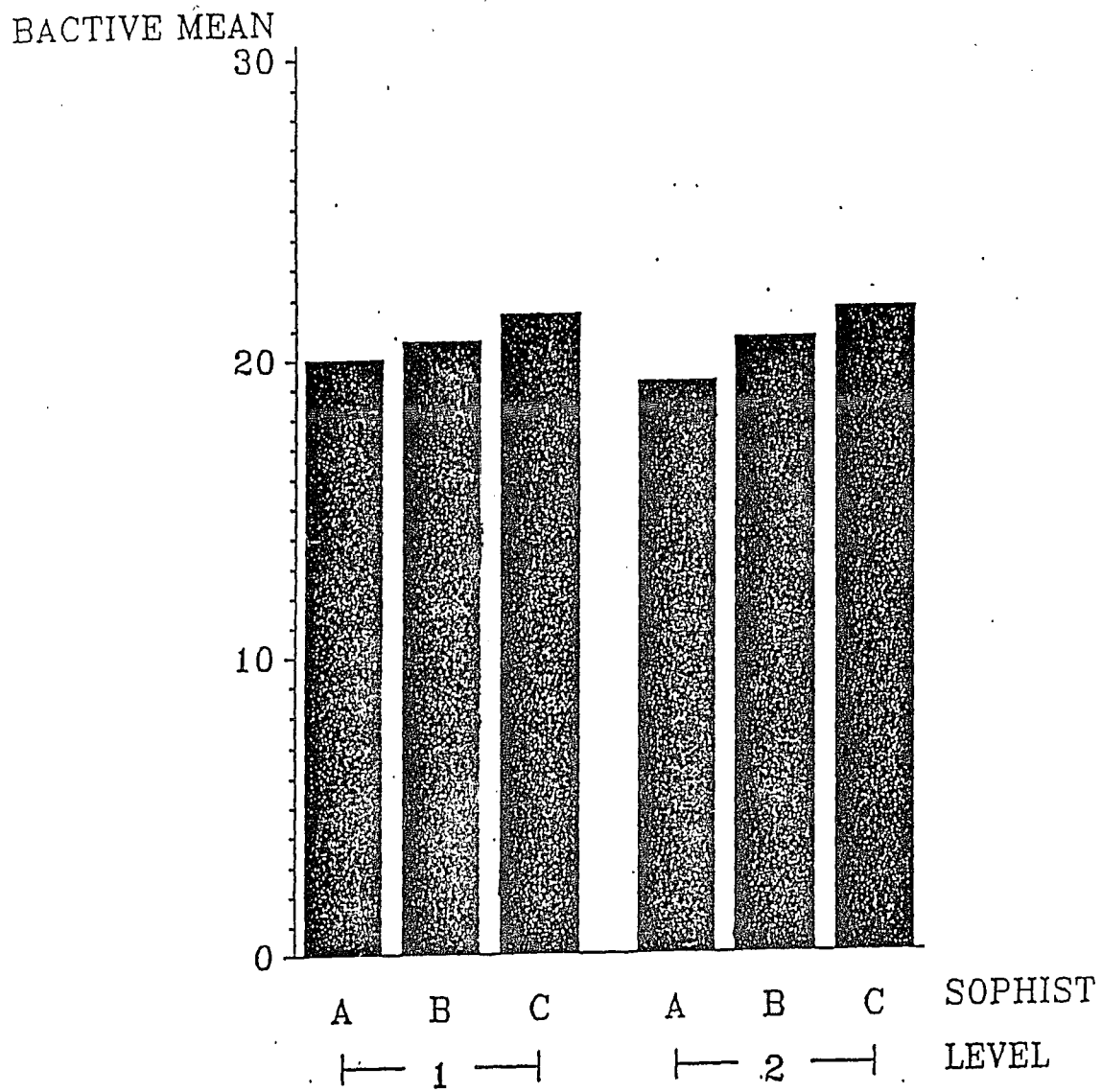


Figure 10. Bar Chart of BACTIVE by Sophist*Level

In this study, Hypothesis 2 examined the potential for pediatricians' stigmatization of the child victim (a 6 month old baby) on 3 dimensions: value (good vs. bad), potency (strong vs. weak) and activity (active vs. passive).

The Bar Chart that follows (Figure 11, page 219) offers a composite presentation of the findings of this study for all 3 dimensions:

On the dimension of value, the low level MSBP baby (case 1c) is more devalued by responding pediatricians than any of the other babies. It is important to note, however, that responding pediatricians have have profoundly devalued the babies in all 6 of the cases presented to them relative to their attitudes about the babies' potency and activity.

On the dimension of potency, all of the babies were perceived as being very strong and healthy. The most potent of the babies are the babies of both Help Seekers (1a and 1b).

On the dimension of activity, both MSBP babies (1c and 2c) are perceived by responding pediatricians as being more active than the other babies.

These findings will be discussed in the Conclusions section.

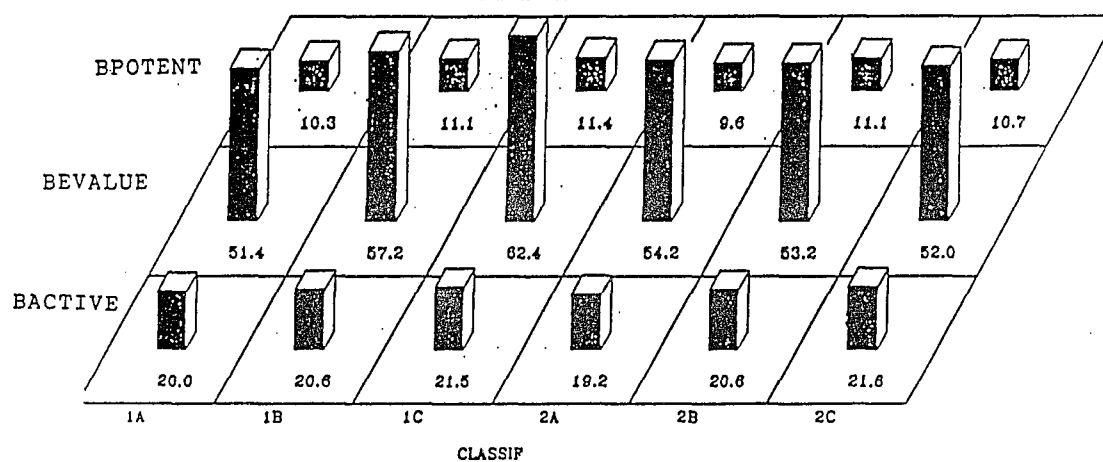


Figure 11. Bar Chart of BEVALUE, BPOTENT, BACTIVE by Sophist*Level

Table 11

Analysis of Variance: MEVALUE

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	6489.20315889	1297.84063178	15.79	0.0001
Error	336	27623.66526216	82.21328947		
Corrected Total	341	34112.86842105			
	R-Square	C.V.	Root MSE	MEVALUE Mean	
	0.190227	15.97860	9.06715443	56.74561404	

Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	61.89797770	61.89797770	0.75	0.3862
SOPHIST	2	1389.47599365	694.73799682	8.45	0.0003
LEVEL*SOPHIST	2	5037.82918754	2518.91459377	30.64	0.0001
Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	215.13737224	215.13737224	2.62	0.1067
SOPHIST	2	1521.86122144	760.93061072	9.26	0.0001
LEVEL*SOPHIST	2	5037.82918754	2518.91459377	30.64	0.0001

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	48.9808	59.2203	59.6825	56.3276
High Level 2	60.0667	60.2727	52.3438	57.1786
	54.3834	59.6699	55.9843	56.7456

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

MEVALUE: Several significant differences emerged in the pediatricians' evaluations of the mothers on the SD scales as can be seen on Table 11 (page 220).

Overall, level, sophistication and their interaction accounted for 19.02% of the variance in pediatricians' responses. Level accounted for a unique 0.63%. Sophistication accounted for a unique 4.46%. The interaction accounted for 14.77%.

No significant differences emerged for level.

A strong main effect was noted for sophistication that accounts for most of the R^2 but does not comport with the researcher's prediction: Both HCAs (1b and 2b) are equally devalued. This phenomenon may represent the pediatricians' negative response to the irritating demands of the HCA mothers.

Moreover, the low intensity MSBP case (1c) and the high intensity Help Seeker (2a) are as devalued as the two HCA cases (1b and 2b). See Bar Chart for MEVALUE¹¹ (Figure 12, page 223). This devaluation may again represent the response of pediatricians to the difficulties or irritations inherent in dealing with mothers in these cases.

¹¹

The higher number represents the greater devaluation (see page 206).

At low levels of intensity, a predicted finding emerges: case 1a (HS) differs from cases 1b (HCA) and 1c (MSBP,) i.e., the Help Seeker is valued as a "better" mother than the HCA and the MSBP.

At high levels of intensity however, the "best" mother is the MSBP mother. Here, no differences were observed in pediatricians' evaluations between the HS (case 2a) and the HCA (case 2b).

Cases 1a (the low intensity HS) and 2c (the high intensity MSBP) receive almost identical levels of more positive evaluation than the other cases. (See Appendix F).

Thus, an unpredicted finding emerges: To the pediatricians who participated in this study, the intense and sophisticated MSBP mother is just as "good" as the low level, unsophisticated Help Seeking mother.

The researcher will discuss these findings and compare them with the findings for pediatricians' evaluations of the babies in the Conclusions section.

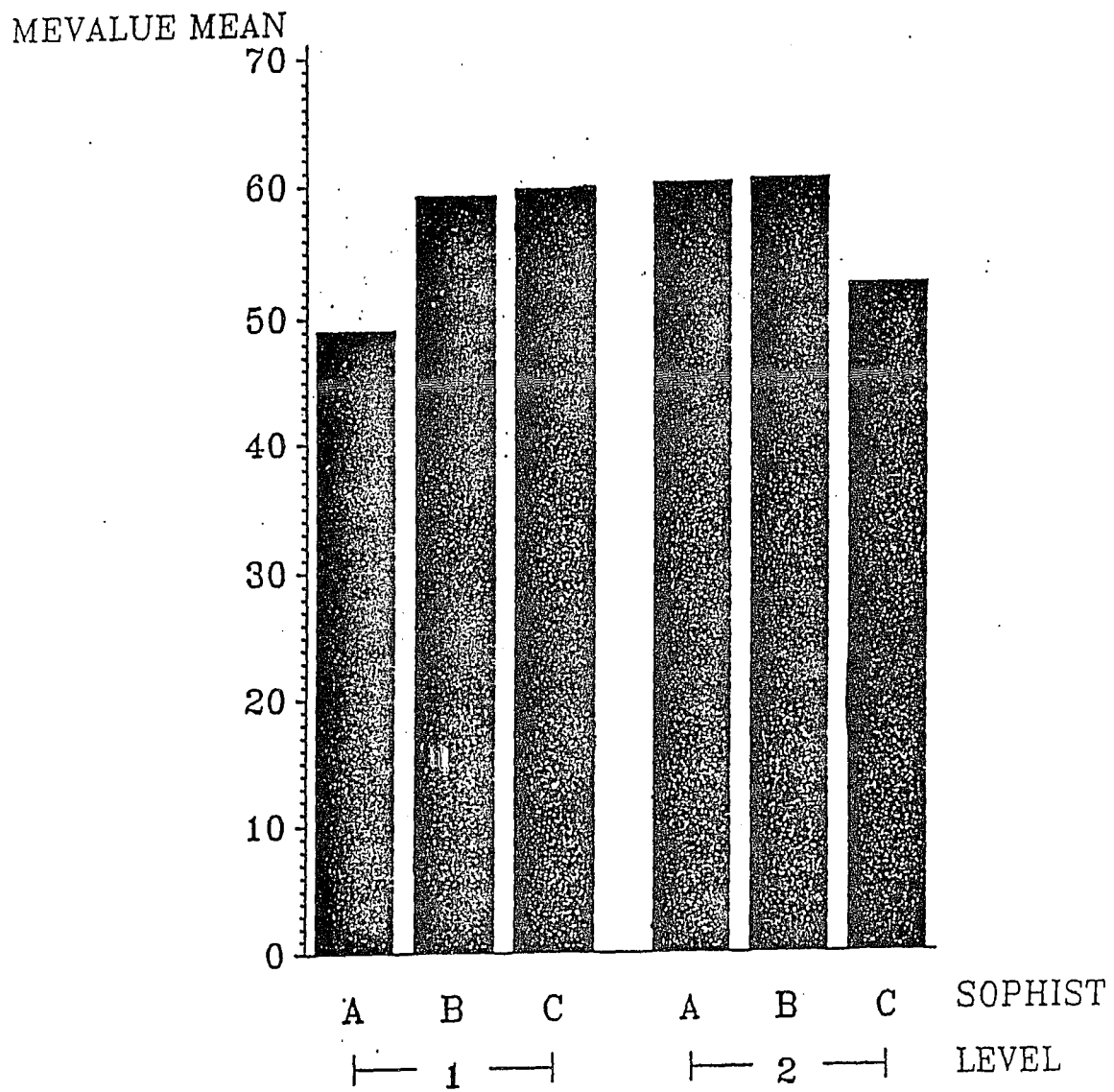


Figure 12. Bar Chart of MEVALUE by Sophist*Level

Table 12

Analysis of Variance: MPOTENT

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	484.57718195	96.91543639	7.69	0.0001
Error	336	4237.13334436	12.61051591		
Corrected Total	341	4721.71052632			
	R-Square	C.V.	Root MSE	MPOTENT Mean	
	0.102627	17.13198	3.55112882	20.72807018	

Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	0.02025538	0.02025538	0.00	0.9681
SOPHIST	2	78.61292258	39.30646129	3.12	0.0456
LEVEL*SOPHIST	2	405.94400400	202.97200200	16.10	0.0001

Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	4.78690951	4.78690951	0.38	0.5382
SOPHIST	2	97.77888402	48.88944201	3.88	0.0216
LEVEL*SOPHIST	2	405.94400400	202.97200200	16.10	0.0001

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	19.3462	20.8475	21.7778	20.7356
High Level 2	21.3833	22.2727	19.0313	20.7202
	20.4375	21.4563	20.3937	20.7281

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

MPOTENT: Several significant differences emerged in the pediatricians' SD ratings of case mothers on the dimension of potency as can be seen on Table 12 (page 224).

Overall, level, sophistication and their interaction accounted for 10.26% of the variance in pediatricians' responses. Level only accounted for 0.10%. Sophistication accounted for 2.07%. The interaction accounted for 8.60%.

Effects were observed for sophistication and for level by sophistication, but no effect was observed for level. (See Appendix F).

As was the case with MEVALUE, there is a main effect for sophistication such that the HCAs are seen as the least potent of the cases.

The interaction consists of the following: At level 1, the mother's potency decreases as sophistication increases.¹² The HS mother (1a) is the most potent, the HCA mother (1b) is less potent and the MSBP mother (1c) is the least potent of the three. This can be seen on Figure 12 (the Bar Chart of MPOTENT, page 227)¹³

12

Mothers should be potent. They should be able to care for their babies. There is a stigma attached to non-potency.

13

It is interesting to note that in reality, the MSBP mother is the most potent. She "potently" manipulates the pediatrician, causing him/her not only to make MEDREFERS, but to view her as the least potent of the level 1 mothers.

At higher levels of intensity, the pattern is almost reversed. Here, the MSBP mother (case 2c) becomes the¹⁴ most potent of the cases.

Thus, an unpredicted finding (similar to the MEVALUE finding) emerges: When level is increased, the Help Seeking mother and the MSBP mother appear to switch places in terms of whom pediatricians have considered the "best" mother.

14

The reader is reminded that a higher SD rating means less potency. (See page 206).

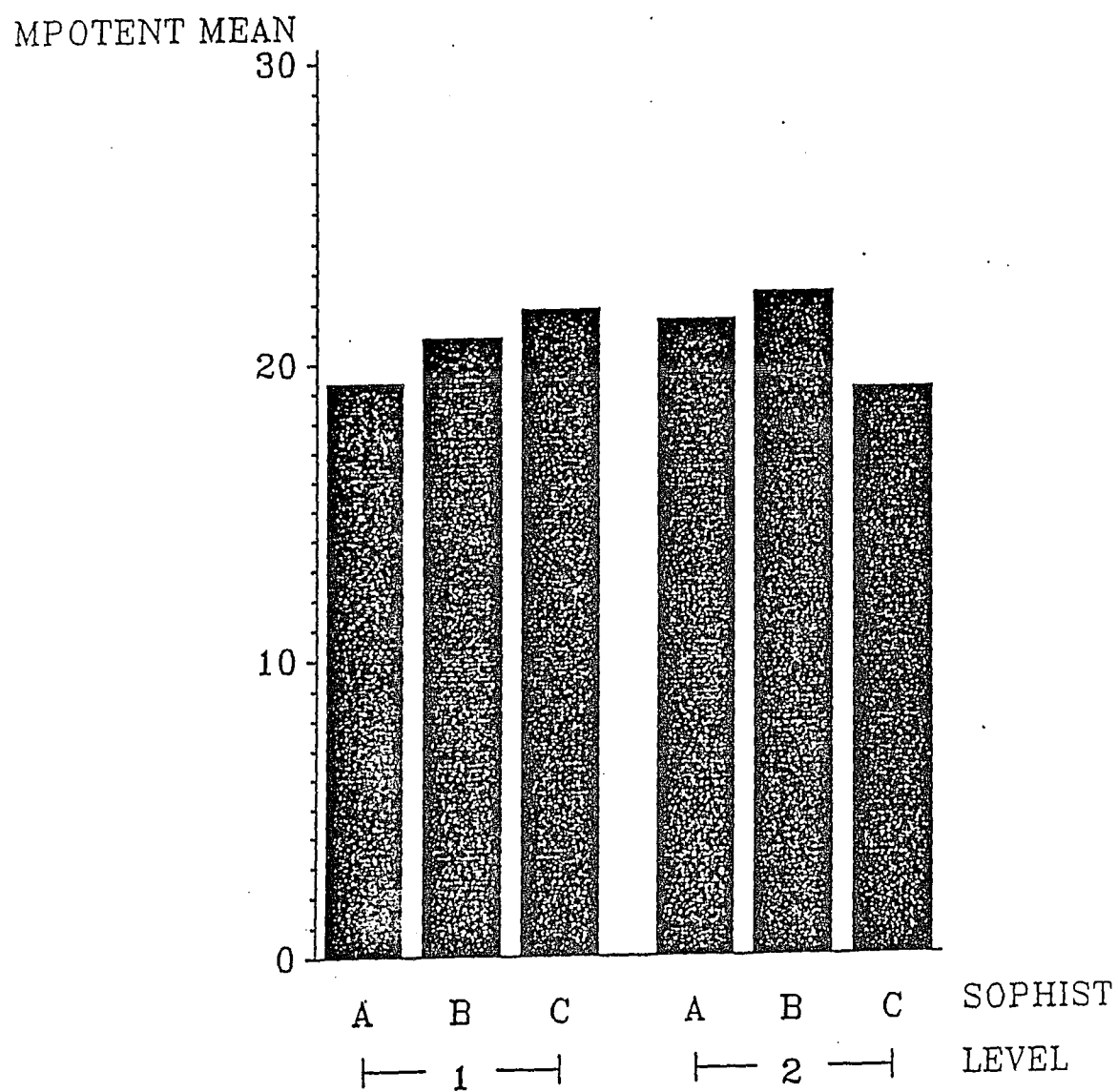


Figure 13. Bar Chart of MPOTENT by Sophist*Level

Table 13

Analysis of Variance: MACTIVE

Dependent Variable: MACTIVE

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	345.26154717	69.05230943	9.77	0.0001
Error	336	2375.71213704	7.07057184		
Corrected Total	341	2720.97368421			
	R-Square	C.V.	Root MSE	MACTIVE Mean	
	0.126889	10.92368	2.65905469	24.34210526	

Source	DF	Type I SS	Mean Square	F Value	Pr > F
LEVEL	1	10.86469406	10.86469406	1.54	0.2160
SOPHIST	2	115.29651399	57.64825700	8.15	0.0003
LEVEL*SOPHIST	2	219.10033911	109.55016956	15.49	0.0001

Source	DF	Type III SS	Mean Square	F Value	Pr > F
LEVEL	1	5.15800967	5.15800967	0.73	0.3937
SOPHIST	2	106.77606217	53.38803109	7.55	0.0006
LEVEL*SOPHIST	2	219.10033911	109.55016956	15.49	0.0001

	Help Seeker a	Health Care Addict b	MSBP c	
Low Level 1	23.8269	24.9831	24.6508	24.5172
High Level 2	25.5500	24.6364	22.5313	24.1607
	24.7500	24.8350	23.5800	24.3421

Cell	N
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

MACTIVE: Several significant differences emerge in the pediatricians' SD scores on the dimension of activity as can be seen on Table 13 (page 228).

Overall, level, sophistication and their interaction accounted for 12.69% of the variance in pediatricians' responses. Level accounted for only 0.19%. Sophistication accounted for a unique 3.92%. The interaction accounted for 8.05%.

No effect is observed for level.

Main effects are observed for sophistication and (the stronger effect) for the interaction between level and sophistication.

At level 1, no significant differences are observed between the three cases. (See Appendix F).

At the higher level 2, the HS mother (2a) is the least active, the HCA mother (2b) is slightly (but not significantly) more active and the MSBP mother (2c) is the most active. See Figure 14 (the Bar Chart for MACTIVE, page 231).

An unpredicted finding is that pediatricians rated the low intensity Help Seeker (1a) as having the same level of activity as the high intensity MSBP mother (2c).

Thus, for all three dimensions on the mothers' SD scales, the interaction consists of the same pattern of pediatricians' ratings: At low levels of intensity, the

Help Seeker is seen as the most potent and the most active of the parents. At high levels of intensity, the MSBP mother is seen as the most potent and the most active of the parents.

These findings will be compared with the findings for the baby SD ratings in the Conclusions section.

