

Folie à Deux* in the Parents of Psychosocial Dwarfs: Two Cases

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Introduction and Purpose

Though the term *folie à deux* (Lasègue and Falret, 1877; Gralnick, 1942) is not common in current psychiatric usage, the phenomenon is recognized from time to time. In its strictest sense it means that two people manifest identically the same symptom, often an *idée fixe*, or a shared delusion. There is no literature on *folie à deux* in connection with the syndrome of reversible hyposomatotropinism or psychosocial dwarfism (recently reviewed by Patton and Gardner, 1975).

The purpose of the present report is to present evidence of pathological collusion which constitutes *folie à deux* in the parents of two separate families. Each family contains one psychosocial dwarf, a victim of child abuse. One parent initiates child abuse while the other condones it.

The Nature of the Syndrome of Reversible Hyposomatotropic Dwarfism

The presenting complaints of the syndrome are: failure of statural growth, which may be so extreme that at age 4½ a child has the size of a 12-month-old baby; failure of mental growth with apparent mental retardation; and various bizarre forms of behavior associated with self-preservation, such as eating garbage and drinking from a toilet bowl.

In affected children, growth hormone secretion is deficient, but the deficiency is subject to reversal upon change of domicile as, for example, when the child is admitted to the hospital. This reversibility is the primary pathognomonic feature of the syndrome. It is accompanied by catch-up statural and mental growth, and by improvement in behavioral pathology.

The behavioral pathology of the syndrome, in addition to disorders of eating and drinking, includes disorders of sleeping; disorders of elimination; pain agnosia; elective mutism; accommodation to somatic trauma; short-lived though infrequent temper tantrums; roaming; impaired IQ; impaired motor development; social distancing; delayed puberty; and, during the recovery phase, compensatory hyperkinesis. Temper tantrums, if present, coexist with affection-seeking and social compliance, as does the social-distancing behavior. The compensatory hyperkinesis appears as limit testing and coexists, during the recovery phase, with an increase in both intellectual and statural growth.

The diagnosis of reversible hyposomatotropic dwarfism is definitively established not by laboratory or clinical findings alone, but by growth acceleration secondary to increased growth hormone secretion, following change of domicile. The syndrome evidences the clearest known example of a correlation between factors in the social and behavioral environment, on the one hand, and impairment of endocrine regulation of somatic growth as well as behavioral maturation, on the other.

*This article is separate and apart from the preceding Symposium.

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Taxonomically, the syndrome of reversible hyposomatotropic dwarfism is known also as psychosocial dwarfism (Reinhart and Drash, 1969). Reversible hyposomatotropinism is a more operational term, and one which does not imply spurious accuracy concerning etiology. In the past, the syndrome has been variously identified with failure to thrive (Barbero and Shaheen, 1967; Pollitt, Eichler and Chan, 1975), and maternal deprivation (Patton and Gardner, 1969). It has also been known as deprivation dwarfism (Silver and Finkelstein, 1967; Gardner, 1972; Patton and Gardner, 1975); and as emotional deprivation and growth retardation simulating idiopathic hypopituitarism (Powell, Brasel and Blizzard, 1967; Powell, Brasel, Raiti and Blizzard, 1967). Recently, the term abuse dwarfism (Money, 1975)* has been used synonymously with psychosocial dwarfism.

The Sample

The two families of this study were selected from forty documented cases of the syndrome, not at random, but because of their diversity. They were similar and different as follows: 1) each family resides within commuting distance of The Johns Hopkins Hospital; 2) there exists sufficient evidence in both case histories to warrant further research into family dynamics, in that one family history clearly indicates psychopathology, whereas the other gives an overt appearance of stability with covert indications that surfaces may be deceiving; 3) one patient is female, one male; 4) the girl spent eight months away from home, the boy eight years; and 5) the girl is a child, the boy an adolescent.

