

Munchausen's syndrome by proxy in Iraq; case series

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Abstract

Munchausen syndrome by proxy is a rare and serious form of child abuse and psychological maltreatment, comprises both physical abuse and medical neglect. It is characterized by a child with symptoms and signs of an illness that have been fabricated by the mother or the caregiver. Ten children less than 7 years of age (eight males, two females) with Munchausen syndrome by proxy were seen in Al-Tifil Central hospital and Tikrit Teaching Hospital between 1998-2007. In three of the patients the mother was the only offender, the child's aunt was the only offender in another one patient, the mother and her sister were the offenders in another patient, the mother and her aunt was the offender in another patient, and in the remaining 4 patients the mother's aunt was the offenders, who named here as the great perpetrator, because she was the perpetrator with 10 victims of different ages. In 9 patients, the relations was the offender's motivation in comparison economic motivation in only one patient. One child died, while the other patient's lives were saved. Difficulties in diagnosis and management in this field are presented. This is a pioneer study for five reasons; 1st: it reveals existence of MSBP in Iraq for the first time, 2nd: it describes a novel type of MSBP, which caused by the great perpetrator, who had 10 victims of different ages; 3rd: it describes 2 patients of adult victims of MSBP, and 4th: describes offenders who act in duet manner 5th: special problems unique to the Iraqi society has been described. Until now, no national legal guidelines exist in the Iraq to child abuse in general and MSBP in particular. Urgent guidelines, policies, and legal system are required. It is necessary to create awareness even in the medical community, to recognize this problem and should therefore be considered in the differential diagnosis of unusual illness with bizarre features, even if the parents' behavior appears normal.

Keywords: Munchausen syndrome by proxy in Iraq.

Introduction

The term Munchausen syndrome by proxy (MSBP) was introduced by Meadow in 1977 to describe a form of child abuse involving the mother's, a parent's, or another guardian's falsifying illness in a child [1]. MSBP is a form of abuse results from the production or presentation of false illness in the child by an adult, usually a parent[2]. MSBP prevalence is 2-4 cases/million in the general population, with 10% fatality rate. MSBP has physical morbidity rate of 75%; and possibly even higher psychological morbidity rate [3, 4, 5]. MSBP is a rare,

potentially life-threatening in which the parent or caregiver may (1) fabricate a medical history; (2) cause symptoms by repeatedly exposing the child to a toxin, medication, infectious agent, or physical trauma; or (3) alter laboratory samples or temperature measurements. Depending on the parent's sophistication and secrecy, a variety of convincing, diseases may be simulated or created. The parent may deny any involvement and, in instances of intentional poisoning, smothering, or trauma, may continue the action while the child is hospitalized [6]. Related behaviors include mothering to death, doctor shopping, overanxious parents. MSBP requires a parent who exhibits the behavior

("the perpetrator") and assumes the sick role by proxy" the term by proxy means through a substitute. [2] & a child who is dependent and unable to prevent the deception and a doctor who is deceived into MSBP [2]. The exact cause of MSBP is not known, but researchers believe both biological and psychological factors play a role in the development of this disorder. Some theories suggest that a history of abuse or neglect as a child or the early loss of a parent might be factors in its development. Some evidence suggests that major stress, such as marital problems, can trigger an MSBP episode [2]. Generally determining the incidence and prevalence of MSBP is difficult for a variety of reasons; 1st: No population-based studies have been conducted, 2nd the true incidence of MSBP is hard to assess because many cases go undetected, 3rd; Often, there are case suspicions, but insufficient evidence exists or is gathered, so these cases are never officially reported or investigated, 4th; furthermore, the diagnosis of MSBP takes time; average time for diagnosis ranges from 6 to 15 months [7, 8]. The incidence of Munchausen by proxy syndrome diagnoses in Iraq is unknown, and to the best knowledge there is no description of the syndrome in Iraqi medical literature and this is the first article describing this syndrome in Iraq.

