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Munchausen Syndrome by Proxy: A Complex Type of Emotional Abuse Responsible for Some False Allegations of Child Abuse in Divorce

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ABSTRACT: Munchausen syndrome by proxy (MSP) is a complex form of child abuse in which an adult, usually a mother, creates the appearance that her child is ill by fabricating evidence and even by inducing symptoms in the child. A contemporary form of this syndrome occurs when the mother creates the appearance that the child has been abused by someone else, generally the father in a divorce and custody or visitation dispute. Warning signs for contemporary-type MSP are presented along with descriptions of the dynamics involved and the factors that are important in diagnosis and case management.

Munchausen syndrome by proxy (MSP) is a complex type of emotional abuse that may overlap with other forms of child abuse. The syndrome was first identified in pediatric settings where some mothers were discovered to be creating the appearance that their children were ill (Money & Werlwas, 1976; Meadow) 1977). These mothers would fabricate evidence to support their claims, falsify health records, contaminate laboratory samples and even induce symptoms in the child. The perpetrator of MSP type abuse is almost always the child's mother, though occasionally a father, grandparent, day care operator, or nurse has been discovered engaging in this behavior.[1]

Physical abuse may be part of the clinical picture, for example, when the mother goes so far as to induce symptoms in her child and when the child undergoes unnecessary tests, surgeries and hospitalizations that are painful or even dangerous. Even when physical abuse is not present, the emotionally abusive aspect of Munchausen syndrome by proxy can be so pervasive as to ruin the child's life, distorting as it does the child's self-concept, sense of reality; and the way in which the child interacts with others. The mother's overwhelming need for her child to be ill results in the child living a life based on lies. Munchausen syndrome by proxy is a reportable form of child abuse.

The term "Munchausen syndrome by proxy" derives from Munchausen syndrome, a phenomenon among adult medical patients in which the individual fabricates or induces his or her own medical symptoms, factitiously assuming the patient role. Munchausen syndrome is named after Baron von Munchausen who was a 17th century teller of tall tales. When an adult fabricates or induces symptoms in a child, placing the child in the patient or victim role, it is called Munchausen syndrome by proxy.

The complex process by which an MSP parent casts her child in the patient role parallels another manifestation of the syndrome in which the mother casts her child in the victim role. In this variation of Munchausen syndrome by proxy, the parent fabricates or induces the idea that the child has been abused by someone else, presenting the child to professionals in the victim rather than the patient role. For purposes of comparison, I refer to cases where the mother creates a factitious medical condition for her child as "classical MSP" and use the term "contemporary-type MSP" for cases where the theme of the fabrication is the child being sexually or physically abused, with the child cast in the victim role (Rand, 1989; 1990).

Contemporary-type MSP has arisen in tandem with the upsurge of social consciousness about child abuse which has dramatically changed the way in which child abuse complaints are handled. Legislation and services addressing this social problem have been proliferating for the last 20 years. In today's climate, the accusation that a child has been abused or molested is accepted at face value, with little, if any, effort made to distinguish between true and false allegations. The energy of the authorities is directed towards keeping the accused away from the child and punishing the accused whenever possible. The fact that there is an adult prime mover of the allegation is rarely taken into account. Additionally, there are many professionals eager to support an accuser on the assumption that they are helping the accuser protect the child. This makes it relatively easy for divorced parents, who are either unscrupulous or blinded by their own emotional needs, to enlist the aid of the authorities in supporting a false abuse scenario.

Classical MSP

There are a variety of ways in which the classical MSP mother creates the appearance that her child is ill. She may fabricate the child's medical history or actually alter medical records. She may contaminate the child's laboratory specimen, for example add her own blood to the child's urine. She may even induce the medical symptoms by such means as rubbing the child's skin with a caustic to produce rash or secretly administering poison to the child. Although physical harm to the child may be done directly by the mother in her efforts to induce symptoms, most of the physical harm is inflicted by doctors who, relying on the mother's report, subject the child to painful, sometimes dangerous tests, treatments, surgeries and hospitalizations (Meadow, 1982; 1989).

The maternal profile in Munchausen syndrome by proxy varies. Some mothers set out consciously and deliberately to create the appearance that their child is ill. Others come to believe, at least intermittently, that their child's symptoms are real, a kind of quasi-delusional thinking (Ravenscroft & Hochheiser, 1980). Caught up in their own ideas, they manipulate reality to fit their needs and seem unaware of their role in creating the child's illness. Some are obsessed with the idea that their healthy child is ill and are never

reassured, no matter how many times they take the child to the doctor. The mother is so driven by her need to keep the child helpless and dependent that she imposes invalidism on the child as a way of life. Regardless of variations in maternal profile, the mother's investment in her child being ill prevents the child from leading a normal life and progressing normally through the stages of child development.

It was originally thought that only very young children could be victims of Munchausen syndrome by proxy because after the age of 5 or 6 a child would be old enough to reveal what was going on. As more cases were discovered, however, it became apparent that even young children will go along with the mother's deception by being aware of what she is doing but not volunteering that information to anyone.

The complex psychological nature of MSP became even more apparent when it was observed that older children may become active participants in creating their factitious illness, with either the child or the mother initiating aspects of the deception with which the other then goes along. Mother and child may develop a ***folie â deux*** relationship concerning the child's medical condition, with both believing that the child is genuinely ill or disabled. Recurrent and/or chronic illness becomes a way of life for these children. Some of them continue this pattern when they become adults, exhibiting Munchausen syndrome. Some are not so fortunate as to reach adulthood. The mortality rate for child victims of classical MSP may be as high as 20 to 30%. This is not surprising in light of the fact that some of these mothers make the child appear ill by smothering or poisoning the child to induce symptoms.

After being involved in hundreds of these cases, Meadow concluded that the boundaries of MSP type abuse are wide and overlap with other forms of abuse (Meadow, 1989). There were abusive aspects to some of these cases that went beyond interface with the medical establishment. For example, some of the MSP mothers with whom he came in contact would not allow the child to attend school because of the factitious illness — not just a day missed here and there but on a regular basis. In some instances the child was forced by the mother to adhere to a diet that was very inconvenient and nutritionally unsound. Some of the children had to sleep in unusual and uncomfortable sleeping conditions which the mother claimed were necessary because of the illness.

Meadow also recognized the power of persistently told false stories alone, explaining in his commentary on Godding and Kruth (1991) that the term Munchausen syndrome by proxy "Has also permitted child care workers and legislators to intervene more easily ... in some serious complex cases of emotional abuse in which mothers were not physically harming their children but were ruining their lives with stories of false illnesses" (p.960). The power of false stories to control a child's life is particularly relevant to the concept of contemporary-type MSP where false abuse scenarios may ruin not only the child's life but the life of the child's father and others.

Meadow views MSP behavior as existing on a continuum, as do beliefs and behaviors regarding illness generally. For example, ordinary people may embellish their medical complaints for sympathy, become overly concerned with their health, go to the doctor excessively, or call in sick to work when they need a day off. Munchausen syndrome by proxy behavior is a matter of degree — more pervasive, extreme, and manipulative, causing identifiable harm to the child. Existing as it does on a continuum, Munchausen syndrome by proxy can be mild, moderate, severe, or fatal. Viewed on a continuum, it is much more common than was previously supposed.

Contemporary-Type MSP

In contemporary-type MSP, the parent creates the appearance that the child has been abused by someone else and is invested in presenting the child as a victim. The most common scenario is for her to create the appearance of the child as sexually abused, though sometimes physical abuse by another is alleged.

As in classical cases, contemporary-type MSP is generally practiced by the mother who most often accuses the father in a divorce and custody or visitation dispute but who also may accuse the father's new wife and her children or the father's relatives. Occasionally, a father practicing contemporary-type MSP may demand repeated sexual abuse exams of the child based on allegations against the mother's boyfriend, new husband or the mother and her new parmer together.

In contemporary-type MSP, the accusing mother welcomes additional sexual assault exams, police interviews, and therapy that focuses on aberrant sexual experiences, just as the classical MSP mother welcomes painful tests, unnecessary hospitalizations and surgeries for her child. In contemporary cases the mother is determined to keep the allegations going and to prove that the abuse occurred. She is not interested in helping the child recover from abuse and moving on. In taking the child from professional to professional, she seeks out those who will validate the alleged abuse and rejects any professional opinion to the effect that abuse did not occur. If the father wants his expert to examine the child, however, she will likely refuse additional examinations on the grounds of protecting the child from further trauma.

