Current Psychiatry

CASES THAT TEST YOUR SKILLS

Ms. J's life revolves around caring for her sickly 4-year-old daughter. A hospital videotape, however, exposes the mother's impulsive, abusive actions toward her child. Is it Munchausen's or child abuse? You decide.

When a mother's love hurts

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INITIAL PRESENTATION A sickly child

Ms. J, age 35, was referred to a psychiatrist after she was observed endangering her daughter. The child's pediatrician provided the following history.

The 4-year-old has frequently required medical attention. As a baby, she wore a breathing monitor at home for almost 1 year after her mother expressed fear that she would die of apnea. Throughout her early years, the child was treated for asthma and abdominal pain and for bruises her parents said were caused when she fell out of her crib.

Recently, the child has suffered with recurring skin infections over her arm and shoulders. Her mother treated those with prescribed topical and oral antibiotics and dressings. The wounds would heal briefly, then become inflamed again.

The pediatrician consulted with a child psychiatrist, who suggested that the girl be hospitalized for a day so that doctors could examine the wound. Despite the mother's protests, her daughter was hospitalized.

That day, Ms. J visited her daughter, unaware that the hospital room was equipped with a concealed video camera. As she was leaving late that evening, she lifted her daughter's bandages as if to check them, then applied irritants to the wounds.

When the staff confronted her about this destructive behavior toward her daughter, Ms. J denied it had occurred. Upon seeing the videotape, however, she wept profusely, exclaiming, "I didn't mean any harm."

Ms. J does not fit the profile of a child abuser. Aside from part-time clerical work at home, she is a full-time mother who is intensely involved in every aspect of her daughter's life. Before the videotaped incident, her pediatrician's office staff had described her as caring and loving, and she had brought them thank-you gifts.

On psychiatric evaluation, Ms. J's speech is coherent and logical, and she has no delusions or hallucinations. In describing her childhood, she recalls her parents arguing constantly. Her father, with whom she had little contact, traveled extensively on business. At home, her mother ruled with an iron fist. Any show of rebellion by Ms. J or her siblings led to a sharp slap on the shoulders.

Ms. J had few friends in grade school. In college, she earned good grades but often visited the

Table

Defining symptoms, features of Munchausen's syndrome

Major symptoms

- **Simulated illness,** usually recurrent
- **Pathological lying** (pseudologia fantastica)
- **Peregrination** (wandering, often with name and identity changes)

Secondary features

- **Medical knowledge** or training
- **Multiple doctor visits** or hospitalizations
- **Several scars** (usually abdominal)
- **Unusual willingness** to undergo diagnostic or treatment procedures
- **History of rejection** or abuse during childhood, with feeling of comfort while receiving medical care
- **Borderline or antisocial personality**
- **Ostentatious presentation** at emergency room or doctor's office

infirmary with nonspecific complaints. She was hospitalized twice without a conclusive diagnosis. She twice saw a psychiatrist to address her medical symptoms and feelings of emptiness.

After college, Ms. J worked as a teacher's aide. At age 30 she married a teacher, and their daughter was born 1 year later. The marriage ended in divorce after 3 years. After divorce the husband tried to visit the daughter but Ms. J interfered, insisting, "I'm enough."

Ms. J told the psychiatrist that her ex-husband at times accused her of being "too clingy." If he went to a sporting event, she would repeatedly ask what time he would come home. If she had to go shopping and he was home, she would ask him to drop everything and accompany her.

Does Ms. J's behavior suggest a straightforward personality disorder, or would you consider a factitious disorder?

Dr. Messer's observations

Ms. J recalled a childhood fraught with rejection and abuse. This finding, plus the deliberate injury to her daughter, points to a diagnosis of Munchausen's syndrome by proxy.

Although not listed in DSM-IV-TR, Munchausen's is the most severe form of factitious disorder (*Table*). First described in 1951, the disorder is named for Baron Karl von Munchausen, an 18th-century German nobleman known for telling tall tales about his life and exploits.[1]

In 1977, British pediatrician Roy Meadow described Munchausen's syndrome by proxy, in which parents induce symptoms in their children—such as by injuring them with drugs or bacterial contaminants—then have doctors treat them.[2] Because persons with Munchausen's tend to frequently change their names and locales, the incidence of Munchausen's and Munchausen's by proxy has never been accurately gauged.

