

## Munchausen syndrome by proxy presented as recurrent respiratory arrest and thigh abscess: a case study and overview

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While many physicians are familiar with the sexual or physical abuse of children, there is little awareness about Munchausen syndrome by proxy (MSBP). As case reports of MSBP increase, awareness among physicians is thought to increase as well. We thus present herein a 16-month-old girl who admitted to Hacettepe University İhsan Doğramacı Children's Hospital with the complaint of seizure, recurrent apnea and thigh abscess, who was later diagnosed as MSBP. The case was being followed by the Child Protection Team of the hospital (Hacettepe University Child Protection Unit [HU-CPU]). HU-CPU contributed to the early detection of this case and protected the child from a possible fatal outcome. The mother was confronted for MSBP and refused to take responsibility for her child's symptoms. As seen in this case, when MSBP is suspected, psychiatric evaluation of the mother, evaluation of the mother-child interaction and collection of a detailed family and social history can have a positive impact on the prognosis in these cases. This case report underlines the importance of multidisciplinary team work to share the responsibility and reduce the burden during the treatment process of these difficult and complicated cases.

**Key words:** Munchausen syndrome by proxy, child abuse, psychopathology, multidisciplinary team.

Munchausen syndrome by proxy (MSBP) is a covert form of child abuse. Although many physicians are familiar with the sexual or physical abuse of children, they are unaware of this particular form of child abuse. The abuser is generally the mother, who fabricates, exaggerates and/or induces physical, psychological, behavioral and/or mental health problems in the child. The perpetrators are willing to fulfill their need for positive attention by hurting their own child, thereby assuming the sick role by proxy. Symptoms usually disappear in the absence of the mother. Signs and symptoms and physical and laboratory findings are highly unusual, discrepant with the patient's presentation or history<sup>1,2</sup>. Although not uncommon, MSBP is difficult to detect and confirm. Diagnosis of the syndrome is extremely important, since mortality from MSBP is not negligible. Physicians need to be cautious and

suspicious for the diagnosis<sup>2,3</sup>. As more cases with different presentations are shared in the professional literature, awareness will increase, harmful unnecessary medical investigations will eventually decrease, and further abuse and fatality will be prevented. Here, we describe a case with recurrent respiratory arrest and thigh abscess, later diagnosed as MSBP.

### Case Report

"A", a 16-month-old girl, was brought to Hacettepe University Children's Hospital by her parents due to repeating apnea attacks and thigh abscess in January 2011. Her parents stated that her complaints started shortly after birth. She was delivered at term by cesarean section weighing 2400 g. She was hospitalized in the intensive care unit due to grunting and indirect hyperbilirubinemia, receiving phototherapy.

Following discharge, the mother complained of tonic upper extremity spasms occurring 10-15 times, each lasting 10-15 seconds. At the age of two months, she was brought to the hospital due to cough, runny nose, breathing difficulties, and continuation of spasm attacks. She was prescribed phenobarbital, vitamin B<sub>6</sub> and ceftriaxone for the diagnosis of epilepsy and aspiration pneumonia, and referred to a tertiary medical center for further evaluation. She was hospitalized for two weeks and her EEG revealed "trace alternant cerebral bioelectric activity"; her magnetic resonance imaging (MRI) report was normal except for mild cortical atrophy. Phenobarbital and vitamin B<sub>6</sub> treatments had been continued up to six months of age and stopped since she had no further seizures.

At eight months of age, she was hospitalized for swelling and redness at the injection site on the left thigh following an intramuscular antibiotic injection for respiratory tract infection. Despite intensive antibiotic treatment, her injection site infection did not improve and a thigh abscess developed. The mother accompanied her during her hospital stay. Although the thigh abscess was drained four times, it recurred, and a port line was implanted into the femoral vein for long-term antibiotic treatment. One month after discharge, the abscess relapsed without any underlying predisposing event. She was hospitalized again for antibiotic treatment. During her hospital stay, she had a seizure-like episode and was referred to our hospital for further evaluation to rule out MSBP. Her physical examination on admission showed no acute soft tissue infection but a deep scar tissue and muscle deformation in her left thigh due to recurrent abscess. Antibiotic treatment was continued as scheduled through the port line. Within the first week of hospitalization, she developed cardiopulmonary arrest, breath holding, cyanosis, and tonic spasm attack. She was admitted to the pediatric intensive care unit (PICU) without her mother. Her physical examination showed left arm dysfunction and temporary loss of vision. Laboratory findings (complete blood count, electrolytes, sedimentation, C-reactive protein [CRP]), liver and renal function tests, ECG (electrocardiography), ECHO (echocardiography), EEG (electroencephalography), MRI, and neurometabolic and immunologic laboratory