The two children have been seen repeatedly by members of the pediatric endocrine clinic and its psychohormonal research unit at The Johns Hopkins Hospital from 1965 (Patient H.K.) and 1973 (Patient J.G.) until the present. They were both referred primarily because of growth failure. Family members were included in interviews when they accompanied the child to a scheduled hospital appointment; or if they agreed to, or requested, individual interviews.

No known systematic bias exists with respect to selection of these two cases from among the other 38 patients with the same diagnosis. Probably the process which brings about referral of reversible dwarfism from the community at large is subject to bias, though to an unknown degree. The morbidity and mortality of the syndrome are unknown. Affected individuals may, or may not, survive without receiving professional attention.

Procedures

Original and followup taped and transcribed interviews and notes were obtained from patients, parents, guardians, social workers, and nurses.

The interviews always began with open-ended inquiry prior to factual and true-false questioning. Direct observation of child and parental behavior in the hospital and during home visits provided additional information, as did school reports.

To provide contemporary followup and to fill any existing gaps in historical data, the two sets of parents of origin in this study were interviewed in their homes for approximately six (Patient J.G.) and eight (Patient H.K.) hours, respectively. The parents consented to the use of their information, including the tape-recorded portions, as data for a written report concerning families of children with the same diagnosis as their own growth-retarded child.

The proper names, including initials, used in this study for patients and family members are pseudonymous.

*The present paper is one of a series on psychosocial dwarfism produced by members of the psychohormonal research unit. See bibliography.

Background Data: The Kirk Family

The parents of 17-year-old Herbert Kirk married twenty years ago. This is the first marriage for the mother and the second for the father. They have always belonged to the blue-collar, lower-white middle class socioeconomically. They have four living sons. The husband is seven years older than his wife.

Two successive miscarriages preceded their second child's birth. This child, Herbert, with a history of reversible hyposomatotropinism, was the product of an unexpected twin birth. The twin who died at four days of age reputedly had cystic fibrosis. The parents' suspicion that Herbert also had cystic fibrosis, because of his odor as a neonate, was not corroborated by medical records.

Herbert has six major hospital admissions during his first six years of life. Reasons for referral varied. Referrals were either initiated by physicians for further studies or initiated by the parents when they were dissatisfied with prior treatments or test results.

When first measured in The Johns Hopkins pediatric endocrine clinic at age 6 11/12 years, Herbert had the height of less than a three-year-old. Accelerated growth occurred during subsequent hospitalizations and five foster home placements. At present he has average height for age 17 years.

A son of the father's first marriage lived with Mr. and Mrs. Kirk for the first two years of their marriage. At approximately age 3 the son was admitted to a state hospital for severe mental retardation. At the present age of 22, he resides at this same hospital.

Mr. Kirk, in a recent interview, reported a suspicion that his first wife dropped the retarded son in early infancy, ostensibly causing brain injury and retardation. The reason Mr. Kirk gave for his speculation was that the first wife refused to take the baby to a physician at any time following the birth, which occurred at home. When asked why he didn't take the child to a physician himself, Mr. Kirk said that his first wife made the decisions and his role was "just going along with her like blowin' with the wind." A similar attitude characterizes his relationship with his second wife.

According to Mr. Kirk, he and his second wife made the following agreements concerning the retarded son:

- immediately after their marriage to assume full caretaking responsibility of their son;
- one year after the marriage, to hospitalize the son, who ostensibly became difficult for the second Mrs. Kirk to manage;
- before and after state hospitalization, to prevent, by legal means, the son's mother-of-birth from visiting him;
- during the past few years, never to visit, plan to visit or make contact with the son at all.

Mr. Kirk's siblings of origin are three brothers, one of whom is younger than he. After his father's death when Mr. Kirk was 17 years old, he helped his mother raise his younger brother. He recalled never "raising a hand" to the younger brother because discipline was his mother's job. His mother and brothers do not, at present, live within easy visiting distance.

