

CASE REPORT

SUCCESSFUL TREATMENT OF MIXED MUNCHAUSEN SYNDROME AND MUNCHAUSEN SYNDROME BY PROXY: A CASE REPORT

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Abstract

Munchausen syndrome by proxy (MSBP) bottom-list diagnosed in medical settings, imposes a large burden and is a matter of concern to public health. It has the ill reputation of being unamenable to treatment. Authors describe a case from Iran suffering from both MSBP and Munchausen syndrome (MS) at the same time. A form of nonpharmacologic intervention specifically tailored for MS was found promising and there was no relapse in a two year follow up.

Keywords • Munchausen syndrome by proxy • factitious disorder

Introduction

Factitious disorder is defined as an intentional production of physical or psychological signs and symptoms to assume the sick role with absent external incentives for the behavior. The classic variant of factitious disorders, Munchausen syndrome is marked by a chronic unremitting course and more obscure psychological motives for the behavior and the exclusive presence of physical symptomatology.¹

Review of the literature since 1965 indicates more frequent reports in recent years, but most health care providers are still not sufficiently aware that factitious disorders are common.² One study reported a 9% prevalence in hospital admitted patients, but these are only suspected when investigations lead to contradictory findings.²

Munchausen syndrome by proxy is a rare condition in which usually a child is presented for medical care with symptoms that are fabricated

by proxy.⁵ Although nearly always committed by the mother, father perpetrator is also reported.^{5,6} If remained undiagnosed, it is often repeated on numerous occasions resulting in frequent hospitalizations, considerable morbidity and even mortality.⁵

The perpetrator is often able to direct the attention of medical staff toward the provision of unnecessary medical treatment through their presentation of concern and cooperation⁴ or their ability to intimate.⁷

Overt psychiatric disturbance is infrequently found.⁴ Having a health professional background, suffering Munchausen syndrome, previous psychiatric treatment and suicidal attempt are usually characteristic in mothers with MSBP.⁴ Serial child MSBP warrant intensive treatment and ultimately have a poor prognosis.⁵ Denial by the mother has been reported to be high even when confronted with substantial evidence of her duplicity and often multiple psychiatric hospitalizations.⁵

Reports on the treatment have not been promising, and it has been stated that only early recognition can prevent possible hazards to the patient and waste of medical resources.²

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or produced by a care taker.⁴ The motivation for the perpetrator's behavior is to assume the sick role

As far as we know there has been only one report of MS⁸ and another report of untreated mixed MS and MSBP from Iran.⁹ We report the first successful treatment of mixed MS and MSBP in Iran.

Case report

Psychiatric consultation was requested by a dermatologist for a 20 year old housewife, middle school graduate and mother of two children who was admitted in the dermatologic ward with multiple abrasive lesions over her thighs and arms unresponsive to outpatient management suspected of dermatitis artifacta. She was wearing a shiny pinky home-robe and no hospital clothing.

In the initial interview she was found to be cooperative. She had passed a course on emergency aid in the Red-Crescent Society, and had always been interested in medical and health issues. She was eager to talk about her long history of diseases and hospitalizations. Interview revealed that she had two children who had received multiple outpatient and inpatient services for their so called "congenital" but poorly diagnosed eye problem.

Diagnosis of Munchausen syndrome and possibility of MSBP was considered and it was recommended to continue hospitalization until thorough examination had been made on her and her two children.

Consequent interview revealed a detailed medical history of multiple admissions to different general medical wards during the last three years due to "renal stones", "jaundice" with normal bilirubin and "ecchymotic lesions" on her skin despite normal platelet and coagulative factors besides many other repeated outpatient doctor shoppings.

According to the patient, both her sons, one five years of age and the other eighteen months old, had problems with their eyes and had underwent repeated inpatient and outpatient ophthalmologic investigations revealing no definite cause since they were six months old. The patient claimed that "it was a problem which was running in the family". The elder child, who had a history of "convulsion", had been on irregular phenobarbital treatment and had ecchymotic lesions on his skin. Repeated medical investigations had failed to find the actual cause of the signs and symptoms.

Following a minor confrontation with the patient, her husband and mother, she was

transferred to the psychiatric ward. During the initial admission routines, she started to protest against hospitalization and was supported by her husband. The husband initially refused to agree with the hospitalization until it was declared to him that a written complaint would be sent to the judicial court, indicating that his children and wife were in danger. During several supportive and insight oriented psychotherapeutic sessions which accompanied every day visits, after achieving therapeutic alliance and establishing rapport, the patient accepted psychiatric care and gradually disclosed the whole history starting as: "following quarrels with my husband when I feel sad and helpless, out of my control. I do something unfavorable".

