

Munchausen Syndrome By Proxy/Factitious Disorder By Proxy

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Introduction

For more than 30 years the diagnosis of Munchausen Syndrome By Proxy (“MSBP”)/Factitious Disorder by Proxy (“FDBP”) has been used as a tool to enable the state and its prosecutors to accuse caregivers, usually mothers, of harming and abusing their children. When such a diagnosis is made, or even surmised, by a state’s expert, the child can summarily be taken away from parents, and parents are put in the position of having to defend themselves against often shadowy, imprecise and almost irrebuttable charges of deceptively “working” the medical system, surreptitiously faking abuse or actually harming their children. Since caregiver deception is at the heart of MSBP, a denial of abuse by a caregiver of a child functions almost the same as a confession of abuse, i.e., both likely make the caregiver “guilty” of neglecting or abusing the child. Thus, in legal proceedings, the allegation of MSBP acts as a “boost” to prosecutors, a sort of evidentiary steroid to fill gaps in cases that often lack direct or even convincing circumstantial evidence. MSBP is the prosecutor’s friend, the means by which suspicions of abuse and parental unfitness can be “confirmed” without having actually to show that any abuse occurred. Like the broomstick in the Sorcerer’s Apprentice, which under the spell of the inexperienced magician at first served a useful function of bringing water but then took over the magician’s life and began to dump far more water than needed, causing a general disaster, so MSBP may have served a useful, if adjuvant, function at one time but has over the years taken on a sinister and dangerous role, harming far more people than it helps. This latter impression is not simply the complaint of disgruntled losers in the legal system; it is the considered conclusion of career psychologists who have worked with MSBP allegations for two decades.¹

With such a powerful tool at prosecutorial disposal, and so much at stake for parents, one would naturally think that MSBP rests on solid observational and scientific proof or, if proof is too strong a word, on almost universal consent that such a condition is readily identifiable. Yet, as this paper will show, there not only is no clear definition of what MSBP is, but there is no consensus on the type of person who should diagnose it. For example, the definition of the phenomenon given in the 1994 DSM-IV differs significantly from the “classic” definition given of the “Syndrome” in a 1987 article. So different are the definitions that the *pediatrician* who first named MSBP in a 1977 article actually agreed, in a 1995 article, that the DSM-IV definition (the *psychological* definition) was to be preferred over the *medical* definition in the 1987 article. Thus, even those who are supposedly most “in tune” with the phenomenon disagree in fundamental ways regarding its definition. So serious has this problem become that the primary

¹ Phone and email conversation with Loren Pankratz, Ph. D., psychologist and frequent expert witness in cases involving MSBP.

professional body that deals with child abuse quietly dropped the label MSBP in 2000, or significantly curtailed its use, in favor of the more limited “Pediatric Condition Falsification.” There is no agreement, then, on what constitutes MSBP or even what it should be called.

Then, there is considerable confusion regarding who should diagnose it. Is it, for example, primarily a *psychological* problem, to be divined by people in that trade, or is it a *medical* condition to be ascertained by pediatricians and treating physicians? To what extent is it a diagnosis, a conclusion reached after intensive examination of the mother/caregiver, or a suspicion, a sort of a hypothesis that should set in motion the wheels of the judicial system by taking the child away from parents and putting the burden of proof on parents that they are *not* abusers of their children? Then, there is confusion in the literature regarding *who suffers* from the “Syndrome.” Most of the legal cases and many articles written by psychologists say that MSBP is a disorder or syndrome suffered by the caregiver, yet the classic 1987 article suggests that it is the child who suffers the disorder.

Then, there is the problem with statistics. We don’t know, for example, if the condition is rare or common. Most of the literature tends to emphasize the relative rarity of the syndrome, but then, in the mid-1990s, an increasing number of articles, without citing any confirmatory statistics, began alleging that MSBP is far more widespread than ever thought. Like ghouls supposedly hiding behind every bush in a bosky wood, so MSBP became the “bogey man,” especially of legal literature in the 1990s. MSBP was supposed not to be rare at all, but was hypothesized to be a drastically under-reported phenomenon and, as such, something that had to be “smoked out” if society was really to stamp out the spectre of child abuse. Make no mistake about it. Abuse of children by caregivers is a most heinous and reprehensible activity, which can sometimes rise to the level of criminal behavior. Inducing illness or injury in children, which is at the heart of the traditional definition of MSBP, no doubt exists and should be ferreted out. But what the “statistical revolution” of the 1990s in MSBP did was to *hypothesize* that the number of cases of MSBP was *much larger* than reported, which led to more vigorous prosecutorial activity against parents who supposedly had this “syndrome.” Wild numbers were suggested without foundation. Whereas the classic 1987 article found 117 cases of MSBP by combing 22 years of psychological literature, by the 1990s there were unsubstantiated and scattered references to that many cases *per year*.

It is a common phenomenon when you want to get recognition of your phenomenon that you inflate the numbers or argue for its widespread rather than rare occurrence. The Americans with Disabilities Act of 1990, for example, would never have so easily passed without the rather fantastic numbers suggested in the “Congressional Findings” of how many disabled people there were in America. Incidentally, the reason you see all those empty “handicapped parking” spaces everywhere you go is that the over-inflated projections of the number of disabled people in America in 1990 led to calculations about how many of these parking spaces we needed all over the place. The 1990s saw a like exaggeration in the number of MSBP people “out there.” Then, when this hyper-inflated, and unsubstantiated, number was linked with the theory of early detection, a movement

in medicine and psychology in the 1990s, you had established all the conditions for a veritable witch-hunt to find the perpetrators/sufferers of MSBP. For if you supposed that the number of MSBP perpetrators was much larger than ever suspected, and if you further believed that early detection was required in order to “save the children,” the state would redouble its effort to try to intervene *as early as possible* into the lives of families where there *may have been* an MSBP person and remove the child from the home. When this philosophy of action is combined with the fundamental notion that MSBP is a disorder which manifests itself in *deception*, you have the conditions set for suspicion, uninformed intervention, ideological prosecution, and unwarranted conclusion that *anything* a caregiver says in his/her defense is further proof of MSBP.

The problem with numbers goes beyond this, if it can be imagined. What I am calling the “classic” study of 1987 was the first which tried to put a numerical face on this condition. But Dr. Roy Meadow, the author of the 1977 article naming the syndrome, vigorously contended that crucial numbers in this 1987 article were over-inflated and, in fact, he tried to warn the profession about rampant over-diagnosis of the condition in a 1995 article. What makes this attempt of Dr. Meadow so poignant is that he was objecting to the *overstatement* of numbers in what later would be considered *the most conservative* article (the “classic” 1987 piece). Thus, as time went on, the *conservative* numbers, especially relating to mortality rates of children in MSBP families who were returned to their families, of the 1987 article, numbers which were discredited by Dr. Meadow himself (because *he* gathered the statistics originally), became the number *on the low end* of potential mortality rates of children returned to home after a MSBP diagnosis. Expert prosecution witnesses in legal cases in the 1990s and 2000s used the discredited 1987 numbers as the *low end* of abuse numbers. We were then working in such a world of smoke and mirrors that almost no “statistical truth” could be established. The Sorcerer’s Apprentice broomstick was flooding the house with water, multiplying the amount even as the stick was cut in two, then four, then eight pieces.

The final irony in the sad history of MSBP is that the one who named the syndrome, Dr. Roy Meadow, who argued for a *more conservative* use of the diagnosis and a *much smaller number* of deaths/injuries of children returned to their MSBP homes, has himself now been fully discredited precisely for *inflating* numbers as an expert witness in several English cases of infant crib death. The upshot of these cases is that Dr. Meadow relied more on philosophy or ideology in diagnosing than on good statistics.

With such a multi-form problematic facing the diagnosis of MSBP, I argue that it is time for the legal, as well as the psychological/medical, community to inter this syndrome next to its eponymous ancestor, the Baron Munchausen (1720-97). If abuse is happening in the home, name the abuse and have that abuse be the reason either for terminating parental rights or prosecuting caregivers under state child abuse statutes. Have the pediatricians or other doctors testify to the supposed abuse, but have them testify as fact rather than as expert witnesses. Use psychologists/psychiatrists only sparingly, if at all, in cases of supposed induced or fabricated illness, and then only to opine on the mental state of caregivers, rather than whether a caregiver suffers from a “syndrome” that has ever-shifting boundaries and no clear and agreed-upon definition. Discard the term

MSBP and the corresponding DSM-IV (and DSM-IV-TR, from 2000) term FDBP, and focus on the facts that are observable rather than a theoretical construct that might help explain the facts in a few instances but probably misleads much more frequently than it informs.

The following paper is, like Caesar's Gaul, divided into three parts. Part I explores the rise of the diagnosis from 1977 until its early "high water mark" after an important 1987 article and court case. If one were to "plot the curve" of MSBP in these years, one would have a line similar to the rise of Starbucks' stock until the last few years, i.e., a steep-upward line or curve. Part II explores the reception of MSBP through the inclusion of it in the DSM-IV as a topic to be further studied in 1994. Part III then shows the bifurcated path of MSBP from 1995-2008. This part will show two things: (a) how large pockets of the psychological community gradually became disenchanted with the diagnosis, even as the "true believers" in that community wanted to "ramp up" the frequency, and (b) how the legal community swallowed, hook, line and sinker, the diagnosis and its supposed growing frequency, and called for even more use of the syndrome. Finally, a brief conclusion summarizes my findings and argues that all professional communities would be well-served by dropping reference to this "disorder" at this time.

I. The Rise of MSBP

A. Meadow's Article

The honor of naming the phenomenon goes to an English pediatrician, Dr. Roy Meadow.² In the mid-1970s he recognized something in two, yes only two, cases which puzzled him and whose symptoms previously had received little documentation in medical literature. A case was reported in which, over a period of six years, the parents systematically provided fictitious information about their child's symptoms to medical personnel, tampered with the child's urine specimens to produce false results and interfered with hospital observations. This caused the child innumerable investigations and many anesthetic, surgical, and radiological procedures in three different medical centers. A second case was where a child was intermittently given toxic doses of salt which, after extensive medical investigation, ended in the child's death.

Meadow noted that the two cases shared common features. The mothers' stories about their children, told to medical personnel, were false, deliberately and consistently false. The mothers' actions caused unpleasant and serious consequences for the children. Both mothers skillfully altered specimens and evaded close and experienced supervision. Yet, seemingly ironically, through the course of the investigation Dr. Meadow and others grew to know the mothers well. In his words, they were "very pleasant people to deal with, cooperative, and appreciative of good medical care, which encouraged us to try all the harder."³ Some mothers who stay in the hospital with children become uneasy or

² Meadow, Roy, "Munchausen Syndrome by Proxy: The Hinterlands of Child Abuse," *Lancet* II (1977), 343-45.

³ *Ibid.*, 344.

bored, he said. But these two mothers “flourished there, as if they belonged, and thrived on the attention the staff gave to them.” Both mothers had a history of falsifying their own medical records, and it seemed as if they were doing the same for their children in these instances. Even though Meadow recognized that parents many times exaggerate their children’s symptoms in order to obtain more thorough medical care, in these instances the motivations of the mothers appeared to be different. In his words, “It was as if the parents were using the children to get themselves into the sheltered environment of a children’s ward surrounded by friendly staff.” Why? Well, perhaps to project on the child her own worries about medical problems she faced.⁴

Meadow suggested that this sort of fabricated story was reminiscent of Munchausen syndrome. Named after an 18th century German soldier-of-fortune, who fought in several battles on behalf of the Russians and then retired to his German estate, only to regale others with his fantastic exploits of military prowess or physical skill (such as pulling himself out of a quicksand swamp by his own hair), Munchausen syndrome was named in 1951 and attributed to people whose fantastic and fabricated stories about their own medical conditions led them to seek frequent treatment in widely-scattered clinics. But here there was the added factor of the parent, the mother in these cases, telling fantastic stories and inducing illness (and death in one case) in *another person*. Thus, the name “Munchausen Syndrome by Proxy” was suggested. Meadow’s first case, he says, seems to be the “first example” of “Munchausen syndrome by proxy.” Even though a 1976 article describing poisoning of children by parents seemed to be similar, Meadow suggested that the poisoning was an “extended form of child abuse,” while he suggested that the acts of abuse suffered in MSBP cases were “so different in quality, periodicity, and planning from the more usual non-accidental injury of childhood that I am uneasy about classifying these sad cases as variants of non-accidental injury.”⁵ Later writers would have no such reluctance.

Thus, from 1977, we have two cases anecdotally described, where the induction of false symptoms was combined with maternal officiousness to such an extent that the medical community was baffled for a long time before concluding that the children’s injuries were actually caused by the mothers. These two cases, and I continue to emphasize the small number two, became the template, then, for others to use to try to “flesh out” this “syndrome.” But already at this point we have the problematic character of MSBP illustrated. It would be described as a “syndrome” where there was not only injury but where the mother’s mental state and actions deceived medical personnel and hindered the medical process. To what extent *all* these things were to become necessary or sufficient characteristics of this “syndrome” would unfold in the ensuing decade.

B. The *Phillips* Case (1981)

⁴ *Ibid.*, 345.