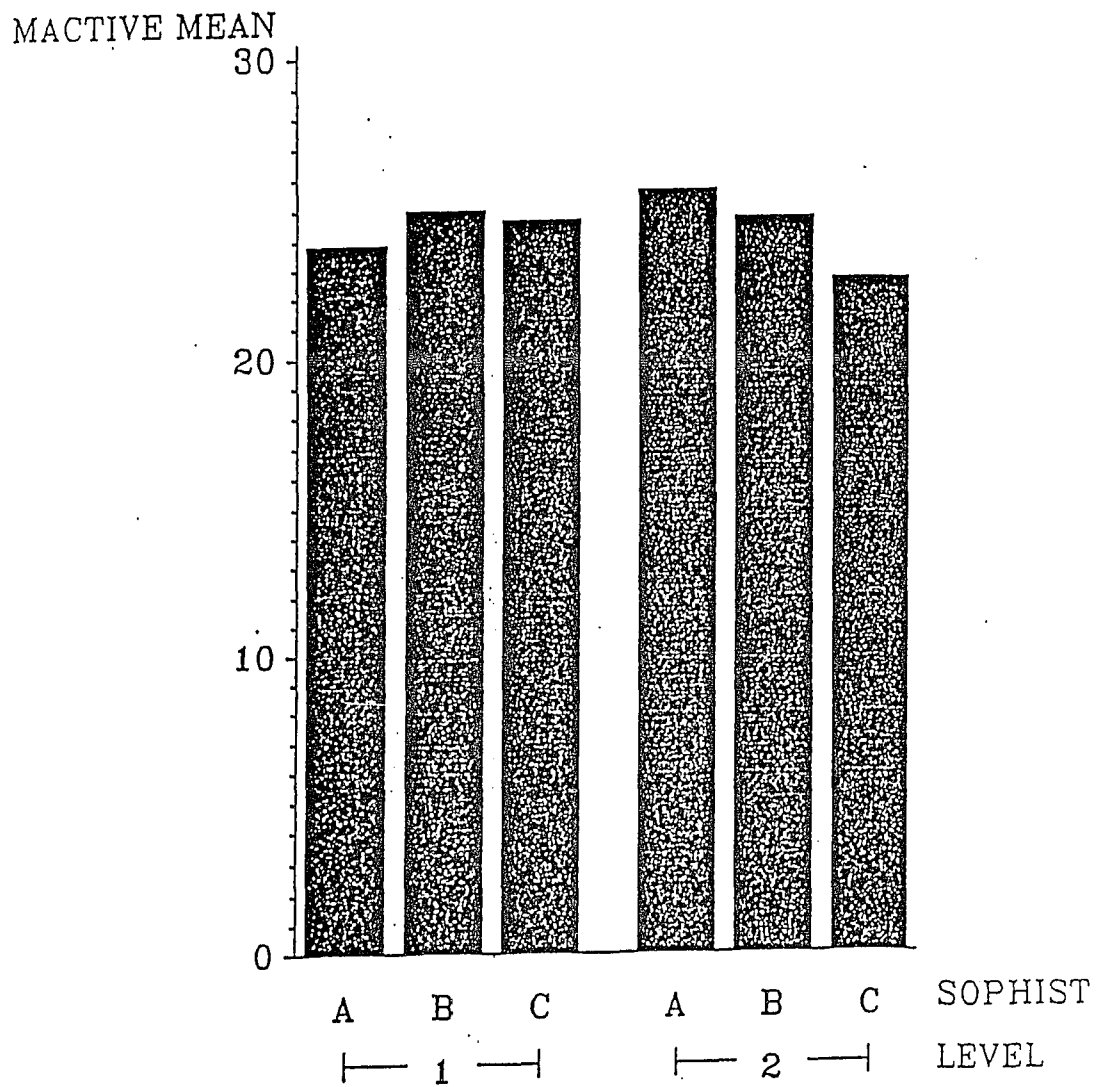


Figure 14. Bar Chart of MACTIVE by Sophist*Level

Hypothesis 2 stated that pediatricians are for the most part unwilling to report cases of MSBP, that is: pediatricians will stigmatize the child victim of MSBP instead of the adult perpetrator.

Seven-step SD scales were utilized to measure the "attitudes" of pediatricians toward the parents in each of the case vignettes along the 3 dimensions of value (good vs. bad,) potency (strong vs. weak) and activity (active vs. passive). The Bar Chart that follows (Figure 15, page 234) offers a composite presentation of the findings of this study for all 3 dimensions.

On the dimension of value, Ss have greatly devalued all 6 mothers (relative to their attitudes on the dimensions of potency and activity). However, the high intensity case of MSBP (2c) and the low intensity case of HS (1a) were less devalued than the other mothers.

On the dimension of potency, all of the parents were perceived by pediatricians as being very strong. It is important to note, however, that overall, these mothers were perceived as being only (approximately) half as potent as their 6 month old babies (see Figure 11, page 219).

At low levels of intensity, Ss perceived the HS mother (1a) as the most potent, the HCA mother (1b) as less potent and the MSBP mother (1c) as the least potent.

At higher levels of intensity, the MSBP mother (2c) is

perceived as the most potent, the HS mother (2a) as less potent, and the HCA mother (2b) as the least potent.

On the dimension of activity, all 6 mothers received low ratings.

Although no significant differences emerged at Level 1, at Level 2, the HS mother (2a) is perceived as the most active, the HCA mother (2b) is less active and the MSBP mother (2c) is perceived as the least active. Indeed, Ss perceived the high intensity MSBP mother (2c) and the low intensity HS mother (1a) at similar levels of activity.

It is interesting to note that when comparing pediatricians' overall perceptions, mothers and babies in all 6 cases received very similarly (low) activity ratings.

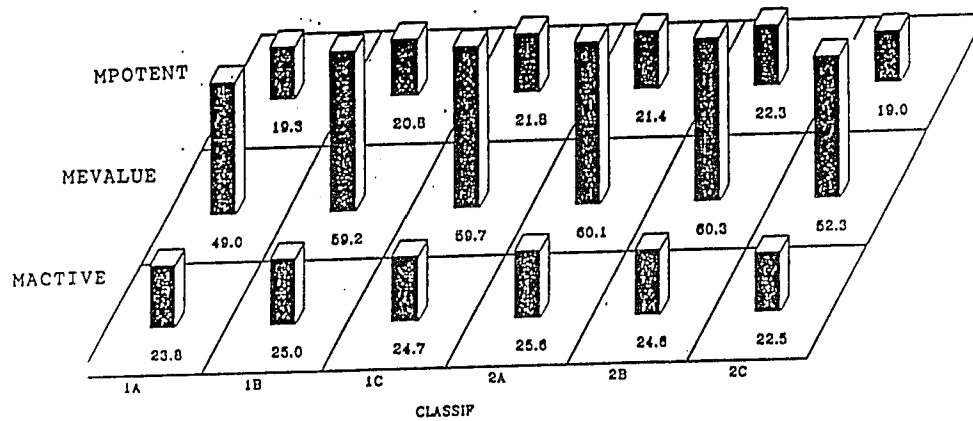


Figure 15. Bar Chart of MEVALUE, MPOTENT, MACTIVE by Sophist*Level

A reference table of the Dependent Variables and the R^2 s accounted for by each of the Independent Variables has been prepared to supplement the reader's understanding of the overall results of this study. This table appears on page 236.

The Dependent Variables are ordered in decending order of the R^2 s accounted for.

Table 14

²
Percent of Variance (R) in Each Dependent Variable
Accounted for Uniquely by Each Independent Variable

<u>Variable</u>	<u>² R Overall</u>	<u>² R Level</u>	<u>² R Sophistication</u>	<u>² R Interaction</u>
MEDREFER	32.10	1.23	20.80	9.41
TOTREFER	31.94	4.65	23.94	3.13
MEVALUE	19.02	0.63 [*]	4.46	14.77
MHREFER	16.77	7.88	5.90	2.76
CRJREFER	12.85	5.59	5.68	0.74 [*]
MACTIVE	12.69	0.19 [*]	3.92	8.05
MPOTENT	10.26	0.10 [*]	2.07	8.60
BEVALUE	9.16	2.25	2.98	4.57
BPOTENT	5.56	0.92	3.85	0.42 [*]
BACTIVE	2.70 [*]			

^{*}
Not Significant.

(4)

MSBP-Specific Questions: This section of the Questionnaire began with the following statement:

Munchausen Syndrome By Proxy represents child abuse in the medical guise. It involves a sophisticated adult who carefully fabricates the symptoms of disease in a child and then inflicts pernicious abuse upon the child through the diagnostic and treatment facilities of the health care system. (See Appendix C).

Ss were asked to reconsider their cases in light of this information and respond to a series of 14 questions.

There were no responses to Questionnaires from cells 1a (HS) and 1b (HCA). None of the usable Questionnaires from the remaining cells contained complete responses to the 14 questions (see page 176). Some Ss from cells 1c, 2a, 2b and 2c left this section blank, other responses ranged from answering one or two questions to answering as many as five or six of the questions. Few Ss, however, responded to the same questions.

There were insufficient Ss responses for comparison.

Part IV

Discussion

Chapter 16:

Conclusions.

Munchausen Syndrome By Proxy (MSBP) involves the interaction of a parent who willfully distorts the medical condition of a child, presenting him/her for treatment with factitious symptomatology and a pediatrician who is coopted into providing (or making referrals to other providers for) excessive and unnecessary invasive diagnostic and treatment protocols for the child.

This study was designed to investigate the role of the pediatrician in MSBP.

It was hypothesized that: (1) due to the blurring of 3 distinct categories of adults (the Help Seeker (HS,) the Health Care Addict (HCA) and the MSBP parent) who bring children into the health care system, pediatricians will be unable to differentiate the criminal nature of MSBP abuse from the pathetic or misguided "disorders" of mothering; and, that: (2) pediatricians will be unwilling to report incidents of MSBP to the appropriate authorities within the criminal justice system because they perceive the MSBP perpetrator as a "good" and well-intentioned person.

A pediatrician who recognizes or suspects a case of child abuse is required to act on behalf of the child. In

the case of MSBP, a pediatrician who becomes aware that a child is being victimized in the medical guise, would be expected to desist from further subjecting the child to unwarranted medical procedures. The pediatrician in this case would also be expected to report this abuse in the medical guise to the appropriate authorities within the criminal justice system.

This study investigated the responses of pediatricians to 6 case vignettes (see Appendix A) involving parents/ mothers who brought their infants to the hospital for emergency care. Each of these cases differed according to the intensity and sophistication of the parent/mother's description of her 6 month old baby's condition.

Libow and Schreier (1986) presented 3 categories of disordered interactions between a mother and a pediatrician. In ascending order of sophistication, these included: the mother who is a pathetic Help Seeker (HS,) the mother who is an aggressive Health Care Addict (HCA) and the MSBP mother. The 6 case vignettes for this study were designed to provide a low intensity as well as a high intensity case for each of Libow and Schrier's (3) mother-pediatrician interactions.

Hypothesis 1:

This hypothesis stated that pediatricians will be unable to "recognize" MSBP, that is, pediatricians will be

unable to differentiate between Help Seeking, Health Care Addiction and MSBP. They will not single out the MSBP cases: They will not refuse to make the excessive number of medical referrals (MEDREFERS) that define the MSBP condition. They will not treat the MSBP cases any differently than cases of serious genuine medical disorders. They will make excessive numbers of mental health referrals (MHREFERS) in lieu of criminal justice referrals (CRJREFERS) for the MSBP cases. They will make comparable numbers of CRJREFERS in all 6 cases.

Ss (who were all practicing pediatricians) were given Questionnaires that asked them to develop treatment protocols for the baby in the case that they received. They were provided with a checklist of potential referrals as well as ample space to add any additional referrals that they might wish to make on their own initiatives (see Appendix B).

The variable TOTREFER represented the total number of referrals made in each of the cases. This variable is instructive, because it indicates the amount of total involvement that the pediatrician was prepared to dedicate to each particular case.

When Emergency Room (hereafter ER) pediatricians treat very mild or straightforward cases of malingering, conversion behaviors, or factitious illnesses, they will generally exhibit the most minimal or perfunctory

involvement. They will make few (if any) referrals. In contrast to their minimal involvement with malingerers, when ER pediatricians are asked to treat more complex and manifestly "medical" cases, they are generally expected to exhibit greater involvement with the patient and her/his case.

The results of this study indicated that Ss have devoted the most attention to the MSBP cases at each level. Moreover, they have devoted more attention to the more intense MSBP case than to the less intense MSBP case. These findings in and of themselves neither confirm nor disprove the author's hypothesis because TOTREFER is the composite of all referrals and as such does not indicate the nature of the referrals being made. Thus, if much of the TOTREFER was accounted for by uniquely MSBP criminal justice referrals (CRJREFERS,) then the author would have to conclude that pediatricians were actually able to recognize the MSBP parent/mother's presenting complaint as factitious. In the alternative, if much of the TOTREFER was accounted for by medical referrals (MEDREFERS,) the author would be able to demonstrate that Ss in this study were unable to recognize MSBP. Indeed, excessive numbers of MEDREFERS for the MSBP cases would indicate indicate that the pediatrician has actually been coopted into the triangle of child abuse in the medical guise.

The most important aspect of the TOTREFER results was the fact that (overall) pediatricians were treating the low level MSBP case (1c) and the high level Help Seeking case (2a) in an almost identical fashion (see Figure 1, page 188). This finding serves to support in a broad way, the hypothesis that a general confusion exists in the recognition of MSBP. It demonstrates that pediatricians were not able to broadly differentiate (in their overall responses) between low levels of child abuse in the medical guise and high levels of Help Seeking.

The variable MEDREFER accounted for the total number of medical referrals that each Ss made for her/his case. In order to evaluate whether or not pediatricians are able to recognize cases of MSBP, it is important to examine whether they proceed to subject the infant in their case to continued medical interventions or whether they refuse to make medical referrals because they recognize that the case before them does not really warrant these referrals.

The pediatrician who recognized a case of MSBP would be expected to make about the same number of medical referrals for this case (very few, if any) as for the HS and HCA cases. The results of this study indicated that at low levels of intensity, there were no significant differences in MEDREFERS for the HS (1a,) HCA (1b,) or MSBP (1c) cases.

They all received similar numbers of referrals. This finding indicates that, in fact, at low levels Ss did recognize that the MSBP infant did not really require extensive medical intervention. Whether Ss actually recognized that the MSBP infant (1c) (who did not require any more medical intervention than the HS infant (1a) or the HCA infant (1b)) was in fact the victim of child abuse in the medical guise can be determined from comparisons of the MEDREFER results with the results for CRJREFER.

At high levels of intensity, Ss made vastly greater numbers of MEDREFERs for the MSBP case (2c) than for either of the other two cases (2a and 2b). (See Figure 3, page 193). The MEDREFER scores mirror the TOTREFER scores for the high intensity MSBP case (2c).

These results provide significant support for the hypothesis that pediatricians are unable to recognize MSBP.

Ss who made the excessive number of MEDREFERs for the high intensity MSBP case vignette (2c) in this study have essentially replicated the behavior of pediatricians who unwittingly become part of the real life MSBP triad.

The variable MHREFER represents the mental health and social service referrals that Ss made for each case. It was hypothesized that pediatricians who failed to recognize cases of MSBP as criminal cases of child abuse,

would make excessive numbers of mental health referrals for these cases (in lieu of criminal justice referrals).

At low levels of intensity, no significant differences emerged between cases 1a and 1b. Case 1c received significantly more MHREFERS than 1a and 1b. Thus, for case 1c (the low intensity MSBP case,) pediatricians are not making the characteristic MSBP medical referrals, but they are making the excessive MHREFERS that would support the author's hypothesis. These findings will be compared with the CRJREFER results.

It is interesting to note that the MHREFER results mirror the TOTREFER results for cases 1c (low intensity MSBP) and 2a (high intensity HS). That is, these two cases are receiving similar numbers of MHREFERS.

The specific results for MHREFER are instructive beyond the general results of TOTREFER because, at high levels of intensity, no significant differences emerged between the MHREFERS for the 3 cases. Thus, while the 3 high intensity cases received a greater number of combined MHREFERS than the 3 low intensity cases, it is important to recognize the fact that cases 1c, 2a, 2b, and 2c all received similar numbers of mental health referrals.

These results neither confirm nor disprove the author's hypothesis. They are only significant in comparison with the number of CRJREFERS that Ss make for these cases.

CRJREFER represents the number of criminal justice referrals that Ss made for each of the 6 cases. As with the MHREFERS, the combined number of CRJREFERS was higher for the high intensity cases than for the low intensity cases. For CRJREFERS, however, no significant differences emerged by sophistication. (See Figure 6, page 203).

At low levels of intensity, cases 1a (HS) and 1c (MSBP) received similar numbers of CRJREFERS, (while case 1b (HCA) received no CRJREFERS at all). These results are consistent with the author's hypothesis (as stated on page 238).

It is now possible to draw some conclusions about the way that Ss responded to the low level case of MSBP (1c). On the whole, pediatricians devoted more attention and made more referrals for this case than for the other low level cases. The fact that these referrals were not overwhelmingly MEDREFERS (and that Ss did not make more MEDREFERS for 1c than for 1a or 1b) demonstrates that pediatricians must have been aware on some level of the factitious nature of the low level MSBP parent/mother's presenting complaint.

While we may conclude that pediatricians recognized some factitious quality in the 1c case, it is not clear that they "recognized" this factitious quality in a criminal (child abuse) context. For, although Ss did make some CRJREFERS for case 1c, they made almost equal numbers of CRJREFERS for case 1a (the pathetic HS case).

Given these results, it would not be possible to

conclude that pediatricians were making MHREFERS in lieu of CRJREFERS for the case of 1c.

Ss made more MHREFERS for case 1c than for cases 1a and 1b. However, these MHREFERS are about the same in number as the MHREFERS for each of the higher intensity cases 2a, 2b and 2c. It is possible to conclude from these results that on some level, cases 1c, 2a, 2b, and 2c all represented "problems" for the ER pediatrician. The boundaries of these distinct cases have been blurred, so that pediatricians are unable to effectively distinguish between these various "problems," and thus, simply make similar MHREFERS for all of them.

The long form of hypothesis 1 (page 153) stated that pediatricians are for the most part unable to recognize MSBP because they have not been prepared to effectively distinguish between the cases of the HS, the HCA and the MSBP. Pediatricians will therefore perceive MSBP as a "mothering disorder" rather than as a criminal act.

The results of this study support the notion that pediatricians do not clearly recognize low intensity cases of MSBP as criminal child abuse. While they may detect a factitious note in the parent/mother's presenting complaint, and, while they may therefore adopt a more conservative medical treatment protocol (than that which was hypothesized,) pediatricians treated this low intensity MSBP

case as a mental health "problem" or "mothering disorder," by making essentially the same (undifferentiated) MHREFERS as they made for all of the other "problems" or "mothering disorders" in cases 2a, 2b, and 2c.

At high levels of intensity, the MSBP case (2c) was treated with a somewhat different approach. Pediatricians exhibited the most interest and devoted the most time to this case based upon their TOTREFER responses. Unlike case 1c (low intensity MSBP,) however, pediatricians who examined case 2c (high intensity MSBP) did not perceive the factitious quality of the parent/mother's presenting complaint. In place of the diagnostic and prescriptive restraints that were exhibited with case 1c, pediatricians appear to have unwittingly become integral parts of the MSBP triangle for case 2c.

It is not possible for the researcher to draw conclusions from either the MHREFERS or the CRJREFERS beyond the fact that pediatricians were not distinguishing between pathetic Help Seeking (2a) and criminal child abuse (2c) for either referral.

In addition to the results that have been presented, several interesting artifacts emerged from the data. The reader will note that Chapter 15 contains a series of Bar Charts for each variable. These Bar Charts have been

utilized to demonstrate that in some cases the pediatricians responded to MSBP as an extension (or as a more severe form) of Help Seeking, while in other cases, pediatricians responded to MSBP as an extension (or as a more severe form) of Health Care Addiction.

While these results are interesting, they are ancillary¹ to the focus of this Dissertation. The entire field of inquiry into the subtleties of the pediatrician--parent interaction is currently in its embryonic stages.

Professor Judith Lorber (a medical sociologist) of Brooklyn College and the Graduate Center of the City University of New York, explained (in a telephone communication, May, 1995) that we do not yet have a formidable literature in this area.

A unique quality of this Dissertation is the potential of its contribution not only to the field of criminal justice, but also to the fields of medical sociology and pediatrics. The results generated by this study may be utilized in the future to complement other research agendas.

1

As the literature in this field does not provide the researcher with sufficient background to draw conclusions about these artifacts (and, moreover, as these artifacts do not serve to either enhance or to detract from the conclusions that the researcher has drawn from the data,) they will not be discussed here.

Hypothesis 2:

This hypothesis operates within the "just world" context (Lerner, 1971) where victims are blamed for their own misfortunes. It stated that pediatricians will make subjective decisions about each of the 6 cases that are based upon their personal perceptions of the mother and the baby in each case.

In order for a pediatrician to report a case of child abuse s/he must view the parent as the perpetrator of a crime. Because pediatricians have traditionally viewed parents as being "good" and well-intentioned people, it is difficult for them to imagine that the parents of their patients could be criminals.

The author hypothesized that pediatricians will rationalize their unwillingness to come to terms with the notion of the abusive parent by stigmatizing the child. That is, they will imply that it is not so much the parent, but the "bad" child who is responsible for anything unusual or irregular that may have happened to her/him.

The results for MEDREFER supported the author's first hypothesis that pediatricians would be unable to "recognize" MSBP as a crime. Under normal circumstances, any pediatrician who would recognize the abuse of the MSBP child, would (at the very least) desist from further harming the child with additional medical interventions.

The pediatrician who would recognize MSBP and distinguish it from Help Seeking and Health Care Addiction would respond with an objective diagnostic decision. S/he would make few, if any further medical referrals, as these would not be warranted.

The author proposed to quantify the objective diagnoses of pediatricians in terms of the number of medical referrals that they would make for a particular child. A pediatrician who recognized MSBP would refrain from participation in the MSBP triangle by not making medical referrals. A pediatrician who failed to recognize MSBP would make the numerous medical referrals that were characteristic of an ongoing unrecognized MSBP case.

At low levels of intensity, the analysis of pediatricians' objective medical referrals indicated that they recognized some factitious quality in the MSBP case. They did not go so far, however, as to recognize the criminal aspects of child abuse in this case.

At high levels of intensity, however, the analysis of Ss objective medical referrals indicated that pediatricians did not recognize MSBP. In fact, they participated in the MSBP triangle by making the numerous medical referrals that would be characteristic of an actual unrecognized MSBP case.

The variable CRJREFER provides a bridge between Hypothesis 1 and Hypothesis 2. Hypothesis 2 stated that

pediatricians would be unwilling to "report" cases of MSBP because they would perceive the MSBP perpetrator as a "good" and well-intentioned person who does not commit crime.

The results for CRJREFER supported the author's hypothesis that MSBP cases are not reported to the criminal justice system with greater frequency than the HS or HCA cases (that should not be reported at all). While these findings are relevant to our understanding of Ss objective decisions of pediatric protocol, they are also relevant to our understanding of the subjective aspects of pediatricians' decisions.

The pediatricians in this study did not make significantly more CRJREFERS for the MSBP cases than for the HS and HCA cases. Hypothesis 2 addressed the question of why pediatricians would be unwilling to make these criminal justice referrals for the MSBP cases.