Munchausen syndrome by proxy

Patients

Patient 1:

AH is a seven-year-old male child, under care of his aunt, frequently seen in the outpatient clinic and admitted for several times to (Al-Tifil central teaching hospital in the period 1997-2000) with complaints of fever and cough. AH and his aunt were very well known to the medical staff in the hospital. The caregiver was a an anxious and irritable, 55-year-old-female. She insisted on admission to hospital every time she visited outpatient

clinic. In one occasion, the child had been seen and diagnosed to have a lower respiratory tract infection for which he received a full course of antibiotic. The aunt was unhappy with the previous treatment. The aunt after 2 weeks bring AH again with the same complaint, & admitted to hospital for 1 week and extensive investigations for pyrexia of unknown origin failed to reveal any pathology, and after that he discharged as a case of PUO under investigation and for follow-up. All the investigations and workup for PUO were done repeatedly in another 2 admissions; and they were negative and the presence of fever and its causes were ruled out. Empirical treatment in form of antibiotics and antipyretics were prescribed and used in every admission.

Then the child's presented with complaint of haemoptysis, which was sufficiently convincing to admit him for a workup (Complete blood count, echocardiography, stool for occult blood etc.) which failed again to reveal any pathology. AH was discharged as a case of haemoptysis under investigation, and treated with antituberculous chemotherapy. On each appearance at the outpatient clinic, the aunt insisted on cough of blood and fever but she didn't bring any sample of the vomitus when she asked. The patient was readmitted again for 4 days and discharged without any intervention or diagnosis. The aunt was very overanxious, cooperative and seemed highly concerned. In every admission his aunt insists on the presence of symptoms and complaints. Apart from this the child is well and with lovely personality. He spends his time during the admissions with playing with the medical and paramedical staff especially in the absence of the aunt. After the fifth admission, we start to think of factitious fever and MSBP. But the aunt insists on presence of fever and did many problems with medical staff who said to her that AH is well and afebrile. This aunt had no relations with the any of the hospital personnel but she insisted on presence of symptoms, and she frequently quarreled with anyone who told her the

truth. Following many problems created by the aunt, she stopped coming to the hospital for no apparent reason. Almost a year later, the aunt told us that she had been admitted to another hospital where another set of extensive investigations had not revealed any pathology.

Patient 2:

AH is a 3-year-old male child seen for the first time in emergency department (ED) because of history of accidental kerosene ingestion for which observed for 24 hours and then got fever and Chest X-ray revealed patches of pneumonia, and admitted for kerosene pnumonitis to the pediatric ward. After 5 days, he improved, but the striking thing that we saw that the mother started to leave her child in the ward for hours specially at night and goes out with different men. And when she was present, she always complain of worsening her child's condition, in contrast to what the examination revealed. Her child was nice, normally developed. The mother insisted on remaining in the hospital for full of 13 days. Every time she discharged, she went to hospital manager and tell him that her child was in a bad condition & in need to remain in the hospital.

Her relations with the ward paramedical staff were on clear and well known by the staff and other patients. After 1 week of her discharge from hospital, she returns again with the same problem. She claim that her child accidentally ingests kerosene, for which she admitted to the pediatric ward, and she insisted on remaining despite of good her child's health in the hospital for another 10 days. After several days of her last 2nd discharge from the hospital we asked to see the same child in ED because of history of accidental kerosene poisoning, for which she admitted for another 2 weeks with her same behavior and multiple relations. At this time the child was severely dysponic and tired. He had severe pnumonitis with pleural effusion. At this time the MSBP was put into the list of differential diagnosis. She was not taking care of her child, she always away from

him at the time of giving treatment to the patient, and leaves him in his bed for hours especially at night. The mother was illiterate and she said that the father was left them few months ago and had a relation with another female. At that time we are sure that the mother intentionally giving her child kerosene to admit him to hospital for the sake of her multiple relation. A legal accusation against the mother was raised in the police station in the area. But some policemen advice us to leave the case because she may create many problems to us, because she engaged in relations with the policemen at the police station. Because of our cultural characteristics she may accuse any one of us with anything.

Patient 3:

A 27-year-old-mother and her 19-year-old sister accompanied the 65-year-old grandmother who admitted to the hospital for a major surgical procedure for a period of 5 weeks. In the hospital, in this period they duet engaged in relations with the hospital staff and other employee. Although the grandmother improved in 7 days of postoperative period, and they refused to be discharged. The surgeons and the staff complaint of the duet's abnormal behavior in leaving the patient for hours. After the grandmother's discharge from the hospital, and in order to return to hospital again, she brought SBS, her 2-year-old male child SH with signs and symptoms of respiratory infection and stay in the hospital for 10 days. The child's general condition improved after 2 day of antibiotic treatment but his mother insists that he is still sick and insists on staying in the hospital. She discharged with her child after 10 days. After few days after discharge the mother brings her child with kerosene poisoning, for which she remain in the hospital for 1 week. During this admission they created problems with some of the pediatricians and residents because of their abnormal behavior for which they moved to another hospital.