Although most commonly found in the context of divorce, contemporary-type MSP does occur in non-divorce situations as well. Loftus and Ketcham (1991) report a case of false accusation against a day care worker in which one of the accusing mothers used overt rewards and punishments to make her young child report and embellish stories of abuse. When, in response to her mother's repeated questioning, the girl admitted that the accused abused her, mother gave her a cookie, a pat on the head, a smile or a hug. The girl was sent to her room if she denied that the accused had done anything, or if she preferred going out to play to talking about abuse.

By contrast, the mother of another little girl at the day care asked her child solicitously about the possibility of abuse by the day care worker in question, but let the matter drop when she was reassured that her child had not been abused. The child whose mother was obsessed with abuse experienced considerable trauma as a result of her mother's obsession, although the mother's actions were attributed to love.

Contemporary-type MSP may be a variant of the cases reported by Herman-Giddens and Berson (1989) in which the children were subjected to painful washing of their genitals, ritualistic inspections of the genitalia, and unnecessary applications of medicines to the genitals, as well as hospitalizations, repeated pelvic exams, and invasive medical procedures related to the genitals. Parents who exhibit this pattern may insist that the reason they focus so much attention on the child's genitals is that someone has molested their child. Libow and Schreier (1986) describe one such case where the mother sought repeated pelvic exams for her child, including one under anesthesia, in an effort to confirm her belief that a female relative had molested the child.

In the context of divorce, where parents allege and believe the worst about one another, it is not surprising that both mothers and fathers have been found to take the child for pelvic exams after every visit with the other parent, using suspicions of abuse to justify the behavior. Ironically, this pattern may itself represent a covert form of sexual abuse.

Elements of classical and contemporary-type MSP were found to overlap in a study of 14 children from seven families, with the mother inventing both physical illness and factitious abuse for the children (Meadow, 1993). The false allegations of abuse were deemed to cause more suffering for eight of the 14 children than the factitious illnesses. It is noteworthy that for most of these children, the discovery that the abuse allegations were false preceded the discovery of the mother fabricating physical illnesses. Thus, it was the false allegations of abuse that lead authorities to discover that these children were also being subjected to classical MSP abuse. This study indicated that children who are involved in false abuse scenarios tend to be older than child victims of classical MSP and that indoctrination of the child with the story of abuse was prominent in the clinical picture. Although the study specifically excluded abuse allegations made at the time of divorce, in four instances ex-partners or ex-husbands were included among the men accused.

Some professionals incorrectly assume that in the context of divorce, false allegations of child abuse have an obvious external motivation — that of gaining custody. Paradoxically, the accusing parent's investment in the abuse scenario is sometimes so irrational that he or she will persist in bringing the accusations to people's attention even when threatened with toss of custody and visitation for continuing to do so. This is particularly true when the accusing parent is delusional and believes the accusation, or when the accusing parent thrives on the attention received from the authorities. I have had to recommend supervised visits until the child reaches majority for some of these parents because they either would not or could not refrain

from imposing their abuse scenario on the child unless there was a court-appointed supervisor present. Despite punishment for the MSP behavior, some of the contemporary MSP perpetrators, just like the classical MSP mothers, seem unable to modify their behavior and will reoffend when given an opportunity to do so.

In some instances, the accusing parent is motivated by both internal and external motivations. For example, she may feel so competitive with her former spouse that she wants to prove she is the best parent, an agenda that goes beyond custody. In another version, her need to control the child may be so great that she will go to any lengths to gain and keep that control, including creating a false abuse scenario to win custody. Parental motivation in custody disputes is often complex, as any custody evaluator knows. Motivation notwithstanding, a false abuse scenario may be developed and maintained through MSP type emotional abuse in a variety of contexts, including, but not limited to, divorce.

MSP and Other Forms of Child Abuse

Munchausen syndrome by proxy can overlap with other forms of abuse, including (but not limited to) mental cruelty, neglect, physical abuse and abduction. In one of the most severe classical cases ever reported, the parents induced abuse dwarfism in their child (Munchausen syndrome by proxy) as well as subjecting him to beatings, being burned, starvation, and being forced to live in a closet. The siblings of the target child were forced to beat him once a week or be beaten themselves (Money, Annecillo & Hutchinson, 1985).

As in other forms of child abuse, it is important to intervene and break the cycle of abuse — abusive parents rarely stop on their own. Recent research involving 56 children who had been victims of fabricated illness showed that both the proxy child and the siblings of such children are at risk for non-accidental injury, neglect, inappropriate medication, and failure to thrive type neglect (Bools, Neale & Meadow, 1992).

The overlap with other forms of child abuse is seen in contemporary-type MSP as well. The case described in ***Bad Moon Rising: A True Story*** () (Ferguson, 1988) involved a divorced MSP mother who was neglectful when the child was young and who tried to abduct him from his father's custody when he was 10. Several years later she used formal brainwashing and physical abuse to induce the boy and his sister to accuse the father's relatives of sex abuse. The book shows how the psychological abduction of the children succeeded where the mother's attempt at physical abduction had failed.

In one case about which I was consulted, a 7-year-old boy was induced by his mother to accuse his father of physical and sexual abuse during a divorce action. As a result, the boy had no contact with his father until, as a young teen, he announced to his mother that he intended to tell the truth. She

responded by beating him and handcuffing him to the bed. As a result of her attack, he was psychiatrically hospitalized. In the investigation that followed, it came out that it was the mother and her boyfriend who had previously engaged in sexually abusive behavior with the boy. Custody was awarded to the father, at which point the mother abandoned all interest in her son.

In the classical cases reviewed by Bools, Neale and Meadow (in press), the child victims and their siblings did not appear to be at unusual risk for sexual abuse. In contemporary-type MSP, there is probably a greater risk for sexual abuse by the MSP parent or her agents since the accusing parent is obsessed with the child as a sexual object. Repeated sexual abuse exams and interrogations of the child about aberrant sexual experiences may constitute an indirect or covert form of sex abuse.

In Munchausen syndrome by proxy, as in other forms of child abuse, the parent is driven to gratify her needs at the expense of the child's. As such, it is to be expected that, in order to prove the father is a molester, a small number of contemporary-type MSP mothers will actually inflict physical findings of sexual abuse on the child. Over the last five years, I have received communications from two different professionals about this type of scenario. In one instance, the professional confronted the mother, who then admitted to rubbing her child's anus with scouring powder to create the appearance of molestation by the father.

Divorce Puts Children at Risk

A number of authors have expressed concern about the emotional burden on children whose needs are subverted in the service of an angry or disturbed parent. Judith Wallerstein, foremost researcher on the effects of divorce on children, devotes a chapter in her book, ***Second Chances*** () (Wallerstein & Blakeslee, 1989), to what she calls the overburdened child. After the divorce, the overburdened child's developmental needs are thwarted by the need to take care of a chronically troubled parent who may be intensely dependent, alcoholic, disorganized, enraged, and so on. With only one parent in the home, there is no adult to buffer the child's pain or to relieve the child of the caretaking burden.

There are many reasons why divorce puts children at risk:

> In most crisis situations, such as an earthquake, flood, or fire, parents instinctively reach out and grab hold of their children, bringing them to safety first. In the crisis of divorce, however, mothers and fathers put children on hold, attending to adult problems first. Divorce is associated with a diminished capacity to parent in almost all dimensions — discipline, playtime, physical care, and emotional support. Divorcing parents spend less time with their children and are less sensitive to their children's needs. At this time they may very well confuse their own needs with those of their children. Divorce is also the only

> major family crisis in which social supports fall away ... Friends are afraid that they will have to take sides; neighbors think it is none of their business ... Grandparents may be helpful but are apprehensive about getting caught in the crossfire. They often live far away and feel their role is limited ... Divorce is a different experience for children and adults because the children lose something that is fundamental to their development — the family structure (Wallerstein & Blakeslee, 1989, pp.7-11).

The hazards of divorce do not necessarily pass with the crisis of dissolution. In their 10-year follow-up, Wallerstein and Blakeslee (1989) found the effects on both parents and children to be profound and long-lasting. They found that one-half the women and one-third of the men in the study were still intensely angry at the former spouse and that anger is a prominent theme in the lives of the children as well. Ten and even 15 years later, one-third of the women and one-fourth of the men in their sample were unhappy with their lives in general, feeling life is unfair, disappointing, and lonely. As for the children, many of them were having problems in adulthood with relationships. Fears of betrayal and rejection were intense and pervaded their relationships with the opposite sex. While longing for a loving, faithful marriage, many were afraid to take the risk and make the commitment.

