

## Munchausen's Syndrome as a Dissociative Disorder

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### ABSTRACT

*A patient is described who was diagnosed as having Munchausen's Syndrome and Munchausen's by Proxy as well as Multiple Personality Disorder. Commonalities between Munchausen's and Multiple Personality Disorder include: multigenerational patterns, self-mutilating behaviors, multiple somatic symptoms, having been accused of lying, use of many different names, and fuguelike disappearances. Commonalities between Munchausen's and child abuse related behaviors include hospital peregrination and the production of inadequate explanations for inflicted injuries. The present case is one of a series of Munchausen's Syndrome case reports in which extreme abuse has been documented in the patient's childhood.*

Munchausen's Syndrome was named in 1951 after Baron Munchausen, a wandering teller of tall tales; in the original report, Asher (1951) described the syndrome as a condition in which the patient repeatedly seeks medical treatment for apparently acute and severe illness. Such patients present a plausible, often harrowing medical history, supported at times by simulated medical records or laboratory specimens or by actual self-mutilation or self-poisoning. Asher noted that Munchausen's patients cheerfully tolerate "the more brutish hospital measures" including painful and invasive diagnostic procedures, repeated x-rays, and multiple surgeries; ultimately, they quarrel with medical personnel and typically leave treatment suddenly against medical advice, especially if denied further procedures or confronted with the factitious nature of their complaints. At this point the patient moves on to a new caregiver, sometimes assuming a new name and a new personal and medical history, and the cycle begins again (Asher, 1951; Bursten, 1965; Spiro, 1968; Cavenar & Maltbie, 1978; Swanson, 1981).

Munchausen's Syndrome by Proxy was first described by Meadow in 1977. In these cases a parent, almost always the mother, pursues Munchausen's activities using her child's body rather than her own. Fifty per cent of these women have also engaged in self-directed Munchausen's behavior (Meadow, 1977; Black, 1981; Meadow, 1984; Jones, 1983; Jones et al., 1986). Often the simulation involves chemical poisoning of the child (as with salt, psychotropics or cardiac medications). Fatality rates of as high as 16 percent have been reported (Palmer and Yoshimura, 1984). In addition these children are at risk for traumatic medical procedures including multiple surgeries, and for chronic invalidism (Meadow, 1984). Some are abused physically or sexually as well as chemically, and there is a high death rate among their siblings (Meadow, 1984). Al-

though the legally mandated removal of the child is necessary in at least half of these cases, this is often foiled by the mother's seemingly appropriate concern about the child's health and her convincing allegations that physicians are accusing her only because of frustration at their failure to identify the child's "real" illness.

Despite the seriousness of these conditions, little is known about the motivations underlying these behaviors. Unlike patients with malingering, these patients gain no rational benefit from their simulated symptoms. Indeed the driven quality of these behaviors is diagnostic. Only half of patients diagnosed as having Munchausen's Syndrome proper are ever even seen by a psychiatrist (Spiro, 1968), and the literature reports fewer than 50 as having received psychiatric treatment (Mayo and Haggerty, 1984). There is no evidence that any treatment, including leukotomy (Barker, 1962), ameliorates these behaviors (Blackwell, 1968; Fras, 1978). Psychosis (either organic or functional), sociopathy, hysteria, and recently borderline personality are the most frequently given primary diagnoses (Nadelson, 1979). Depression, sometimes quite severe, has been noted both in patients with Munchausen's Syndrome and Munchausen's by proxy. (Snowden et al, 1978; Evans et al, 1984).

The present report describes a woman with both syndromes—Munchausen's and Munchausen's by Proxy—who was also found to have Multiple Personality Disorder (MPD). Extreme forms of child abuse were present both in her own childhood and in her handling of her four children. Her Munchausen's behaviors represented repetitions of her own abuse which had included both medical neglect and deceptive explanations for parentally inflicted physical injuries.

