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Munchausen's syndrome by proxy and Lyme disease: Medical misogyny or diagnostic mystery?

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Summary Chronic, tertiary Lyme disease, a vector-borne infection most accurately designated neuroborreliosis, is often misdiagnosed. Infectors of the human brain, Lyme borrelial spirochetes are neurotropic, similar to the spirochetes of syphilis. Symptoms of either disease may be stable and persistent, transient and inconsistent or severe yet fleeting. Characteristics may be incompatible with established knowledge of neurological dermatomes, appearing to conventional medical eyes as anatomically impossible, thus creating confusion for doctors, parents and child patients.

Physicians unfamiliar with Lyme patients' shifting, seemingly vague, emotional, and/or bizarre-sounding complaints, frequently know little about late-stage spirochetal disease. Consequently, they may accuse mothers of fabricating their children's symptoms – the so-called Munchausen's by proxy (MBP) "diagnoses."

Women, following ancient losses of feminine authority in provinces of religion, ethics, and healing – disciplines comprising known fields of early medicine, have been scapegoated throughout history. In the Middle Ages, women considered potentially weak-minded devil's apprentices became victims of witch-hunts throughout Europe and America. Millions of women were burned alive at the stake.

Modern medicine's tendency to trivialize women's "offbeat" concerns and the fact that today's hurried physicians of both genders tend to seek easy panaceas, frequently result in the misogyny of mother-devaluation, especially by doctors who are spirochetally naïve. These factors, when involving cases of cryptic neuroborreliosis, may lead to accusations of MBP.

Thousands of children, sick from complex diseases, have been forcibly removed from mothers who insist, contrary to customary evaluations, that their children are ill. The charges against these mothers relate to the idea they believe their children sick to satisfy warped internal agendas of their own. "MBP mothers" are then vilified, frequently jailed and publicly shamed for the "sins" of advocating for their children. In actuality, many such cases involve an unrecognized Lyme borreliosis causation that mothers may insist is valid despite negative tests.

Doctors who have utilized MBP tactics against mothers are likely to be unaware that in advanced borreliosis, seronegativity is often the rule, a principle disagreed upon by its two extant, published, peer-reviewed, Standards of Care. These are guidelines for Lyme disease management – the older system questioning the existence of persistent Lyme and the newer system relying on established clinical criteria.

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Mothers must be free to obtain the family's preferred medical care by choosing between physicians practicing within either system without fear of reprisal. Doctors and mothers together may then explore medical options with renewed mutual respect toward the best interest of children's health.

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"Cotton Mather, the minister of Boston's Old North church, was a true believer in witchcraft. In 1688, he had investigated the strange behavior of four children (who) had been complaining of sudden pains and crying out together in chorus. He concluded that witchcraft, specifically that practiced by an Irish washerwoman ... was responsible for the children's problems..."

Biography by Doug Linder, Professor of Law.

Overview of the MSBP "diagnosis," concern regarding its inappropriate use and the possibility of related misogyny

Serious consequences have followed specific medical misjudgments – ill-conceived actions that have plagued mothers of many children afflicted with Lyme disease and other cryptic illnesses. These sequelae are worthy of thoughtful scrutiny and concern. Abhorrent outcomes have followed misuse of specific diagnostic labels that appear to be related to parental gender. Entities such as "Munchausen's syndrome by proxy" (MSBP or MBP) or proposed psychiatric titles, "Factitious disorder not otherwise specified" or "Factitious disorder by proxy" (FDBP) as well as various other intricate artifices have been used inappropriately and usually against innocent mothers of Lyme-infected children. "MSBP describes a caretaker ... who purportedly induces or exaggerates illness in her child to gain attention from the medical profession. It is a... controversial 'diagnosis'." [1].

Employment of such inaccurate "diagnoses" has imperiled the health of genuinely sick children and imprisoned their mothers. Presumably, many supposed cases of MSBP, had they been fully investigated, would have revealed underlying infections, [2] or other difficult-to-diagnose, poorly understood illnesses as true causes of the children's problems. Misapplication of the MBP hallmark onto a mother of a child who actually has contracted a medically puzzling case of neuroborreliosis (neuro-Lyme disease) is a crucial example. Typically, an unrecognized infection has led parents on urgent quests for definitive diagnoses and treatments. Misidentification of the cases as MBP has resulted in tragic consequences regarding chil-

dren's recoveries and has created serious legal consequences for parents – most often the blameless mothers.