The author hypothesized that pediatricians would be unwilling to report cases of MSBP to the appropriate authorities within the criminal justice system because they would perceive the MSBP perpetrator as a "good" and well-intentioned person who would not commit the crime of child abuse.

When a competent pediatrician examines an MSBP baby, s/he has several options. In order to reconcile any manifest discrepancies between the MSBP parent's report about her

infant's condition and the pediatrician's objective medical findings upon examination, the pediatrician will either suspect that the parent is making some form of mendacious report, or inhibit such suspicions by paying more attention and giving greater credibility to the MSBP mother's report than s/he would to the reports of other parents.

The pediatrician who is suspicious of the MSBP parent, may be willing to act upon those suspicions by reporting this case to the appropriate agencies within the criminal justice system. Or, the author hypothesized, the pediatrician may instead consider the possibility that extenuating circumstances such as the difficulties (that may be) inherent in handling a "bad" baby mitigate the requirements for mandated reporting. In the latter case, the pediatrician may give the MSBP parent great latitude by referring to the mental health system for empathic assistance with "mothering" a "bad" baby, rather than referring to the criminal justice system on charges of criminal child abuse.

In fact, at low levels of intensity, pediatricians did recognize the factitious qualities of the MSBP case. They did desist from making excessive medical referrals. They did overwhelmingly refer the MSBP cases to the mental health system. They were unwilling to report to the criminal justice system.

Hypothesis 2 stated that this unwillingness of pediatricians to report MSBP to the criminal justice system may be attributed to the stigmatization of the MSBP baby. That is, the MSBP mother would be treated gently because the blame for her actions would be attributed to the "bad" baby.

At high levels of intensity, pediatricians did not recognize the factitious qualities of the MSBP case. They did not desist from making excessive medical referrals. They did participate in the further abuse of the child. They were unwilling to report to the criminal justice system.

Hypothesis 2 further attributed these findings to the stigmatization of the MSBP infant. It proposed that pediatricians could subjectively decide to ignore the evidence of MSBP abuse if they were able to view the MSBP mother as "good"² and her infant as "bad"³ and somehow deserving of her fate.

Support for Hypothesis 2 would derive from a comparison of pediatricians' subjective perceptions of the MSBP mother with pediatricians' subjective perceptions of the MSBP baby.

²

That is, just as good as the other mothers.

³

That is, worse than the other infants and perhaps somewhat "guilty" for what has occurred.

Under normal circumstances, the author anticipated that a pediatrician would evenly evaluate her/his pediatric patient and this patient's parent. The pediatrician could be expected to view both the parent and the baby as "good" (or at the very least as not "bad") people. S/he would treat them both as being valued.

In cases of child abuse, however, the pediatrician must adjust her/his perceptions of the parent and the child. If the pediatrician decides to report a case of suspected child abuse, what s/he is actually doing is subjectively attributing more negative qualities to the abusing parent, while attributing "good" qualities to the victimized baby. The parent now deserves punishment (because she is a criminal child abuser), while the baby deserves relief.

In the alternative, if the pediatrician decides not to report a case of suspected child abuse, what s/he is actually doing is subjectively attributing "good" qualities⁴ to the abusing parent, while attributing negative qualities to the victimized baby. The parent now deserves relief and⁵ assistance, while the baby deserves whatever s/he gets.

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In order to allow them to perceive the abusing parent as equivalent to all other parents.

5

Any "good" parent who has a "bad" child deserves relief and assistance.

Ss were asked to complete seven-step Semantic Differential Scales for the mother and the baby in the cases that they had diagnosed for Hypothesis 1. Ss responses were measured on dimensions of evaluation (good vs. bad), potency (strong vs. weak), and activity (active vs. passive).

If Ss would recognize MSBP and be willing to report it, then, they would evaluate the MSBP mothers as the worst of all mothers and the MSBP babies as the same as all of the other babies.

Support for Hypothesis 2 would thus derive from the following: On the dimension of evaluation, the MSBP mothers would receive the same SD ratings as the other mothers, while the MSBP babies would receive the (highest) most negative SD ratings of all of the babies.

The high intensity MSBP mother would be the same as the low intensity MSBP mother. The high intensity MSBP baby would be seen as even worse than the low intensity MSBP baby.

On the dimension of potency: No differences would emerge between the strengths and weaknesses of the MSBP mothers and those of the other mothers. These distinctions would be blurred.⁶

The MSBP babies would be perceived as the same as the
other babies.⁷

On the dimension of activity: the MSBP mothers would
be perceived as the same as other mothers.⁸

The MSBP babies would be perceived as having more power and responsibility for the outcomes of their cases. They would be seen as active perpetrators (low SD scores) who are somehow responsible for their own situations.

The results for Hypothesis 2 are presented by dimension. For the dimension of evaluation, the variable BEVALUE represents Ss evaluations of the baby in their case vignette. The variable MEVALUE represents Ss evaluations of the mother of that baby. The findings for each variable are presented and then BEVALUE and MEVALUE are compared.

For the dimension of potency, the variable BPOTENT represents Ss SD ratings of the potency of the baby in their

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Apart from some foreign substances which were alleged to have originated in their ears, the MSBP babies in the case vignettes have not yet been severely abused in the medical guise. Therefore, there is no objective reason for the pediatrician to view these babies as being any less potent than the 6 month old HS and HCA babies. On the subjective level, however, Ss may view the MSBP babies as victims who (are less potent than the other babies because they) are not potent enough to defend themselves against an abusing parent.

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The activity levels of the mothers in the 6 case vignettes will be discussed in Chapter 17.

case vignette. The variable MPOTENT represents Ss ratings of the potency of the mother of that baby. The findings for BPOTENT and MPOTENT are presented and then BPOTENT and MPOTENT are compared.

For the dimension of activity, the variable BACTIVE represents Ss SD ratings of the activity of the baby in their case vignette. The variable MACTIVE represents Ss ratings of the activity of the mother of that baby. The findings for BACTIVE and MACTIVE are presented and then BACTIVE and MACTIVE are compared.

Evaluation:

BEVALUE measured pediatricians' evaluations of the babies in the 6 case scenarios. Seven-step SD scales included descriptives such as good--bad, cute--monstrous, victim--perpetrator and innocent--guilty, etc.

At low levels of intensity, the author's hypothesis appears to be upheld. The MSBP baby (1c) is the most devalued ($\bar{X}=3.90$) of the three babies. The HCA baby (1b) was less devalued ($\bar{X}=3.57$) and the HS baby (1a) was least devalued ($\bar{X}=3.21$). The differences between 1a and 1b were not significant. (See Appendix F, for 7-Point Scale Means).

At high levels of intensity, no significant differences emerged between Ss SD ratings for babies 2a ($\bar{X}=3.39$), 2b ($\bar{X}=3.24$) and 2c ($\bar{X}=3.25$).

In fact, the only significant difference that emerged

was between the low intensity MSBP baby 1c and all of the other babies. (See pages 207-210).

These results will be compared with the results for MEVALUE.

MEVALUE measured the pediatricians' evaluations of the mothers in the 6 case scenarios. Seven-step SD scales included descriptives such as good--bad, nice--awful, gentle--violent and victim--criminal, etc.

At low levels of intensity, the (1a) HS mother received a slightly better evaluation ($\bar{X}=3.50$) than the (1b) HCA ($\bar{X}=4.23$) and (1c) MSBP ($\bar{X}=4.26$) mothers.

At high levels of intensity, the (2a) HS mother ($\bar{X}=4.29$) and the (2b) HCA mother ($\bar{X}=4.31$) received about the same ratings as the low level (1b) HCA and (1c) MSBP mothers. The (2c) high level MSBP mother ($\bar{X}=3.73$) received a better rating than the other mothers at her level. In fact, the high level MSBP mother (2c) and the low level HS mother (1a) received similar ratings.

Pediatricians were given some objective information that would clue them in to the potential abuse in the MSBP cases 1c and 2c. Yet, the high intensity MSBP mother (2c) who is in fact perpetrating a sophisticated and potentially pernicious form of child abuse was perceived as similar to the low level pathetic HS mother (1a).

Support for the author's hypothesis derives from the fact that Ss rated the MSBP mothers, HCA mothers and HS

mothers similarly on the dimension of evaluation. Moreover, the results of this study indicated that Ss viewed the high level MSBP mother as the best of all mothers.⁹

In fact, pediatricians appear to be treating the MSBP cases as routine ER cases that require medical intervention. At high levels of intensity, the MSBP baby (2c) is the same as all of the babies. She is neither particularly good nor bad. Her mother, though, is slightly better than the other mothers.¹⁰

This finding is congruous with the findings for Hypothesis 1, where pediatricians made excessive numbers of medical referrals for the high level MSBP case (2c). Ss appear to be unwittingly participating with this "good" mother in the medical abuse of her child.

At low levels of intensity, the author's hypothesis was

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This conclusion transcends and amplifies the author's hypothesis in that it serves to highlight the confusion of pediatricians when confronting cases of child abuse in the medical guise.

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In Chapter 17, the author will present a theoretical discussion of why pediatricians may view the MSBP mother (2c) as the best of all mothers.

The author will assert that this "better" perception of the high level MSBP mother (2c) is grounded in more than her providing the ER staff with complementary coffee and donuts. In fact, the low level MSBP mother (1c) also provided the ER staff with coffee and donuts (see Appendix A) and these gratuities do not appear to have had the same positive impact upon Ss perceptions of her value.

upheld. Ss perceived the MSBP mother (1c) as essentially the same as all of the other mothers. They perceived the MSBP baby (1c) as the worst of all of the babies.

Merging the findings of Hypothesis 1 with the findings for Hypothesis 2, the author notes that Ss did not make large numbers of medical referrals for the (1c) low level MSBP case. They were not willing to go along with the mother's report and subject the infant to abuse in the medical guise.

In fact, it is almost as if the pediatricians who examined this case were implying that "Baby Lisa" had somehow (on her own, perhaps inadvertantly) gotten hold of her mother's menstrual fluid and touched it to her ear. In this scenario, the baby could be perceived as slightly naughty (but not very bad), the mother could be perceived as ordinary and the entire issue of child abuse need not be confronted.

Were "Baby Lisa" a toddler or an older child who was mobile enough to somehow get into her mother's trash, this might be a plausible view. However, because "Baby Lisa" is only 6 months old (and not likely to have access to the trash unless she is being neglected and left in dangerous places), Ss responses to her case are indicative of a significant problem in the way that pediatricians have come to perceive MSBP babies.

Potency:

BPOTENT measured pediatricians' subjective ratings of the potency of each of the 6 babies described in the case scenarios. Seven-step SD scales for potency, included descriptives such as healthy--sick and whole--damaged, etc.

None of the babies were perceived as "whole." It is interesting to note that pediatricians rated all 6 babies as being moderately potent. That is, (with a mean score of 3.56 on the 7-step SD scales), they were all perceived as being more healthy than sick and more whole than damaged. No significant differences emerged between Ss perceptions of the potencies of any of the babies.

These results support the author's hypothesis. Yet, they are disturbing in the sense that pediatricians who examined totally healthy babies rated them (overall) as being less whole than they objectively were.¹¹ It is important to note that these results are cause for further concern when examined together with Ss MEDREFER scores for Hypothesis 1.

The BPOTENT scores indicated that pediatricians neither perceived the "Baby Lisas" in the 6 case vignettes as

¹¹

The author initially anticipated that healthy babies would score between 1.00 and 2.00 on seven-step SD scales for potency.

"whole," nor did they see the infants as being in need of serious medical interventions. Yet, Ss whose BPOTENT scores indicated that they regarded the high intensity MSBP case (2c) as no less potent (healthy) than any of the other babies, nevertheless made excessive medical referrals exclusively for this baby.

These findings will be compared with the results for MPOTENT, BACTIVE and MACTIVE.

MPOTENT measured pediatricians' subjective ratings of the potency of each of the 6 mothers described in the case vignettes. Seven-step SD scales for potency, included descriptives such as healthy--sick, strong--weak and normal--crazy.

Although the author hypothesized that no significant differences would emerge between pediatricians' ratings of the potencies of the 6 mothers, some differences did emerge.

At low levels of intensity, the (1a) pathetic HS mother ($\bar{X}=3.87$) was the most potent, the (1b) HCA mother ($\bar{X}=4.17$) was slightly less potent and the (1c) MSBP mother ($\bar{X}=4.36$) was about the same as the (1b) HCA mother.

At high levels of intensity, the results present a reversal of the results for the low intensity cases. The (2c) MSBP mother ($\bar{X}=3.81$) was the most potent. She was perceived as similar to the low level (1a) HS mother. The (2b) HCA mother ($\bar{X}=4.45$) and the (2a) HS mother ($\bar{X}=4.28$) were seen as slightly less potent (and almost the same as

the (1b) low level HCA and (1c) MSBP mothers).

Two sets of checks and balances were built into the Questionnaire in order to measure the consistency of Ss responses. The first, involved the connection of MPOTENT and BACTIVE with MHREFER and the second, involved the connection of BPOTENT with MEDREFER.

The author's entire thesis is based upon the notion that pediatricians have received poor and ineffective professional preparation that renders them incompetent to recognize and deal with cases of child abuse in the medical guise (Hoagberg & Federson, et. al., 1982; Jones, 1987; Kim, (undated) & Kaufman & Coury, et. al., 1989). The various categories of non-criminal "mothering disorders" have been confused with criminal child abuse. Pediatricians will therefore experience dissonance between the objective diagnosis of the child and a variety of subjective factors that may impose upon that diagnosis. This dissonance will most often be resolved to the detriment of the abused child.

Under optimal circumstances, the pediatrician who observed a "sick" mother or even a "well" mother who is struggling with a hyper-active child, might be expected to make a referral that would provide the mother with some form of assistance. In this study, the only referral available for the mother was the mental health referral.

Similarly, under normal circumstances, the pediatrician who observed a "sick" baby would be expected to treat the

baby in some way. In this study, numerous medical options were made available to the pediatrician.

The results of this study indicate that the subjective evaluations of pediatricians do not comport with their objective diagnoses of the 6 cases presented to them. In fact, when comparing the results for Hypothesis 1 and Hypothesis 2, there appears to be no correlation between pediatricians' perceptions of the (potency) physical and mental health of the mothers in the 6 case vignettes and the mental health referrals that Ss made for these cases.

Indeed, although the (2c) high level MSBP mother was seen as the most potent (healthiest?) of all of the mothers, she received more mental health referrals than any of the other mothers. These results cannot be attributed to the activity of her baby, because the MSBP baby is not perceived as being any more active than any of the other babies. (See BACTIVE below). Moreover, the (1a) low level pathetic HS mother (who was seen as equally potent (healthy) as the (2c) sophisticated high level MSBP mother) received only about one quarter as many MHREFERS as the (2c) high level MSBP¹² mother.

In considering Ss responses to the 6 babies, it is

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In Chapter 17, the author will propose an alternative reason for these mental health referrals.

important to note that there was no consistency between Ss evaluations of the potencies of the 6 babies and the MEDREFERS that they made for each baby.

Activity:

BACTIVE measured pediatricians' subjective ratings of the activity levels of each of the 6 babies described in the case scenarios. Seven-step SD scales for activity, included descriptives such as active--lethargic and playful--aloof.

No significant differences emerged between pediatricians' perceptions of the activity levels of the 6 babies. They were all perceived as moderately active.

MACTIVE measured pediatricians' subjective ratings of the activity levels of each of the 6 mothers described in the case scenarios. Seven-step SD scales for activity, included descriptives such as active--passive and controlled--accidental.

At low levels of intensity, no significant differences were observed between pediatricians' responses to the three cases.

At high levels of intensity, the (2a) HS mother was seen as the least active ($\bar{X}=4.26$), the (2b) HCA mother was slightly (but not significantly) more active ($\bar{X}=4.10$) and the (2c) MSBP mother was perceived as the most active ($\bar{X}=3.76$).

Once again, Ss rated the (1a) pathetic low intensity

HS mother as having the same attributes as the (2c) sophisticated high intensity MSBP mother. Both were perceived as similarly potent and both were perceived as similarly active.

The author hypothesized that the MSBP babies would be seen as more active than the other babies. They were not.

The author further hypothesized that the MSBP mothers would be seen as being equally as active as the other mothers. At low levels of intensity, the 3 mothers were perceived equally. At high levels of intensity, however, the MSBP mother was perceived as slightly more active than the HS and HCA mothers.

When evaluating the combined results for all of the variables analyzed for Hypothesis 2 of this study, the author noted that (overall), all of the babies were rated similarly. The combined mean scores for BEVALUE (3.45), BPOTENT (3.56) and BACTIVE (3.44) on the seven-step SD scales were almost identical. The mean scores for the mothers, MEVALUE (4.05), MPOTENT (4.14) and MACTIVE (4.06) on the seven-step SD scales were almost identical as well.

Support for the author's hypothesis derives from the fact that overall, pediatricians have not distinguished between any of the 6 cases in a meaningful way.

The author therefore concludes that pediatricians who made excessive MEDREFERS for the MSBP babies did not do so because they believed that the babies were really sick.

Having rated the MSBP babies as being as healthy as the other babies, they have removed the objective evidence of physical pathology as the cause for their referrals.

These findings comport with the long form of Hypothesis 2 (pages 154-155) in which the author asserted that the pervasive terror of malpractice litigation would cause pediatricians to over-test and over-prescribe for the MSBP cases. Pediatricians would engage in misguided attempts at parental compliance rather than invoking the dangers (of malpractice litigation that may be inherent) in challenging the credibility of the child's presenting symptoms.

In fact, Ss did not objectively find that the MSBP babies were any different (on the dimension of potency) than any of the other babies. Although Ss did not comply with the demographics portion of the questionnaire (so that it was not possible for the author to actually measure the potential impact of malpractice litigation upon their decision making processes,) the fear of malpractice litigation remains a plausible factor in their contemporary
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MEDREFER decision making.

13

It is important to note that while the problem of MSBP may significantly antedate the advent of medical malpractice litigation, the precursor of such litigation (i.e., the stigma that physicians such as Sigmund Freud feared if they

The author further concludes that pediatricians were not drawn in to the MSBP triangle because of any great admiration or affinity that they felt for the MSBP mother. All of the mothers (including the MSBP mothers) seemed to have received columns of ratings that were for the most part straight down the middle (i.e., neither good nor bad).

Schreier and Libow (1993a) are foremost amongst the theorists who have removed MSBP from the arena of criminal child abuse and relegated it instead to the psychoanalytic mystique of disordered maternal symbioses. There, it defies understanding, diagnosis and remediation.

If MSBP could be attributed to this type of fetishism, then the responses of pediatricians to this study would be indicative of their roles in such a symbiotic relationship. That is, we would anticipate that pediatricians who were enamored of the "disordered" mothers' adulations, would give them strongly positive evaluations. Pediatricians who were offended or repulsed by these mothers would rate them negatively.

The fact that all of the mothers were rated around the midline of the SD scales, indicates that pediatricians must

were to openly challenge the right of a parent to abuse a child) may represent a fundamental aspect of the pediatricians' role in MSBP that has heretofore been underrepresented.

be entering the MSBP triangle for some reason other than their responses to the alleged symbiosis of the MSBP mothers. The pediatricians neither developed strong feelings for the mothers nor against them.

MSBP has been described as a triadic interaction between a parent, a pediatrician and a child. Libow and Schreier (1993a) have advocated that we focus on the mother as the main protagonist of MSBP. In fact, it may be the pEDIATRICIAN rather than the parent who ultimately steers the course of child abuse in the medical guise.

Child abuse can take a myriad of forms involving almost infinite variations in modalities. Parents (mothers and fathers) can abuse their children in many ways, but, MSBP can only occur in the arena of medical intervention.

There are many theories of crime and criminality. They run the gamut from those who believe that any and all deviance should be penalized..., to those who believe that any and all deviance is the result of mental illness.¹⁴

Individuals who (have been taught to) believe that child abuse is an example of criminal activity will readily

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This approach posits that "normal" people are people who are not deviant from the norms of anticipated social behaviors. Therefore, anyone who commits an act of deviance (crime) is not normal.

consider the child abuser as a criminal who should be handled (punished and/or rehabilitated) by the criminal justice system. Individuals who believe that child abuse represents an example of mental illness (or deviance from the norm of mental health) will consider the child abuser as "unfortunate" or "sick" and deserving of (empathic) intervention from the mental health system.

In the United States of America, all pediatricians have been legally mandated to address child abuse as a criminal act. Indeed, according to Kalichman (1995, p. 156):

the law does not permit mandated reporters to engage in a decision-making process when there is reasonable suspicion of child maltreatment.

Child Abuse statutes clearly demand of pediatricians the view that child abuse represents a crime that must be reported to the criminal justice system.

In spite of these legal obligations, Kalichman observed that:

...surveys of professionals and an examination of cases of unreported suspected child maltreatment show that professionals do engage in decision-making processes with regard to mandated reporting. When professionals surpass a reporting threshold and choose not to report, it is usually because they are inhibited by competing concerns..., (p. 156).

Competing with criminal justice concerns are not only the variety of personal, social and political beliefs that pediatricians themselves may hold, but the emphatic concerns of liberal/ feminist social activism that have been represented in the continuing medical education programs designed to teach pediatricians about child abuse.

In fact, mandated child abuse reporting is only possible when pediatricians elect to abide by the requirements of the law. That is, when pediatricians place the imperatives of the law above any imperatives of liberal social activism.

15

Pediatricians who surpass reporting thresholds and elect not to report cases of child abuse as mandated, do so in varying degrees. There are pediatricians who will make rare exceptions to the law (perhaps, in the instances when they encounter unusual (mitigating) circumstances). There are pediatricians who will place competing concerns (such as fear of malpractice litigation, apprehensions about disrupting the pediatrician--parent relationship and questions about the effectiveness of the child protection system...,) ahead of legal mandates more frequently. And,

there are pediatricians who may frequently or even always place liberal social activist agendas above the legal requirement to report child abuse cases.

16

Cases of child abuse in the medical guise may actually represent some of the more extreme and flagrant accounts of pediatricians who have (completely) abrogated their mandated roles as child abuse reporters in lieu of competing concerns.

In Chapter 6 (pages 74-75) the author noted the similarities between two cases of child abuse. The first case (reported by Rosen, et. al., 1983) involved a parent who restrained two young children in their cribs and induced potentially fatal episodes of apnea (cessation of breathing). The second case ("It's life for killer mom," New York Post, 7/29/95) involved a parent (Susan Smith) who restrained two young children in their car seats and then caused their asphyxiation by pushing her car into a muddy South Carolina lake.

