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Munchhausen Syndrome by Proxy with Psychiatric Features

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Abstract

Although Munchhausen syndrome by proxy (MSP) with somatic expression is a familiar diagnosis to paediatricians and psychiatrists, the psychiatric form has remained more confined to the literature. This clinical form is distinguished by the allegation of artificial psychiatric disorders to convince others that a child suffers from these disorders. After an update on the classic form of MSP via somatic expression and its diagnostic issues, we present a brief review of the literature to explain the peculiarities of MSP with psychiatric expression. We detail the psychological complications for the child through a case report and analysis that illustrate the difficulty of identifying this particular disorder, the treatment of which is complex. The delay in diagnosis is several years, during which time the symptoms can be recast to mask a psychiatric reaction to this particular form of abuse. The suffering of the child and his parents will be shortened if the diagnosis is quickly established and the appropriate treatment is instituted.

Keywords Munchhausen syndrome by proxy; Schizophrenia; Differential diagnosis; Professional-family relations; Psychopathology; Treatment

Introduction

Munchhausen syndrome by proxy (MSP), first described by Meadow in 1977, is defined in the International Classifications of Diseases as a factitious disorder by proxy [1,2]. This pathology, expressed through the intermediary of a child, constitutes serious abuse. Although MSP has long been misunderstood by practitioners, it is now a subject of great editorial interest, particularly in paediatric literature. Because of the emotions and questions that this syndrome raises, the media regularly refers to this issue. Therefore, the general public is currently well aware of MSP. After an update on the classic form of MSP via somatic expression and its diagnostic issues, we present a review of the literature to explain the peculiarities of MSP with psychiatric expression. This clinical form is characterized by the allegation of artificial psychiatric disorders to convince others that a child suffers from these disorders. We detail the psychological complications for the child through a case report and analysis that illustrate the difficulty of identifying this particular disorder, the treatment of which is complex.

I… Munchhausen syndrome by proxy with psychiatric features

Classical description of MSP

In the classical description of MSP, a young child suffers from atypical symptoms of paroxysmal evolution. However, the clinical and paraclinical exams do not find any physical etiology. This discordance exists because the symptoms are alleged and / or produced by an abusive adult who plays the sick role through his or her child. The parent who fabricates the symptoms is often the biological mother, particularly in medical situations or early childhood. Intensely "devoted" to her child, she initially attracts the compassion of the care team and becomes a ubiquitous presence in the hospital. Eventually, the fluctuation and temporality of the symptoms begin to cause doubts. When the family's deception is about to be foiled, the parent that induced symptoms becomes ambivalent and even aggressive towards caregivers. The family and the child must then be monitored, as they would otherwise continue their medical nomadism. It should be noted that the child may take an active part in the deception [3]. Moreover, the medical profession, which is exploited in this case, is indirectly involved in the child abuse. Invasive paraclinical examinations are sometimes conducted and very often treatments with side effects are administered: in addition to the resulting morbidity, there is an overconsumption of treatment. The psychological effects on the child can be multiple, combining anxiety disorders, mood disorders, attachment disorders and finally factitious disorders when the child takes part in the deception. The parent who induces the disorder, often having suffered serious abuse or neglect in childhood, generally has a history of somatization disorder, self-mutilation, voluntary drug intoxication and dangerous use of psychoactive substances. Prevalent personality traits are histrionic and borderline.

Fabricated psychiatric form

Many fictitious somatic symptoms have been described, with a predominance of bleeding, apnea, fever, convulsions, and hypoglycaemia. Psychiatric forms are likely frequent but understated, and very few clinical observations are referenced in the literature. However, Bools noted cases of poisoning by psychotropic substances and other causes of neuropsychiatric disorders [4]. Furthermore, Giniès et al. [5] described the clinical case of a child whose mother administered suppositories containing a solution of noramidopyrine to the child to induce neuropsychiatric and digestive symptoms [5]. Fischer et al. reported a psychiatric expression of MSP in the form of fabricated schizophrenia with allegations of oddities and visual hallucinations [6]. The clinical presentation of MSP with psychiatric features may include various nosographic settings, such as alleged behavioral disorders, factitious mood disorders, fabricated schizophrenia, and artificial post-traumatic stress disorder [7]. Even if