examinations were found unremarkable. Her condition improved rapidly and no seizure-like episode was observed during her PICU stay for two weeks. After discharge of the patient from the PICU, the child was hospitalized with the mother under very close monitoring of the hospital staff, but when left alone a similar attack of apnea, cyanosis and spasm occurred. The femoral port line was immediately removed due to a strong suspicion of maternal intervention through the port line (air injection using an injector) despite denial by the mother. When discharge was discussed, the mother became hostile and started to blame medical personnel for her daughter's condition. The Hospital's Child Protection Team (Hacettepe University Child Protection Unit [HU-CPU]) immediately reported the case to legal authorities. The mother was confronted and denied all the charges.

**Psychiatric assessment and clinical process:** Her psycho-developmental status was evaluated and the child-mother relationship and interaction was assessed during a free play observation. This evaluation revealed mild mental motor developmental delay and a problem with mother-child bonding. Meanwhile, individual psychiatric interviews were also arranged for the parents in order to evaluate their mental health status and uncover family dynamics. The mother-child interaction assessment revealed that the mother only met the child's physical needs but was unresponsive to her emotional needs. The relationship did not have qualities such as trust, love and mutual interaction. Her attachment style was categorized as insecure. The mother had a tendency to deny her mental-motor developmental delay. To establish a healthy mother-child relationship, it was decided to continue her hospitalization, but without the attendance of her mother. Her aunt accompanied the patient during her three-month period of hospitalization. Special times were arranged for the mother to visit her under the supervision of health personnel. The mother and child were also brought together during play therapy, and a psychologist/play therapist from the Child Psychiatry Department worked on mother-child interaction and relationship through 45-minute sessions daily. Meanwhile, the mother's individual psychiatric treatment continued three times per week.

**Psychiatric assessment of the mother:** The mother was 23 years old. She was born to a low income family as the eldest of three children. She grew up in a large and crowded family. She had a close relationship with her father. She described her mother as a jocund and hard-working woman. She described herself as a successful student. However, she ran away from home and dropped out of school at the age of 16 to marry her husband, who was eight years older. Her family did not approve of the marriage. She stated that if she had been able to continue her education, she would have wanted to be a doctor. She became pregnant immediately after her marriage and has a 5-year-old son and two daughters, 3.5 and 1.5 years old (our case). They live in a small village house with her mother-in-law. Her relationship with her family, friends and neighbors was restricted by her husband and mother-in-law. They were critical of how she did housework and cared for her children and did not like or approve of anything that she did. She was also physically abused by her husband. The presented patient was an unwanted and unplanned pregnancy. During this pregnancy, she learned that her husband was having an affair and had a very stressful pregnancy. This child was born with polydactyly and was considered as different by her parents. Shortly after the delivery, the mother had to remain away from home because of the frequent health problems and long hospital stays of the child. Her mother-in-law took care of her older children during her hospital stay. She was the only one dealing with the illness and medical health of this child. Her sacrifices and interest in this child were appreciated by others. Her husband's physical violence had stopped and the mother felt relieved.

### Follow-Up

**The child:** As the emergency of the case was considered, a modified "Watch, Wait, Wonder (WWW)" technique was applied to address the parents' and the child's problem by an experienced clinical psychologist/play therapist who had received the theoretical orientation but is not certified to use this technique. WWW is an infant-led, infant-parent intervention, which focuses on the relationship between the parent and infant, considers "reflective observation" as essential, and emphasizes the importance

of play<sup>4-6</sup>. The main idea was to create an atmosphere in which the parent and infant could have an emotional experience together. The parent - especially mother (also father when available) - baby and the play therapist met daily in the playroom for approximately 45 minutes. The parents were instructed not to initiate but to follow the infant's lead. Through reflection of the parents' feelings by the clinician, the parent(s) had the opportunity to feel safe to rely on their own feelings and not on the clinician for advice or insight. By utilizing this intervention, it was planned to put the infant in the position where she could use play and activity to master difficulties in relation to the parent, and in which she might play out developmental struggles using toys. The play therapist's role was to engage in the parallel process of watching, waiting and wondering about the interactions between the infant and the parent. The play therapist also provided a safe hold and contained environment in which the parent might explore feelings, including the conflicting ones<sup>7</sup>. The child had developmental delay in many domains. Although she was 17-18 months of age, she was unable to walk or use words or phrases. In order to gain the attention of an adult, she made some sounds that were the same for a variety of different occasions. In the initial sessions, the child was observed to have very limited range of affective expressions and exploratory behaviors. The child seemed to be indifferent to the person proximal to her whether it was her mother or a member of the hospital staff, looking blank, without showing any kind of interest in people, happenings or toys. In the playroom, the mother was told to follow A's lead, letting her take the initiative. The play therapist suggested that the mother respond to the child when she initiated an interaction. However, the therapist also encouraged the mother to be guided by her understanding of what her child wanted without using words. During each session, the mother's observations and meanings that she gave to them were discussed.

