Munchausen syndrome by proxy and child's rights

Fatima A. Al-Haidar, MBBS, KSF.

ABSTRACT

تعد متلازمة منشهاوسن بالوكالة إحدى الصور المتقدمة لإساءة معاملة الأطفال ، حيث يحدث المعتدي إصابات قد تودي بحياة أطفاله . وقد تم عرض لحالة متلازمة منشهاوسن بالوكالة بشكل يوضح صعوبات تشخيص ومعالجة مثل هذه الحالات في هذا الجزء من العالم، إذ حتى يومنا هذا لا يوجد تنظيم وطني محدد في المملكة العربية السعودية للتعامل مع حالات إساءة معاملة الأطفال عموماً وحالات متلازمة منشهاوسن بالوكالة على وجه الخصوص. وقد ختمت الحالة الوصفية بالتوصية ببرامج حماية وطني يتسم بالإعداد الجيد .

Munchausen syndrome by proxy (MSBP) is an extreme form of child abuse in which perpetrators induce life-threatening conditions in their children. A case of MSBP is described in detail. Difficulties in diagnosis and management in this part of the world are presented. Until now, no national legal guidelines exist in the Kingdom of Saudi Arabia (KSA) to child abuse in general and MSBP in particular. Urgent guidelines, policies, and legal system are required in the KSA.

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From the Division of Psychiatry, King Khalid University Hospital, Riyadh, Kingdom of Saudi Arabia.

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Address correspondence and reprint request to: Dr. Fatima A. Al-Haidar, Division of Psychiatry, King Khalid University Hospital, PO Box 7805, Riyadh 11472, Kingdom of Saudi Arabia. Tel. +966 (1) 4671717. Fax. +966 (1) 4672571. E-mail: alhaidar4@hotmail.com

In 1977, Dr. Roy Meadow described Munchausen syndrome by proxy (MSBP) as an extreme form of child abuse in which parents actively induced life-threatening conditions in their children.[1] Two categories of MSBP can be distinguished, the first one is simulation which is mild and a rare form. This occurs when the perpetrator verbally feigns an illness of the victim by presenting an untrue history of a non-existent illness or condition, which may lead to hospitalization and possible invasive diagnostic and therapeutic measure. The second one is production, which is severe and the most frequent form. In this form the perpetrator actively produces symptoms of illness in the child.[2,3] In fact, the concept of MSBP is not included as an official diagnosis in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV), although a factitious disorder, and factitious disorders by proxy are described in an appendix relating to items needing further research. Both are mentioned in the proposed text revision titled DSM-IV TR as conditions for possible inclusion in forthcoming official editions.[4,5] If someone looks to the diagnosis of MSBP, it is very difficult to establish. Sometimes it takes years, sometimes it might only be possible retrospectively after the suspicion has been raised.[6] Lack of clarity of the diagnosis, or its certainty may lead to legal implications. This may result in misdirected legal decision, judgment, and harmful or deadly outcome for children. Also action against doctors who have diagnosed MSBP brought by an alleged perpetrator of MSBP covers a wide spectrum of activity that ranges from justifiable litigation at one end, through harassment to criminal act at the other.[7] The management may be considerably affected by the role and expectations of parents in different cultures, and by local legal structures set up to deal with child abuse, for example, neutral professional foster homes will probably not be available in developing countries where the primary disposition is almost always placement with relatives. Also, some countries lack child protection law and agencies. Other that do have laws lack an enforcement structure or legal protection for clinicians whose good faith reports of abuse are not corroborated.[8] The lack of national guidelines or legal regulations in the Kingdom of Saudi Arabia (KSA) towards managing cases of child abuse has been noted.[9] A literature review revealed no structured national guidelines for child protection in other Arabian Gulf countries as well. In KSA there have been calls for the establishment of a national committee for prevention and management of child abuse and neglect, which will make reporting of child abuse cases mandatory and facilitate multidisciplinary team management of the affected children and their families.[9,10] This case is presented to highlight some difficulties in diagnosis and management of MSBP in the presence of poor social support and absence of a legal protective system.