In a review of the subject, Allison and Roberts [3] averred that "The label 'Munchausen Syndrome' never denoted a coherent syndrome. From its 'discovery' in 1951, it has served [only] as a catchphrase..." Regarding the specific label of Munchausen's Syndrome by Proxy (MSBP), these authors considered the concept of such a syndrome to have been associated exclusively with the medical stigma that is too frequently attached to worried mothers of chronically ill children.

Writing in the *British Medical Journal*, Charles Pragnell [4] summed up injuries resulting from erroneous MBP labels: "... such a 'diagnosis' has had a devastating and damaging effect on many hundreds of children and families in the United Kingdom and around the world. Emotional damage is caused to children, their parents, and siblings due to their being separated and placed into state care; or where stigmatized parents avoid contact with doctors because they would be dismissed as child abusers if they presented their children for medical treatment. Consequently some very ill children have not received the medical attention they so desperately needed." Hundreds of mothers have been jailed on false MBP diagnoses (258 by one doctor alone) and thousands have had their children forcibly removed from their homes.

The intention of this paper is to explicate and justify hypotheses alternative to those represented by Munchausen's by proxy concepts, with the purpose of highlighting the positions of unjustly accused parents, typically mothers, and their children who suffer from chronic illnesses. Neuro-Lyme, a persistent disease, is the primary focus here. The article also aspires to foster prevention of such false accusations in the future. Usually unrecognized by the involved providers, misogyny on the part of physicians may greatly compromise the health of entire families.

Definitions of Munchausen's syndrome and MSBP

Munchausen's syndrome, itself, is a factitious (deliberately fabricated) disorder, manifested by

physical or psychological symptoms that enhance the perpetrator's psychological need for attention. Munchausen's by proxy, on the other hand, is supposed to be a "syndrome" in which a person, usually a mother acting surreptitiously, deliberately causes, prolongs, or feigns physical or psychological symptoms in another for the originator's self-fulfillment. Neither concept is included as an official diagnosis in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) although Factitious Disorder and Factitious disorder by proxy are described in an Appendix [5] relating to items needing further research. Both are mentioned in the proposed text revision titled DSM-IV-TR [6] as candidates for possible inclusion in forthcoming official editions.

A type of child abuse similar to Munchausen's syndrome by proxy has been shown to exist in unusual situations but a study of the literature and litigation shows that "MBP" is most often assumed to be present only after unproductive medical and other limited investigations have been employed [7]. What were once labeled as "medical challenges" by previous generations of physicians now are increasingly and mistakenly categorized as parental MSBP, causing unending trauma to all family members. This is especially a problem when children with tertiary stage Lyme disease characterized by shifting, irregular and unfamiliar neurological patterns have sero-negative blood tests – not at all unusual in these cases. Symptoms caused by infected tissues, cytokine excess, neurotoxins, cerebral hypoperfusion and other generally unrecognized encephalopathies are under-appreciated by many physicians.

The scope of the problem

Although accusations of "MBP" abound, *well-documented* cases in the USA and abroad are considered rare by many authors and researchers [1,8]. Legal hearings regarding MBP accusations usually are conducted in total secrecy so that statistics are unavailable and one is left to depend on "exit reports" of those involved, the words of politicians, and investigative newspaper reports. Mothers who have been convicted of MSBP have been released from prison only after the true cause of their child's illness came to light when the child tragically died due to the underlying causes of illness while being fostered in the state system. MSBP concepts, therefore, are under scrutiny by public, judicial and scientific communities internationally [9,10]. Of special interest to the parents of weak-

ened, Lyme-ill children, chronic fatigue syndrome "CFS" of unknown etiology in youths was described in *The Scotsman* newspaper of September 29, 1998, as a diagnosis frequently targeted for a MBP label in England and Scotland. This investigative article was entitled "The worst accusation a parent can face."

