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Supermom or Child Abuser? Treatment of the Munchhausen Mother

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ABSTRACT. In this article the phenomenon of the actual creation of illness in one's own child is explored. Distinction is made between two forms of child abuse: Munchhausen by Proxy and Polle Syndrome. The author elaborates on possible causes of such an unusual condition and takes a feminist perspective in recommending treatment approaches that might be used in handling the problem.

She came to me indicating that she had serious medical problems and that the doctors could find nothing physically wrong with her. A call to her doctor ascertained that although she complained of serious symptoms, a series of medical tests found no diagnosable illness. He had referred her for therapy because he felt her problems were perhaps psychological in origin. Her history indicated that serious medical problems were part of her family background and that she had been treated extensively as a child, having been brought to the hospital on numerous occasions by her mother. The mother, too, had an extensive medical background although causes of ill-

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ness were rarely found. Eventually the doctor and I began to suspect that this was a case of Munchhausen Syndrome and that the young woman had actually grown up as a Munchhausen-Polle Syndrome patient. Now she was moving into the second generation of created and fabricated illnesses.

Recently we have seen a spate of information on a provocative and compelling area of medical treatment, the Munchhausen Syndrome (Lear, 1988; Lipsitt, 1983). Although that syndrome is both fascinating and frightening, a more serious and potentially dangerous disorder, Munchhausen Syndrome by Proxy, or Polle Syndrome, is emerging as a new area of child abuse. This pathological condition is of particular interest to feminist therapists since most of the perpetrators are women and it also appears that the causes could well be the bizarre result of the extreme in the traditional socialization of women as caretakers and nurturers.

DEFINITION

Munchhausen Syndrome as a condition has been with us for quite some time. The term was coined by Richard Asher in 1951 and was applied to patients who gave dramatic but untruthful medical histories and feigned signs in an apparent attempt to secure hospitalization and medical care (Malatack, Wiener, Gartner, Zitelli & Brunetti, 1985). Historically, Baron Karl Friedrick Hieronymus von Munchhausen was an 18th-century German mercenary cavalry officer for the Czar of Russia during the Russo-Turkish war who was known for his lies and elaborate fabrications of war exploits. His son, Polle, died under unusual circumstances just one year after his birth, thus the derivation of the term "Polle Syndrome." Polle Syndrome has been suggested as the term to be used for cases of maltreatment involving children of patients who have suffered from Munchhausen Syndrome. It is a term used to alert physicians to the child abuse from which children may suffer when their parents have been fabricating their own illnesses (Guandolo, 1985).

The third term related to this condition is that of Munchhausen Syndrome by Proxy, which is used to describe parents who, by falsification, cause their children innumerable harmful hospital pro-

cedures. These are children who are victims of parentally induced or fabricated illness, but whose parents are not, themselves, victims of Munchhausen Syndrome (Rosen et al., 1983). The term was first applied to child abusing parents by John Money in 1977. In this study the offspring of the reported parents became dwarfs unless they were removed from the home of parental abuse (Money, 1986). The term was later developed more fully by Roy Meadow (1977; 1982).

PURPOSE OF ARTICLE

It is my intent in this article to cover the last two conditions discussed above, Munchhausen Syndrome by Proxy and Polle Syndrome. They will be addressed as one issue and will be identified as a form of child abuse which needs understanding and treatment by feminist therapists. It is often hard for those of us in the helping professions to believe that a parent would deliberately inflict injuries upon her or his own children. Needless to say it is hard to imagine many reasons as to why one would do such a thing and we like to believe that such actions by a parent are at best temporary and treatable. Unfortunately, little is known thus far and little has been written about how one would treat such a phenomenon. Thus it will also be the purpose of this article to describe some of the cases that have been noted in the medical literature as well as to elaborate on the cases that have come to my attention over the last few years. It is also my intention to address some of the treatment issues that have emerged in my own practice now that I have begun to see a few of these abusing parents and their children.