Patient 4

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Ten-month-old-female child from a rural area admitted to the pediatric ward because of cough and shortness of breath of 2 days duration. From the history, the family has only 3 children. On admission chest X-ray taken and reveal a patch of pneumonia. The child received antibiotics and supportive measures. On day 3, the sick child improved, but the mother insisted in remaining in the hospital despite of her child's well condition. The reception unit in the hospital claimed that the mother spend her nights outside the hospital and away of her sick child. The mother advised frequently by the staff and other patients relatives and she replied that the father and his child don't deserve. On day 7 the child got mucoid bloody diarrhea with high fever, and stool examination revealed *E. histolytica* and treated with IV metronidazole and IV fluid and antipyretics. She improved at day 10, but the mother insisted on remaining in the hospital for an additional week. Fortunately the child remain healthy during this period, and in order to avoid problems she discharged on day 17 by a decision from a pediatric committee.

Patient 5

Amma is a 55-year-old female was an aunt of 4 young ladies (beautiful daughters of her brother), as she said she lived with them after her separation from her husband. She brought up the 4 young brother's daughters and assisted them in their life and marriage. Amma and her (20 years old) oldest and most beautiful brother's daughters (SHA) accompanied her brother's wife (who was 55-year-old) to the Tikrit Teaching Hospital for cholecystectomy on 2005, for which they remained in the hospital for 45 days. Amma represent a teacher and a leader for brother's daughters (SHA), and this admission seems to be the training course for both of them for learning of how to use the hospital as a place for spending a nice nights. Both companions held relationships with the hospital employee during this admission. The medical staffs responsible for the grandmother's condition claimed

that this duet want to stay in the hospital for a longer period of time, and they think that they were responsible for most the complications and problems of their patient. The surgeons thought that the duet intentionally interfere (they didn't give the treatment to the patient in a proper way) with the management of the patient to prolong the hospitalization time. The presence of such patient's companions with this behavior was a distressing to hospital because the staff should keep the patient's life form the disease and from bad and abnormal behavior of the companions.

Hardly they could discharge the patient home after this long admission. This woman Amma was the great perpetrator because she was the perpetrator with multiple victims. The brother's wife was the first victim and her 20-year-old-brother's daughters was the second victim, and her younger brother's daughters were the other 3 victims. After this admission she didn't leave the hospital over a period of two years, every time she enters to the hospital with one of these ladies children.

After they were discharged from hospital, and to return to the hospital Amma and SHA, were transformed to the use of the (Second victim). A. A. was a nine-month-old female, brought to the hospital by the duet (her mother and the mother's aunt) because of diarrhea, vomiting, & fever of 5 days duration. On examination; the child was pathetically unhappy, complaining eyes" mercy's seeking eyes", the child was miserably found to be moderately dehydrated, febrile, pale, marasmic with wasting, oral thrush, fungal napkin dermatitis & was appeared to be neglected with dirty clothes. She was admitted & investigated thoroughly and treated with intravenous fluid & antibiotic. The absence of response to treatment and child's condition deterioration was strange. After careful observation, it was discovered that the mother was starving her child, & was blocking the stream of intravenous fluid. She was always absent at the time of morning tour & at the time of giving treatment by the nursing staff. She

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refused to do the investigations under many excuses, & was visited by many hospital personnel, except the father who was never seen. While she was neglecting her child she was taking care of her teases & grandstanding behavior that are inapplicable with a mother having a critical child in the hospital. The MSBP jumped in the differential diagnosis & the history taking, clinical assessment reviewed. The mother was a 20, young lady, illiterate housewife. She was obliged to marry 45 years old footballer, to form an unstable family with many marital & social problems; she was physically abused by her husband, lived in 2- room-flat with poor socioeconomic status. After months of problems, she gets pregnant with A. A., & abortion was unsuccessfully attempted. The family had two other healthy children. The victim was exclusively bottle fed since birth she was using only one old & dirty bottle for feeding.

