

Munchausen syndrome by proxy: The emerging face of child abuse in Saudi Arabia

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ABSTRACT

A case of Munchausen Syndrome by proxy abuse involving a Saudi child is reported. The child has suffered a skull fracture, repeated attacks of respiratory distress, multiple attacks of status epilepticus, and untold psychological trauma at the hands of his mother who eventually admitted to the abuse. It is intended that this report will make the medical community aware of the emerging face of child abuse in these parts of the world and the unique factors that surround the issue. Along with other types of child abuse it may be heralding a change in reporting patterns and increased awareness that demands immediate attention to formulate appropriate policies to identify and protect abused children.

Keywords: Child abuse, Saudi Arabia.

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Child abuse in Saudi Arabia is a newly emerging entity. The Saudi Arabian society in the heart of the middle-east is based on strong cultural and traditional values which for centuries have upheld a nurturing atmosphere in the family. Child abuse is still considered a relatively rare occurrence in these parts, but it is not non-existent. Modernization and industrialization has affected the entire region, and this has also resulted in ideas imported from other societies blending into traditional rearing patterns. The issue of child abuse in Saudi Arabia in modern times was raised a decade ago.¹ In our own experience in the emergency room (ER) where about 30,000 cases are seen annually,² the incidence is steadily rising although it is very low as compared to the total number of patients seen. It has presented in varied forms such as physical abuse, child neglect, sexual abuse and Munchausen Syndrome by proxy (MSBP). The case described here presented to us as

a case of suspected physical abuse and later on evolved into a full blown case of MSBP. Child abuse when it presents poses a challenge to the physician and makes it incumbent upon us to think about early identification and management issues concerning this new entity.

Case Report. F.L. was brought to the emergency room (ER) by his parents at five months of age with a history of a generalized convulsion an hour before arrival to the ER. A month before he had been admitted with fever and a brief convulsion and on investigations was found to have low serum calcium (1.2 mmol/l) and high alkaline phosphatase suggestive of vitamin D deficiency. He also had a microcytic hypochromic anemia and was discharged on vitamin D, calcium and iron supplements. F.L. was a second boy in the family born normally after

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an uneventful pregnancy. His father was Saudi and 55 years old. His mother was 20 years old. She was his second wife and came from a neighboring country. They had another 3 year old son who was also brought along to the hospital and noticed to have multiple mouth ulcers from ingestion of Clorox (a bleaching agent) a week ago. He had been treated at another hospital.

On examination F.L. was found to be fretful and looking very pale as if in pain. A large sub-galeal hematoma was felt over the entire parieto-occipital area stretching from one side to the other. The mother stated that her elder son had hit F.L. with a shoe or probably F.L. fell down from his bed. An X-ray of the skull had revealed a fracture of the calvarium extending from one parietal bone to the other. The child was admitted as a case of head injury and a CT-scan revealed the fracture, the sub-galeal hematoma and a minimal sub-dural hematoma without any midline shift. The bone profile was normal and there was no significant drop in his Hb.

Two months later F.L. was brought to the ER with an acute onset of respiratory distress. He looked distressed and moribund with excessive secretions through the nose and mouth and excessive lacrimation. His sensorium was dull. Chest X-ray was suggestive of an aspiration pneumonia. He was admitted, treated with broncho-dilators and antibiotics, then discharged after he made a complete recovery within a few days. Before his next follow-up appointment the child was brought again with a prolonged convulsion for more than 30 minutes, which was difficult to control. He was intubated, required diazepam and phenobarbitone. He made a dramatic recovery after a few hours in the Pediatric Intensive Care Unit (PICU). All blood investigations were normal including serum calcium and alkaline phosphatase but unfortunately toxicology screen was not performed at that time. An EEG showed non-specific slowing and CT-scan of the brain showed a resolving sub-galeal hematoma. He underwent more investigations including neuro-metabolic screening and others but all were reported to be normal. Skeletal survey was also normal. He was given Phenobarbitone and discharged, but soon returned to the ER with status epilepticus which was again difficult to control. The patient was admitted again to the PICU to make a full rapid recovery within few hours. Carbamazepine was added to the treatment and the patient discharged home, to come back after few days with an attack of shortness of breath and excessive salivation. At this stage the question of abuse was strongly considered, especially since the mother did not seem concerned with her child's repeated illnesses. She kept the child to herself but the child did not show affection towards her. Physicians and social workers empathetically talked to the mother. Psychiatric consultation was obtained.

Although the mother was not found to suffer a mental illness the psychiatric team agreed to the likelihood of Munchausen syndrome by proxy abuse. The mother was confronted but she denied vehemently. However, the idea of administration of a toxic substance to the child was entertained and discussed with the father who himself had started becoming suspicious of the child's repeated visits to the ER with either status epilepticus or acute breathlessness that defied natural course of any disease. The mother and child were discharged with a follow-up appointment. In the absence of a clear policy and lack of authority to separate the child from the mother we had to contend with an assurance from the father that further harm will not be done.

