

Understanding and responding  
to Medical Child Abuse  
(aka Child Abuse in Medical  
Settings, MSBP, Health Anxiety  
and FIIBP)

Sue Foley  
Des Runyan



# About us – we are both ISPCAN Counsellors

- Mrs Sue Foley, BSocStud, MA, MSW, MEd, Cert IV WAT, MAASW. is currently the Director of The Children's Court Clinic in Sydney, NSW. Australia.
- I have been a social worker since 1975 and have worked in medical, child welfare, legal, foster care, counselling and mental health areas since that time.
- I have co-authored a number of articles in this area of potentially serious child abuse.
- I believe that many families are not able to access helpful interventions when they need it!!



# Mrs Sue Foley

- I gained experience in working with this population of children and families in the following contexts:
  - A child welfare department in Sydney Australia, from 1985 - 2000
  - A foster care agency where children affected by FIIBP were in foster placements
  - A Paediatric Hospital's Child Protection Unit, and the same hospital's multi-disciplinary psychiatric consult liaison team.
  - In a private practice in assessment and therapy
  - In consultations to various agencies trying to identify FIIBP
  - In long terms case management and monitoring of foster carers.
  - In a Children's Court Clinic attached to a Care and protection court.



## Dr Des Runyan

- Jack and Viki Thomson Chair in Paediatrics and Director of the Kempe Centre at the University of Colorado School of Medicine
- MD, DrPH, FAAP, FACPM (Paediatrics, Child Abuse Paediatrics, and Preventive Medicine Certified specialist)
- Paediatrician conducting child abuse evaluations and research for more than 35 years
- I have evaluated a number of children for this condition and published on the phenomena



# About this topic and this webinar

- The webinar seeks to raise the issues of prevention and intervention with FIIBP, MSBP, MABP.
- Much of the practice and research literature is about identification and prosecution or other legal matters
- The presentation is by Sue and Des will be the discussant
- You are welcome to provide questions to the moderator during the session using the webinar tools



# Participants

- How many of you have ever had to manage or be involved with one of these cases??



## Specific framework definition

**A clinically useful framework is provided by Boots et al (1992)**

- 1. Illness in a child which is fabricated by a parent or someone in loco parentis.**
- 2. The child is presented for medical assessment and care usually persistently, often resulting in multiple medical procedures.**



## Specific framework definition

- 3. The perpetrator denies knowledge of the aetiology of the child's illness.**
- 4. Acute sxs and signs of the illness (es) decrease when the child is separated from the perpetrator.**

**What is the motivation for this form of abuse?**

**Any comments from a medical perspective?**

**What are psychosocial associates?**



# Psycho-social components

- Overly caring parents ?
- Terrified parents
- Absent fathers
- Over-engaged mums?
- More than the average knowledge of medical issues
- Perhaps too strong as an advocate?



# Is it Child Abuse ???

**It can have horrific consequences.**

**Christopher Bass and David Jones say:**

**‘It is a rare form of Child Abuse but relatively little is known about the psychopathology of the perpetrators’ .**

**It is usually recognised as a form of physical, emotional and psychological child abuse**

**Carers may also have been childhood sufferers, or adult sufferers**



## Accounts of sufferers are rare: Julie Gregory: Sickened: 'The Memoir of a Munchausen by Proxy Childhood.'

- *'I was conceived in the sickly womb of a sickly mother – who starved herself and in turn starved me. She was highly anaemic and blind with toxemia at the time of my birth – the result, she explained of high blood pressure cutting off the circulation to her eyes. I was pushed into this world premature at 3 pounds seven ounces, an embryonic little bird, glowing translucently ....*