**The mother:** Psychiatric evaluation of the mother revealed neither psychotic nor affective symptoms in the beginning. Although the mother did not fulfill the Diagnostic and Statistical Manual of Mental Disorders (DSM) V criteria for any personality disorder, she was

considered as having a narcissistic personality trait. During the child's hospital stay of three months, the mother regularly received individual psychotherapy three times per week. The mother's psychotherapist also interviewed and worked with other family members (the father and mother-in-law) to collect more information about the family dynamics and increase the family members' collaboration with the mental health team after discharge. The mother was initially very defensive during sessions. She described her family relations as excellent. It was impossible to get her to elaborate on her individual and family history. The therapist, meanwhile, aimed to provide insight and understanding about the underlying motivation and the nature of the illness/MSBP. Consequently, a relationship and trust was created between the mother and her therapist. She started to share her disappointments and concerns about her marriage and her problematic relationships with her mother-in-law. Her sadness was remarkable during these moments. Her motivation during the follow-up interviews was high. She frequently visited the therapist earlier than the scheduled appointment. She had a tendency to ignore her own behaviors and place the blame on others (including her husband, mother-in-law, health personnel) for what happened to the child. The therapist recognized the manipulative nature of her acts or words and her tendency to devalue or idealize different medical staff, as well as her manipulative language/behavior.

The progress achieved during play therapy and the improvement in the child and mother-child interaction and relationship were also evaluated during these sessions. Although she was pleased with her daughter's improvement (recovery and growth), she expressed her fear about her child gaining independence. This would mean that she would not need her anymore. The therapist emphasized the importance of an emotional bond and healthy attachment on A's development, instead of her having only a physical dependence. A's motor and emotional improvement with appropriate intervention during the treatment process increased the mother's guilt. The mother mentioned that during the period of inducing illness in the child, she saw her as a part of herself. She considered her child as an inanimate object and never considered that she

was hurting another human being. The child's recovery and improvement in her interaction with others increased her awareness about the lethal consequences of her behavior. She also stated that the only thing that stopped her was her daughter's liveliness.

At that particular period of the mother's psychotherapy, her depressive mood became prominent, and the therapist noticed her extreme anxiety about what would happen after her discharge. A serotonin reuptake inhibitor (20 mg/day) was prescribed for depressive and anxiety symptoms. The mother confessed that while she knew that there was something wrong with what she did, she did not know why she did it. She did not clearly remember the moments when she generated her child's illnesses. Though she knew the doctors were suspicious, she insisted on returning to the same hospital, perhaps subconsciously wishing to be caught.

The child was discharged after a three-month hospitalization. As a precautionary measure, a decision regarding treatment of the family was made, and the case was committed to the protection of her father. She has since been followed by family protection in collaboration with the local social services. A home visitation program emphasizing the health and well-being of the infant and family was applied by the local social services in her village. Her follow-up continued on an outpatient basis every other week by the departments of pediatrics and child psychiatry until she was 32 months of age. The family has been followed by a child psychiatrist for the last year in their hometown. Despite the continuation of her manipulative behaviors after discharge, the mother did not cause the child any harm during her follow-up. The child is now 40 months of age. The mother has continued to live with the father, her three children and the mother-in-law in the mother-in-law's home (extended family). The family has a low socioeconomic status.

## Discussion

Herein, we describe a case with repeating thigh abscess and apnea attacks. No etiological causes were detected to explain this medical condition and no signs or symptoms of her illness occurred in the absence of the mother. This case carries most of the classical characteristics

of MSBP: a mother who was unusually calm despite the child's serious medical problems, reluctant to leave her daughter, and highly attentive, and who appeared to be medically knowledgeable and intrusive towards any kind of medical intervention. She was considered to be a very concerned and committed mother by the medical staff and the other mothers in the ward. The father seemed to have a distant emotional relationship with his family. He was not aware of the medical history of the child and had not witnessed any of the apnea attacks<sup>2,8,9</sup>.