DISTINCTIONS IN TERMINOLOGY

There is an entire range of symptoms which can be created as an interaction between the mind and the body. We are often aware of hypochondriacs, people who feel real pain but are unaware that they are simulating or exaggerating their illnesses. Many of us are also familiar with malingerers who lie in order to reach a conscious objective, such as soldiers in combat who play up their injuries in order to avoid return to the field (Lear, 1988). Munchhausen is of

another order, however, in that the patients are addicted to hospitals and are willing to engage in risky and dangerous procedures in order to further their medical conditions. Munchhausen by Proxy and Polle Syndrome are of yet another order, in that they create illness and symptomology in otherwise healthy children. The term Munchhausen Syndrome by Proxy, as defined by Meadow (1985), is used to refer to "parents who by falsification caused their children innumerable hospital procedures" (p. 385).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-III) deals extensively with this area of psychological and physical symptoms. The distinction is made between Factitious Disorders, in which symptoms are produced by the patient, and Malingering, in which symptoms are produced for obvious gain and as a result of environmental circumstance, rather than due to a patient's own psychopathology (American Psychiatric Association, *DSM-III*, 1983). A person with a Factitious Disorder has no apparent goal other than to assume the patient role. It usually implies psychopathology, most often a severe personality disorder. In the past this condition had been subsumed under the category of Hysteria, but now with more cases emerging, Factitious Disorder is being expanded into an entity of its own.

The DSM-III has finely defined Factitious Disorders. The Factitious Disorder with Psychological Symptoms often finds the patient creating symptoms of a mental disorder, while the Chronic Factitious Disorder with Physical Symptoms is the topic which is more popularly discussed. Unfortunately, the DSM-III has yet to include a diagnostic category for those parents who create illness in their children. This new category has even been categorized as the medicalization of child abuse, although little is known about its etiology and causation, and could eventually be included under the Factitious Disorder rubric.

CASE EXAMPLES FROM THE LITERATURE

When one reads of various cases handled by medical authorities it becomes obvious that major intervention is indicated for such situations. For the most part there is a dearth of information as to what should be done for perpetrators of this form of child abuse.

Doctors indicate they are aware of the severe psychological problems of such clients, but little is said as to why this occurs and what to do about it.

In one case (Rosen et al., 1983), two children, a 7-month-old girl and a 4-year-old boy, had recurrent episodes of cardiorespiratory arrest that were induced by the mother who would then skillfully revive them. The hospital staff could find nothing wrong with the children when hospitalized but upon release the symptoms reappeared. Eventually a hidden camera was utilized and the mother was seen placing her palm over the baby's face for 90 seconds and then resuscitating her. She claimed that this was the first instance of such behavior but when the mother was no longer permitted to be alone with the children, neither child had further episodes.

In another case a 2 1/2-year-old boy was suffering from symptoms of fever, joint pain and diarrhea. While in the hospital he developed bloody stools, although no bleeding site was found. Various exploratory surgeries were performed and a colostomy was done. Eventually it looked as if he was bleeding from the upper and lower gastrointestinal tract and was placed in intensive care. There the symptoms stopped but further complications developed when he was transferred to his old room. Finally the physicians suspected the mother of causing the gastrointestinal tract bleeding and, when observed, she was found to be draining blood from the catheter and placing it in his diaper, colostomy bag, ileostomy bag and down his nasal tube (Malatack et al., 1985).

In a third case (Guandolo, 1985), a 5-year-old boy was treated for 4 1/2 years with over 250 entries in the medical records since birth, mostly on an outpatient basis. The child was treated for ear pain, persistent vomiting, respiratory distress and multiple seizures. Although little actual illness was found, the child received prescription drugs to treat the alleged symptoms. Over the years the child received phenobarbital and other medication for the neurological problems, as well as antibiotics, decongestants, bronchodilators and anti-emetics. Eventually the child came to look forward to medication and medical attention. Finally, the physicians questioned the mother's veracity, since it appeared that she was fabricating stories about her personal life, as well as the child's medical history. When the child's father was finally contacted, the truth was ascertained

and all medical treatments were curtailed. With the intervention of psychotherapy and the threat of report to the child abuse authorities, the mother finally ceased fraudulent claims of illness.

