Brit. J. Psychiat. (1981), **138**, 466–469

The Extended Munchausen Syndrome: A Family Case

DOROTHY BLACK

The Munchausen syndrome was first described by a physician (Asher, 1951), the classical criteria being exaggerated symptoms, factitious physical signs, and the tendency to wander between hospitals (Bursten, 1965).

The early reports emphasized the medical aspects of the condition, defining subgroups related to the physical symptomatology. The patients were often pejoratively labelled liars, swindlers or malingerers, though in many cases no conscious gain could be identified. Their management was often punitive or legalistic (Blackwell, 1968), and few were referred to psychiatrists. Spiro (1968) emphasized the need for a psychiatric diagnosis, and noted that only 16 of the 36 cases described in the literature to 1968 had been so assessed. The majority were diagnosed as neurotic, psychopathic or hysteric.

In the last five years paediatricians have described a similar syndrome in children (Sneed and Bell, 1976), and a related group of conditions where the symptoms are invented for children by their parents who give an erroneous or distorted history, the so called Munchausen by proxy (Meadow, 1977; Verity *et al*, 1979). In some cases physical symptoms have been produced by giving the children potentially harmful substances (Rogers *et al*, 1976), a situation more clearly allied to non-accidental injury. In others a spurious pattern of illness was produced by tampering with the urine. In another case (Kohl *et al*, 1978) there was maintenance of illness by the covert withdrawal of appropriate medication by the mother.

In these reports the main emphasis was on the child's presentation of illness, and only brief mention was made of the psychological state of the mother, or the family psychodynamics. Burman and Stevens (1977) reported in one of their cases that the mother had afterwards been found to be a Munchausen of 16 years standing. Lee (1979), reporting a case of Munchausen by proxy in twins, noted that following the removal of the affected children into care, the mother herself presented with spurious haemoptysis, and a bleeding lesion of the breast which was slow to heal, suggestive of self-infliction. Evidence reported in the Dauphin of Munchausen case (Sneed and Bell, 1976) suggested that the mother certainly condoned and may have been instrumental in falsifying signs in her son.

In the present report the mother was the first to be recognized as a Munchausen case, but from the family history she gave it was found that her three children were affected by proxy. In all four there was evidence of an exaggerated and distorted history (given by the mother), misleading physical findings, and simulated patterns of illness, giving rise to painful and potentially harmful diagnostic and treatment procedures.

Case Report

Mrs M., aged 30, was referred in 1978 for psychiatric assessment of intermittent depression. She complained of anxiety, feelings of irritation and aggression towards her husband and children, and described visual pseudohallucinations of her dead first husband. She initially gave no previous psychiatric history, but a florid past medical history of multiple renal, gynaecological and neurological problems. She claimed to have had abnormal pregnancies and deliveries, and stated that her youngest child had agammaglobulinaemia, and that her elder daughter suffered from pyelonephritis.

A survey of her medical notes revealed that from the age of 16 years she had been under the care of 22 consultants. She had been admitted to five hospitals on 30 occasions. Ten of these admissions were as an emergency. Inevitably she had undergone multiple haematological, biochemical and radiological investigations.

A prominent feature of her case histories was the distorted and exaggerated past medical history at each new referral. Her family history similarily became increasingly florid, either her parental family members or her children supposedly having suffered illness similar to each of her new complaints. The solitary objective finding was a possibly abnormal intravenous pyelogram at age 16, never later seen on further investigation. Her complaints of urinary symptoms were never associated with positive laboratory findings, and there was no evidence on cystoscopy to

explain the grossly blood-stained urine samples she presented.

Further search of her records revealed previous psychiatric referrals. Her first shortly predated her third pregnancy in 1971. At that time she was described as having an hysterical personality, with chronic physical ill health. During therapy, in this her longest psychiatric admission, she commented 'fantasy is less painful than reality', and also remarked that in childhood she had gained concern by being ill. In her second psychiatric admission in 1972, as an emergency, she was depressed with fears of harming herself or her children. The youngest child was then aged four months. There was no response to antidepressant measures. The main feature of her admission as seen in retrospect was her reluctance to be discharged and her ability to avoid this possibility by her manipulative behaviour towards staff.

Her further two psychiatric contacts in 1974 and 1977 were brief. Both followed overdose attempts, in one of which no biochemical evidence was found to confirm her story. Following all her psychiatric admissions she failed to keep out-patient follow-up appointments.

She was an only child. Her childhood had been disturbed, with parental marital discord, and physical violence by her dominant, dogmatic father to both herself and her mother. She described her mother as being anxious and inadequate. She expressed dislike of her father, and little emotion towards her mother. During her childhood she had learned that 'being ill' protected her from her father's violence, and increased her mother's concern. She had never made close friends.