By self-report, Mr. Kirk has been unemployed for the past 12 years owing to a "heart condition and nerves." Hospital records include suggestions by a cardiologist and two psychiatrists that Mr. Kirk return to work. As a former union laborer, he now receives unemployment disability payments sufficient to support his family. He spends his time building intricate wooden models, for example, of locomotives, and performing light housekeeping chores.

Mrs. Kirk is the second of four siblings and has two living brothers. She had an allegedly mentally retarded younger sister who died at age 19 at a state hospital, the day following the birth of Herbert and his deceased twin. Because her mother worked, Mrs. Kirk as a young girl had caretaking responsibility for the sister until her admission to the

state hospital three weeks before her death. Mrs. Kirk adamantly refused to release the medical records of her sister. Nothing is known concerning the etiology of her mental retardation, or indeed of the authenticity of its diagnosis.

Mrs. Kirk has always lived within easy visiting distance of her parents and brothers. She has, during the past two years, attempted to work as a shop clerk from time to time. Family illness was, by her report, the reason for her inability to work steadily. Mrs. Kirk said that she "took care of," when they were ill, the following members of her immediate family: her sister; her husband's son; her second child, Herbert; her husband, who 12 years ago was briefly hospitalized for psychiatric reasons, and has recurring attacks of "nerves"; her aging parents; and her fourth son, 10-year-old Luther.

Luther was designated by his parents as the surrogate, or substitute patient, when Herbert left the Kirk family. His behavior, according to the parents, was similar to Herbert's behavior while living in their home (see Findings).

Mr. and Mrs. Kirk, within the past year, moved from their long-term residence in an apartment in the home of Mrs. Kirk's parents into a house of their own. They presently have two of their four children living in their three-bedroom home. Herbert arranged to have himself adopted by foster parents. Approximately two months after Luther's residential placement, Mr. Kirk became ill again, according to Mrs. Kirk. Luther is living at a residential school for emotionally handicapped children. The reasons for the move, according to Mrs. Kirk, were to prevent her mother's interfering with the firm discipline used by Mrs. Kirk in her attempt to control Luther's behavior, and to be closer in distance to Herbert's new home.

During recent husband-wife interviews in the Kirks' home, Mrs. Kirk was observed clearly to dominate the conversation while Mr. Kirk repeatedly nodded his head in agreement. Mr. Kirk did state that he loves his wife and sees her as a wonderful woman who can manage almost anything. The statement was repeated by Mr. Kirk at a later date during an individual interview.

Background Data: The Gray Family

The parents of Joanne Gray were married 11 years ago. This is the only marriage for both parents, whose age difference is four years, the husband being older. Occupationally, the father has been able to upgrade his family's socioeconomic status so it is now blue-collar, managerial, black-middle class.

The parents have six children, five boys and one girl. The fifth child in birth order, Joanne, age 7, is diagnosed as having reversible hyposomatotropic dwarfism. The third child in birth order, 10-year-old Matthew, was the designated surrogate patient in this family; he exhibited symptoms similar to his sister's, such as growth failure and behavioral impairments. Matthew's diagnosis was not confirmed owing to his parents' failure to bring him to the hospital for outpatient appointments. His impairments of growth and behavior accelerated during the time Joanne's growth and behavior improved.

Home visits were conducted between two and three years after Joanne's diagnosis and treatment. During these visits, neither Joanne nor Matthew was observed to exhibit the behavioral characteristics typical of reversible hyposomatotropinism. However, the sixth child, age 5, was, by sibling and parental report, different from the others. His behavior, as observed by two interviewers, was hyperactive and included hitting, kicking and punching siblings; jumping, tumbling and running during a quiet recording session; and dumping the contents of a large drawer on the floor.

During this same home visit, Mr. Gray reported that no problems presently exist with respect to any of the children. Mrs. Gray agreed with him. Together they seemed oblivious to their sixth child's hyperactivity. They ignored it, much in the same way as they had ignored Joanne's and Matthew's former physical and behavioral impairments.