the diagnostic process is the same in the somatic and psychological form of the disorder, it is necessary to discuss the possibility of MSP and confirm it. The practitioner should avoid encouraging the development of additional symptoms, as a wrongly prescribed neuroleptic treatment may cause neuropsychiatric side effects that appear to confirm the initial, artificial diagnosis. The clinician should bear in mind that medication dosages may be revised by the abusive adult. The diagnosis can only be confirmed or refuted through child hospitalization in pediatrics or child psychiatry with limited external visits and evaluations of the psychological complications of abuse. The secondary psychological complications of MSP can be difficult to distinguish from the factitious symptoms. The psycho-affective impact on the child is primarily displayed through behavioral disorders and eating disorders [8]. The defense mechanisms are expressed alternately through inhibition or aggressive episodes of acting out, which further support the clinical wrong diagnosis. Many conversions and a hypochondriac dimension emerge in the child, complicating the diagnosis of MSP. After a few years, the abused child may exhibit a genuine Munchhausen syndrome without a proxy dimension [4]. Unlike a psychological complication of the MSP, a true psychiatric disorder may be the initial trigger or facilitator of parental rejection that expresses itself as MSP with psychiatric dimensions. Differentiating between symptoms prior to the abuse, factitious symptoms, and the psychological impact of MSP is particularly complex. The accurate characterization of the objective medical history is still the key of the positive diagnosis. But furthermore, in order to discover the psychopathological construction of the child which is a diagnosis argument too, the psychiatric evaluation has to be repeated over time after the abuse has been stopped.

Parental problems

As frequently occurs in cases of abuse, the parents causing the MSP reproduce a climate in which they suffered during their own childhood. Parental history of physical or mental abuse, somatic disorders, and childhood diseases are common. Through interviews with more than 65 mothers responsible for their child's factitious disorders, Adshead and Bluglass found parental history of serious illnesses or accidents in childhood [9]. Almost half of the group had undergone psychotropic treatment during their life. A history of psychoactive substance dependence, suicide attempts [10], and anti-social behavior [4] is common among these parents. Moreover, the presence of a borderline personality, narcissistic, or histrionic disorder was found with high frequency [10-13]. Most authors found a component of anxiety or depression [14,15]. However, only a minority of abusive parents had an Axis I psychiatric diagnosis. Fischer et al. [6] noted that the salient features of temperament in these socially isolated individuals are low self-esteem and a high sense of self-deprecation [6]. The assessment of these risk factors in the suspected parent can make a case for positive and differential diagnosis.

Treatment

The principles of treatment follow the therapeutic guidelines of Sander and Stirling et al. [16,17]. Hospitalization is typically necessary to ensure the child's safety and resolve the crisis in a protected environment. The attitude toward the abusive parent depends on whether he/she recognizes his/her own troubles and accepts psychotherapeutic support. An interview with the child and parents should be conducted to announce the diagnosis and suggest (or require) a separation treatment. For the physician, the priority is to protect the child and to discuss a medical pathology of the adult-child relationship. If an administrative or judicial report is made, the medical personnel must maintain a therapeutic position and not serve as a substitute for law enforcement officials. Parents' commitment to psychotherapy is difficult to generate. The motivational determinants of the parents should be identified by analyzing the links established with the child and with the medical world.

II…Clinical case

Peter, a twelve-year-old only child, was sent to us as a matter of routine from the infirmary of an educational institute for diagnostic evaluation and therapy for behavioral problems. The medical records showed that Peter regularly beat and insulted his parents during family differences with violent interactions. Regular trips to the emergency room were common to manage this aggression and the resulting injuries. The violence began two years before our contact with him, and Peter had previously visited multiple pediatric psychiatrists and other psychiatrists. Several psychotropic treatments were prescribed, notably four antipsychotics (tiapride, risperidone, olanzapine, and amisulpride). At the request of Peter's parents, experienced practitioners indicated infantile psychosis, schizophrenia, and a symptomatic description of a psychosis in his medical records.

A family separation was imposed by the juvenile court following a medico-social investigation, which was expedited following a report from Peter's school. The report was motivated by the parents' apparent need for medical and educational assistance. When we met him, Peter had enjoyed two weeks of residence in the boarding house of an educational institution and returned to spend weekends with his parents. Educators and nurses at the boarding house did not notice any abnormal behavior, but wanted the child to have a specialized follow-up because of his background. Due to the physical necessity of driving Peter to the consultation, his parents accompanied him. They immediately attempted to impose themselves when we asked to speak to the child alone for a first conversation. By insisting that they would be subsequently received and that this method of organizing the consultation was required by protocol, we spoke with Peter alone before talking with the parents. This required several minutes of negotiations, during which the parents were uneasy, as manifested by aggressive defenses. This initial reaction was consistent with previous medical reports that indicated ambivalence with the health care system, as the parents demanded urgent assessments and care while they systematically discredited the care.

