Munchausen Syndrome and Munchausen Syndrome by Proxy: A Case Report

A 43-year-old divorced woman patient with postpartum depression had visited our psychiatric outpatient clinic regularly since 2011. Her parents were divorced when she was in her teenage, and she had to rely on a friend of her sister. She had a quick marriage with her ex-husband after they met and dated for three months. She suffered from domestic violence after her son was born in 2003, and she also had conflicts with her mother-in-law at the same time. She developed depressive symptoms gradually. They were in a legal separation soon and then got divorced in 2006. When recalling her ex-husband's violent behaviors or irrational memories, she had poor appetite, insomnia with nightmare, and even suicidal ideas.

We made the diagnosis of double depression, and prescribed 60 mg/day of mirtazapine with some hypnotics. Later, we switched the mirtazapine to 60 mg of duloxetine, but her mood disturbance remained "ups and downs."

According to her medical records, she had visited our emergency department (ED) more than 20 times per year from 2011 to 2019. Most of her mild complaints included itching skin rashes, slight cold, dizziness, and slight contusion injury. We also found that she faked unusual symptoms during hospitalization.

Her son was diagnosed with attention deficit disorder and had received regular treatment in our pediatric psychiatry outpatient clinic from 2008 to 2012. In March 2012, she sought for intelligence assessment for him due to learning difficulties. During the test, the psychologist found that he was reluctant to cooperate with the test and hid true expression. Besides, our observation was not like what his mother's statement. Finally, the assessment did not finish due to the unreliable results. She was dissatisfied and then refused the follow-up.

In August 2016, he was admitted to another hospital "A" because she said he had voices which commanded violent behavior toward her and a suicidal tendency. But the medical staff observed that he had no obvious psychotic features after admission and then he was discharged home from the hospital. She fabricated other psychological symptoms again to refuse discharge with the same old trick.

To our surprise, he had a total of 522 clinic visits and many admissions in different hospitals from 2009 to 2016. He was admitted 5–6 times every year at our hospital, and the longest length of hospitalization lasted for 10 months. The diagnoses during various hospitalizations included brain concussion, contusion injury of extremities, acute bronchopneumonia/bronchitis, and acute lymphadenitis. He had had many unusual accidental injuries. We also found a seizure attack as a main symptom told by his mother in our ED since 2015, but we did not find any evidence for supporting this diagnosis. The psychiatric staff thought that he was a victim of factitious disorder imposed on another.

The medical staff separated the child from his mother immediately and contacted other community resources, including the Center for Domestic Violence and Sexual Assault Prevention, schools, different hospitals, chief of the village, police department, fire department, and the lawyer, with an objective of helping this family restore normal life.

After a 15-month treatment with the efforts from multiprofessional approaches, his mental and physical conditions were improved steadily. But he did not meet the diagnosis of intellectual disabilities after reassessment. A closer and stronger intra-family relationship was built, and then, he returned to the original family.

Unfortunately, we heard that she suddenly "died" from a hypovolemic shock due to unexpected fall in the restroom during hospitalization in hospital "B" in October 2019. Her mother (i.e., the boy's grandmother) told us that her general condition got better, and the doctor allowed her discharge the next day. The story was weird that something happened before discharge, but this time was the end of the tragedy.

Comment

The clinical course of the mother–son pair was characterized by repetitive hospitalizations and wandering from one hospital to another. Their somatic symptoms were diffuse, nonspecific but were controlled by herself. She was once caught faking fever symptom by using hot towel on her son's ear lobe, and she was also suspected creating worsening wound condition at the clinic. When doctors mentioned discharge, she always made an excuse to refuse. We could not judge whether she wanted to play the sick rôle, but we think that she wanted to get attention. Her family was poor, and she did not change any material condition after hospitalizations. Besides, she did not have any legal problems or other external incentives. We suspect that she was a case of Munchausen syndrome by proxy (MSBP) and highly suspected combined Munchausen syndrome (MS).

An estimated 30%–70% of abusers have both MS and MSBP, and mothers are the most common characters [1, 2]. Most victims are often reported in pediatric journals rather than in psychiatric periodicals [3]. Children's mean age is 3 years 2 months, and often under the age of 6 years [4]. The death rate among the victims is around 7.6%, of which the younger

ones are substantially higher [5, 6]. Separating the child from an abuser and providing a safety place are necessary.

In this case report, her son was 13 years old when receiving help, and he should fight against her deception. Long-term hospitalization may lead to his cultural deprivation, and he may be forced by his mother's intention.

MS cases often have combined personality disorders, such as borderline or narcissistic personality disorder [3]. We had a chance of arranging for a psychological assessment for her in July 2017, and the result showed the tendency toward cluster B personality disorder.

Psychotherapy may be effective for patients combined with personality disorder. But no enough evidence exists to show biologic or psychological therapy having efficacy on them [7]. Only 12% of patients agree to receive treatment [8].

MS and MSBP are not easily identified and diagnosed, and they are associated with high morbidity. The availability of electronic medical information and good cooperation between inpatient and outpatient staff can help medical professionals to diagnose earlier, so we can avoid unnecessary treatment and waste of medical resources. The long-term supportive and later confrontational psychotherapy can be conducted to increase awareness toward their diagnosis and strengthen treatment adherence. Although being limited with a single case report here, we still suggest that a multidisciplinary team can facilitate a more comprehensive and holistic approach to those patients, thus preventing the risk of tragic adverse events during hospitalization. (This case report was approved by the institution review board of Tri-Service General Hospital [IRB protocol number = V1-20201120, and date of approval = December 4, 2020] without any stipulation of obtaining informed consent from the patient).

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Conflicts of Interest

The authors declare no conflicts of interest in writing this report.

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