Women as perpetrators: abnormal illness behaviour by mothers

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Munchausen’s syndrome by proxy

- A description of a behaviour
- A mother presents her (generally) non-verbal child as ill, when they are not

- The mother
  - Makes up accounts of symptoms
  - Provides false evidence of symptoms
  - (rarely) induces symptoms in the child
A problematic label

- It is a maternal behaviour that causes illness in a child
- A diagnosis represents a commonly agreed narrative of signs and symptoms that have a natural history and prognosis
- Treatment based on underlying pathology
- How could maternal behaviour be a diagnosis in a child?
Change the label!

- Now there is a diagnosis in children called ‘factitious or induced illness’ (DoH, 2006)
- But no diagnosis for mothers
- No good account of what these mothers are thinking
- Nor where they fit into the range of ‘normal’ mothering
- Or where their psychopathology might lie
Normal care giving by mothers

- Includes eliciting care from health care professionals
- Mothers of new babies (first borns) are often heavy users of GP services
- Average consultation rate for under 10s: 3-4 per year
- Factors affecting consultation rates: mother’s own illness behaviour pattern
Mothers and health care providers

♦ Mothers who present too often (by whose standard?)
♦ Mothers who present too little (ditto)
♦ Mothers who will not be reassured
♦ Mothers who will not take advice
♦ Mothers who disagree with doctors
♦ Mothers who do not tell the truth about symptoms
What is the ‘truth’ about symptoms of illness?

♦ Sociology of illness and disease
♦ Illness is what patients see and complain of: a story of symptoms
♦ The doctor listens to the story, and looks for characteristic signs of disease (exam or Ix)
♦ He then provides a medical technical story to replace the patient’s
♦ What if narratives conflict?
Symptom stories

- If they don’t make sense, they are called ‘medically unexplained’ (MUS)
- Link with somatisation of distress
- Somatising mothers tend to present children more; and have children that somatise
- The creation of a story by medical investigation and research
- Also by public culture
Malignant mothering

- Helplessness and incompetence
- Neglect and failure to protect
- Emotional abuse
- Physical abuse (including sexual)
- Abnormal care giving and eliciting:
  - Failure to care
  - Toxic caring
  - Abnormal relationships with carers
Abnormal care giving and eliciting

- Asking child to care for parent
- Controlling caring: investment in child being needy and dependent
- Identification with role as carer; or sick role
- Denial of need in the self: avoidance of care eliciting
- Hostility to care givers
- Proxy abnormal illness behaviours
Proxy Abnormal Illness Behaviours

Over-interpretation of child’s symptoms as serious illness (cf hypochondriasis)

Treatment and reassurance resistance (somatising disorders)

False accounts of illness: intention to deceive or manipulate carers or what?

Fabrication of symptoms: ditto

Induction of symptoms: ditto
People don’t ‘have‘ behaviours

♦ They have minds full of meaning
♦ Actions as non-verbal communications
♦ Greater or lesser degrees of agency and ownership of actions
♦ Some mental disorders make behaviours more possible or likely
♦ Complexities of inferring mental states from behaviour
Research into a behaviour that harms others e.g. Proxy AIB

- Context: social constructions of illness and motherhood, base rates of harmful behaviours
- Sampling bias: we only see detected cases, and severe cases may be over-represented
- Need to avoid over-simple complex social behaviours e.g. Most mothers with BPD do not act in this way, so higher prevalence of diagnosis is misleading
Theoretical paradigms for care giving and eliciting

- Attachment theory provides useful paradigm (Henderson, 1974)
- Mental representations of care-giving and care eliciting
- Hostile, helpless or controlling representations affect care giving behaviour
Normative data

- Review of large scale population studies (n=10,000)
- Insecure attachment occurs in 40% of normal population
- Highly disorganised insecure attachment in 2-5%
- Much higher prevalence of all insecure attachment patterns in clinical populations
Attachment in Proxy AIB

- A very few secure mums (tend to be associated with fabricated accounts and excess use of services)
- Mainly dismissing attachment i.e. claims to strength and normality, derogation of vulnerability and weakness, dismissal of own needs, derogation of care-givers
- Link with offending: lack of empathy?
Issues

- How does anyone learn to be a carer for sick children?
- Should individual or group norms operate?
- How do we conceptualise cruelty and hostility to the vulnerable in women?
- Is it always pathological? Defensive?
- Can women say that they hate caring for their children safely?
Conclusion

♦ What’s wrong with these mothers?
♦ Still do not have good account of what this behaviour means to them
♦ Without this, risk assessment is hard to do well. No good way yet of differentiating low from high risk of recurrence OR progression
♦ Helping these mothers: what possibility of risk is acceptable?
References