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Munchausen Syndrome by Proxy and Factitious Illness: Symptomatology, Parent-Child Interaction, and Psychopathology of the Parents

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The term Munchausen syndrome by proxy is used to diagnose children presenting symptoms of an organic disorder resulting from manipulations initiated by their caretakers. Even in early infancy it happens that injuries are induced, and that drugs, poisons or medicine are administered in order to provoke and feign clinical symptoms of severe diseases. Exact data on prevalence are not available but it is obvious that Munchausen syndrome by proxy is a rare psychiatric disorder. There is a body of evidence that Munchausen syndrome by proxy is nothing but the extreme of a broader clinical entity for which the term factitious illness has been introduced. In this group children are included whose mothers invent a history of disease in order to produce symptoms without actually damaging their children. It is not well established whether such a distinction is necessary and whether there are differences in long-term outcome. Onset of symptoms is as early as three weeks up to twelve years, and mean age of diagnosis according to a more comprehensive study is 3 1/4 year. The estimated mortality rate of children with Munchausen syndrome by proxy is 9 percent. In three of the four cases of children reported here clinical presentations were dominated by symptoms of central nervous disorders. All mothers showed unsure and inconsistent parental behaviour and inefficient coping. None of them received support from their partners, if present. In interaction the children always wanted to dominate their mothers. The high amount of personality disorders observed in the caretakers might be the reason for the often reported failure of psychotherapeutic interventions.

Keywords: Munchausen Syndrome by Proxy, Child, Factitious Illness, Parental Personality Disorders, Sexual Abuse, Psychopathology, Case Reports

Introduction

The Munchausen syndrome is well known and often reported in adults, with symptoms of an organic disorder induced or produced by the patient himself to initiate investigation and treatment. Meadow (1977) was the first to describe children presenting symptoms of an organic disorder which result from manipulations initiated by their caretakers. He introduced the term Munchausen syndrome by proxy (synonymous Meadow's syndrome). Verity et al. (1977) used the term Polle's syndrome to describe children presenting feigned symptoms, caused by parents suffering from Munchausen syndrome. But there is a body of evidence that Munchausen syndrome by proxy might be nothing but the extreme of a broader and much more common clinical syndrome for which the term factitious illness has been introduced. This group also includes children whose mothers or caretakers only invent a history of disease but do not induce symptoms by means of drugs, medication or physical violence. There is a broad spectrum of health care seeking behaviour of parents for their children evoked by the concern about

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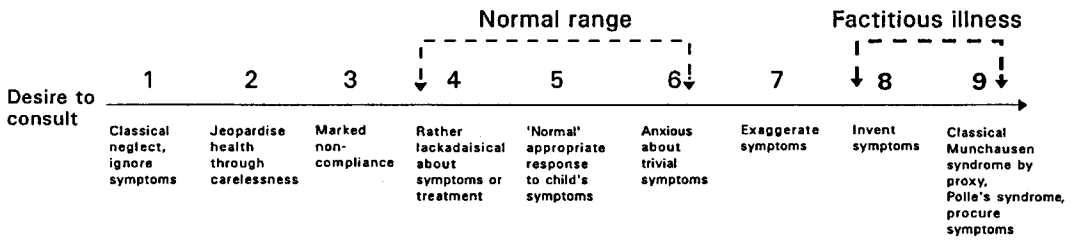

Figure 1. Differences in parents' concern about their child's symptoms (modified from Eminson & Postlethwaite, 1992).

child's symptoms (Eminson & Postlethwaite, 1992). It extends from total ignorance of symptoms, an adequate level of concern to procured illness, as shown in Figure 1. But up to now there is no convincing evidence that these two types are significantly different concerning long-term outcome of the children and the response of caretakers to psychotherapeutic interventions.

In a metastudy of 117 reported cases with Munchausen syndrome by proxy conducted by Rosenberg (1987), 10 percent of the mothers were diagnosed as certainly suffering from Munchausen syndrome and another 14 percent had some symptoms. Drugs, poisons or medicines are administered, even in early infancy, in order to provoke and feign clinical presentations of severe diseases.

