Medical Child Abuse: Evolution and Treatment

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Disclosure

• I receive (scant) royalties from the sale of our book:

*Medical Child Abuse: Beyond Munchausen syndrome by proxy*

American Academy of Pediatrics Press 2009
Historical Context

• 1962 Kempe – The Battered Child Syndrome
  • Kempe, Silverman, Steele, Droegemuller, Silver “The battered child syndrome” JAMA

• 1977 Kempe – Sexual abuse
  • Kempe “Sexual abuse, another hidden pediatric problem” Pediatrics 1978

• 1977 Meadow – MSBP
  • Meadow “Munchausen Syndrome by Proxy; the hinterland of child abuse” Lancet 1977
MSBP to MCA

• 1975 – Kempe, Uncommon manifestations of BCS
• 1977 – Meadow, MSBP
• 1987 – Rosenberg. Web of Deceit
• 2002 – Special issue of Child Maltreatment
• 2007 – AAP statement on MCA
• 2009 – Roesler and Jenny, Medical Child Abuse
• 2018 – APSAC joint statement
Similarities with Physical, Sexual, and Emotional Abuse

• Child is the victim, most often a caretaker is the perpetrator
• Behavior occurs on a continuum from mild to moderate to severe
• Society determines the threshold that constitutes abuse
• The threshold changes by time and geography
• Perpetrators usually lie about the behavior
• They take responsibility only when compelled by the community
• The emotional effects of the various forms of abuse are similar
• Perpetrators have similar histories of childhood deprivation
Differences

• Perpetrators are primarily female
• The caretakers often have histories that emphasize expressing emotional issues through physical symptomatology
Controversies

• What to name it
• How frequently does it occur
• Who is the patient
• Is there a profile of a perpetrator
• Does the motivation of the perpetrator matter
• Is it treatable
What to name it

• Munchausen Syndrome by Proxy
• Polle’s syndrome
• Pediatric condition falsification
• Factitious disorder imposed on another
• Fabricated or induced illness by a caretaker
• Medical child abuse
How frequent is it?

• Very rare

  • McClure 0.5 / 100,000
    • McClure, Davis, Meadow, Sibert “Epidemiology of Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation” *Archives of Diseases in Childhood*, 1996

• Not so rare

  • Ferrara, et.als. 530 / 100,000
    • 4/751 admissions
    • Ferrara, Vitello, Bottaro, Gatto, liberatore, Binetti, Stabile “Factitious disorders and Munchausen syndrome: The tip of the iceberg” *Journal of Child Health Care*. 2012
Who is the patient?

- Is it the child who was harmed or the parent who caused the harm
- DSM-5
Is there a profile of a perpetrator

• No

• There are descriptors of people found guilty of MCA but they do not predict who would perpetrate
Motivation?

• Motivation matters just as much as for other forms of child abuse (but no more)
• It comes into play when discussing returning the child to the home environment
Is it treatable

• Yes, if you mean treating it like other forms of child maltreatment
What is Medical Child Abuse

• A child receiving unnecessary and harmful or potentially harmful medical care at the insistence of a caretaker
Implications of the name MCA

• The child is the patient/person being abused
• The medical profession is involved
• A caretaker precipitates unneeded medical care
• The diagnosis can be made without considering the motivation of the perpetrator
• We can expect there to be mild, moderate, and severe presentations
• Treatment will follow steps used to treat other forms of maltreatment
The continuum of MCA

• Mild cases – impacting everyday life of child and family
  • Too many medical visits
  • Too many prescriptions for colds
  • Too many missed school days for “my child doesn’t feel well”

• Moderate cases – Having potential long term medical risks
  • Medication prescribed after a parent lies about symptoms
  • Non invasive diagnostic procedures for non existent illness

• Severe case – life threatening
  • Unnecessary invasive procedures
  • Unnecessary surgery
What kinds of symptoms do caretakers claim?

• Almost any illness can be involved
• Most likely are illnesses that rely heavily on parent report
Types of unnecessary care received (n=87)

• Unnecessary medical visits—81
• Unnecessary medications—74
• Unnecessary invasive tests—46
• Unnecessary minor surgery—33
• Unnecessary major surgery—21
Treatment (including evaluation)

• Identify it
• Stop it
• Provide for ongoing safety
• Repair the damage
• Maintain family integrity as much as possible
Identify it

• Have a healthy index of suspicion
• Be aware of a breakdown in the doctor/patient relationship
Think about why we guarantee confidentiality