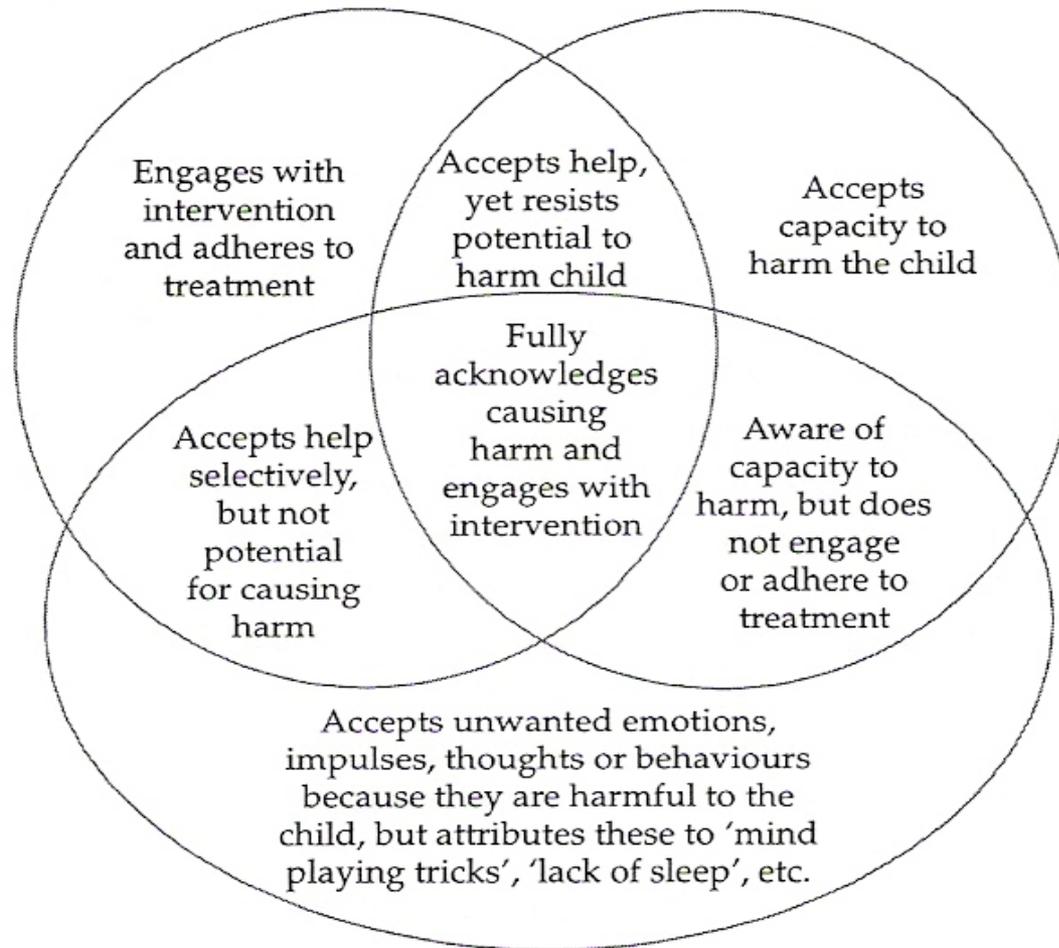
*After that my health only balanced precariously on the edge of a let's get to the bottom of what's wrong with this kid kind of existence'. (p3)*



# The dilemma with these cases

- In the literature, it is understood as parents intentionally creating or exaggerating symptoms in children to meet the parents' own needs (usually without full understanding of the implications).
- It is usually understood in black and white terms – mainly conceptualised as a form of child abuse.
- Most Child protection and psychiatry systems believe parents have to admit to abuse before it can be treated
- Clinically this is not a very useful approach.





**Fig. 1 The main components of acknowledgement.**  
 (Adapted by D. Jones from David, 1990.)



# Denial

- What is the benefit of denial?
- What is the road through denial?
- Is confrontation the only or best way?
- What about unconscious blocking?