By imitation of symptoms often painful and sometimes harmful examinations are initiated in some cases resulting in false diagnosis (Kahn & Goldman, 1991; Sofinowski & Butler, 1991). One of the most striking and frequently observed facts is the ambivalence shown by one of the caretakers, who is caring and concerned about the child but simultaneously insists on painful interventions which can lead to impaired physical functions. Table 1 (modified from Jones et al., 1986) shows anamnestic data and clinical symptoms which should lead one to consider the diagnosis of Munchausen syndrome by proxy.

Table 1. Anamnestic data and clinical symptoms of Munchausen syndrome by proxy.

1. Persistent or recurrent illness for which a cause cannot be found
2. Discrepancies between history and clinical findings
3. Symptoms, and symptoms that do not occur when a child is away from the mother
4. Unusual symptoms, symptoms or hospital course that do not make clinical sense
5. A differential diagnosis consisting of disorders less common than Munchausen syndrome by proxy
6. Persistent failure of a child to tolerate or respond to medical therapy without clear cause
7. A parent less concerned than the physician, sometimes comforting the medical staff
8. Repeated hospitalizations and vigorous medical evaluations of mother or child without definitive diagnosis
9. A parent who is constantly at the child's bedside, excessively praises the staff, becomes over-attached to the staff, or becomes highly involved in the care of other patients
10. A parent who welcomes medical investigation of her child, even when painful
11. A caregiver suffers from Munchausen syndrome

Epidemiology

Despite the fact that exact data are not available it is obvious that Munchausen syndrome by proxy in the narrow sense is a rare psychiatric disorder. Godding and Kruth (1991) identified 17 families (1 percent) out of 1648 patients with childhood asthma as having this disorder. In at least 54 (0,27%) out of a total of 20 009 children with risk of apnea observed by special apnea monitoring programmes, evidence of a Munchausen syndrome by proxy could be found and three of them as well as five siblings died during unknown circumstances (Light & Sheridan, 1990). Onset of symptoms is as early as three weeks up to twelve years, mean age of diagnosis in 67 children studied by Rosenberg (1987) was 3 1/4 years. As Munchausen syndrome by proxy is a subgroup of factitious illness, the latter therefore is much more common than expected, but exact data is not available.

Outcome

In a survey of 117 case reports Rosenberg found a mortality rate of 9 percent. Unknown circum-

stances led to the death of 10 siblings of the affected.Diagnostic interventions (e. g., explorative laparatomy) also may cause persistent physical impairments. Long-term morbidity due to impairment of gastrointestinal functions, destructive joint deformities, mental retardation and cerebral palsy was assessed in 8 percent of the children. This is the rationale for regarding Munchausen syndrome by proxy as an extremely severe type of child abuse which can be compared with the battered child syndrome in severity. It is very difficult to estimate the impact on social-emotional development. In every single one of the four investigated children Roth (1990) observed a severely disordered social-emotional development, even though their physical impairments were mild. Considering the obsessive tendency of the caretaker to repeat this behaviour although psychotherapeutic interventions have been applied, the outcome of Munchausen syndrome by proxy occurs to be even more doubtful than expected (Stone, 1977; Schreier, 1992).

Hypothesis of the Motivational Aspects

Again it was Meadow (1982) who tried to define the personality traits of the perpetrators. Several other investigators have tried to gain insight into the motivational aspects of this parental behaviour (for a short review see Palmer & Yoshimura, 1984). From a psychoanalytic point of view the basic shortcoming is regarded to be an early object loss, the mother thus seeking a very close relationship to her physician. But this relationship is always threatened because of her own early negative experiences. She then uses her child as an object of control of the relationship.

Mother's histories are frequently marked by abuse and their manifest psychopathology shows numerous indications of serious personality disorders (Plassmann, 1994).

Objectives

On the basis of four case reports we want to demonstrate clinical presentations as well as typical personality traits of the parents and characteristics of the parent-child interactions.