The mother was observed during preparation of feeds, she was never sterilized the bottle & she prepared two diluted feeds daily with tap water (she gave the child only 15 ounces per day) & the milk remained in the bottle for 8-10 hours & she just put the bottle in the child's mouth & supported by pillow & left supine in bed for hours. The victim was not given any type of solid food; and the excuse was that the child was spit up any type of food. The Mother was badly handling her child, with no signs of empathy. The mother was never seen smiling with or holding her child. The child was neglected, with dirty napkin, clothes & bed. She was left alone for hours while the mother is loafing & engaged amours & flings. Regarding developmental history; the mother gave wrong developmental history, she said that her child was crawling & walking but not sitting, the child was hypotonic, always bed ridden, never seen sitting, but on examination she was normal. Child's condition was deteriorated till the stage of septicemia & impending death. The patient & her mother was put under close observation, the visitors were restricted.

The first aim was to save victim's life, through treating septicemia & protecting her from the mother's abnormal behavior. To avoid problems which might be created: first by the mother by telling her about the real problem, second by mother's relatives, & to persuade those who they want to dismiss the mother & her child out of hospital because of socially unacceptable behaviors. It was explained to the mother indirectly "that her child is in need for help & asked to do her best to save her child's life.

There was an effort to teach the mother to take care of her child properly. There was calling of her relative's help but without benefit. After a difficult time mother was persuaded, to be examined by a psychiatrist, who diagnosed her to have "personality disorder, depressive disorder, & poor social performance" & started her on treatment. After twenty five days the victim's life was saved, started to improve, & gain weight but discharged with ambiguous future.

Patient 6

AH was a 4 months old male child admitted 10 times over a period of a year to the pediatric ward in Tikrit Teaching Hospital accompanied each time by his mother IHA and mother's aunt (Amma) for a period of 7-10 days with different causes; gastroenteritis, chest infections, febrile convulsion and meningitis. IHA is 18 year-old nice lady had good and happy marital status. Her husband had visited his child and wife frequently. During all admissions the mother was very respectable woman, taking care of her child very well, and had no abnormal relations in the hospital and always was refusing her aunt behaviors. But their problem was that (Amma), who was continued her abnormal and multiple relationships in the hospital. Because the previous history of Mother's aunt (Amma), the suspicions arise that she may induce these diseases by giving the child something to made him sick. With time the family also had the same suspicions. She

came to hospital with the mother and child but she spent most of time away from them. The child's mother knew that her aunt had abnormal relations. After 3 months of her last admission, the mother and her child seen in gynecology outpatient, the child was healthy and happy. The mother said that her aunt left their house 2 months ago.

Patients 7 and 8

MHA was 18-year-old nice lady had happy marital life, from a which of two male children MMK and SMK.

Patients 7: MMK is a 2-year-old-male child admitted over 8 times for different causes over a period of a year to the pediatric ward in Tikrit Teaching Hospital for a period of 6-7 days with different causes; gastroenteritis, chest infections, urinary tract infections.

Patients 8: SMK was 4 months old admitted over 6 times for different causes over a period of 6 months to pediatric ward. The causes were as following chest infection, gastroenteritis, and meningitis. In two of the admission the children were admitted together. In each admission the children were accompanied each time by their mother **MHA** and mother's aunt (**Amma**). Only the aunt was continuing her abnormal relationships, while the mother **MHA** refused her aunts behaviors.

The family had good and happy marital status. The husband had visited his child and wife frequently. During all admissions the mother was very respectable woman, taking care of her child very well, and had no abnormal relations in the hospital and always was refusing her aunt behaviors.

Patient 9

WHA was 17-year-old nice lady, was living with her 3 months old male infant and husband in a stable and happy marital. Mother's aunt (**Amma**) came to live the family every now and then to help the mother in daily housework and taking care of the child. AAA was 3 months old male infant, admitted for 8 times because of gastroenteritis over a period of 10 months, with each admission lasts for 5-10

days. Every time accompanied by his mother and mother's aunt (**Amma**). Also only mother's aunt (**Amma**) gets benefits from these admissions through her relationships, so she resisted discharge strongly at every time the pediatrician tried to discharge her victim.

