Case Series

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Paediatric Symptom Falsification ('Munchausen Syndrome by Proxy') – Psychiatric Manifestations

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ABSTRACT

Aims

The aim was to explore the importance and inherent challenges of child abuse presenting with spurious psychiatric manifestations ('Munchausen Syndrome by Proxy') through a case series.

Methods

Three cases of child abuse are described, each presenting with falsification of psychiatric features and symptoms by caregivers. Similarities and differences from classical 'Munchausen Syndrome by Proxy' are explored, and the nosological status of this entity is discussed.

Results

1. Caregiver characteristics resembled those in classical 'Munchausen Syndrome By Proxy'. 2. Cases differed from typical medical presentations in age at presentation, in course, and in prominence of educational consequences. 3. The relationship of the mother with the child's physician was less prominent than some suggest in classical 'MSBP'.

Conclusions

The incidence of Paediatric Symptom Falsification may be higher than generally believed, and psychiatric presentations differ from classical presentations. Reporting to child protection agencies is essential, but this is difficult and tends to be avoided for various reasons. There is a need for more education of mental health and allied professionals about this condition to prevent the suffering of many children. 'MSBP' involves psychological problems in the mother which are very difficult to manage, and which require understanding and compassion, but which should not be a barrier to protecting the child. In so far as it describes a situation and not a disease, 'MSBP' is a disorder only by analogy. Provided this is borne in mind, its difference from other forms of child abuse argues for the retention of a specific descriptive name, so that it can be better detected and prevented.

KEYWORDS

Munchausen Syndrome by Proxy; Paediatric Condition Falsification, Paediatric Symptom Falsification; Psychiatric

Introduction

'Munchausen Syndrome by Proxy' (MSBP) was first described by Meadow in 1977 [1], as a form of child abuse in which the caregiver (generally the mother) causes or simulates illness in the child for psychological gain. Three features are required for diagnosis: 1. The history, signs and symptoms of disease are not credible; 2.The child is receiving unnecessary and harmful, or potentially harmful, medical care; 3. If so, caregivers are instrumental in instigating the evaluations and treatment [2]. As has been emphasized, the motivation of the mother (her psychological needs), is important in distinguishing MSBP from other forms of Paediatric Condition Falsification (PCF) [3]. Initial reports described young children with acute, life-threatening events, such as sleep apnoea, epilepsy, diarrhoea, or bowel obstruction [4,5]. Sudden Infant Death Syndrome (SIDS) has an ominous association with MSBS which has survived controversy [6-9]. MSBP has been reported in children in learning disability settings;[10] whereas there have been few, if any, reports in general child psychiatry. Causal factors for this may be that it is perceived to be less exciting, of a multi-disciplinary nature, and, arguably, due to more humdrum circumstances which surround it. Initial descriptions, indeed, required that the child present with organic symptoms [11]. Psychiatric presentations may be more difficult to detect because of the paucity of objective diagnostic tests, with the consequent greater reliance on the history provided by caregivers. Caregivers who simulate school refusal in their children have been considered not to have MSB [12], (though they do show PCF). The exclusion of psychiatric presentations is noteworthy, because such psychiatric presentations may differ in important ways from the typical, dramatic, presentations seen in very young children. Since psychiatric diagnosis in children is so dependent upon parental history, such cases may also be more difficult to detect, and therefore more common than previously thought. Three cases are described here, which, though typical of MSBP in many ways, differ in their psychiatric symptoms, in their age, and in the prominence of school refusal.

Cases

Case X

This girl was born at 37 weeks gestation by emergency caesarean section because of a slowing of the foetal heart rate. She was the eldest of 4 children. Her father was severely disabled with a chronic degenerative disease. No distress was evident at birth, but she had short stature (3rd centile for height

and weight). At 9 years of age, she presented to a Child & Adolescent Mental Health service with low self-esteem and an eating problem. Her parents attributed this to bullying at school, which, the mother told doctors in a subsequent interview, took place when the child was 7, and was characterised by beatings so severe as to leave her with multiple bruises, and 'a voice which changed following this trauma'.