She had been married twice. Her first marriage at age 16 when already pregnant, ended with the death of her husband in an accident. She confirmed that this marriage, precipitated by a premarital pregnancy, was to escape from the family. Though she had come to idealize her first husband the reality had been an immature demanding young man, who pursued his bachelor activities throughout their marriage. Again pregnant, her second marriage was to a more dependable man, whom nevertheless she compared unfavourably with her first husband. He provided her with material stability but failed, as she perceived, to give her overt affection and emotional support. She expressed sexual dissatisfaction in this marriage.

By her first marriage she had two children, K., a boy, aged 14 years, and E. a girl, aged eight years. She had a second daughter L. aged six years, by her second husband. She expressed no feelings of affection towards her children, but emphasized their frequent illnesses and the anxiety this had created. She claimed her husband left the care of the children to her, and had only shown concern about his own child, L., who had been found to have hypogammaglobulinaemia at birth.

She stated she was obsessional about her housework, and found the demands of her children intrusive in maintaining her high standards in the home. She had little contact with her parents, her father remaining critical of her.

A search was made of her children's hospital records. From the birth of her third child onwards they showed a similar pattern of frequent emergency admissions to several paediatric units under the care of a multiplicity of consultants. There was a paucity of clinical findings to confirm the mother's claims of symptoms.

Her son K. was less frequently referred than her daughters. Most of his admissions were for 'asthma' or accidental injury. During his last admission following claims by his mother of his irritability and personality change following a head injury the previous year he denied his mother's story completely.

Her eldest daughter E. most commonly presented with complaints by her mother of either abdominal or urinary symptoms. These immediately followed the mother's own investigations for similar symptoms. Her blood picture on one admission raised suspicion that she had been covertly given illicit medication either before or during her hospital admission. The sudden appearance of haematuria while in hospital raised the possibility that blood had been added to the urine. As she became older a history of accidental injury became more frequent.

The youngest child L. was found to have hypogammaglobulinaemia at birth. This had resolved at six weeks after birth. Thereafter her mother presented her with complaints of urinary or abdominal symptoms. Her admissions were interspersed with those of her mother. Like her sister, her later admissions were following alleged accidental injury. In one admission she was described as showing a 'watchful silence'. In another, a fine petechial rash was noted on her thighs and abdomen; no explanation was profered for this.

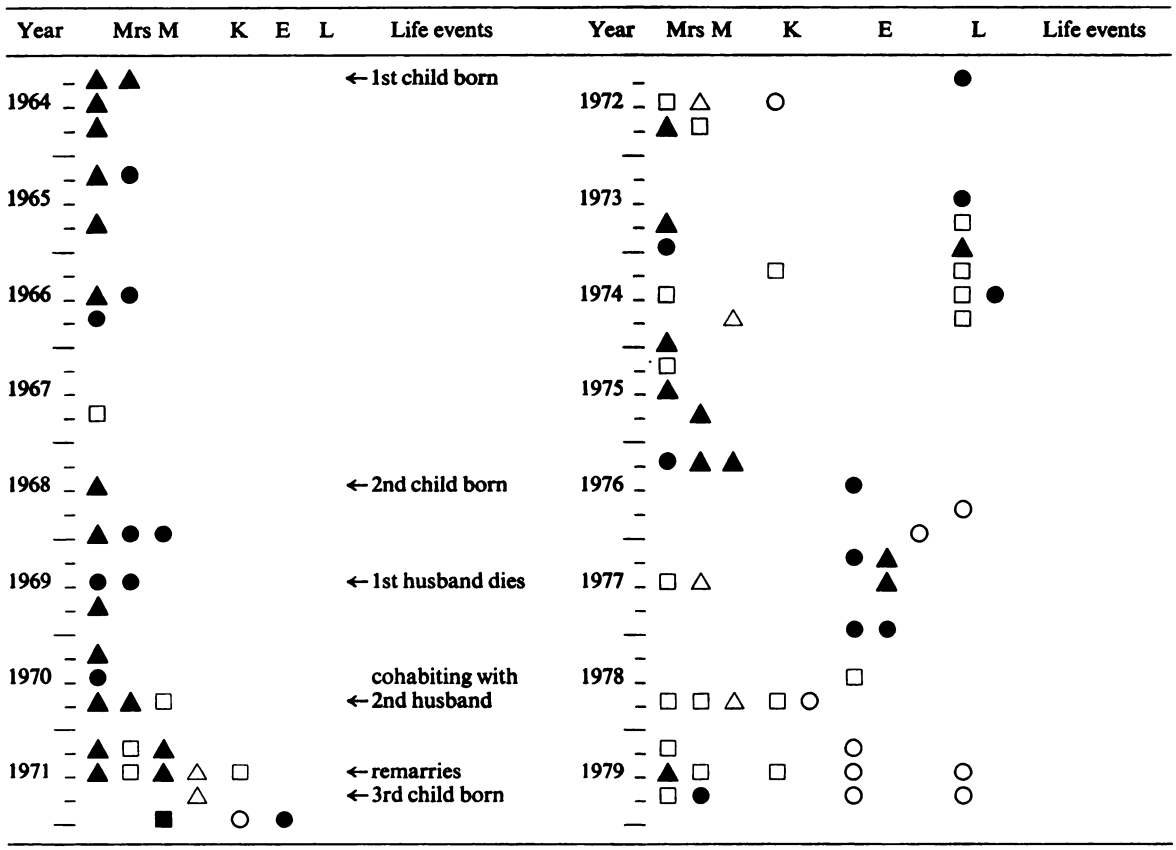
During her children's admissions Mrs M. was regarded as being a good attentive mother, though occasional comments were made about her overconcern. Nevertheless, following discharge the children were rarely brought back for out-patient follow-up, despite repeated reminder letters being sent.