Patient 10

ATN was 8-month-old-male infant a member of a unstable family consisted of the parents with 5 children. The family had many problems and bad marital relationship. **ATN** was seen after frequent and repeated admission (10-15 days admission for 15 times) because of malnutrition and persistent diarrhea. History revealed that the mother had a relationships with a man in the hospital, with whom went out every night leaving the child alone. She had daily problems with the father about their child's condition. Other patient relatives and mothers who share the room, told us that she was not giving her child the proper feeding and not giving her child the intravenous fluids and injections. Because the child didn't improved the father consulted many pediatricians, and create many problems with medical and paramedical staff. The father was very angry person; every time he came, he should do problems with the mother, hospital employee and with the pediatricians. He interfered with investigations treatment. The child's condition got worse in every admission despite all medical care which include a detailed workup and treatment. Unfortunately the child died because of septicemia.

Discussion

The patients in this study, are fulfill the definition of MSBP [6] . All of the patients had been seen by numerous doctors and All patients displayed wide range of symptoms, typically suggestive of a "multisystem disorder". In this study , mean age of affected victims was 20.4

months and this lower than what found by Meadow R that affected age was 38 months [9]. In this study, the victims were preschool children, and this explain that 9 patients are of preschool children [10, 11]. In this study , 8 victims were males and the remaining 2 were females and this is differ from what seen by Meadow R, that boys and girls are equally affected [9] as in table 1, and this can be explained by the sample and social differences. The perpetrators (as in table 2) in these patients were females which goes in accordance with studies which found that MSBP perpetrators are disproportionately females [12, 13]. The female preponderance may be attributed to the typical socialization pattern which encourages females to seek the sympathy and assistance of others while males who do so are considered to be "weak". It is not known whether this predilection to seek sympathy also has a gender-based genetic component. MSBP may also be attributed to another prevalent socialization pattern, that which places females in the primary caretaking role [2].

In this study, the mother was the only offender in three patients, and played a member of duet in victimizing her child in 2 other patients(as in table 2). This goes in accordance with studies that revealed that the vast majority of patients of MSBP, the perpetrator is the child's mother [14]. This result disagrees with A study showed that in over 85-90% of cases of Munchausen by proxy, it is the mother who is the abuser, and this can be explained by the sample and social differences [12, 13]. In other patients, the MSBP abuser is another female caregiver and this explain that nine of the patients the mother involved in causing the disease. Similar to what found by Catherine C, in this study, there was presence of a relative perpetrator in 6 patients, as main offender or as participant in the deception that is at the core of the perpetrating caregiver's victimization of the child [14].This result is higher than Stephen L. who found that 10-15% of patients, the MSBP abuser is another female caregiver [13]. The

presence of multiple perpetrators which found in 3 patients, is an interesting phenomenon. This is explained by the fact that Iraqi society gives the mother's aunt a guardianship or custody right to some relatives, and this should be considered in the treatment and prevention plans.

The perpetrators are usually perceived by the medical personnel as devoted and 'co-operative' [6, 15]. In contrary, in this study, the patient's mother were seen as a negligent females, criticized by physicians and nurses by her neglecting the child, this is another interesting points. This study patients suffered from multiple types of abuse, especially emotional abuse or neglect, medical neglect, this similar to what found another study by Louisa that all types of may occur in MSBP [16]. In this study, the False histories provided by perpetrators were not so impressive in medical detail and fabricated symptoms, which differs from that noticed by Meadow. Although the methods used was simple but with some cunning, dexterity, and, less often, medical knowledge [9]. It is noteworthy that, in this study the perpetrators got with some medical knowledge with repeated admissions which is differ from what seen by meadow[9].

Only one of the victims died and this is goes in accordance with Louisa who found that that 6-10% of MSBP victims die [16]. Regarding the benefits or motivation for such pathological behavior of perpetrator was as follows; relations was the benefit in 8 patients, punishment for the father in 2 patients, and economical in another 1 patient. Family problems was present in 6 patients and this is due to the fact that MBP is more than an abusive interaction between mother and child: It is also a family system disorder.[14]. It should be mentioned that family problems present to some degrees in all the cases from the start as a cause for MSBP or as a result and a cause of continuation of harm. Stephen L, & Anthony R. were indicate that in most cases, child abuse must be understood as a symptom of family

dysfunction that spans generations. In this study, all perpetrators stated that they suffered from abuse especially physical as adolescents and as mothers. This is higher than other studies that indicate that child abuse occur in 33-77% of families in which there is abuse of adults [17], and this may reflect a common problems in this society domestic violence.