One of the emotional burdens to which children of divorce may be subject is that of Parental Alienation Syndrome in which one parent seeks to sever the child's ties with the other, sometimes using fabricated sex abuse to help accomplish this goal (Gardner, 1987, 1992). In a significant number of cases, Gardner has found that the child, as well as the alienating parent, has an emotional agenda that is met by the Parental Alienation scenario, such that the child may actively participate in the alienation. (More discussion of the child's agenda in divorce appears below.) Parental Alienation with fabricated sex abuse may involve Munchausen syndrome by proxy type abuse.

The fact that divorce has become common does not make it any less traumatic. Some people are able to make a healthy adjustment and to move on with their lives constructively. They understand that children need both parents. Unless the other parent is really awful, they set aside their personal feelings enough to insure that the children have a relationship with both parents. When contemporary-type MSP occurs in divorce and the accusing parent is supported by the legal system, as is often the case, the child loses not only their two-parent nuclear family but one whole parent as well. The child is used as a tool to ruin the father financially, destroy his reputation, and even send him to jail. Contemporary-type Munchausen syndrome by proxy can be seen as a severely maladaptive adjustment to a problematic life event.

Literature on Munchausen Syndrome by

There has been a steady increase in the number of MSP articles in medical

and psychological journals since Meadow first reported his findings in 1977. Ten years later, a literature review of Munchausen syndrome by proxy was published in ***Child Abuse & Neglect*** (Rosenberg, 1987). For their upcoming book on MSP as experienced in their hospital practice, Libow and Schreier estimated that over 200 articles have been published (personal communication). Books have been written about the true stories of classical MSP cases that ended in children's deaths (Elkind, 1983; Wright, 1984). Recently, the FBI featured an article on MSP in their ***Law Enforcement Bulletin*** (Hanon, 1991). Several years ago, the TV program, ***A Current Affair***, introduced the public to a woman with adult Munchausen syndrome; "the blind skier" she was called, except that she was not blind. Newspapers report with some regularity on cases of MSP that are particularly shocking, for example a mother caught suffocating her child in the hospital to induce seizures.

The first references to the connection between MSP and some sexual abuse allegations appeared in the early 1980s. Goodwin (1982) reported mothers obsessed with the idea that their child had been abused, although this did not appear to be the case. These mothers not only took their children for repeated pelvic exams that the mother observed, but the mother actually repeated the pelvic exam again at home.

One of the first reports in the literature of false sex abuse accusations in divorce was by Kaplan and Kaplan (1981). They diagnosed the mother/child dyad as exhibiting ***folie â deux***, a clinical phenomenon that is associated with a number of psychiatric illnesses (Munro, 1986), including Munchausen syndrome by proxy. Schuman (1986) reported on 7 cases of false accusation in divorce, suggesting that MSP might be operating in some instances. Wakefield and Underwager (1988) described a mother who had taken the children for sex abuse exams after visits with their father, as well as examining the children's genitals herself. True stories of contemporary-type MSP in divorce have also been made into books (Spiegel, 1986; Ferguson, 1988). In February, 1993, the Minneapolis ***Star Tribune*** reported on a mother in a divorce action who lost custody based on findings that she had been practicing contemporary-type MSP with the children.

The study of false accusations of child abuse is discouraged in the current social climate, which is unfortunate since clinical information on the topic is much needed. Seeking to meet that need, Ackerman and Kane (1991) published my list of warning signs for contemporary-type MSP in the supplement of their book, ***How to Examine Psychological Experts in Divorce and Other Civil Matters*** (A)(A)(A). This list, printed below, was adapted and expanded from Jones, Butler, Hamilton, Perdue, Stern & Woody (1986), who originally took it from Meadow.

Warning Signs for Contemporary-Type MSP

1. The accusing adult seems to know more about what allegedly happened than does the child.
2. The child answers negatively about abuse when questioned away from the mother/accuser; the child reports to evaluator, "Mommy says I was molested."
3. The adult accuser and/or the child manipulates information by fabrication, omission, or distortion of the truth, e.g. erroneous statements about medical history and findings, employment, school records.
4. The accuser is more interested in building a case than in helping the child deal with abuse and moving on.
5. The child continues to be presented in the victim role through "add on" allegations, "add on" details to the original allegation, and "newly remembered" episodes of abuse.
6. The adult accuser gives a history of herself having been molested as a child, although this view is inconsistent with the view of the family held by the majority of its members and also when this view is inconsistent with the family history as constructed by evaluator interviews with different family members.
7. The allegations of abuse are factually contraindicated, e.g. the molester is alleged to have taken the child upstairs for molest when he had a medical condition that prevented him from climbing stairs.
8. The allegations of abuse are bizarre or improbable, with multiple family members accused, including grandparents.
9. The child appears well-adjusted during the period that the abuse was supposed to have occurred.
10. The child does not recover from abuse through therapy or a previously well-adjusted child regresses during therapy, developing nightmares, bed wetting, etc.
11. The child recites allegations in a rote manner; the child is eager to tell story of abuse; the child describes abuse in same language as the accusing adult.
12. The adult accuser has child repeatedly evaluated for abuse and is dissatisfied with negative or equivocal results.
13. The adult accuser welcomes repeated sexual assault exams and interrogations of the child, even though these may be painful or upsetting to the child.
14. There is a symbiotic, enmeshed relationship between mother and child, e.g. the mother insists on staying in the room with the child for the child's evaluation or therapy interview.
15. The Parental Alienation Syndrome is either present or in process, with the child inappropriately alienated from the accused parent while presenting a united front with the accuser.

The Mother, Mother/Child Dyad, and the Child in MSP and Divorce

The Mother/Accuser

In contemporary-type MSP, the mothers have been variously described as histrionic, obsessed, angry, fanatical, self-righteous, aggressive, emotionally labile, manipulative, dramatic, unpredictable, and unable to distinguish fact from fantasy. Like classical MSP mothers, they are often observed to be anxious and overprotective. Perhaps for this reason, some of them have also been described as wonderful mothers, devoted to their children, just like classical MSP mothers who are often seen by medical staff as loving and attentive to the child, until the deception is discovered (and sometimes after that).

Out of 72 parents who falsely accused in divorce, Wakefield and Underwager (1990) found four fathers, three of whom were described as hypervigilant, defensive, hostile, paranoid, intimidating and controlling, which is consistent with my clinical experience. The fourth father presented as docile and passive, a passive-aggressive individual.

Research has recently been completed in England on 47 classical MSP mothers (Bools, Neale & Meadow, in press). When their lifetime psychiatric histories were studied it was found that 27 of these mothers had engaged in acts of self-harm, 10 had a history of alcohol or drug misuse, 34 had exhibited factitious or somatoform disorder, and 9 had been convicted of offenses other than child abuse, for example theft or arson. This finding suggests that more careful attention should be given to the presence of antisocial features when MSP is suspected. A unique aspect of this study was the fact that 20 of the mothers were interviewed 1 to 15 years after the original fabrications. Some mothers admitted to the interviewers that they had fabricated, while others maintained complete denial of their actions.

The aspect of the Bools et al. (in press) study that specifically examined maternal psychopathology indicated that 18 of the 20 mothers who were interviewed not only had personality disorders, but met the criteria for several personality disorders. Where this was the case, the researchers determined which personality disorder was predominant, concluding that borderline, histrionic and dependent disorders tended to characterize the mothers in their sample.

Wakefield and Underwager (1990) found personality disorders in three-fourths of the 72 parents who falsely accused in the divorce/custody context. These parents were compared to 67 divorcing parents who did not bring false allegations of abuse, of whom only one-fourth were diagnosed as having personality disorders. Histrionic, borderline, paranoid, passive-aggressive, and mixed personality disorders characterized the majority of the falsely accusing group.

Persons with personality disorders tend to have chronically maladaptive coping styles that do not necessarily render the individual non-functional but may result in a variety of life difficulties. Only a few of the falsely accusing parents in Wakefield and Underwager's sample were dysfunctional to the point of losing touch with reality although some exhibited bizarre behaviors, or believed themselves to have rare spiritual powers or religious connections. Of the seven accusers that Schuman (1986) reported on, only one was diagnosed as mentally ill, although all displayed intrapsychic and

familial dynamics that were active in generating the accusations.