Subjects

Two of the children were referred to our child psychiatric clinic for in-patient treatment, the other two were examined and diagnosed as out-patients. Prior to first contact with the clinic each child had had at least three episodes of treatment in hospitals or by general practitioners.

Case One

A.B.: 4 1/2 year-old boy, the younger of two children. Physical complaints were recurrent gastrointestinal dysfunctions, excessive vomiting, and reported episodes of apnea. Repeated investigations (X-ray examinations, laboratory investigations and clinical observations) revealed no evidence of organic cause. Administration of laxantia were assumed. Examinations as an out-patient in the department of child and adolescent psychiatry demonstrated developmental disorders of language and motor performance.

Family characteristics: one parent family. The child's mother reported repeated sexual abuse by her father during her childhood. She had had several short-term partnerships. Her parenting behaviour was permissive, she was not able to discipline her son. Her housekeeping was without regular mealtimes. She reported recurrent episodes of paranoid delusions and depressed mood. In these situations she unrealistically expected help from the little boy. Conversely, she was incapable of giving the child appropriate attention and support development of self-esteem. She denied any developmental progress and treated him as a toddler. When referring her child to hospital, she simultaneously was looking for persons (members of the staff) who were willing to discuss her every day problems in detail, but she did not present any signs of ideations or delusions in these moments.

Case Two

C.D.: 3 year-old girl, only child. Symptoms: obstipation, stuttering. In addition, the mother reported that her child had been sexually abused.

Clinical observations of the girl as an out-patient revealed evidence of overactive behaviour, she was very distractable, quickly tired of play and did not keep distance in her contact seeking behaviour.

She presented a slight developmental language disorder and stuttering.

Family charcteristics: The child derived from her mother's first marriage. The actual partnership was complicated by sexual problems. The mother claimed that her husband was impotent. The child was engaged in most parental conflicts. The mother suspected persistent sexual abuse, insisted on invasive examinations in order to receive the exact diagnosis. In the course of the examination the mother became very tense and decompensated by presenting signs of delusions (amelling gaz) and paranoid ideations (she thought, everybody was engaged in a conspiracy against herself and the child). Her parenting behaviour was characterized by uncertainty, inconsistency and ambivalence. This was partly due to feelings of guilt because she had put her daughter in day care during early infancy. During the child's examination all utterances were interpreted by the mother as indications of the desired diagnosis of sexual abuse. Additionally, the little girl received more attention when acting as the mother wished and thus was reinforced by operant conditioning.

Case Three

E.F.: 6 year-old girl, the younger of two children. The elder sibling is in foster care.

Symptoms: hematochezia/melena, allergy towards food ingredients, cerebral seizures and blurred vision. Moreover, the mother pretended sexual abuse of her daughter. Clinical observations and laboratory findings (EEG-recordings, X-ray investigations, colonoscopy including biopsy) were without evidence of organic impairments. Neither visual defect nor allergy could be detected.

Family characteristics: After intervention of the youth welfare office the elder sibling (19 years of age) was first taken away from his mother and then adopted by other parents, and thereafter placed in a foster home. The mother reported having been sexually abused in her own childhood and having lived in foster care after the age of twelve. At the age of 16 she got married for the first time. Again she was often sexually abused by her husband and the divorce followed seven years later. Her second child was born during her next relationship to an alcoholic. The actual partner had not finished school, he was now working as a skilled workman. He suffered from an inflammatory bowel disease (Crohn's disease) and arthritis, but we assumed Munchausen syndrome. The mother reported a history of asthma with recurrent episodes of apnea, all her teeth had been extracted because of persistent unclear facial pain. This may be interpreted also as Munchausen syndrome or as being part of her schizophrenic symptoms. She reported strange symbols and writings on the wall and that the water in her kitchen had been poisened. She claimed that she was being surveyed by people in the neighbourhood.

Case Four

G.H.: 9 year-old girl, the youngest of five children, the other aged between 14 and 20 years.

Symptoms: cerbral seizures (reported predominantly by the mother). During the last two years the girl had been referred to at least five general practitioners. The mother claimed, that the seizures only occured in the presence of the child's father or when the child returned from a visit to him.