A week later the child was rushed by the father to the ER with an acute onset of respiratory distress and lots of secretions from the nose and mouth. He stated that he had seen the child in a very good and playful condition half an hour ago. Then he went out of the house for a short time and returned to find the child in his room alone, short of breath and smothered by his own secretions. The mother was in the kitchen and apparently did not know anything about how the child suddenly became distressed. On examination the child was obviously distressed with lacrimation, rhinorrhea, and excessive salivary secretions. His pulse was 138/min and BP was 106/68. There were bilateral crackles upon examination of the chest. Now the father volunteered information which strongly suggested that the mother has been administering some sort of chemical agent(s) that is responsible for the child's illness. He stated that on different occasions the mother had requested him to buy lignocaine spray for her apparently painful tooth. Once he remembered the day F.L. was due to be discharged from the hospital he developed a convulsion. The mother's handbag revealed small traces of white powder. Then on another occasion he noticed the mother cleaning the child's nose with a lot of tissues (apparently hiding something within the tissues) and throwing them out of the window. He had quietly retrieved a 3 cc syringe from the tissues and noticed in it a strong smell of a kerosene-like substance. Examination of the syringe revealed a definite smell of something like an organo-phosphorous compound (? "Raid" cockroach killer).

The mother as usual denied her involvement in the child's illness or any knowledge of factors leading to the child's complaints. Next day the child's salivary secretions, blood and urine were screened for organo-phosphorous compounds and other toxic substances, but there was no evidence except traces of organo-phosphorous compound in the urine. The mother was seen again by the psychiatrist and finally she admitted that she has been administering lignocaine spray in the child's nose at least on four occasions in the past and one time she had even instilled Flash

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(drain cleaner) into the child's nose. She also admitted that she had given a bleaching agent (Clorox) to her elder son. The reasons given by her was that she was extremely unhappy with her marital life, and wished to get away from the house. She also felt bored and depressed.

A meeting was called between the mother, the father, the psychiatrist and the treating consultant and it was explained to the parents that they have been involved in causing harm to the child, actively by the mother and passively by the father because he failed to protect the child at home. An agreement was signed whereby the child was to be transferred to the maternal grandmother for protective custody. After his last discharge from the hospital the child was seen in the Out-patient clinics thrice within a period of three months and seemed to be doing well.

Discussion. The spectrum of child maltreatment presents unique challenges to physicians caring for children in many settings. Sobel first called our attention to repetitive "accidental" poisoning as a subtle form of child abuse and Dine and McGovern underscored this phenomenon in their description of intentional poisoning of children.¹

MSBP is a rare form of child abuse defined as the fabrication of a child's medical history and/or medical symptoms by a parent, most commonly the mother, with the intent of securing unnecessary medical evaluations, procedures and hospitalizations.⁴

The DSM-IV criteria fulfilling requirements of defining a case of MSBP are as follows: 1. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care. 2. The motivation for the perpetrator's behaviour is to assume the sick role by proxy. 3. External incentives for the behaviour (such as economic gain) are absent. 4. The behaviour is not better accounted for by another mental disorder.

The mother may be exceptionally loving and caring outwardly, cooperative with the medical staff.⁴ She may have a medical background or training. She commonly uses therapeutic and prescribed drugs such as laxatives, hypnotics, or anti-convulsants to make her young child ill. Sometimes household products, including cooking ingredients, pest killers and horticultural agents are given.⁵ The mother in our case was not highly educated, she had no medical background and she was not cooperative with the staff either. Usually she had an expressionless face and did not show any emotion towards her child. In a proven case of a Saudi child the mother's personality was described as not caring for her child and frequently depressed.⁶