Other medical cases have included children who had extensive treatment for false seizures which in some cases actually led to brain damage and death, children who were intentionally poisoned through the use of extensive insulin injection (Bauman & Yallow, 1981) and a child who was given laxatives to cause diarrhea and resultant dehydration (Ackerman & Strobel, 1981). In all of these documented cases, according to the authors, the perpetrator of the condition was the mother, and in all the cases these women appeared to be model parents: concerned, loving and caring. (For further case discussions and elaboration see Berger, 1979; Chan, Salcedo, Atkins and Ruley, 1986; Dine and McGovern, 1982; Libow and Schreier, 1986; Mayo and Haggerty, 1984; Roueche, 1986.)

CASE EXAMPLES FROM AUTHOR'S PRACTICE

In the case example given at the opening of this article, in which the client had progressed to the second generation of the Munchhausen phenomenon, the actual perpetrator of the initial illness – the client's mother, was deceased. The client, when confronted about the enormity of her medical history and the lack of veracity, felt that both the therapist and the physician did not understand her and her condition. Soon after confrontation, the client ceased therapy and later it was determined that she had gone to yet another physician in search of treatment. The therapy and physician's style of direct dealing with the client proved futile.

A second case that has come to my attention is that of a 14-year-old boy who was being raised alone by his widowed mother. This child had a history of being taken to numerous outpatient facilities for illnesses which had no physical explanations. The child was kept home from school for minor ailments such as sore throats and vague stomach symptoms. It appeared as if the mother might have been undergoing separation anxiety over having her child leave home. School grades were failing and the child appeared withdrawn and depressed, showed poor attention and stared off into space reg-

ularly. The school authorities became alarmed and suggested that the mother finally prove absences with medical verification. Eventually the local court system was called in to intervene, but the mother and child infrequently showed up for appointments with the assigned probation officer. The child was reticent to discuss his problems and the mother believed that the agencies were in collusion to undermine her. When psychological treatment was suggested, the mother became indignant. Eventually the courts dropped the case because the mother refused to sign a release form giving permission that medical authorities could be consulted. To this point in time the child is receiving no aid.

The final case with which I am familiar is that of a young mother who voluntarily came to me seeking assistance. She had been accused of fabricating her child's illness and was being threatened with exposure to the Child Protective Services unless she found some help for herself. Her story indicated that although she had not been ill as a child, she had been socialized to be a "proper mother" and to stay home with her children while they were young. The woman was well educated and had worked outside of the home prior to the birth of her son. She was now bored and lonely, finding solace and attention in her visits to the doctors and hospitals. In our therapy sessions she said that although she knew that she had "done wrong," she maintained that she had never put her child in life-threatening situations and that she was not a child abuser. The mother was remorseful and was eager to get to the "bottom of her problem," as she put it. She had been confronted by enough people to begin to think she might need some assistance.

ETIOLOGY

Although there are as yet no clearly identified causes to this strange and frightening conditions it is possible to conjecture as to the etiology, based on the clinical cases cited. Certainly there is no one answer. The causes are probably social, psychological and perhaps even economic. Various authors have attempted to define common features and characteristics of the perpetrators in order to further their thinking (see Jones et al., 1986; Meadow, 1982). Thus far it appears that these induced childhood illnesses all show bizarre