It is uncommon in both classical and contemporary-type MSP for the mother to be diagnosed as floridly psychotic, although psychotic features may be present. Particularly when the fabrication involves sex abuse, the allegations may be one of the early signs that the mother/accuser is decompensating, although this may not be recognized at the time. Some of these cases unfold over several years and the decompensation of the accusing parent only becomes apparent with time and subsequent events.

Diagnostic labels such as *borderline, histrionic, paranoid, narcissistic,* and *antisocial* are used in the DSM- III-R (American Psychiatric Association, 1987) to describe personality disorders and/or personality features. They may also be used in combination, for example borderline with narcissistic and antisocial features. In other instances, more probably when the contemporary-type MSP is mild to moderate, the Axis II diagnosis may be limited to histrionic features or narcissistic features, etc. Individuals with borderline, histrionic, paranoid, narcissistic and antisocial features and personality disorders are more likely than normals to distort or misinterpret events, harass others, lie and otherwise manipulate people, including their children. Divorcing parents with some or all of these characteristics may instigate false allegations of abuse in their maladaptive effort to grapple with the myriad problems of divorce. I have outlined below a series of profiles for parents who exhibit predominantly borderline, histrionic, paranoid, and antisocial personality styles.

Mother/accusers with borderline features or borderline personality disorder: These parents often exhibit remarkable rage that does not seem to abate with time. They experience extraordinary mood swings, so they may appear normal one day and "off the wall" another. This can pose problems for the custody evaluator since the relatively limited time spent with each parent may preclude seeing the borderline parent at their worst. On their "off the wall" days, these parents may exhibit "transient periods in which bizarre behaviors, irrational impulses, and delusional thoughts are exhibited ... they may be driven to engage in erratic and hostile actions ... These episodes of emotional discharge serve a useful homeostatic function since they afford temporary relief from mounting internal pressures" (Millon, 1981, p.334).

It is not difficult to imagine how a divorcing borderline mother might become caught up in the idea that the husband who left her has abused the child. Professionals sometimes minimize the pathology of this rage because it seems understandable that a woman would be angry because her husband left her. Among the cases I have become involved in, however, are those in which it is the borderline mother who left her husband. This woman never seems to get over her disappointment and rage that the marriage did not meet her expectations. In either scenario, the hostile action of trying to destroy the father with false allegations of abuse provides a release for her hostility, helps her gain control of the situation, and binds the child more closely to her so that at least she has someone.

Mother/accusers with histrionic features or histrionic personality disorder: The parents want others to pay attention to them and they achieve this through dramatic and energetic behavior. They habitually manipulate others to get attention so that the manipulation of the child and of professionals in MSP type abuse is just another

expression of this interpersonal style. They become easily excited, have angry outbursts, and prefer playing their own hunches to a more rational, reasoned approach. They are suggestible and easily influenced by social trends (the current focus on child abuse could certainly be considered a current social trend). The histrionic mother might notice a rash on her daughter's thigh, become excited and angry, and play her hunch that father molested the child. The child would be overwhelmed by the mother's emotions and accommodate to her expectations, creating the mutually reinforcing cycle discussed by Schuman (1987).

Mother/accusers with paranoid features or paranoid personality disorder: There are a number of variations on the paranoid theme, including paranoid features, personality disorder, and delusions. Paranoids are angry and suspicious. When the accusers in this group suspect someone has bothered their child, they badger the child until the child gives in just to be left in peace. They are also aggressive towards those who they feel have slighted them and use their feelings of hurt and humiliation as an excuse to harm others. Individuals in this category are often litigious and may harass those by whom they feel persecuted. They tend to distort objective reality and to construct a new reality in its stead, preferably a new reality which affirms their personal stature and significance. The accusers in this group avoid any blame for the divorce and gain personal stature as the virtuous protector of an abused child. Individuals with paranoid features will counterattack in response to any perceived threat, and divorce, by its very nature, offers many of these.

The paranoid coping style can pervade many areas of the person's life or it can be limited to a specific area as in paranoid delusions. An idea need not be bizarre to be a delusion. When the accuser really believes that the child was molested by the former spouse or his agents, she may be exhibiting delusions of persecution "by proxy." Delusions are fixed, false beliefs that are confined to a single theme. Persons with delusional paranoid disorder may appear relatively normal in their intellectual and occupational functioning, although their marital functioning is often disturbed because of their tendency to blame, become angry and be suspicious.

Rogers (1992) reports on five cases in which delusional disorder preceded the mistaken or false sexual allegations in the divorce/custody context. For the clinician, Rogers offers some good differential diagnostic considerations:

> There is a range of conditions that may share some commonality with Delusional Disorder where there may he varying degrees of loss of a reality basis with overvalued ideas at one end of the continuum merging into actual delusional thinking at the other. ... Disorders that should be considered and ruled out include Affective Disorders, especially Bipolar Disorder, Schizophrenia, Schizophreniform Disorder, Brief Reactive Psychosis, organic delusional syndromes ... and Paranoid Personality Disorder. ... Differential diagnosis is important because the prognosis of the affected individual may vary; some of these individuals have a good outlook and may recover well enough to carry out all of their parenting functions, while others have a less positive outcome (p.48).

Rogers' list is a helpful reminder that there are a number of psychiatric conditions which are characterized by erroneous beliefs and actions consistent with such beliefs.

Whenever there is an adult prime mover of abuse allegations, professionals should consider the diagnostic alternatives for that person and the social influence that person has on the child.

Paranoid delusions may be shared between two or more people. When, as a result of their association with each other, two people hold the same fixed, false belief, it is called *folie â deux*. In contemporary-type MSP, the accuser, the child, certain friends and relatives may actively share the fixed but false belief that the child was molested by the father.

Mother/accusers with antisocial features or antisocial personality disorder: Accusers who lie deliberately and who feel no compunction about telling the child to lie may have antisocial features or full-blown antisocial personality disorder. Antisocial features were exhibited by the mother described above who had instructed her son to lie about his father abusing him, then handcuffed him to the bed when he threatened to reveal the deception. Antisocials have no regard for authority or for the rights of others, including their children and their former spouses. They want personal power and have no compunction about enlisting the power of the authorities to achieve their personal goals, such as getting a former spouse jailed and being free permanently from the inconvenience of sharing the child with the father. By the same token, parents in this group feel justified in flouting the law and kidnapping their children to protect them from the falsely accused former spouse. Gender bias in diagnosis may make evaluators reluctant to diagnose antisocial features in women.

Mother/accusers misperceived by professionals: It is often difficult for professionals to reconcile the incongruity between how caring the MSP mother seems to be and what she is really doing that is harmful to her child. Based on involvement with over 200 classical cases Neale, Bools and Meadow (1991) found that, "With MSP abuse, mother-child interaction often appears close, although on inspection is actually over-controlled. The child may appear materially well cared for by a loving mother. Some mothers went to great lengths to foster that impression" (p.8).

There are a number of reports in the literature of classical MSP mothers who, upon psychiatric evaluation, appeared quite normal. One can only assume that the mothers so described must have outwitted their examiners. The limited nature of the evaluation itself may be a factor in some instances. The examiner is at a disadvantage unless he or she has the opportunity to carefully compile and verify an accurate, comprehensive history. My own experience is that even in severe cases of contemporary-type MSP, where the MSP parent exhibits what most people would consider significant psychopathology, there is often at least one professional involved who is willing to offer a benign diagnosis.

Mother/Child Dyad

The interaction between mother and child can provide important clues in diagnosing Munchausen syndrome by proxy. Custody evaluators have a unique opportunity to evaluate this interaction since it is customary to meet with all the parties for this type of assessment.

The mother-child relationship in MSP is often described as enmeshed, symbiotic, mutually anxious and overprotective. The mother has no sense of psychological boundaries between herself and her child and therefore it is difficult for the child to develop boundaries with respect to her. In contemporary-type MSP it is not unusual for the mother to insist on staying in the room with the child during an evaluation. She may send the child to individual therapy sessions with a tape recorder so that the mother can go over the session with the child later.

The lack of boundaries between parent and child is illustrated by a common feature of MSP in which the mother "donates" her symptoms to the child, assigning symptoms to the child that are similar to ones that she reports having had herself. In classical cases, the mother may assert that both she and the child have a history of treatment for abdominal pain. Likewise, mothers who have induced the idea that the child was molested by the father may assert that they, too, were molested as children, even though the mother's adult-molested-as-child scenario is quite new and is at odds with the view held by the rest of the family.