The mother also reported sexual abuse for her own part.

Examinations as an out-patient (including standard EEG-recordings and after sleep deprivation) revealed no clear evidence of cerebral seizures. Thus, the child was referred to the child psychiatric department as an inpatient. Careful observations on ward during a period of six weeks and repeated EEG-recordings (including a EEG-recording during sleep) showed no evidence of organic cause of the seizures. A provocative sexualized behaviour could be seen frequently and the girl demonstrated a marked conduct disorder. Sexual child abuse was assumed by the physicians. During treatment as an out-patient after discharge from hospital this suspicion was confirmed by the mother and the child. Thus, the girl was separated from her father.

Family characteristics: The mother had divorced her alcohol dependent husband two years ago. A period of violence against the mother preceded the separation. However, due to financial problems they were still living in the same apartment despite the mother's knowledge of the father's sexual abuse of their daughter.

Mother-child interaction: the girl showed marked oppositional behaviour, always wanted to be the focus of attention especially in the presence of her mother, and tried to dominate her. On the

other hand the mother was not able to discipline her. She treated her daughter like an adult.

Personality of the Parents

Three out of the four mothers presented symptoms of personality disorder, i. e., paranoid personality (F60.0, according to ICD-10, WHO, 1991) in two cases and a histrionic personality (F60.4) in the other. In addition, clear schizophrenic episodes could be found in two persons. At least two of them had been sexually abused in their childhood or in their marriage. One partnership was complicated by sexual problems caused by the husband. All the mothers were divorced, and the actual partnership, if a partner was present, was tense. Educational level was low in three cases, school career incomplete.

Mother-Child Interaction

A striking uncertainty in handling their child was predominant in all interactions. They were not able to spell out rules or to encourage their child in an age-appropriate manner. The interaction and the tightness of the partnership was absolutely determined by the child dominating its mother. On the other hand, it was obvious that the child's age-appropriate wishes were not perceived by the mother, except in the fourth reported child.

When a partner existed, the mother sought support, but usually she was left alone and when offered help only accepted, if it was in accordance with her own point of view. This behaviour was also seen in the mother-therapist relationship. She sought closeness as long as the physician seemed to fulfill her expectations. But she terminated the relationship as soon as her demand of additional examinations of the child had been refused.

Course

The persistent way the mothers or both parents insisted on organic disorder in their children was very striking. Cautiously presented doubts on data given by the parents led to their resistance and distrust. With special emphasis on the physical and socio-emotional development it appeared to be necessary to take the children away from the families or their mothers. The caretakers of course did not agree with these proposals except for case four, in which sexual abuse became evident and the separation from the abusing father therefore was conducted. But in none of the other cases was it possible to achieve a decision by court to the advantage of the child. Up to now those children have remained in their families.

Discussion

The four cases reported here demonstrate the broad spectrum of clinical presentations characterizing the definition of factitious illness. According to the definition given by Eminson and Postlethwaite (1992) only one case represents Munchausen syndrome by proxy in its strict sense, with the mother administering laxantives to her son in order to induce symptoms of gastro-intestinal dysfunction. In the other cases clinical symptoms had been feigned without active manipulations for producing symptoms. But it is not sure whether such a distinction might be helpful. Despite the fact that in factitious illness the symptoms are feigned, the parental complaints commonly lead to invasive diagnostical investigations with possible physical impairment. Furthermore it is not well established that there are different personality traits or motivational aspects in the prepetrators. In the small sample reported here differences did not occur except for one case. This tends to suggest that such a distinction is of no clinical importance, but further investigations are needed.

Although similar in clinical presentation, there were some differences in the motivational aspects leading to the caretakers' behaviour. This concerns case four, in which both the patient as well as the mother intended to receive shelter by presenting somatic symptoms. Although sexual abuse had really taken place neither mother nor daughter reported it, but the child had been referred to general practitioners or hospitals with somatic complaints. The negative consequences of in-patient treatment including invasive examinations were assessed to be much less unpleasant than the effects following a disclosure of the sexual abuse. Thus, there was a silent agreement between mother and child and the latter supported mother's complaints about child's symptoms. In this case the clinical presentations are better characterized by the term simulation, according to DSM-III-R (APA, 1987).