signs and symptoms which fit no recognizable malady and are inconsistent. The signs and symptoms begin only when the parent is alone with the child and usually the medical staff or fathers do not see the episodes. The mothers (in all documented cases thus far the culprit is the mother; see Meadow, 1977; Zitelli, Seitman & Shannon, 1987) tend to show model behavior and are overly calm. They thrive on attention from medical staff and seem to revel in being a "perfect parent." Certainly on the surface they present normally. However, deeper investigation indicates psychological disturbance. In one case (Nicol & Eccles, 1985) the mother said: "I liked the sympathy, I needed my daughter to be ill so that I was important. I felt I was somebody on the ward" (p. 346). These women have either their own histories of unusual illnesses or their families have such conditions. Nicol noted that with his client there was a "family culture of excessive illness behavior." Often the women are lonely and come to the understanding and caring environment of the medical world in order to relieve their isolation. For Nicol's client the hospital environment relieved her depression and acted as a prop for her self-esteem. Further, it has been found that these women lack self worth and tend to flourish in the hospital where they are cared for in a sheltered environment (Meadow, 1977). There is also some evidence, at least for Munchhausen patients, that they might feel some anger at physicians for some previous medical affronts and there is conjecture that this syndrome is a retaliatory effort (Lipsitt, 1983).

Waller (1983) has suggested that "the child's fabricated illness seems to express the parent's sense of being 'sick' and in need of attention and help" (pp. 82-83). The father generally fits the stereotypic absent father who maintains a low profile or might actually be removed from the family entirely (Meadow, 1977). Needless to say, this is a dysfunctional family in which the medical authorities have been triangulated into the system in order to provide for the emotional needs of the mother which are not being met within the family.

Interestingly, the mother has been variably diagnosed depending on the practitioner involved. On the surface, she presents as a model parent but under that facade the mother is quite narcissistic, with grandiosity carried to the extreme of determining her child's

own health, and life or death conditions. She has a problem with empathy in that her own emotional needs are far more important to her than the very health of her child. She seeks and receives the attention she needs vicariously through her child; constantly seeking admiration and attention, her self-esteem is fragile and dependent on how she is regarded by the medical staff. Her condition has been diagnosed as that of a personality disorder in that she has significantly impaired the functioning of her own child as a result of her own emotional needs. All of these personality characteristics are frequently present at the same time, often making it hard to ascertain an accurate assessment. In one case (Rosen et al., 1983), the mother "appeared to be a woman who is highly influenced by her environment . . . and seemed to be a woman who feels empty inside and must rely on her external environment to give her life substance" (p. 719).

Why would a mother do such a thing to her child? Most of the evidence indicates that this is a mother who is well trained and competent at mothering. She is nurturing, loving and caring, and has been well socialized into the role of motherhood. In fact, she is so well socialized that her main identity comes from caring for an ill child and receiving praise and confirmation for herself as a person from highly respected social authorities, for example, the medical establishment. It appears to me that this syndrome is actually a predictable outgrowth of the dominant patriarchal social order and its training of women. If a woman feels that she has little means to gain selfhood beyond that inherent in the role of mother, then this syndrome could be the consequence. It is a bit surprising that we have not seen more cases of this syndrome, especially at an earlier point in history, when other identity options were not as easily open to women. The implication is that motherhood is not the work of choice or reinforcing enough (for the woman's identity) in these cases. The issue of the mother's need for power and a sense of accomplishment, and the limited options available to her (M. Hill, personal communication, winter, 1989) are factors which lead the mother to use drastic measures in obtaining those goals.

A second reason "is the mother's emotional neediness and her efforts to get cared for through the attention and security of the medical establishment" (M. Hill, personal communication, 1989).

It appears that these women have crucial unmet emotional needs from childhood and then go through life trying to compensate for those needs by turning to the medical establishment for the love and nurturance they lacked. Each appear to have different specific unmet needs but it is unclear what are the "internal or external restrictions that prevent them from meeting those needs in less destructive ways" (M. Hill, personal communication, 1989). It appears that further work might be useful to determine just what occurred in childhood that so dramatically injured these women.