⁵ *Ibid.*

Surprisingly, the next forum which took up the MSBP diagnosis was not the medical literature but was a legal case in one of the appellate courts of California. This relatively rapid adoption of expert witness testimony on MSBP by a trial court in 1979 and an appellate body in 1981 shows that law was already inclined to lend a helping hand to any new psychological theory that might claim to protect children. The facts of that case, and the discussion in court regarding accepting the testimony of a psychologist, perhaps appropriately named Dr. Blinder, are important to note.⁶ For those familiar with MSBP cases, the court's recitation of preliminary facts is ominous:

“By nearly all accounts, Priscilla Phillips was a kind, helpful and loving person, a dutiful wife to her husband and a devoted mother to their two sons, who at the time of trial were nine and six years of age. Highly educated, with a master's degree in social work, she was employed in the Marin County Health and Human Services Department. After the birth of her sons, she turned her attention increasingly to religious and civil volunteer work, and became active in a variety of community organizations. Among the many organizations to which she volunteered time and energy was the Child Protective Services Unit of the Marin County Child Abuse Agency.”⁷

She had a hysterectomy in 1975 but later regretted her decision and decided, with her husband, to adopt Tia, a Korean child. Shortly after Tia arrived in the Phillips family, Mrs. Phillips began to take Tia to doctors with a variety of symptoms, from vomiting to ear infections to diaper rash. Numerous doctors were called in to deal with her symptoms, which seemed to improve when Tia was in the hospital. Upon return to home, however, her conditions returned. Later tests revealed she was suffering from extreme levels of sodium in the blood. The doctors had no explanation for this phenomenon. Repeated releases and returns to the hospital with extreme levels of sodium eventuated in Tia's death in Feb. 1977.

The Phillips' then adopted another Korean girl, and two years from the day of Tia's death she began to develop symptoms identical to Tia. A doctor finally decided that since there was no biological connection between the sisters that poisoning might be at work. After the child improved when isolated from the mother in the hospital, the hospital staff contacted Child Protective Services. Mrs. Phillips was then charged with the murder of Tia and abuse of the second child, Mindy.

At her trial in 1979, the prosecution called psychologist Dr. Martin Binder as an expert witness so that he might opine about a motive for a poisoning that seemed so unexpected. Dr. Binder had read Dr. Meadow's three-page article described above, and testified, over defense objections, on Munchausen Syndrome by Proxy.⁸ Note the way that information

⁶ *People v. Phillips*, 122 Cal. App. 3d 69 (1981).

⁷ *Ibid.*, 73.

⁸ The Court noted that Dr. Blinder actually cited six authorities on which he relied, one of which was Dr. Meadow's study and one a summary of his work in an American journal. The four other articles reported cases of apparent parental poisoning of their children.

gathered from the three-page article is already “exploding” into a “profile” of a suspected MSBP mother.

Dr. Blinder said that a mother who repeatedly and surreptitiously administered a sodium compound to her adopted children in facts such as related displayed symptoms consistent with MSBP. MSBP, he said, is a syndrome in which an individual either directly or through the vehicle of a child feigns, simulates or actually fabricates a physical illness, usually a serious one. The mother is outwardly devoted to the child; invariably (!) the child is less than two years of age (despite one of Dr. Meadow’s patients being six). The key to MSBP, according to Dr. Blinder, was that the mother typically transfers her own unmet parental needs to pediatricians, nurses and other caregivers. He further testified that mothers who do this normally “flourish on the ward.” She seems almost to blossom in the medical drama of the hospital. She is concerned, competent and intelligent, and this fact makes it hard for doctors to suspect them as the possible cause for their child’s illness. When confronted with evidence she is in fact responsible for her child’s condition, she cannot accept responsibility.⁹

Mrs. Phillips was convicted of murdering Tia and endangering the health of Mindy. On appeal the court had to deal with the admissibility of Dr. Blinder’s testimony. Even though the testimony concerned a phenomenon not attested in the recently-published DSM-III (1980), the court failed to strike the testimony. The testimony was relevant, the court opined:

“While a prosecutor ordinarily need not prove motive as an element of a crime, the absence of apparent motive may make proof of the essential elements less persuasive. Clearly this was the principal problem confronting the prosecution here. In the absence of a motivational hypothesis, and in the light of other information which the jury had concerning her personality and character, the conduct ascribed to appellant was incongruous and apparently inexplicable. As both parties recognize, Dr. Blinder’s testimony was designed to fill that gap.”¹⁰

Since information about MSBP was beyond the knowledge of jury members, and because it was attested in “the literature,” the court decided that the trial court didn’t err in admitting Dr. Blinder’s testimony. One qualification has to be added here. When an appellate court reviews a trial court’s admission of an expert witness to testify, it does so with what is known as an “abuse of discretion” standard. Such a standard asks, ‘did the court clearly err or was there no justification for allowing such testimony?’ It is not a *de novo* review of the trial court’s decision, which would allow the appellate court to exercise its independent judgment on admissibility of Dr. Blinder’s testimony. An “abuse of discretion” standard is much more deferential to the trial court’s decisions.

None of the other articles used the term MSBP to describe these cases of non-accidental poisoning.

⁹ *Ibid.*, 78.

¹⁰ *Ibid.*, 84.

Thus by 1979, the time of Mrs. Phillips' trial, we have a surprisingly robust picture of MSBP. The factors of induced illness, maternal denial, her unmet psychological needs while apparently showing dramatic concern for the child and medical personnel, seem to be at the heart of this developing "syndrome." But the court's clear desire to help the prosecution, by allowing testimony of MSBP to fill the evidentiary gap, is striking. In something as important as child abuse prosecutions apparently the prosecution needs all the help it can get. Striking also is the fact that such expert testimony was accepted, and was so crucial, when the "identified" cases of MSBP in the literature up to this time were two in number.

3. Rosenberg's "Classic" Study of 1987

As if aware that the paucity of MSBP cases might be a problem, Prof. Diane Rosenberg wrote an article, published in *Child Abuse and Neglect* in 1987, which claimed to identify 117 cases of MSBP in the medical literature from the preceding 22 years.¹¹ After describing a generally emerging profile of MSBP, without footnote, she presented her definition of MSBP, which remained fairly standard until the 1994 DSM-IV definition and until Rosenberg herself considerably revamped her own definition in 2003. The resultant confusion, of having *three* definitions of this so-called syndrome, has not been remarked upon to date in the legal literature. Definitions two and three will emerge in due course of this paper.

In short, she declared, "in Munchausen syndrome by proxy the following constitute the syndrome cluster:"

- “1. Illness in a child which is simulated (faked) and/or produced by a parent or someone who is *in loco parentis*;**
- 2. Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures;**
- 3. Denial of knowledge by the perpetrator as to the etiology of the child's illness; and**
- 4. Acute symptoms and signs of the child abate when the child is separated from the perpetrator.”¹²**

After reciting the facts of one case, where she strikingly said that the *child*, rather than the mother, suffered from MSBP, and after stressing that the condition was "uncommon," she emphasized that a limitation in her study was that inferences of MSBP had to be made in many instances from the literature because not enough information about each case was presented in the source. Without wondering, then, whether her method in fact *manufactured* more cases than it *discovered*, and without giving us the particulars or even citations to any of the cases from which she culled the data, she gave us the following

¹¹ "Web of Deceit: A Literature Review of Munchausen Syndrome by Proxy," *Child Abuse and Neglect* 11 (1987), 547-63.

¹² *Ibid.*, at 548-49.

relevant facts: (1) Information on simulation or production of illness was available in 72 cases, of which 25% of these were simulation cases. Most (72%) of the simulation cases took place while the child was in the hospital. In 95% of the production cases, however, production took place in the hospital. (2) An enormous range of symptoms, signs and laboratory findings were presented. Children suffered everything from abdominal pain (“a”) to weight loss (“z”). (3) Most striking to here were the “morbidity” rates of children after they were released to their parents. She said that of these 117 children, 10 died, and of the 107 survivors, at least 8% had long-term morbidity.¹³ Thus, the mortality rate of the MSBP children released back home was 9%. In language that seems chillingly “non-scientific,” she continues: “All the children died at the hands of their mothers....Four of the mothers had some nursing training, and one mother was a social worker..In 20% of the cases, the parents had been confronted with the diagnosis of MSBP and the children had been sent home to them, subsequently to die.”¹⁴ (5) In 15% of the 117 cases the mother completely admitted to the deception, and in an additional 7% of the cases there was partial admission. Mother’s statements regarding denial were unknown in 60% of the cases. (6) An overwhelming number of mothers were described as having an affable and friendly demeanor and being social adept.¹⁵

In the face of these statistics, Rosenberg had a number of recommendations, a few of which are noteworthy because they entered into the legal and medical lore of how to handle these cases. First, she suggested that despite the paucity of cases of MSBP, pediatricians ought to consider MSBP in their “differential diagnosis” (a process of elimination in getting to the actual diagnosis of illness).¹⁶ Thus, from the beginning a suspicion of parents ought to be incorporated into diagnosis. Second, because the rate of subsequent death of children in MSBP families was so high (9%), doctors ought to be encouraged to “take steps to protect the child immediately.”¹⁷ Finally, psychiatric care should be offered to the mother and father immediately *after* diagnosis of MSBP.¹⁸ Thus, the model envisioned is that the pediatrician and other attending physicians should come up with the diagnosis, spring it on the mother, quickly move to isolate and protect the child and then get the mother/father into counseling. After all, since nearly 10% of the kids *die* when they are left in the hands of their mothers, the medical profession was morally obliged to intervene.

Many things can be said in analyzing Rosenberg’s article and numbers, but let’s first begin with the reaction of none other than Dr. Meadow himself. He would, you would think, be most interested in supporting research such as Rosenberg’s, especially since she seemingly wanted to be cautious in her discovery of the syndrome (117 cases in 22 years—or only about 5.1 per year in the medical literature). One can tell, however, that instead of being delighted he was quite disturbed. In a letter to the editor of *Child Abuse*

¹³ *Ibid.*, 552.

¹⁴ *Ibid.*, 553.

¹⁵ *Ibid.*, 555.

¹⁶ *Ibid.*, 556.

¹⁷ *Ibid.*, 558.

¹⁸ *Ibid.*, 559.

and Neglect, he said that Rosenberg’s numbers, which of course was the whole purpose of her study, were faulty. “Extreme caution should be applied to its quantitative aspects...”¹⁹ This was especially true on two figures quoted above—the 9% mortality rate and the notion that 20% of those who died were “sent home subsequently to die.” He felt competent to deal with the 9% mortality figure because *he* had gathered the data and *she* had misquoted him. As he tried to say gently, “Most of these reports do not mention that the same child is reported elsewhere in another series.” That is, she has not just “double-counted,” but she has perhaps multiplied the original number so much that her numbers are meaningless. As Meadow says, “Adding up these cases gives false information,” and in the end, “the overall picture in relation to morbidity and mortality becomes even more false.” Then, taking off the gloves, he continued, “The statement that in 20% of the deaths the parents had been confronted and the child sent home ‘subsequently to die’ is particularly misleading.”²⁰ In fact, he said that he knew of only one case, yes one, in which a child had been returned to a mother who had been subject to full confrontation and had directly harmed that child or a subsequent child. Thus, he was particularly offended that in legal cases in the British Courts lawyers and psychologists were blithely quoting the 20% mortality figure as gospel. It simply wasn’t true.

To Dr. Meadow’s frosty assessment of the two linchpin statistics of Dr. Rosenberg’s article, I add the following. First, as noted above, one has no reason simply to accept her number of 117 cases of MSBP in the literature, especially when 12 of the 22 years she surveyed were *before* the first cases cited by Dr. Meadow. Second, though “simulation” or “production” is essential to the definition of MSBP, Rosenberg said that information on this was only available in 72 cases, about 65% of the total. Thus she includes, in her 117 cases, 45 cases where the essential element of the definition of the syndrome is absent. This brings “math-challenge” to new dimensions. Third, she notes that in 60% of the cases, about 72 cases, there is no information about whether the mother admitted or denied the allegations of simulation/production. Then, in about 15% of the cases the mother “admitted completely” the deception and in another 7% there was “partial admission.”²¹ So, in more than 80% of the cases the mother either admitted her culpability or we have no information about admission of culpability. This directly contradicts the third part of her definition—that the mother denies responsibility for the simulation/production. Fourth, she mentions that in most cases the symptoms seemingly *got worse* in a hospital setting. Or, using her language, she mentioned that of the 72/117 cases for which there was information, simulation took place in 25%, production in 50% and both simulation and production in 25%. In 72% of the “simulation-only” cases, simulation happened in the hospital; in 95% production took place in the hospital; in 84% simulation and production took place in the hospital. Without more, these statistics mean nothing or, possibly more ominously, they mean that the child got worse when medical care was administered. She gives no reason to believe that the mother in all these cases is standing by the bedside inserting her own urine into her daughter’s sample or otherwise tinkering with the catheters or other medical devices. Thus, without more, it looks as if

¹⁹ *Child Abuse and Neglect* 14 (1990), 289.

²⁰ *Ibid.*

²¹ Rosenberg, *Op. Cit.*, 555.

things get worse when the child is in the hospital—out of the mother’s care. This would contradict the fourth prong of her definition.

Finally, we need further reflection on the fourth part of her definition, because mental health professionals often point to the abatement of symptoms when the child is separated from the perpetrator as evidence of production or fabrication of MSBP in the child. We can look at this issue from three angles: (a) the data which Rosenberg brings forward to support her point; (b) the expected result when a child is separated from a perpetrator; and (c) the way that the proposed definition of “Factitious Disorder by Proxy” in the 1994 DSM-IV (and 2000 DSM-IV-TR) deals with the issue.