The girl was found to have an IQ in the borderline range. Her mother reported that she had 'allergies to milk and eggs'. At another interview she said the allergy was to 'shellfish and nuts', and that it had been discovered when she developed an anaphylactic reaction in another country at 18 months of age. The mother also claimed that eczema was diagnosed at that time. Her diet was restricted, and her mother commented that she 'needed to buy special foods', and that 'asthma developed at age 7'. The child was found to be unhappy, but not depressed. There was no evidence of weight loss, but an eating disorder was diagnosed on the basis of maternal reports.

X's brother had been diagnosed as having ADHD, and was prescribed psychostimulants. Aggression and odd behaviour had given rise to suspicion of an autism spectrum disorder. After a number of assessments, no diagnosis was made. Compliance with medication was a problem, the mother claiming that, although she personally administered tablets, he had somehow avoided swallowing them, and adduced this as a reason for their lack of efficacy. The mother later reported that 'he was doing extremely well off all treatment'.

The mother expressed dissatisfaction with the attention and care her daughter had received from one service. However, a letter, written shortly afterwards, gives an insight into her personality, and the relationship which had developed with professionals. She wrote: 'I did not realise I was so overpowering towards you all... I only feel constant pain & hurt at what has happened to our daughter. Let me know if you do not want to see us anymore.'

It was at this point that the ability of the parents to care for their children was questioned, when it was discovered that the mother had been leaving the children unsupervised overnight, so that she could help with a scout camp (with which none of her own children were involved). School authorities were also alarmed that the children were left unsupervised for long periods before school opening, and that they arrived hungry and dishevelled. The mother opposed involvement by social services, and, in the absence of any formal complaint, they were not notified.

Unhappy with the treatment she received from her psychiatrist, the mother sought a second opinion. To this doctor, the mother reported that there had been an increase in frequency of nocturnal enuresis at 7 years. She reported that her daughter was happy at school, but that there were problems at home. She reported that her daughter was 'unable to swallow solid food'; she was 'able to take liquidised food only', and 'she became increasingly anxious about solids'. The mother said she had contacted the Anorexia Nervosa Society 'who advised she had a phobia about food'. The mother reported that when she gradually re-introduced solids, eating recovered and that appetite returned.

At 14 years, X's mother told a paediatrician that her problems started at age 7, when she had been bullied by several children in the class. This doctor found her to have constitutional short stature. No allergies were reported or found. The mother resisted attempts to obtain copies of previous medical records. A neurologist found 'no evidence of regression'. The mother quoted a paediatrician to another professional as having said, 'It would be disastrous for her if she had a period', and she told another paediatrician that the referring doctor had said she was being referred, 'to sort out her psychological problems immediately'. She was referred to a third child psychiatrist, who found low mood, social withdrawal, and 'recent adjustment problems'. She was then referred again to local psychiatric services for follow-up. At this stage, her mother wrote: '... it is now confirmed that her short stature has a psychological basis, and that this started at 6 years of age because of bullying'.

At her mother's insistence, X was seen then by another psychiatrist, 'to discover the psychological cause of her short stature'. No psychopathology was found. Mother declared that she was 'astounded' and demanded to know how the doctor could explain 'the dramatic fall in IQ which had taken place at age 10'.

By the time of referral to social services, the child had been seen by 3 paediatricians, 4 psychiatrists, and numerous other mental health professionals.

Case Y

This boy was born without complication, developing normally up to middle childhood. When he was 3 years old, a younger sister was born. She died at the age of 3 months, and a coroner's verdict of SIDS was returned. His mother experienced a pathological grief reaction.