By Mrs. Gray's report and Mr. Gray's agreement, Joanne's birth was different from the

births of the other five children in that Joanne "was taken from" the mother. According to hospital records, delivery, at about the expected due date, was accomplished by Caesarean section 1½ hours after admission. The diagnosis was placenta praevia. The newborn was normal and weighed six pounds two ounces.

On the surface, the family appears to give no evidence of psychopathology:

—Mr. Gray is successful in his work.

—Mrs. Gray tried working but prefers to be home with her children.

—The home, in a well-kept residential area, is itself well-kept but not scrupulously clean.

—Neither parent has received psychiatric treatment.

—The parents speak positively about all their children.

—Mr. Gray talks of pleasurable family outings, both past and planned.

—Both parents keep in contact with their own families of origin.

—Both parents have high ambitions for their children's success.

Mrs. Gray is the second child in a family of 13 and the oldest living girl. Her parents are both living. She had, in her family of origin, caretaking responsibility of a retarded sibling. As observed in the clinic and at home, she appeared to be impaired in spontaneity and to experience some degree of constraint in emotional expression and responsiveness, though placid and pleasant. She was described by school personnel as cooperative and congenial. By contrast, a psychologist described her as quasi-catatonic.

Mr. Gray is personable, outgoing, and verbal. In interviews with hospital professionals he supplied most of the information concerning the development of the children. He is third in a family of four. He has an older sister and brother and a younger sister. Since the death of Mr. Gray's mother six years ago, his father lives alone and visits the family frequently.

During eight months in a recovery center, nearly three years ago, Joanne exhibited a remarkable reversal of growth and behavioral impairments. When first seen at The Johns Hopkins Hospital at age 4 3/12, she had the weight of a four-month-old, the height of a one-year-old and the bone age of a 15-month-old. While in the recovery center, she gained over 12 pounds and grew 6 inches in eight months. The growth rate was 10 inches a year and demonstrated the catchup growth spurt by which the diagnosis of reversible dwarfism was confirmed. After returning to the home of origin, her growth rate decreased to approximately three inches a year, a rate within the normal limits of yearly growth, but not sufficient for adequate catchup growth.

The parents did not agree to discharge from the recovery center to a foster home, but did consent to having their daughter stay with an aunt who lived near them and who had always shown a special degree of understanding for the child. Then they unilaterally decided to keep their daughter at home, without informing their doctors or other case workers of their action.

Both Mr. and Mrs. Gray presented to friends, relatives and professionals an image of their family life as intact and harmonious. There were, however, obvious discrepancies with this image which are included in the following sections.

Examples of Abuse: Two Families

For the purposes of this paper, abuse is defined as documented noxious motor and/or vocal behavior of parents or guardians toward a child such that it injures or impairs either their somatic or behavioral and mental growth, or both, to such a degree that an impartial jury of peers in consultation with experts would call the child abused. Medical reports of the initial referrals of both Herbert Kirk and Joanne Gray to The Johns Hopkins Hospital document impairments of growth and behavior.

The existence of parental abuse was not recorded in the medical history at the time of the children's initial visits. It required followup interviews with both the Kirk and Gray

families to ascertain the following forms of abuse: corporal punishment; deprivation of food, sleep, social contact and sensory stimulation.

Mrs. Kirk, in the presence of her husband, admitted that she had used the following disciplinary techniques with Herbert: whipping; locking him in a closet; tying him to his bed and also to a chair; restricting food and drink by constant watchfulness; and restricting social play.

The following disciplinary actions which occurred in his home-of-origin were reported by Herbert to his present adopted mother: he was locked in a closet for several days without food; he was tied to his bed; he was given only mushy cereal to eat while siblings ate fresh cereal; he did not get enough to eat, whereas his siblings had plenty; often he was tied to a chair; and he had been made to lie naked on the floor next to his mother's bed while his mother stepped on him.