In 2002, the English Royal College of Paediatrics and Child Health authored a lengthy treatise re-defining and updating the syndrome by officially *deleting* the label of MSBP. It was to be viewed as a diagnosis no longer appropriate or helpful – "therefore recommending that pediatricians talk instead about *Fabricated or Induced Illness (FII)*": http://www.rcpch.ac.uk/publications/recent_publications/FII.pdf. [11]. This document made an attempt to be more accurate than the DSM versions as related to cases primarily of mothers ("carers") whose pathology was suspected to affect children in their charge: "In essence, we wish to increase understanding of the way in which the health care system may be used to *harm* children, rather than benefit them, and the way in which health workers may become the unwitting instruments of this harm." Unfortunately, however, the Royal College retained many of the old MSBP criteria in creating a definition of the new FII syndrome. In Article 4.7 (pages 27–8) the document states, "Existing mental health difficulties have been reported. These include somatizing and somatoform disorder (formerly Munchausen syndrome), personality disorders, eating disorders, self-harm, alcohol and drug abuse." They continued, "See "MSBP Abuse: a practical approach" Jones, Byrne and Newbould, 2000 ..." and pointed out that "Many (carers) deny their activities when challenged, may be very guarded and defensive and may seek alternative healthcare" (Article 6 – pdf page 29). A related UK Department of Health document, safeguarding children in whom illness is fabricated or induced, reinforced the changed diagnoses based on the same diagnostic criteria. http://www.cpsig.org.uk/documents/dh/dh_safeguarding_children2002.pdf.

In a news interview in Great Britain, the Government's Minister for Children discussed the staggering "burden that would ensue if thousands of falsely accused MBP families would have to be reunited after years of separation." The article quoted her as saying "We cannot reunite thousands of mothers with children wrongly taken from them." (This article by Melissa Kite, in the *Daily Telegraph*, 12-18-04, cited the likelihood of 5000 MBP cases occurring over 15 years of British MBP diagnoses.)

As awareness of frequent false MSBP diagnoses grew in England and Australia, pressure followed from a multitude of affected mothers and from some members of Parliament to disclaim MSBP as a legitimate diagnosis. The Minister for Children openly questioned “whether this is a proper diagnosis.” Reviews of thousands of cases were ordered but investigations were assigned to the agencies that originally made the diagnoses. In some cases, MBP review was not made available to parents whose case labels by then had been changed to Fabricated/Induced Illness. The United Kingdom has been forced to re-evaluate its policies for several years due to medico-legal evidence proving innocence of imprisoned mothers. The US has barely begun to question MBP concepts.

Specific components of MSBP

MSBP as a diagnosis has a number of specific features according to Appendix listing in DSM-IV [5]. These include:

(1) Persistent symptoms existing without adequate medical explanation. (2) The patient’s history appearing not to match laboratory, ancillary study or physical exam findings. (3) The patient is not the complainant; another person insists there is an illness. (4) That person fabricates, prolongs, or causes pain or illness in the subordinate one in his/her care. (5) Finally, this second person supposedly experiences significant secondary psychologic gain from identifying with and receiving attention as a result of the patient’s illness. According to these criteria, external gain cannot be the motivating factor and the behavior cannot be better explained by another diagnosis. There are other standards, however, that do not focus on the perpetrator’s motives at all [12].

The first two aspects of MBP occur in every complex illness that has no visible, specific cause so far as the extent of the examiners’ experience and knowledge of medicine goes. Thus, these two criteria cannot stand alone as reasons to label parents as creators of MBP – the remaining features are meant to be present. Otherwise, MBP stays an unsolved medical mystery – an illness or condition with which the involved doctors are not sufficiently familiar. In actual practice, use of the label of MSBP is often expanded to include a case such as that discussed below wherein the motives of the complainant and/or his girlfriend were not immediately clear.

A composite case history wherein essential criteria *supposedly* were present but which actually demonstrates confusion surrounding use of a MSBP/MBP label is as follows: (a) An infant was found to have a medically perplexing history of skin bruising. (b) Medical evaluations were interpreted as negative; (c) The baby’s father, estranged from his wife and wanting custody, agreed with baby’s doctor that the child’s mother should be accused of MBP – of making the child sick. (d) A hidden camera in the hospital documented a visitor pinching the child repeatedly. This person was identified as the childless, infertile girlfriend of the baby’s father.

Without the feature of medical-clinical-hard evidence, a “MBP” diagnosis is at best, merely speculative [4,13,14]. The “typical” example above is confusing, considering the fact that the DSM-IV specifically cautions that a diagnosis of MBP does not involve malingering, another mental illness or obvious external gain on the part of the perpetrator [5]. In the example given, the child abuser may have had all of these traits, was not the complainant, nor was she the accused MBP parent.

