

A Case of Munchausen Syndrome by Proxy in the Context of Folie A Famille



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SUMMARY

The occurrence of similar psychotic symptoms in two or more people is called shared paranoid disorder. In this disease, the person who exhibits psychotic symptoms first is the “primary patient”. The symptoms are contracted by the other people through persuasion. This disorder is seen among people who share the same house or are emotionally bound. In some cases, shared paranoid disorder may include other diagnoses, such as Munchausen Syndrome. This report discusses the case of a six-year-old, sexually abused boy who, when admitted to the hospital at the age of 10, claimed to have been repeatedly sexually harassed by several different people. His family’s frequent changes in hospitals, negative perceptions of and accusations against medical staff, and improper methods of responding to harassment led clinicians to a diagnosis of Munchausen by proxy syndrome. In addition, both parents believed the abuse story, suggesting a potential diagnosis of shared psychotic disorder. In the literature, Munchausen by proxy has rarely been reported with symptoms of sexual abuse. The psychotic symptoms were shared by the family, complicating the case. This report emphasizes that psychodynamic evaluations of Munchausen by proxy and shared psychotic disorder may be helpful in understanding underlying factors.

Keywords: Munchausen by proxy, sexual abuse, child, shared paranoid disorder.

INTRODUCTION

One of the most important factors affecting the mental health of a child is the mental state of the child’s parents. The child is at serious risk for poor mental health when a defect or deviation in the parents’ reality testing manifests in delusions surrounding the child, especially when the child becomes the target of the parental delusions (Savvidou et al. 2002, Van der Kolk 2005a, Van der Kolk 2005b).

Parental Munchausen and shared psychotic disorder are risk factors for disturbed mental health in children. Munchausen syndrome was first described by Asher in 1951. Patients with the disorder produce physical symptoms intentionally, cause confusion for physicians, and make frequent trips to hospitals. In 1977, Meadow reported that Munchausen patients do not

always create symptoms for themselves but sometimes invent symptoms for a significant other, who then needs the perpetrator’s nursing, care and attention; Meadow named this type of the disorder Munchausen by proxy. According to McGuire and Fieldman (1989), as child victims get older, they begin to actively participate in parental deceptions. It has also been suggested that child victims believe that their mother’s love is dependent on their alleged illness (Sigal et al. 1989).

Though it is not common, Munchausen by proxy may also occur with shared psychotic disorder. In 1860, Baillarger defined shared psychotic disorder, referring to it as folie communiquée, as the transference of delusional ideas and/or abnormal behavior from one person to one or more others who have been in close association with the primarily affected patient (Gralnick 1942). In general, Munchausen by proxy

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occurs among members of the same family or people who are close to each other. The primarily affected patient usually has a psychotic disorder (Howard 1994). Çetin has indicated that the mother-child separation individuation process may lead to folie a famille, a shared psychotic disorder among family members (Çuhadaroglu-Çetin 2001).

Understanding the factors underlying both of these disorders seems to be very important in preventing and treating the disorders. In fact, to our knowledge, no case of Munchausen syndrome by proxy comorbid with shared psychotic disorder has been reported in Turkey.

In the current case report, parental delusions of sexual abuse, supposedly perpetrated on their child, are discussed within the context of Munchausen by proxy syndrome and shared psychosis. In the literature, there are very few reports concerning similar delusions.

CASE REPORT

H, a 10-year-old boy, presented to our clinic with a pre-diagnosis of sexual abuse. His parents stated that H had been raped several times and had a long history of sexual abuse.

History: According to the mother, H was raped at the age of six by a 23-year-old boy who lived in their apartment building. The boy, who the family had known for a long time, threatened to kill H if he told anyone. The mother had been suspicious of the boy because she had seen him holding H and leaving H back in an irritated manner when he realizes her. She and her husband decided to talk to the boy only to learn that he had already moved.