Case Report. A 7-month-old Saudi boy is a product of 35 weeks of gestation with birth weight of 1.8 kg. After delivery, he was kept in the neonatal intensive care unit for 2 weeks due to mild respiratory distress, otherwise, his clinical examination and investigations were within normal limits. Developmentally, he is age-appropriate. At 5 months, he was presented to the emergency room with grunting and irritability. He was admitted to the hospital and treated as pneumonia. Incidentally, chest x-ray showed bilateral multiple rib fractures **(Figure 1)**. So, child abuse was suspected. A skeletal survey was carried out for him at that time and revealed no abnormality. Investigation for child abuse was non-conclusive, and he was discharged home. One month later, the child was admitted to the hospital again through the emergency room with history of irritability and vomiting. Physical examination revealed an irritable child with 2 symmetrical oral ulcers in the hard palate. Head circumference was normal but the anterior fontanelle was slightly tense. Eye examination revealed retinal hemorrhage, and brain CT scan showed large subdural collections of 2 densities suggesting old hemorrhage (hygroma), and brain atrophy **(Figure 2)**. Non-accidental injury was highly suspected. A form was filled up and faxed to the Ministry of Social Affairs (MSA). The parents were interviewed by members of the Ministry, but denied any sort of abuse, and the child was discharged home. On both admissions, the child and his parents were not evaluated by a child psychiatrist or psychologist. One month later, the child was admitted to the hospital for the third time through the emergency room with injuries and swelling of both feet and scrotum **(Figure 3)**. He was managed as a case of cellulitis, but child abuse was suspected. On this admission, the child psychiatrist was consulted. The child and the parents were evaluated psychologically, and socially. Assessment revealed a mother who is a 32-year-old high school graduate working as a clerk. The father is 9 years younger than the mother with a 6th grade education, holding a simple job with poor income. The parents have financial difficulty and debts. The mother was a rather difficult person, demanding with restricted emotional interaction with her son. She expressed marital dissatisfaction and social difficulty. The father tends to be passive, and over-protective for his wife. Child abuse was highly suspected, the mother was expected to be the perpetrator, and a diagnosis of MSBP was considered. The case was reported to the Ministry of Social Affairs but with no response. Efforts to approach members of the extended family or other relatives have failed. Although the parents rejected the idea of child abuse, they agreed to sign a contract that the father will be the responsible figure for the child protection and safety and he will be responsible for bringing the child for his regular visits to the pediatric clinic and the mother signed a contract to attend psychiatric out-patient clinic

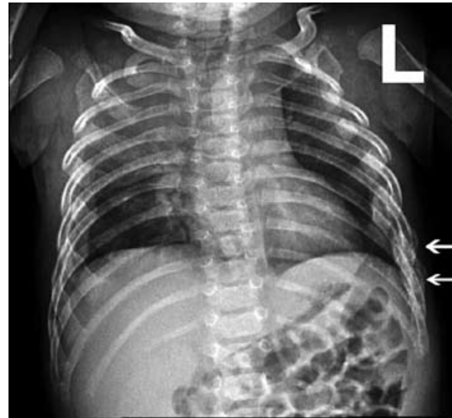

Figure 1 - Chest x-ray showing bilateral multiple rib fractures.

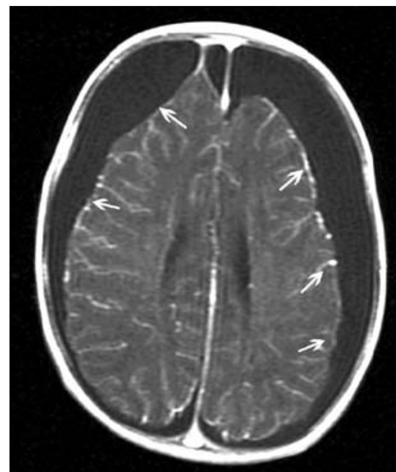

Figure 2 - Brain CT scan showing hemorrhage and brain atrophy.