Munchausen's occurs in both sexes, although men tend to exhibit more-dramatic symptoms such as self-induced fevers, bleeding, and seizures. Antisocial behavior is common among men with Munchausen's, and many are jailed at some point. One man flying from New York to London feigned a heart attack so convincingly that he forced an emergency landing in Halifax, Nova Scotia, where he was hospitalized and released with a referral to his cardiologist.

By contrast, women with Munchausen's or Munchausen's by proxy—often nurses or hospital personnel—are more difficult to diagnose because they usually are agreeable and compliant with medical staff. Staff members tend to ask themselves, "Could such a caring person be putting us on?"

Some persons with Munchausen's visit disease-specific support groups and draw attention or sympathy by faking illness. Having amassed significant medical knowledge through Web searches and frequent doctor visits, they present themselves as both patient and lofty advisor. Their antisocial tendencies can negatively alter group discussions, and the revelation that a fellow group member is an impostor can distress legitimate participants.[3]

Ms. J exhibited no evidence of a delusional disorder, which occurs rarely among parents with Munchausen's by proxy. Her allegedly "clingy" (dependent) behavior toward her daughter and ex-husband, however, indicates borderline personality disorder or antisocial personality disorder, which are common in both forms of Munchausen's. Like Ms. J, these patients

- have strong fears of rejection and abandonment
- are often impulsive
- exhibit damaging behavior to self or others
- have an unstable sense of self
- are unusually willing to comply with clinical tests or procedures
- and describe feelings of emptiness.

How would you confirm a diagnosis of Munchausen's? What features in Ms J's case distinguish Munchausen's from other factitious disorders?

Box

Munchausen's and allegations of child sexual abuse

- **Munchausen's syndrome by proxy** has been reported in women who were sexually abused in their youth. As adults, some of these women become hypervigilant against sexual abuse of their children.
- **The disorder** has been cited in several legal cases in which a suspect—usually a teacher or religious leader—was falsely accused of sexually molesting a child.[4] Psychiatrists involved as expert witnesses or examiners in such cases should consider these allegations as a possible manifestation of Munchausen's.
- **If the accused denies the charges** and no evidence is uncovered, the alleged victim's mother should be interviewed. In some cases the mother was sexually abused and sought help, but the perpetrator was never apprehended. She may harbor resentment toward men and repeatedly ask her child whether he or she has been touched inappropriately. The child—besieged by frequent inquiries or unsure of what constitutes an inappropriate touch—may answer "yes," prompting the mother to press charges against the named individual.

Dr. Messer's observations

When taking the patient history, look for:

- **a pattern of rejection or abuse in youth.** In women who have been sexually molested, Munchausen's by proxy may manifest as allegations that their children have been touched inappropriately (*Box*).[4]
- **history of multiple surgeries.**[5] Because Munchausen's can coexist with genuine physical illness, the psychiatrist and other doctors need to carefully review the findings to determine the existence of medical symptoms or Munchausen's. Doctors usually choose to operate if there is any suspicion that medical symptoms exist.

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- **memories of sympathetic and nurturing medical care early in life.** A severe emotional crisis can awaken these memories. For example, emotional pain after a divorce or break-up can trigger a Munchausen's episode in a subconscious attempt to repair this hurt.

Carefully reviewing the history will turn up glaring discrepancies in the patient's account of his or her illness. Patients with Munchausen's or Munchausen's by proxy usually present to numerous clinicians and do not describe their "illness" the same way twice. Sharing information with other members of the care team—many of whom may feel anger after learning that a patient has been feigning illness—is crucial to confirming the diagnosis.

DIFFERENTIAL DIAGNOSIS

Munchausen's should not be confused with symptoms of other lookalike disorders:

- **Hypochondriasis** applies to patients who are convinced they have a serious illness despite lack of a medical basis. The person may misinterpret normal bodily functions and suffer severe distress. The symptoms may express inner psychic conflict.
- **Somatoform disorder** is a physical complaint that cannot be explained as a known medical condition. This may include preoccupation with an imagined defect in appearance or loss of physical capacity. The deficit usually coincides with emotional conflict and—unlike Munchausen's—there is no fabrication of illness.
- **Malingerers** purposely fake physical symptoms for specific gain, such as money, hospital care, disability, drugs, or avoiding military duty.