Besides the often reported disability of the parents to distinguish between their own and their child's needs, the desire of shelter for the child became evident in another two cases although the assumed sexual child abuse was not true.

Sigal et al. (1989), who put special emphasis on the complicated relationships between perpetrator and victim and also on their interaction with the medical staff, observed that especially the older children partly showed a contribution to disorder from the very start or in the course of illness. There is a remarkable passivity concerning the perpetrator's acts.

Usually the age of affected children at onset of symptoms is in the range between a few weeks after birth and twelve years (Palmer & Yoshimura, 1984; Jones et al., 1986; Caruso et al., 1989). Mean age in our small sample was 5,8 years which is slightly higher than in Rosenberg's (1987) study, in which a mean age of 3 1/4 years was reported. At that age it is obviously easier for parents to induce or simulate symptoms in their children than it is in adolescents.

The predominating symptoms in our cases concerned the central nervous system, which had been reported to be affected in three of four cases, and gastro-intestinal dysfunctions. This is in accordance with other findings. About half of the children with Munchausen syndrome by proxy presented symptoms of central nervous disorders (Griffith & Slovik, 1989), but the clinical presentations are almost as often dominated by gastro-intestinal bleedings (Malatack et al., 1985; Rosenberg, 1987).

All mothers were incompetent and uncertain in their parental behaviour and lacked support from their partners, if present. One parent families or unsupportive relationships have been described as a parental factor in the genesis of Munchausen syndrome by proxy (Eminson & Postlethwaite, 1992).

At least two mothers had been sexually abused during childhood or in their marriage. These experiences may have caused their typical choice of supposed symptoms. But there is also a tendency within parts of society to put special emphasis on sexual child abuse. Thus, all provided data related to this special aspect receive excessive attention and are therefore reinforced.

Godding and Kruth (1991) reported adverse psychosocial circumstances in all of the 17 families in which they assumed Munchausen syndrome by proxy as causation for asthma in childhood. In most cases they found a neglect of the children. This adverse characteristic was not present in the four families we investigated.

Three of the four mothers presented symptoms of personality disorder, two of them a paranoid personality. The high amount of personality disorders also observed in the caretakers here could be the reason for the often reported failure of psychotherapeutic interventions (e. g., Mehl et al., 1990). In addition, three of the four mothers had had schizophrenic episodes. Psychiatric disorders like anxiety, depression or psychosis were seen as another parental factor in the etiology of Munchausen syndrome by proxy (Eminson & Postlethwaite, 1992). Special attention should be payed to the study of the case histories of family members. Roth (1990) put strong emphasis on the disturbed mother-child interaction and Alexander et al. (1990) demonstrated that compared to others, mothers of children with Munchausen syndrome by proxy often had a long lasting history of psychiatric disorders, frequently Munchausen syndrome. Considering those findings we investigated parents' histories very carefully and assumed Munchausen syndrome in at least one mother and one stepfather. This is in accordance with other studies in which it was possible to detect Munchausen syndrome in children's mothers by studying case histories of family members. Siblings were also often referred to the practioner or hospital with similar symptoms or there were reports from sudden infant death syndromes (Mehl et al., 1990; Light & Sheridan, 1990). The number of fathers as the cause of factitious illness is usually small, but in one of the here reported children the father was directly involved in the interaction. His behaviour as well as his remarks fulfilled the criteria for diagnosing paranoid personality disorder, and Munchausen syndrome was assumed.

Poor outcome concerning long-term morbidity and especially the danger of recurrent episodes of the same behaviour despite psychotherapeutic interventions demand careful assessment in case intermediate or definite foster care is indicated mollanrum. But it is often impossible to achieve the necessary decision in court, because factitious illness and Munchausen syndrome by proxy are widely unknown clinical syndromes, the caretakers demonstrating an impressive concern for their children's health.