The family holidayed abroad periodically; such trips were frequently marked by attendance at the A&E department of the local hospital, where the boy presented with sundry somatic complaints. There were occasional brief hospitalisations, but no physical abnormality was ever diagnosed.

The child's mother made several unsubstantiated allegations of bullying at school. His father disputed these, though he did not oppose them. Thorough investigation failed to substantiate any such episode. The father complained to doctors of his powerlessness in the face of his wife's over-protective, domineering approach; he recognised the harmful effect this was having on their son.

Whereas the mother complained that her son had 'loss of interest', 'poor concentration', was 'not eating', and had suffered weight loss; the boy told doctors, 'I'm good at school'; and 'I'm always happy with my friends'.

His mother had a benign brain tumour, which had presented initially with epilepsy when she was in her teens, but was well controlled. During her mid-40's, she presented frequently with pseudo-seizures and other odd neurological symptoms. To each doctor she met, she presented herself has having a 'terminal brain tumour'. She told her neurologist that she was 'distancing herself from her son', as she was 'going to die soon', and 'he would have to be tough enough to get on without her'.

On one occasion, when brought to hospital because of suicidal ideation, Y commented that 'school was good', and that he had 'a few good friends'. He listed a few favourite subjects, and responded appropriately to wishes about the future. The conclusion was that he was euthymic. Notwithstanding his reports to doctors, he was kept at home for prolonged periods because of 'bullying'. The mother claimed that her husband 'can be abusive to the child when angry', though the impression of numerous psychiatrists was that he had a passive, dependent personality. He begged professionals for help in protecting his child, and when a referral to social services was eventually made, he was profuse in his gratitude.

Case Z

This boy's monozygotic twin brother presented to a private psychiatrist at 1 ½ years of age with 'behavioural problems', and a diagnosis of autism was made. No standard observational assessments were performed, nor neurodevelopmental history taken. He was referred to specialist autism services, who found no abnormality following a multi-disciplinary assessment. When the twins were 7 years of age, the mother brought the other twin, Z, to community child psychiatric services with vague concerns regarding 'development' and 'social skills'. By this she meant that he '[had eaten] his food off the floor when he was younger', and that he currently 'behaved in a silly, immature way'. She said that 'teachers complained of disruption', and she, in turn, complained of poor cooperation from the school. Independent contact with the school disclosed no such behavioural concerns. Her husband spent most nights away on business, and the twins slept in her bed. They 'would not settle for hours' and she 'had to sing to get them to sleep'.

His mother had been treated for depression in the past. She reported that she had given up her job in order to look after her children, whom she felt had 'special needs'.

At clinical interview she was extremely reluctant to leave her son, and her prolonged departure from the room was accompanied by exaggerated displays of affection, which clearly embarrassed her son. He, on the other hand, separated easily. On his own, he was initially reserved, but became talkative and happy when discussing his friends, school, interests, etc. There was no evidence of any autistic-type disorder, nor indeed any other psychiatric problem.

At the time of writing, she has refused to accept the assurances of two different services that there was nothing wrong with her son, and she was continuing with attempts to have him re-assessed.

Discussion

All three of these children presented with complaints from mothers, which, while perhaps credible in isolation, became more and more far-fetched when viewed together as a whole. In all cases harm resulted to the child from excessive investigation, social isolation, and absence from school. In all cases, mothers had narcissistic personality problems, and fathers had a subordinate role (one because of chronic illness, another because of a dependent personality). All children had siblings with dubious or unexplained illness. All cases involved many physicians and allied professionals, who became involved in what transpired to be, when they started to communicate with one another, a pattern of simulated illnesses and symptoms. There was a general reluctance to refer to social services, and a delay in their involvement, perhaps because of the absence of acute or marked abuse, and because the caregivers seemed the opposite of the 'typical' negligent, abusive mother. These children were somewhat older than most cases of factitious disorder by proxy, who also differ in presenting with acute, life-threatening events or surgical emergencies. Although probably less lethal, psychiatric presentations may offer more scope for abuse, due to the greater reliance on parental reports in child psychiatry. Unwitting collusion by schools, in part caused by an understandable sensitivity to bullying allegations, may have facilitated presentation to psychiatric services.