In divorce, these mothers assume that since they have no further use for the father, the child does not either. The idea that the child has a need for the father that is independent of the mother or the marital relationship is inconceivable to these women. In classical MSP the father is also excluded from the mother/child dyad although he is usually in the home. Fathers in families where the mother fabricates illness are not privy to the deception. They tend to be more passive and in the background, with lives of their own to lead. This is similar to how Blush and Ross (1987) described the fathers in their sample of cases of what they term the SAID Syndrome, an acronym for sex allegations in divorce. The picture that emerges is that the mothers are much more dominant than the fathers in relationship to the children.

There may be behaviors of concern in the mother/child interaction that do not relate directly to the allegations. In one custody evaluation I reviewed where MSP was suspected, the mother was asked to work with her 3-year-old daughter to create a family drawing. Given the child's age, the evaluator expected the mother to organize the task. The mother had no sense of organization in her approach, did not follow the evaluator's instructions, and the task was never carried out, despite repeated instructions and encouragement from the evaluator. The evaluator further observed that the mother projected her feelings onto the child and spoke to the child using concepts that were much too old for her. This child was also unable to meet with the evaluator without her mother present, exhibiting obvious separation anxiety.

Especially as the child grows older, mother and child in contemporary-type MSP may share a mutual delusion or *folie â deux* that is limited to the allegations of abuse against the father. The fact that their shared belief system is delusional may go unrecognized by the authorities for several reasons: 1) mother and child seem to be in touch with reality in other areas, 2) the authorities believe the allegations to be true, or 3) the allegations cannot be disproven. In evaluating cases where *folie â deux* is suspected, consideration should be given to the adaptive function of such a delusion, for example it allows mother and child to identify with each other, channel aggressive drives outside their relationship and preserve intimacy in the face of a world they experience as lonely or hostile.

The Child in MSP

The primary focus in the classical MSP literature was originally on the mother, although increasingly attention is being given to the child. A study of the psychological effects of classical MSP on child victims concluded:

> (P)sychological development (was) thwarted at the most basic level-basic parental trust. ... toddlers and preschoolers were not allowed separation and individuation and developed withdrawn) hyperactive, and oppositional behaviors ... The older children and adolescents developed conversion symptoms, cooperated with their parent's deceptions, and began to fabricate their own history and symptoms. In these cases and several others we have seen, the syndrome is dearly multigenerational ... the child victims of Munchausen syndrome by proxy become adult Munchausen syndrome patients (McGuire & Feldman, 1989, p. 291).

There are multigenerational effects on the child victims of contemporary-type MSP as well. If they come to believe the allegation, they may live the rest of their lives rejecting their father, based on the belief that they were molested by him. Children in this category may tell their children about the molest so that it becomes part of the family history. Male role models become negative. Family relationships that were broken off because of the accusations will result in loss of those same relatives by the next generation. Thus, when the child grows up and has children, those children are deprived of paternal grandparents and other relatives on the father's side. Children who remained conscious of the fact that the abuse scenario was a lie may carry the knowledge of the lie into adulthood and feel considerable guilt.

The tragic consequences of one case of contemporary-type MSP were related by a psychologist, "Dr. Smith" (Smith, 1991). A 17-year-old girl came to him and revealed her anguish over going along with the mother's program years before of accusing the father of sexual abuse. The father was sent to prison and eventually committed suicide. When the girl found out the consequences of how her mother had used her, she overdosed on her mother's sleeping pills and died. In this case, the multigenerational effect of the MSP type abuse was that there would be no further generations.

An understanding of how children react to divorce at different ages may shed light on how the child's needs can be exploited by the MSP parent in this context. Young children are vulnerable by virtue of fearing further abandonment. Having lost one parent, they are afraid they will lose the other. The mother may reinforce the child's anxiety that there is only one parent who can be relied on by telling the child, "He doesn't care about you. He never cared about anyone but himself." The fact that the father has left the home and has been prevented from seeing the child will seem to the child to validate this. Children in this situation are going to do everything in their power to preserve the alliance with the remaining parent.

According to Wallerstein and Blakeslee (1989), children who are between 5 and 8 years of age at the time of the divorce tend to experience the divorce as a fight in which they must take sides, with or without parental coaching. If there is parental coaching, children in this age group may go along. If the child initiates a non-valid report of abuse, the parent predisposed to MSP abuse has only to take advantage of the situation and

claim they are not responsible for what the child is saying.

At ages 9 to 12, Wallerstein and Blakeslee found the children were especially furious at the parent whom they blamed for the divorce. It was mainly children in this age group who formed "mischievous alignments" with one parent for the purpose of humiliating or harassing the other parent. False accusations of abuse can readily spring from this dynamic.

Adolescents need limits setting more than any other age group but parents caught up in their own troubles may not be able to provide the kind of supervision and limits setting the adolescent needs. Feeling angry and abandoned, teens of divorcing or divorced parents may act out through accusing the parent with whom they feel they have the least to lose. Alternatively, they may use an accusation to get the attention of the parent in the home or to enlist sympathy from concerned school personnel and others outside the home. They may receive more attention for accusation of abuse than they have ever received before. Children accustomed to years of emotional coldness and rejection by their mother may suddenly find her hanging on their every word as long as they can come up with more and more stories about how daddy abused them.

The issue of the child initiating deceptions was raised earlier with respect to classical MSP. One case study describes a 10-year-old boy who inserted a small stone up his urethra to simulate the passage of kidney stones (Sneed & Bell, 1976). In a more contemporary-type scenario, Goodwin, Cauthorne and Rada (1980) reported on 3 girls, ages 9 and 10, who created the appearance of neglect by their adoptive parents. They went so far as to change into rags on their way to school so as to support their claims.

In addition to situational factors, each child has his or her own personality and behavioral tendencies that influence how the child perceives, feels, and behaves. Problems with anger, impulsivity, dependence, or truthfulness in a child prior to the divorce are likely to come into play as the child grapples with the divorce and its aftermath. Not only are some parents more prone to MSP type abuse, some children may be more predisposed to participating by virtue of their personality and their relationship with the MSP parent. During a presentation on MSP that I was conducting at a local hospital, a colleague described a mother who invented medical symptoms for her two daughters up until age 6. After that, one of the girls flatly refused to go along with the factitious illness scenario any longer, while the other continued to along with the mother's deceptions into adulthood.

As the above example indicates, more than one child in a family may be subject to MSP abuse. In a recent study examining serial Munchausen syndrome by proxy, Alexander, Smith and Stevenson (1990) maintain it is an underestimate that multiple-child MSP is found in 25% to 33% of all cases. Where more than one child was victimized, they found the mother's level of psychiatric/behavioral disturbance to be high. They also expressed concern that when the MSP abuse was not stopped with the first child, the mother went on to abuse additional children, underscoring the importance of breaking the abuse cycle.

In some instances, siblings may actually provide reinforcement for each others' participation in *folie â deux* and MSP. Likewise, sibling rivalry may prompt a child to

develop the same symptoms as a sibling who is using the symptoms to get attention. In contemporary-type MSP one sibling may act as a confederate of the mother and manipulate the other sibling into maintaining the accusation (Ferguson, 1988; Gardner, 1989).

Professional Participants in MSP

The MSP triangle would not be complete without the "professional participants," those who co-operate with the mother in her MSP abuse of the child (Zitelli, Seltman, & Shanon, 1987). The professionals may be well-meaning or they may be negligent, misinformed or financially motivated, but their precise motivation is not at issue. What is at issue is that the mother, or the mother/child dyad if the child is older, manipulates professionals into responding as if the child were really ill or victimized. Just as doctors cause most of the direct physical harm in classical MSP, in contemporary-type MSP it is the sex abuse therapists, protective service workers, detectives, etc. who do much of the reinforcing of the abuse scenario in the child's mind. The support of sex abuse therapists, protective service workers, judges, attorneys and detectives make it possible for the mother to accomplish her agenda.