In the Gray family, the father disclosed that he regularly used his belt to discipline his daughter for soiling herself. He self-righteously used her age, four years, as his criterion for bowel control, ignoring the fact that she weighed only 13 pounds. The mother disclosed that she restricted Joanne's food and drink because of bad eating habits. She kept the child isolated in her crib away from other family members for most of the time she was awake, claiming she was happier when left alone. The child had a deep scar across the bridge of the nose, possibly from being trapped between the rungs of the crib.

Findings

The parents in each of the two families maintained their role as child abusers in such a way that amounted, within their contriving, to psychopathological collusion. This was true whether the abuse was somatic or psychic.

Sometimes each parent reiterated the pathological idea of the other. Sometimes each endorsed the pathology of the other by way of silent consent instead of critical intervention. Their collusion was manifested in such a way that it was difficult for professional observers to differentiate beliefs from rationalizations, or *idéés fixes* from quasi-delusions.

Collusion: The Kirk Family Discipline

When both parents together were interviewed at home, the interviewer noted that the father agreed verbally and by head nodding that his wife's descriptions of past punitive actions with Herbert were necessary "for the good of the family." They gave the following examples of Herbert's behavior, each time failing to mention why he may have done it: a) he constantly frustrated his mother and would not allow her to have any peace of mind; b) he deliberately provoked other family members; c) he roamed the house at night whenever he could get away with it; d) he had to be watched constantly because he would eat anything he could get his hands on; e) he made strange repetitious whining and moaning noises and talked and sang to himself; f) he picked bedding and clothing to pieces and tried to hide the resulting lint; g) he drank water from the toilet bowl; and h) he sat in one position, without responding, once for as long as 47 minutes.

Subsequent investigations revealed that the parents, knowingly or unknowingly, instigated the behavior they deplored. For example, the child's bizarre eating and drinking habits and roaming at night appeared, in retrospect, as a response to being hungry and thirsty. His alleged provocation of family members was probably a response to documented physical abuse from siblings as well as parents. His perseverative sounds and activities were a response to discipline and to long periods of isolation.

Consistently in all their interviews over the years, both parents maintained that Herbert had created "a wall" between his mother and himself since birth. They cited this wall as the main reason for their use of harsh discipline. Both of them believed that the

wall prevented Mrs. Kirk from communicating with Herbert in the same way she communicated with her other children.

It was the opinion of all the professionals concerned with the case that the mother was the primary initiator of abuse and the father, the secondary consentor.

Placements

Mr. and Mrs. Kirk's collusion was unbroken when Herbert was away from their home in the hospital or a foster home. According to medical records, during each placement they pled for their child's return to the home. The last time he was returned home they became frustrated with his behavior, threatened to send him away, and again requested his removal from their home.

Interviews with present and past foster parents included the following examples of the Kirk parents' behavior during Herbert's placements: They would plead with him to visit them and then mistreat him with verbal and physical abuse; they would, for long periods of time, make no effort to contact him or return his phone calls; they seemed unable to treat the child as a human being; they would repeatedly break promises; they once responded to a phone call from Herbert, who said he'd be a little late for his expected Christmas visit to their home, with "Don't bother to come at all."

When Herbert at age 19 had himself legally adopted by his foster parents, both Mr. and Mrs. Kirk agreed that it was a shame. Mrs. Kirk said that one of the reasons (see Background Data) she wanted her family to move from their former residence was to be closer to Herbert. The adoptive mother said that she viewed the move as another attempt by Herbert's family to interfere with his progress. She cited that prior to the adoption, Herbert ceased his former practice of phoning the Kirks and/or requesting to visit them.

Because of his adoptive father's change of job, Herbert and his adoptive family recently moved out of state. The patient maintains contact with the psychohormonal research unit. He is doing well.