The mother claimed that, after the 23-year-old moved, she saw a green car approach her son, and “a man with eye-glasses and a hat” provided him a ride. Observing the car, she felt highly uncomfortable, but, according to her statement, she did not understand that sexual abuse was occurring because she was unaware of previous events. Although H was a successful first grade student, he told his mother that he did not want return for the second term. In explanation, the mother stated that a young man had rented a house opposite H’s school and was taking H to his house during recess. He and his friends were forcibly raping H. Because of changes in H’s behavior, his teacher directed the family to a child mental health clinic. H was treated in a university clinic for a year and a half.

During this period, H’s family decided to independently solve the harassment problem. They disguised themselves in order to observe their son and the rapists; the mother wore a headscarf and an overcoat, and the father wore sunglasses. During the first treatment period, the mother mentioned noticing that her son was unable to sit on his hip and would come

home with dirty clothes. Her anxiety increased, so she talked with her son.

According to the mother, H stated that he was inviting everyone to rape him, including university clinic personnel, school staff, teachers, neighbors, neighbors’ children, and the manager of the building. All had accepted. The mother decided to catch all the perpetrators, so she watched her son at school. She pretended to drop her son off at class and watched the teachers’ behavior. She observed that when the teachers wanted to rape H, they used jests to signal him to come near them. Each time, H ran to them. One day she saw a member of the school cleaning staff looking at her son, and H told her he was one of the men who had raped him. The mother argued with the staff member. The family called the police, and ultimately, 25 men were accused with abuse and stood trial.

Afterwards, the family moved to a new city, and their son changed schools. However, the abuse allegations continued. H’s parents claimed that, while the trial was underway, teachers and staff at the new school also began to rape H. The family decided not to go to the police this time because they were highly irritated with the legal process. Instead, they placed a camera in the school to collect evidence, but they never succeeded in obtaining any.

Assessment: The child was assessed by experts from three different professions: psychology, psychiatry, and forensic medicine. During the psychological assessment, the Wechsler Intelligence Scale for Children-Revised (WISC-R), the Bender Gestalt Visual-Motor Perception Test, the Beck Depression Inventory, the Beier Sentence Completion Test for Children, the Draw a Person Test, the Draw a Family Test, and the Symond’s Projective Test were administered, and the child was also observed during a play session.

At the beginning of the interview, H related the sexual abuse he had experienced, his family’s search for treatment, and his unavoidable sexual urges. He talked in a non-stop manner, using words borrowed from his mother. The child’s expression was superficial, the content of his speech lacked depth, and his behavior was thought inappropriate. Though the mother argued that H had strong sexual urges and asked for sex without any feelings of shame, H seemed to feel guilt during his interview. H seemed to structure and process his thoughts normally, but his thoughts focused on sexuality and the theme of guilt. He was slightly depressed. He claimed that he was not capable of controlling his sexual urges. However, he gained satisfaction from being the center of attention. Psychological evaluations indicated that he had a normal level of intelligence; however, he was immature for his age and had an active imagination. In his stories for the Symonds Projective Test, the main themes were the “loss of a loved one” and “problematic relationships between men and women”. In

addition, the main themes of the structured play session were a perceived threat from a mother and the need for protection.

Clinical Progress: In the first interview, H's mother insisted that, if they left H alone in the waiting room, he could be sexually assaulted by the staff of our clinic. His parents asserted that their son still had difficulty controlling his sexual urges, so the father remained with his son rather than joining the session. The mother was highly anxious, speaking fast and repeating the same thoughts over and over without being able to stop. The mother was manipulative and had a tendency to devalue previous treatments and to idealize our clinic. She also had difficulty relating what had happened in an organized manner. She had a deep affective isolation when telling their story. She stated that her life had been affected by these events and she had not been able to find time for herself in the last two years. She also mentioned that her relationship with her husband had been negatively affected. She described her feelings using the following words: "Whenever my husband touches me, I feel like something bad is happening to my son, like he is being raped". Her actions were observed to be consistent with her words. She stated that the first time they learned about the rape, they felt so desperate that they planned to commit suicide by turning on the gas.