She explained that she herself inserted a few small stones in her vagina and urethra simulating renal colic and hematuria. Later she had colored her skin with a yellowish food additive and ingested large amounts of drugs including cotrimoxazole before she developed the ecchymotic lesions. The erosive lesions were produced by herself, by repeated forceful rubbing of a coarse fabric on her skin until bleeding occurred, while the patient perceived to pain.

Later she disclosed that she had splashed detergent material on her child's face that developed irritation and inflammation of the entire face including his eyes, and she induced blunt trauma to their eyes while pouring prescribed eye drops even in the ophthalmologic ward. Giving overdose medication to her children including phenobarbital was the cause of the so called "convulsions" (truly comatose episodes) and probably the cause of the ecchymotic lesions found on the child's skin.

She confessed that in doing so her goal was to assume the sick role from which she gained satisfaction. During the illness periods her husband's behavior which was usually verbally and physically abusive changed considerably. In this way her husband had to stay with his wife and obtained "patient-in-accompany-exemption" for his missed workdays.

History revealed that her "diseases" were mock models of true cases in the family especially her husband's probands. She was found to suffer from dysthymic disorder and mixed histrionic and dependent personality traits but no borderline psychopathology.

No medication was given and non pharmacological intervention was started with

supportive psychotherapy and continued with behavioral shaping and cognitive therapy. Stress management techniques and problem solving training sessions were the cornerstone of the treatment. Psychoeducation was also given to all family members, including her mother and the husband's family.

She gradually developed considerable insight and admitted that when feeling frustrated she "should talk and seek help from the therapist and the family instead of doing unusual acts".

She was discharged after one month on a stepwise basis. The couple signed an agreement indicating that she should have regular monthly visit to the hospital and should visit her doctor when the children are sick with whom the therapy team could have contact. During the two years of follow-up, the patient and her children had no problems.

Discussion

This psychiatric illness usually manifests itself in medical or surgical settings with bulky records from multiple hospital admissions.⁴ Hence it crosses over both primary clinicians and specialists. Evidence of self-induced physical signs which were contradictory and unresponsive to routine management with no obvious cause, interest in and knowledge of illnesses and medications in our patient were clues to proper diagnosis.

Interaction of personality traits and psychosocial stress can produce the syndrome.¹ In our patient histrionic and dependent personality structure, coming across with unpleasant circumstances, her husband's sympathetic U-turns during relapses and the tertiary gain (husband receiving work exemption) may be responsible for the frequency and chronicity of the problem.

It has been stated that admission of factitious disorder patients in psychiatric wards may change the course of the illness in the direction of a new spectrum of symptomatology,⁴ but in our case, continuous evaluation, close observation, regular psychotherapy and prevention of signing out were the optimal paths to health. In fact no new symptoms, somatic or psychological were noted at follow up.

The literature tends to be divergent on the issue of confronting these patients to stop the factitious behavior. The result has been cessation of the behavior at least for a time⁶, reacting with rage or

denial but then acceptance¹⁰, being useless or even risky in patients with fragile egos, leading to depression, psychosis or even suicide,^{4,10} causing them to intensify their effort to demonstrate that the child is really ill.¹¹ In our patient, following confrontation, her denials faded away during admission in the psychiatric ward and she became cooperative.

Multiple child MSBP may reflect more significant maternal psychopathology than found in other cases of MSBP or it may indicate deteriorating consequence to the mother and other children in the family if the syndrome is not identified with the first child and effective intervention not made.⁵ This holds true in our cases. In fact most factitious manipulations on herself and her second child could have been prevented if the case had been diagnosed earlier.

We assume that a great number of these patients who stay in various clinico-medical settings are not correctly diagnosed by specialists and general practitioners² and whenever diagnosed they are not treated efficiently.⁹ In order to solve the problem, improving general awareness and the need for early diagnosis are emphasized.³ The physicians should consider the possibility of factitious disorder along their primary differential diagnosis, rather than the diagnosis by exclusion. We highly recommend compulsory psychiatric admission once the diagnosis has been made.

In spite of chronic unremitting course of Munchausen syndrome and MSBP and the poor prognosis that is repeatedly reported^{2,3,5} our patient accepted psychiatric care and disclosed her problem completely in her first psychiatric admission. During regular follow up she had no recurrence for two years.

Dynamic supportive psychotherapy, behavior therapy including aversion therapy and biofeedback, family therapy, psychoanalytic group psychotherapy have been tried with different outcomes. No long-term follow-up is available.^{11,12} There has been no systematic study on the efficacy of psychiatric treatment in these patients. However, early psychiatric consultation¹³ preferably of case oriented approach¹¹ is believed to be helpful. Our experience supports this view.

This is the first report of successful treatment of mixed Munchausen syndrome and MSBP in Iran. In addition to the general ignorance of this disorder, it seems that strong traditional belief about the romantic mother-child relationship in Iran and the negative attitude of the medical

system toward psychiatric interventions may hamper treatment.

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