As a result of these findings and in consultation with paediatric colleagues the children were placed on the 'At Risk' register and a social worker was involved with the family to provide domiciliary support. The general practitioner was alerted to the possibility of spurious illness in both mother and children.

Mrs M. continued in supportive psychotherapy with

TABLE I

Hospital admissions and new referrals



Key

▲ Urogenital symptoms
● Abdominal pain/vomiting
○ Trauma
□ Other
△ Psychiatric

myself at 4–6 week intervals. During these interviews her need to be recognized as a significant person and a good mother was acknowledged by me. Discussion of her feelings of rejection and inadequacy in her childhood, originating in her father's attitude and later reinforced by her husband's criticism, allowed her to relate her feelings of anger and frustration to her physical symptoms. In hospital she felt important, as attention and concern were centred on her. Her anxiety about her children's health began following the birth of her last child with hypogammaglobulinaemia. Her need to be seen as a good mother led to her emphasizing their symptoms. Their admissions to hospital provided her with social approval and concern, and relieved her from the stress she felt in balancing her high standards of household care and the demands of the children. Her husband's expressed concern about his own child compared to his criticism of her increased her resentment towards him.

Since the supportive treatment she more readily accepts reassurance rather than expecting medication or further medical referral. Up to one year none of the four has been readmitted to hospital, and the children appear to have escaped further physical harm. Mrs M. still regards her husband as unsympathetic, but his criticism is less now that she is no longer frequently away from the home in hospital. At a recent home visit she appeared to have been drinking heavily. The possibility that she is using alcohol as an alternative defence against her anxiety and anger remains to be explored.

https://doi.org/10.1192/bjp.138.6.466 Published online by Cambridge University Press

Acknowledgements

I should like to thank Dr J. A. Black, Dr S. Kinghorn and my secretary, Lynne Mallinson, for their interest and help in tracing and follow-up of this family, and to Dr C. P. Seager for his helpful criticism.

References

ASHER, R. (1951) Munchausen's syndrome. *Lancet*, *i*, 339–41.

BLACKWELL, B. (1968) The Munchausen syndrome. *British Journal of Hospital Medicine*, **1**, 98–102.

BURMAN, D. & STEVENS, D. (1977) Munchausen family. *Lancet*, *ii*, 456.

BURSTEN, B. (1965) On Munchausen's syndrome. *Archives of General Psychiatry*, **13**, 261–8.

KOHL, S., PICKERING, L. K. & DUPREE, E. (1978) Child abuse presenting as immunodeficiency disease. *Journal of Pediatrics*, **93**, 466–8.

LEE, D. A. (1979) Munchausen syndrome by proxy in twins. *Archives of Disease in Childhood*, **54**, 646–7.

MEADOW, R. (1977) Munchausen syndrome by proxy. The hinterland of child abuse. *Lancet*, *ii*, 343–5.

ROGERS, D., TRIPP, J., BENTOVIM, A., ROBINSON, A., BERRY, D. & GOULDING, R. (1976) Non-accidental poisoning: an extended syndrome of child abuse. *British Medical Journal*, *i*, 793–6.

SNEED, R. C. & BELL, R. F. (1976) The Dauphin of Munchausen: Factitious passage of renal stones in a child. *Pediatrics*, **58**, 127–30.

SPIRO, H. R. (1968) Chronic factitious illness. *Archives of General Psychiatry*, **18**, 569–79.

VERITY, C. M., WINCKWORTH, C., BURMAN, D., STEVENS, D. & WHITE, R. J. (1979) Polle syndrome: Children of Munchausen. *British Medical Journal*, *ii*, 422–3.

* Dorothy Black, M.B., M.R.C.Psych., D.C.H., *Lecturer in Psychiatry, University Department of Psychiatry, Royal Hallamshire Hospital, Glossop Road, Sheffield S10 2JF*

* Now Senior Medical Officer, Department of Health and Social Security, Elephant and Castle, London SE1.

(*Received 17 July 1980; revised 6 February 1981*)