Each of these cases involved parents who attempted to murder their 2 children by suffocation. The first case

16

An example of pediatricians who have categorically refused to treat child abuse as a crime was discussed on page 24. These pediatricians diagnosed the cases of child abuse that they treated as "*trauma X*" in order to remove them from the purview of the criminal justice system. (See page 24).

involved a parent who preferred that the pediatrician should assume ultimate responsibility of abusing (killing) the 2 children involved. The second case involved a parent who preferred to actually complete the task of killing her 2 children on her own. She then proceeded to lay the responsibility for her children's deaths on a "black man."

While it is true that descriptions of MSBP cases may sound exotic and shocking, they nevertheless simply represent descriptions of events in which children have been abused and/or killed. Even for those who believe that child abuse represents a mental health issue rather than a criminal justice issue, MSBP actually represents no more or no less a "disorder" of mothering ¹⁷ or fathering than any of the variety of other forms of pernicious child abuse that some pediatricians elect to shunt from the criminal justice system (to mental health interventions).

In demystifying the MSBP scenario, the author effectively places child abuse in the medical guise along side of child abuse in the ritual guise ¹⁸ and child abuse

17

The author has already discussed (page 41) the fact that pediatricians and social service workers have treated and processed numerous cases of MSBP perpetrated by fathers.

18

Child abuse in the ritual guise would involve occult and other religious rites and practices in which a parent

19

in the sexual guise. For whatever reason(s), parents can and do hand their children over to physicians, occult priests and pornography producers--some well-intentioned, others not--in order to have the child abused by the hand of another.²⁰ These children are always hurt, often disfigured and in many cases dead as a result of their abuse.

The author asserts that the psychodynamics of MSBP are probably not that very different from the psychodynamics of many other forms of child abuse.²¹ That is, whatever it is

delivers her/his child to an adult official to be abused and/or killed.

19

Child abuse in the sexual guise involves child pornography as well as a variety of other instances in which a parent delivers her/his child to another adult in order to be sexually abused.

20

Two forms of (equally) pernicious child abuse have been described. One involves the parent who him/herself inflicts abuse upon a child. The other, involves the parent who delegates the abuse of the child to another adult.

In Chapter 18, the author will describe some of the methodology of child abuse and some of the preparations that sophisticated abusing parents make in order to carefully facilitate the injury and/or death of their children.

It is as yet unclear whether the parent who delegates the abuse of her/his child to another adult does so because of personal squeamishness or because of a well-calculated assessment of the expediency (less danger of apprehension) of employing a surrogate.

21

An in-depth discussion of the psychodynamics of child abuse would be beyond the scope of this Dissertation.

(psychodynamically) that will serve to motivate an adult to harm a child, will serve to motivate the adult to seek the most efficient means with which to inflict that harm upon the child.

Child abuse has been perpetrated through a variety of reprehensible means. In fact, the seemingly exotic qualities of the MSBP cases may actually pale by comparison with some of the gruesome cases of child abuse that have been documented by the media. What is unique (and what actually operationally defines) MSBP cases, therefore, is not so much the parent who is abusing the child in flagrant disregard of modern child protection statutes, but the pediatrician who is abusing the child in flagrant disregard of those same statutes.

MSBP has been described as a "triangle" of interaction between a parent, a pediatrician and a child. It differs from other forms of dyadic child abuse that involve only a parent and a child. It also differs from other forms of triadic child abuse in that it can only occur when a ²²
p pediatrician is an active participant in the abuse of the child.

Schreier and Libow (1993a) set the tone for emphasizing

the "mother's" role in MSBP research and education. This author has demonstrated some of the inconsistencies in Schreier and Libow's approach.

Schreier and Libow have unilaterally attempted to address MSBP with theories of irrational maternal fetishism. They have almost completely ignored the fact that the MSBP perpetrator is a criminal child abuser, in favor of the notion that she is part of a continuum of pathetically "disordered" mothers. They have effectively exonerated the pediatrician from any wrongdoing (within the MSBP triangle,) by presenting the pediatrician as the "unwitting" object of the mother's psychopathological fetish.

In presenting MSBP as child abuse in the medical guise, the author has described the MSBP perpetrator as one of many varieties of criminal child abusers. The author has further distinguished between the criminal behavior of the MSBP perpetrator and the variety of "disorders" of parenting that (while potentially upsetting, irritating, or frustrating,) have not been associated with criminal behaviors. Moreover, the author has emphasized the fact that the role of the pediatrician is neither ancillary nor ambiguous, but integral to the execution of child abuse in the medical guise.

One of the most important aspects of child protection legislation is the emphasis that this legislation has placed

upon the role of the pediatrician as the first line of defense against child abuse. The pediatrician is mandated to recognize and to report child abuse cases to the appropriate authorities within the criminal justice system so that they can be investigated and remediated.

Pediatricians who willfully surpass reporting thresholds in order to advance personal or liberal social agendas are not only thereby violating the child protection laws. They are actually thwarting the attempts of the criminal justice system to effectively redress crimes of child abuse.

Pediatricians who actively participate in the MSBP triangle do more than subvert the agendas of the child protection system by inhibiting the criminal justice system from accessing (and dealing with) child abusing parents. These pediatricians actually exhibit a role reversal in which--instead of acting as protective intermediaries between the abusing parent and the abused child--they literally (themselves) assume the child abusing role in lieu of the parent.

This dissertation paves the way for an important secondary inquiry into the recognition and reporting behaviors of pediatricians: The author hypothesizes that the pediatricians who participate in the MSBP triangle probably represent a significant sub-group of the pediatricians who have the lowest regard for their mandated

obligations as child abuse reporters.

If this were the case, then the key to eradicating MSBP would involve not only criminal justice initiatives designed to deter parents from child abuse in the medical guise, but significant initiatives to insure that pediatricians would be more compliant with their mandated roles as child abuse reporters (and would thus be less likely to (unwittingly) abuse children in the medical guise).

In the next three chapters, the author will detail some of the contemporary issues that relate to our perceptions of child abuse in the medical guise. Chapter 17 examines the feminist perspectives on MSBP and discusses aspects of the HS and HCA cases from within these perspectives. Then, Chapter 18 places child abuse in the medical guise in the larger context of other forms of abuse in the medical guise. In this context, two alternatives to Schreier and Libow's (1993a) conceptualization of the MSBP mother will be proposed. Finally, Chapter 19 discusses the confusion inherent in the name MSBP and the implications that the term "MSBP" has for the criminal justice system's involvement in cases of child abuse in the medical guise.

23

In Chapter 18, the author hypothesizes that when better methods of detection of MSBP become available, parents will seek out other (perhaps even more exotic) "detection-proof" means of harming their children.

Chapter 17:

MSBP as a Feminist Issue.

The Questionnaire for this study asked pediatricians to assess cases in which parents brought their 6 month old infants to the ER for evaluation and treatment. The objective (diagnostic) reactions as well as the subjective (personal perception) responses of pediatricians to these cases were evaluated.

The mothers (named "Debby Green") in each of the 6 case vignettes that pediatricians examined for this study were described as having the same concerns. In each case, Debby Green's husband had moved out to be with his girlfriend. In each case, Debby "has no job, no money, no man." (See Appendix A).

These circumstances, while problematic in certain respects, do not necessarily imply that the pediatrician should be more vigilant in her/his evaluation of the child ("Baby Lisa") that has been presented for ER intervention. Indeed, (especially, but not exclusively in public hospitals,) parents who lack financial means, have utilized¹ the pediatric ER in lieu of the pediatricians and pharmacies

1

The author spent several mid-night hours (October 4-5, 1995) in the pediatric ER of Coney Island Hospital (a New York City Public Hospital) and had the opportunity to

2

that they are unable to afford. ER pediatricians are thus accustomed to treating babies and older children who really should not be seen in the ER.

When a parent has elected to bring her/his child to the ER instead of the pediatrician's office (or clinic), s/he no longer engenders any real stigma. S/he will probably have to wait a while, but then s/he may anticipate receiving appropriate diagnosis and treatment. S/he will probably not receive any special referrals before her/his child is

observe the interactions of pediatric staff with patients and their parents. Patients who fit the profile of "Debby Green," (the mother in each of the 6 vignettes whose husband moved out, who has no job and no money, etc.,) utilized the hospital ER in lieu of routine or sick-visits to the pediatrician's office and/or the neighborhood pharmacy.

In just one hour, the pediatric resident on duty in the Coney Island Hospital ER, treated 3 children (who didn't appear to the author to be very ill,) by prescribing mild anti-biotics, which the nurse on duty proceeded to prepare and dispense from a well-stocked cabinet.

No mental health or social service referrals were made for any of the non-emergency cases that pediatricians in the Coney Island Hospital pediatric ER treated during this period.

2

Due to the crisis of health care in the 1980s-1990s a growing number of people who cannot afford health insurance --but are not eligible for Medicaid--resort to hospital emergency rooms when they or their children require even the most basic medical care. New York City Hospitals (as well as hospitals in other areas) now service this population.

3

Individuals who utilize the ER for routine medical care may experience longer post-triage waits than actual emergencies.

discharged from the ER.

This study did not compare the subjective responses of pediatricians to the "normal" Debby Greens⁴ that they would be likely to encounter in the ER with their responses to abusing parents. Instead it examined pediatricians' responses to 3 separate forms of problem patients.⁵

The Help Seeking mothers in the case vignettes were different than the "normal" Debby Greens (who utilize the ER because they cannot afford a pediatrician or are ineligible for Medicaid). Cases 1a and 2a were not coping normally with the responsibilities of motherhood. They had come to the hospital ER--not because "Baby Lisa" needed medical attention--but, because they themselves were seeking some form of special relief from their problems.

In the low intensity case (1a), Debby Green had placed cranberry juice in Baby Lisa's diaper and reported that she came to the ER because she discovered "some reddish stuff" in the diaper. Her report was pathetic and transparent.

4

A "normal" Debby Green would be a parent whose child requires routine pediatric care which she is unable to access in the pediatrician's office or clinic.

5

A "problem patient" refers to a parent who is more difficult for the pediatrician to deal with than the "normal" Debby Green. These parents utilize the ER in order to sustain and/or further agendas that are other than their infant's need for routine pediatric care.

In the high intensity case (2a), the report was less transparent. The reddish substance in Baby Lisa's diaper "had no particular odor or consistency of blood," but did not smell of cranberry juice or any other immediately recognizable substance. Additionally, while the parent in case 1a made no report of any other problems with her baby, the parent in case 2a reported that her baby "was behaving strangely."

The parent in case 1a was described as "attentive to the infant and cooperat[ive] with the staff at all times." The parent in case 2a "appeared to be very distraught as she paced the floors." While these behaviors are not in and of themselves suggestive of any pathology, when combined with the parent's report of her child's presenting problem, they serve as a barometer for the intensity of the parent's perceived need for assistance.

It is important to note that the mothers in cases 1a and 1b have come to the ER in search of some respite for themselves from the "depleting" qualities of infant care⁶ (Swigart, 1991). Although neither Help Seeker has harmed her baby in any way, both are malingerers by proxy. That

6

Jane Swigart (1991) described the care of infants in terms of both the gratification and depletion that the new mother may experience in attempting to meet her infant's needs.

is, both have utilized their babies to seek assistance for themselves. Both are expecting the swift and reassuring response of the ER pediatrician. (See page 120).

Elaine Leeder (1990) discussed the concept of the "mother's emotional neediness and her efforts to get cared for through the attention and security of the medical establishment," (page 77). In an article for the journal Women and Therapy, titled: "Supermom or child abuser: Treatment of the Munchausen mother," Leeder asserted that one of the factors involved in MSBP is the mother's feeling of "emptiness."

Although Leeder did differentiate between the clinical diagnoses of malingering and factitious disorders (page 72), her presentation of the feminist perspective on MSBP does not differentiate between the etiologies of malingering by proxy and the etiologies of Munchausen Syndrome by Proxy. In offering 4 reasons to explain MSBP within a feminist framework, Leeder actually blurs the distinctions between HS, HCA and MSBP mothers. In fact, the second reason that she offers for MSBP may actually represent an apt description of some of the psychodynamics of Help Seeking rather than of MSBP:

It appears that these women have crucial unmet emotional needs from childhood and then go through life trying to compensate for those needs by turning

to the medical establishment for the love and nurturance that they lacked...., (page 78).

The author suggests that Help Seekers turn to physicians instead of to other means of fulfilling their emotional and physical needs because they perceive that physicians will be able to provide them with safety and security. Primary Help Seeking adults may make an appointment with their personal physicians or come to the ER with a variety of vague (and non-threatening) symptoms that only provide them with an entre to discuss (with the physician and thereby receive assistance with) all sorts of matters that are unrelated to the practice of medicine.

Secondary Help Seekers, or Help Seekers by Proxy will similarly utilize their child's visit to the pediatrician or to the pediatric ER as a vehicle to generate assistance with problems that do not have medical etiologies. In order to secure access to the "helping" pediatrician, however, the HS parent must produce evidence of some vague (and non-threatening) disorder in the child.

The response of the pediatrician to the HS cases will in great measure be determined by her/his own personality. The pediatrician who has a very paternalistic/maternalistic nature might be expected to take pity on the HS mothers, to see them as good, but needy women who have come to be nurtured. They might (without objective reasons) have viewed

the HS babies as more difficult (especially baby 2a, whose mother factitiously reported that she had been behaving "strangely"). These attitudes would have been reflected in pediatricians' SD ratings as "halos," or high valuation (low scores on the dimension of evaluation) for the HS mothers, and devaluation (high scores on the dimension of evaluation) for the HS babies, especially for baby 2a.

The pediatrician who has a low tolerance for people who are not self-sufficient, will devalue (give high SD scores on the dimension of evaluation for) the HS mothers. S/he will view them as evading their responsibilities to their highly valued (low SD scoring) babies.

Ancillary to the emphasis of this study, the author anticipated results for BEVALUE and MEVALUE in cases 1a and 2a and Likert-type scale scores for mother and baby that would have resembled a see-saw pattern. Either good mother with bad baby, or bad mother with good baby.

Furthermore, in light of the results for MHREFER, where

7

The reader should keep in mind that no actual child abuse has taken place. Therefore, a "bad" SD rating would be a purely subjective response of the pediatrician to the case vignette.

8

In light of the discussion of the differing personality traits of pediatricians, it might be possible to propose that the pediatricians who examined the low intensity HS case (1a) made few MHREFERS because they are not tolerant of

the pediatricians who examined case 1a made the fewest numbers of mental health referrals, but the pediatricians who examined case 2a made large numbers of mental health referrals, the author anticipated that significant differences would emerge in the overall answers (to all of the sections of the Questionnaire) that pediatricians supplied for the mothers and babies. The author then hoped to analyze the Questionnaire findings in association with Ss demographic characteristics.

These analyses were not possible due to lack of Ss compliance with several sections of the Questionnaire. (See page 174).

The Health Care Addict mothers described in the case vignettes differ from the "normal" Debby Greens who utilize the pediatric ER in place of primary care. The HCAs were impatient and unwilling to wait for the doctor to be ready to see their babies. As described above (page 280, note 3,) parents who utilize the ER in place of primary care may have to wait longer than actual emergency cases to receive

the parent's helplessness, while the pediatricians who examined the high intensity HS case (2a) made many MHREFERS because they are a more maternalistic/ paternalistic group.

While this notion is interesting and provides an avenue for future research, it can neither be documented nor refuted by the data collected for this study.

medical attention. The HCA mothers were not prepared to wait. They became belligerent and demanding.

HCA parents are difficult for the triage nurse to handle. They make demands that other parents do not make. HCA parents may characteristically harass the nurse to the point where s/he will have to treat them as s/he would treat aggressive parents who are acting out (Chamberlain, 1974).

The case vignettes provided descriptions of the HCA mothers' behaviors. (See Appendix A). However, in order for Ss to formulate their own opinions about mothers 1b and 2b, there was no mention made of the triage nurse's behavioral management these cases.

HCA cases present the pediatrician with difficulties because they may represent any one of a number of conditions. The parent may be describing some form of hysteria by proxy in which the child has exhibited some temporary symptoms at the parent's suggestion. The parent may be acting out excessive and misplaced (hyper-) concerns for the child's well being by exaggerating the significance of some minor symptom. Or, the parent may be genuinely concerned that the pediatrician has overlooked some real and significant pathology that must be treated.

Baby Lisa was only 6 months old in the case vignettes. She was therefore neither suggestible nor susceptible to conversion phenomena by proxy.

In the low intensity HSA case (2a) Debby Green reported

that Baby Lisa "had been lethargic for several hours." In fact, the triage nurse reported that the baby "appeared to respond to visual as well as auditory stimulus." (See Appendix A). The report of the baby's lethargy appears to be mendacious. The parent may be pathologically over-reacting to some minor behavioral changes in her baby, or, perhaps hysterically amplifying the baby's history of "viral meningitis at 2 months of age" into a current concern.

It is important to note, however, that the parent in case 2a may have some cause for genuine concern that is not immediately apparent to the pediatrician. In some cases, pediatricians have been known to overlook or to minimize symptoms that parents (through experience and familiarity with the child's day-to-day habits) have actually observed.

The parent in the high intensity HCA case 2b also presented a baby that she claims has been lethargic for several hours. This baby also responded to stimuli and was clearly not lethargic upon examination by the triage nurse.

Unlike the low intensity HCA case 1b, however, this baby had no prior history of meningitis. There was less room for the pediatrician to err on the side of caution--by assuming that the 2b mother was responding to personal knowledge or even amplifying a minor existing condition--when she demanded an immediate "spinal tap" in order to have her baby checked for "viral meningitis."

The mainstream psychology article that adopts the

feminist perspective on MSBP was written by Robins and Sesan for the journal Professional Psychology: Research and Practice (1990). It was titled: "Munchausen Syndrome By Proxy: Another women's disorder?"

Robins and Sesan asserted that certain feminist theories of "women's psychological development" can best explain the etiology of MSBP. They explained that men and women develop their senses of identity in different ways and thus adopt different adult roles:

...women develop a sense of identity in a context of connection to and caring for others; a relational mode of development thus ensues. Men, on the other hand, develop a sense of identity based on experiences of separation and competition. The different paths that men and women follow toward identity leave each gender vulnerable to developing difficulties in different spheres (page 286).

Robins and Sesan adopted the view that women's paths of development place them at risk for over-developing the aspect of caring for others. They apply the feminist theory that "Western culture" has fostered and supported an:

imbalance of self-care versus other care [that] can lead to feelings of deprivation, neediness, depression and anger (p. 286).

According to this feminist perspective, "good women" or "good mothers" are those who are motivated to sacrifice self-care in lieu of the care of others (children).⁹

Integral to the socialization of the "good woman" is the notion that autonomy and freedom of expression must be sacrificed (i.e., repressed). Therefore, when "good women" --who have "chronically" sacrificed their self-care over long periods of time--become dissatisfied and angry with their roles, they have no direct way to express their feelings.

Robins and Sesan asserted that "good women" who are dissatisfied and angry will find indirect means with which to care for themselves and gain power. These indirect means may include Health Care Addiction "or in more extreme cases" MSBP.¹⁰

9

By omitting the notion of care of the husband, Robins and Sesan create a (fictional) scenario in which MSBP exclusively represents the response of the woman to the societal constraints of mothering a child.

10

The reader is reminded that the author has modified all references to Libow and Schreier's (1986) "Doctor Addicts" to read "Health Care Addicts" or "HCAs".

The reader is further reminded that although different abbreviations for Munchausen Syndrome by Proxy have appeared in the literature (including the "MSP" that was utilized in this case by Robins and Sesan,) the notation "MSBP" is used (exclusively) throughout this text in order to prevent the reader's confusion.

When Robins and Sesan blame the constraints of female socialization to "Western culture" for child abuse, they accomplish 4 things:

First, they negate the (potential and actual) existence of MSBP perpetrated by males/ fathers.

Second, by engaging in "mother blaming," they obliterate the fact that fathers can and do abuse their children in a variety of ways. Writing some 8 years after Breines and Gordon's (1983, p. 504) feminist challenge to this approach--in the form of the "significant question": "Why do men who do so little child care physically abuse children so much?"--Robins and Sesan emphatically ignore the the father in their conceptualization of child abuse.

Third, they blur the boundaries between the pathetic Help Seeker who may in fact exemplify the passive "good mother," the aggressive Health Care Addict and the MSBP abuser.

Fourth, they blur distinctions between the dissatisfied, self-sacrificing "good mothers" who finally explode (and hurt or kill their children) because they can¹¹ no longer tolerate their self-sacrificing roles and the

11

Rich (1986) presented the case of Joanne Michulski who was so overwhelmed by her sacrifice of self-care that--deprived of another outlet--she chopped up her two youngest children with a butcher knife.

dissatisfied self-sacrificing mothers who plot and
premeditate their childrens' abuse.¹²

Robins and Sesan list "compulsive eating, depression and somatization" as the alternatives to their "imbalanced" woman's HCA--MSBP continuum. Thus, they blur two distinct categories of behavior. The first involves masochism/ self-abuse. The second involves the abuse of another/ the child.

It is by no means clear that HCAs are child abusers. Moreover, it is by no means clear that that HCAs are the well-acculturated "good mothers" that Robins and Sesan have described.

HCAs are actually often bold and aggressive people who are clearly able to make their feelings and wishes known. They do not behave as restricted and repressed "good women." When they are angry, they make sure that the pediatrician is aware of their imperatives.

Ancillary to the emphasis of this study, the author anticipated that pediatricians would not like the Debby Greens in the HCA cases (1b and 2b). They would significantly devalue her in both cases (with higher SD scores on the dimension of evaluation and very low ratings on the Likert-type scales). They would devalue case

¹²

The author will address some of the distinctions between sudden and premeditated child abuse in Chapter 18.

2b more than case 1b.

The author further anticipated that because the HCA mothers would irk the pediatricians and upset them, the HCA babies would become almost irrelevant when considered with their mothers. Pediatricians would therefore be expected to evaluate babies 2a and 2b as being moderate to good (i.e., give them low to moderate SD ratings and high Likert-type ratings).

Once again, because Ss did not complete all of the sections of the Questionnaire, it was not possible to fully appreciate pediatrician's attitudes toward the HCA mother.

One interesting artifact did emerge from the data that was collected for MEVALUE. At low levels of intensity, pediatricians rated the HCA mother (1b) as being almost identical to the MSBP mother (1c). At high levels of intensity, they rated the HCA mother (2b) as being almost identical to the HS mother (2a).

These findings would be very puzzling on their own. However, when examined together with the instruction that pediatricians have received in the Robins and Sesan-type liberal feminist approach, these findings actually serve to demonstrate that pediatricians will in many cases mirror what they have been taught.