The Surrogate (Substitute) Patient

In the Kirk family, the patient's youngest brother, Luther, has consistently been the surrogate, although his statural growth has not been retarded. His two admissions to a children's psychiatric ward were for treatment of school phobia and other behavioral symptoms. The first admission coincided with Herbert's possible permanent placement in a foster home, while the second corresponded with Herbert's legal adoption by a foster family.

Luther's problems were described by Mrs. Kirk, with Mr. Kirk in agreement, in the following manner: "Yes, he's picked up some of Herbert's way because Luther always watched everything he did. And true, he picked up his 'oohing' bit" (tic-like moans) "and his throwing a fit if he can't have his way. He knows, because he used to watch Herbert and all, and he has taken up at the same place Herbert left off. And I tell him to stop that. I'll tell him, I'll tell him too, 'You're acting just like Herbert.'" The parents described other undesirable behavior that Luther had copied from Herbert, classifiable as social distancing; temper tantrums; problems of eating, sleeping, playing; and pain agnosia. An example of pain agnosia, as well as abuse, was evidenced when Mrs. Kirk described Luther's standing outside in the cold in his bare feet and not feeling the cold. She reported that since Luther doesn't feel anything, she pulled him up the steps by the hair ("for that he feels") to get him out of the cold.

The Kirk parents did not allow Luther to join the Boy Scouts, as formerly they had prohibited Herbert from doing. The two other siblings were active in scouting. Luther, in the presence of an interviewer and both parents, said he wanted to join the Scouts. The mother, with the father verbally supporting her, said that Luther could not join because

he would come running home on the first camping trip. As if they together followed the same script, both parents gave their son several reasons why he would come running home.

Luther presently lives in a residential institution. In the absence of both Luther and Herbert, Mr. Kirk is the member of the family who has developed psychiatric symptoms which, according to his wife, require her to stay home and care for him.

Collusion: The Gray Family Discipline

Mr. Gray accepted his wife's absurd dietary ideas. During a home interview he actually verbalized agreement with her stated reasons for restricting Joanne's nutrition. Mrs. Gray said that Joanne had bad eating and drinking habits, which included gulping food and drink, eating too fast, eating garbage, chewing and swallowing poorly, and intermittently refusing to eat. These habits ostensibly caused the daughter to have a bloated stomach, to wheeze, and to be susceptible to germs. According to the mother, food restriction was a method of discipline to correct bad habits as well as to prevent physical illness.

Collusion with respect to discipline was further evidenced by Mrs. Gray's denial of any knowledge that her husband used his belt to beat the 13-pound child. Mr. Gray had reported spanking his daughter "maybe two or three times a week" for soiling her diapers. Mrs. Gray, in a separate interview, said, "I will spank her if she's really wrong but my husband, he won't spank her."

Joanne's isolation from family activities involved further parental collusion in defining the daughter's isolation from her brothers not as deprivation or punishment but as a form of protection. According to Mrs. Gray, the other children were not permitted to go upstairs near Joanne's crib because she caught colds and germs easily. Mrs. Gray agreed with his wife's statement that Joanne "was always the type to stay to herself. She didn't want to be around nobody." The parents said that, rather than being with the other children, Joanne preferred being quiet most of the time; playing with her hands; staring; just sitting; and mumbling to herself.

Placements

During Joanne's 8-month placement in the recovery center, her parents visited regularly. Mrs. Gray's actions during those visits were described by a hospital clinician as "removed and distant." She would, for example, sit and do needlework while watching Joanne play rather than attempt to talk or play with the child directly.

Though Mr. Gray did play with Joanne during these visits, he did not attempt to involve his wife in closer contact with her daughter.

During her 8-month stay at the recovery center, Joanne learned to walk, to control elimination, and to speak in three-word sentences. She grew rapidly in height and weight (see Background Data).