Most cases of MSBP have emerged from the U.S. The phrase 'Psychological needs' has been emphasised, and suggests vagueness, an impression strengthened by the initial psychodynamic terms in which these case were couched. It may be a useful term, nonetheless, in that it distinguishes motivations such as revenge, delusions, or poverty, from those in which the perpetrator behaves in this way to, for example, fool doctors or exhibit herself as an ideal parent [13]. Schreier and Libow [14] suggested that a key psychological factor may be an ingratiating relationship which the mother pursues with the child's physician, who tends to be male, isolated, and idealistic. The preponderance of mothers among perpetrators may be due to a satisfaction obtained by deceiving 'authority' or 'power' figures, but this (and any other explanation) has not yet been substantiated. Such manipulation was not present in any of these three cases. This may be due to the central role which the family doctor retains in many other countries, and to the multi-disciplinary nature of health care, particularly mental health services, in other health systems, which precludes the doctor from seeming a 'hero figure'.

'Munchausen Syndrome by Proxy' is clearly not a disease, and can be considered a disorder only by analogy. This, as well as the general tendency in medicine to abandon eponymous diagnostic labels, argues for use of the term 'Paediatric Condition Falsification', preferred by the American Professional Society on the Abuse of Children (APSAC) [15]; or 'Factitious Disorder by Proxy', as preferred by the Diagnostic & Statistical Manual of Mental Disorders (DSM) [16]. Notwithstanding these compelling reasons, the radically different profile of the 'caring mother', in cases like those under discussion, make it essential to distinguish the situation described in this case series from other circumstances in which mothers harm children. The mother's motivation is crucial if the child is to be protected: specific remedies in other circumstances may offer hope of an amelioration, but the rate of recidivism in 'Munchausen Syndrome by Proxy' [17,18], means that these children will require vigilance and protection for as long as they are in contact with their mother.

It is important to consider how these episodes might have been detected earlier. Good history-taking would have revealed the falsehood of an allergy to dairy products in the first case. A higher index of suspicion might have led to greater communication, and better detection, among disparate professionals as in the case of Munchausen Syndrome in adults. Formal channels for reporting concerns without fear of recrimination could be established in hospitals and out-patient settings. Greater institutional support for healthcare workers with concerns, as well as broader awareness among family doctors, nurses, psychologists, and social workers, is a prerequisite. In medical presentations, a bizarre, inconsistent history, a failure to cooperate with attempts to obtain medical records, features of a maternal histrionic or narcissistic personality, and any history of abuse towards other siblings, should raise the alarm. These apply also in the case of psychiatric presentations. In medical presentations, abuse can be detected by observing 'recovery' of the child when removed from the parent's reach. The chronicity and gradual nature of psychiatric symptoms make these cases appear less dramatic, and such a 'test' impractical, but certain other features may help. Unconvincing reports of bullying at school, despite thorough investigation, poor school attendance without an adequate explanation, and an incongruity between maternal reports and the child's mental state, may all be helpful.

Conclusion

Reports of Psychiatric presentations of Paediatric Symptom Falsification are rare, but there are good reasons for suspecting that the true incidence may be higher. Psychiatric presentations are probably not typical of Paediatric Symptom Falsification, and may for this reason be missed. Experience shows that reporting to child protection agencies is essential, but this is difficult and tends to be avoided for various reasons. There is a need for education of mental health and allied professionals in this condition so that much suffering of children can be avoided. Paediatric Symptom Falsification involves psychological problems in the caregiver (generally the mother), which are very difficult to manage. These require understanding and compassion, but should not be a barrier to protecting the child.

The authors declare that they have no conflict of interest.

Competing Interests
None declared
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