• Our job would be infinitely more difficult if we were not making decisions based on accurate information
• This is what happens with MCA – It is not the fact of the lie – it is the result of the lie.
<table>
<thead>
<tr>
<th>DATE</th>
<th>PROVIDER</th>
<th>COMPLAINT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/18/89</td>
<td>Pashley (ENT)</td>
<td>Chronic ear infections</td>
<td>According to mother, there was an attempt at removal of was and/or tubes by use of a water pik. An audiogram was performed in Longmont which seemed to reveal a conductive hearing loss. Mother can’t remember the name of the child’s disease, but she thinks it is eosinophilic granuloma. There are multiple allergies documented to penicillin, erythromycin, and Keflex, but according to mother, child can take low dose Ceclor. He snores and mouth breathes. On physical exam, he has hypertrophied tonsils and adenoids and retraction of the tympanic membranes. Needs tonsillectomy, adenoidectomy, and insertion of PE tubes.</td>
</tr>
<tr>
<td>5/26/89</td>
<td>Albin (Plastics)</td>
<td>Granuloma annulare</td>
<td>Mother says, “His Dad had some removed.” Doctor says, “The mother has been told in the past that they will resolve spontaneously.” Rx: Scheduled excision and grafting.</td>
</tr>
<tr>
<td>6/1/89</td>
<td>Pashley (ENT)</td>
<td>Post-op ✓</td>
<td>Tubes in place and dry. Follow-up in 3-4 months with hearing test.</td>
</tr>
<tr>
<td>7/21/89</td>
<td>Albin (Plastics)</td>
<td>Post-op ✓</td>
<td>Wounds doing well. Skin grafts have taken. Mother instructed in wound care. She is to change wraps every other day. Keep Cisco from walking too much. Follow up in 2 weeks.</td>
</tr>
<tr>
<td>7/31/89</td>
<td>Albin (Plastics)</td>
<td>Post-op ✓</td>
<td>Missed appointment.</td>
</tr>
<tr>
<td>9/15/89</td>
<td>Albin (Plastics)</td>
<td>Post-op ✓</td>
<td>Has 2 small draining areas on the large skin grafts on foot and pretibial area. Rx: Warm soaks, bed rest elevate foot.</td>
</tr>
<tr>
<td>10/6/89</td>
<td>Albin (Plastics)</td>
<td>Granuloma annulare</td>
<td>“Mom’s niece had surgery for the same thing--grandfather had it and lost 3 toes and part of R hand. Send Derm at University Hospital.” Physical exam shows new lesions and repeatedly traumatized anterior skin grafts. Rx: Shin guard to protect grafts. “Spoke with pathologist Gail Willstein who will send his slide one or two soft tissue pathology experts in the country since (per mother of child) two relatives on h mother’s side had very aggressive granuloma annulare as well.”</td>
</tr>
<tr>
<td>10/27/89</td>
<td>Albin (Plastics)</td>
<td>Granuloma annulare</td>
<td>New lumps on R pretibial area. Grafts healing well.</td>
</tr>
<tr>
<td>11/15/89</td>
<td>TCH Plastics (Albin)</td>
<td>Granuloma annulare</td>
<td>SURGERY--Excision of 8 recurrent sites of granulomata. Path Dx: Granuloma annulare.</td>
</tr>
<tr>
<td>12/1/89</td>
<td>Albin (Plastics)</td>
<td>Granuloma annulare</td>
<td>No recurrent lesions. New lesions on L knee, L ankle. Pathology report from Barnes Hospital shows granuloma annulare. There is a minority of patients who have a generalized form of this. Rx: &quot;At no moment there is nothing to do but to continue pursuing these lesions. Schedule surgery.”</td>
</tr>
<tr>
<td>1/5/90</td>
<td>TCH Plastics (Albin)</td>
<td>Granuloma annulare</td>
<td>SURGERY--Excision of 3 sites on L ankle. Path Dx: Granuloma annulare</td>
</tr>
<tr>
<td></td>
<td>TCH ENT (Pashley)</td>
<td>Recurrent otitis media</td>
<td>SURGERY--Tympanostomy and placement of PE tubes. Tympanosclerosis noted.</td>
</tr>
</tbody>
</table>
Identify continued

• Remember with a healthy level of suspicion we won’t have this pile of records to go through

• Access social media
Stop the abuse

• Get the doctors to agree (this is often the most difficult step)
• Have an informing session
• Set out the new rules for getting medical care
• Write contracts
• Stop the most lethal treatments first
Provide for ongoing safety

• If not before, here is where involving Social Services is vitally important
  • Work closely with your multidisciplinary team
  • And Social services
  • And legal system
Repair the damage

• Stopping the treatments goes a long way

• Emotional effect are like other abuse
  • Anxiety disorders
  • Depression
  • PTSD
  • Distorted relationship with the medical profession
Maintain the integrity of the family

- Now we need that psychological evaluation

- Individual treatments for perpetrators
  - Motivational interviewing
  - CBT/DBT

- Family interventions
  - Use extended family members
  - Other community resources
Treatments of mild, moderate and severe presentations (In general)

• Mild presentations can be treated in the office and hospital environments (many times without making a child abuse referral)

• Moderate - Child abuse team, social services almost always necessary

• Severe – Also include legal resources
The secret of successful treatment

• We want to modify, significantly, the family belief system surrounding uses of medical care

• The caretaker’s belief system most likely stems from her family of origin but is being maintained by the existing family network

• We need to “pop the bubble” using increasing effective/intrusive means until we meet the objective
In summary

• Have a healthy index of suspicion - Don’t believe everything you hear
• Try to intervene early – deal with the mild cases before they get big
• Get all the doctors to agree to the need for change in treatment and in the new rules
• Use contracts to make the doctor/patient relationship specific
• Be ready to bring in help from social services
• If necessary, be ready to advocate termination of parental rights
• When parents threaten the life of their children they can be prosecuted for criminal acts