The third specific cause that I see is the role of the father. This problem should not be viewed as solely due to the pathological condition of the woman. Hill further questions, "Is the father not even curious when his child develops recurrent medical conditions? When the father is living in the home, does he *never* suspect the mother's role in the child's illness?" (personal communication, winter, 1989). Thus far there are no documented cases in which the father has shown enough involvement with his family to be aware of what is happening. The father truly absents himself from the family so that the mother, left totally alone, feels that there is no place else to turn but to the medical authorities.

The final cause, as I see it, is the mother's anger and hostility. Obviously, "unnecessary medical treatment is a form of torture, which suggests significant anger" (M. Hill, personal communication, 1989). The anger might well be in retaliation against the medical establishment, as is the case with patients who cause their own illnesses. But it might also be that the mother "is furious with the child for limiting her life. Perhaps the rage that she might otherwise feel at the constrictions and damage of a patriarchal society gets expressed through her efforts to damage her child" (M. Hill, personal communication, 1989). Certainly anger is a cause that needs addressing when we consider later how to treat this condition.

Given the severity of the problem we can also only wonder how many cases of this condition are actually undiagnosed at this time. It may be far more common than we first might think. Perhaps we are now only just beginning to put the pieces together on this syndrome.

TREATMENT ISSUES

Having identified some of the factors that seem to lead to this condition and having seen both the psychological and social issues that are related to it it is imperative to begin to deal with this life-threatening type of child abuse. My own clinical experience is such that I find treating these women both challenging and fascinating. Because they are articulate and well educated, the women are delightful clients; and therein lies the problem. Their ability to use medical terminology and manipulation of information makes it difficult to confront them. In fact, if one does confront them directly, it is quite likely that they will quickly curtail treatment. Often the initial reaction is "angrily to deny any wrongdoing" (Waller, 1982). The Munchhausen mother prefers to go from hospital to hospital and from one medical authority to another, rather than confront her own emotional needs and vulnerabilities. It is for this reason that the therapist must be both sensitive and supportive in her work with such a client.

In my own work, I have delineated a treatment approach that involves a three-stage process: engagement, development and termination. Within that framework therapy is first done with the mother; then if the partner is still present in the family, work is done with that person. Eventually, I also do couple work with the two. Finally, I attempt to work with the child victim, if that child is old enough to engage in such a process.

Treatment of the Mother

Because it is imperative to not scare the mother away from treatment, I find that at the beginning stage of such work it is useful to hear the full details of the medical conditions that the mother is alleging. Often the first few sessions are spent hearing about all the hospitals and medical facilities which have failed to find the cause of the child's illness, or the types of treatment that the child has had to undergo. I often take an extensive history of such cases, from the moment of conception through the child's current condition.

Once trust has been established, I begin to explore the client's own family history as well as medical background. In most of the cases I have thus far treated, there is an exceptional use of medical

terminology and somatization of symptoms. The client thinks and talks in terms of illness and treatment. More often than not, the entire family of origin comes from either a medical background or has extensive medical histories.

In the cases with which I am familiar, mothers presented themselves as within normal limits psychologically and had no evidence of any psychosis. This seems to contradict the evidence presented in the literature, but was my clinical experience, nonetheless. They all used denial as a primary defense mechanism and appeared to be well functioning in all areas of their lives. Family background usually revealed poor communication patterns, and conversation within the family appeared to be related to medical issues. One client felt that she had an inconsequential position within the family which was mitigated when illness and medical discussions developed. In other words, the client learned that an illness would gain her credibility and attention within the family system. Although one of my clients did not manifest Munchhausen Syndrome in her own behavior, she found that when her child became ill, her parents had more to discuss with her and they became more integrated into her life. In all of these cases, I found that ascertaining family background helped provide the threads which would later be developed when the abuse syndrome was finally discussed.