## These cases are complex – what makes a case complex?

- **The type of abuse alleged**
- **The reliability of interpretation of symptoms in a child**
- **The needs of the child**
- **The context of the family**
- **The engagement of the staff with the child**
- **The interaction of the professionals involved**
- **The impact of complex issues on the child protection focus**
- **The legal situation and principle of least intrusive actions**
- **Disbelief !!**

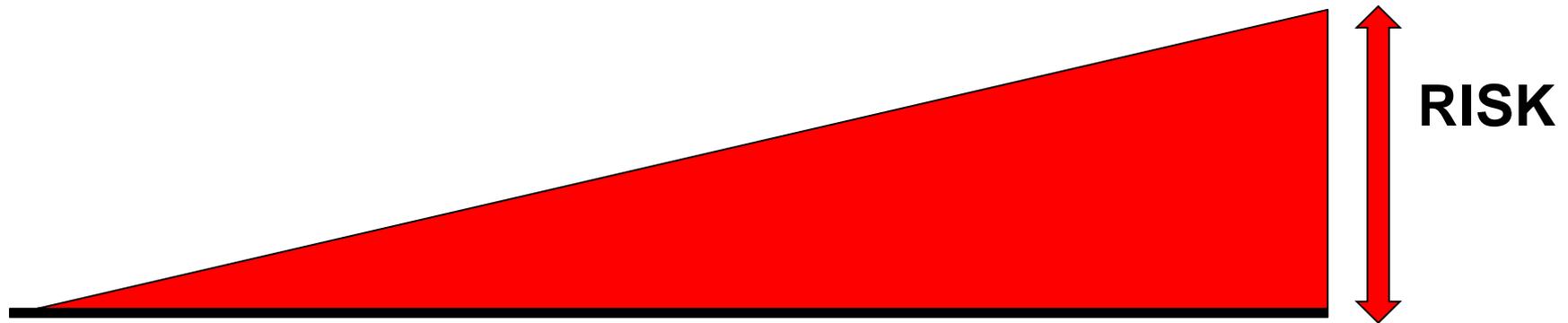


## In the Department of Psychological Medicine - frequent referrals.

- A small but constant number of referrals were received each year where there are concerns that physical symptoms may be being exaggerated.
  - Epilepsy, urine retention, pain and nocturnal fits, breathing problems secondary to Arnold Chiari malformation, vaginal bleeding, abdominal pain
- In the literature referred to as Munchausen's by proxy, factitious illness by proxy etc.
- Significant parental distress – both childhood and as parents



# A different way of thinking about the range of these cases



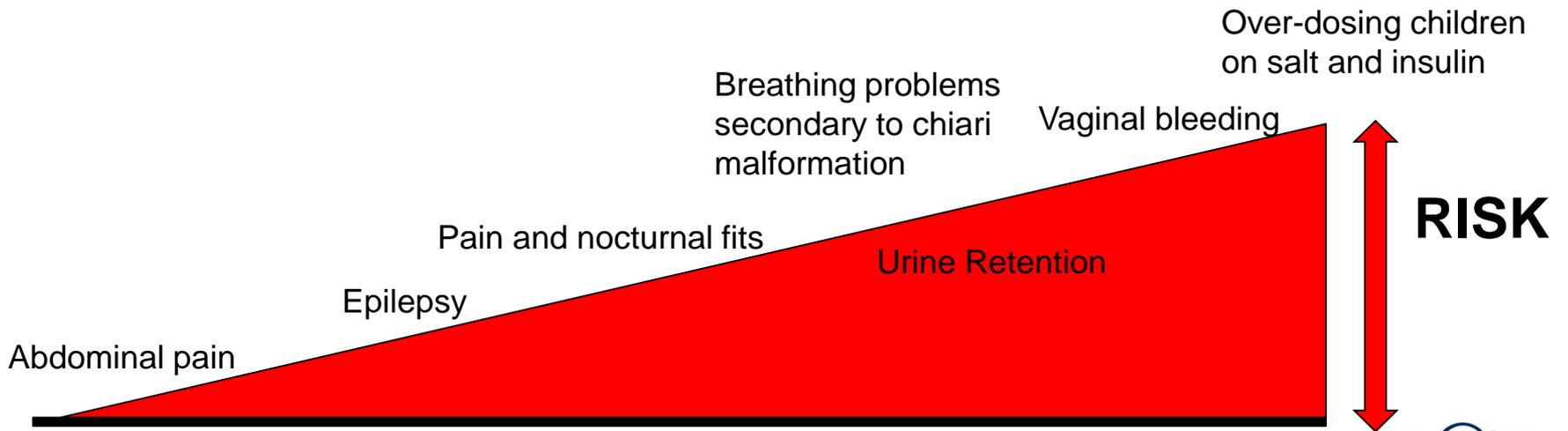
Somatising symptoms that get a lot of attention