The case of MSBP is in many ways analogous to the case of Down's Syndrome (Haslam & Milner, 1992) where pediatricians have been educated to adopt alternative

attitudes that may have been contrary to their basic beliefs and intuitions. In both cases, pediatricians have been taught to be more "positive" and "optimistic." In the case of Down's Syndrome, this has resulted in pediatricians holding greater and more positive expectations for their Down's Syndrome patients. In the case of MSBP, this has resulted in pediatricians adopting a more rosy picture of the child abuser by blurring important distinctions between child abuse, HS and HCA.

Pediatricians have been conditioned to expect to encounter normal parents as well as problem parents in the course of medical practice. This study did not consider pediatricians' responses to normal mothers. Instead, it focused on pediatricians' responses to 3 distinct categories of problem mothers.

Problem parents generally fall within one of two exclusive categories: they are either overly self effacing and (perhaps) incompetent, or, they are belligerent and aggressive. The MSBP parent is probably successful because s/he is neither self-effacing nor belligerent.

The MSBP mothers in this study (cases 1c and 2c) presented differently than the other mothers. Apart from their initial reports about their babies, they appeared to be more concerned with the needs of others than with their own needs or the needs of their babies. (See Appendix A).

The low intensity MSBP mother (1c) was described as "very generous in her caring and support of other patients in the waiting area." She also provided coffee and donuts for staff members at midnight.

The high intensity MSBP mother (2c) was described as "very calm and cooperative." She was "empathic to the priorities of staff and the needs of other patients." She also provided coffee and donuts for staff members at midnight.

The affects displayed by the MSBP parents were inappropriate for their alleged roles. Both mothers reported that their infants suffered from severe and potentially life threatening symptoms. Yet, neither MSBP mother exhibited anxiety over her baby's condition, or concern for herself.

The low intensity baby (1c) was presented with a mendacious report or "some reddish stuff oozing from her ear." The triage nurse observed that the reddish fluid appeared to have "the odor and consistency of menstrual fluid."

The high intensity baby (2c) had some "pinkish fluid oozing from her left ear." She was brought into the ER with a small container of the same fluid which the mother "had collected over the past few hours." The triage nurse asserted that the fluid appeared to be "cerebrospinal fluid."

The MSBP mothers have begun to abuse their babies. They may even be attempting some exotic form of infanticide (Lukianowicz, 1972). They have actually placed some foreign substances inside of Baby Lisa's ears. If, in case 1c, the reddish substance was indeed menstrual fluid, then, (unless removed,) it may damage the child's ear and/or cause serious infection. If, in case 2c, the pinkish fluid was some homemade concoction, then it may do more than damage Baby Lisa's ears. It may seep through the baby's ear's canal and cause brain damage as well. In either case, any foreign substance that was inserted into the baby's ear would be harmful, unless properly drained.

The case vignettes did not describe any real pathologies for babies 1c and 2c. With the exception of the mothers' mendacious reports (that these fluids had actually oozed out of their babies' ears,) the babies exhibited none of the classical symptoms that would be associated with an aural hemorrhage or a cerebro-spinal fluid leak.

Furthermore, the mothers did not even describe such

¹³
symptoms.

13

The differential diagnosis of MSBP is often made by contrasting the report of the parent with the known symptomatology of the disease in question.

The MSBP parent will often engage in extensive medical research and then make mendacious reports of her/his child's condition that have been purposefully designed to confound

The author hypothesized that in spite of the abuse that MSBP parents have already rendered (in order to bring their babies into the health care system,) they would receive the best evaluations.

As stated earlier (page 294), pediatricians recognize two categories of problem parents, the self effacing and the belligerent. The author suggests that pediatricians experience dissonance when dealing with the MSBP mother precisely because she is neither self-effacing nor belligerent.

The MSBP mother is not pathetic like the Help Seeker. She not only maintains herself, but has the extra wherewithall to cater to the needs of other parents and staff members.

The MSBP mother is a child abuser. Yet, she neither fits the aggressive and demanding profile of the HCA mother, nor the nasty stereotype of child abusers.

the pediatrician.

The reader is referred to pages 138-141, where Gilbert & Pierse, et. al.'s case (1987) of recurrent left otalgia in a 13 year old boy was discussed. Before it was discovered that the pink cerebro-spinal fluid in that case was actually a beet juice derivative, the boy was severely abused in the medical guise.

Case 2c was designed to determine whether pediatricians who examined a healthy baby (with no evidence of cerebral incident,) and observed the baby's mother as unaffected and unconcerned, would even suspect that they may have been duped with a container of bogus cerebro-spinal fluid.

The author suggests that pediatricians can like MSBP parents because of two factors:

The MSBP parent is "good" without being pathetic. This is particularly true in cases where the MSBP perpetrator is the mother. Some pediatricians may view her as an exemplary, caring, nurturing (coffee and donuts) individual who services others without being very needy herself. This conceptualization may help to explain why distinct similarities emerged in Ss ratings (on all three dimensions)¹⁴ between the low intensity HS case (1a) and the high intensity MSBP case (2c).

Of perhaps greater importance, is the fact that the MSBP parent does not overtly challenge the pediatrician in any way. S/he does not exhibit the personality characteristics (Evans, 1981) of a bully or of an overly strict disciplinarian. S/he is never belligerent.

The pediatrician may encounter "problem" parents who deny their children important and even life sustaining medical care (Swan & Houy, et. al., 1981; Sokolosky, 1981-1982) because of personal or religious beliefs. In stark contrast with these "problem" parents, the MSBP parent never offers any resistance to medical interventions (not even to

14

For MEVALUE, see page 223.
For MPOTENT, see page 227.
For MACTIVE, see page 231.

the most invasive and potentially harmful procedures).

In fact, MSBP children are probably the best candidates for drug trials and and medical experimentation. They probably represent the academic pediatrician's "dream" because their parents will allow the pediatrician to do anything (regardless of inherent risks) to them.

In this way, MSBP babies may be more desirable than HS and HCA babies. The author suggests (though offers no proof for the assertion) that the lack of support for the hypothesis that pediatricians would stigmatize (devalue) the high intensity MSBP baby (2c) actually derives from the notion that high intensity MSBP babies are very valuable research subjects.

MSBP parents are successful in their attempts to abuse their children in the medical guise because they are very sophisticated. They are apparently able to practice and to adopt the persona of "good" people who are neither pathetic nor aggressive. The methods of MSBP parents are effective primarily because they do not underestimate the value of a compliant parent to a busy pediatrician.

Chapter 18:

The Larger Context of Abuse in the Medical Guise:

Child abuse in the medical guise occurs when a manifestly "good" and even-tempered parent (or adult acting in loco parentis) makes mendacious reports of his/her child's illness to a pediatrician (or other health care professional) in order to have this child subjected to unnecessary, pernicious medical interventions.

This dissertation examined the mechanics of child abuse in the medical guise by analyzing the roles of the parent, the pediatrician and the child in the MSBP triangle.

The author explained how child abuse in the medical guise is perpetrated. That is, how the parent researches a medical condition that is likely to interest and/or to frustrate the pediatrician and how the parent is able to initially dupe the pediatrician into becoming an "unwitting," working accomplice to the child's abuse.

The author explained why pediatricians may be susceptible to participating in the MSBP triangle. Remaining unresolved, however, is the question of why parents initiate and promulgate child abuse in the medical guise.

Several theories have presented MSBP as a "disorder" (Schreier & Libow, 1993a) and as an "imbalance" (Robins & Sesan, 1991) that exclusively afflicts women/mothers. These

theories are rooted in the combination of Freudian psychoanalytic doctrine and in modern feminist approaches that almost unilaterally blame women/mothers for any and all problems that children encounter.

Theoretical issues relating to "mother blaming" have been extensively argued. The specific application of "mother blaming" theory to MSBP has received more modest¹ attention. While a comprehensive analysis of the polemics involved in the various theoretical approaches (pro and con) to the broader conceptualization of "mother blaming" would be beyond the scope of this dissertation, the author offers a three-part challenge (presented seriatim) to the specific application of "mother blaming" theory to MSBP.

The author asserts that "mother blaming" theory--whether credible or not--is simply insufficient to be utilized as an explanation for MSBP behavior.

First, it is important to note that child abuse in the medical guise cannot be explained as a "mothering disorder" because it is an irrefutable fact that child abuse in the medical guise has not been exclusively limited to women/mothers.

1

In one case (see page 45), Roy Meadow utilized the medium of private correspondence to challenge some of Schreier & Libow's (1993a) assertions about MSBP mothers' motivations and behaviors.

The oral reports of individual physicians attending continuing medical education programs on child abuse, indicate that some have (themselves) treated numerous cases of MSBP that were perpetrated by fathers (see page 41, note 3). Several published case reports about "father as perpetrator" (Makar & Squier, 1990) and the family systems (Mehl & Coble, 1990) involved in MSBP, indicate that "mothers" need not be perceived as the linchpins of MSBP.

If MSBP is not an exclusively female-perpetrated crime, then, "mothering" (which is an exclusively female condition,) cannot be considered as the central issue in MSBP. Moreover, if "mothering" cannot (in and of itself) be considered as the central issue of MSBP, then, "disorders" and "imbalances" of mothering may be (partially or entirely) irrelevant to the etiology of MSBP.

Second, child abuse in the medical guise is actually only one of several documented varieties of abuse in the medical guise. The application of the narrow and restrictive "mother blaming" theory to MSBP effectively shunts MSBP into a (nebulous) corner from which it cannot be considered in the context of various other abuses in the medical guise.

2

For lack of a better term, a variety of abuses in the medical guise have been labeled "MSBP". These include:

1. Elder abuse in the medical guise:

A. According to Smith and Ardern (1989), it is possible for peers (people of the same age) to be involved in MSBP. This is especially true when one senior citizen will make mendacious reports of his/her significant other's medical problems in order to inflict unnecessary and pernicious medical interventions upon the unwitting peer.

B. The author was involved (in the early 1980s) in three separate cases in which adult children made mendacious reports of their elderly parents' medical conditions in order to subject these parents to invasive medical
3
procedures that were unnecessary. In one case, a 40 year old woman reported that her 76 year old mother (who spoke little English) suffered from severe gynecological problems, in order to have the mother subjected to an unnecessary

2

The operational utility of the term "MSBP" (to describe cases of abuse in the medical guise) will be discussed in Chapter 19.

3

It is important to note that none of these cases involved adult children who lived with their parents. None of these adult children had been saddled with the day-to-day responsibilities of caring for their parents (so that it would not be possible to assert that a role reversal had taken place where the adult children could have been "mothering" their parents).

Some factor--other than a "mothering disorder"--must have motivated these three adult children to abuse their elderly parents in the medical guise.

laparoscopy. In another case, a 56 year old man mendaciously reported that his father had not had any bowel movements in seventeen weeks, causing the father to undergo a very comprehensive battery of gastro-intestinal⁴ assessments. And, in yet another case, a 36 year old man gave his 80 year old diabetic father proscribed foods (claiming that they were from a (non-existent) gourmet shop for diabetics on Madison Avenue in New York City). The son then reported that--in spite of strict compliance with the physician's instructions--his father's medications were not working.

2. MSBP perpetrated by a pediatric nurse in a hospital setting:

According to Roy Meadow (Jenkins, 1993) the 1991 case of Beverly Allitt fits the clinical pattern of MSBP. During the 59 days in 1991 in which Nurse Allitt was employed at Grantham Hospital in England, she killed three babies, attempted to kill three other children and severely assaulted an additional six children (one of whom sustained

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The reader will note the remarkable similarities between this case of elder abuse in the medical guise and the case of child abuse in the medical guise (in which a mother mendaciously reported that her 10 year old son had never had a bowel movement) on page 42.

permanent brain damage).

The Times of London reported (Jenkins, 1993) that as a child, Allitt had worn bandages over non-existent injuries. She later engaged in self-mutilation and made mendacious reports about non-existent medical problems. She was diagnosed as suffering from Munchausen Syndrome.

Critical of the fact that someone with a "personality disorder" as severe as Beverly Allitt's could gain employment in a public hospital, The Times referred to a "precedent" in the 1972 case of a mentally ill Jordanian doctor. Dr. Ahmed Alami (who murdered three babies in a children's ward in 1972) was hired as an eye specialist at Victoria Hospital even though he had a record of serious mental disorders.

The author notes that the case of Nurse Allitt can be differentiated from the case of Dr. Alami in many ways. Beyond being responsible for killing babies in a hospital ward, Allitt and Alami had virtually nothing in common.

Apart from differences in age, gender, country of origin, education and lifestyle, each suffered from a mental disorder that was very different from the other's. Allitt had been diagnosed with MS and eating disorders (Katz, 1993), while Alami had been diagnosed with (and treated for) paranoid schizophrenia (Alderson, 1993).

Moreover, the descriptions of the crimes that were

committed by Alami and Allitt were not at all similar to one another. Alami appeared to have had an incident in which he suddenly "snapped," while Allitt appeared to have been very much in control of what she was doing to the children at Grantham Hospital.

Although Dr. Alami was a physician, there is no evidence to suggest that his actions were part of any medical regimen. Dr. Alami's crimes occurred when he (unexpectedly) entered a children's ward. There, he went on a knife-wielding rampage in which he suddenly attacked two nurses and five sleeping babies (three of whom died). Nurse Allitt's crimes were committed over a 59 day period in her regular ward. There, she engaged in the careful process of killing or injuring her victims in the medical guise. In the course of her daily routine, Nurse Allitt repeatedly injected some of the children with substances such as insulin (that caused heart attacks) and slowly suffocated the other children in various ways, (Jenkins, 1993).

It is interesting to note that Nurse Allitt--herself an MS patient--appeared to have put her own "health care" on hold while she inflicted abuse in the medical guise upon her nursing charges.

3. Pet abuse in the medical guise:

In presenting some of the issues relating to the Help Seeker's quest for the physician's assistance, the author

suggested (page 284) that there are several forms of HS. Primary HS would involve the adult who turns to her/his own physician (by making an unnecessary appointment for a medical consultation) for assistance with matters that are not related to the practice of medicine. Secondary HS would involve the adult who (without medical cause) takes her/his child to see the pediatrician, so that the adult can ask for assistance with matters that are not related to the practice of medicine.

Yet another form of secondary HS (or perhaps, a tertiary form) involves individuals who bring their pets to visit the veterinarian in order to seek assistance (for themselves) with matters that are not related to the practice of veterinary medicine.

While some of these veterinary Help Seekers are simply malingerers by proxy who invent symptoms in their pets because they are lonely or in need of personal advice, others will actually go so far as to induce mild symptoms (in their pets) that will lend manifest purpose and credibility to their veterinary visits.⁶

In addition to (the not uncommon) cases of veterinary

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The author is grateful for the information provided by Dr. John Saidla, Professor of Veterinary Medicine at Cornell University in Ithaca, New York, (telephone communication, August 14, 1995).

HS, there appear to be cases of pet MSBP (or pet abuse in the medical guise)⁷. In these cases of pet MSBP, mendacious reports and sophisticated methods (that could only represent the fruits of careful research and planning) have been utilized in order to prepare household pets for unnecessary and pernicious veterinary-medical interventions. In fact, in cases of pet MSBP, the abuse of pets has been remarkably similar--in nature and consequence--to the abuse of children.

The third component of the author's challenge to the application of "mother blaming" theory to MSBP, involves the specific component of "mother blaming" theory that relates child abuse to a cyclical pattern. It has been asserted that child abuse can be explained as a phenomenon in which a mother--who was herself abused as a child--continues "the cycle of abuse" by abusing her own child.

The "maternal cycle of abuse" theory has been applied to MSBP, so that MSBP has been presented as the result of MS. Indeed, it has been asserted that female children who were victims of MSBP grow up to become adult female MS patients. These adult female MS patients repeat the "cycle of abuse" by inflicting MSBP upon their own children.

7

No data exists (at this time) on the incidence of pet abuse in the medical guise.

The author recognizes the fact that many MSBP cases have been perpetrated against (both male and female) children by parents (both male and female) who are/were themselves MS patients. This observation may be meaningful, but instead of helping to explain why MSBP has been perpetrated, it merely places the reader in a "chicken and egg" situation from which no conclusions can be drawn.

In the ensuing discussion, the author will lay the groundwork for an alternative approach to MSBP, that explains MSBP--not as a function of mothering--but, as (perhaps) one of the integral components of (male and female) MS that may have been previously overlooked.

This approach emanates from the author's research into the etiology of pet abuse. In the course of several conversations (during the month of August, 1995) with clinical staff at the New York City office of the American Society for the Prevention of Cruelty to Animals; clinical staff at the Small Animal Clinic of the College of Veterinary Medicine at Cornell University; clinical staff at

8

A classic example of circular reasoning has been the question of "What came first, the chicken or the egg?"

9

The attribution of MSBP to a female "cycle of abuse," does not account for the existence of male perpetrators and male victims of MSBP. Moreover, this approach does not permit us to transcend the "cycle" in order to examine why MSBP occurs.

the Animal Medical Center in New York City; representatives of the Latham Foundation of Alameda, California; and, in the course of reviewing several important articles in refereed journals (Arkow, 1994; Deviney & Dickert, et. al., 1983; Roscoe & Haney, et. al., 1987), the author has learned the following:

A. While the child protection movement has been waning in favor of liberal/feminist social agendas, pet rights activists have been picking up the child protection agenda and combining it with their own.

B. Several important conferences were held in the years 1994-1995, in which pet rights advocates and criminal justice-minded child protection activists have participated in joint ventures.

C. Pet rights activists such as the Latham Foundation, believe that people will treat animals and children similarly. That is: Those individuals who abuse or exhibit cruelty to pets, will probably also abuse children. Those individuals who abuse children, will probably also abuse pets. Conversely, those individuals who are kind and understanding in their interactions with pets, will be kind and understanding with children. And, those individuals who are kind and understanding in their interactions with children, will be kind and understanding with pets.

D. According to Professor John Saidla of the College of Veterinary Medicine at Cornell University (telephone

conversation August 14, 1995), people will abuse pets for a variety of reasons. One reason that has come to the forefront in recent years is the "trial run." That is, individuals (especially teenagers) who contemplate suicide, conduct "trial runs" of various techniques that cause death by testing these techniques on household pets.

In a bizarre analogy to the drug trials that pharmaceutical manufacturers conduct on small animals before employing human subjects, (Professor Saidla instructs his students that) people contemplating suicide may methodically test techniques such as suffocation, exposure to carbon monoxide, ingestion of toxins, or overdoses of medication on their small pets. They then analyze the data obtained from these "trials" in order to determine the most desirable
10
method of personal suicide.

Based upon this information (regarding the abuse of pets in suicide planning,) the author concludes that there are (at least) two separate varieties of abuse in the
11
medical guise, neither one of which is necessarily related

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A survey of academic veterinarians will probably reveal that most (if not all) of them are (in some measure) familiar with these facts through a growing professional literature that describes the use of pets for "trial runs" in suicide planning.

11

Here, the author refers (not only to child abuse in the

to feminist/psychoanalytic theories of "mother blaming."

In many ways, the MSBP perpetrator resembles the laboratory scientist who reviews the professional literature and then conducts clinical trials in order to test a hypothesis. Lab scientists do not (generally) become emotionally involved with their subjects. MSBP perpetrators are not (manifestly) emotionally involved with their children. Lab scientists are expected to conduct their research within a collegial atmosphere. MSBP perpetrators conduct the process of child abuse within a very collegial atmosphere.¹²

Abusers in the medical guise, are all attempting to harm and/or kill their victims through premeditated medical means.

Abusers in the medical guise probably do what they do for one of two important reasons: They either wish to commit

medical guise), but to all varieties of abuse in the medical guise. (See pages 302-303).

12

Key distinctions may thus be drawn between the HCA and the MSBP parents. The HCA will be aggressive, belligerent, scream, disturb and insult staff in order to seek out treatment (necessary or otherwise) because this parent believes (correctly or misguidedly) that the child that they love so much, needs help. The MSBP parent will be pseudo-clinical in demeanor. S/he will be calm, polite and excessively concerned with the needs of medical staff. Everything that is done to his/her child will be viewed with clinical detachment.

homicide, while evading the criminal justice system. Or, they wish to commit suicide, utilizing only a method that has been "tried" and meets their approval.

In the first type of abuse in the medical guise, the perpetrator wishes (for any number of reasons) to be rid of the victim. The perpetrator realizes that modern laws proscribe homicide. The perpetrator further realizes that the more traditional methods of killing another human being have been easily detected by police and severely punished by the criminal justice system. The perpetrator then does extensive research in the hope of finding some "fool-proof" method that will ultimately result in the death of the desired victim, (preferably at the hand of another,) without resulting in the apprehension of the perpetrator.

Abuse in the medical guise, offers the perpetrator almost boundless (and "fool-proof") techniques with which to have a parent, a child, a significant other, or even a pet killed (by the hand of another individual).

In the second type of abuse in the medical guise, the perpetrator is an individual who is contemplating suicide. Not everyone who contemplates suicide is actually able (or

willing) to go through with it. A myriad of factors--
personal, ethical, religious and psycho-social--will¹⁴
be influential in the final suicide decision-making process.

The author has already noted the distinction between those individuals who actually do commit suicide and those individuals who spend years of their lives as "suicide" cases. Moreover, the author has explained (see page 148-149) that in the Adlerian (psychoanalytic) view, Munchausen Syndrome probably represents a form of lifelong ("piecemeal") suicidal behavior.

Combining this Adlerian position on suicide with information (page 310-311) about the "trial runs" that (some) people contemplating suicide perform, it may be possible to draw additional conclusions about MSBP. Indeed, it may be possible to assert that the second form of abuse in the medical guise actually represents the perpetrator's attempt to "try out" a particular method of harm/death on a parent, child, other adult or pet (before deciding whether it is appropriate for him/herself to utilize).

Thus, while "cyclical" theories have attributed all of MSBP to "disordered" women who were themselves MSBP victims,

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It is beyond the scope of this dissertation to discuss the myriad of considerations relating to the suicide decision-making process.

this author proposes to explain the linkage that (sometimes, but not always) occurs (regardless of gender) between MS and MSBP within the context of adult suicidal behavior. The prevalence of MSBP perpetrated by MS sufferers may be an indication that MSBP represents the "trial runs" that help the MS sufferer determine what course of "suicidal" action would be most appropriate for themselves in the future.

In fact, some of the published cases of MSBP provide evidence of the fact that the perpetrator was an MS sufferer who was "between" hospitalizations.¹⁵ Thus, it may be possible to propose that some MS sufferers take a "research sabbatical" and engage in the MSBP abuse of another human or pet in order to inform the path of their (own) future factitious disorders.¹⁶

15

The newspaper accounts of the Nurse Allitt case (page 304-306) described her as a person who had suffered from MS. Even in this case, it may be possible to hypothesize that a hiatus between factitious illnesses could have been utilized for pseudo-empirical research that would inform future episodes of MS.