With respect to the data, I only need to reformulate the argument made previously by focusing on the specific kind of evidence Rosenberg brings forth. She says there is only data on the issue of symptoms for 72 of the 117 cases, or about 60% of them. In 25% of the cases (or 18 cases), the illness was simulated; in 50% of the cases (36 cases) there was production of the illness; in 25% (18 cases) there was *both* production and simulation.²² Rosenberg further says that the vast majority of these cases were simulated or produced in the *hospital* (about 85%).²³ Thus, we have the curious phenomenon, if we take her at her word, that in 85% of the cases where she has data (and this is only in 65% of the cases), there apparently wasn’t *any* production/simulation of symptoms until the child got to the hospital/medical facility. Thus, MSBP, according to her numbers, is primarily a phenomenon induced *in the medical setting*. This is strange indeed, but there is no language in her presentation or analysis of data which suggests that the illness was *re-presented* or *re-induced* in the medical context. Thus, by reading her data as she presents it, one would think that it is the *medical personnel*, rather than the mother or other caretaker, who are responsible for appearance or exacerbation of symptoms. Of course, that is exactly the opposite of what she claims, but her data lead us to that point.

Her data thus show an increase in symptoms of child when in medical care. But the fourth part of her definition is that when the child is removed from the caregiver’s oversight, symptoms recede. We have a contradiction here. She can’t have it both ways. In any case, if the symptoms actually got worse under medical care, wouldn’t a better hypothesis be to examine the nature of the medical experience than to blame the caregiver? Or, on the contrary, if the symptoms improved when the child was in medical care and was removed from the caregiver (which she wants to argue—for which she has no data), wouldn’t that sort of be expected? Generally, do we find it surprising if medical symptoms abate when the doctors/nurses are able to attend to a situation? Isn’t that, in fact, the job of medical staff—to try to get symptoms to abate?

²² *Ibid.*, 552.

²³ *Ibid.*

In fact, Rosenberg has not shown anything. She simply asserts a fourth criteria or prong of a definition, but her data point the opposite direction of her point. But even if her data seemed to support her assertion (abatement of symptoms when caretakers are removed from the equation), isn't that just about what we would expect? If mothers/caregivers have some kind of shadowy disease/syndrome called MSBP because their loved ones get better when doctors attend to them, maybe the incidence of this syndrome exists in about 95% of the population.

Perhaps because of some of these difficulties, the 1994 (repeated in 2000) definition of “Factitious Disorder by Proxy” (discussed below) in the DSM-IV has no reference to the child’s medical condition once removed from caregiver oversight. One can’t necessarily say that the abandonment of this prong of the definition is because there is no evidence for this amelioration, but one can’t really say that Rosenberg’s data (or any other that I know) support the fourth part of Rosenberg’s definition.

Thus, in conclusion, one can say that Rosenberg’s study, which has been quoted affirmatively by every subsequent study in the MSBP literature, has deep methodological and quantitative flaws relating to every aspect of the definition for MSBP she proffers. In the end, those not adept at statistics might simply skip over her inconsistencies and focus on her recommendations—of early intervention, of including a dimension of suspicion in differential diagnosis, of springing diagnosis on the mother before she even sees a mental health professional. But her numbers, which is the whole purpose of her article, simply won’t support the definition she advances. And her effort is the “solid rock” on which all subsequent MSBP research is based.

4. A New York Legal Case From 1987

Early in 1987, before Rosenberg’s study was published, a New York family court, informed by the *Phillips* case in CA and the growing body of medical literature on MSBP, invoked the legal doctrine of *res ipsa loquitur* (“the thing speaks for itself”) to conclude that MSBP testimony adequately explained how Mrs. “Z” systematically injected large doses of laxatives into her daughter Jessica’s food for a four month period, causing her intense pain and diarrhea.²⁴ The crucial thing to notice about this case, however, is not that expert testimony was allowed but the way that MSBP was, in the court’s mind, already taking on such a solid scientific validity that a rather full “profile” of an MSBP perpetrator was emerging. The court listed the following factors which were “commonly found in the case histories of MSP” and which were reported in the medical literature:

- “1. The child’s prolonged illness which presents confusing symptoms defying diagnosis, and is unresponsive to medical treatment.**
- 2. The child’s recurring hospitalizations, surgery and other invasive procedures.**
- 3. The child’s dramatic improvement after removal from mother’s access**

²⁴ *Matter of Jessica Z*, 515 NYS 2d 370 (NY Family Ct, 1987).

and care.

4. **The mother's training as a nurse or in medically related fields.**
5. **The mother's unusual degree of attentiveness to child's needs in hospital.**
6. **The mother's unusually supportive and cooperative attitude towards doctors and hospital staff.**
7. **The mother's symbiotic relationship to the child.**²⁵

Even though Rosenberg's four-pronged definition wouldn't be published until later in the year, we note an overlap of only two factors—hospitalizations and improvement after removal from mother's care. Of course, you wouldn't have *any* kind of a problem if you had no hospitalizations, so that leaves the only substantive overlap in the two definitions to be the child's improvement after removal from mother's care. Rosenberg's data don't show this, as mentioned. They show the opposite. Factors 4-7 of the NY family court are based on observations by Meadow in his two cases and by other researchers, but their problematic nature should be noted here. Normally one thinks of a supportive mother or a "symbiotic" relationship of mother and child to be a good thing, both in hospital and family living. Indeed, parents who are attentive to their children's medical condition are normally praised. But the "insidious" nature of this syndrome, according to the court, is that this is being done in a deceptive manner that leads the medical people down many false roads of diagnosis and hinders care for the child.

Yet, as the court says, quoting a 1986 study, the mortality rate for 23 poisoned children released back to parental care was 22% (more than doubling the figure that Meadow showed was unreliable in the Rosenberg literature review). Thus, with so much at stake and with children literally dying in their parents' care, there was no reasonable alternative other than to try to intervene rapidly and early in cases of suspected MSBP. But note the problematic nature of the assumptions here. Since the so-called syndrome is based on deception, and the mother manifests signs of concern that normally would be applauded by the medical community, the pediatricians and other medical professionals confronting the child's illness must now also be experts in *deception*. As one leading psychologist on deception explained to me, medical personnel get no training in medical school on how to identify deception, its nature and course, its warning signs and how it should be handled.²⁶

The court quoted with approval the following two statements: "The roles played by the parents and doctors have been examined in hopes of alerting other physicians to the possibility of MSBP when a baffling pediatric problem is being considered. The swift recognition of this condition may prevent irreparable harm to a child..."²⁷ And, again, "The act of abuse in these cases is a continuous seemingly unconscious act, motivated by the parents psychopathology. Mental health professionals need to be alerted to the

²⁵ *Ibid.*, 371.

²⁶ Telephone conversation with Dr. Loren Pankratz, psychologist and frequent expert witness in MSBP cases, May 5, 2008.

²⁷ *Jessica Z*, at 372 (quoting Vincent Guandolo MD, "MSBP: An Outpatient Challenge, *Pediatrics* 75 (1985), 530).

warning signs of MSBP and be prepared to face the often difficult job of managing the treatment of these complex and often life threatening cases.’²⁸

Four observations in the wake of the *Jessica Z* case are appropriate. First, we see that law has now lost whatever original skepticism it first might have had about MSBP. Now that CA and NY courts have accepted expert witnesses on the phenomenon and recognized its existence and danger, other states would quickly follow suit. After all, the courts are our ultimate societal guardians of the most helpless in our midst (children); if they don’t respond to a clear “crisis” out there, no one else will. And, when you think that there might be a morbidity rate in excess of 20% (though no one combed or critically evaluated these figures), well, the court simply has to act. Second, the court recognizes “extensive difficulties” in identifying MSBP because of the confusing behavior of the mother. Third, even though physicians and pediatricians are not trained in deception, they must intervene early with their suspicions in order to save children. Finally, a profile is emerging of the “MSBP mom,” a most dangerous person. She presents herself as ‘one of us’—a concerned and responsible parent. But underneath she is a deceptive person, who will manifest her Jekyll and Hyde (my terms) character and, if she isn’t stopped, probably will kill her child.

With legal “findings” or implications like this, what can one do? Or, better said, if you are a parent accused of MSBP you really can’t do very much. The concern with child abuse, which fueled the MSBP diagnosis, was such an overriding concern of courts in the 1980 and 1990s that any credible psychological diagnosis that would help us win this kind of ‘war on terror’ would be used by the courts.

But any ideological movement (i.e., a movement motivated by largely by philosophy rather than one grounded primarily in science or statistics) is going to run into difficulties when it begins to face some of the complexities of life. The next portion of the paper deals with a few complications that emerged in the early 1990s. In the end, however, by 1995, the “faith” in MSBP had been largely reaffirmed.

II. MSBP in the early 1990s—Questions but Reaffirmation

1. Child Abuse Reporting and Immunity

In order to flesh out these “complexities,” I need to trace for a moment the contours of the ideology or spirit “in the air” in the 1970s and 1980s which would have allowed the rampant and seemingly uncritical growth of a diagnosis of MSBP when it rested on such flimsy definitional and empirical grounds. In a word, it was the entry of child abuse and neglect into our vocabulary and collective focus. The phrase “battered child syndrome” first entered medical vocabulary in 1962; by 1965 the first legal cases had appropriated the term. Rather than being content with a psychological “syndrome” and its manifestations, however, state lawmakers decided to take the concept of the “battered

²⁸ *Ibid.* (quoting Chan et al, “MSBP: A Review and Case Study,” *Journal of Pediatric Psychology*, 11 (1986), 80).

child,” as s/he was known, and provide statutory protections for children and punishments against those who “battered” or neglected children. By the late 1970s, each state had in place a fledgling child abuse statute which would aid state authorities in identifying the abuse, protecting the child, giving immunity to reporters of child abuse, and punishing those who perpetrated the abuse. These statutes would be revised and enhanced in the 1980s and 1990s. At the heart of these statutes was a definition of child abuse or neglect, which invariably had the following two features: (1) an act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or (2) an act or failure to act which presents an imminent risk of serious harm.²⁹

Two features of child abuse legislation that are important to understand in the context of MSBP are the “reporting requirement” and the notion of “immunity from prosecution.” Each state has a provision in the child abuse law requiring certain professions to report actual or suspected child abuse to appropriate authorities (usually child protection services of the state). The philosophy behind “mandatory reporter” statutes is that certain professions that normally have extensive contact with children should be aware of the signs of suspected child abuse and, for the sake of the child, be willing to report what they see. The following professions are “mandatory reporters” in most states: (1) social workers; (2) teachers and other school personnel; (3) physicians and other health-care workers; (4) mental health professionals; (5) childcare providers; (6) medical examiners; (7) law enforcement officers. As time has gone on, the list of mandatory reporters has grown; in some states the list includes far more people than this. The point to notice, however, is that each state from the very beginning had a provision requiring physicians and other health-care workers to report suspected child abuse to appropriate authorities. In what circumstances is this report necessary? Again, the precise requirements vary from state to state, but as this web site says, “typically, a report must be made when the reporter, in his or her official capacity, suspects or has reasons to believe that a child has been abused or neglected. Another standard frequently used is when the reporter has knowledge of, or observes a child being subject to, conditions that would reasonably result in harm to the child.”³⁰

As one soon discovers when dealing with legal concepts, basic definitions embranch you in ever-deeper and more complex spirals of further questions which end up, sometimes, forcing you to go to law school. Since most “mandatory reporters,” or even “permissive

²⁹ This definition is taken from the 2003 Federal Child Abuse Prevention and Treatment Act (CAPTA; 42 USC sec. 5106g), which mimics state statutes.

³⁰. Sorry for the long reference to follow. Just do an Internet search on “reporting requirements” in “child abuse statutes.” One result:
http://209.85.173.104/search?q=cache:iOgILvJX5YAJ:www.childwelfare.gov/systemwide/laws_policies/statutes/mandatall.pdf+mandatory+reporters+of+child+abuse+summary+of+state+laws&hl=en&ct=clnk&cd=2&gl=us&client=firefox-a;
 last visited May 9, 2008.

reporters,” don’t have that interest or luxury, they must make an “educated guess” regarding what “suspicion” of child abuse is and act on those suspicions. And, since the concept of suspicion is “frozen” in statutory form, it justifies intervention even when surmise, uncertainty, conflicting data or even whim may be at work.

But child abuse reporting requirements wouldn’t really have “teeth” unless those required to report suspected or actual abuse are protected from prosecution in making reports. That is the purpose of “immunity from prosecution” portions of the child abuse statutes. All states provide some form of immunity from liability for persons who in good faith report suspected instances of child abuse or neglect under the reporting laws. In a word, immunity statutes protect reporters from both civil and criminal liability that they might otherwise incur (such as through violation of libel or slander laws). But “good faith” in law is as hard to pin down as “terrorism” in political science. In its most general form, “good faith” refers to the assumption that a reporter, to the best of his/her knowledge, has reason to believe that neglect or abuse has occurred. Even if the allegations are not substantiated or, more chillingly, even if children are removed from homes and parents are further punished by the judicial system upon a report that later turns out to have been erroneous, the reporter is still provided with immunity.

State laws on immunity differ, and this isn’t the place to comb the various statutes. Most common is a provision that extends immunity not only to a reporter of suspected child abuse but also to that individual in subsequent judicial proceedings, if s/he acts as a consultant or witness. The thought behind the immunity statutes is that if we are requiring people to come forward with information on child abuse, to “stick their necks out,” as it were, we have also to be willing to provide them protections so that they will be willing to comply with the reporting law.

