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Case Report

CHILD ABUSE IN A MEDICAL SETTING: CASE ILLUSTRATIONS OF TWO VARIANTS OF MUNCHAUSEN SINDROME BY PROXY.

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ABSTRACT

Munchausen syndrome is a complex type of abuse, which is often underdiagnosed or misdiagnosed in clinical practice, and has harmful consequences for children. Its relationship with child abuse, of which it is a variety, must be recognized in clinical and forensic practice. The authors report herein two observed cases of different types of Münchausen syndrome by proxy (MSbP). The first, is the most severe form of MSbP, with induced, true illness and related pathological symptoms into victim. The second case is a moderate form, much more complex to detect, in which a perpetrator parent simulates and aggravates the child's illness. Adequate training of health professionals and investigators is essential in revealing cases of MSbP. Diagnosis must be based on the study of the different forms of "abuse" and the knowledge of clinical protocols used to validate any suspected behaviour which could be potentially harmful to the child. Moreover, a lack of training may lead to misleading interpretations of medical history interpretation and fallacious conclusions. Our study aims to review the features that are to be considered in a suspected case of MSbP, in accordance with a recently updated consensus statement by the Committee on Child Abuse and Neglect from the American Academy of Pediatrics.

1. Introduction

Munchausen Syndrome by Proxy (MSbP) is a related type of abuse (actively perpetrated) in which those who take care of the child, often parents, deliberately and repeatedly, exaggerate the narrative of a real disease. This may manifest in thinking up a story of disease that it is not real; and/or inducing objective problems into the victim to make their own history believable [1-7]

The term "Munchausen syndrome by proxy (MSBP) "is derived from "Munchausen syndrome", a psychiatric disorder that belongs to factitious disorders, first described in 1951 by Dr. Richard Asher. People suffering from this syndrome, fabricate diseases or manufacture them by deliberately injuring themselves in some way [8]. In Munchausen syndrome by proxy, a parent will repeatedly injure their child — occasionally fatally — to gain the same attention from doctors and medical facilities. In 1977, Meadow described an extreme form of child abuse, where mothers invent false stories about symptoms of the disease in their children, or they produce such symptoms deliberately [9]. The syndrome is termed "Factitious Disorder imposed on another." (DSM V). More recently, [10-11] the term Factitious illness by proxy seems to be preferred in the pediatric setting compared to the original MSbP; nevertheless, these terms have all been used interchangeably [12]. The behavior, documented in scientific literature for cases of MSbP, includes: suffocation, poisoning, induction of infection, sexual abuse, children who have been subjected to unnecessary surgery, invasive diagnostic procedures, and supply via catheters. All this means that MSbP is abuse encompassing further abuse; therefore, it is a complex phenomenon that claims an exclusive nosographic place so as to be considered as "abuse itself." MSbP is almost never isolated to a single episode, but rather characterized by a repetition of events. Over time, the perpetrator becomes progressively more skilled, with careful attention to detail. Disputes between parents, separation or divorce could co-occur and suggest this syndrome.

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2. Characteristic features for diagnosis

Health professionals have to receive proper information about different types of abuse, and understand the features characteristic of MSbP. In this case, medical staff should include a pediatrician, and preferably a psychiatrist, a psychologist, social worker and expert medical examiner. Information must be integrated and analyzed correctly by the interdisciplinary team to minimize pitfalls. The clinical case should be evaluated by an external examiner, serving to avoid emotional entanglements that may affect conclusions. A clinical forensic examiner should be involved in the process of differential diagnosis, until all the information gathered does not disprove the existence of the abuse.

Elements of suspicion to take into consideration are:
• Co-existence of discrepancies between the medical history and what the doctor observes; or that the information is not compatible with the physical and psychological conditions (implausibility);
• The problems do not respond to therapy, contrary to what is expected;
• The events could coincide with cases of exaggeration, fabrication or induction;
• The problems seem to occur primarily or exclusively in the presence of the care giver parent;
• The problems seem to disappear or decrease when the child is removed from the parent;
• Problems recur after the doctor finds that the child has recovered, is getting better and therefore is to be discharged. Alternatively, problems recur shortly after the return of the child to home or the course of treatment is about to end;
• Careful investigation of the family of the child reveals unexplained illness and unexplained deaths;
• The suspect usually has a pattern of behavior attributable to exaggeration, fabrication and induction.
• The problems are often associated with other events (e.g. husband leaving home).
• The problems occur in a context in which external factors are also involved (financial gain).
• Induction or manipulation are observed or suspected.