Patient 1:

In this patient, the aunt was the offender, who was psychologically ill. Her main benefit was an economical one to get money from HA parents. Her way to keep her patient in hospital was a simple mean by insisting on the presence of symptoms and by making problems with the staff. In this case, MBPS was diagnosed clinically because of complete normal investigations and child's wellbeing. The child Missed 1 year of school as well as being prescribed a range of drugs including antibiotics, steroids and 27 other medications and this goes in accordance with (Libow, 1994) who found that child may show academic delays from "chronic absenteeism," and problems with concentration, emotions, and behaviors [18]. This diagnosis was done upon clinical bases when the clinical picture is atypical or does not appear medically plausible MBPS need to be part of the differential diagnosis [19].

Patient 2:

In this patient, the offender was the illiterate mother. The mother's motivation was the relations. Kerosene was used to make the child sick in a criminal manner, typically as written in studies that the offender may cause symptoms by repeatedly exposing the child to a toxin [6]. This patient reflect the special Iraqi situation in form of absence of social and medical awareness, legislation or centers to protect the child. It indicate also the difficulties faced by the physician who are aware of such form of abuse.

Patient 3:

In this patient, the offender were multiple (mother and her sister who act in duet manner) both of them were illiterate and their motivations were relations. Here there is presence of duet perpetrators (as in table 3). Here there was also 2 victims (the grandmother and the toddler). The presence of adult victims is supported by Judith A. Libow [20]. In this case the oldest offender played the role of teacher and leader for the second offender, and it absolutely contain an element of emotional abuse. The interesting thing was also neglecting of the victim and engagement in a relations and insisting on remaining in the hospital.

Patient 4

This patient regarded as the simplest form of MSBP, because the offender was illiterate for which she used simple and clear methods. I think this is the commonest form in Iraq but usually passed unnoticed. This is the only patient from a rural area, this reflects the social characteristics of rural area in terms of strict rules controlling the familial relations and secrecy of the females lives. The motivations was relations. In this case there was no element of inducing disease apart from using the patient as an excuse to remain in the hospital for a longer time.

Patients 5

This was a very interesting and a novel form of MSBP because the main offender was mother's aunt, who called here as the great perpetrator because she had multiple victims as follows; 60-year-old female, 4 adolescent mother(as in table 4) and 4 infants and 1 toddler (as in table 1). This is can be explained by the characteristics of Iraqi society which gives some relatives especially of the father some guardianship roles. Her main benefit was relations and to enjoy times. Her behavior include some criminal acts but because of society and unsecured situation and absence of suitable legal frame, she remain out of responsibility. The mother and her aunt (act in duet) after the 1st admission transformed to the use of the new victim AA, who was 9-month-old-

infant. This child was admitted with actual disease which was gastroenteritis, which may be result intentional starvation, emotional abuse, neglect. This goes in accordance with who found that the child's symptoms, their pattern, or the response to treatment may not be compatible with a recognized disease. Presence of scars of previous skin injuries indicate presence of physical abuse[8].

In this case the suspicion of MBPS was thought because the infant is not responding to treatment plus atypical prolonged course. In this case failure to thrive & gastroenteritis were induced by starvation by deliberately not feeding the child adequate amount of old diluted milk. In addition to abstaining from giving treatment to her child & abstaining from doing the investigations required. The mother insists on feeding her own child, using single old bottle which was badly sterilized. Infectious or toxic agents may be administered by any available orifice [7] this was the way by which infection induced. Julia Youll, stated that formula milk should not be left out of the fridge at room temperature for longer than it takes to feed your baby about 1 hour due to the risk of contamination from bacteria in the air [21].

The perpetrator had the following criteria of Schmitt BD child abuse & neglect- high risk checklist for infants from the physician's office observation (lack of handling, holding but no signs of attachment, rough handling, hygiene neglect, spanking of a young infant, & all are serious), from the prenatal observation & data; (abortion is unsuccessfully sought or attempted, history of severe marital discord, history of violent behavior), & from the maternity ward observations (the mother feeds her baby in a mechanical or other inappropriate way, prolonged separation of the baby from the mother due to marital discord, inadequate visiting pattern by the father, reluctance to come in for the baby when discharged approved) [22].