On first glance we can recognize the virtue of this kind of law. Indeed, if you have a plague or an epidemic, or a dangerous criminal in your midst, you want to encourage all people to do whatever they can to rid the land of the scourge. Thus, mandatory reporting and immunity statutes are designed to provide the necessary incentives to end the danger. That these rather impressive defensive battlements can also be used to lob dangerous explosives into the camp of innocent people is one of the “downsides” of this legislation. But, the spirit of the 1970s and 1980s was such that we were willing to face the substantial risk of false accusation in order to make sure that we identified and eliminated the child abuser from our midst.

2. Two Troublesome Legal Cases

Yet, as Chinua Achebe reminds us, things fall apart.³¹ Two legal cases, which are more illustrative of problems with MSBP than unique instances, show how laws that were originally meant to protect children went horribly awry when allegations of MSBP were

³¹ Chinua Achebe’s 1958 novel, *Things Fall Apart*, describes the corrosive influence of English colonialism and Christian missionaries on the Igbo (Ibo) people of Nigeria in the late 19th and early 20th centuries.

thrown into the mix. The first concerns the Stallings family of St. Louis, MO.³² In July 1989, five-month-old Ryan Stallings spent two weeks in a hospital after suffering abdominal pains—the diagnosis was severe metabolic acidosis of ethylene glycol (radiator antifreeze). Since his mother took him to the hospital in St. Louis which had expertise in poison issues, deliberate poisoning was suspected. Child Protective Services was notified, a suspicion of MSBP was voiced by social workers, and Ryan was whisked away to a foster home. His parents were granted one hour of supervised visitation per month. Four days after one of the parental visits, Ryan became acutely ill and was taken to the same hospital where he was originally treated. His metabolic acidosis was even more pronounced than previously, and once again ethylene glycol poisoning was diagnosed. Ryan then died in September 1989. A search of the Stallings' home discovered a half empty container of antifreeze. Patricia Stallings, who was five months pregnant with her second son, was arrested, charged with murder and imprisoned. Two months after the second son's birth, while she was still incarcerated, he became acutely ill and was admitted to Children's Hospital, a different hospital than the one which treated his brother. He, too, was found to be acutely acidotic with respiratory illness, symptoms identical to his deceased brother. Yet close laboratory tests on the second brother revealed that he was not suffering from ethylene glycol poisoning but had a rare metabolic error called "methylmalonic acidemia."

Despite the evidence that Ryan's brother suffered from a rare genetic disorder that yielded chemicals in the blood quite similar to those found in Ryan, prosecutors brought Mrs. Stallings to trial. Though she was described as a "very loving mother" who loved to care for her baby, the circumstantial evidence of antifreeze poisoning, combined with the half-full can of antifreeze in the garage, convinced the jury that she had murdered her child, and she was sentenced to life imprisonment as a result. Several months later, however, chemists from St. Louis University became interested in the case and retested frozen samples of Ryan Stallings' blood. They concluded that the original lab tests yielded incorrect results and, in fact, Ryan had died from the same genetic disease that afflicted his brother. On Sept. 20, 1991 prosecutors then came forward to dismiss all charges against Patricia Stallings, after she had lost her first son and had spent fourteen months in prison.

Though this case is fascinating in the medical profession to illustrate the phenomenon known as "context" or "expectation" effect, where there is the tendency to interpret data in a manner consistent with expectations or prior theories, it also can be seen as a case where MSBP provided the added nudge, when evidence was only circumstantial, quickly to remove the child from the home and then permit the filing of charges against the mother. The effect of an allegation of MSBP is thus, often, to freeze or stop an investigation rather than to pursue it in more detail to see if the surmise was justified.

³² This summary is derived from many sources, among them Michael Flannery's article, "Munchausen Syndrome by Proxy: Broadening the Scope of Child Abuse," 28 *U of Richmond Law Review* (1994), 1175ff.

If the Stallings case illustrates how a shadowy suspicion of MSBP can, combined with other factors, lead to murder charges, conviction and false imprisonment, the *Gustafson* case from Washington State shows how mental health professionals are immune from repercussions following from their diagnoses of MSBP, *even if they later retract their diagnoses after the harm has been done.*³³ Here are the relevant facts of the case. In Sept. 1996 Margrett Gustafson and Michael Baker, husband and wife, engaged in a custody dispute over the daughter Maddison. Maddison’s guardian *ad litem* determined that psychological examinations of the three would help her recommend a primary residential parent for Maddison. A clinical psychologist, Dr. Irene Mazer, whose role was to administer psychological tests, conduct interviews and report her findings, was retained for the job.

Maddison’s guardian notified the psychologist that Gustafson appeared to have caused illnesses in Maddison in order to maintain the position of an excellent caregiver. As will be shown below, this type of language is taken from the literature of MSBP in the 1990s, culminating in the DSM-IV’s designation of the syndrome as one to be further studied. Similarly, the father accused Gustafson of subjecting Maddison to unnecessary medical treatments. These allegations, as we know, are part and parcel of the MSBP allegation. Indeed, when Gustafson met with Dr. Mazer, she said that her husband accused her of having MSBP.³⁴

Dr. Mazer had no previous experience with MSBP, but she decided to do what any competent psychologist would do. She read some Internet articles on it and read several medical articles, reviewed Maddison’s medical records (which showed that Maddison had seen a dozen doctors in three years), and consulted with some MSBP experts. Heedless of the warnings given her by the “experts,” to the effect that she should not try to make such a diagnosis if she lacked adequate training or experience, Dr Mazer said in her report that there was “reasonable case to suspect that Gustafson suffered from MSBP.”

Alea iacta est—“the die was cast.” Once MSBP was mentioned by a professional, things came to a screeching halt. Or, better said, the guardian *ad litem* had Dr. Mazer put her diagnosis in a memorandum for Maddison’s custody hearing. On November 12, 1996 the court granted transfer of custody of Maddison to the father; the Spokane Police Department went to Gustafson’s home to remove Maddison. Over the next several months several things happened in the case, but finally in June 1997 Dr. Mazer submitted another psychological report on Gustafson and Baker, concluding that her allegations of MSBP were unsubstantiated.

Gustafson, understandably enraged, sued Dr. Mazer in state superior court on theories of negligence and defamation in Mazer’s preparation of the erroneous report alleging Gustafson had MSBP. The court dismissed her suit, holding that the psychologist was entitled to witness immunity under Washington law. On appeal, the court affirmed,

³³ The case is *Gustafson v. Mazer*, 54 P3d 743 (Wash. App. 2002).

³⁴ *Ibid.*, 744.

saying that under the *Bruce* case in Washington absolute immunity from prosecution is afforded to expert witnesses not only in their testimony but “also [in] acts and communications which occur in connection with the preparation of that testimony.”³⁵ Hence, Mrs. Gustafson’s suit was not allowed to proceed.

These two cases illustrate at least four factors which the legal system ought to recognize as encouraging irresponsible and terribly harmful allegations of MSBP. First is the problem of *who can diagnose* MSBP. In *Stallings* the suspicion was voiced by a social worker; in *Gustafson* it was by a clinical psychologist with no training in MSBP. Other cases have suspicions of MSBP made by disgruntled spouses or ex-spouses, teachers, pediatricians or a whole host of people that is even broader than the list of mandatory reporters in the child abuse statutes. Because the allegations of MSBP can come from *so many sources*, with such immediate and dramatic consequences, one is more correct to see it as a vague label attached to a person rather than a clinical diagnosis in the traditional sense. Thus, it functions sort of as a rumor with consequences, a not-so-firmly stitched “A” to the dress of the distressed mother.³⁶ The fact that Dr. Mazer felt she could make a diagnosis of MSBP by reading a few articles and talking with a few other professionals goes back to the first diagnosis in law of MSBP, made by the aforementioned Dr. Blinder who, on the basis of a few articles read, described with confidence this new “syndrome.” Yet it obviously exposes the Achilles heel of the diagnosis, too. If *almost anyone* can diagnose it, then we are left with gobbledygook, pure and simple.

Second, these cases illustrate the problem of *when* MSBP should be diagnosed. Is it something that is a label that aids in voicing a suspicion or is it a diagnosis that can only be made after examination of the mother, medical records of the child and interviews with attending physicians? That is, is MSBP a sort of preliminary suspicion or a considered conclusion? If it is both, it really is nothing. Or, if it *is* a preliminary suspicion, is it subject then to a battery of serious tests, like any other medical procedure, to try to differentiate it from a variety of competing “syndromes”? Because this fundamental question also is unanswered, MSBP can serve as a sort of roving trump card, to be played by anyone at any time in any proceeding, to bring it to a screeching halt and then remove the child from parental guidance and control.

Third, these cases illustrate the problem of the *basis* on which such a conclusion, or hypothesis, of MSBP is made. In short, what are they? And, when, along the way, can such a diagnosis be made? Finally, we see a problem with immunity, described above. While many people will use the reality of immunity to encourage them to act responsibly and report boldly when they might have otherwise been reluctant to report suspected child abuse, many other people (as is evident in the case of Dr. Mazer) can use immunity as a shield to hide behind, a sort of prophylactic against incompetence and

³⁵ *Ibid.*, 745, citing *Bruce v. Byrne-Stevens & Assocs.*, 776 P2d at 666.

³⁶ Referring, of course, to Nathaniel Hawthorne’s description of the garment of Hester Prynne, who took exquisite and sensual care in shaping the “A”, standing for “adulteress,” which she had to pin to her dress in *The Scarlet Letter*.

irresponsibility. As a result, the true losers in these cases are families and children. Mrs. Gustafson was accused of MSBP by a disgruntled spouse. A compliant psychologist, catching the popular *Zeitgeist* that anyone can diagnose MSBP, blithely suggested it in her report. The judge, probably a hard-working and diligent but overworked public servant not especially trained in psychological theories, went along with the “expert’s opinion.” MSBP, then, was used to add to, rather than to reduce, the net calculus of pain suffered in the Gustafson/Baker family. Any responsible investigator of MSBP would conclude that allegations and use of the diagnosis were completely out of control by the mid-1990s.

3. The DSM-IV (1994)

As if to throw more uncertainty into an already confused situation, the DSM-IV in 1994 included its first description of MSBP, which it called “Factitious Disorder By Proxy.”³⁷ The DSM-IV-TR (“text revision”) of 2000 copied the 1994 treatment word-for-word, and its pagination will be reflected in what follows. What should be clear at the outset, however, is that FDBP was not adopted as a new category of mental disorder in the DSM-IV but was noted along with other Factitious Disorders and then described in Appendix B, where conditions deserving *further research* before inclusion in the official DSM list were placed. It is sort of like an 11 year-old who placed third in his/her state spelling bee and attending but not participating in the National Spelling Bee in Washington DC, because only the top two from the state could qualify for the National Bee, and hoping for future inclusion in subsequent years.

Factitious illnesses are presented in 300.16-.19. They are characterized by “physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role.”³⁸ Sec. 300.19 is entitled “Factitious Disorder Not Otherwise Specified.” The note in the text of the DSM says that this category includes those who don’t meet the criteria for Factitious Disorder. “An example is factitious disorder by proxy: the intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual’s care for the purpose of indirectly assuming the sick role.”³⁹ A further discussion of this “wannabe” syndrome is, as mentioned, in Appendix B.

The Appendix B description of FDBP, beginning on page 781, is consistent with many of the list of symptoms given by the court in the *Jessica Z* case, described above. I need not go into all the language. One example will show how familiar we all are with the general description by now: “The essential feature is the deliberate production or feigning of

³⁷ The *Diagnostic and Statistical Manual of Mental Disorders* already had an entry for “Factitious Disorders” (i.e., Munchausen Syndrome) in its 3rd edition (1980), but the 1994 edition was the first where FDBP was noted. The exotic-sounding name “Munchausen” was dropped so that syndromes would be named in a descriptive rather an appellative way.

³⁸ DSM-IV-TR (2000), 513.

³⁹ *Ibid.*, 517.

physical or psychological signs or symptoms in another person who is under the individual's care."⁴⁰ The mother's medical knowledge, efficient and cooperative care, anger when confronted, etc. are then confidently related. At the end of the description, the DSM-IV appendix gives us four "Research criteria for factitious disorder by proxy."

- A. Intentional production or feigning of physical or psychological signs or symptoms in another person who is the individual's care.**
- B. The motivation of the perpetrator's behavior is to assume the sick role by proxy.**
- C. External incentives for the behavior (such as economic gain) are absent.**
- D. The behavior is not better accounted for by another mental disorder."⁴¹**

While there is some similarity between this and Rosenberg's four 1987 criteria, there are significant differences. First, there is no mention here of repeated seeking of medical advice or "doctor shopping." Second, there is no mention of mother's reaction when confronted. Indeed, since Rosenberg's data contradict her third point, perhaps the DSM folk felt that they should quietly drop any reference to that subject. Third, the DSM definition stresses what might be called the "mental state" of the perpetrator. The perpetrator does this so she (usually the mother) can "assume the sick role." That is, the DSM suggests that the psychological motivation is attention-getting. This criterion throws a sort of monkey wrench into the definition because it suggests that in order to have FDBP (equivalent to the earlier MSBP) one needs to divine the mother's motivation until you discover that her motivation is to shift the focus from the child to herself. Fourth, the DSM specifically emphasizes that no monetary incentives are present. Here we see the need of the DSM-makers to make a "consistent" manual. That is, they want to distinguish this possibly-new syndrome called FDBP from another recognized disorder, Malingering—where a person feigns or induces illness in order to secure monetary gain (social security disability or unemployment benefits, for example). So, we see a "systematizing" desire in the DSM definition, which is absent in Rosenberg's definition.