As recommended by the American Academy of Pediatricians (AAP) in the last Committee revision, the medical staff, in pursuing an ever-more-elusive organic diagnosis, may lose sight of its ultimate implausibility. Essentially, two circumstances are needed to make a diagnosis of this form of abuse: harm or potential harm to the child involving medical care and a caregiver who is causing it to happen. The investigative process requires a combination of clinical observation, interviews, examination of written documents and, in the worst scenario, video camera surveillance.

The records and all facts that objectively could support the hypothesis of abuse are as follows:
• number of hospitalizations and their medical records;
• number and type of diagnostic tests performed;
• type and quantity of drugs taken; access to drugs available only on prescription (if you have other family members with diseases whose medications are available to the perpetrator);
• number of days (and related circumstances), when the child was absent from school;
• presence of any past cases of SMPP or other factitious disorders in the same family;

Case 1: Fabricated Illness in a Child: Antiepilectic Poisoning by mother

The description of C.'s medical history originates from records and documents available from the Hospital where the child was in treatment for more than one year. Interviews from health care professionals (psychiatrists, psychologists, nurses, social workers, medical doctors) were taken into consideration for a conclusive diagnosis.
C., a six year old girl, was born in 2003 in a small town in southern Italy. In 2010, she was referred to the emergency hospital department due to an accidental fall which had occurred at home; neuroimaging protocol was immediately applied to exclude brain hemorrhages. C. was transferred to the Department of Child Neuropsychiatry where she underwent electroencephalographic procedure. VPA (valproic acid) therapy was initiated; the girl was discharged from hospital after nine days; the recovery was complicated by respiratory infections.
After a month and a half, however, a second hospitalization was needed, because of a side effect from VPA (blood counts alterations and alopecia). Valproic acid was then replaced by Oxcarbazepine and Clobazam. The second admission was followed by five more admissions with increasing frequency, due to epileptic episodes described by the mother. These episodes had progressively long lasting post-ictal symptoms, not compatible with the clinical picture. In the most recent episodes, the post-ictal syndrome was interpreted as a drowsy state.
On the seventh day of the child's last hospitalization, doctors had excluded all possible etiological hypotheses (encephalopathy, cerebral hemorrhage, generalized epilepsy). The complete list of all medical procedures applied to C., are reported in Table 1.
Physicians had to exclude the voluntary administration of drugs depressing the nervous system (BDZ). The toxicological examination of urine sample showed an alarming overdose of Clobazepam, not compatible with drug therapy. Since it was very difficult to separate the mother from the child, doctors decided to keep C. in the Resuscitation Unit.

• Inconsistency between reported history and physical examination and instrumental;
• The symptoms do not respond to therapy;
• The problems seem to occur mainly in the presence of the caregiver suspected;
• The symptoms resolve in the absence of the caregiver;
• At a time when illness seems to meet a resolution an inespicable relapse happens;
• Family histories of abuse or neglect;
• A pattern of behaviors attributable to exaggeration, fabrication and induction regarding perperator himself;
• Illness in children usually takes place concurrently with events of family crisis (separation of spouses);
• Problems may arise in a context in which they are involved also external factors (financial gain);

Table 1 - Indicators of possible fabricated illness in a child

Once separated from the mother, C. awoke, thus confirming the suspicion of a Munchausen Syndrome by proxy. Family medical history, revealed that the mother suffered from anxiety and major mood disorders. The case of C. was reported to the Juvenile Court and to the community care services, to provide for care of the mother and the entire family.

Case 2: Medical travelling and manipulation

The following case required a period of direct observation extending from September 2012 to March 2013. The clinical observation comprised also three interviews in a neutral environment and five interviews on the phone. Two of the three conversations involved the mother and the younger sister of the child, and a final meeting involved all family members. At the end of each meeting, a team composed of psychiatrists, psychologists and medical experts, gathered to discuss items which emerged from each observation, and were able to develop their own values.

In addition, the medical staff utilized documents available from the hospital brought by the mother.

Z., was a thirteen year old, born in January 2000 in a region of Northern Italy, suffering from symptomatic focal epilepsy due to cerebral palsy (spastic-dystonic quadriplegia). On the fourth day of life, Z. showed signs of intracranial hypertension, and, given the presence of hydrocephalus, she underwent emergency surgery for implantation of an external device, which had to be replaced on two other occasions within the following month. In February of 2000, a ventricul-peritoneal device was implanted and replaced in the June.