One of the most common scenarios in contemporary-type MSP is for the accusing parent to take the child from therapist to therapist until one is found who will validate abuse. As legislation and services to child abuse victims have burgeoned, a cadre of professionals, who Gardner (1991) called the "validators," has arisen. The validators do not see their job as discerning which allegations ate true and which are not. Rather, they act on the assumption that all allegations are legitimate. They often use persistent, leading questioning, sexually explicit dolls, and selective rewards as part of evaluation and treatment. In addition to convincing the child that abuse occurred, validators often help the mother mobilize the power of the authorities on behalf of her agenda.

Attorneys and custody evaluators can be professional participants in contemporary-type MSP as illustrated in the following case. The custody evaluation complete, the evaluator found it highly unlikely that the father had molested his young daughter. However, to help the child become more independent of her mother, the evaluator recommended that the child continue in the therapy the mother had previously enrolled her in, even though the therapist had refused to speak to him and there was every indication that the therapist was a validator. Some time later, attorneys for the mother and father were in court without the parties when the mother's attorney told the judge that the girl had been recommended for therapy by the evaluator because she had been sexually abused by her father. The report given by the mother's attorney of the evaluator's opinion became part of the court record.

In an interesting variation on the theme of professional participants, Meadow (1990) describes an MSP mother who agreed with workers from five different agencies that her MSP abuse of two of her children was really a cry for help because she claimed to have been molested as a child. The alleged molest occurred when she was 10, sitting on her uncle's knee. The MSP abuse of her children resulted in the death of one and brain damage to another.

Perception, Social Influence, and Memory

Divorce engenders extraordinary emotions in children and adults alike. As such, events are subject to misinterpretations and distortions of all kinds. This is true even in an amicable divorce, witness the following scene. The parents were discussing their divorce and in a friendly spirit one of them commented that things were going to work out, meaning that the practical steps of the divorce were going smoothly. The child overheard and, perception colored by his needs, thought that "things working out" meant that his parents were getting back together.

Misinterpretation is not always so benign, especially when the divorce is acrimonious. Wallerstein and Blakeslee (1989) describe, with grave concern, how a teenage boy in their sample had "rewritten history." They knew for a fact that it was the father who had insisted on the divorce while the mother, especially concerned that her children not have a broken home, had tried hard to keep the family together. Years later, the boy was convinced that it was his mother who had asked for the divorce. He invented a number of other "facts" about his mother to support his new view of reality, for example that she was gay and hated men. The boy may have been responding to paternal influence, he may have created the story to shore up his identification with his father, Wallerstein and Blakeslee do not say.

Subtle social influence can be as effective as an obvious brainwashing campaign. Schuman (1987) describes a mutually reinforcing cycle between parent and child whereby the child accommodates to parental expectations and perceptions. The parent experiences this as reinforcement of his or her point of view. The child responds to the parent's increased confidence by accommodating further. The result is that mother and child may come to hold "true beliefs" which are not valid but which are not "lies" either.

In MSP social influence comes not only from the mother/accuser but from the professional participants whom she mobilizes. The professional participants can be viewed as a group cultivated by the mother to help her manipulate rewards and punishments so as to promote new learning in the child and to control the child's activities. This constellation is one of the conditions necessary for brainwashing, a form of social influence that relies on a group with a charismatic leader. Other conditions for brainwashing include naiveté of the subject (in this case a child), physical and psychological dependency of the subject on the influencer (in this case a parent) who is looked up to as an authority figure, reinforcement of the dependency by the influencer, and discouraging of outside attachments and influences that would compete with the influence over the subject. These conditions are met in many polarized divorced situations.

One of the tragic aspects of contemporary-type MSP is that the child's memory of events may actually be altered, so that loving interactions with the father are obliterated and replaced by negative ones. New information, in the form of leading questions or hearing others talk about the alleged abuse, may become incorporated into the child's memory so that the memory is altered, distorted, or contaminated (Loftus & Ketcham, 1991). Adult memory can be altered in the same way. Schuman (1986) observes that multiple evaluations and sex abuse therapy for non-abused children result in the child displaying increased accommodation of both memory and affect.

MSP and the DSM-III-R

Munchausen syndrome by proxy belongs to the class of factitious disorders, which were first included in the Diagnostic and Statistical Manual in 1980. The DSM-III-R (American Psychiatric Association, 1987) describes various forms of adult factitious disorder but does not yet specifically list Munchausen syndrome by proxy or the more generic factitious disorder by proxy. Factitious disorder by proxy is expected to be included in the DSM-IV (Widiger & Trull, 1991).

According to the DSM-III-R, factitious disorders are "(C)haracterized by physical or psychological symptoms that are intentionally produced or feigned. ... the judgment that the symptom is intentionally produced is based, in part, on the person's ability to simulate illness in such a way that he or she is not likely to be discovered" (p.315).

When discovered, individuals exhibiting factitious disorder have been found to produce a variety of physical and psychological symptoms, including factitious psychosis, factitious depression, factitious bereavement, and factitious rape. Since the only limit on the type of symptoms created is what professionals will accept and respond to, it is to be expected that there will be some cases of factitious sex abuse, and some of these will be "by proxy." Variations of the syndrome will emerge continuously: "By their very nature, fictitious illnesses must be adaptive to changing circumstances, or they would be too obvious. ... The probable range of variations in the presentation of Munchausen Syndrome is likely to develop in parallel with the evolution of medical and social services" (Sinanan & Haughton, 1986, p. 465).

Until the DSM-IV comes out, factitious disorder not otherwise specified can be used on Axis I to identify Munchausen syndrome by proxy or the more generic factitious disorder by proxy. There can be more than one diagnosis on Axis I, so that if another diagnosis also applies, for example bipolar disorder, it can be listed here as well. The underlying personality disorder, if there is one, would be listed on Axis II. When the accuser's thought process with respect to the alleged sex abuse can be characterized as "persistent, non-bizarre delusions," a diagnosis of delusional (paranoid) disorder may be listed on Axis I. When the clinical picture can be characterized as *folie â deux*, a diagnosis of induced psychotic disorder (shared paranoid disorder in DSM-III) may be appropriate, although the conceptualization in the DSM-III-R is not very satisfactory.

Evaluating for Contemporary-Type MSP

A major obstacle to the early diagnosis of contemporary-type MSP is the assumption by many professionals who come in contact with the case that the allegations of MSP parent are true. In an effort to deal with this problem, the American Academy of Child and Adolescent Psychiatry came out with a position paper in 1988 in which they recommend always considering the possibility of false accusations, "particularly if allegations are coming from the parent rather than the child, if parents are engaged in a dispute over custody or visitation, and/or if the child is a preschooler" (Schetky et al., 1988, p. 655-656).

It is not enough to make a determination as to whether the allegations are true or false.

In addition to assessing the validity of the abuse allegations, it is important to assess what factors in the accusing parent, the child, and the parent/child relationship have contributed to the development of a false accusation. The evaluator must not only identify whether the child is subject to a complex form of emotional abuse by the accusing parent, but must be able to articulate how this is harmful to the child. All this requires considerable time and expertise, since the evaluator is trying to sort out if the child was molested by the accused, if the accuser is the one abusing the child, and depending on the answer to these questions, which parent should have custody of the child and how visitation should be structured.

In classical cases, the realization tends to come slowly that the child's medical condition is not bona fide but is an artifact created by the mother (Meadow, 1985). The same holds true in many contemporary-type MSP cases as well. Psychological evaluations tend, by their very nature, to be one shot deals. If the evaluator was on the right track but did not quite get to the MSP type abuse the first time, it may be appropriate after more time has passed to seek a court order for the evaluator to reexamine the parties.

A single evaluator is recommended to assess the mother, father and children, as opposed to having one evaluator for the mother, another for the children and so on. There is another type of evaluator, preferably someone with expertise in MSP who reviews all the documentation in the case, including the report of the primary evaluator, and renders an opinion as to the likelihood that MSP type abuse is operating. This type of evaluator integrates all the material on the case and does a meta-analysis.

Meadow (1985) offers guidelines for evaluation of classical MSP which are equally valuable for contemporary-type cases:

1. Study the history to decide which events are likely fabricated and which ones are real.
2. Look for the temporal relationship between illness events and the presence of the mother.
3. Check the details of the personal, social and family history that the mother has given — often she will have lied about them.
4. Make contact with other family members.
5. Look for the motive for the behavior.