“Profiles” used as short cuts to accusations of MSBP

With an assumption of MSBP determined by circumstantial evidence, as frequently happens when an ex-mate of the child’s caretaker makes the charge, it is very easy for those in authority to use a MBP “profiling list” instead of facts to justify the diagnosis. The profile involves a roster of supposed “warning” signs that are vague and non-specific but also perfectly valid for normal, caring parents (e.g.) “Mother is overly solicitous when a child is sick,” Mother is medically knowledgeable, or “Mother is doctor-shopping.” By not relying on factual medical data, investigations are directed away from true causes of illness and blame is placed once again onto an active but defenseless parent, usually not the father [15]. Because these profile “symptoms” are ambiguous, “*generalized warnings*” not confirmatory signs, the idea that a true syndrome is involved has been shown to be disqualified [16]. In addition, the reasoning of accusers is circular [17]. For example, if the mother denies responsibility for causing a child’s illness, she is assumed to be “hiding something.” Parental denials are viewed then as confirmation of maternal guilt. This reasoning is outside of the scientific practice of medicine.

Influence of special vested interests upon a MBP diagnosis

There is an inherent bias in favor of a diagnosis of MSBP by a variety of special interests. A Munchausens' classification is particularly tempting to those authorities with economic, medical-political status, or other conflicts of interest. That the resultant false allegations persist is in large measure due to the highly subjective nature of a MBP diagnosis especially when the doctor is confronted with apparent diagnostic complexities of chronic diseases regularly manifested by many subjective, seemingly vague, shifting and irregular symptoms, as exemplified by tertiary neuroborreliosis.

False allegations have come from family members, the aforesaid ex-spouses (particularly in custody disputes) or from personal enemies. Without warning, children have been taken away from their mothers. These allegations are reminiscent of the tragedy of millions of persecuted women burned alive at the stake when accused by neighbors during 300 or so years of the Inquisition.

Health insurers, physicians, hired "expert" witnesses, and even school districts may have economic incentives for favoring a MBP diagnosis. This may particularly apply if a MBP diagnosis avoids future costly diagnostic tests, expensive treatment, educational accommodations or if it promises inflated consultant fees in exchange for court testimony against the parents. In the US, a mother can be sent to jail for 5–10 years if convicted for "giving misleading information" or "doctor-shopping." A provider may use the accusation to disqualify a malpractice suit if a child is injured while under his or her care [15].

Just as the diagnosis of MSBP/MBP curtails insurance companies' obligations to pay for persistent illnesses, it also rapidly gets patients with multiple problems out of medical offices, relieving providers of time spent investigating complex causes. In a blatant example of automatic misogyny, a pediatric specialist at one prestigious Maryland, USA, hospital angrily decreed a MBP diagnosis over the phone, refusing to see the mother or child as soon as he heard the referring physician's request for assistance. To the detriment of their patients, physicians who allow conflicts of interest to impact medical decisions, may intend to save time and money with a mere stroke of a pen or a phone call while attributing the mother's concern to a "diagnosis" of MSBP. This accusation may henceforth go unquestioned by medical and legal authorities.

Deprived of basic choices, mothers actually acting on behalf of their own children have been and

are being prosecuted today. Medically compromised children have been taken away from them without any proof that harm has been or likely would be done to them at home. Children have even been removed suddenly on the say-so of ill-informed physicians without their parents ever having been consulted. In such cases, *Children's Protection Services* may have been overly trusting in that they have tended to defer full analysis of the situation to the physician who made the original accusation. Parents' anguished protests have been coldly disregarded. They are silenced due to the realistic fear their further protests may increasingly jeopardize the rest of the family [18]. Helen Hayward-Brown, Ph.D., a respected authority on the subject, wrote (personal communication): "*Common patterns in these cases are fabrication of evidence against mothers, the tampering of files, inaccurate files or mixing of files with other children, and bad faith allegations following parental complaints.*" The unspoken agendas of health professionals who have a personal position to promote or something else to gain have indeed resulted in many mothers being unjustly persecuted. False allegations by overly protective authorities at school, day care, or medical facilities [18] may also arise from misinterpretation of medical findings or from patient behaviors. Many doctors and educators have not familiarized themselves with the diagnostic and treatment complexities of the on-going epidemic of neurological Lyme disease (neuroborreliosis, sub-acute borreliac encephalitis and cerebral vasculitis) in children, for example. They rarely are aware of the substantial, peer-reviewed, scientific evidence that supports a necessity for long-term treatment of these persistent multi-symptom, multi-system, infections – on-going antimicrobial treatment that is considered perfectly acceptable in the treatments of TB, acne and Q-fever, for examples. Neither are they aware of the psychological intricacies of the illness nor do they know the modern standard of care is easily available to them in published, peer-reviewed, NGC (National Clearing house-accepted) Guidelines [19]:http://www.guideline.gov/summary/summary.aspx?doc_id=4836&nr=3481&string=Lyme.