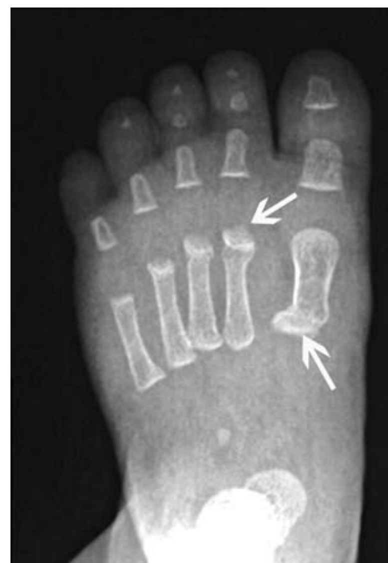

Figure 3 - Bone x-ray showing left foot swelling.

regularly to improve her skills in dealing with stress, and child care. Unfortunately, they did not comply with the contract and the Child Protection Unit of the MSA did not show any active response. Reviewing the case note of the child in the hospital has revealed no further follow up over 10 months.

Discussion. This case reveals 3 difficulties that may be faced when dealing with patients of MSBP. The first one is confirming the diagnosis of MSBP. The second one is the absence of social support that can help in protecting the child when the expected perpetrator is a parent. The third one is a poor legal protective system that is expected to protect the child from further abuse and ensure child safety and well-being.

Looking at the first difficulty, although the child was admitted 3 times to the same hospital with presentations suggestive of child abuse, the treating team failed to obtain a confession from the expected perpetrator or a clinical incontrovertible evidence of the commission. There are different degrees of diagnostic certainty, definitive diagnosis of MSBP, possible diagnosis of MSBP, inconclusive determination, and definitely not. The definitive diagnosis of MSBP is the clear diagnosis. It can be made either by inclusion or exclusion. Inclusion is the one supported by incontrovertible evidence of commission, for example, when the perpetrator was captured while conducting the act of abuse directly or via covert videotaping, while a diagnosis by exclusion is the one where all other possible explanations for the child's condition have been considered and excluded after all exhaustive investigations are carried out, and all possible medical conditions are definitely excluded.[7] A possible diagnosis of MSBP is one amongst several likely diagnoses when no other explanation is readily apparent and no findings appear to exclude illness falsification and the condition cannot be fully explained medically despite a reasonable initial evaluation at least.[7] Inconclusive determination means that though the collection of data is complete, the data is insufficient to establish the diagnosis of MSBP or eliminate it confidently.[7] Definitely not means that the diagnosis of MSBP is absolutely eliminated.[7] According to the above description, the diagnosis of MSBP in the presented case is the definitive diagnosis by exclusion. The issue of definitive proof is an important one to protect children from abuse, and the care taker from false allegation.[11]

The second difficulty in managing this case was the poor social support. The presence of the extended family and supported social net in developing countries like KSA allows for great protection against abuse by one member of the family and offers a chance of a foster family with the extended family when it is for short period, for example, during the period of investigation or rehabilitation of parents, or for ever when the parents are not fit to care for the children. In this situation, no relatives were available to give further history or to take care of the child. The last and the most important difficulty in this case is the absence of active legal regulation that offers protection of the child from further abuse and forces parents to indulge in family counseling or parenting programs.

Previous reports from KSA have made the medical community aware of maintaining a high index of suspicion for detecting cases with child abuse.[9,10,12] Beside published medical articles, local magazines and newspapers have reported cases of abused children and raised the issue of child abuse, and the urgent need for a legal system of protection. Calling for urgent establishment of a national committee of prevention, and management of child abuse and neglect in KSA has been carried out many times as well.[13] Such a committee has been established recently in KSA. However, establishing the committee is not the problem. The important issue is the quality and the functioning of such a committee. Resources, preparation, good quality, effort, and time are needed to make such a committee active, functioning, and beneficial. Involving the actively working figures from the social services department, police, medical staff, religious heads, and volunteers are also essential.

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