Exaggeration of real illness symptoms by anxious parents

Deliberate creation of symptoms



# We mapped our cases on a continuum



## Also framed in a similar way by the Royal College of Paediatrics and Child Health

They use the language 'a spectrum of presentations which identify presentation, iatrogenic harm, carer's insight and 'underlying factors' (like mental health issues), which contribute to a 'management' framework.



## One way of thinking about these cases...where there is medium to low risk

- Usually anxiety and unresolved loss in the parental history are part of the dynamic.
- Parents become hyper-vigilant to medical symptoms.
- Parents can genuinely believe their children are ill and fear they will die.
- Parents struggle with trust in medical and other health professionals.



## One way of thinking about these cases...where there is medium to low risk

- Health professionals struggle to trust parents.
- Some become overly punitive or suspicious, others become overly supportive – polarisation in a team can occur.
- Anxiety can infiltrate the system.
- Safety must always come first.
- Ongoing curiosity and teamwork.



# A therapeutic approach – Working in the grey areas

- Different from a forensic approach, we work to seek to understand.
- How did the family come to be organised the way it is?
- What are the attachment processes at work – overly caring, care-eliciting?
- What are their motivations?
- We take a curious stance as joint investigators (with the family).



## A therapeutic approach – continued

- Allows us to engage with the family in a non-blaming and non-punitive way.
- Simultaneously assessing risk and staying alert to the possibility of being co-opted or enticed or triangulated
- A pragmatic focus on the family's functioning and exploring what obstacles are getting in the way of improved functioning, helps us to avoid blaming.
- The work is slow – most cases take six months to two years.



# Understanding the systems issues that maintain the behaviour

What are the interactions:

- In the family (over-functioning and under functioning parent)
- Between the family and health professionals (dismiss and exaggerate)
- Between different health professionals (polarisation or competitiveness)
- Between different agencies (CS, school, health services)



# The intervention / treatment processes - Because of the complexity: multiple lenses and approaches are needed

- For example:
  - Multi-systemic family therapy
  - Dynamic Maturation Model of Attachment
  - Trauma, grief and loss frameworks
  - Cognitive behavioural approaches
  - Parenting programs
  - Narrative approaches
  - Psycho-education
  - Motivational Interviewing
  - Signs of Safety



## Principles we use

- Good communication
- Respect
- Transparency
- Clear roles and teamwork
- Stop the action – reduce opportunity
- Advocating for the family
- Accepting, curious, empathic



## Effective intervention means noticing and managing the anxiety all around

- Reviewing safety
- Containment: family, other professionals, the therapist!
- Understanding and leaning into anxiety in the system (as opposed to avoiding)
  - Giving the parent a therapist in our team
- Working to understand the parents' "anxious" story



# Managing risk and child protection

- Issues of neglect and emotional abuse as well as original forms of abuse
- When and how to get child protection services involved?
- How dangerous is the situation?
- What role do you need them to play?
- Need ongoing assessment of risk factors and protective factors



# Case study: intervention

- Engage the parents
  - Admission to hospital
- Name the anxiety
  - Helping parents see the effect of their own behaviour on symptoms
- Contain the anxiety
  - Set medical appointments
- Involve child protection if needed to set safety limits
- Working with systems