Résumé

On parle de "Syndrôme de Munchausen par procuration" chez des enfants, qui présentent des troubles organiques résultant de manipulations de leurs responsables éducatifs. Des blessures, l'administration de médicaments, de drogues ou de poison – même chez des enfants très jeunes – ont pour effet de provoquer et simuler un tableau clinique sévère. Il s'agit d'un désordre psychiatrique rare – les chiffres exacts de prévalence sont difficiles à évaluer. Le Syndrome est décrit chez l'enfant à partir de l'âge de trois semaines jusqu'à 12 ans. L'âge moyen est de trois ans et quart. La mortalité chez les enfants porteurs d'un syndrome de Munchausen par procuration est estimé à 9%. Dans trois des quatre cas présentés le tableau clinique est dominé par des symptômes d'ordre neurologique. De manière supplémentaire trois mères rapportent un abus sexuel de leurs enfants. Les mères se caracterisent par leur incompétence et inconséquence éducative; souvent elles sont sans soutien éducatif de leur partenaire. Dans l'interaction mère – enfant les enfants ont un comportement dominant envers leur mère. La non-efficacité des interventions psychothérapeutiques peut être liée a un pourcentage élevé de troubles de la personnalité chez les parents.

Zusammenfassung

Die Diagnose Münchhausen "Stellvertreter Syndrom" wird bei Kindern gestellt, die Symptome einer organischen Erkrankung zeigen, die durch Manipulationen von Eltern oder anderen Sorgeberechtigten hervorgerufen werden. Vielfach werden bereits im frühen Kindesalter den Kindern Verletzungen beigebracht, Drogen, Gifte oder Medikamente verabreicht, um die klinischen Merkmale schwerer Erkrankungen vorzutäuschen. Obwohl genaue Angaben zur Häufigkeit fehlen, kann man insgesamt von einer seltenen Störung ausgehen. Es gibt zahlreiche Hinweise dafür, daß es sich beim Münchhausen Stellvertreter Syndrom um die seltene, aber sehr schwere Ausprägungsform in einer größeren Gruppe von Störungen gleichartigen klinischen Bildes handelt, für die man den Begriff der vorgetäuschte Störungen geprägt hat. In dieser Gruppe werden auch die Kinder erfaßt, deren Mütter ausschließlich Symptome und eine zugehörige Krankheitsgeschichte erfinden, die aber keine körperlichen Eingriffe (einschließlich Drogen- und Medikamentenverabreichung) vornehmen, um organische Symptome zu simulieren. Unklar ist, ob eine solche Unterscheidung notwendig und hilfreich ist. Bisher fehlen Hinweise auf Unterschiede in der Prognose im Langzeitverlauf zwischen den Untergruppen. Die Symptomatik eines Münchhausen Stellvertreter Syndroms konnte bereits bei Kindern im Alter von 3 Wochen beobachtet werden und wurde noch bei 12jährigen gefunden. In einer größeren Studie wurde ein mittleres Alter von 3 3/4Jahren für den Zeitpunkt der Diagnosestellung ermittelt. Die Sterblichkeitsrate wird auf 9 Prozent geschätzt. Bei den vier Kindern, über deren Symptomatik hier berichtet wird, standen bei drei zentralnervöse Störungen im Vordergrund. Drei Mütter gaben zusätzlich den Verdacht des sexuellen Mißbrauchs ihrer Kinder an. Die motivationalen Aspekte lassen deutliche Unterschiede erkennen. Bei drei Müttern bestand der Wunsch nach Schutz des Kindes vor realem oder vermeintlichem sexuellem Mißbrauch des Kindes. Alle Mütter hatten mindestens eine gescheiterte eheliche Beziehung. Im Erziehungsverhalten wirkten sie unsicher, inkompetent und inkonsistent; von ihren Partnern, sofern vorhanden, erhielten sie keine erzieherische Unterstützung. In der Mutter-Kind Interaktion vermochten die Kinder über die Mütter zu dominieren. Der hohe Anteil an Persönlichkeitsstörungen bei den hier beschriebenen Sorgeberechtigten könnte der Grund für das häufig berichtete Scheitern psychotherapeutischer Interventionen sein.

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