This case prompted a reexamination of the symptoms of Munchausen's Syndrome which revealed

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numerous parallels with symptoms of dissociative disorders. Multiple somatic symptoms are found in MPD as well as Munchausen's. Such symptoms, based on somatic memories of extreme abuse often result in multiple frustrating medical investigations, multiple diagnoses, and numerous unpleasant caregiver-patient interactions for MPD patients (Bliss, 1985; Kluft, 1985). As with Munchausen's patients, patients with MPD are often accused of lying, so often that this is a diagnostic indicator (Goodwin, 1985); lying results when compulsively driven, homicidal or mischievous personalities perpetrate actions that the host cannot remember but must explain. Pseudoseizures are common in MPD (Bliss, 1985) and are also one of the most frequent manifestations of the Munchausen's Syndrome and Munchausen's by Proxy; they are reported in 50% of proxy patients (Meadow, 1979). Active imagination with production of long dramatic changeable pseudohistories characterizes both Munchausen's and MPD, and in both conditions the patient may use several different names. Recurrent self-mutilation and potentially fatal self-harm are present in both disorders. The sudden departures and peregrinations of the Munchausen's patient are reminiscent of the fugues seen in the MPD patient (Chapman, 1957). Prior extreme child abuse, present in over 90% of MPD patients (Putnam, Guroff, Silberman, Barban & Post, 1986) is often the only element in the history of a Munchausen's patient that remains substantiated once old records and other documents arrive (Ford, 1973; Jones, 1983; Sparr and Pankrantz, 1983; Fisch & Zimran, 1984). However, because Munchausen's patients tend to produce so many factitious accounts of traumatic events—auto accidents, combat experiences, gang rapes—their accounts of childhood traumata are sometimes dismissed without investigation (Cheng & Hummel, 1978; Mayo & Haggerty, 1984; Sparr & Atkinson, 1986).

There are also parallels between Munchausen's syndrome and child abuse syndromes. Hospital peregrination is a major problem in both disorders; inter-hospital registers are recommended both for battered children and for Munchausen's patients (Sylvester, 1957; Verity et al, 1979). Also, the production of an inadequate explanation for an injury is the cardinal diagnostic signs of child abuse (Kempe, Silberman, Steele, Droegemueller, & Silver, 1962). It is possible that some of these peregrinating Munchausen's patients who fabricate explanations for inflicted injuries are perpetuating as adults a pattern begun by their parents. The Proxy Syndrome provides a mechanism whereby this reenactment can be extended to the next generation.

#### A CASE EXAMPLE: MUNCHAUSEN'S SYNDROME, MUNCHAUSEN'S BY PROXY, MULTIPLE PERSONALITY DISORDER, AND EXTREME ABUSE.

Theresa H. was a married pregnant mother of three referred to a protective service agency because her 6-month old daughter had severe facial bruises and was failing to thrive. Multiple problems were identified including: 1) Mrs. H's first child was illegitimate and had been given up for adoption; 2) her second child, a 3-year old boy, had been seen at many emergency rooms for "febrile seizures" and "accidents;" 3) Mrs. H. believed her current pregnancy to be the result of rape; 4) all her pregnancies had been complicated by rheumatic heart disease; and 5) Mr. H. beat Mrs. H. severely and repeatedly.

Mrs. H's childhood history was confirmed by her mother and by her husband. Mrs. H's alcoholic father had abused her physically until he abandoned the family when she was 10. At 8, the child had admitted herself to the hospital with rheumatic fever; her family had responded to her fatigue and lassitude by punishing her for failing to complete chores. A new stepfather, also alcoholic, sexually abused Mrs. H. from ages 10 to 14. At 14, she ran away from home and was admitted to a psychiatric hospital after cutting her wrists. She was sent to live with relatives where she delivered an illegitimate child. Later in the course of her treatment Mrs. H. disclosed that the step-father had fathered this baby and that she had been pregnant when she ran away. She also gave further details about her pre-teen years and was more graphic in describing severe beatings by both her mother and her natural father. When she had disclosed this to a grade school teacher, her parents had successfully "explained the bruises away."