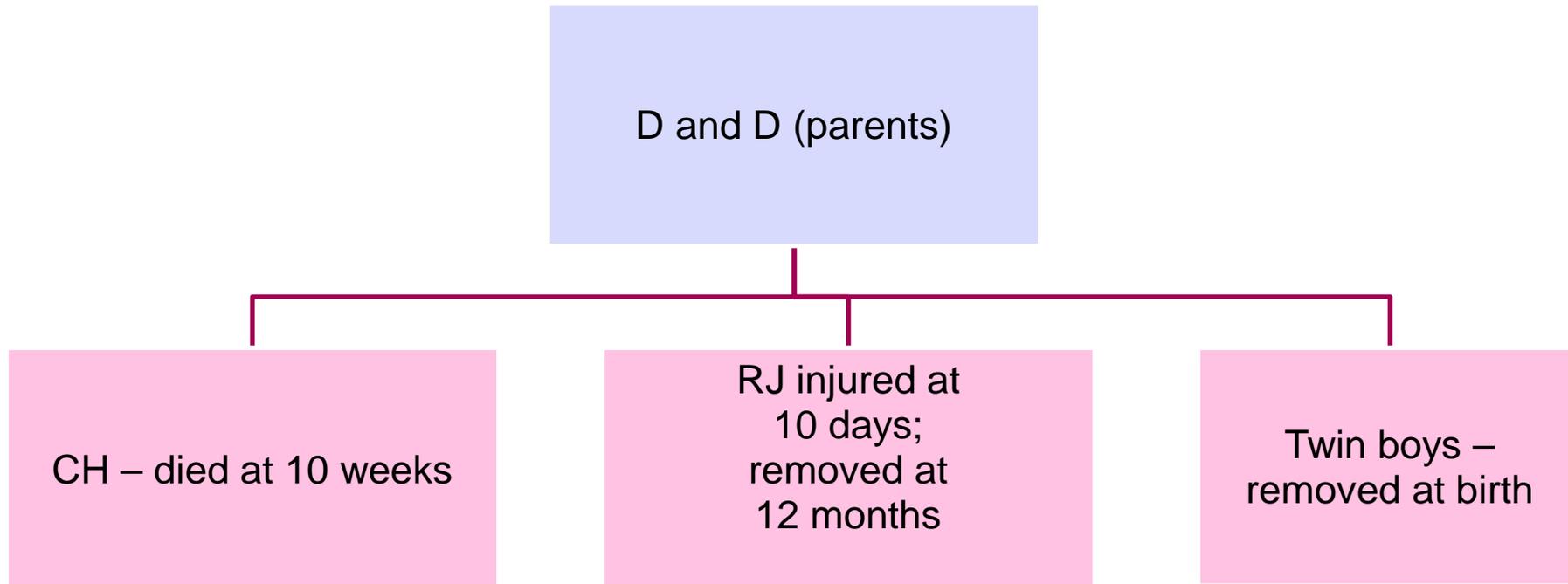


Not all cases can be treated

Is this true??



# The Larker Family



## Introducing the Larker Video

- 2 children abused the same way (MSBP); medication and insulin used; salt poisoning and possible shaking in hospital
- Twins implicated in the mother's MSBP processes by her telling lies to the neonatologist which may have led to unnecessary investigations
- Someone interfered with twin's feeding tubes



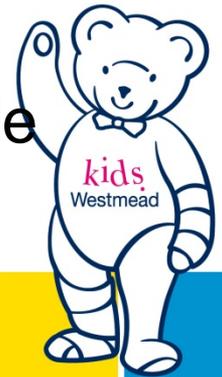
## Discussion

- Mother charged with indictable assault
- What are the issues that this video raises for us?
- Intervention: Removal
- Could it have been handled differently?
- Ongoing issues for everyone



## Case Study EM

- EM then age 6 (middle of 7 children)
- Referred by neurology for headaches – lined up for brain surgery; only partially attending school ; believed she as dying
- Removed and placed in foster care for 8 weeks
- Use of AAI assisted with engagement and therapy
- Parents have been in treatment for 2 years – partial admission – still somatising
- Child now well; parents acknowledge their own role and their symptoms



## Some reflections and discussions?

- Is it always possible to prevent?  
Is it possible to recognise early
- Is it possible to treat without admission?
- Do we always need to separate the child from the family? For how long?



## More issues to be considered

- Definitions – not always agreed on
- A Team Approach
- Reporting to Child Protection
- Documentation
- Advising Insurers/ Medical Administration
- Complaint Management
- Media and Reputation



Thank you



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