As noted, however, the primary difference between the two definitions lies in the emphasis on perpetrator intent. Perhaps it is understandable for a psychological manual to emphasize intent, since it, like law, is interested not simply in manifestations but also in motivations. Yet the potential inclusion of FDBP in the DSM-IV has another potentially ominous sign especially for those who would like some clarity in the MSBP/FDBP mess. By placing it in the Appendix, the mental health profession was taking the tentative, but fairly firm, step of saying that the diagnosis of this "syndrome" or "disorder" rested with them. If that is the case, it is something that is diagnosed *after* examination and not before, by a mental health professional, who is interested not simply in manifestations but also in intent.

The result of the DSM-IV's inclusion of FDBP as a potential mental disorder in 1994 is not the same as throwing a match on dry tinder; it is more like speaking Middle English

⁴⁰ *Ibid.*, 781.

⁴¹ *Ibid.*, 783.

to an interlocutor who is asking you questions about your life. The interlocutor would think, after a while, that unnecessary confusion is being brought into a situation that ought to be able to be handled much easier. Thus, the presence of the DSM-IV definition added to the confusion. Whereas some confusions are, in poet Wallace Stevens's felicitous phrase, "blessed rages for order," many are simply a result of terminological, definitional, and empirical confusion. The latter is certainly the case for MSBP/FDBP.

4. A Reaffirmation--1994

When rampant confusion, inconsistency, and unjust application of a suspected disorder exist, the most urgent desideratum is for someone to enter into the situation, declare a sort of truce and then try to sort out some of the confusions listed so far in this paper. In words of the Book of Job, it would have been nice for a "mediator" of sorts to "lay his hands on us both" (i.e., Job and God, the antagonists in this drama) and bring reason to the discussion.⁴² Or, alternatively, it would have been nice had someone decided to stop honoring an MSBP diagnosis until these issues had cleared up. Even the United States Supreme Court, which isn't in this day known to be too sympathetic to criminal defendants, decided in 2007 to put all executions in America on hold for several months until it could bring clarity to the topic of the constitutionality of lethal injection as a form of capital punishment.⁴³

Instead of pursuing what one might call a "rational" course, the literature continued to cry for prosecution of MSBP perpetrators and continued vigilance to smoke out examples of it. Typical of this wave of reaffirmation even while significant questions remained unresolved is a 1994 law review article.⁴⁴ Though not ultimately significant in the MSBP/FDBP debate, this article serves to indicate that law was fully oblivious to the "early-warning" signs I have laid out so far. Naivete is coupled with advocacy in such a blatant fashion that one can only conclude that the rather thick film of ideology has occluded vision. The article claimed that incidents of child abuse continue at an "alarming rate." "Suspected cases" of child abuse have to be reported. Although some commentators argue that overzealous reporting may result in exaggerated statistics, "reports are generally made out of genuine concern for the welfare and safety of the child."⁴⁵ And, now that we have MSBP we can "broaden" the scope of child abuse. Cases that "normally" would be "weeded out" in the course of overzealous reporters may, in fact, "become an exclusive subcategory of child abuse."⁴⁶ Even though MSBP is a complex phenomenon that professionals are "struggling" to understand, it needs to be identified early and prosecuted vigorously. After all, the fate of children is at stake.

⁴² Job 9:33-37.

⁴³ Resolved in the *Baze* case in April 2008. The executions have now started up again.

⁴⁴ "Munchausen Syndrome by Proxy: Broadening the Scope of Child Abuse," 28 *U of Richmond Law Review* 1175ff. (1994).

⁴⁵ *Ibid.*, 1178.

⁴⁶ *Ibid.*, 1179.

The article then went on to report on a “recent and growing understanding” of the disease which has led to “increased numbers of reports and diagnoses” each year. Much of the published literature addressing MSBP, according to our author, considers only the sensationalized cases. “However, there are innumerable [!] cases in hospitals and courtrooms throughout the world [we really have expanded the scope of inquiry, haven’t we?!] that are discovered and treated; unfortunately, even more go unrecognized and unreported.”⁴⁷ Of course there might be some danger in overzealous suspicion and identification but since it is being done for the benefit of the child, most allegations are at least driven by a good heart.

I really need go no further in describing the nature of this article, an article which was typical in the legal literature of the mid-1990s. Without any foundation the authors suggest that the number of MSBP cases was far more than reported, and that the responsibility then rested on all of us to ferret out this most noxious form of child abuse. Like the hypothesis of hundreds of miniscule undiscovered islands that still exist in the Pacific Ocean, so the MSBP hypothesis proposed that there were still hundreds of cases of undiscovered MSBP. MSBP was not only a serious condition but it was a seriously underreported phenomenon. To be clear, my paper does not deny the existence or danger of child abuse, but the allegations brought forward in this 1994 article rested on such a gossamer web of unsubstantiated allegations that little clarity or truth could possibly be injected into the debate.

III. MSBP/FDBP 1995-2008; Two Roads Diverge in a Not-so-Yellow Wood

This section proposes to describe how MSPB/FDBP has been handled in the psychological and legal literature from the publication of the DSM-IV in 1994 until the present. It also surveys the unfortunate professional history of the *Urvater* of MSBP, Dr. Roy Meadow, whose professional reputation, primarily because of his false statistical inferences as an expert witness, has been irreparably tarnished. To this end I will divide this part into three sub-parts: 1. The growing and insistent questions within a portion of the mental health profession regarding the diagnostic label MSPB/FDBP; 2. The attempt to rehabilitate the syndrome through narrower definitions, continued studies of purported cases and legal articles; and 3. The discrediting of the founder/namer of the phenomenon and its questionable status today in England and other English-speaking countries.

1. Doubts in the Mental Health Profession

In a series of articles from 1995 to 2008, significant voices within either the medical or mental health field pointed out some of the persistent problems with a MSBP/FDBP diagnosis. I have already mentioned many of these problems, since they were so evident to anyone who would have done a careful literature review before 1995. But hindsight frequently provides a better vantage point than contemporary sight. This section will show that significant questions were raised by professionals in these fields regarding the *breadth* of the diagnosis, the *naming* of it as a syndrome, who should *diagnose* the

⁴⁷ *Ibid.*, 1186.

problem, the *skewed numbers* of the phenomenon, and the *definitional confusion* created by the variety, conflicting nature and application of the two definitions (Rosenberg's 1987 attempt and the DSM-IV in 1994).

We begin with the strong statement of skepticism raised by none other than the namer of the syndrome in 1977, Dr. Roy Meadow. In a 1995 article he raised a number of “red flags” regarding the diagnosis of MSBP/FDBP.⁴⁸ His primary concern was that the imprecision in definition of the phenomenon between 1977-94 had led to dangerous levels of over-diagnosis. In his own words:

“While the introduction of the new term, in 1977, achieved its aim in lending to the recognition of many under recognized, ill described, and new forms of child abuse; its over use has led to confusion for the medical, social work, and legal professions.”⁴⁹

What is the nature of the problem? It is several-fold, according to Meadow. First, Rosenberg's four-fold 1987 definition is unhelpful. In his words, “As a diagnostic aid, these criteria lack specificity: many different occurrences fulfil them.” That is, it is common for children suffering physical or other forms of abuse to be presented repeatedly for medical assessment, and for the perpetrating parent to deny that they have injured the child. Yet, as he says, “most of that abuse should not be classified as MSBP.”⁵⁰ The problem with the definition is not simply that it provides no clarity or guidance for researchers, but it also causes havoc among care providers. As he says:

“Currently the term Munchausen syndrome by proxy seems to cause great insecurity and panic among some of those who work with abused children.”⁵¹

This “panic” will be described later in the section—it is the need for case workers to make what they believe is an instantaneous diagnosis in order to keep the child from going home to face a probable death. Of course, this supposition was fueled by erroneous statistics, but it didn't displace the “panic” of which Dr. Meadow speaks.

A second problem he isolates is that the term is imprecisely used regarding the *person* to whom it applies. At first the term was used to describe a form of child abuse, rather than to describe the parent's behavior. Nevertheless, as time has gone on, he notes, colleagues in other professions have begun to talk about mothers who “suffer from MSBP.” But, for Meadow, MSBP is a term describing the *abuse* rather than the *abuser*. This was also Rosenberg's approach, but is almost completely rejected in the legal literature. There it is the *abuser* who *has* MSBP. In a fit of pique he gives the following example:

⁴⁸ “What is, and what is not, ‘Munchausen syndrome by proxy?’” *Archives of Disease in Childhood* 72 (1995), 534-38.

⁴⁹ *Ibid.*, 534.

⁵⁰ *Ibid.*

⁵¹ *Ibid.*, 535.

“In the past I have resented being asked in court whether someone is ‘suffering from MSBP’: it has seemed no more appropriate than being asked if a man who has buggered his stepson is ‘suffering from sex abuse.’”⁵²

Third, Meadow’s dissatisfaction with Rosenberg’s definition leads him to adopt, in large measure, the DSM-IV definition, despite the fact that he is a medical, and not mental health, provider. In Meadow’s understanding, the problem is not simply the result of physical injury. He says:

“However, although it often involves physical abuse, a more important and pervasive aspect is the associated and continuing emotional abuse. The DSM-IV criteria would reinforce that....”⁵³

In other words, he wants to inject a “mental state of the mother” into the diagnosis of MSBP/FDBP. Indeed, by so doing, he hoped to limit the use of the diagnosis. By making maternal motivation (to assume the sick role) an essential aspect of the definition, Meadow hoped to curtail its wild application. In his words, the limitation suggested by the DSM-IV definition will “prevent the term being used for many forms of child abuse for which it is currently used inappropriately.” To illustrate his point, he lists eight prevalent forms of child abuse which, by themselves, really ought not to be described as MSBP: (1) unrecognized child abuse; (2) failure to thrive/neglect; (3) overanxious parents; (4) mothers with delusional disorder; (5) masquerade syndrome; (6) hysteria by proxy; (7) doctor shopping; and (8) mothering to death.⁵⁴ Meadow’s timely observations not only indicated the problem of over-diagnosis circa 1995 but provided a means, by following the DSM-IV criteria, of limiting these “panic” allegations of MSBP.

The barrage continued in the same issue of *Archives of Disease in Childhood*, as two clinicians argued that MSBP was not a “syndrome” after all.⁵⁵ If Meadow was bothered by the over-diagnosis of MSBP, Fisher and Mitchell were plagued by the imprecision in language surrounding its description as a syndrome, which they felt eventuated in unhelpful “leaping to conclusions” by a variety of diagnosing professionals. They noted that it was pediatricians, in their experience, who raised a suspicion that fabrication occurred when discrepancies were noted between the perpetrator’s history, physical findings or course of the illness. Then, the pediatrician tended to make the “diagnosis.” They go on to say:

“It is clear that a ‘diagnosis of MSBP/FIBP [the “I” stands for “illness”] only describes a single or series of observed anomalies and discrepancies. The word diagnosis is usually understood as the identification or inferring of the presence of a disease by means of a patient’s symptoms. MSBP/FIBP is not a

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ *Ibid.*, 536-37.

⁵⁵ GC Fisher and I Mitchell, “Is MSBP really a syndrome?” *Archives of Disease in Childhood* 72 (1995), 530-34.

diagnosis in a traditional sense but an observational description with implications regarding cause.”⁵⁶

Thus, when making such a series of observations, an “observational description,” pediatricians ought *not* to opine about mother’s mental condition. Nevertheless, in their experience:

“at the point the observation is made or the label MSBP/FIBP applied there appears to be an almost automatic reaction by many medical and adjunct staff to assume an illness called MSBP/FIBP is present in a parent.”⁵⁷

Thus, breathless social workers and lawyers ask, “Does the mother have MSBP as if it were a diagnosable disease entity with specific psychopathology that is the same in all cases.” In fact, as Fisher and Mitchell argue, it is not simply an imprecise use of *diagnosis* but also of *syndrome* that is at fault. A *syndrome*, they say, is “a grouping of symptoms and signs that recurrently appear temporally together in many persons.” But here the victims present with a *wide variety* of symptoms (Rosenberg lists nearly 100) and the perpetrators demonstrate “an extensive assortment of psychopathological dysfunctions, syndromes, and illnesses.”

The upshot is that “these observations have far reaching implications.”⁵⁸ We cannot rightly call MSBP/FIBP a disease or a syndrome. If it exists at all, we must realize that the perpetrators have various psychological “pathways” that lead to a behavior of fabricating or inducing illness in a child. Such pathways could include personality disorder, depressive illness or severe family and social stressors. In their opinion, the term MSBP/FIBP should be reserved only for parents who themselves have Munchausen syndrome or factitious illness and for various unique reasons, manifest these symptoms through their children.

One doesn’t have to agree with the last sentence to realize that they are doing substantially the same thing as suggested by Dr. Meadow—sharply limiting the diagnosis or identification. While Meadow emphasizes his interest in avoiding a rush to judgment and an imprecise category, Fisher and Mitchell seem to wonder whether the imprecise words surrounding MSBP/FIBP have completely eviscerated all meaning from the term. Instead of going along with Meadow’s suggestion to follow the DSM-IV definition, Fisher and Mitchell are content to emphasize that the primary focus of pediatricians ought to be on close description of the observed situation, without any hypothesis regarding MSBP as a cause. It is for the consulting mental health professional to speculate on the perpetrator psychopathological “pathways” leading to the parent’s behavior.

⁵⁶ *Ibid.*, 532.

⁵⁷ *Ibid.*, 5322-33.

⁵⁸ *Ibid.*, 533.