Mrs. H's daughter was placed in foster care. Both she and her son were asked to participate in a therapeutic nursery program. Marital therapy was initiated to deal with the spouse abuse. Mrs. H. participated in an incest victims' group. She was referred for prenatal care and started on digoxin and erythromycin for her rheumatic heart disease.

However, extensive cardiologic testing revealed no heart disease. Cardiac medications were withdrawn, but the pregnancy continued to be plagued by complications. Mrs. H. underwent a hysterectomy one month after the birth of her second daughter. The daughter she had abused was returned to the home. Shortly thereafter Mrs. H. began to appear at the Emergency Room with complaints of seizures. She reported that one seizure began just as she was about to spank this toddler, who was being toilet trained prematurely. Despite a negative neurologic workup, phenytoin and carbamazepine were started.



Both older children continued to show developmental delays and to sustain inadequately explained injuries. Mrs. H. variously admitted to having hit them, asserted that they must have an undiagnosed disease, or attributed their injuries to her violent husband. Both children were removed from the home and ultimately freed for adoption.

Mrs. H. was hospitalized after overdosing on her seizure medications. She spiked a fever in the hospital but was observed by nurses to be warming her thermometer under the hot water faucet. Her anticonvulsants were discontinued.

Later, when further spouse abuse had sent Mrs. H. to a battered woman's shelter, she brought her remaining daughter to the Emergency Room complaining that the child had febrile seizures. As with the complaints of seizures in her son, this could not be confirmed.

Two more rapes were reported by Mrs. H.; on the last occasion she admitted to police under interrogation that the knife wound on her chest, initially attributed to the "rapists," had been self-inflicted. However, she managed to obtain a leg cast and told her doctors she had broken her leg fleeing from rapists.

She was next diagnosed, after a few months after she began nurses' training, as having brittle diabetes; she was started on insulin. After a near-fatal hypoglycemic coma she accused her husband of having injected her with insulin in an attempt to murder her. She said the bruises found on her daughter after this incident must have been inflicted by the husband.

At this point a complete record review clarified the Munchausen's pattern in Mrs. H. and also the Munchausen's by Proxy behaviors, with factitious seizures reported in two children. Chronic lying, episodic alcohol abuse, and one criminal conviction were also documented. Record review also indicated that she had given four different birthdates and three different names to various hospitals. Theresa H., born January, 1952, had sought medical help for rheumatic heart disease, seizures, and diabetes. Theresa H. II, born in January, 1958, sought treatment for both her own prior child abuse and her abuse of her own child. She worked with protective service workers, received rape therapy from crisis counselors and attended an adult incest victims group. Vanessa F., born in December, 1962, had consulted psychiatrists because of almost continuous depression, and 5 suicide attempts since age 8. Vanessa said that her major interest in medical investigations and treatments was to find a way to die. Terry H., born December 1960, had sought marital therapy and pediatric care for her children, and had been seen at battered women's shelters. Several therapists had noted that Mrs. H. "spaced out" in sessions and that she "could change tremendously" from session to session. Changes were most noticeable at the beginning of a treatment as Mrs. H. negotiated which name and birthdate to use.

Confronted with these findings, the patient said that the real Theresa had been killed by her abusive parents. She—the replacement Theresa—had been illegally adopted to replace this murdered child. Vanessa F. was her "real" mother's maiden name. It was because she was forced to act the older age of the dead Theresa, that she always performed so poorly and failed so often.