During the interview, the mother displayed a domineering personality. She rejected all suggested solutions and rendered the clinicians helpless. She also gave the impression that she enjoyed the situation. The symptoms displayed by the child seemed to serve the needs of the family.

The family was informed that the child should be examined in the forensic medicine and pediatric surgery units. The mother then stated that she had treated her son with medicine and lotions, and so the doctors would not be able to find any evidence of sexual abuse. There were many inconsistencies and gaps in the story, and each time the family told the story, there were changes. The story was flexible and changeable according to the present conditions.

The father was depressed and sometimes angry, due to feelings of guilt related to H's sexual abuse. The story he told, although less detailed, was the same as the mother's. He was planning to move to an isolated town where the family could avoid contact with others so that his son's sexual urges would diminish; thus, he could protect his son. He would then verify his son's recovery by returning H to the city for a trial period, during which he would check H's underwear every day. H's father stated that he would not leave H alone and would not send him to school for this two-year trial period. The father had a hostile and paranoid demeanor throughout the interview. He refused to have his son hospitalized.

Although the father introduced himself as the head of his family, his neighbors described him as an aggressive, antisocial person. In addition, the negative characteristics attributed

to him in stories told during H's projective tests contradicted the father's self-description. Although the family was from a region in which honor in sexual matters was extremely important, similarly to the mother, the father was more concerned with proving the truth of their story than with guarding or protecting his son. Thus, to succeed, he was willing to recount the tragic experiences of his son.

During the evaluation performed at the hospital's forensic medicine department, no physical signs of acute or chronic anal penetration were found. The parents were asked to bring their other son and their daughter to the clinic as well, for a comprehensive family assessment. However, they never complied. Difficulty in gathering information about the family's dynamics was attributed to their psychopathology. According to our clinic's assessment, the child may have been sexually abused once; however, the sexual abuse was definitely not a continuing process. Meanwhile, the parents were traumatizing and abusing the child by not sending him to school, frequently directing him to tell fantastic abuse stories, and not allowing him to receive treatment. Although both parents were informed, they refused to continue treatment.

The clinic determined that, if the parents' psychopathology was not treated, the patient would be the victim of continuing abuse. Therefore, we requested that the judicial system require the parents and their son to undergo psychotherapy. The family was diagnosed with folie a famille. Legal proceedings were started to ensure that the child would be protected and would receive the necessary medical care and rehabilitation.

DISCUSSION

Serious inconsistencies and holes in the case history increased the difficulty in diagnosing the patient. In addition to the delusions and manipulative tendencies of the parents, frequent hospital changes, hostility towards and accusations against medical personnel, the unusual approach of the family to the legal process, and the family's attempts to control the sexual harassment via inappropriate methods suggested a diagnosis of Munchausen by proxy syndrome (MBPS) comorbid with shared psychotic disorder.

As in the present case, MBPS mothers tend to exhibit paranoia towards therapists, have anxiety or depression, attempt suicide (Vennemann et al. 2006), and use primitive defense mechanisms, such as projection, denial, and splitting (Berg and Jones 1999, Adshead and Bluglass 2005, Pompili et al. 2003). There have been previous factitious disorder cases involving a history of sexual or physical abuse (Schreier 1996, Meadow 1993, Savvidou et al. 2002, Hornor 2001, Lipian et al. 2004). Similar to our case, in these studies, the perpetrator was the mother, and MBPS occurred in the period following a divorce or marital conflict. However, child victims of

MBPS in previous studies were older than in the present case. MBPS may originate from a dependent and hostile relationship pattern, and the recipient of the emotional transference is generally a doctor, school psychologist, social worker, or judge (Pompili et al. 2003, Schreier 2002, Lipian et al. 2004, Rogers R 2004). If a child also becomes part of the fabricated fantasy, the clinical diagnosis is folie a famille.