If these authors have severely damaged the continuing vitality of MSBP/FIBP as a common diagnosis (both of them refer to it as a “rare” condition), psychologist Eric Mart has argued, from statistical theory, that the danger of over-diagnosis and, consequently, misdiagnosis is so great that the label is all but useless.⁵⁹ While he makes many points in his article and book, only one will concern me here—the so-called “base rate” problem. The concept of “base rate” is important in statistics, and it requires that the smaller the incidence of a phenomenon, the greater precision in definition of the phenomenon is required or else one will end up with too many “false positives,” (i.e., incorrect identifications). That is, Mart attempts to illustrate from statistical theory the same problem that doctors and mental health professionals refer to by observation—that the diagnosis is used excessively, irresponsibly and harmfully.

To illustrate the “base-rate” problem, Mart gives the following example. Let’s suppose, he says, that a test has been developed which accurately identifies 100% of serial killers, but misidentifies only one percent of non-serial killers as serial killers. That is, it, like most tests, isn’t 100% infallible; it is only 99% so. Let us also assume that the base rate of serial killers in the general population is 1 in 100,000 individuals. Let us further administer the test to 100,000 individuals. We will identify that one bona fide serial killer, to be sure, but since there is a 1% error rate, we will also identify 999 people whom the test says are serial killers but, in fact, are not. In ferreting out the one genuine serial killer, we would have misidentified 999 people and, if we got carried away with it, we might actually destroy their lives and reputations as they tried to extricate themselves from allegations that they were serial killers.

Let’s now move this over to the field of MSBP. Almost all researchers stress how “rare” this phenomenon is. The legal articles which talk about its being vastly underreported cannot be accepted as good “data” on this question. Mart points to one study that found that out of 20,000 children identified as having sleep apnea, 54 cases (.27%) were suspected of being related to MSPB/FDBP.⁶⁰ Another study looked at babies with serious episodic health problems and found that five cases (1.5%) might be related to MSBP/FDBP. So, it is a “rare” phenomenon.

Let us take the MSBP/FDBP “profile” given in the description of the *Jessica Z* case above, and say that the typical MSBP/FDBP mother is overly attentive to the sick child, solicitous of the medical staff, and has a medical background. If we hypothesize that the base rate of MSBP/FDBP mothers among mothers of chronically ill children is 1% (that is, one percent of mothers of chronically ill children are MSBP--probably a high estimate), and if we further assume that the rate of all mothers who are attentive to their seriously ill children, solicitous of medical staff and have a medical background of some sort is 10% (which is probably low), we would have the following calculations. In looking at 100 mothers which present with these three issues, as well as a seriously ill

⁵⁹ “Problems with the Diagnosis of Factitious Disorder by Proxy in Forensic Settings,” *American Journal of Forensic Psychology* 17 (1999), 69-82; *Munchausen Syndrome By Proxy Reconsidered* (Bally Vaughn, 2002).

⁶⁰ *Munchausen Syndrome By Proxy Reconsidered*, 33-34.

child, only 1 of the mothers would, in fact, be a MSBP/FDBP mom. But, since 10% of mothers fit the profile, our test would identify 10 mothers in this potential MSBP/FDBP category. Thus, the error rate would be 9:1; nine errors for each correct identification, based on these three factors. We would have identified nine “false positives” for every correct identification.

It ought now to be clear that when you have a suspected rare disease or medical condition, you need very tight criteria in order not simply to identify the true sufferers of the disease but also not to include in your number many that don't suffer from it. But that is precisely what we *don't have* in the definition. The results have been devastating. Instead of displaying caution in diagnosing MSBP/FDBP, social workers and prosecutors, fueled by the aforementioned problems of child abuse in our society, have used the label as a broad brush to paint large numbers of “false positives” as people who “have” MSBP/FDBP. Countless family lives have thus been shattered from the “false positive” problem. And, writing as a person who was a litigation attorney, I can testify that the amount of money it costs a person to extricate him/herself from a false allegation can frequently run into the six figures.

An attempt to bring some reason or calm rationality to the aforementioned problems and hasty/false diagnoses lies behind the work of Oregon psychologist Dr. Loren Pankratz. In two articles, dealing with persistent problems with the identification of MSPB/FDBP, he not only agrees with the analysis of the three articles/books just reviewed but wants to develop a more *collaborative* and not *confrontational* model of dealing with mothers who may, in fact, be having difficulty managing the medical problems of their children.⁶¹ Make no mistake about it. Dr. Pankratz believes that allegations of MSBP are usually irresponsibly made. He says:

“My clinical experience with MSBP has convinced me that the problems with this diagnosis are far more extensive than the concerns I raised in my earlier writings [referring to some of his work in 1998/1999]. The medical literature on MSBP often mentions false accusations, or the possibility of false accusations, but does not convey the prevalence of these misunderstandings or the devastating consequences of a wrong diagnosis.”⁶²

He understands that the development of an MSBP “profile” was a response to Meadow’s distress about the excessive time it took him and other pediatricians to consider the parent as a source of the child’s problems. Yet, the profiling of mothers leads to false positives, leaping to judgment and allegations that often *end*, rather than *begin*, the diagnostic

⁶¹ One article is “Persistent Problems with the Munchausen Syndrome by Proxy Label,” *Journal of the American Academy of Psychiatry and Law* 34 (2006), 90-95; his latest, in press, is entitled, “Persistent Problems with the ‘Separation Test’ in Munchausen Syndrome by Proxy.” I am grateful to Dr. Pankratz for making the latter article available to me and for a one-hour conversation on his experience of more than 20 years in diagnosing MSBP and testifying as an expert witness around the country in such cases.

⁶² Pankratz (2006), 90.

process. In other words, because the profile data is so vague (a problem Mart mentioned through his statistical example), extreme care must be taken to determine if these generic profile features really eventuate in actual cases of MSBP. The DSM-IV makes it “impossible to confirm the diagnosis without an evaluation of the intentions and motivations of the mother.” Thus, if a responsible diagnosis of MSBP is to be given, it must only happen after extensive interview and observation. Unless you have “smoking gun evidence,” such as video surveillance (and even that kind of evidence has been brought into question on ethical and clarity grounds), the circumstantial evidence has to be teased out carefully by professionals before a diagnosis is made.

But that is precisely what *doesn't* happen. Instead of doing the patient work of analysis, people leap to conclusions, sometimes without interviewing the mother. Dr. Pankratz tells of several “horror stories” in which psychiatrists jumped to conclusions about MSBP without even examining the mother, where mothers are accused of MSBP simply because physicians disagreed about the medical management of their child or because spouses are trying to “get back” at each other in divorce proceedings. Dr. Pankratz’s approach is that MSBP, if it continues to be used as a diagnosis, be done in a way that tries to enhance the well-being of the family, rather than as an accusatory tool to allow prosecutors an advantage in trials. MSBP, therefore, should be an adjunct to treatment, rather than a label, like “sexual abuser,” that leads to panic, disruption of families and huge legal and psychological bills. Finally, the irresponsible use of morbidity statistics, which he illustrates and I have mentioned, is a problem. It is meant, purely and simply, to whip up fears about MSBP mothers. Tales of children quietly going to their death after being returned to suspected MSBP mothers/parents are almost always sufficient for a judge to order a child into protective custody, even without an assessment of the mother.⁶³

With these damning indictments of an MSBP diagnosis used as a club with which to beat often unsuspecting parents into submission, as well as with the persistent problems in defining the phenomenon, in who can diagnose it, in what its leading features are, in what its incidence is and in how to treat it (most literature in the 1980s-1990s said that if a mother “had” MSBP, it was a nearly untreatable condition), we might wonder how anyone could credibly plow ahead and ignore the cogent and well-reasoned objections I have related. Indeed, the attacks I have mentioned, if not shaking the foundations of those who trusted the diagnosis implicitly, caused a three-fold response. On one hand, there was an attempt to narrow the definition of MSBP so as not to run aground of all the definitional problems I have described. On another hand was an effort to minimize use of the term by inventing yet a third term. Finally, law, which fully bought into the phenomenon by the early 1990s, continued to accept it as a legitimate psychological diagnosis with almost no objection. Let’s turn to that response now.

2. Redefining (and Reaffirming) MSBP/FDBP

One of the reasons that the diagnosis of MSBP/FDBP survived and even flourished at the end of last decade was because of the publication, in September 1997, of the immensely

⁶³ *Ibid.*, 94.

popular *The Death of Innocents: A True Story of Murder, Medicine and High-Stake Science*. It was named a Notable Book of the Year by the *NY Times*. The major point made by the authors, husband and wife team Richard Firstman and Jamie Talan, was that the wave of SIDS deaths (Sudden Infant Death Syndrome) documented from the 1970s – 1990s may have been fueled by parental murder of children rather than inexplicable crib deaths. They tell their story like a crime thriller worthy of John Grisham. The book begins by bringing us into the investigation of the deaths of three Van Der Sluys siblings—deaths that had been written off as accidental choking or SIDS. Ten years, three exhumations and a trial later, the determination of a group of law enforcement professionals was rewarded when a judge found the father of the children guilty of murder. He had suffocated the children for the life-insurance proceeds. For the rest of the book the authors detail the sordid story of the deaths of five siblings in upstate New York which had been described as a classic SIDS cases in a 1972 article in *Pediatrics*. When the prosecutors in the Van Der Sluys case did some digging, however, they identified the children and found that the mother, Mrs. Hoyt, was, you guessed it, an suspected MSBP sufferer. She was convicted of murder. The *Pediatrics* article had contended that the children were victims of a rare genetic disease.

The effect of *The Death of Innocents* among most child abuse specialists or mental health professionals was to shelve their doubts about MSBP/FDBP for the moment and refocus their efforts on combating child abuse and its perpetrators. Yet, the imprecise and conflicting definitions of MSBP/FDBP provided by Rosenberg (1987) and the DSM-IV (1994) had to be addressed. In 1998 the American Professional Society on the Abuse of Children, the leading organization of those professionally concerned with the problems of child abuse, published a consensus paper on definitional issues in MSPB.⁶⁴ They recognized the problem that the phenomenon had been called several things in the literature since 1977—MSBP/FDBP, and even “medical battering.” Some people were fed up with the definitional problem and simply wanted to classify cases according to the method of assault—suffocating, poisoning, infecting. The definitional problem was exacerbated, they said, because when one expert opined that MSBP was present, a defense expert would simply rebut the allegations, often causing confusion for judge and jury alike.⁶⁵ Then, there was the problem of the “exotic” nature of the word *Munchausen*. Finally, there was the difficulty with the DSM-IV definition that emphasized the mental state of the mother. Because the issue of *abuse* was central to their professional interest, with the *abuser* being important but not quite as central as the *abuse*, they proposed another term be used to cut through the confusion of MSBP/FDBP jargon. That new term, “Pediatric Condition Falsification” (“PCF”) emphasized that their concern, fundamentally, was with the child and not the mental state of the mother/perpetrator. To be sure, they said that one might continue to use the old labels (preferably FDBP) when the issue was a concern over whether the mother had assumed the “sick role,” but their focus from then on would be on “Pediatric Condition Falsification.”

⁶⁴ “Definitional Issues in Munchausen,” 11 *APSAC Advisor* 7 (1998).

⁶⁵ Described more fully in “Mommie Dearest? Prosecuting Cases of MSBP,” *Criminal Justice* 13 (Winter 1998), 27.

Though the APSAC report never specifically said it was changing its terminology because of some of the problems highlighted in this paper, it seems clear that the Society felt that focus on the mother's intent distracted them from their major task of dealing with the child's needs. Their interest was in determining whether the child's illness was "fabricated" (either through simulation or production) and not *why* it might have been fabricated. What is interesting to note here is that their terminology, though picked up in many ways in the medical and child abuse literature, has not really made it into law. While there are more than 100 *appellate* cases in law (cases that have gone to state appeals courts; many more cases on MSBP don't go beyond the trial stage) in the past decade that refer to MSBP, there are only four that use the moniker "Pediatric Condition Falsification"—and one of these cases talks about PCF as a *subset* of MSBP cases, which is clearly a misunderstanding.

This narrowed definitional focus was picked up by none other than Professor Rosenberg in a 2003 article. We recall her "classic" fourfold definition of 1987, a definition which, when combined with a gradually-emerging "profile" of the "MSBP mom," served to convince courts and others of the prevalence, insidiousness and need for early intervention where MSBP was suspected. In 2003, however, we see a different Professor Rosenberg, one who has seen how "the term MSBP has been used somewhat variably," and who wants to bring precision into the resulting linguistic fog.⁶⁶ The problem is that unclarity may hinder prosecution of MSBP cases. As she says: "Because there are legal implications when MSBP is suspected, lack of clarity about the diagnosis or its certainty may be transported to the legal arena."⁶⁷ She recognizes how imprecision may result in "misdirected" legal decisions (that is a new term for me, a former law professor) as well as lawsuits against doctors who have diagnosed MSBP. Her thought is that narrower and more precise definitional criteria for MSBP may help remedy these problems.

But like the uncertain trumpet that confuses rather than urges the troops to battle, she then goes on to construct such a *narrow* definition of MSBP that its implications would lead to a complete rewriting of all the MSPB literature and also call into question the importance of the diagnosis. After stressing the importance of focusing on *observed* criteria, she suggests the following as a "definitive diagnosis" for MSBP. Her definition by inclusion consists of the following:

- “1) Child has repeatedly presented for medical care,**
- 2) Test/event is positive for tampering with child, or with child’s medical situation.**
- 3) Positivity of text/event is not credibly the result of test error or misinterpretation, nor of miscommunication or specimen mishandling.**
- 4) No explanation for the positive test/event other than illness falsification**

⁶⁶ "Munchausen Syndrome by Proxy: medical diagnostic criteria," *Child Abuse and Neglect* 27 (2003), 421-30.