In searching for the motive for the behavior, it is helpful to investigate how both the parents and children are adjusting to the divorce, although the allegations often form a smoke screen that makes this material difficult to explore. Which parent left the other? It is not always the case that the MSP mother is taking revenge on a husband who has left her. Sometimes it is the mother who left, and she wants the father completely out of her life, without the bother of shared custody. Who does the child blame for the divorce? This is particularly pertinent with older children who may be participants in the MSP, initiating allegations or going along with them because of their own unresolved feelings. How are parents and children dealing with the feelings of loss, loneliness, guilt and anger engendered by the divorce? Do the allegations serve a defensive function, staving off feelings of failure, disappointment, and loss?

Collateral contacts with family members can provide insight into some of these issues. They can also help clarify which items are fact and which are distortions or fabrications and provide a clearer picture of the family history and dynamics. Family dynamics may shed considerable light on the diagnosis along with evaluation of the mother and children (Griffith, 1988). In addition to providing a more objective view of events, contact with family and friends sometimes reveals a *folie â deux* relationship between the accuser and another adult who is supporting her in the allegation.

Collateral contacts with school personnel, child protective service workers and other professionals are also important. Information should be obtained from all previous and current investigators/treaters/examiners, whether or not the information they have is directly relevant to the current evaluation. How have each of the parents used these services? Did the parents use these services in good faith, manipulatively, evasively and so on? It should be spelled out in the beginning that the evaluator has the permission of both parents to talk to whomever the evaluator deems appropriate. Failure to establish this ground rule enables the MSP parent to control the information available to the evaluator by withholding consent.

Obtaining a history of the allegations is essential. Careful attention should be paid to the following: the context in which the allegations were made; the manner in which the allegations have evolved, including sequence and timing of the allegations; any and all social influences that may be affecting the child, including interviews by investigators and professionals; social influence between professionals; and the motivations, both practical and intrapsychic, of the adult(s) invested in the allegation. What I usually do is develop a working timeline of the allegations based on my review of all the documents in the case.

Evaluators who focus narrowly on what the child says are unlikely to be successful in helping to bring these cases under control. There is social pressure on mental health professionals to "believe the child." Bending to this pressure undermines the evaluator's effectiveness. Another handicap for the evaluator is the difficulty in knowing for sure that sex abuse did not occur. The problem of evaluator confidence is compounded if the accused father, though not a child molester, exhibits psychological difficulties of his own. The greater the evaluator's confidence in the fact that sex abuse did not occur, the more likely he or she is to take a strong stand with respect to the mother/accuser's pathology.

Typically, some professionals involved will believe that abuse occurred while others will believe it did not. The evaluator must decide where the preponderance of evidence lies. The evaluator should be cautious about accepting at face value someone else's determination that abuse occurred. To the extent possible, the evaluator should investigate specifically how the conclusion was reached.

Any videotapes of the child being interviewed about the alleged abuse are of particular importance. A therapist in one case told me that she had seen a video of the young child being interviewed by a police investigator and the child was very believable. I looked at the video myself and noted that the interview had been rehearsed. In addition, there was persistent use of leading questions, pressure and rewards to shape the child's disclosures. I asked the therapist to view the tape again in light of my observations. She agreed, and after watching it a second time called me back to say not only that she saw what I was talking about, but she had significant concerns about

some of the professional participants in the case. Until I became involved in the case, she had been afraid to verbalize her concerns about the role of other professionals in shaping the allegations.

Interviews that rely on leading questions, pressure and rewards, as well as repeated interviews of the child, often teach the child what the allegation is supposed to be. Since the evaluator also interviews the child about the allegations, the evaluation itself can become a vehicle for perpetuation of the MSP abuse. Sometimes, new "disclosures" by the children will occur during the evaluation, which the evaluator must report, muddying the waters further.

The allegations need to be laid to rest one way or the other, otherwise the MSP mother will continue her manipulations that put the child in the middle. If warning signs for MSP are present, they may actually aid in the determination of whether or not the mother's accusations are valid. It is often not enough for the evaluator to determine that the allegations are not true. He or she should be prepared to explain how the allegations came to be if they are not valid. The evaluator may need to take an active role in educating the court and the various professionals involved about emotional abuse and how it is harmful to the child.

Unlike most diagnostic labels that apply to only one person, MSP involves a triangle of mother, child, and the professional participants. Sometimes the mother's attorney will attempt to debunk the diagnosis by bringing in an expert who will testify that this is not *really* Munchausen syndrome by proxy. The appropriate response to this is that, no matter what one calls it, the situation is emotionally abusive to the child.

Part of stopping the MSP abuse is articulating to others how this type of emotional abuse is harmful to the child. The inappropriateness of using the child to ruin the other parent's life deserves comment. Involving the child in manipulation and dishonesty is a clear detriment to the child's moral development. In contemporary-type MSP the child's psychic energy is tied up in carrying out the accusing parent's agenda rather than allowing the child to love freely, invest energy in mastering normal developmental tasks, and master the psychological adjustments of divorce. The importance for children of experiencing the love and care of both parents needs to be reiterated.

Child victims of contemporary-type MSP abuse are exposed to repeated talk of sex, deviant sexuality, and sexual contact with once loved relatives. The child may be exposed to this material many times a day. One mother used to wake her young daughter in the middle of the night to talk to her further about the alleged abuse. The mother/accuser may enlist her boyfriend or another adult in these talks so that it is two adults against one child. These contacts are clearly emotionally abusive. They may constitute a kind of mental sex abuse as well. The child who is subjected to hours of talk about sex organs and sex acts may become over-stimulated and engage in aggressive, hyperactive or sexualized behavior which may be misinterpreted by some of the professional participants as behavior consistent with the alleged sexual abuse.

Contemporary-type MSP almost always entails the child losing not only the relationship with the father, but with relatives — the paternal grandparents, aunts, uncles, and cousins. In addition to the love and support that children often receive from extended family, these people may act as important role models.

Child Abuse Reporting

Munchausen syndrome by proxy is a reportable form of child abuse, yet child protective service workers, mental health professionals and others may never have heard of it (Kaufman, Coury, Pickrel, & McCleery; 1989). If they have, they have often been oriented to a very narrow definition of MSP that defines it in terms of production of factitious physical symptoms to get the attention of medical personnel. They may not have been exposed to the concept of contemporary-type MSP abuse or may not accept the fact that it is involved in some false accusations of sex abuse. Thus, a suspected child abuse report on the MSP mother in contemporary-type cases may further complicate the picture.

While the reporting of emotional abuse is at the discretion of the mandated reporter, if the MSP includes physical or sexual abuse by the MSP parent then a suspected child abuse must be filed. If reporting is optional, the reporter should give careful consideration as to the possible consequences of making the report. There may be some merit to having the suspected MSP on record with the local protective service agency. If the mother's maltreatment of the children escalates and the protective service agency receives another report, they may be more likely to take the report seriously if the family is already known to them.

The disadvantage of making an optional report is that it invites protective service involvement, and child protective service workers are often among the professional participants who the mother/accuser mobilizes to her cause. There is always the risk that an inexperienced or overzealous social worker will align herself with the mother/ accuser. Instead of protecting the child from the mother's emotional abuse, the power of the system may be used to support and continue it. I know of a number of cases where this has occurred, even after the MSP diagnosis was made by a protective service's psychologist/evaluator. Social workers and therapists may ignore the evaluator's findings, convinced that mother and children are being given short shrift. The MSP mother is skilled at drawing in professional participants and continues to try and do so even after her abuse has been reported.

Management of Munchausen Syndrome by Proxy

Once the diagnosis is made, the goal is to protect the child from the mother/accuser's influence and to set limits on her behavior, as in any other form of child abuse. The key to protection of the child is case management rather than therapy for the mother. Prior to diagnosis of the MSP, the mother and her pathology have controlled the child and the family system. Case management preempts the mother's control. with the backing of the court, the situation is structured so that the mother must comply or face sanctions and the child can experience normal growth and development protected from the mother's subversive influence. The problem with therapy in these cases is that it becomes another vehicle for the mother's agenda. In their outcome study on the management of over 200 classical MSP cases, Neale et al. (in press) summarized their findings:

> While many mothers superficially appeared cooperative, they tried a variety of ways to manipulate situations to their advantage. In the best managed cases, with the best outcome for the children, access for the mother was strictly controlled and supervised, particularly when the children were old enough to collude with her. Often the management was hampered by differing perceptions among professionals, particularly concerning the nature of the abuse itself; and the psychological condition of the mother. Wide differences of opinion sometimes occurred because of the mothers' ability to deceive and to present as perfectly normal women ... Overall the mother's propensity to manipulate and deceive was best kept in check where professional/client interaction was carefully controlled; where presenting information was verified; where adult psychiatrists declined the role of advocate in child care proceedings; where the child was well represented; and where professional communication was optimized through frequent case conferences and well established procedures for feeding back information between meetings (pp.15-18.)