Similarly to our case, children and adolescents with folie a famille may be unable to distinguish between real and factitious. In such families, fear of subject loss is exposed (Sigal et al. 1989, Lipian et al. 2004, Rogers 2004), as in the present case, and confrontation challenges familial balances and aggravates conflicts concerning fidelity. Children subjected to folie a famille have fears of victimization, abandonment, and exclusion. These children regard and use fabrication as a method for obtaining love and care. In accordance with their mother's insistence, they participate in their own harassment and develop a factitious disorder. By accepting their parents' fantasy, children not only support their parents but also establish a way to communicate with them. In the present case, the parents were so preoccupied with their abuse story that the only way the child could communicate with his parents and receive their full attention was by accepting and continuously repeating the abuse story.

From a psychodynamic perspective, H is an identification object for the mother and the only meaningful person in her home-centered life. H's mother never mentioned any ambivalent feelings she may have been experiencing towards her son. Thus, denial is the most common defense mechanism which could explain her psychopathology. The mother's ego was fragile in stressful situations, and she had developed a psychotic disorder that prevented her from evaluating reality. Therefore, she likely had basic trust problems, regressive tendencies, and poor self-organization.

The mother reported feeling sexually distanced from her husband for the previous two years as a result of a deep identification with her son. She mentioned that sexual relations with her husband reminded her that her son had been raped, so she rejected her husband. The mother's statements seemed to support the existence of a disturbed male-female relationship. Themes observed in the projective tests pointed to separation anxiety, which was consistent with our marital strife hypothesis. H's drawings and his stories clearly illustrated his need to be the center of attention. However, he could express these needs only via tests and stories. In both his projective tests and his role play, the father died. The following themes were common: losing a father, having a bad father, fighting between parents, and experiencing anger towards a bad father. These themes suggested a strong Oedipus complex. Having the shield of a factitious abuse history would help him cope with oedipal guilt and keep his parents together. External danger, occurring outside the home, was always the focus of

the abuse story, also reinforcing the family's separation anxiety and tendency towards symbiosis—H was never allowed to be alone; the mother checked H's underwear; and H had not been sent to school for a long time.

To meet his narcissistic needs, H needed to be at the center of this symbiotic network, so he continued to repeat and support the story. The gains he obtained from perpetuating the story far exceeded his losses. In his projective tests, H told stories which included themes of aggression, death, and jail; however, his stories also included characters that lived happily ever after following traumatic events. Just as in these stories, H was living happily with his family despite the tragic events he and his family related and the restrictive and pervasive mistrust. Denial, repression of his emotions, and his secondary gains explain his ability to maintain his psychopathology.

The data obtained from the projective tests conflicted with the information provided by the mother. The mother was deceiving herself by denying her negative feelings about her family members, her anger, her sexual impulses, and her anxiety about repressing her sexual impulses. The evaluations suggested that the mother was using projection and projective identification defense mechanisms. After experiencing a provoking event, the mother began to project her aggression, anger, and repressed sexual impulses to all men and to her son. She thought that her son would be raped and would invite people to rape him. The thought led to her desperate need to control her environment and her son and allowed her to gather satisfaction from the action of controlling. For the mother, controlling her son meant controlling her own sexual impulses and her unconscious tendencies related to those impulses, which she feared she would be unable to repress. Her restraint over herself and her impulses would increase as her control over her son increased. The struggle strengthened her, so she wanted to maintain focus on the abuse issue, and she denied that the fabricated abuse caused real abuse to her son. Her unconscious satisfaction surpassed her wish to protect her son.

The father's prior aim was to calm *himself* and repair *his* own trauma instead of helping his son. His son's rape had triggered his internal conflicts. The rape, assuming that one instance of rape did actually occur, had destroyed his sense of trust. Rather than using more developed, mature, and realistic defense mechanisms, he joined in the shared psychotic disorder. The father's loss of trust and perceptions of self-weakness may have caused the father to become part of the shared psychosis. The father ignored the traumatization that these fabricated abuses could have on his son and overlooked the many holes in his wife's story. He failed to realize the importance of supporting his son and the similarities between the effects of the psychosis and those of sexual abuse.