There seemed to be real amnesia for the insulin injection, and the working hypothesis was that the suicidal Vanessa had used somatizing Theresa's medications for her own suicidal purposes, leaving Terry to interpret this in terms of her own marital preoccupations. Chronically angry and child abused Theresa II was felt to have inflicted the daughter's bruises. However, before the patient's multiple ego states could be fully explored and treated, she regained full custody of her one remaining child and left the area. She had remained in one city for over 5 years, under the mandate of protective services, receiving treatment from at least 7 psychotherapists and sustaining medical and psychiatric admissions to 4 hospitals.

#### OTHER CASES IN WHICH MUNCHAUSEN'S BEHAVIORS AND DISSOCIATIVE SYMPTOMS COINCIDE

One other case report describes amnesia for Munchausen's behavior (Nininger, unpublished). A 23-year-old woman with compulsive lying and an eating disorder was amnesic for having told co-workers that she had breast cancer. She was highly hypnotizable and described the incident under hypnosis.

In the present case the false reports of seizures in the children may have been one alter's attempts to explain the results of beatings by an abusive alter. Rogers and co-workers (1976) reported that one of their five Munchausen's by Proxy mothers had been diagnosed as having a depersonalization disorder. Chan and co-workers (1986) described a Proxy mother who denied recollection of injecting her child with a diuretic. It is difficult to differentiate self-protective claims of amnesia in these cases from true amnesia (Lansky and Erickson, 1974). However it is possible that amnesia and the presence of alters could account for some of the extremely convincing denials by Proxy mothers when they are confronted with evidence that they are harming their children (Waller, 1983). Similarly convincing denials are seen in MPD mothers when it is an alter who is abusing the child and the host has no memory of this (Kluft, 1985).

The presence of multiple names is a diagnostic indicator of Munchausen's disorder. In some cases histories there is a suggestion that the names are connected to relatively stable ego states. For example, one of Asher's original cases (1951) complained of intestinal obstruction when she was Margaret Coke of Houston, Texas. When she was Elsie Packoma, London prostitute,

she admitted herself to hospitals for urinary complaints. Spiro (1968) described a patient whose impostureship was split off from his Munchausen's behavior. In the hospital he was disabled by renal pain. In bars at night he became an imposing criminal lawyer, or a private investigator, or a physician. Many of the Munchausen's patients portray themselves as war heroes suffering from old wounds (Asher, 1951; Sparr and Pankrantz, 1983) or as victims of bereavement or other trauma (Snowden, Solomons, and Druce, 1978). It is unclear to what extent these pseudobiographies function as alter identities for the Munchausen's patient (Wells, 1986). Atypical auditory and visual hallucinations occurring in some psychiatric Munchausen's patients are usually understood as evidence for the factitious nature of psychiatric complaints (Snowdon, Solomons, and Druce, 1978; Sale, Burvill, and Kalucy, 1979). However they could also represent the kind of visions and voices of alters which produce the atypical hallucinations characteristic of MPD (Kluft, 1987).

The earliest reported case in which Multiple Personality Disorder coincided with feigned somatic symptoms was documented in a seventeenth century Italian abbess by investigators from the Inquisition (Brown, 1986). This woman's illness began with visions of a youth called "Jesus" and a group of five young male angels. These visions raped and beat her causing chronic pain. Later she would episodically go into a trance, assuming the physical appearance of a young adolescent boy, speaking in a male voice in several different dialects, not her own. She ran afoul of the Inquisition when one of these angelic alters, named Splenditello, commenced a sexual affair with another nun. The abbess was also observed to simulate the stigmata by picking at her own flesh. She convincingly denied memory for the actions of "Jesus"—who inflicted the stigmata—or Splenditello—who raped the nun. She was diagnosed as possessed rather than intentionally misbehaving. Nonetheless, she was sentenced to life incarceration.