16

In order to continue to be regarded as a "patient" in need of medical intervention, the MS patient must engage in continual research. Factitious conditions that were diagnosed and treated in the past may not be easily feigned or perpetrated in the future.

While some MS sufferers do "experiment" with MSBP, others adopt strategies that are less costly to others.

During the course of the author's work at Bellevue Hospital in New York City (1978-1979), she had the opportunity to

The second type of MSBP may be understood as a byproduct of the MS patient's quest for new material. In addition to utilizing the fruits of his/her own imagination, the MS sufferer may engage in one, two, or all three of the following in order to prepare for the (manifestly credible) future reporting of factitious disorders: S/he may engage research of the medical literature. S/he may observe other patients' illnesses and treatments. And/or s/he may engage in MSBP "trial runs" in order to assess the observable outcomes of specific techniques.

When MSBP is conceptualized as the product of one of two forms of abuse in the medical guise (that have different goals, but similar outcomes), it no longer represents some nebulous "mothering disorder." Instead, it represents a real form of premeditated crime that the criminal justice system can address.

Abuse in the medical guise appears to be the type of

interact with several adult MS patients. Two of these MS patients not only came to the hospital for repeated procedures, but, they also came to the hospital to visit other patients (with whom they were not necessarily acquainted), and to volunteer their services by assisting medical staff with a variety of tasks.

At that time, it appeared to the author that these MS patients were looking for some illness or syndrome, observing its course (including the effects of medications and procedures) and then mendaciously reporting their own afflictions with the (by now well-researched) medical condition.

crime that follows other forms of abuse. The author suggests that the perpetrator of abuse in the medical guise (of either type) has probably undertaken (many) other strategies in order to accomplish his/her goals, before resorting to MSBP.

In the case of the homicidal abuser, the author hypothesizes that the victim has been abused in more traditional ways before being subjected to abuse in the medical guise. Indeed, in the cases presented on page 143-144 (note 2), the author described two separate situations in which parents--in one case a mother and in the other case a father--resorted to MSBP, only when more "traditional" methods of child abuse had been detected.

In the case of the (suicidal) MS abuser, the author hypothesizes that the victim is selected and abused only after the abuser has exhausted various other methods of self-abuse or factitious symptom production. Indeed, the author has noted (page 315) that--in some of the published reports of MSBP--the perpetrator appears to have been an MS patient who was utilizing the time "between" hospitalizations" to research new MS complaints.

In order for the criminal justice system to effectively address cases of abuse in the medical guise, these cases must be operationally distinguished from other cases where no abuse has been intended or perpetrated. The distinctions between the three categories of "problem" patients--the

HS, the HCA and the MSBP--that have been blurred, must now be effectively clarified.

MSBP (of either type) involves the act of researching, creating and reporting a new set of serious (factitious) medical symptoms in a child (or adult, or pet). The intended outcome of MSBP is the harm, disfigurement and/or death of the victim.

Help Seeking involves the act of malingering by proxy. That is, the act of implying that a child (or adult, or pet) is suffering from a (non-existing) medical condition. The HS's report is generally pathetic and transparent. No symptoms are induced, and the evidence that may be provided to substantiate the HS claim of existing symptoms is generally too contrived to be credible. No abuse is actually inflicted by the Help Seeker. Unlike MSBP, the intended outcome of HS is free advice or access to some non-medical service (that the physician can refer to).

Health Care Addiction is a form of hypochondriasis by proxy. It neither involves the fabrication of symptoms, nor the report of a non-existing medical condition. Instead, it represents the exaggeration or amplification of symptoms that do exist or that have existed in the child in the past. Unlike MSBP, the intended outcome of HCA is the "good" of the child.

Health Care Addicts may be well-intentioned, but they are often seriously misguided. They genuinely believe that

their children are ill enough to require serious medical attention. Even in the face of conclusive evidence of the child's perfect health, the HCA may demand that the child be evaluated and/or treated for some (hypochondriacal) condition.

While some HCAs can be deterred from further subjecting their children to medical intervention, others persist¹⁷ (eternally) in their quest to "help" their children.

The author has noted (page 130) that some parents who are well-intentioned--but not misguided--have been mistaken for HCAs or for child abusers in the medical guise. These are parents who are not reporting the fruits of hypochondriasis by proxy, but the actual symptoms of serious illness that physicians may have overlooked. These parents demand that their children receive appropriate medical attention. These parents do not relent when told that their children are "fine." These parents are not "disordered." The desired outcome of their involvement in medical care is the wellness of their child (at whatever cost).

The author notes that--although it is still too

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A discussion of the psychodynamics of HCA is beyond the scope of this dissertation.

The author notes, however, that HCAs are probably "disordered" parents who cannot simultaneously nurture their children and allow these children to develop as independent individuals.

premature to design formal assessment instruments for MSBP-- a simple "rule of thumb" can probably assist pediatricians in the differential diagnosis of MSBP. This can be derived from an analysis of the case vignettes for MSBP (1c and 2c)¹⁸ that were utilized for this study. (See Appendix A).

When a parent arrives at the ER with a child and reports that the child has had (reddish or pinkish) fluid oozing from his/her ear, the hospital staff make note of the existence of or the lack of existence of symptoms that would corroborate the parent's report:

Is the child's ear oozing fluid now? Or, did the fluid ooze out prior to the ER visit?

Does the fluid that the parent presents (as having emanated from the child's ear) resemble any known body fluid (that could escape from the ear)? Or, does it resemble some (known or unknown) foreign substance?

Does the child exhibit any of the symptoms that may be associated with such fluid oozing out of the ear? Is the child agitated or in pain? Is the child somnolent or lethargic? Are the child's breathing and vital signs in order?

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These case vignettes were actually derived from information contained in the MSBP case reports of Gilbert & Pierse, et. al., 1987 and Guandolo, 1984.

The answers to these basic triage questions are very important, because they provide the basis for whatever action will next be taken on behalf of the child.

If the child is virtually symptom-free and the substance that was alleged to have oozed from his/her ear is discovered to be theatrical make-up, ketchup, wine or strawberry preserves; if the parent's presentation is pathetic; and, if the parent's demeanor is one of quiet and compliance, then this is probably a case of Help Seeking.

If the child is either symptom-free, or the child has symptoms that do not comport with any known disorder; if it appears as if the fluid that (allegedly) oozed from the child's ear may be cerebrospinal fluid; and, if the parent's appearance and manner of conduct are not pathetic and compliant, then the role of the pediatrician becomes more complicated.

It may take some time for the laboratory to analyze the fluid in question. Even then, the results may or may not be conclusive. In the interim, the pediatrician must make an initial diagnosis. That is, the pediatrician must hypothesize (subject to later verification) whether s/he is dealing with an earnest, but frustrated parent who him/herself does not understand what is happening to the child, with an HCA, or with a case of MSBP.

The "rule of thumb" that the author proposes involves the notion that the MSBP parent is a pseudo-scientist who

will exhibit a clinical detachment (from the crisis at hand) that an ordinary non-abusing parent would probably be incapable of.

In cases where a child may in fact have a cerebro-spinal leak, one might anticipate serious parental concern that may manifest itself as either the parent's worry for the child, the parent's worry for him/herself, or, both. In fact, there is probably an entire spectrum of parent behaviors that would be considered "normal" or "appropriate" in this context. Some parents withdraw and cry or pray. Other parents become aggressive and belligerent. Indeed, some parents alternate between action and withdrawal as time progresses.¹⁹

The HCA parent is not a "normal" parent. S/he will be aggressive and belligerent. S/he will demand that his/her child be treated. S/he will demand that the treatment be immediate and comprehensive. S/he will not easily relent. When and if the fluid that allegedly oozed from her/his child's ear actually turns out to be (something like) cranberry juice that dripped out of the child's bottle and across her/his face (as s/he was drinking in her/his crib), this parent probably won't exhibit relief.

19

The author notes that "normal" parents whose children may be seriously ill may exhibit a broad variety of behaviors.

The MSBP parent is never aggressive or belligerent. S/he is always polite, courteous and deferential to medical personnel. S/he does challenge authority or make demands. S/he makes polite suggestions and makes a point of demonstrating how well s/he is following instructions.

The most important factor for the pediatrician to consider--when the nature of the fluid and the differential diagnosis appear to be inconclusive--is the focus of the parent. The author refers here to the fact that the mothers in cases 1c and 2c both provided coffee and donuts for the ER admitting staff at midnight.

The pediatrician needs to ask him/herself the important question: What parent whose child may be leaking cerebro-spinal fluid has the initiative to think about the recreational snacking proclivities of the ER admitting staff?²¹

Pediatricians are only human. They--like most people--will tend to respond more favorably to parents who are collegial and compliant, than to parents who are aggressive

20

The MSBP parent may in fact become belligerent after apprehension (when confronted with evidence of wrongdoing).

21

The author recognizes that the exceptional (non-abusing) parent may (in very rare instances) have the initiative to do this.

and belligerent. Yet, in order for abuse in the medical guise to be diagnosed, reported and addressed, pediatricians will have to be taught to transcend the pleasantries (of smiles, coffee and donuts) in favor of greater diagnostic objectivity.

Then, in order for the reports of pediatricians to be more meaningful, the criminal justice system will have to be prepared to deal more effectively with abuse in the medical guise.

In Chapter 19, the author will discuss some complex criminal justice issues surrounding the deterrence and remediation of MSBP.

Chapter 19:

MSBP and the Criminal Justice System.

Child abuse may occur as the result of a variety of adult conditions. It may occur episodically--at unspecified intervals--as a response to specific incidents of parental stress. Or, it may occur consistently as the result of parental premeditation.

The more typical forms of child abuse have been described as those in which the abusive parent(s):

...live[s] in a state of precarious balance between emotional supply and demand.

Any crisis, even a small one such as a broken washing machine, becomes unmanageable... [and] culminates in an abusive act, (Steele in Helfer & Kempe, 1987, p. 89-90).

Child abuse that responds to situational parental stress has clear parameters. Finite individual episodes of such abuse may be triggered by feelings of acute frustration and anger. These episodes end when the abusing parent has expended enough anger/ energy (in abusing the child) to calm down.

The more atypical forms of abuse involve dynamics that are not as clearly understood. These forms of abuse are neither intermittent nor necessarily responsive to specific

emotional upheavals that may be experienced by an abusing parent. Instead, they represent (carefully) planned and calculated acts that often have specific goals (such as the eradication of "the devil" within the child, or, the ultimate death of the child).

Child abuse in the medical guise does not represent the fruits of an acute episode of parental anger. Instead, it represents a chronic state in which manifestly calm parents (and later "unwitting" pediatricians) plot a calculated course of events for the child that will be both painful and pernicious.

The author has presented child abuse in the medical guise as a crime that may produce the same desired results for two types of abusers who operate from differing perspectives.

The first type of child abuser in the medical guise intends to harm and/or to kill his/her child. S/he has (unsuccessfully) attempted other means of abusing his/her child. S/he fears detection and apprehension. S/he has carefully researched a "medical" method of abuse that appears to be "fool proof."

The second type of child abuser in the medical guise intends to harm and/or kill him/herself at some future date. S/he has a record of treatment for Munchausen Syndrome. S/he has taken a temporary hiatus from MS in order to to do further research and execute "trial runs." S/he uses the

child as a human experimental subject upon whom s/he can observe the effects of various medical interventions.

The deterrence and the remediation of the more impulsive and "typical" forms of child abuse have been difficult to achieve (Gelles, 1979; Helfer, 1976; Hampton & Gullotta, et. al., 1993; Martin & Beezley, 1976; Wiehe, 1992). The author suggests that sophisticated forms of child abuse--such as child abuse in the medical guise--will be even more difficult to redress.

The child abuser in the medical guise is unlike the typical, impulsive, violent child abuser (who in many cases exhibits remorse following an abusive incident that was precipitated by some stressful event). The child abuser in the medical guise acts as a remorseless and calculating individual with an (explicit) agenda of his/her own.

The author hypothesizes that the "homicidal" child¹ abuser in the medical guise (hereafter CAMG) may exhibit the following profile: The parent may have begun to abuse his/child before the child was born. There may² have been (failed) attempts to induce abortion. Then, there

1

The author will refer to the child abuser in the medical guise who is seeking a "fool proof" method of harming/killing his/her child as the "homicidal CAMG" and the MS patient on "hiatus" who is performing "trial runs" on his/her child as the "suicidal CAMG."

may have been episodes of severe physical abuse during the infant's first few weeks (or months) of life (Bakan, 1971, page 50-54). A pattern of physical abuse may have been suspected or detected by pediatricians, child care workers, or family members. This abuse may have suddenly ceased. After some time, the child in question may develop some mysterious medical condition.³ The parent who was previously suspected of abuse, now appears to be a model parent who is very committed to the child's well being.⁴

The author further hypothesizes that the "suicidal" CAMG parent may exhibit the following profile: There may be a chronic pattern of MS in the parent's history. Repeated episodes of mendacious reporting of unusual symptoms, hospitalizations for invasive procedures (that produced inconclusive results), and/or a series of injuries (that may have been self-inflicted) may have occurred over many years. There may be a temporary hiatus, during which it appears as

2

These may have been attempted by either parent.

3

That is, the parent who has desisted from openly abusing the child (in fear of detection and apprehension), has had the opportunity to research a "fool proof" method (of CAMG) with which to abuse/kill the child.

4

Although the author is focusing on CAMG, (that is, specifically on the abuse of children), the same profile could apply to the abuse of pets, parents and peers.

5
if the MS patient may be in remission. After some time,
the MS patient's child may develop some mysterious medical
condition. The child will be brought to the pediatrician.
The parent will become very involved in assuring that
no medical procedure (that can possibly be performed on the
6
child) will be overlooked.

In both the "homicidal" and the "suicidal" cases of
MSBP, the perpetrators must engage in significant medical
research in order to produce (or to allege) a medical
condition that is sufficiently sophisticated to warrant
7
continuing medical interest. In some cases, this research
will involve only the utilization of a medical school
library or the purchase of some relevant textbooks. In
other cases, research will include nursing or allied health
profession classes and perhaps, some form of applied
clinical (internship) experience. In addition to this
research, some CAMG parents may volunteer their services in

5

That is, there have been no recent manifestations (or
complaints) of factitious disorders.

6

As in the case of "homicidal" CAMG, the author's profile
could also be applied to the abuse of pets, parents and
peers.

7

The sophistication of the medical symptoms insures that the
CAMG parent will not be mistaken for a Help Seeker.

hospitals or clinics, so that they can observe the course of various illnesses and their treatments.

The deterrence of child abuse in the medical guise is very difficult to accomplish. It is important to realize that perpetrators of CAMG are not impulsive individuals who can (perhaps) be taught to modify their behaviors and keep their emotions in check. Instead, the perpetrators of CAMG are chronic recidivists who are working toward real goals.

Several methods that have been proposed to deter the more typical forms of child abuse, have also been proposed to deter CAMG. These are: public education, parent education and more comprehensive record-keeping. The author will discuss some of the pros and cons of each of these methods.

Public education about the prevalence of child abuse has indeed fostered an awareness that child abuse exists. Individuals and groups have responded by calling child abuse hotlines (in order to report cases that they have observed). Religious and community organizations have created support groups and have undertaken outreach efforts on behalf of "problem" parents.

Public education about CAMG is in its embryonic stages. Apart from several media accounts of actual cases and several television dramatizations, (such as a 1994 episode of NBC's "Law and Order" (Balcer & Rappaport, 1994) which

dedicated an episode to an MSBP case), the general public has not been made aware of the existence, prevalence, or, dynamics of CAMG.

Greater pediatrician awareness of CAMG will probably produce better recognition and reporting of CAMG. However, the author is concerned that public education about CAMG may produce undesirable results (unless conducted with the upmost care).

It has been asserted (Bakan, 1971) that many people harbor wishes and fantasies about harming their children. Some people act out those fantasies. Other people do not. While it would be beyond the scope of this dissertation to provide a detailed analysis of "why" some people act out child abuse fantasies and others do not, the author suggests that one important factor is "opportunity." Some people who fantasize about abusing their children and actually wish to abuse their children have no "fool proof" method (with which to do this) at their disposal. By increasing public awareness about CAMG, we may actually be encouraging some of these latent abusers to perpetrate CAMG.

Parent education or "parental consciousness" (Newberger, 1979) has been at the center of many child abuse prevention programs. It has been suggested that if parents are taught to reduce or to channel their anxiety and stress and if parents are taught to find objects (other than their children) for their anger, that child abuse incidents will

decline.

While parent education programs have been successful to varying degrees in cases of "typical" child abuse, the author suggests that the current prototype for such programs will be inappropriate (and probably useless) when applied to CAMG.

In the author's professional experience, parents who attend parent education programs (whether voluntarily or involuntarily) are either repentant and motivated to improve their parenting skills, or angry at their children for
8
having been detected.

CAMG parents belong to neither of these categories. They are either bewildered (perhaps, righteously indignant) about the requirement to attend such a program, or, they attempt to re-enact with the instructor (of the program) the type of collegial relationship that they had temporarily enjoyed with the pediatrician (before being apprehended).

CAMG parents may benefit from information about the role of children in American society. The "homicidal" CAMG

8

Parents who enroll voluntarily are generally interested in improving themselves. Parents who have been enrolled involuntarily (because they were remanded by the court or by a social service agency) may be motivated to improve, or, they may be angry that their children were not careful enough to obscure the injuries and scars that brought them to the attention of the authorities.

9

may benefit from information about foster care or adoption as realistic options that exist for unwanted children. Alternatively, however, deterrence from CAMG, may drive these "homicidal" CAMG parents to seek even more exotic means of abusing/killing their children.

The "suicidal" CAMG may be unaffected by information about the rights of children and the responsibilities of parents (that are routinely discussed in parent education programs). Alternatively, "suicidal" CAMG parents may utilize the information in question in order to rationalize the selection of an alternative victim upon whom to perform "trial runs."¹⁰

More comprehensive record-keeping in the form of national child abuse data banks may help to lower the incidence of all forms of child abuse. If abusing parents know that they can and will be treated as repeat offenders (if they continue to abuse their children), then they may

9

The author suggests that further research is necessary to determine the likelihood of "homicidal" CAMGs actually benefiting from such educational programs.

10

The author notes that (unfortunately) apart from interventions designed to address the personal situation of the "suicidal" CAMG (that do not focus on the child), a subscription to the Hemlock Society (or some similar organization) providing information about proven methods of suicide, may be the only effective deterrent to "suicidal" CAMG.

desist from such abuse.

In the case of CAMG, national data banks may be invaluable in the detection of existing cases and in the deterrence of future cases. A pediatrician (or social service worker) who encounters a case that may be CAMG, could refer to the child abuse data bank to rule out¹¹ "homicidal" CAMG. S/he could further refer to a health care¹² data bank in order to rule out cases of "suicidal" CAMG. Moreover, s/he could even investigate whether this parent or¹³ this child had ever been previously treated for CAMG.

While the suggestion that a more sophisticated form of medical and criminal justice system record-keeping may be invaluable to the deterrence and detection of child abuse is

¹¹

The author's profile of the "homicidal" CAMG (page 327-328) described an abuser who has resorted to CAMG only after other methods have proven to be unsuccessful. The seemingly congenial and concerned parent who is actually a CAMG, may have a record of these previous abuses.

¹²

The author's profile of the "suicidal" CAMG (pages 328-329) described an abuser who has a personal history of MS. A parent's record of numerous hospitalizations and/or treatments for factitious disorders will be instructive to the pediatrician who considers a case of CAMG.

¹³

CAMG as well as adult MS patients are notorious for "skipping" from hospital to hospital (even across broad geographic areas) in order to avoid detection. At this time, physicians cannot access the medical (or criminal justice) records of patients in different states.

welcome in some circles, it is also an issue which many Americans regard with apprehension. For, apart from the perpetrators of crimes whose personal histories would become accessible to researchers, all of the honest and law abiding citizens of this country would be subject to similar invasions of privacy.

There are many other options that can be considered for the deterrence and the remediation of CAMG. However, the author asserts that before we can consider any of these options, we must address one fundamental issue that impedes all efforts on behalf of children (or others) who may be abused in the medical guise.

The author refers to the fact that abuse in the medical guise is currently referred to as "Munchausen Syndrome By Proxy." MSBP, is a "jolly" term that belies the nature and the severity of the abuse that is suffered by its victims.

"Munchausen Syndrome" (MS) is the term that has been employed to label a variety of acts involving individuals who present themselves to physicians for medical evaluation and intervention with a mendacious report of their own symptomatology.

"Munchausen Syndrome by Proxy" (MSBP) is the term that has been employed to label a variety of acts involving parents who present their children to a pediatrician for medical evaluation and intervention with a mendacious report of the child's symptoms.

The term "Munchausen" was borrowed from the jolly European raconteur who traveled extensively and entertained his guests with wildly exaggerated accounts of his escapades.

The term "syndrome" implies the adoption of the medical model. That is, the notion that MS and MSBP are "syndromes" that are somehow analogous to other syndromes that can be medically remediated.

The term "by proxy" implies that it occurs when one party has the "authority" to act on behalf of another party.

It is important to analyze each of these terms and to evaluate their utility in operationalizing the acts for which they have been employed.

Munchausen: It has been demonstrated that the original Baron von Munchhausen was neither (himself) suicidal nor abusive to others. In fact, he was a gracious and hospitable host who provided his guests with food, drink and merriment. The appropriation of the name "Munchausen" to describe instances of pernicious self-abuse or the abuse of others is thus manifestly inappropriate.

Seeking to relieve some of the discomfort associated with the almost oxymoronic association of the gregarious von Munchhausen with the notion of abuse, scholars and researchers have attempted to remove the name of Munchhausen from their descriptions of pernicious acts, especially those acts involving the abuse of children. These attempts have included the following:

1. MS has been referred to as the "parent" syndrome of MSBP. It has been suggested that if Baron von Munchhausen is the "parent," then we should have a "child" to represent MSBP. Thus the "Polle Syndrome" movement (Meadow, et. al., 1984c) that attempted to allege the existence of a young¹⁵ Munchhausen daughter who was named "Polle" and who died in infancy.

2. The proposal of "Meadow Syndrome" (Lazoritz, 1983) to rename MSBP after Roy Meadow, the physician who first described it in the medical literature.

3. The movement to remove all personal names from the acts previously labeled MS and MSBP and to refer to the "parent" condition of MS as "factitious disorder" and the "by proxy" condition as "factitious disorder by proxy" (American Psychiatric Association, 1994).

15

Elaine Leeder (1990) described "Polle" as a son of the Baron von Munchhausen.

Syndrome: Although MS and MSBP both consist of unnecessary and inappropriate medical interventions, it is important to consider whether they constitute "diseases" or medical syndromes in and of themselves.