One of the first steps in managing these cases is for the court to order that the mother/accuser not be allowed to initiate any more evaluations or therapy sessions for the child without the permission of the court or permission of someone designated by the court. I have consulted on cases in which the child's therapist resisted the validator role and was concerned about what the mother was doing. An effective case management strategy in these cases has been to structure the situation so that the mother takes her concerns about abuse to the therapist who will then determine whether a protective services or emergency room contact is warranted.

Once the allegations of the mother or the mother/child dyad are determined to be invalid and the MSP diagnosis is made, consideration must be given to where the child should live. In classical cases of MSP, removing the child from the mother's custody is often the first step in protecting the child from physical harm. This is often necessary in contemporary-type cases as well, even though it may be harder to gain the court's support for this option since psychological rather than physical harm is generally the main issue. Unfortunately, if the child is allowed to continue living with the mother, she will continue to sabotage the father/child relationship, reinforcing the abuse scenario at every opportunity.

The need for some sort of separation from the mother/accuser, whether temporary or permanent, is particularly important once the child is old enough to initiate verbalizations about abuse in accordance with the scenario that the mother supports. If the accused father has been a good father and was previously involved with the children, it may be appropriate to make him the custodial parent. If he is fit but never had a relationship with the children, then a transitional get-acquainted period with the assistance of a family therapist may be helpful. Placement with relatives who are not aligned with the mother may also be considered.

In severe cases of contemporary-type MSP involving older children, psychiatric hospitalization can be helpful in separating the children from the mother's influence and reorienting them to a loving relationship with the father. This option is particularly appropriate if the children are threatening suicide or homicide if they have to have

contact with the father. In order for hospitalization to be successful, the mother must not be allowed to see or telephone the children while they are there and hospital staff must work cooperatively with the professional who diagnosed MSP. In addition to giving the children an opportunity to regain their sanity, hospitalization allows them to become reacquainted with the father in a safe setting so that they will eventually feel comfortable going home in his custody.

After custody, the issue of visitation should be addressed. Like classical MSP mothers, the mother in contemporary cases often continues her emotional abuse of the child even during brief visitation contacts. An unsupervised visit gives her the opportunity to grill the child about whether the father has engaged in inappropriate touching, interpret the child's normal misbehavior as a result of father's abuse, or take the child to a sex abuse exam or call child protective services with another complaint against the father. A court order restraining her from talking to the child about abuse is unlikely to be effective unless her visitation contacts with the child are supervised. If she is able to conform to such restraints during supervised visits, then unsupervised ones may become appropriate. The burden should be on her to prove that she can behave appropriately with her child.

Limiting the mother/accuser's contact is especially important at first while the children are making an adjustment to living with the father. Negative input from mother will cripple or even defeat this process. Phone calls from the mother/accuser may be prohibited for awhile since they are difficult to supervise.

Therapy for the mother should be at her discretion. Sometimes the court holds off on case management and is persuaded to give her a chance, ordering the mother into individual therapy or accepting her "plea bargain" to enter therapy as an alternative to loss of custody and visitation. Some of these mothers benefit from the support of individual therapy, but it is not at all realistic to expect that therapy will modify their MSP behavior since they are manipulative, untruthful, and lack insight into themselves and their interaction with the child and others. They reject reassurances that the child has not been abused by the other parent. They resist efforts to make them more aware of what the false abuse scenario is doing to the child. They refuse to believe that it is they who are harming the child. It comes down to the fact that there are strong intrapsychic motivations for MSP behavior which are not subject to change through reason or persuasion. The literature on MSP is replete with observations that the mothers do not improve with therapy, at least where the MSP behavior is concerned.

If the mother is already in therapy, the court would be wise to instruct the evaluator to notify the mother's therapist of the diagnosis and to provide the therapist with information about Munchausen syndrome by proxy. The purpose of this contact is to help the therapist maintain the appropriate neutrality and not become a professional participant.

Informed psychotherapy for the children may be indicated if it is integrated into a larger case management plan. Psychotherapy for the children is not a substitute for case management any more than is psychotherapy for the mother. Therapy for the child after the MSP abuse is diagnosed should be carefully supervised with the goals of treatment clearly spelled out. The child's therapist should be free to communicate with others involved in the case. If the mother holds the privilege then she can continue to control

the flow of information by withholding her consent for communication. If the child is already in sex abuse therapy, a decision will have to be made about terminating that therapy, and if so, how this should be done. It may be appropriate for the evaluator who diagnosed the MSP to make this recommendation.

Management of these cases is most effective when the person who officially diagnosed the MSP remains involved in the case. Continued involvement of the person who made the diagnosis will help to insure the necessary cooperation among family members, professionals, various agencies and the courts. This is a more active role than most evaluators are accustomed to, but is absolutely essential given the turnover within agencies and the courts, each new person representing an opportunity for the MSP mother to enlist a professional participant.

Even when custody is given to the father, ongoing case management and monitoring may be needed. This can be done by a competent psychologist or psychiatrist, with an understanding of MSP type abuse, whose decisions are backed by the court.

Special Master Program

In Mann County, California, an innovative program has been instituted called the Special Master Program.[2] The Special Master Program was developed to meet the needs of divorcing and post-divorce families where the parents, for a variety of reasons, have been unable to cooperate or mediate with respect to custody, visitation and other decisions about the children. The Special Master provides a type of informed, ongoing, binding arbitration that focuses on the child's best interests. When parents stipulate to a Special Master, the agreement includes their giving consent for the Special Master to access all documents and records related to the case, as well as consent to speak with anyone who may have pertinent information. The Special Master evaluates and then makes orders with respect to issues raised by either parent. The Special Master's decisions have the weight of a court order. A potential pitfall of appointing a Special Master is that his or her services may also become a vehicle for the mother's agenda.

Generally speaking, the Special Master is appointed by stipulation of the parties. The MSP mother may resist this coopting of her control. However, when the program is backed by the court, the court has various means of "motivating" parents to stipulate to a Special Master. The parties stipulate as to how long the Special Master will be in place, which can be, for example, one year, five years or indefinitely. Only if both parents agree can the Special Master arrangement be terminated before the stipulated time. The court serves as a back-up in the event a parent wishes to appeal a Special Master ruling, or to enforce a Special Master with which the other parent refuses to comply.

When contemporary-type MSP is at issue, the Special Master can function as the case manager. The Special Master is authorized to meet with the father, mother, children, and any other relevant professionals for the purpose of determining the propriety of visitation between the mother and children, as well as the conditions under which it might take place. It would be the function of the Special Master to attempt to educate the mother regarding the harm caused to the children by her conduct and to encourage

modification of her behavior. The Special Master should be empowered to structure supervised visits for the mother and children. Such visitations are usually supervised by a psychologist or a qualified paraprofessional.

Because the Special Master is an integral part of the evaluation, management and treatment of the case, the Special Master can take immediate action to protect the best interests of the children. If modification of contacts between the mother and the children ate needed, whether expanded or reduced, the Special Master can accomplish this promptly. There is no need to initiate protective court remedies to protect the children which are not only expensive but may not address the specific problems in time to adequately protect all family members.

The unique role of the Special Master allows for very creative problem solving in difficult family situations. The court rarely has the time or the interest in evaluating and ruling on points such as how visitation transitions should be handled, or who in addition to the mother may be present for visits. For example, it might come to the Special Master's attention that the mother becomes agitated and starts yelling every time she picks up the child for a visit. The Special Master might fine tune the situation so that the children are exchanged in neutral setting, such as a therapist's office or even the fire department. Another example is that of the mother who has a friend or relative who has been agitating on behalf of the abuse allegations. To maximize her influence, the mother may arrange for this person to be involved with the child as much as possible. The Special Master can evaluate the pros and cons of other people's participation and determine what level of involvement is appropriate.

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1 Since the creator of factitious illness for the child is almost always the child's mother, the perpetrator of MSP abuse will generally he referred to as the mother. [Back]

2 For information about the Special Master Program contact Sami M. Mason, American Mediation Services, 700 Larkspur Landing Circle, Ste. 260, Larkspur, CA 94939, (415) 461-8900. [Back]

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