In 2003, her clinical condition was complicated by the occurrence of the epileptic problem, characterized by deviation of the right eyeballs, diffused hypertonia, clonus of right hemisoma with loss of contact followed by post-ictal sleep. Valproic Acid therapy was then introduced.

From 2004, Z. was followed simultaneously by two hospitals in the city where her family lived and at other major level hospitals, she was also regularly monitored at the hospital where she was born. In total, she was referred to five institutions between hospitals and advanced health centers. According to the opinions of most of the medical specialists who visited the child, the disease was controlled by medication; psychomotor development proceeded according to plan which seemed to give the expected results. In 2006, the family started a long series of “medical travels”, in order to undergo visits by "reputable" doctors, scattered throughout Italy and Europe [Florence in 2006, Poland from 2006 to 2008, Sorrento (Na) 2007, Germany 2007-2011, Aosta 2009, Bari 2010, neurosurgical consultation with renowned professor US (NY), Foggia 2012 neurosurgical consultation, Milan 2012, Turin from 2000 to 2012].

To date, Z. continues to be followed by the various hospitals and persists in the pilgrimage to which she is submitted by her mother. The woman, thirty-two, from a wealthy family, whose parents split up when she was still a teenager, on several occasions has shown a detailed knowledge on the medical field, as well as a remarkable ability to manipulate the opinion of the doctors with whom she comes into contact.

3. Conclusions

‘Münchausen syndrome by proxy’ is a complex kind of abuse, often underdiagnosed and misdiagnosed, and its consequences may have a significant impact. Pathologists or clinical forensic physicians may be called upon to confirm – or even detect – how and by whom the injuries have been inflicted on the child [13]. As a possible object of clinical forensic practice, this clinical entity is worthy of investigation also in medico-legal literature. [14-24]. These two cases represent two different types of MSBP, requiring multidisciplinary cooperation between pediatricians, medico legal experts, child neuropsychiatrists and nurses. The first here documented is of the most severe form, in which the author actively produces disease symptoms in the victim, while the second case is a milder form, more complex to diagnose, in which the author simulates and aggravates the illness of the victim through the presentation of a false history of a disease or condition that is not real [25]. In both cases, a lot of time was spent on the formulation of a clear diagnosis of MSBP. This was due to a lack of knowledge of the phenomenon related to abusive behaviour, and unavailability of standardized protocols used to detect it. “Simulation” is the most common technique used by an abuser, and abuse is never limited to a single episode, but it is repeated with increasingly specific details [26]. The "conscious purpose" of the abuser must not be underestimated and, in this circumstance, the psychiatry and forensic science disciplines should merge their competencies to ensure the effective protection of the child, as the first and absolute obligation. Rehabilitation of the guilty parent must be done only after the child has been taken into custody, if necessary. A comprehensive grounding of child "abuse" phenomenology and the creation of rating scales that can validate the intuition or the suspected diagnosis of a phenomenon so detrimental to a child’s growth is required.

Exaggeration, fabrication and induction, are the three main manifestations of a potential perpetrator. Knowledge of these, when faced with possible MSbP, allows health professionals to anticipate future moves of the perpetrator; no hypothesis should be excluded, and the possibility of the worst clinical scenario ensures serious consideration of any new item collected. This consideration allows for such items to become decisive, so that the suspicion at any time may be refuted or confirmed, thus preserving the life of the child [27-30].

In this regard, as recommended by AAP, to make the diagnosis physicians must firstly ask whether the history, signs and symptoms of disease are credible; secondly, whether the child is receiving unnecessary and harmful or potentially harmful medical care [7]. Child abuse is not a diagnosis of exclusion; to date, however, more training in skills and competencies for paediatricians is required; as they run the risk of stumbling into an erroneous interpretation of a clinical case and drawing false conclusions. Bridging this gap of training is essential, considering the sensitivity of the issue. The victims of MSbPare often not known; correct diagnosis is paramount, in an effort to minimize the impact on child health because some acts of custody, even if motivated by good intentions, could have an equally negative impact.

Each story in life, as in medical practice, is characterized by its absolute uniqueness and individuality, which is why it is good practice not to come to rapid conclusions and to always bear two principles in mind: those of "beneficence" and "do not harm".

This ensures the protection of patient health and integrity; in the knowledge that making choices, even though motivated by good intentions, could have irreparable consequences.

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