Extreme suicidality, as described in the case of Theresa H. and in other Munchausen's patients, (Black, 1981; Fisch & Zimran, 1984), is found in 68 percent of MPD patients (Putnam, Guroff, Silberman, Balban, & Post, 1986). The self-mutilation and self-poisoning that are part of Munchausen's have themselves been interpreted as suicidal equivalents (Menninger, 1934). Ford (1973) found suicide attempts in six of 13 patients with classic medical Munchausen's; Snowden and co-workers (1978) report prior suicide attempts in seven of their 12 cases with feigned bereavement. One patient who presented factitious rape allegations as well as feigned bereavement finally hanged himself (Sale, Burvell & Kalucy, 1979).

Extreme child abuse, found in almost all patients with MPD, has been described in some Munchausen's cases. Ford (1973) found that eight of 13 Munchausen's patients had been rejected by parents; six had been

sadistically abused, and seven had been placed outside the home. Fisch and Zimran (1984) described a cardiac Munchausen's patient whose psychotic mother had tortured him by burning him with cigarettes. One of the war hero imposters (Sparr & Pankrantz, 1983) was freed for adoption at age 3 after his mother set fire to the house with him and his two siblings inside. In two reported cases the patient in childhood witnessed a parent's death (Hoyer, 1959; Spiro, 1968). Documenting the history is of course the central problem in these cases. Stone (1977) reported a case in which parents said that the patient's complaints of sexual and physical abuse were feigned. However, it is not clear that he was able to document the parents' version from outside sources. Healy (1915) noted over 50 years ago that imposters and patients with pseudologia fantastica often report childhood trauma, particularly sexual traumata. Sexual abuse is reported in several of the Munchausen's case histories (Sparr and Pankrantz, 1983; Mayo and Haggerty, 1984) and genital anesthesia, pain or surgery are commonly seen in the syndrome (Bursten, 1965; Rimon, Kampman, Ikonen, & Reunanen, 1980).

#### IMPLICATIONS FOR DIAGNOSIS AND TREATMENT

Screening Munchausen's patients for undiagnosed dissociative disorders should include evaluation for amnesia, alters, hypnotizability, and prior child abuse. Many authors have recommended that therapists renounce any attempt to assemble an accurate history in Munchausen's Syndrome (Bursten, 1965; Mayo & Haggerty, 1984). However, for the subgroup with amnesia and child abuse, this is not good advice; as in MPD, the patient assembly of an accurate autobiography using pediatric, school, and other records and family and outside informants, as well as uncovered memories is an essential goal, if a long-term one (Goodwin, 1985). With such patients the usual compartmental segregation of medical from psychiatric from legal histories cannot be allowed to occur (Merrin, Van Dyke, Cohen, & Tusel, 1986). The case of Theresa H. warns us that some recognized psychiatric Munchausen's patients may be pursuing simultaneously a medical Munchausen's career (and vice versa). When, as in the present case, sociopathy complicates the dissociative and Munchausen's symptoms, the therapist needs to be aware of the criminal record so that treatment can be anchored by some legal hold.

Munchausen's pseudonyms should be explored to determine whether they are attached to a fixed pattern of symptoms, to an elaborate fantasy identity, to hallucinations of that identity's appearance and voice, and episodes of amnesia; some of these pseudonymous identities may go beyond impostureship to constitute alternate ego states (Wells, 1986). Prior conversion, symptoms, eating disorders, and family history of dissociation may also be found in this subgroup with facti-



tious and dissociative symptoms (Goodwin, in press).