Persons with Munchausen's have no external incentive for their behavior. Aside from the medical staff's admiration, Ms. J had nothing to gain from injuring her daughter or portraying her as sickly.

TREATMENT Coming home

Ms. J's daughter responded well after being placed in the home of a relative who had a 3-year-old daughter of her own. Ms. J was allowed to see her daughter for 2 hours each day under strict supervision by a retired schoolteacher hired by the family. If Ms. J. violated the agreement, such as by leaving the house with her daughter, she was prohibited from seeing her child the next day.

Ms. J agreed to long-term therapy; in exchange, judicial proceedings were deferred. In most cases, the mother is referred to police and charged with child abuse/endangerment. However, the medical staff in this case felt treatment and supervision would provide ample rehabilitation.

The mother was referred to a psychiatrist trained in psychoanalysis. By making her aware of her unconscious responses, the doctor sought to improve Ms. J's ability to cope with stress. Patients with a borderline personality disorder seldom respond in psychoanalysis, but Ms. J exhibited significant ego strengths and intelligence—and was motivated to regain custody of her daughter.

Ms. J's transference response was predictable: She tried to please the doctor in everything she said or did. This reaction was analyzed and the insight helped Ms. J understand why she exaggerated or exacerbated normal childhood illnesses in her daughter. She discovered that she had hungered for approval since childhood and went as far as injuring her daughter to achieve this fulfillment. Early in treatment she developed a mantra: "I have behaved toward my daughter as my mother behaved toward me."

After 8 months of therapy 3 times a week, Ms. J regained custody. She continued to receive once-weekly psychotherapy for 1 year.

Two years after regaining custody, Ms. J developed a stable, loving relationship with her daughter. She works full-time while her daughter is in high school and participates in many activities. The relative who assumed temporary custody stays in touch, as does her pediatrician.

The girl is seen by her father on alternate weekends. She tells friends she wants to become a nurse.

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How can psychiatrists facilitate early diagnosis and treatment of Munchausen's?

Dr. Messer's observations

Although primary care physicians or general surgeons treat most patients with Munchausen's, the disorder is psychiatric in nature.

For that reason, psychiatrists should participate when possible in the early medical workup of a patient who presents with an apparently severe illness. This way, the psychiatrist can:

- help detect Munchausen's or another factitious disorder sooner
- establish a rapport with the patient early on. If Munchausen's is subsequently diagnosed, the patient may be less likely to resist treatment or bolt when confronted.

When confronting someone suspected of fabricating or inducing symptoms, tell the patient that he or she might have Munchausen's syndrome. Describe the disorder and cite cases, then challenge the patient to find a more appropriate way to cope with stress.

Munchausen's syndrome by proxy should be considered in a parent when a child has an inexplicably protracted illness or injury. Childhood trauma and low self-esteem are key to confirming the diagnosis. Psychoanalysis can provide insight into the patient's behavior.

Bottom Line

Related resources

- Adshead G, Brooke D (eds). *Munchausen's syndrome by proxy. Current issues in assessment, treatment and research*. Singapore: World Scientific Publishing, 2001.
- Munchausen's syndrome by proxy. www.gktscientific.com

References

1. Asher R. Munchausen's syndrome. *Lancet* 1951;1:580-5.
2. Meadow R. False allegations of abuse and Munchausen's syndrome by proxy. *Arch Dis Child* 1993;68:444-7.
3. Feldman MD, Eisendrath SJ. *The spectrum of factitious disorders*. Washington, DC: American Psychiatric Publishing, 1998.
4. Schreier HA. Repeated false allegations of sexual abuse presenting to sheriffs: when is it Munchausen's by proxy? *Child Abuse Negl* 1996;20:985-91.
5. Menninger KA. Polysurgery and polysurgical addiction. *Psychoanal Q* 1934;3:883-9.

Have a case from which other psychiatrists can learn?

Current Psychiatry

Check your patient files for a case that offers **"lessons learned"** and send it to **pete.kelly@dowdenhealth.com**. Keep it to 2,000 words, outlining history and treatment options, with interspersed commentary to reinforce the key points.

If you have questions before writing, contact Pete Kelly. Our editorial board and case history editor will review your article—and you'll hear from us soon.