The diagnosis of MSBP is extremely difficult. Only an experienced and suspicious clinician can recognize these cases. With the passion to investigate a rare and unusual diagnosis, healthcare professionals can be part of this abuse. They can injure the children unintentionally by conducting excessive and invasive tests and medical procedures<sup>10</sup>. Recent research emphasizes the importance of a multidisciplinary team approach in managing MSBP cases<sup>11</sup>. There has been an increase in the awareness of child abuse and neglect in Turkey within the last 10 years. The number of established CPUs has been increasing within the university hospitals. The HU-CPU has provided services within our center since 2005. The multidisciplinary team approach of the CPU prevents circumvention of abused patients, and provides early recognition and proper management of these cases. Further, decisions made after detailed multidisciplinary meetings have a positive impact on the process and have allowed us to work with the mother.

The child was referred to our center with two of the most common presentations of MSBP, repeating apnea attacks<sup>12</sup> and thigh abscess<sup>13</sup>. The mother confessed to triggering the apnea attacks by injecting air through the child's port line. These repeated apnea attacks, while in progress, led to brain damage, temporary vision loss and left arm dysfunction. The child had delayed walking due to repeated thigh abscesses caused by the mother. During her psychotherapeutic process, the mother stated that "I was not aware at those moments, but now I realize that I may have caused the death of my daughter". Although MSBP is a rare condition, it can be fatal. Overall mortality rates for MSBP are between 6% and 10.5%<sup>14</sup>

and are as high as 33% for MSBP associated with suffocation<sup>15</sup>.

Motivation for the perpetrator's bizarre behavior continues to puzzle both medical and mental health professionals. Three major types of MSBP perpetrators are described in the literature as: "help seekers", "active inducers" and "doctor addicts". Help seekers are the mothers who seek attention for their children in order to communicate their own anxiety, depression or exhaustion. Active inducers are the mothers who connect with doctors in order to cope with and compensate for their early childhood traumatic experiences. Doctor addicts are the mothers who believe that their child is really sick and do not accept that evidence proves otherwise<sup>16</sup>. We thought it would be appropriate to categorize the presented mother as "help seeker". The mother became aware of her husband's affair during this pregnancy. We believe that the mother's heavy psychosocial stress in the family at home and her difficulty to cope with her responsibilities drove her to search for medical help for her daughter. She regained the sympathy and attention of her family after her daughter's illness. She also earned a reputation of being a devoted and loving mother. Her time at the hospital with her daughter provided her a social life. She thus perceived her relationship with medical professionals as a solution to her difficulties, and she induced illnesses in her daughter as a repeated quest for help. Fabricating illness in the child kept the mother away from her heavy responsibilities and also supported her mothering skills and fulfilled her narcissistic needs.

The main hurdle in the treatment in MSBP is the classically described intense symbiotic bond between the abused child and mother<sup>17</sup>. From a developmental perspective, a normal separation-individualization process of a child is possible when this child is ready to operate independently. For this reason, separation of the child from this symbiotic bond is necessary. Enabling the physical separation and autonomous functioning of a child helps in establishing a sense of being separate from the caregiver<sup>18</sup>. However, an invasive, overly intrusive, and inseparable mother, like in our case, interrupts the natural course of development of separation-individualization.

The mother had no close friends and her relationship with her own family was distant. By generating illness, the mother kept control over ownership of the body of the child, and this led to the maintenance of this symbiotic relationship. We also believe that the child's affective and behavioral unresponsiveness, physical and emotional dependence, and indifference to the world might have facilitated the mother's tendency to see the child's body as an extension of her own while harming her. Separation of the child from the mother during the therapy process contributed positively to the separation-individualization process of the child. Furthermore, this was a turning point in the therapeutic process of the mother. It helped to ease her anxiety about not being needed by the child anymore and to build an appropriate relationship in accordance with her developmental stage.

Munchausen syndrome by proxy (MSBP) is being increasingly recognized and reported throughout the world since its first description in 1977. The first case in Turkey was published in 1995, and since then, case reporting has increased over the years<sup>19-26</sup>.

In conclusion, although MSBP is a rarely seen condition, it is a severe form of child abuse with high mortality rates. Its diagnosis is difficult. Experienced and alert health personnel are necessary and important for an early diagnosis<sup>2,3</sup>. Teamwork is crucial for proper management and effective treatment planning of these cases. Multidisciplinary teamwork also helps to divide the responsibilities and reduce the burden during the treatment process of these very difficult cases. The HU-CPU contributed to the early detection of this case and protected the child from a possible fatal outcome. When there is a suspicion of MSBP, as in our case, psychiatric evaluation of the mother, evaluation of the mother-child interaction and acquisition of a detailed family and social history have a positive impact on the prognosis of these cases.

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