After the child's discharge from the recovery center, the parents missed the next three scheduled appointments at the pediatric endocrine clinic. The father brought the child for a check-up only after the family was informed that protective services would be notified if the patient missed further appointments.

The parents cited their prayers as an explanation for her growth during the recovery placement. Acknowledged with head-nodding by her husband, Mrs. Gray said, "All I know is we prayed every night, and by her being out there, our praying and the different climate she was surrounded by, I think it really caused her to start growing and walking and doing all the things she was supposed to be doing."

Mr. Gray gave his description of the recovery center as: "You know, that's the place where all the children go, out there, and they let them run wild and let them do anything

they want to do." Mrs. Gray nodded in approval of his statement.

The Surrogate (Substitute) Patient

In addition to Joanne, Matthew, who is two years older than his sister, has exhibited symptoms of lack of statural and behavioral maturation. As if on a see-saw, one child's health has been balanced by the other's illness.

Prior to Joanne's birth, Matthew was the growth-retarded patient of the family. At age 1½ he was hospitalized and diagnosed as failure to thrive. He allegedly ceased to have growth and behavior problems near the time of Joanne's first hospitalization at age two, when she was diagnosed as failure to thrive. The parents did not keep clinic appointments for Matthew during the three years that Joanne was the obvious, non-growing, nonmaturing patient in the family. Matthew returned for a medical check-up at a comprehensive clinic at the time of Joanne's return home from the recovery hospital. Mrs. Gray reported that Matthew overate, gulped his food, and had "milk poisoning" which caused his stomach to bloat. She forbade him to eat any food at school except what she gave him. When he returned home from school, she lifted his shirt to see if his abdomen was bloated. If so, that was her proof that he had illicitly eaten milk-containing food at school.

The family pediatrician suggested residential placement for Matthew, but the parents refused. Again, they did not keep scheduled appointments. When the family was threatened by protective services for missed appointments, both Joanne and Matthew improved in growth and behavior.

At present, the Gray parents have been keeping appointments at a comprehensive clinic for Joanne and Matthew. During a recent home visit the parents spoke with pride of their two children who formerly "were shy and didn't grow."

None of the Gray children appears shy or dwarfed at present. Their sixth child, however, a boy age 5, is regarded by parents and siblings as the "trouble causer." He shows classic signs of the hyperactive child. His activity rarely is shared with that of his siblings, and he is recognized in the family as being odd.

Discussion

The present findings may relate to the findings of Spitz (1946) with respect to hospitalism and those of Bowlby (1969, 1973) with respect to separation and loss. Neither of these two authors, however, recorded measures of statural growth. Also, neither author construed the behavior of adults in the child's social environment in terms of psychopathological collusion.

It is fair to make the inference that, in the case of the institutions studied by Spitz, the hospital personnel accepted what today would be considered a pathological philosophy of caretaking which is a *de facto* form of collusion. Pathological collusion is not synonymous with voluntary malevolence. It can happen covertly and without planned intention; it can also be defended with self-righteous devotedness, as in the case of the parents presented in this paper. The same may well apply to the parents studied by Bowlby.

The findings of the present paper obviously relate to those of authors who have used the diagnostic terms "failure to thrive" (Barbero and Shaheen, 1967), "maternal deprivation" (Patton and Gardner, 1969; Rutter, 1976), and "deprivation dwarfism" (Silver and Finkelstein, 1967, and Gardner, 1972). These authors were clearly aware of noxious events in the child's social environment as well as the failure of statural growth, though at the time of their observations, the pathological behavior of adults was recognized only in individual clinical observations. With respect to pathological parental collusion, these same authors, like Spitz and Bowlby, did not report it. There is no case

study delineating the collusion between parents in which abuse masquerades as devoted parenthood.