Peter was remote or opposing at the beginning of the interview, apparently reproducing the parental discourse, but for another reason. He informed us that he did not understand why he was there, that he had visited several "shrinks", and that he "is not crazy." Indeed, the first contact did not evoke schizophrenia or any tendency to psychosis. The interview did not find any notable mood or anxiety disorders, somatisations, trouble with sleeping, or eating behaviors. Peter did not become disinvested in his interpersonal relationships and had many friends that he met in school. He readily admitted relationship problems with his parents, and he wanted to end this situation. We then received the entire family for the second stage. As soon as his father and mother were in the counselling office, Peter did not say a word. The parents were voluble and in active pursuit of a medical diagnosis. They claimed the "psychosis" and "schizophrenia" of their son, a disease that had been diagnosed for many years. Specifically, several medical hypotheses were generated but not confirmed by regular medical care or a hospital evaluation. The "symptoms" were clearly dramatized in the parental discourse. The parents alleged the presence of hallucinations and alternating

behavioral episodes of autistic withdrawal and heteroaggression. Throughout the interview, Peter did not contradict his parents and seemed to acquiesce through his passivity. His parents were surprised by our refusal to prescribe drug treatment despite their repeated entreaties. They protested, however, a review of their child in a second consultation. After several interviews in which Peter was involved, we confirmed the absence of psychiatric disorders and emerging personality disorders. Peter's did not manifest difficult behavior in his new boarding house; in particular, he did not display heteroaggression toward his peers or the management. No signs of psychosis or schizophrenia were present. The production of "psychotic symptoms" was induced by the parents' allegations of hallucinations and encouragement of heteroaggressive episodes that occurred during periods of family excitement. Peter's heteroaggressive episodes contributed to the sustainability of the ambiguous symptoms. These parental descriptions were compelling enough that the medical community produced certificates on which the terms "psychosis" and "schizophrenia" appeared.

With Peter's permission, we contacted the medical officer of social security for an administrative investigation of his care over the past two years. Many specialists in psychiatry and child psychiatry were consulted, and several general practitioners were occasionally consulted for repeat prescriptions. After contacting the practitioners concerned, we learned that the advice provided in specialized consultations never lead to follow-up outpatient psychotherapeutic support. The psychiatrists who prescribed antipsychotic treatment could not perform medical monitoring to assess the efficacy and safety of the treatment instituted.

Conclusion

The clinical observations reported here describe a factitious disorder by proxy in which psychiatric signs and symptoms predominate. The delay in diagnosis was two years, and only the placement of the child in a medical-educational institute, legally ordered by a third party, allowed the MSP to come to light. The observation of the patient in neutral conditions by a single medical practitioner was instrumental in the positive and differential diagnosis. The psychological impact of the abuse favored the occurrence of aggressive symptoms as a defense mechanism, and thus, these symptoms were non-pathological. The parents' motivation was driven by the desire to play the sick role through the intermediary of their son. Peter's psychosis brought secondary benefits to the couple by perpetuating cohesion around a constructed subsidiary pathology. Note that neither parent suffered from distinctive psychiatric disorders, although the mechanisms of splitting and projection predominated in their mutual relations. However, theorizing about this psychopathology is complex, as access to the parents is difficult due to the nature of the disease. The announcement of the diagnosis of a factitious disorder to Peter and his parents helped re-establish a family atmosphere that was more conducive to communication. Permitted weekends with his parents ran smoothly. Peter's separation from the parents is currently underway.

Although Munchhausen syndrome by proxy with somatic expression is a familiar diagnosis to pediatricians, the psychiatric form has remained more confined to the literature. The delay in diagnosis is several years, during which time the symptoms can be recast to mask a psychiatric reaction to this particular form of abuse. The suffering of the child and his parents will be shortened if the diagnosis is quickly established and the appropriate treatment is instituted. Caregivers, teachers and social workers have to keep this syndrome in mind. A social inquiry has to be made in doubt. The accurate characterization of the objective medical history is still the key of the positive diagnosis. Define a standardized diagnosis is very difficult because of the polymorphism of the fabricated symptoms. Many countries have developed strategies to diagnose MSP with the measuring of care consumption or with hospital video surveillance. When the diagnosis is confirmed, a brief separation between the child and the family is necessary before the beginning of a familial therapy.

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