⁶⁷ *Ibid.*, 421.

is medically possible.

5) No findings credibly exclude illness falsification.”⁶⁸

Three observations about this proposed definition are appropriate. First, it looks surprisingly similar to the PCF definition in the APSAC report, detailed above. She, too, has recognized the “fog” or “haze” that enters into the analysis when too much focus is on the mother/perpetrator rather than the effects on the child. Yet, for some reason she keeps the label MSBP for this narrower definition—something that will provoke *more* confusion, to be sure. Second, she has eliminated most of her 1987 definition from consideration, especially the two prongs regarding maternal/parental denial and child improvement when removed from parent’s care. Since all of the MSBP literature since her 1987 article assumed her earlier definition, we are left up in the air now on how to view the mother/perpetrator. Third, one should note her emphasis on elimination of other possibilities before a determination of MSBP is made. This responds to the growing consternation in the literature of the late 1990s that MSBP was used as a sort of “you’re it!” as if diagnosis was a sort of sophisticated game of “tag.” The only way to read her proposed definition, then, is to conclude that a MSBP diagnosis has to happen *at the end* of a rigorous clinical differential diagnosis (professional process of elimination). This is a strikingly different emphasis from the way the MSBP label had been used up to that time.

But she goes one step further in the remainder of the article, for she maintains that any attempt to divine maternal/perpetrator intent is beyond the scope of her definition. Since intent is not directly observable, it cannot be quantified and cannot be used to determine if a person can be diagnosed with MSBP.⁶⁹ And, she adds another qualifier. Since she now wants the diagnosis of MSBP to come after a long differential diagnosis process, where every other logical possibility is excluded before a MSBP label is affixed to someone, she says, “rather than increasing the weight of medical evidence in support of a diagnosis of MSBP, accumulating data may sometimes instead diminish its likelihood.”⁷⁰ These two qualifications are significant; they point to, in my judgment, a sort of chastened awareness not only of the damage that a misplaced MSBP diagnosis can effect but of the need to be as precise as possible in defining it, lest the legal system be bogged down in confusion.

Despite the debatable proposition that maternal/perpetrator intent ought to be left to the side in defining MSBP/FDBP, Rosenberg’s salutary “conversion” in this article indicates that even the “true believers” aren’t believing quite so uncritically in MSBP as they did 20 years ago. Yet, as if to show that generalizations in the study of MSBP/FDBP are hard to come by, a 2003 article by social work professor Mary Sheridan attempts to build on Rosenberg’s 1987 article without noting her 2003 “conversion.”⁷¹ What Prof.

⁶⁸ *Ibid.*, 424.

⁶⁹ *Ibid.*, 422.

⁷⁰ *Ibid.*, 425.

⁷¹ “The deceit continues: an updated literature review of Munchausen Syndrome by Proxy,” *Child Abuse and Neglect* 27 (2003), 431-51.

Sheridan purports to do in this article is to “update” the numbers of cases since 1987. While pursuing a method of literature review slightly different from Rosenberg, Sheridan claims to have identified a total of 451 cases in 154 journal articles published between 1972 and 1999.⁷² There really is no need to relate all her numbers and statistics; suffice it to say that she measures only *one* of the four features of Rosenberg’s 1987 definition. That is, she says nothing about the frequency of medical visits, what percentage of denials the caregivers give when confronted that they are likely MSBP sufferers, or how the children improve when separated from caregivers. Thus, one already has significant doubts about the value of her study. Her identification of all the manifestations of this abuse, such as upset stomach, blood in urine, rickets, seizures, etc. (she lists more than 100 symptoms suffered in the children) is quite interesting but really beside the point. The fact that a mother might hit her kid over the head with a shovel would dutifully be recorded as a “symptom” of MSBP, though it really would tell us *nothing* about underlying motivation, frequency of service, denial by mother, etc. Thus, Sheridan majors on the minors, so to speak.

Her numbers also don’t make sense at times. For example, she said that 27 of the 451 children (6.0) “were dead, with an average age of death of 18.83 months.”⁷³ But then she says earlier that the average age of diagnosis was 48.6 months.⁷⁴ How could it happen that people die 30 months before they are diagnosed? She *might* mean that the average survival time after diagnosis/allegation was 18.83 months, but that isn’t what she says. Then she says that in 21 cases of death the illness “had been produced.” Does that mean that the original insult to the child was produced, or that after the child had been returned to the family the death was through the production of the illness, however measured? This kind of maddening obscurity tends to vitiate whatever interest one still might have after realizing that she doesn’t key her numbers to the 1987 Rosenberg definition (which she does adopt in the article). Other statistics are problematic. The numbers of mothers with medical training is considerably fewer than in Rosenberg’s 1987 article. In fact the most frequent life situation which “might lead to” a diagnosis of MSBP is no longer the triad discussed earlier in this paper but the mother’s “depression.”⁷⁵ Once we are removed to that level of generality, however, we cease to have helpful identifying markers.

Thus, even though there has been some attempt in the recent psychological/medical literature to rehabilitate MSBP/FDBP, its intellectual foundations remain shaky and definitional precision is elusive. This has not stopped law, however, from its eager embrace of MSBP. A survey of legal writing since 1995 has yielded more than a handful of articles devoted exclusively to the theme of MSBP, with most emphasizing the need for eager prosecution of cases of suspected MSBP. One of those articles, noted below, combs through MSBP litigation at the end of the 1990s, and illustrates the way that courts have gradually accepted the diagnosis of MSBP as an evidentiary “boost” for the

⁷² *Ibid.*, 433.

⁷³ *Ibid.*, 435.

⁷⁴ *Ibid.*, 433.

⁷⁵ *Ibid.*, 438.

prosecution. While a close review of these works really isn't necessary here, a few comments will suffice to show the tenor of these articles.

Even though the psychological literature refers to the "syndrome" as rare or relatively uncommon, and the cases cited by Rosenberg and others don't give one confidence that even the few cases isolated fit the full definition of MSBP (either Rosenberg's or the DSM-IV definition), by the late 1990s the legal literature referred to it as not rare at all. Suzanne Mochow called it "not uncommon,"⁷⁶ and a 1999 article, with the inflammatory title of "Mommie Dearest?"⁷⁷ not only highlighted Rosenberg's discredited mortality rates from her 1987 article but talked about a growing caseload of more than 300 published cases.⁷⁸ In fact, rather than speaking about a possible 9% mortality rate, which Meadow showed was hugely excessive, Holland and Yorker speak of a mortality rate as "at least 10 percent." The editors of that volume of *Criminal Justice* highlighted that figure, placing it in bold and enlarged letters in the text of the article.⁷⁹ That is, any overworked judge quickly leafing through the publication would be assaulted by this figure, a figure so worrisome that s/he would certainly tend to exercise caution on the bench in child custody proceedings and order a child to be taken from the home when MSBP was even suspected. And, if the judge had some time to read the article, s/he would read sentences such as "The repetitive, compulsive nature of MSBP and the high mortality rate make this one of the more dangerous forms of abuse."⁸⁰ One can hardly imagine a statement more damaging to families than this, especially since it isn't really supported by data.

Nevertheless, this was the legal tone that tended to engulf MSBP cases in the late 1990s and early 2000s. Despite Mochow's salutary warning that parents' constitutional rights needed to be protected in child-custody proceedings,⁸¹ the general tone of law review articles is that this insidious, confusing, nearly untreatable and deadly dangerous form of child abuse was "out there," masquerading under the form of concerned mothers. It needed to be detected early before children meekly went home to probable deaths at the hands of deceptive mothers. Only one law review article raised the possibility that this latest assault on mothers was really a not-so-subtle form of negative gender stereotyping, but this article didn't really suggest any way out of the morass.⁸² In fact, instead of rushing to the defense of falsely accused mothers, one article suggested that lawyers

⁷⁶ Suzanne Mochow, "Munchausen Syndrome By Proxy: A Subtle Form of Child Abuse and Potential Due Process Nightmare," 18 *Journal of Juvenile Law* 167 (1997).

⁷⁷ Lynn Holland Goldman and Beatrice Crofts Yorker, "Mommie Dearest? Prosecuting Cases of Munchausen Syndrome By Proxy," 13 *Criminal Justice* (Winter 1998), 26-33.

⁷⁸ *Ibid.*, at 29.

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ Mochow, *Op Cit.*, 169ff.

⁸² Clearly, Melinda, "Mothering Under the Microscope: Gender Bias in Law and Medicine and the Problem of Munchausen Syndrome by Proxy," 7 *T.M. Cooley Journal of Practical & Clinical Law* (2005) 183-250.

consider arguing a “diminished capacity defense” for mothers so accused.⁸³ The effect of such a defense would be to admit the charge but to argue that somehow “Munchausen’s made me do it, “ and thus try to get a lesser sentence or leniency from the court.

The reason why these seemingly hapless defense tactics were suggested, however, is that the prosecutors definitely had the upper hand in MSBP/FDBP prosecutions in the last decade or so. In a carefully-researched piece, again with the passionate title, “Mothers Who Maim and Kill,” Melissa Prentice showed how the MSBP “profile” has gradually been used to help judges and juries “believe the unimaginable.”⁸⁴ Prentice looked at 37 cases from the late 1990s where the diagnosis was introduced in a trial context, and then followed each of these cases from trial to appeal (when there was an appeal). Her conclusion was that there was a “clear trend” in more than a dozen states in these years to recognize MSBP as a valid diagnosis in courtrooms. In fact, in all 19 cases she studied where MSPB was in play and child protective services requested removal of the child from the home, the court granted prosecution motions for removal.⁸⁵ Though not many cases concerning MSBP reached the appellate level by the late 1990s, “recent appellate decisions in Connecticut, New York, Ohio, George and the federal Second Circuit also show a growing acceptance of decisions by family court judges endorsing the reliability of MSBP diagnoses.”⁸⁶ The evidence adduced in trial was circumstantial in most cases (61%); in the 39% of cases in which direct evidence was available, it came mostly through covert surveillance video, confessions and autopsy results.⁸⁷ Though she recognizes the existence of defense-oriented expert witnesses and even the group “Mothers Against Munchausen Syndrome by Proxy Allegations,” she confidently closes her article with the point that MSPB diagnoses have firmly established themselves in the legal field.⁸⁸

As if to confirm Ms. Prentice’s observation, the most recent exhaustive treatment of child abuse issues in legal literature gives an extensive and positive review of MSBP.⁸⁹ Because this article is a survey article, it doesn’t either critically examine the diagnosis or the “profile” of the MSBP “mom.” Rather the author simply assumes, as does much of the legal literature, that the intellectual foundations of the diagnosis are pretty sturdy and are growing sounder all the time.

⁸³ Steeleman, E. Selene, “A Question of Revenge: Munchausen Syndrome by Proxy and Proposed Diminished Capacity Defense for Homicidal Mothers,” 8 *Cardozo Women’s Law Journal* 261 (2002).

⁸⁴ Prentice, Melissa A., “Mothers Who Maim and Kill: A Profile of Munchausen Syndrome by Proxy Litigation in the Late 1990s,” 28 *American Journal of Criminal Law* 373, 375 (2001).

⁸⁵ *Ibid.*, at 397.

⁸⁶ *Ibid.*, 398-99.

⁸⁷ *Ibid.*, 405.

⁸⁸ *Ibid.*, 410-12.

⁸⁹ Wright, Nancy, “SOS (Safeguard Our Survival): Understanding and Alleviating the Lethal Legacy of Survival-Threatening Child Abuse,” 16 *American University Journal of Gender, Social Policy and Law* 1, 74ff. (2007).

3. Looking at the Founder/Parent of the “Syndrome”—Dr. Roy Meadow

Though it is neither charitable nor wise to assume that a hard-favored visage in the parent necessarily implies ugliness in the child, we ought to pause if the parent, once thought to be beautiful and now exposed as quite unsightly, continues to tout the beauty of his child. To get to the point of this section, the founder and original “namer” of MSBP, Dr. Roy Meadow, has now been discredited in his native England for hyper-inflated child-abuse statistics he gave in several cases where he was an expert witness. Whether this professional misjudgment fully discredits the syndrome he named is not immediately apparent, but what is ironic is that the he, the doctor who discredited early MSBP statistics (in Rosenberg’s 1987 essay) for being irresponsibly high has now *himself* been caught exaggerating statistics. So, we have the interesting problem that if one convicted, so to speak, of exaggerating, says that the numbers of *other* MSBP researchers are exaggerated, where does that leave the numbers cited by MSBP writers? Doubly-exaggerated?

But even if it can’t conclusively be demonstrated that the founder’s exaggerations necessarily imply that MSBP is a “hyped” diagnosis, the way that he became discredited ought to give pause to those in America who still think that MSBP is a useful diagnostic tool. Space only permits a brief narration of the two leading incidents: the wrongful conviction of Solicitor Sally Clark and Dr. Meadow’s subsequent disciplinary proceedings before the General Medical Council. The “Net” is full of both stories, if you want to pursue them at your leisure.

To set the context: after Dr. Meadow’s 1977 article and his tireless efforts to identify and deal with the shocking problem of child abuse, he was knighted by the Queen. His career, which rose meteorically in the wake of these events, began to include testifying as an expert witness in parental termination cases. He developed a special expertise in SIDS (Sudden Infant Death Syndrome) cases and, throughout the 1990s, testified on possible parental responsibility for many SIDS deaths. After the 1997 publication of *The Death of Innocents*, mentioned earlier in this paper, he became an expert witness in the murder trial of Sally Clark, accused of murdering her two boys, both of whom died as infants.