### THEORETICAL IMPLICATIONS: MUNCHAUSEN'S SYNDROME AS A REPETITION OF CHILDHOOD ABUSE

Most authors have postulated somewhat sociopathic motivations for Munchausen's Syndrome—the desire to achieve the sick role because that makes available 1) shelter in a hospital, 2) nursing attention, 3) drugs, 4) escape from onerous obligations and 5) opportunities to trick and deceive physicians (Asher, 1951; Bursten, 1955; Sale, Burvill, & Kalucy, 1979). However, a few investigators have sought childhood origins for Munchausen's behaviors. Fenichel (1915; Barchelon, 1973) provided the classic formulation of the psychodynamics of compulsive liars: "If it is possible to make someone believe that untrue things are true, then it is also possible that true things, the memory of which threatens me, are untrue" (pp. 528-529). Following Reik (1949) and Grinker (1961), Bursten (1965) saw the Munchausen's impostureship as a "flight forward" into the helpless victimization the patient most fears but with the patient's deception providing secret control and an ultimate reversal and undoing of the victimization (Schneck, 1970). Justus (1980) reported a case which illustrated concretely how Munchausen's behaviors can serve the aim of denial. His patient sought hospital admission for filariasis while vehemently denying his actual diagnosis of leukemia. In the case of Theresa H. her compulsive seeking of medical attention also enacted her conflict about wanting the abuse to be diagnosed finally while continuing to want to maintain the lies and the secrecy.

Another way to connect the Munchausen's behaviors to childhood trauma is to focus on the actual abuses perpetrated by the patient on his own body. Munchausen's Syndrome can be seen not only as a response to abuse, but as a reenactment of the abuse. Patients with Munchausen's Syndrome poison themselves, mutilate themselves, lie to doctors and flee appropriate medical care. Munchausen's by Proxy patients poison and mutilate their children, lie to doctors, and deprive their children of appropriate medical care. Meadow (1984) has observed the evolutionary process whereby the child ultimately takes over from the parent as the Munchausen's perpetrator. One of Meadow's patients, factitiously labeled by his mother as having spina bifida, hydrocephalus and retardation, maintained this story into adulthood and refused to walk. Since all forms of child abuse typically include deceptive explanations to physicians and medical neglect of inflicted injury, Munchausen's can also represent an adult repetition of physical and sexual abuse, as in the present case.

Table I. indicates how the named forms of child abuse reflect various forms of human attack which are also observed in the panhuman, cross cultural practices

of torture (Stover & Nightingale, 1985). Each form of torture is also a form of child abuse and each can be perpetrated on the self and present as a form of adult psychopathology. The diagnostic picture is more complicated than Freud initially believed in the era of his "Trauma Theory" (Goodwin, 1985). Freud (1962) initially believed childhood trauma to be the source of all neuroses; however experience and common sense suggest that reenacted child abuse is only one of many etiologies for self-destructive behaviors. Probably only a small percentage of Munchausen's patients have suffered concealed injury or medical neglect in childhood and likely many of the Munchausen's by Proxy mothers are simple sociopaths without a history of abuse in their childhoods. However, practitioners should be alert for the patient who presents at various times most or all symptoms listed in Table 1.: repeated victimizations, self-mutilation, somatization, pseudologia, sexual disorders, eating disorders, dissociative symptoms, agoraphobia, substance abuse, overdoses, depression and compulsive but poorly integrated creativity. Often such patients prove to be survivors of extreme and multiple abuse. These are the patients who can be identified and possibly helped if physicians learn to include dissociative disorders in the differential diagnosis of Munchausen's Syndrome.

TABLE 1.

Subtypes of child abuse and manifestations of adult psychopathy arranged by type of attack.

<u>TYPE OF ATTACK</u>	<u>TOWARD CHILD</u>	<u>TOWARD SELF</u>
Physical beating and torture	Battering Physical abuse	Victimization syndromes Self-mutilation
Concealment of injury	Medical neglect Deception	Somatization disorders Pseudologia
Rape	Sexual abuse	Sexual disorders
Starvation	Failure to Thrive	Eating disorders
Isolation	Neglect Abandonment	Dissociative disorders: Depersonalization Fugues
Incarceration	Confinement	Agoraphobia
Poisoning	Chemical abuse Munchausen's by Proxy	Substance abuse Overdoses Munchausen's Syndrome
Psychological torture	Emotional abuse	Depressive disorders Borderline personality Paranoid disorders
Exploitation	Educational neglect Pseudo-parentification	Disorders of creativity Creative blocks Work addictions Fragmentation of work identity

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