Other work in the initial stages of therapy emphasizes the woman's upbringing and training as a mother and a wife. Interestingly, even though in two cases the women's mothers had worked outside of the home, both of these clients believed that a mother should stay home with her children. Both of them had felt abandoned by their mothers and did not want to do the same to their children. Additionally, both of these women believed that women should have careers, but that they should be postponed until after the children were teenagers. Thus for these women, their children had become their sole occupation.

In the initial stage of therapy it is also useful to ascertain the dynamics of the couple relationship, if the client is still partnered. In the cases with which I worked, two clients had husbands who were absent for long periods of time due to their work. In another case, the husband had abandoned the client early in the child's life. Basically, all the women felt that they were alone in raising their

children and were glad to turn to physicians and nurses to help them. In essence, by asking for medical help they were really asking for help in parenting but more importantly, for their own nurturance needs to be met. The medical establishment became the absent father and provided the aid that could not seem to be found elsewhere. Given that the clients already came out of a medically oriented background, and that they had no place to turn for their own emotional needs to be met, it became a natural step to turn to this institution for assistance.

In the initial stage it becomes obvious that my clients have very poor self images and gained self confidence by being around doctors and nurses who validated them. One of my clients has actually said that she was more comfortable in the hospital than anywhere else in her life. She felt safe and cared for there. These women are young and vulnerable and enjoy the attention they receive from well trained and competent hospital staff. It appears that the medical facilities became home and family for these women. The doctors and nurses become the father and mother whom they feel did not care for them in childhood. The medical staff may also become the absent partner who had not assisted her with the child care.

After the beginning of such work in which trust and rapport has been established and the background is fully ascertained, the difficult work of development of these themes is necessary. I have found that careful and gentle exploration of these items with the client is imperative. Confrontation of the truth, even at this stage, can send the client fleeing. It becomes crucial to identify a specific treatment plan that addresses the unmet emotional needs of childhood so that the women begin to confront the emptiness that leads them to abuse. I help the client to see the family system as one which relies heavily on medicalized material for communication. I might actually use a genogram or family photos in order to see these themes more clearly. This tends to work because the client can come to the realization herself, rather than feel attacked or confronted. It is also possible that after seeing the medical centeredness of her family system and after looking at the consequences of that thinking, the client will begin to view this approach more critically. One client recognized that adopting this family world view may have been adaptive while living within it, but admitted that it was

now maladaptive and no longer a viable option because of the negative consequences of that choice.

Of course, this level of insight requires a great deal of ego strength and might not work for some of the more defensive and frightened clients. One of my clients, when shown the family script of illness, decided that this was in fact a script that was real, and chose to ignore the consequences of the scenario. In fact, she went off to arrange for surgery for herself, now that there was "nothing wrong" with her child. The mother had been a Munchhausen by Proxy mother who became a Munchhausen Syndrome patient instead. I actually saw this as slight progress in that she was no longer inflicting unnecessary treatments upon her child.

Resolution of Problem

As one moves toward resolution in working with Munchhausen mothers it is useful to explore self-image and other areas in which the client might begin to gather competence and self-confidence. Since one of the causes is that mother is "dissatisfied with the restrictions of the mothering role, then treatment must include teaching the mother to identify her needs and giving her permission to have needs". She should also be given "information and support about the sociocultural factors that have contributed to the problem." This is especially effective because it "honors the mother's denial in agreeing that *she* is not the entire cause of the problem" (M. Hill, personal communication, 1989). The results from therapy come when the client begins to explore other options for herself besides only the role of mother. Needless to say, she will still hold that role as one of her most primary, but with the realization that she can do and be more than that as well comes the possibility of her giving up the abusive interactions with her child. When the mother is encouraged to find work or creative outlets and is given positive feedback for those undertakings, the therapist will begin to see a relief in the medicalized thinking. These become important points in resolving the problem.