Both parents belittled previous health centers while praising the current health team. All three family members perceived the inside of the home as positive, safe, and trustworthy, and the world outside their home as dangerous and disingenuous. Splitting and separating negative and positive emotions, as well as denying negative emotions, was common among all three members. Each of the family members exhibited some form of splitting, which is one of the most common defense mechanisms occurring in Munchausen by proxy cases.

CONCLUSION

In the literature, there are very few reports concerning Munchausen by proxy with symptoms of sexual abuse. In the present case, a factitious sexual abuse narrative was used to perpetrate real child maltreatment. Munchausen symptoms were shared by the whole family increasing the difficulty in reaching an accurate diagnosis. The current case report and psychodynamic evaluations are important for understanding the factors underlying Munchausen by proxy and shared psychotic disorder.

REFERENCES

- Adshead G, Bluglass K (2005) Attachment representations in mothers with abnormal illness behaviour by proxy. *Br J Psychiatry* 187: 320-33.
- Berg B, Jones DPH (1999) Outcome of psychiatric intervention in factitious illness by proxy (Munchausen's syndrome by proxy). *Arch Dis Child* 81: 465-72.
- Çuhadaroğlu Çetin F (2001) Folie a famille and separation-individuation. *Eur Child Adolesc Psychiatry* 10: 194-9.
- Gralnick A (1942) Folie a deux: the psychosis of association – a review of 103 cases. *Psychiatr Q* 16: 230- 63.
- Hornor G (2001) Repeated Sexual Abuse Allegations: A Problem for primary care providers. *J Pediatr Health Care* 15: 71-6.
- Howard R (1994) Induced psychosis. *Br J Hospital Med* 51: 304-7
- Lipian MS, Mills JM, Brantman A (2004) Assessing the verity of children's allegations of abuse: A psychiatric overview. *Int J Law Psychiatry* 27: 249–63.
- Meadow R (1977) Munchausen syndrome by proxy: The hinterland of child abuse. *Lancet* 2:343-5.
- Meadow R (1993) False allegations of abuse and Munchausen syndrome by proxy. *Arch Dis Child* 68:444–7.
- McGuire TL, Feldman KW (1989) Psychologic Morbidity of Children Subjected to Munchausen Syndrome by Proxy. *Pediatrics*, 83:289-92
- Pompili M, Mancinelli I, Girardi P et al (2003) The importance of transference and countertransference in Munchausen Syndrome by Proxy. *Child Abuse Negl* 27: 353-5
- Rogers R (2004) Diagnostic, explanatory, and detection models of Munchausen by proxy: extrapolations from malingering and deception. *Child Abuse Negl* 28: 225–39.
- Savvidou I, Bozikas VP, Karavatos A (2002) False allegations of child physical abuse: a case of munchausen by proxy-like syndrome? *Int J Psychiatry Med* 32: 201-8.
- Schreier H (2002) On the importance of motivation in Munchausen by Proxy: the case of Kathy Bush. *Child Abuse Negl* 26: 537–49.
- Schreier HA (1996) Repeated false allegations of sexual abuse presenting to sheriffs: When is it munchausen by proxy? *Child Abuse Negl* 20: 985-91.
- Sigal M, Gelkopf M, Meadow R (1989) Munchausen by proxy syndrome: The triad of abuse, self-abuse, and deception. *Compr Psychiatry* 30: 527-33.
- Van der Kolk (2005a) Child abuse and victimization. *Psychiatr Ann* 35: 374-8.
- Van der Kolk (2005b) Developmental trauma disorder. *Psychiatr Ann* 35: 401-8
- Vennemann B, Perdekamp MG, Weinmann W et al (2006) A case of Munchausen syndrome by proxy with subsequent suicide of the mother. *Forensic Sci Int* 158: 195–9.