Patients 6, 9

The great perpetrator was the only offender, and relations was the main benefit. The father was present, and this indicate the stability of the family and family harmony. The mother was embarrassed with her aunt's behavior. The syndrome ended when the family and especially the father knew that the aunt was the source of the problem.

Patients 7 and 8

In this case the great perpetrator was the only offender, and relations was the main benefit. The father was present, and this indicate family harmony. The mother was embarrassed with her aunt's behavior. The syndrome ended when the family and especially the father knew that the aunt was the source of the problem. The striking thing was the 2 victims in the same family and a common offender. In this family 2 siblings were involved, and this goes in accordance with what found by Alexander that 25% to 35% of the time, MSBP is perpetrated serially on siblings [3].

Patient 10;

Here the offender was the mother and relation was the benefit. Neglect and interfering with the management was the method of inflicting the disease. Family problems bad marital relation was the cause of this abuse. The father was present but his role was negative one.

Common notes to all

Regarding the Management: theoretically, MSBP management often requires a team that includes social workers, foster care organizations, and law enforcement, as well as the health care providers, and unfortunately these are not present in Iraq. In these cases a lot of difficulties were faced and the social, cultural, and religious characteristics of Iraqi society and sensitivity of this issue add more to the MSBP complexity. In Iraqi society, women's relations outside marriage are absolutely unacceptable. That is why these patients are very difficult for

all pediatrician to treat and to deal with them socially and legally. It should be mentioned that pediatricians and even the medical staff and health authorities prefer either to discharge the patient or transfer him to another hospital to avoid endless problems, and surely this will lead to continuation of maltreatment. And when one of the medical and nursing staff is a part of this relation with the perpetrator will complicate the situation. Regarding the diagnosis, all the cases were diagnosed clinically when the children didn't respond to treatment and caregiver's abnormal behavior [18, 22]. Physicians should be aware of this syndrome in order to avoid unintentional participating in this morbid scenario by performing useless invasive examinations or by prescribing dangerous medication^[16]. And to detect less obvious cases of child abuse, the physician must be sensitive to the more subtle signs & must take the time to obtain an expanded history & behavioral observation^[23]

Regarding the treatment: All these cases were treated as a medical emergency, because it has high morbidity and mortality rate^[24]. The first concern in cases of MSBP is to ensure the safety and protection of any real or potential victims. This might require that the child be placed in the care of another. This was tried in case 5 without benefit. Another important point should be taken in to consideration in handling of MSBP, is that, the perpetrator are also in need for medical care and psychosocial rehabilitation to be good mothers or caregiver. This also is faced by many social and cultural characteristics of Iraqi society, so only one perpetrator accept psychiatric assessment and treatment.

Conclusions

MSBP is present in Iraq, but the medical community is not aware of it. Behind dispute there are many of victims of child and women abuse in our society

and are not known and they are suffering saliently which simply means more and endless harm, because if the child escapes death, or serious injury, he or she is subjected is severe emotional trauma, the scars of which are difficult to erase^[19]. This study reveal two novel and unique type of MSBP which was characterized by presence of duets perpetrators, and the great perpetrator (with multiple victims of different ages). Also this study revealed 2 adult victims of MSBP. This article is also describe special problems unique to the Iraqi society and culture. It is necessary to create awareness to recognize this problem and should therefore be considered in the differential diagnosis of unusual illness with bizarre features, even if the parents' behavior appears normal. In a long term base, building a constructive and legislative system suitable for the social, cultural, and religious background of Iraqi society. This can be only achieved by a comprehensive studying of the reports and studies on this sensitive issue of child (women) abuse and neglect are from western countries, which have a different socioeconomic and cultural pattern.

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Munchausen's syndrome by proxy in Iraq; case series