The mother should be helped to understand the deep emotional needs that were unmet in her own childhood and how and why she developed this method of having those needs met. Hers is a skewed

pattern of meeting needs, and a depth awareness of how she developed this coping mechanism for emotional deprivation can lead to insight and then growth.

The mother also certainly needs assistance in understanding and expressing her anger: at society, at her family of origin and her absent partner. She must learn to feel and to express this anger in appropriate ways and to realize that it is partly anger that led to the problem.

When the mother is also able to confront the absent father and begin to find other ways for her emotional needs to be met, either by him or other friends and loved ones, we begin to see the resolution of Munchhausen by Proxy or of the Polle Syndrome. It is at this stage, the middle course of treatment, that it is best to bring in the husband, if at all possible.

Treatment of the Couple

Before the couple is seen for marital counseling, I have tried to see the husband alone for a few sessions. This is generally done with the permission of the Munchhausen mother so that she will not feel colluded against. It is also done long after trust has been established, and much after the depth work has been done individually. When seeing the husband, it is important to ascertain his understanding of the medical problems and also how he views his role in this scenario. Often the partner believes that the problem is his wife's alone. In one case of psychotherapy with a Munchhausen mother as noted by Nicol and Eccles (1985), the father was not included in the therapy, although he was involved in rehabilitation. In that case, he tended to see his wife as "needing help" and through the process became more involved in the family life and support of his wife. Even if the partner fails to take responsibility for some of the problem, it is useful for him to understand some of his wife's background and the reasons that she chose this path to obtain validation from others. Eventually he will also have to take some responsibility for the problems, perhaps because of his absence on a physical or emotional level as a partner and certainly because of his absence in the role of parenting. He is not to blame for her actions; they are hers. Her emotional problems are not the

husband's "fault" or his responsibility to resolve. This is something she must claim for herself. Nonetheless real communication and understanding of each other's needs is essential to a healthy relationship.

With this understanding, which can come either individually or within couples therapy, the door is open for real communication between the two. Without it, unfortunately, the dynamic will be perpetuated and hopes for a real understanding of each other's needs cannot happen. Therefore it is imperative that the partner be part of the therapy, making the problem part of the whole system rather than blaming the woman for the situation. It is helpful to see how the family system enables or perpetuates the problem and how the husband informs that system. Neither she nor he are to blame for the problem, but both are needed to help change the problem.

When the two are present for joint counseling, the work moves from exploration of causes to real treatment and change of dynamics between them. At this stage, the woman may choose to share with her partner what she has learned in therapy to date, as it relates to their relationship, especially the anger and abandonment issues. With the support of the therapist, she may begin to speak of needs that are not being met within the couple relationship. He, too, may begin to discuss how he feels about the financial responsibilities of the medical care and his feelings about the whole situation. Hopefully with encouragement and permission to fully discuss the problems, and with skills learned from the therapist in how to communicate and hear each other, a beginning may be made in real expression of needs and how to meet them. Since his absence is so crucial to the etiology of the problem, he must be involved more integrally in the parenting responsibilities as well as helping his partner meet her emotional needs.

I find it useful in the couples work to have the two tell the entire story of their relationship, from the moment they first heard of or saw the partner right through the present. This has a healing quality to it in that it rekindles old positive feelings and reminds the partners of what it was that originally drew them together. In the history section it is also useful to determine the sexual history as well, to determine if this is an area that needs further work. Often it is the case. Examining these areas aids the therapist in determining some

of the themes that are problematic in the relationship and ascertaining when and where the problems developed. It is in this portion of the therapy that the issue of emotional needs can be addressed, questioning whether or not certain needs have been met and how they might better be taken care of in the future.

The couples therapy, if there is a partner, is a crucial component to the treatment of the Munchhausen by Proxy or the Polle Syndrome client. Without it the woman will feel attacked and will flee from therapy. Even with it, she possibly will flee or remain so well defended as to not be willing to deal with the situation. That is why a treatment plan must be carefully constructed to address all the etiological concerns.