As Ross (Gerbner, et. al., 1980) has noted, in recent years, the "disease" model has been utilized in order to present child abuse as a "medical problem." This approach is based on the notion that child abuse can be remediated through appropriate forms of medical intervention.

Ross is very critical of this "sickness" approach. He explains that when we anticipate "disease," we actually commit two errors: First, we abrogate the entire notion of "agency" in human behavior. Then, we ignore the essential role of the parent-child conflict as a normal intrafamilial process that may (and often does) become deviant.

The medical model of child abuse is seriously flawed, because medical science has not demonstrated that there is, or even that there can ever be medical "cures" for the "disease" of child abuse.

While adults may feign disease in themselves or report mendacious episodes of disease in their children, it is by no means clear that "medical intervention" will in any way remediate their situations. In fact, it is precisely "medical intervention" that they are employing to hurt themselves and/or their children. Thus, the DSM IV does not apply the term "syndrome" to either MS or MSBP, but utilizes

"disorder" as the more appropriate referential term.

By Proxy: This term implies some form of consent. For example, a consenting adult voter who cannot be present to represent her/his own interests might issue a "proxy" so that an agent who will be present in lieu of the consenting adult voter may duly represent those interests on the voter's behalf.

Three problems emerge with the usage of the term "by proxy" to represent the acts involved in MSBP:

1. The adults who inflict medical abuse upon their infants and young children cannot possibly be acting with the knowledge and consent of their victims.

2. Even in cases where it has been alleged (but not proven) that older children may participate in their own MSBP victimizations, the nature of the folie a deux-type interaction would require the simultaneous participation of both the parent and the child, thus excluding the (either--or) notion of "proxy."

3. Acting as a "proxy" implies that one is acting on behalf of and representing the interests of another. It is difficult to construe acts of pernicious child abuse in the medical guise as acts of "proxy."

Thus, the term "Munchausen Syndrome by Proxy" does not accurately describe the nature or consequences of the interactional triad of child abuse in the medical guise.

For, instead of evoking a serious and somber response to the pernicious physical harm that is perpetrated by a parent upon a helpless child through the (unwitting) participation of a pediatrician, the term MSBP invokes the lighthearted quality of some "funny" (barely pronounceable) medical condition that involves the "proxy" or agency of another.

16

The term "MSBP" therefore joins other forms of child abuse about which knowledge has been banished (Miller, 1990) by faulty association.

Explanations and rationalizations have been offered for society's inability or unwillingness to recognize and to eradicate child abuse. One of the most compelling reason has been the use of euphemisms to mask actual events. Thus, invoking religious symbolism (Greven, 1990), or speaking of "proper upbringing" (Miller, 1990) has historically exonerated both the perpetrator and the observer from knowledge about and deterrence of child abuse.

Thus, although MSBP actually represents "another form of child abuse" (Rees, 1987) whose young victims may need formal protection from potentially "life threatening parents" (Alexander, undated), the very name "Munchausen Syndrome by Proxy" confuses and diminishes the seriousness

of the events involved.

The author concludes this dissertation with the observation that child abuse in the medical guise is a serious crime.

The challenge currently before the criminal justice system with regard to CAMG may be stated as follows: Will we continue to describe CAMG in jolly, unpronounceable terms (such as "Munchausen Syndrome By Proxy") that have dubious meaning? Or, will we begin to soberly appraise the pernicious abuse that children suffer at the hands of parents who abuse them in the medical guise?

APPENDIX A

Vignettes

1/a

Pretty, brown haired Debby Green had worked as a hospital technician for two years. Her husband John had moved out to be with his girlfriend. Debby has no job, no money, no man. All she has is a 6 month old named Lisa. To make matters worse, one day Debby had to bring Lisa to the Emergency Room at the Hospital with some reddish stuff in her diaper.

The triage nurse noted that:

- a. the stained diaper had a sweet cranberry-like odor.
- b. the mother appeared attentive to the infant and cooperated with staff at all times.

1/b

Pretty, brown haired Debby Green had worked as a hospital technician for two years. Her husband John had moved out to be with his girlfriend. Debby has no job, no money, no man. All she has is a 6 month old named Lisa who had already had viral meningitis at 2 months of age. Debby brought Lisa to the Emergency Room at the Hospital and reported that Lisa had been lethargic for several hours. The triage nurse noted that:

- a. the baby appeared to respond to visual as well as auditory stimulus.
- b. when other children in the waiting area were treated ahead of Lisa, the mother became quite belligerent and insisted that a "spinal tap" be performed on her baby "at once," "or else...."

1/c

Pretty, brown haired Debby Green had worked as a hospital technician for two years. Her husband John had moved out to be with his girlfriend. Debby has no job, no money, no man. All she has is a 6 month old named Lisa who cried and cried. Debby brought Lisa to the Emergency Room at the Hospital with some reddish stuff oozing from her ear.

The triage nurse noted that:

- a. the reddish fluid appeared to have the odor and consistency of menstrual fluid.
- b. the mother was very generous in her caring and support of other parents in the waiting area. She was also kind enough to provide coffee and donuts for the admitting staff at midnight.

2/a

Pretty, brown haired Debby Green had worked as a hospital technician for two years. Her husband John had moved out to be with his girlfriend. Debby has no job, no money, no man. All she has is a 6 month old named Lisa. Debby brought Lisa to the Emergency Room at the Hospital and reported that the baby was behaving strangely and had a reddish substance in her diaper.

The triage nurse reported that:

- a. the stained diaper had no particular odor or consistency of blood.
- b. the mother appeared to be very distraught as she paced the floors.

2/b

Pretty, brown haired Debby Green had worked as a hospital technician for two years. Her husband John had moved out to be with his girlfriend. Debby has no job, no money, no man. All she has is a 6 month old named Lisa. Debby brought Lisa to the Emergency Room at the Hospital and reported that Lisa had been lethargic for several hours.

The triage nurse noted that:

- a. the baby appeared to respond to visual as well as auditory stimulus.
- b. when other children in the waiting area were treated ahead of Lisa, the mother became quite belligerent and insisted that an immediate "spinal tap" be performed on her baby "to check for viral meningitis."

2/c

Pretty, brown haired Debby Green had worked as a hospital technician for two years. Her husband John had moved out to be with his girlfriend. Debby has no job, no money, no man. All she has is a 6 month old named Lisa. Debby brought an otherwise peaceful Lisa to the Emergency Room at the Hospital with pinkish fluid oozing from Lisa's left ear. She also brought a small container of the same fluid which she had collected over the past few hours. The triage nurse noted that:

- a. the pinkish fluid appeared to be cerebrospinal fluid.
- b. the mother was very calm and cooperative. She was empathic to the priorities of staff and the needs of other patients. She was also kind enough to provide coffee and donuts for the admitting staff at midnight.

APPENDIX B

Questionnaire

Part I

Please identify and detail the protocol that you would follow as the first pediatrician to examine Lisa in the Emergency Room of the Hospital.

Which referrals would you make in this case?

Please utilize this checklist and feel free to add any other

☐ Ambulatory Care	☐ Gynecology
☐ Arthritis Clinic	☐ Geriatrics
☐ Admitting	☐ Gastroenterology
☐ Anesthesiology	☐ Laboratory
☐ Bureau of Child Welfare	☐ Neurology
☐ Breast Feeding Support Group	☐ Neurosurgery
☐ Cardiac Care Unit	☐ Police
☐ Cancer Screening	☐ Pathology
☐ Child Abuse Hotline	☐ Psychiatry
☐ Community Nursing	☐ Recreation Therapy
☐ Dietician	☐ Social Services
☐ Dermatology	☐ Urology
☐ District Attorney	☐ X-Ray
☐ Other _____	☐ Other _____

The questions on this page refer to the infant Lisa:

1. At first impression, do you believe that Lisa is:

- ☐ very ill
- ☐ moderately ill
- ☐ mildly ill
- ☐ not ill at all

2. At first impression, do you believe that Lisa is a:

- ☐ good baby
- ☐ basically good baby, but a little fussy
- ☐ challenging baby
- ☐ very challenging baby who might try the patience of any parent

3. Baby Lisa plays _____ role in Debby's life.

- ☐ a very important
- ☐ an important
- ☐ a minor
- ☐ an insignificant

4. Baby Lisa is:

- ☐ treasured
- ☐ very loved
- ☐ moderately loved
- ☐ unloved

The next page consists of pairs of words which form a scale.

Please make an "X" along the scale to indicate what you would associate with Baby Lisa:

If you feel that Baby Lisa is highly related with one end of the scale, you would place an "X" mark as follows:

up__::__:__:__::X down OR down X:__:__:__:__:up

If you feel that Baby Lisa is moderately related to one or the other end of the scale, you would place an "X" mark as follows:

cold__::__:__:__::X:__:warm OR warm__::X:__:__:cold

If Baby Lisa only seems to be slightly related to one side as opposed to the other, you would place an "X" mark as follows:

in__::__:__:X:__:out OR out__::X:__:__:in

If you consider both sides wqually related, or would classify Baby Lisa as somewhere in the middle, or really can't tell, you would place your "X" in the middle space on the scale:

calm__::__:__:X:__:nervous

Please be sure to check every item. Even if you feel that a particular pair of words may not apply, or if you are undecided, place an "X" in the center space. Do not leave the line blank.

Never put more than one "X" mark on any scale.

Do not spend more than a few seconds marking each scale. Your first impression is what we would like to learn about. We have found that you can work quicker if you form a picture in your mind of Baby Lisa, and after that check each scale rapidly.

Baby Lisa

cute ____:____:____:____:____:____:____ monstrous
cuddly ____:____:____:____:____:____:____ intense
clean ____:____:____:____:____:____:____ messy
sweet ____:____:____:____:____:____:____ sour
gurgling ____:____:____:____:____:____:____ screaming
serene ____:____:____:____:____:____:____ upset
loveable ____:____:____:____:____:____:____ unlovable
fragrant ____:____:____:____:____:____:____ smelly
joyous ____:____:____:____:____:____:____ troublesome
natural ____:____:____:____:____:____:____ unnatural
familiar ____:____:____:____:____:____:____ unfamiliar
nourished ____:____:____:____:____:____:____ malnourished
loved ____:____:____:____:____:____:____ unloved
bonded ____:____:____:____:____:____:____ unbonded
healthy ____:____:____:____:____:____:____ sick
whole ____:____:____:____:____:____:____ damaged
intelligent ____:____:____:____:____:____:____ unintelligent
playful ____:____:____:____:____:____:____ aloof
active ____:____:____:____:____:____:____ lethargic
adjusted ____:____:____:____:____:____:____ disturbed
good ____:____:____:____:____:____:____ bad
charming ____:____:____:____:____:____:____ dreadful
pleasant ____:____:____:____:____:____:____ unpleasant
victim ____:____:____:____:____:____:____ perpetrator
honest ____:____:____:____:____:____:____ dishonest
innocent ____:____:____:____:____:____:____ guilty

The questions on this page refer to Debby Green, the mother:

1. Debby Green is:

- ☐ a very responsible parent
- ☐ a responsible parent
- ☐ an irresponsible parent
- ☐ a very irresponsible parent

2. Debby Green is:

- ☐ very stable
- ☐ stable
- ☐ unstable
- ☐ very unstable

3. Debby Green is mentally:

- ☐ very healthy
- ☐ healthy
- ☐ unhealthy
- ☐ very unhealthy

4. Debby Green would sacrifice _____ on behalf of Lisa.

- ☐ everything
- ☐ some things
- ☐ very little
- ☐ not at all

5. Debby Green is:

- ☐ able to take care of most of her needs
- ☐ able to take care of some of her needs
- ☐ able to take care of few of her needs
- ☐ able to take care of none of her needs.

The next page consists of pairs of words which form a scale.

We would like to learn about your impressions of Debby Green. We have found that you can work quicker if you form a picture in your mind of Debby Green, the mother.

Please make an "X" along the scale to indicate what you would associate with Debby Green.

Debby Green

good	___:___:___:___:___:___:___	bad
strong	___:___:___:___:___:___:___	weak
calm	___:___:___:___:___:___:___	agitated
pleasant	___:___:___:___:___:___:___	unpleasant
brave	___:___:___:___:___:___:___	cowardly
nice	___:___:___:___:___:___:___	awful
active	___:___:___:___:___:___:___	passive
healthy	___:___:___:___:___:___:___	sick
familiar	___:___:___:___:___:___:___	strange
obvious	___:___:___:___:___:___:___	subtle
simple	___:___:___:___:___:___:___	complex
happy	___:___:___:___:___:___:___	sad
violent	___:___:___:___:___:___:___	gentle
unique	___:___:___:___:___:___:___	commonplace
sincere	___:___:___:___:___:___:___	insincere
controlled	___:___:___:___:___:___:___	accidental
truthful	___:___:___:___:___:___:___	deceitful
sensitive	___:___:___:___:___:___:___	callous
kind	___:___:___:___:___:___:___	brutal
normal	___:___:___:___:___:___:___	crazy
righteous	___:___:___:___:___:___:___	diabolic
loving	___:___:___:___:___:___:___	hating
unfair	___:___:___:___:___:___:___	fair
dishonest	___:___:___:___:___:___:___	honest
criminal	___:___:___:___:___:___:___	victim

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Part II

In many jurisdictions, pediatricians are required to complete continuing education hours in the area of "Child Abuse and Neglect."

Are you required to do so? ___ yes ___no

Have you done so? ____yes ____no

Do you believe that baby Lisa may have been the victim of child abuse? ____yes ____no

Why? _____

Do you believe that Debby Green is a potential or actual child abuser? ____yes ____no

Why? _____

Part III

Munchausen Syndrome by Proxy

Munchausen Syndrome by Proxy represents child abuse in the medical guise. It involves a sophisticated adult who carefully fabricates the symptoms of disease in a child and then inflicts pernicious abuse upon the child through the diagnostic and treatment facilities of the health care system.

1. If Lisa's symptom's have been fabricated, should Debby Green be reported to the appropriate authorities within the criminal justice system?

___ yes

___ no

2. If Lisa's symptoms have been fabricated, should
Debby Green be referred to Psychiatric Services?

☐ yes

☐ no

3. If Lisa's symptoms have been fabricated, should
Debby Green be referred to Social Services?

☐ yes

☐ no

4. If Lisa's symptoms have been fabricated, what is
your recommendation in this case?

5. Is Lisa a victim of Munchausen Syndrome by Proxy?

 yes

 no

6. Why did you respond this way to question 5?

7. Would you recommend that Debby Green be reported to the authorities for this incident of child abuse?

 yes

 no

8. Why did you respond this way to question 7?

9. Would you recommend that Debby Green be referred to
Psychiatric Services?

____yes

____no

10. Why did you respond as you did to question 9?

11. Would you recommend that Debby Green be referred to
Social Services?

____yes

____no

12. Why did you respond as you did to question 11?

13. Would you recommend that baby Lisa be removed from
Debby's home?

____yes ____no

14. Why did you respond as you did to question 13?

APPENDIX C

Demographic Survey

A

For practicing pediatricians and pediatric residents:

1. Gender: _____
2. Age: _____
3. Racial background: _____
4. Ethnic background: _____
5. Religion: _____
5. Place of birth: _____
6. If you were not born in the U.S.A.:
 - a. Number of years in U.S.A.: _____
 - b. Citizen? _____
7. Medical School: _____
8. Pediatric Residency: _____
 - a. Number of years completed: _____
9. Other Specialties: _____

* If you are a pediatric resident please go on to
page 367.

* If you are a practicing pediatrician please go on to
the next page.

B

Practicing Pediatricians Only:

8. Please check off as many descriptives as apply to your pediatric practice setting:

a. Private Practice (Solo) _____

b. Group Practice (2 or more) _____

Please describe: _____

c. HMO-type _____

d. Clinic _____

e. Hospital-based _____

f. Other _____

Please describe _____

9. What percentage of your practice involves Medicaid patients? _____

10. Do you hold a faculty appointment at a medical school?

11. Are you a F.A.A.P. ? _____

***Have you ever attended or participated in any continuing
education program on Munchausen Syndrome by Proxy?

yes_____

no_____

If yes, please describe.

Thank-you very much for your cooperation.

If you would like to receive a copy of the results of this
research (when it is completed) please fill enclose your
business card in the plastic sleeve attached below.

APPENDIX D

Physician Compliance with Mail and Telephone Surveys.

Because of the difficulties inherent in sampling pediatricians by mail or by phone (described supra page 156-159), the researcher consulted with the following experts for advice and assistance in this undertaking:

1. The American Academy of Pediatrics (AAP): I spoke with Ms. Karen O'Conner, the Administrator of Research Projects on December 8, 1994. Ms. O'Conner asserted that pediatricians who are AAP Fellows (FAAP) are very compliant when surveyed by their own association. She added that if my research proposal was congruous with the "goals or objectives of the Academy and its committees," then it might be possible for the Academy to include my questionnaire in their "periodic survey" of Fellows. If this were done, however, I would not be permitted access to this data for at least 5 years.

In the alternative, there is a "costly" (prohibitive) process of requesting a random sample of Fellow mailing labels from the Academy. Pediatricians sampled in this way will not necessarily comply because there can be no identification whatsoever of this research with the AAP.

2. Columbia University School of Public Health:

On December 12, 1994, I spoke with Professor John Columbotis whose seminal article (Columbotis, 1969) describes personal and telephone interviewing of physicians. Professor Colombotis recently completed a major survey of physicians on the subject of treating AIDS patients. He has served on the Public Health dissertation committees of doctoral candidates who have attempted to survey physicians.

According to Prof. Columbotis: "mail questionnaires among scattered samples of pediatricians without major organizational sponsorship don't work."

In Prof. Columbotis' own current research, he has resorted to sending the questionnaire to the physician by Federal Express with a \$25.00 check as a token payment. This method has generated a 60% compliance rate.

3. Dr. Betty Levin, Associate Professor of Health and Nutrition Sciences at Brooklyn College, CUNY has conducted several studies of pediatricians and surveyed them on issues of ethics and decision making. One of her studies was endorsed by the American Academy of Pediatrics. It involved pediatricians' attitudes about the aggressive treatment of catastrophically ill newborns.

Dr. Levin is in the process of preparing a Letter to the Editor of the American Journal of Public Health in which

she will explain that in studies without AAP endorsement, a 50% response rate for pediatrician surveys is "outstanding." In her AAP endorsed study (which also carried the endorsements of several prominent pediatricians,) she was never able to achieve better than a 2/3 compliance rate.

I spoke with Dr. Levin on December 13, 1994. She asserted that "it is a lost cause to try to get a random sample of pediatricians." Instead, she advocated sampling pediatric residents and fellows because they can be the most compliant. Her methods of achieving compliance have included announcing "free pizza lunch on Friday" for pediatric residents who will come to fill out a questionnaire (while eating their pizza). She notes that SUNY Downstate and Kings County Hospital pediatric residents are the most receptive to pizza because they do not have access to any, while Albert Einstein College of Medicine pediatric residents are the least receptive because pharmaceutical companies are now frequently offering them pizza in return for compliance with their surveys.

4. The American Medical Association: I spoke with Dr. Lorayn Olson of the Research Department on December 12, 1994. She informed me that pediatricians are by no means the most difficult physicians to survey. Internists are

considerably more difficult. Dr. Olson further asserted that if I could develop a very brief questionnaire (1-2 pages at most, but preferably one page,) then it could probably be faxed over to pediatricians, and if it was short enough, they would probably comply and fax it back immediately.

Dr. Olson cautioned against attempting to survey physicians at medical conferences. It has been her experience that compliance is only possible at conferences where conference organizers and other physicians will agree to promote the survey.

Dr. Olson further asserted that any type of random pediatrician sampling (by mail and/or by phone) without organizational backing would require extremely arduous and expensive procedures such as multiple calls and follow-up mailings and would thus be beyond the scope of a graduate student whose research was not appropriately funded.

APPENDIX E

Letter of Approval from the Committee on the Protection of
Human Subjects.



THE
GRADUATE SCHOOL
AND
UNIVERSITY CENTER

OFFICE OF SPONSORED RESEARCH
AND PROJECT PLANNING

33 WEST 42 STREET, NEW YORK, NY 10036-8099
212 642-2059 FAX 212 642-2546

THE CITY UNIVERSITY OF NEW YORK

December 7, 1994

Esther S. Rister
5622 14th Ave.
Brooklyn, NY 11219

RE: Your proposal, "Child Abuse in the Medical Guise: Munchausen Syndrome by Proxy"

Dear Ms. Rister:

The Committee on the Protection of Human Subjects has reviewed and approved your proposal.

Best wishes for success in your research.

Sincerely,

Daisy Edmondson

Daisy Edmondson
(for Jane Gentilini)

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EUGENIO MARIA DE MORTOS
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(AFFILIATED)
NEW YORK CITY TECHNICAL COLLEGE
QUEENS COLLEGE
QUEENSBOROUGH COMMUNITY COLLEGE
YORK COLLEGE

Appendix F:

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Table F-1

Group Means

<u>Cell</u>	<u>N</u>
1a	52
1b	59
1c	63
2a	60
2b	44
2c	64

Table F-2

Significance Tests on Individual Means: TOTREFER

General Linear Models Procedure

Bonferroni (Dunn) T tests for variable: TOTREFER

NOTE: This test controls the type I experimentwise error rate but generally has a higher type II error rate than Tukey's for all pairwise comparisons.

Alpha= 0.05 Confidence= 0.95 df= 336 MSE= 2.638133

Critical Value of T= 2.95634

Comparisons significant at the 0.05 level are indicated by '***'.

CLASSIF Comparison	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit	
2C - 1C	0.8040	1.6563	2.5085	***
2C - 2A	1.1434	2.0063	2.8691	***
2C - 1A	2.0482	2.9447	3.8412	***
2C - 1B	2.1286	2.9952	3.8619	***
2C - 2B	2.1022	3.0426	3.9830	***
1C - 2C	-2.5085	-1.6563	-0.8040	***
1C - 2A	-0.5162	0.3500	1.2162	
1C - 1A	0.3888	1.2885	2.1881	***
1C - 1B	0.4690	1.3390	2.2089	***
1C - 2B	0.4430	1.3864	2.3298	***
2A - 2C	-2.8691	-2.0063	-1.1434	***
2A - 1C	-1.2162	-0.3500	0.5162	
2A - 1A	0.0287	0.9385	1.8482	***
2A - 1B	0.1086	0.9890	1.8694	***
2A - 2B	0.0833	1.0364	1.9894	***
1A - 2C	-3.8412	-2.9447	-2.0482	***
1A - 1C	-2.1881	-1.2885	-0.3888	***
1A - 2A	-1.8482	-0.9385	-0.0287	***
1A - 1B	-0.8628	0.0505	0.9639	
1A - 2B	-0.8857	0.0979	1.0815	
1B - 2C	-3.8619	-2.9952	-2.1286	***
1B - 1C	-2.2089	-1.3390	-0.4690	***
1B - 2A	-1.8694	-0.9890	-0.1086	***
1B - 1A	-0.9639	-0.0505	0.8628	
1B - 2B	-0.9091	0.0474	1.0038	
2B - 2C	-3.9830	-3.0426	-2.1022	***
2B - 1C	-2.3298	-1.3864	-0.4430	***
2B - 2A	-1.9894	-1.0364	-0.0833	***
2B - 1A	-1.0815	-0.0979	0.8857	
2B - 1B	-1.0038	-0.0474	0.9091	

Table F-3

Significance Tests on Individual Means: MEDREFER

Alpha= 0.05 Confidence= 0.95 df= 336 MSE= 1.255107
 Critical Value of T= 2.95634

Comparisons significant at the 0.05 level are indicated by '***'.