Another point of discussion is with reference to infantile autism (Kanner, 1948), childhood schizophrenia (Bradley, 1941; Bradley and Bowen, 1941), and symbiotic psychosis (Finch, 1960). In these conditions impaired statural growth is not a standard feature. However, the following behavioral symptoms are uncannily similar to those observed in psychosocial (abuse) dwarfism prior to the catchup growth spurt: seclusiveness; bizarre eating habits; catatonic manifestations including posturing and grimacing; awkward gait; preoccupation; daydreaming; and physical inactivity.

There exists a great deal of documentation concerning covert collusion in the parents of children diagnosed as schizophrenic. In fact, it has been theoretically fashionable to point the etiological finger at parents, attributing pathology in the child to the parents' collusive pathological behavior.

Nowadays, however, there is greater willingness to accept the hypothesis that an infant may actually trigger some pathological behavior in the parents. The mechanism of this triggering may, by speculation, occur neonatally as an impairment of the infant's ability to react in such a way as to elicit parental caretaking responses, thus impeding the establishment of a parent-child pair-bond.

Failure of pair-bonding may very well be a common factor shared or manifested in the syndrome of childhood schizophrenia and the syndrome of abuse dwarfism, despite the differences in the ultimate phenomenology and prognosis of each syndrome. There may also be a difference in the etiological factors responsible for the failure to pair-bond in each syndrome.

In Spitz's and Bowlby's hospitalized infants, the etiology of the failure to pair-bond clearly lies in the institution's methods of caretaking. The etiology of the failure in abuse dwarfism or childhood schizophrenia remains unknown.

In addition to the syndromes of hospitalism, failure to thrive, and childhood schizophrenia, there is a fourth condition which has relevance to abuse dwarfism, namely Munchausen's syndrome. In its classic form, Munchausen's syndrome is a condition in which the etiology of symptoms appears completely hidden but, in fact, the symptoms are self-induced. There is a close parallel with the symptoms observed in abuse dwarfism except that the symptoms are parent-produced instead of self-induced. Whereas in Munchausen's syndrome the patient gives a false medical history, in abuse dwarfism the parents give the false history while the patient remains silent. That is to say, one has a case of Munchausen's syndrome by proxy.

The same condition of Munchausen's syndrome by proxy also occurs in cases of child abuse without dwarfism. There is not yet enough comparative information to permit a statement as to why some abused children become dwarfs whereas others are presented simply as victims of trauma.

There is also not yet enough comparative information to permit a statement concerning how specific is the relationship of reversible IQ impairment to the syndrome of abuse dwarfism. There is, however, one important study (Dennis, 1973) concerning reversible IQ impairment secondary to institutional rearing. The institution was a founding home in Beirut, Lebanon, in which children were subject to severe social deprivation. Dennis took advantage of a new law that in 1956 permitted legal adoption for the first time in the country. Before 1956, all foundlings lived in the home throughout childhood and adolescence. Among them, the average IQ was slightly above 50. After 1956, if adoption occurred before age 2, then the IQ distribution of the children was normal, the average IQ being 100. Children who lived in the institution for longer than two years lost six months of mental age for each year of residence in the institution. After adoption, when catch-up mental growth began, they were unable to catch up the 50% of deficient mental growth. Thus if a child of 12 would be adopted with a mental age of 6, the missing six years could not be regained in catch-up growth. The six

years were lost forever, and represented a permanent IQ impairment. Though the evidence is still incomplete, it would appear that the same type of permanent IQ impairment occurs in abuse dwarfism, and is thus a by-product of parental collusion.

Summary

The two families studied in this report, each with one child diagnosed as having reversible hyposomatotropinism, represent diverse as well as similar aspects of collusional psychopathology. Parental complementarity in these two families is, in part, *folie à deux* in that both sets of parents share a delusion of righteous parenthood. This self-righteousness permitted the parents to perpetrate or condone both covert and overt child abuse. Parental collusion does not, however, explain the phenomenological reversibility of growth failure and behavioral disorder. More familial and individual evidence is needed to determine what common factors preceded the final common pathway to reversible growth failure and reversible behavior disorder.

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