The literature indicates that many such clients do flee, no matter how carefully the issue is handled. Perhaps by developing an awareness of the client's unmet needs and talking about those needs, this flight behavior might be controlled. Some clients seem to transfer their search for solace and attention from the medical establishment to the therapy establishment. It appears that this is, in fact, a viable route, in that it moves attention and actions away from vicarious means of meeting personal emotional needs through the child, to dealing with them directly.

If the client does not have a partner the treatment is even more difficult, in that she actually has no one to turn to for assistance in parenting or in obtaining support in developing a healthy self-concept and personality. In this case trusted friends or family members might be enlisted to work with the woman on parenting and finding other ways to meet her own emotional needs. In fact, even a parent aide or some outside support might need to be employed to prevent further abuse. This certainly remains true as an interim measure until she becomes more healthy and acknowledges that her behavior has been abusive rather than caring.

Treatment of the Child Victim

In many cases, the child victim of this syndrome is too young to engage in psychotherapy. Perhaps when the children are older, play therapy or other forms of treatment may be helpful. My own experience in this area has been limited, but in one case I was able to work

with an adolescent victim. The client fully believed that she was ill and had not been properly diagnosed. She began to take herself to physicians even after her mother had ceased to do so and had taken over an invalid mentality and self-image. In fact, even though I had hoped to help her see how this script was perpetuating itself generationally, the young woman actually went to a hospital and convinced a physician to operate on her for a back malady, as yet undiagnosed. The last that I saw of this young woman, she was wearing a back brace and undergoing physical therapy after her recently completed surgery. Unfortunately, even with treatment, this syndrome can go on from generation to generation with no diminishment of the patterns. Certainly much remains to be investigated and developed in the area of treatment for the child victim.

Termination of Treatment

It is hard to know when and if a case of this complexity is ready for termination. It may appear as if the woman understands the nature of the problem and that the couple, if there is one, is relating well. Unfortunately, there is no guarantee that the symptoms may not recur. Of course, this is often the case with other forms of therapy as well; we never know for sure. The best that is possible is that the client feels confident and the partners are actually communicating and are each attempting to recognize and find ways to fulfill their own needs. I actually have come to maintain that regularly scheduled follow-up appointments for the mother might be best. In it she can feel as if there is someone, actually an authority figure, to whom she may turn in case of a return of the problems. In essence she will have substituted the occasional support of the therapy establishment for the frequent (or constant) support of the medical establishment. Hopefully she has not substituted psychological symptomology in the child for the medical symptoms she has recently abandoned. If she has achieved learning directly about her own emotional needs and has given herself permission to verbalize those needs, hopefully the vicarious seeking of fulfillment through the child will cease.

CONCLUSIONS

Munchhausen Syndrome by Proxy and Polle Syndrome are two recently discovered forms of child abuse. This abuse seems to be caused by an extreme consequence of the traditional socialization of the mother into a nurturing and caring woman. This is due to "the mother's need for power and sense of accomplishment and the limited options available to her" (M. Hill, personal communication, 1989). It is coupled with specific factors which contribute to this particular manifestation, including the mother's "neediness and her efforts to get cared for through the attention and security of the medical establishment" (M. Hill, personal communication, 1989). It is also caused by the mother's extreme level of anger as a product of her limited options. Finally, it is caused by the father's absence or emotional availability which hinder the mother from having her needs met.

The treatment of such a phenomenon is a complex one and there are no easy answers as to why one would do such a thing to one's own child, or exactly what the best approach to dealing with it might be. This is a beginning attempt at understanding the feminist implications of this syndrome and formulating a treatment approach that looks at the entire family and sociocultural system, rather than blaming the mother for her pathological condition. By looking at the family dynamic, both in the family of origin and in the current family, and at the culture that limits women's choices, a feminist therapist may begin to find her way to understanding this fascinating and potentially dangerous phenomenon.

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