In December 1996, Clark’s son Christopher was found dead in his crib at 11 weeks of age while her husband Stephen was away on business. In January 1998 her second son, Harry (eight weeks old), was also found dead at home. Though there were no signs of foul play, and though prosecutors were unsure how to handle the cases, they decided to move for her arrest in February 1998 on two murder charges. When she came to trial in Chester crown court in October 1999, one of the leading prosecution witnesses against her was Dr. Roy Meadow. He had developed “Meadow’s Law” with respect to crib deaths (called “cot deaths” in England) which some sources say was never actually uttered by him but became associated with him during the 1990s. It was that one sudden infant death was a tragedy, two were suspicious and three were murder. During the 1990s he had discovered, he claimed, 81 cases of SIDS which were actually parental murder of

children but, unfortunately for all, he had destroyed the evidence linking the parents to the murders. In the case at hand, he testified that the chances of Sally and Stephen's two sons dying of SIDS was 1 in 73,000,000. In other words, the chances of "innocent deaths" of the boys, in Dr. Meadow's judgment, would happen about once per century in England.

On the strength of his testimony, a sort of "evidentiary steroid" as I earlier referred to it, as well as other testimony, Mrs. Clark was convicted and sentenced to life in prison. The prosecution had argued that she smothered her first son and shook her second son to death. Her sentence was upheld on appeal in 2000. But Meadow's number sparked immediate and vociferous controversy in England. Statisticians almost universally condemned his numbers, and the President of the Royal Statistical Society wrote the Lord Chancellor that the figure had "no statistical basis."⁹⁰ An article that goes into the statistics in detail and explains it for a high school audience, is here.⁹¹ The truer numbers, as suggested by the just-cited article, are the product of 1/1,303 (the chance of a loss of the first child innocently) and 1/100 (the chance of a loss of the second child to SIDS) or about 1/130,000. Since about 650,000 children are born in England and Wales each year, the country really could expect about 5 families a year in England to suffer an "innocent" second tragic loss, such as suffered by the Clark family. Though the incidence is still rare, it is nothing like the 1 in 73 million that Dr. Meadow suggested.

In 2002, while Sally Clark was in prison, the former doctor for her younger son Harry came forth with information, which he had already known at trial but for some reason didn't reveal, that Harry had suffered from *Staphylococcus aureas*, a common staph infection. This new evidence, combined with the controversy swirling around Meadow's inflated and irresponsible statistic, lead to another consideration in the court of appeal, and in January 2003, Mrs. Clark's conviction was overturned. Although the reason for reconsideration didn't in the first instance have to do with Dr. Meadow's numbers, the judges stated in their opinion that "if this matter had been fully argued before us we would, in all probability, have considered that the statistical evidence provided a quite distinct basis upon which the appeal had to be allowed."⁹²

Three reactions followed the quashing of Sally Clark's conviction for murder. On the political front the reversal allowed politicians of all stripes to call for the cessation of a MSBP as a diagnostic tool. This culminated in the statement of Lord Howe, speaking in February 2003 in the House of Lords, to the effect that a diagnosis of MSBP was "one of the most pernicious and ill-founded theories to have gained currency in childcare and social services over the past 10 to 15 years." He went on to say, "It is a theory without science. There is no body of per-reviewed research to underpin MSBP. It rests instead on the assertions of its inventor and on a handful of case histories." Then, on the judicial front there was a cry both to re-examine the cases in which Dr. Meadow had served as

⁹⁰ http://en.wikipedia.org/wiki/Roy_Meadow

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<http://plus.maths.org/issue21/features/clark/index.html>

⁹² Op. Cit., note 87.

expert witness where the mother was convicted of killing or seriously injuring her child. Though only a few cases were re-opened, his testimony in the June 2003 trial of Trupti Patel for killing her three babies was disregarded by the jury and a verdict of “not guilty” was quickly brought back. In December 2003, the highly-publicized reversal of the conviction of Angela Cannings for murdering two of her three children largely on the testimony of Dr. Meadow, took place. Thus, one might say that by the end of 2003 his reputation as an expert witness had been considerably compromised if not tarnished completely.

But that wouldn't be the final thing that Dr. Meadow had to face. Chagrined by the false allegations against his daughter Sally Clark, Mr. Frank Lockyer, a retired police officer, submitted a complaint against Dr. Meadow to the General Medical Council (“GMC”), which regulates the practice of medicine in England. In July 2005 the GMC struck him from the list of qualified physicians in England, a fall from grace seemingly only surpassed by Mulciber's fall from heaven after siding with Satan in his revolt against God.⁹³ So severe was this sanction for one who had been knighted for his work that many felt that such severity would cause professionals to reconsider whether they would make themselves available as expert witnesses in later trials. Yet, the GMC's sentiment reflected the public outcry against MSBP, Dr. Meadow, and the way that his cavalier use of numbers had destroyed the reputation, family and health of an honorable English woman. Indeed, Mrs. Clark would end up dying in 2007, at age 42, of complications which many thought were brought on by the horrifying, humiliating and heart-rending process she suffered for most of the decade before her death.

Dr. Meadow, as expected, launched an appeal against the GMC ruling and in February 2006 the High Court judge found in his favor, reversing the decision to strike him from the medical register. On appeal, the Appeal Court, in October 2006, held that the High Court decision that Dr. Meadow was not guilty of serious professional misconduct should stand. On that issue, however, the court divided 2-1, with the dissenting judge, Sir Anthony Clarke, opining that Meadow was guilty of serious professional misconduct. One judge who sided with Meadow, however, said that he was “undoubtedly guilty of some professional misconduct,” but it “fell far short of serious professional misconduct.”⁹⁴ While the upshot of this case has as much to do with immunity of expert witnesses as it does with Dr. Meadow's conduct, it sent a clear signal that what he had done, though not a damning professional error, was serious nevertheless.⁹⁵

⁹³ The story of Mulciber (Hephaestus) being thrown out of heaven is graphically told by John Milton in *Paradise Lost*, Book I, lines 735ff.

⁹⁴ <http://www.richardwebster.net/cotdeaths.html>

⁹⁵ In December 2007 the other leading figure in England active in aggressively pursuing suspected MBSP mothers, Dr. (Professor) David Southall, was struck from the registry of physicians in England for severe professional misconduct. The GMC, which concluded that Dr. Southall had a “deep-seated attitudinal problem” found him guilty of serious professional misconduct twice in three years. Southall was already suspended from child protection work because of his irresponsible action in the Sally Clark case (opining murder with no basis). The fallout from this Southall verdict will probably take years,

As a result of the furor surrounding Dr. Meadow and Dr. David Southall (see note 95), MSBP has largely been discredited as a diagnosis in England. The *Wikipedia* article on “Fabricated or Induced Illness” stresses also how Australian Courts are now more than chary to grant credence to allegations of MSBP.⁹⁶ England’s experience with Dr. Roy Meadow ought to inform lawyers and judges in the United States who face this problem. We ought to recognize that the diagnosis stands on such a flimsy evidentiary basis that it is best for all concerned that these diagnoses be eliminated or significantly curtailed.

Conclusion

Until the following five issues are clarified, the “diagnosis” and expert testimony for or against MSBP/FDBP ought to be eliminated. First, we need to know what the alleged phenomenon is and what it ought to be called. There are three very different definitions and names of the phenomenon “out there” and they simply can’t be “smushed together” to come up with one grand syndrome. The “classic” MSBP definition comes out of Rosenberg’s 1987 article; her definition has been quoted dozens, if not hundreds, of times in subsequent literature. Is *that* what MSBP is? Or, in fact, is it to be called FDBP and is its definition found in the Appendix of the DSM-IV and DSV-IV-TR? I have laid out how the definitions differ considerably earlier in this paper. Which is it? Or, are you one of those people who say, after Shakespeare, “a plague o’ both of your houses” and have constricted the definition of the phenomenon in agreement with the professional society on child abuse so that you now call it “Pediatric Condition Falsification”? Which is in view here and which definition will you use? And, once you decide which terminology/definition you will use, which literature actually is appropriate for your definition? Some of the literature builds off one, some off another, and some indeed off the third definition.

Second, diagnoses and expert testimony on MSBP/FDBP ought to be curtailed until we know *who are the proper people to diagnose* this problem. Throughout the literature and court cases we have “diagnoses” by pediatricians, other attending physicians, social workers, teachers, psychiatrists, and other mental health professionals. Because of the imprecision regarding who can diagnose it, internet “gurus” and others have arisen who for a large fee will fly around to pronounce on it whenever diagnosis is needed. Until we decide, however, if this is something that can be divined by anyone who hangs out a shingle, we ought not to permit it in the courtroom.

Third, we ought to stop the diagnosis until it is clear *when* the diagnosis ought to happen and *what* its function is. Is it a tool of *suspicion*, something that can be mentioned *at the*

though it adds to the growing revulsion in England regarding the precipitate, arrogant and irresponsible way in which “diagnoses” of MSBP were used irreparably to harm families.
<http://www.richardwebster.net/cotdeaths.html>

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http://en.wikipedia.org/wiki/Fabricated_or_Induced_Illness

beginning of the process, when parental abuse is just one possible explanation for baffling medical symptoms in a child? Or, is it a product of *examination, testing and investigation*, with the diagnosis only arrived at after a well-considered process? This question isn't completely separate from the second concern. That is, if *anyone* can diagnose, we might as well let them diagnose whenever they want. If you give a whistle to a child and call him a referee, then he might just blow the whistle whenever he wants, sometimes even for his own pleasure.

Fourth, we ought to stop the diagnosis of MSBP/FDBP in the legal proceedings until we have some good statistics to know what exactly we are talking about. Ever since Dr. Meadow discredited some leading numbers in Prof. Rosenberg's 1987 paper (and I showed how others of her numbers either didn't make sense or were not properly keyed to her definition of MSBP), there has been strong suspicion that the "numbers game" played by proponents of MSBP is a sort of "shell game." It certainly is with respect to mortality figures. It probably is with respect to cases actually diagnosed. Without good numbers courts are held hostage by experts who opine without data or with data that are based on so few studies that they mean next to nothing. Until we have some good numbers, then, the diagnosis is suspect and expert testimony on MSBP ought not to be permitted.

Fifth, until we answer some of the preceding four questions, courts and other legal proceedings ought not to allow "profile data" on MSBP. One of the powerful tools prosecutors have is to paint the likelihood of a person's guilt by showing a "typical profile" of an MSBP perpetrator. But this "typical profile" fails the base rate test, as I showed when discussing the work of Dr. Eric Mart, and it really isn't "typical" after all. Profiling is used as an impressionistic tool, a sort of postmodern "throw the paint on the canvas" to see if any of it sticks and then call it art. Profiling MSBP mothers is no different than profiling African-American or Latino drivers in American cities or profiling Terrorists by the complexion of their skin, length of beard or variety of dress. If civil rights groups and others rightly call "Foul!" when the latter is used to the exclusion of other forms of evidence-gathering or even as an evidentiary "boost," why shouldn't we all cry "Foul!" when the same kind of profiling is used against mothers who are suspected of being "MSBP" moms?

Thus, the problems with a MSBP/FDBP diagnosis are, like the spirits cast out of the Gadarene demoniac, Legion.⁹⁷ These are significant and severe problems, problems that should make any judge or lawyer pause before pursuing a case where suspected MSBP is a factor. In the closing words of this paper, I will suggest what to do when credible allegations of something that may have traditionally been called Munchausen Syndrome by Proxy are brought forth.

One must realize that the physicians who treat the child will be the principal witnesses in any legal case that goes forward. But, they will be "fact witnesses" and not "expert witnesses." They will rely on their specialized knowledge, to be sure, but they will be

⁹⁷ The interesting Biblical story about this exorcism is found in Mark 5.

testifying regarding what they actually saw in the child or the behavior of the mother/caregiver. If the court decides that the mother/caregiver ought to be subject to an examination, then it can so order a mental health professional *preferably with an expertise in deception* to examine the suspected perpetrator. Such a professional could be called as a witness in a legal proceeding and would, in fact, be an expert witness. If it could be demonstrated that there was such a thing as MSBP (the five hurdles listed above must first be cleared), then the expert could testify as to whether the caregiver was so afflicted. But until the questions I have posed are answered, the role of the expert mental health witness will be to describe, to the best of his/her ability, the psychological profile of the caregiver without the aid of an MSBP/FDBP diagnosis.

If after all this the trier of fact (judge or jury) decides that the caregiver is guilty of child abuse, then s/he should be convicted under the abuse statutes of the state. If the conduct demonstrated at trial doesn't reach the level of abuse as contemplated by the statutes, the child still may at times be removed from the home, since a lesser burden of proof is needed to remove than to convict. But in all of this any word about MSBP ought either not to be permitted or be permitted only in very narrow circumstances—where the mother's/caregiver's conduct seems to "fit" the DSM-IV or the 1987 definition perfectly.

But until the five issues raised here are competently and clearly answered, we ought to declare a "moratorium" on MSBP/FDBP diagnoses. And, if the scholarly community is given a period of time within which to come up with some kind of consensus on this so-called disorder, and it is unable to do so, then MSBP/FDBP ought to be declared dead, brought in through the lichgate of the cathedral, honorably commended to the dust, carried out to the prepared plot and, without further ado, solemnly interred next to the remains of its eponymous ancestor, Karl Friedrich Hieronymus, Freiherr von Munchhausen.⁹⁸

⁹⁸ This is the official German spelling. The Americanized spelling drops an "h" from Munchhausen, and also drops the umlaut over the "u."