CLASSIFICATION Comparison	Simultaneous		Difference Between Means	Simultaneous	
	Lower Confidence Limit	Upper Confidence Limit		Lower Confidence Limit	Upper Confidence Limit
2C - 1C	0.8574	2.0330	1.4452	0.8574	2.0330
2C - 1A	0.9886	2.2253	1.6070	0.9886	2.2253
2C - 2A	1.2746	2.4650	1.8698	1.2746	2.4650
2C - 1B	1.4401	2.6356	2.0379	1.4401	2.6356
2C - 2B	1.6681	2.9654	2.3168	1.6681	2.9654
1C - 2C	-2.0330	-0.8574	-1.4452	-2.0330	-0.8574
1C - 1A	-0.4588	0.7823	0.1618	-0.4588	0.7823
1C - 2A	-0.1728	1.0221	0.4246	-0.1728	1.0221
1C - 1B	-0.0074	1.1927	0.5927	-0.0074	1.1927
1C - 2B	0.2209	1.5223	0.8716	0.2209	1.5223
1A - 2C	-2.2253	-0.9886	-1.6070	-2.2253	-0.9886
1A - 1C	-0.7823	0.4588	-0.1618	-0.7823	0.4588
1A - 2A	-0.3647	0.8903	0.2628	-0.3647	0.8903
1A - 1B	-0.1991	1.0609	0.4309	-0.1991	1.0609
1A - 2B	0.0314	1.3882	0.7098	0.0314	1.3882
2A - 2C	-2.4650	-1.2746	-1.8698	-2.4650	-1.2746
2A - 1C	-1.0221	0.1728	-0.4246	-1.0221	0.1728
2A - 1A	-0.8903	0.3647	-0.2628	-0.8903	0.3647
2A - 1B	-0.4392	0.7753	0.1681	-0.4392	0.7753
2A - 2B	-0.2104	1.1043	0.4470	-0.2104	1.1043
1B - 2C	-2.6356	-1.4401	-2.0379	-2.6356	-1.4401
1B - 1C	-1.1927	0.0074	-0.5927	-1.1927	0.0074
1B - 1A	-1.0609	0.1991	-0.4309	-1.0609	0.1991
1B - 2A	-0.7753	0.4392	-0.1681	-0.7753	0.4392
1B - 2B	-0.3808	0.9386	0.2789	-0.3808	0.9386
2B - 2C	-2.9654	-1.6681	-2.3168	-2.9654	-1.6681
2B - 1C	-1.5223	-0.2209	-0.8716	-1.5223	-0.2209
2B - 1A	-1.3882	-0.0314	-0.7098	-1.3882	-0.0314
2B - 2A	-1.1043	0.2104	-0.4470	-1.1043	0.2104
2B - 1B	-0.9386	0.3808	-0.2789	-0.9386	0.3808

Table F-4

Significance Tests on Individual Means: MHREFER

Comparisons significant at the 0.05 level are indicated by '***'.

CLASSIF Comparison	Simultaneous		Difference Between Means	Simultaneous		
	Lower Confidence Limit	Upper Confidence Limit		Lower Confidence Limit	Upper Confidence Limit	
2C - 2A	-0.2943	0.0125	0.3193			
2C - 1C	-0.1730	0.1300	0.4329			
2C - 2B	-0.0673	0.2670	0.6014			
2C - 1B	0.2671	0.5752	0.8833			***
2C - 1A	0.3207	0.6394	0.9581			***
2A - 2C	-0.3193	-0.0125	0.2943			
2A - 1C	-0.1905	0.1175	0.4254			
2A - 2B	-0.0843	0.2545	0.5934			
2A - 1B	0.2497	0.5627	0.8757			***
2A - 1A	0.3035	0.6269	0.9504			***
1C - 2C	-0.4329	-0.1300	0.1730			
1C - 2A	-0.4254	-0.1175	0.1905			
1C - 2B	-0.1983	0.1371	0.4725			
1C - 1B	0.1360	0.4453	0.7545			***
1C - 1A	0.1896	0.5095	0.8293			***
2B - 2C	-0.6014	-0.2670	0.0673			
2B - 2A	-0.5934	-0.2545	0.0843			
2B - 1C	-0.4725	-0.1371	0.1983			
2B - 1B	-0.0319	0.3082	0.6482			
2B - 1A	0.0227	0.3724	0.7220			***
1B - 2C	-0.8833	-0.5752	-0.2671			***
1B - 2A	-0.8757	-0.5627	-0.2497			***
1B - 1C	-0.7545	-0.4453	-0.1360			***
1B - 2B	-0.6482	-0.3082	0.0319			
1B - 1A	-0.2605	0.0642	0.3889			
1A - 2C	-0.9581	-0.6394	-0.3207			***
1A - 2A	-0.9504	-0.6269	-0.3035			***
1A - 1C	-0.8293	-0.5095	-0.1896			***
1A - 2B	-0.7220	-0.3724	-0.0227			***
1A - 1B	-0.3889	-0.0642	0.2605			

Table F-5

Significance Tests on Individual Means: CRJREFER

Bonferroni (Dunn) T tests for variable: CRJREFER

NOTE: This test controls the type I experimentwise error rate but generally higher type II error rate than Tukey's for all pairwise comparisons.

Alpha= 0.05 Confidence= 0.95 df= 335 MSE= 0.331637
Critical Value of T= 2.95640

Comparisons significant at the 0.05 level are indicated by '***'.

CLASSIF Comparison		Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit	
2A	- 2C	-0.2841	0.0219	0.3278	
2A	- 1C	-0.1115	0.1968	0.5051	
2A	- 2B	-0.0106	0.3273	0.6652	
2A	- 1A	0.1044	0.4269	0.7495	***
2A	- 1B	0.2878	0.6000	0.9122	***
2C	- 2A	-0.3278	-0.0219	0.2841	
2C	- 1C	-0.1285	0.1749	0.4783	
2C	- 2B	-0.0280	0.3054	0.6388	
2C	- 1A	0.0872	0.4050	0.7229	***
2C	- 1B	0.2708	0.5781	0.8854	***
1C	- 2A	-0.5051	-0.1968	0.1115	
1C	- 2C	-0.4783	-0.1749	0.1285	
1C	- 2B	-0.2051	0.1305	0.4661	
1C	- 1A	-0.0900	0.2301	0.5503	
1C	- 1B	0.0936	0.4032	0.7129	***
2B	- 2A	-0.6652	-0.3273	0.0106	
2B	- 2C	-0.6388	-0.3054	0.0280	
2B	- 1C	-0.4661	-0.1305	0.2051	
2B	- 1A	-0.2491	0.0997	0.4484	
2B	- 1B	-0.0664	0.2727	0.6119	
1A	- 2A	-0.7495	-0.4269	-0.1044	***
1A	- 2C	-0.7229	-0.4050	-0.0872	***
1A	- 1C	-0.5503	-0.2301	0.0900	
1A	- 2B	-0.4484	-0.0997	0.2491	
1A	- 1B	-0.1508	0.1731	0.4969	
1B	- 2A	-0.9122	-0.6000	-0.2878	***
1B	- 2C	-0.8854	-0.5781	-0.2708	***
1B	- 1C	-0.7129	-0.4032	-0.0936	***
1B	- 2B	-0.6119	-0.2727	0.0664	
1B	- 1A	-0.4969	-0.1731	0.1508	

Table F-6

Significance Tests on Individual Means: BEVALUE

Bonferroni (Dunn) T tests for variable: BEVALUE

NOTE: This test controls the type I experimentwise error rate but generally higher type II error rate than Tukey's for all pairwise comparisons.

Alpha= 0.05 Confidence= 0.95 df= 336 MSE= 149.8532

Critical Value of T= 2.95634

Comparisons significant at the 0.05 level are indicated by '***'.

CLASSIF Comparison	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit	
1C - 1B	-1.344	5.213	11.769	
1C - 2A	1.670	8.198	14.727	***
1C - 2B	2.073	9.183	16.293	***
1C - 2C	3.895	10.318	16.741	***
1C - 1A	4.161	10.942	17.723	***
1B - 1C	-11.769	-5.213	1.344	
1B - 2A	-3.649	2.986	9.621	
1B - 2B	-3.238	3.971	11.179	
1B - 2C	-1.426	5.106	11.637	
1B - 1A	-1.154	5.729	12.613	
2A - 1C	-14.727	-8.198	-1.670	***
2A - 1B	-9.621	-2.986	3.649	
2A - 2B	-6.198	0.985	8.168	
2A - 2C	-4.383	2.120	8.623	
2A - 1A	-4.113	2.744	9.600	
2B - 1C	-16.293	-9.183	-2.073	***
2B - 1B	-11.179	-3.971	3.238	
2B - 2A	-8.168	-0.985	6.198	
2B - 2C	-5.952	1.135	8.222	
2B - 1A	-5.654	1.759	9.172	
2C - 1C	-16.741	-10.318	-3.895	***
2C - 1B	-11.637	-5.106	1.426	
2C - 2A	-8.623	-2.120	4.383	
2C - 2B	-8.222	-1.135	5.952	
2C - 1A	-6.133	0.624	7.380	
1A - 1C	-17.723	-10.942	-4.161	***
1A - 1B	-12.613	-5.729	1.154	
1A - 2A	-9.600	-2.744	4.113	
1A - 2B	-9.172	-1.759	5.654	
1A - 2C	-7.380	-0.624	6.133	

Table F-7

Significance Tests on Individual Means: BPOTENT

Alpha= 0.05 Confidence= 0.95 df= 336 MSE= 6.78294
 Critical Value of T= 2.95634

Comparisons significant at the 0.05 level are indicated by '***'.

CLASSIF Comparison	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit	
1C - 1B	-1.0680	0.3269	1.7218	
1C - 2B	-1.1751	0.3377	1.8504	
1C - 2C	-0.5942	0.7723	2.1388	
1C - 1A	-0.3409	1.1016	2.5442	
1C - 2A	0.4730	1.8619	3.2508	***
1B - 1C	-1.7218	-0.3269	1.0680	
1B - 2B	-1.5229	0.0108	1.5444	
1B - 2C	-0.9442	0.4454	1.8351	
1B - 1A	-0.6898	0.7748	2.2393	
1B - 2A	0.1234	1.5350	2.9467	***
2B - 1C	-1.8504	-0.3377	1.1751	
2B - 1B	-1.5444	-0.0108	1.5229	
2B - 2C	-1.0732	0.4347	1.9425	
2B - 1A	-0.8132	0.7640	2.3411	
2B - 2A	-0.0039	1.5242	3.0524	
2C - 1C	-2.1388	-0.7723	0.5942	
2C - 1B	-1.8351	-0.4454	0.9442	
2C - 2B	-1.9425	-0.4347	1.0732	
2C - 1A	-1.1081	0.3293	1.7668	
2C - 2A	-0.2940	1.0896	2.4732	
1A - 1C	-2.5442	-1.1016	0.3409	
1A - 1B	-2.2393	-0.7748	0.6898	
1A - 2B	-2.3411	-0.7640	0.8132	
1A - 2C	-1.7668	-0.3293	1.1081	
1A - 2A	-0.6985	0.7603	2.2191	
2A - 1C	-3.2508	-1.8619	-0.4730	***
2A - 1B	-2.9467	-1.5350	-0.1234	***
2A - 2B	-3.0524	-1.5242	0.0039	
2A - 2C	-2.4732	-1.0896	0.2940	
2A - 1A	-2.2191	-0.7603	0.6985	

Table F-8

Significance Tests on Individual Means: BACTIVE

NOTE: This test controls the type I experimentwise error rate but higher type II error rate than Tukey's for all pairwise compar

Alpha= 0.05 Confidence= 0.95 df= 334 MSE= 27.23794

Critical Value of T= 2.95647

Comparisons significant at the 0.05 level are indicated by '****'.

CLASSIF Comparison	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit
2C - 1C	-2.6397	0.1099	2.8594
2C - 2B	-2.0643	0.9574	3.9791
2C - 1B	-1.8012	0.9836	3.7684
2C - 1A	-1.3025	1.5938	4.4900
2C - 2A	-0.3456	2.4271	5.1998
1C - 2C	-2.8594	-0.1099	2.6397
1C - 2B	-2.1940	0.8475	3.8890
1C - 1B	-1.9326	0.8737	3.6800
1C - 1A	-1.4330	1.4839	4.4007
1C - 2A	-0.4771	2.3172	5.1115
2B - 2C	-3.9791	-0.9574	2.0643
2B - 1C	-3.8890	-0.8475	2.1940
2B - 1B	-3.0473	0.0262	3.0996
2B - 1A	-2.5384	0.6364	3.8111
2B - 2A	-1.5928	1.4697	4.5322
1B - 2C	-3.7684	-0.9836	1.8012
1B - 1C	-3.6800	-0.8737	1.9326
1B - 2B	-3.0996	-0.0262	3.0473
1B - 1A	-2.3400	0.6102	3.5603
1B - 2A	-1.3855	1.4435	4.2725
1A - 2C	-4.4900	-1.5938	1.3025
1A - 1C	-4.4007	-1.4839	1.4330
1A - 2B	-3.8111	-0.6364	2.5384
1A - 1B	-3.5603	-0.6102	2.3400
1A - 2A	-2.1054	0.8333	3.7721
2A - 2C	-5.1998	-2.4271	0.3456
2A - 1C	-5.1115	-2.3172	0.4771
2A - 2B	-4.5322	-1.4697	1.5928
2A - 1B	-4.2725	-1.4435	1.3855
2A - 1A	-3.7721	-0.8333	2.1054

Table F-9

Significance Tests on Individual Means: MEVALUE

NOTE: This test controls the type I experimentwise error rate but
higher type II error rate than Tukey's for all pairwise compa:

Alpha= 0.05 Confidence= 0.95 df= 336 MSE= 82.21329
Critical Value of T= 2.95634

Comparisons significant at the 0.05 level are indicated by '***'.

CLASSIF Comparison	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit	
2B - 2A	-5.114	0.206	5.526	
2B - 1C	-4.676	0.590	5.857	
2B - 1B	-4.287	1.052	6.392	
2B - 2C	2.679	7.929	13.179	***
2B - 1A	5.801	11.292	16.783	***
2A - 2B	-5.526	-0.206	5.114	
2A - 1C	-4.451	0.384	5.220	
2A - 1B	-4.068	0.846	5.761	
2A - 2C	2.906	7.723	12.540	***
2A - 1A	6.007	11.086	16.165	***
1C - 2B	-5.857	-0.590	4.676	
1C - 2A	-5.220	-0.384	4.451	
1C - 1B	-4.394	0.462	5.319	
1C - 2C	2.581	7.339	12.096	***
1C - 1A	5.679	10.702	15.724	***
1B - 2B	-6.392	-1.052	4.287	
1B - 2A	-5.761	-0.846	4.068	
1B - 1C	-5.319	-0.462	4.394	
1B - 2C	2.039	6.877	11.715	***
1B - 1A	5.141	10.240	15.338	***
2C - 2B	-13.179	-7.929	-2.679	***
2C - 2A	-12.540	-7.723	-2.906	***
2C - 1C	-12.096	-7.339	-2.581	***
2C - 1B	-11.715	-6.877	-2.039	***
2C - 1A	-1.642	3.363	8.368	
1A - 2B	-16.783	-11.292	-5.801	***
1A - 2A	-16.165	-11.086	-6.007	***
1A - 1C	-15.724	-10.702	-5.679	***
1A - 1B	-15.338	-10.240	-5.141	***
1A - 2C	-8.368	-3.363	1.642	

Table F-10

Significance Tests on Individual Means: MPOTENT

NOTE: This test controls the type I experimentwise error rate but higher type II error rate than Tukey's for all pairwise

Alpha= 0.05 Confidence= 0.95 df= 336 MSE= 12.61052
Critical Value of T= 2.95634

Comparisons significant at the 0.05 level are indicated by '***'.

CLASSIF Comparison	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit	
2B - 1C	-1.5677	0.4949	2.5576	
2B - 2A	-1.1943	0.8894	2.9731	
2B - 1B	-0.6659	1.4253	3.5164	
2B - 1A	0.7761	2.9266	5.0770	***
2B - 2C	1.1855	3.2415	5.2974	***
1C - 2B	-2.5576	-0.4949	1.5677	
1C - 2A	-1.4993	0.3944	2.2882	
1C - 1B	-0.9717	0.9303	2.8323	
1C - 1A	0.4647	2.4316	4.3986	***
1C - 2C	0.8833	2.7465	4.6097	***
2A - 2B	-2.9731	-0.8894	1.1943	
2A - 1C	-2.2882	-0.3944	1.4993	
2A - 1B	-1.3890	0.5359	2.4607	
2A - 1A	0.0481	2.0372	4.0263	***
2A - 2C	0.4655	2.3521	4.2386	***
1B - 2B	-3.5164	-1.4253	0.6659	
1B - 1C	-2.8323	-0.9303	0.9717	
1B - 2A	-2.4607	-0.5359	1.3890	
1B - 1A	-0.4956	1.5013	3.4982	
1B - 2C	-0.0786	1.8162	3.7110	
1A - 2B	-5.0770	-2.9266	-0.7761	***
1A - 1C	-4.3986	-2.4316	-0.4647	***
1A - 2A	-4.0263	-2.0372	-0.0481	***
1A - 1B	-3.4982	-1.5013	0.4956	
1A - 2C	-1.6451	0.3149	2.2749	
2C - 2B	-5.2974	-3.2415	-1.1855	***
2C - 1C	-4.6097	-2.7465	-0.8833	***
2C - 2A	-4.2386	-2.3521	-0.4655	***
2C - 1B	-3.7110	-1.8162	0.0786	
2C - 1A	-2.2749	-0.3149	1.6451	

Table F-11

Significance Tests on Individual Means: MACTIVE

NOTE: This test controls the type I experimentwise error rate but higher type II error rate than Tukey's for all pairwise .

Alpha= 0.05 Confidence= 0.95 df= 336 MSE= 7.070572
Critical Value of T= 2.95634

Comparisons significant at the 0.05 level are indicated by '***'.

CLASSIF Comparison	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit	
2A - 1B	-0.8743	0.5669	2.0082	
2A - 1C	-0.5188	0.8992	2.3172	
2A - 2B	-0.6466	0.9136	2.4739	
2A - 1A	0.2337	1.7231	3.2125	***
2A - 2C	1.6061	3.0188	4.4314	***
1B - 2A	-2.0082	-0.5669	0.8743	
1B - 1C	-1.0919	0.3323	1.7564	
1B - 2B	-1.2192	0.3467	1.9125	
1B - 1A	-0.3391	1.1561	2.6514	
1B - 2C	1.0330	2.4518	3.8706	***
1C - 2A	-2.3172	-0.8992	0.5188	
1C - 1B	-1.7564	-0.3323	1.0919	
1C - 2B	-1.5300	0.0144	1.5589	
1C - 1A	-0.6490	0.8239	2.2967	
1C - 2C	0.7244	2.1195	3.5147	***
2B - 2A	-2.4739	-0.9136	0.6466	
2B - 1B	-1.9125	-0.3467	1.2192	
2B - 1C	-1.5589	-0.0144	1.5300	
2B - 1A	-0.8008	0.8094	2.4197	
2B - 2C	0.5656	2.1051	3.6446	***
1A - 2A	-3.2125	-1.7231	-0.2337	***
1A - 1B	-2.6514	-1.1561	0.3391	
1A - 1C	-2.2967	-0.8239	0.6490	
1A - 2B	-2.4197	-0.8094	0.8008	
1A - 2C	-0.1720	1.2957	2.7633	
2C - 2A	-4.4314	-3.0188	-1.6061	***
2C - 1B	-3.8706	-2.4518	-1.0330	***
2C - 1C	-3.5147	-2.1195	-0.7244	***
2C - 2B	-3.6446	-2.1051	-0.5656	***
2C - 1A	-2.7633	-1.2957	0.1720	

Table F-12

Tables 8-13 Rescaled to Reflect a 7-Point Scale

<u>From Table 8</u>			<u>From Table 11</u>		
<u>BEVALUE</u>		<u>7-Point Score</u>	<u>MEVALUE</u>		<u>7-Point Score</u>
Overall	55.2414	3.45	Overall	56.7456	4.05
1a	51.4321	3.21	1a	48.9808	3.50
1b	57.1525	3.57	1b	59.2203	4.23
1c	62.3651	3.90	1c	59.6825	4.26
2a	54.1667	3.39	2a	60.0667	4.29
2b	53.1818	3.24	2b	60.2727	4.31
2c	52.0469	3.25	2c	52.3438	3.73

<u>From Table 9</u>			<u>From Table 12</u>		
<u>BPOTENT</u>		<u>7-Point Score</u>	<u>MPOTENT</u>		<u>7-Point Score</u>
Overall	10.6901	3.55	Overall	20.7281	4.14
1a	10.3269	3.44	1a	19.3462	3.87
1b	11.1017	3.70	1b	20.8475	4.17
1c	11.4286	3.81	1c	21.7778	4.36
2a	9.5667	3.19	2a	21.3833	4.28
2b	11.0909	3.70	2b	22.2727	4.45
2c	10.6563	3.55	2c	19.0313	3.81

<u>From Table 10</u>			<u>From Table 13</u>		
<u>DACTIVE</u>		<u>7-Point Score</u>	<u>MACTIVE</u>		<u>7-Point Score</u>
Overall	20.6118	3.44	Overall	24.3421	4.06
1a	20.0000	3.33	1a	23.8269	3.97
1b	20.6102	3.44	1b	24.9831	4.16
1c	21.4839	3.58	1c	24.6508	4.11
2a	19.1667	3.19	2a	25.5500	4.26
2b	20.6264	3.44	2b	24.6364	4.10
2c	21.5938	3.60	2c	22.5313	3.76

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