Legal aspects of MBP accusations

Although legislatures generally grant legal immunity to health practitioners who report child abuse, the devastating and sometimes irreversible medical/psychological consequences that accrue from

mistaken MSBP allegations should deter health care providers from using such nametags in cases with even remotely possible underlying medical causes [10]. The *American Psychological Association Ethical Principles* [20] and the *Specialty Guidelines for Forensic Psychologists* [21] specify that when evaluating a condition in a forensic context, the evaluator has an obligation to explore all logical alternative hypotheses about the nature and causes of an allegedly fabricated illness.

When two standards of care exist for the treatment of a particular condition, as they do in the diagnosis and treatment of Lyme disease, the appropriate question is whether the medical intervention at issue is legitimate under *either* standard of care. If so, the treatment decision belongs to the patient, or, in the case of a minor, to the parent. Hence, consultations with physicians specializing in treatments that are in accordance with the standard of care selected by a parent should be the norm [22].

A review of MBP/MSBP allegations in legal cases associated with Lyme and/or other tick-borne diseases was conducted in 1999 in the United States. In this research, 16 allegations involving 18 parent/children accused of MSBP associated with Lyme and/or other tick-borne diseases were identified. The accused parents resided in seven American states (New Jersey, New York, Connecticut, Pennsylvania, Ohio, Illinois and Michigan). There was no evidence from independent investigators that any of these cases represented MSBP; and in addition, a study of the peer-reviewed medical literature failed to identify a single *confirmed* case of "MSBP" associated with Lyme and/or other tick-borne diseases. (Personal communication about his MBP research from Neuropsychiatrist, Robert C. Bransfield, M.D. of Red Bank, New Jersey, USA).

Unfortunately, when the MSBP diagnosis/accusation is eventually proven to be erroneous and negligent in cases wherein significant harm or *even death* of the child has resulted, both physicians and Children's Protection Service workers have been allowed to hide behind the guise of *Good Faith Immunity Laws*. The physician may proclaim that s/he has a legal responsibility to report even the slightest suspicion of abuse, even if s/he had not followed standard medical guidelines for researching all possible conditions that would produce the same symptoms. CPS workers, in turn, may retort that they were only responding to the expert's opinion [15]. Eric G. Mart, Ph.D., Forensic Psychologist, begins summation of his own comments relating to the legality of MBP with these words: "The results of this analysis suggest that testimony

about FDBP (MBP) most likely does not meet evidentiary standards for admissibility." [16].

Should real injury occur or be likely to occur to a child it is customarily required that a doctor must document exactly what evidence s/he has witnessed or discovered and why these observations portend danger to the designated minor. If there is actual evidence of an immediate risk to a patient, physicians need to follow established routines such as completing and filing "Alleged Abuse" forms.

Conclusions and recommendations

If there is possible validity to accusations in a case wherein a "caretaker," usually the mother, believes that infectious disease plays an adverse influence in the health of her child, there must be direct clinical or evidentiary proof of harmful parental/caretaker misconduct before proceeding against her. Otherwise, as in all other situations representing the vast majority of cases, *the matter should be dropped*. Should health care providers persist in their MBP accusations, they must use existing systems already established to prove alleged child abuse.

The possible loss of custody of her own children should not be used against mothers as an incentive, forcing them to comply, for example, with MSBP "therapy." Such threats have been used to extract a false admission of guilt, while assuring parents that cooperation will enable a quicker reunification (Cotton Mather-Salem witch hangings and redemption concepts redux?). Neither should there be grounds for a child's removal from its parents while investigations proceed [4]. Financially and emotionally drained from their children's long illnesses, many mothers have been snared in these malicious strategies causing inability for them to mount an adequate defense [15].