Table 1: Summary of the victims

	<u>Victim's Age</u>	<u>Victim's Sex</u>	<u>Perpetrators</u>	<u>Perpetrators History of abuse</u>	<u>Presentation</u>	<u>Hospital</u>	<u>Time of presentation</u>
1.	7 yrs	Male	Aunt	Emotional, neglect	PUO	Al-Tifil Central hospital, Baghdad	1998-2000
2.	3 years	Male	Mother	Physical , emotional, neglect	kerosene poisoning, chest infection	Al-Tifil Central hospital, Baghdad	2000
3.	2 year	Male	Mother and mother's sister	Physical , emotional, neglect	kerosene poisoning, chest infection	Tikrit Teaching Hospital	2006
4.	10 months	Female	Mother	Physical , emotional, neglect	Pneumonia, gastroenteritis	Tikrit Teaching Hospital	2006
5.	9 months	Female	Mother and mother's aunt	Physical , emotional, neglect	Gastroenteritis, dehydration and septicemia	Tikrit Teaching Hospital	2005-2006
6.	4 months	Male	Mother's aunt	Physical , emotional, neglect	Gastroenteritis, chest infections, febrile convulsion, meningitis	Tikrit Teaching Hospital	2005-2007
7.	4 months	Male	Mother's aunt	Physical , emotional, neglect	chest infection, gastroenteritis, and meningitis	Tikrit Teaching Hospital	2005-2007
8.	2 years	Male	Mother's aunt	Physical , emotional, neglect	Gastroenteritis, chest infections, UTI	Tikrit Teaching Hospital	2005-2007
9.	3 months	Male	Mother's aunt	Physical , emotional, neglect	Gastroenteritis , dehydration	Tikrit Teaching Hospital	2005-2007
10.	8 months	Male	Mother	Physical , emotional, neglect	Septicemia, death	Tikrit Teaching Hospital	2005-2006

Munchausen's syndrome by proxy in Iraq; case series

Table 2: Summary of perpetrator's characteristics.

Victim	Perpetrators age	Age year	Marital status	Family environment	Social class	Level of education	Motivation	Action	Psychiatric assessment
1.	Aunt	55	Widow	Problematic	Middle	Read and write	Economic	Fabrication	Refused
2.	Mother	24	Married	Problematic	Low	Not read and write	Relations	Intentional kerosene poisoning	Refused
3.	Mother	30	Married	Problematic	Low	Not read and write	Relations	Neglect, Intentional kerosene poisoning	Refused
	Mother's sister	19	Unmarried	-----	Low	Read and write	Relations, feel liberty	Co-perpetrator	Refused
4.	Mother	26	Married	Problematic	Low	Not read and write	Relations, punishment for the father	Neglect, Fabrication of failure of response to treatment,	Refused
5.	Mother	20	Married	Problematic	Low	Not read and write	Relations	Neglect, physical abuse, interfere with treatment, Induce the disease?, Fabrication of failure of response to treatment, resist discharge	Personality, Depressive disorder Poor social performance
	Mother's aunt	55	Divorced	Loneness	Low	Not read and write	Relations	Leader and teacher of Abuse	Refused
6.	Mother's aunt	55	Divorced	Good and happy	Low	Not read and write	Relations	Induce the disease?, Fabrication of failure of response to treatment, resist discharge	Refused
7.	Mother's aunt	55	Divorced	Good and happy	Low	Not read and write	Relations	Induce the disease?, Fabrication of failure of response to treatment, resist discharge	Refused
8.	Mother's aunt	55	Divorced	Good and happy	Low	Not read and write	Relations	Induce the disease?, Fabrication of failure of response to treatment, resist discharge	Refused
9.	Mother's aunt	55	Divorced	Good and happy	Low	Not read and write	Relations	Induce the disease?, Fabrication of failure of response to treatment, resist discharge	Refused
10.	Mother	38	Married	Problematic, bad	Middle	Not read and write	Relations	Neglect and interfering with the management	Refused

Table 3: Duet perpetrator characteristics

Duet	Member of duet	Perpetrator role	Adult MSBP	Presentation	Pediatric MSB	Presentation
First	Mother	Main offender	55-year-old female	cholecystectomy Complication	2 year male	kerosene poisoning, chest infection
	Mother's sister	Secondary offender				
Second	Mother	Main offender	60 year old female	cholecystectomy Complication	9 months female	Gastroenteritis, dehydration, septicemia
	Mother's aunt	Secondary offender				

Table 4: Summary of adult victims of the great perpetrator

	<u>Victim's Age</u>	<u>Victim's Sex</u>	<u>Action</u>
1.	60 years	Female	Emotional abuse, neglect, interfere with treatment, Induce the disease?, Fabrication of failure of response to treatment, resist discharge
2.	20 years	Female	Emotional abuse,
3.	19 years	Female	Emotional abuse
4.	18 years	Female	Emotional abuse
5.	17 years	Female	Emotional abuse