As was stated by Kattan et al a clinician's usual

skills may not be enough to distinguish such cases and as such, their investigative vision requires that they look at other etiologic possibilities.⁷ That is why it took us such a long time and extensive investigations to rule out other possible diagnoses. The seizures in this case were most likely due to lignocaine spray. Seizures resulting from oral viscous lignocaine locally applied to the mouth have been reported.⁸ The mother denied any abuse and did not reveal her involvement until she was seen by the psychiatrist and social workers a number of times over a period of two months. In one study Meadow reported that confessions usually emerged slowly and full details of the way in which mothers fabricated illness did not emerge until two to eight years.⁹ Therefore early referral of difficult or undiagnosed cases to a tertiary care centre is indicated to avoid or minimize morbidity to such children. The elder sibling of F.L. was found to have caustic burns due to administration of a bleaching agent (Clorox) although later he was not subjected to abuse. Siblings of index children have been reported to suffer morbidity in various studies.¹⁰ The mother in our study was a second wife from a neighboring country and she was extremely unhappy with her marital life. Marital conflict is a well recognized cause for child abuse.^{4,10,11} The differences in social culture & age of the parents and lack of social support and early marriage were identifiable risk factors in this case. According to Meadow it is common for the perpetrators to have no specific mental illness on psychiatric evaluation⁴ which is true for our case. Most cases of child abuse get repeatedly abused before they come to medical attention as it happened with F.L. Morbidity and mortality associated with child abuse should be of great concern to the practicing pediatrician. This is best illustrated by the report of ten cases of child abuse by Kattan¹² of which two children died, five had serious injuries and three had moderately severe injuries. Al-EissáDin in the first publication on child abuse from the Kingdom had reported seven cases, at least one of them had resulted in severe physical and mental disability. To prevent such tragic outcomes, pediatricians have to be more aware of this entity and should have a low threshold of suspicion. Risk factor recognition and recognition of early signs of abuse are necessary for prevention of this phenomenon. Management of MSPB requires knowledge of the syndrome, confidence in making the diagnosis, a direct approach that emphasizes helping rather than condemning the family, and when available, other social support.¹³ Final conclusion regarding the late outcome of this case cannot be drawn due to the fact that follow-up is short though still regular. The medical prognosis of patients with MSBP is ominous.¹⁴ Of 117 victims Rosenberg¹⁵ reported 9% death rate and 8% long term morbidity. Two out of

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four MSBP cases of Kattan¹² series have resulted in death of the victim. Meadow reported 22% mortality.¹³ Unfortunately, at the present time there are no clear guidelines within the health and social welfare systems in the Kingdom for managing such cases. We are sparing no efforts in trying to establish a child protection agency in our hospital. This is only the first step towards establishing comprehensive child protection programs in the country. More research is needed to formulate the best approach tailored to our society for intervention in such cases.

In conclusion, this is another case of MSBP reported from Saudi Arabia. It was inferred then that the report of such a case will lead to recognition of MSBP and other types of child abuse. Clearly, there is a need for establishing a Child protection team in tertiary care centres.

References

1. Al-Eissa Y. The Battered Child Syndrome: Does it exist in Saudi Arabia. *Saudi Med J* 1991; 12(2): 129-133.
2. Al-Ayed IH, Shaikh JA, Qureshi ML. Patterns of Pediatric Emergency Room visits at King Khalid University Hospital, Riyadh. *Ann Saudi Med* 1997; 17 (2): 360-362.
3. S Kharasch, R Vincel, R Recco. Esophagitis, Epiglottitis, and Cocaine alkaloid ("Crack"); "Accidental" poisoning or child abuse? *Pediatrics* 1990, Vol 86, No 1.
4. Meadow R. Munchausen Syndrome By Proxy: The hinterland of child abuse. *Lancet* 1977; 2: 343-345.
5. Meadow R. Non-accidental Salt poisoning. *Arch Dis Child* 1993; 68: 448-452.
6. Al-Jumrah S, Al-Downish A, Turkenjeji H, Frayh NH. Munchausen Syndrome By Proxy in a Saudi Child. *Ann Saudi Med* 1993; 13: 469-471.
7. Kattan H, Sakati N, Abduljabbar J, Al-Eisa A, Nou-Nou L. Subcutaneous fat necrosis as an unusual presentation of child abuse. *Ann Saudi Med* 1995. Vol 15 (2): 162-164.
8. Wolfram SM, Rose R. Seizures in a Infant caused by (or related to) oral viscous lignocaine use. *Journal of Emergency Medicine* 1992; 10: 587-590.
9. Al-Mugieren M, Gannell R5. A suspected case of Munchausen Syndrome By Proxy in a Saudi child. *Ann Saudi Med* 1990; 10: 662-665.
10. Rogers D, Tripp J, Benrovin A, Robinson A, Barry D, Goulding R. Non-accidental poisoning: an extended syndrome of child abuse. *Br Med J* 1976; 1: 793-796.
11. Dine MS, McGovern ME. Intentional poisoning of children - An overlooked category of child abuse: report of seven cases and review of literature. *Pediatrics* 1982; 70: 32-35.
12. Kattan H. Child abuse in Saudi Arabia: Reports of ten cases. *Ann Saudi Med* 1994; Vol 14 (2): 129-133.
13. Meadow R. Munchausen's syndrome by proxy. *Arch Dis Child* 1982; 57: 92-98.
14. McGuire TL, Feldman W. Psychologic morbidity of children subjected to Munchausen syndrome by proxy. *Pediatrics* 1989; Vol 83 (2): 289-292.
15. Rosenberg DA. Web of deceit: A literature review of Munchausen syndrome by proxy. *Child Abuse Negl* 1987; 11: 547-563.

ARABIC TO FOLLOW