In an ironic twist, as mothers have learned more about tick-borne diseases, it is increasingly likely that this knowledge will be held against them by their accusers in MBP cases. Parental use of the Internet for self-education may also be considered evidence of over-involvement with a MBP charge applied as it has been, for example, against mothers who "are preoccupied with information on the subject." Such unethical practices are unworthy of the field of Medicine and need to be prevented for the good of all. Parents' own problem-solving skills should never again be used against them to bolster accusations of abuse.

It should not be considered abuse for a parent or caretaker to bring a child to multiple doctors in sequence for further diagnosis of unexplained illnesses, and then, when aware of a diagnosis of persistent infection (chronic Lyme disease being a prime example) to advocate that the patient be treated as long-term as necessary in accordance with a standard of care published in peer-reviewed guidelines. A formal child abuse procedure should be unnecessary in most cases but when healthcare providers persist in ignoring caretakers' concerns, an abuse hearing could provide opportunity for presentation of medical evidence that could level the playing field toward the best interests of the child patient.

In all cases of alleged MSBP involving Lyme and/or associated tick-borne diseases, a second opinion should be sought from a professional healthcare provider who annually treats at least 100 cases of *persistent* tick-borne diseases. *Medically unexplained symptoms do not equal parental guilt* yet easy availability of the "MSBP/MBP" insignia has posed special dangers for Lyme-ill families in that regard. The widely held but false assumptions of unsophisticated physicians that a negative serology rules out Lyme disease infection has led to neglect of children's urgent medical needs and has indicted innocent modern mothers. Their children may audibly lament pain, malaise, and mental confusion much akin to those children whose cries brought cruel attention from the misogynous "hanging judges" of Old Salem.

Consideration of parental abuse should not occur when valid illnesses such as chronic Lyme or other tick-borne diseases are present to explain the patient's symptoms, and the patient is being treated according to an accepted, peer-reviewed standard of care [15,19,23]. Greater understanding of the role of misogyny as related to the label of MBP, especially when "MBP" is applied to chronic tick-borne disorders, may assist advocates who are attempting to defend parental rights in these cases. Since there are at least two officially described schools of thought on Lyme disease management, it is important that a parent have a right to choose personally preferred standard of care options. This concept must be supported while parents retain the right to weigh risk/benefits and likelihood of disease/pathology with their own doctors in their own family's situations [23]. Each case should be understood and judged only in respect to the system of care that has been chosen by the parent.

Emphasis should not be placed on "MSBP," but on whether or not a child has been or is actually likely to be harmed [1]. MBSP labels have tended to close medical minds toward in-depth investiga-

tions of the complex symptoms of neuroborreliosis. The lack of scientific validity involved in a diagnosis of MBP/MSBP as applied to mothers because they are concerned that their children have chronic Lyme or other tick-borne diseases, calls for further education of physicians in this vital field and for the *complete elimination of the MSBP label*. Any behavior that is observed to be actually abusive, however, should be described and reported precisely as child abuse.

Historically, authorities have all too readily blamed mothers for what they either feared, did not understand, or that which fit with their personal agendas. The Church of old was reluctant to stop women's executions long after they were known to be based on falsehoods because the Church feared culpability for wrongdoing. Likewise, today's MSBP labeling continues on in part due to some practitioners' attempts to defend prior mistakes regarding MBP diagnoses and to avoid future malpractice suits. MSBP labeling and resultant judgments against women continue to represent modern forms of misogyny reminiscent of immolation for many anguished mothers of children—children whose psyche and soma—brains to joints—have been invaded by persistent Lyme borrelia [24].

Understanding the historical roots of misogyny in MBP may help motivate uncertain physicians as they find the courage to protect worried mothers. By lending investigative expertise and compassion to families afflicted with spirochetal and other frustrating diseases, physicians can undertake professional care of such complex problems, earning maternal and societal respect while leading their patients toward recovery.

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Notation from the biography of Cotton Mather is by Doug Linder, Professor of Law (University of Missouri-Kansas City Law School) http://www.law.umkc.edu/faculty/projects/ftrials/salem/SAL_BMAT.HTM.

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