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SINGLE CASE STUDY

Munchausen Syndrome in a Mother and Daughter: An Unusual Presentation of Folie à Deux

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The author describes a mother and daughter, both admitted to a major medical center on the same day to the same room, and both with a clinical presentation consistent with Munchausen syndrome. To the author's knowledge, this is the first report of Munchausen syndrome presenting as a folie à deux.

Folie à deux, first reported in 1877 (Lasègue and Falret, 1877), has been defined as the "transference of delusional ideas and/or abnormal behavior from one person to one or more others who have been in close association with the primarily affected patient" (Gralnick, 1942a, p. 232). Asher first described Munchausen syndrome as the voluntary production of physical symptoms when no real symptoms exist, in order to assume the sick role (Asher, 1951). This paper describes two cases of Munchausen syndrome occurring in the same family that meet classic clinical criteria for folie à deux.

Case Report

A mother and daughter were both admitted to the same room on the neurology service with similar complaints. They were referred by the mother's son, a physician, who completed a detailed referral summary on both patients for the attending neurologist.

The mother was a 59-year-old white female college graduate. She was married almost immediately after college graduation and worked for several years until the birth of her first child, when she became a full-time mother. She had two children, both in their 20s at the time of the admission. Six years before admission, she entered professional school part-time and graduated 4 years later. She then began working with her husband, who worked in the same profession.

The mother initially stated to the admitting neurology resident that she was well until 2 years before admission, when she developed a flu-like illness with intermittent fevers, night sweats, vibratory sensations, a feeling of anxiety, and palpitations. She stated that since then she had developed "noises" in her ear, blurring of vision, and throbbing down her spinal cord, as well as generalized weakness. She noted that she had been seen by "several doctors" and had had persistent laboratory abnormalities including "elevated erythrocyte sedimentation rates, abnormal liver function tests (LFTs), positive Epstein-Barr virus antigens, and abnormal electromyograms." She presented the house staff with a detailed diary explaining her symptoms, along with a summary of medical evaluations performed at several major medical centers. Although she frequently referred to a large collection of documents she kept at her bedside in a manila envelope, she would let no member of her treatment team see those documents.

The daughter was a 25-year-old white single female student in her first year of professional school in the same profession as her parents. She initially stated that she, too, was well until about 2 years before admission, when she experienced a flu-like illness associated with fever, myalgias, nausea, vomiting, and headaches. One year later she noted the development of light-headedness without loss of consciousness; nausea without vomiting; and visual dimming without palpitations, chest pain, dyspnea, or headache. She also noted the onset of increasing fatigue along with recurrent fevers. She, like her mother, related several evaluations by different physicians at major medical centers, with lab findings notable for "a mild anemia, thrombocytosis, and an elevated erythrocyte sedimentation rate." She stated her weakness and fatigue had become such a problem that she had dropped out of professional school.

A psychiatry consultation was requested on the third hospital day to "rule out agitated depression" in the mother and because both patients seemed to be giving inconsistent stories to different members of their treatment team. Both patients were seen by different psychiatrists.

The mother was interviewed in the presence of her husband. She told her psychiatric consultant basically the same information that she had given her neurologists but additionally noted that she had seen at least

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four different psychiatrists in the past 3 years in an attempt to "work up the anxiety symptoms of my illness." She stated she was certain that she had an "Epstein-Barr virus-induced depression" and referred, by title, to a recent journal article in the *Annals of Internal Medicine* (Jones *et al.*, 1985). She was initially unwilling to give the name of any of her previous psychiatrists, but was eventually convinced to provide the name of her last psychiatrist. The husband, although asked, did not provide any additional information during the interview.

The mother's mental status examination was significant for intact cognition. No hallucinations, delusions, formal thought disorder, obsessions, compulsions, or phobias were noted. She self-rated her mood as anxious, but she appeared calm during the interview and quite animated when describing her symptoms. She agreed to the great majority of symptoms on a review of symptoms checklist designed to screen for somatization disorder.

The daughter was evaluated by another psychiatric consultant. She gave the consultant no additional information, but noted that her symptoms were seriously interfering with her life. Her mental status examination was completely normal except that she, too, had a positive somatization disorder screen and a bright affect when describing her symptoms.

The mother's last treating psychiatrist was contacted and explained that he had been treating the mother for a "mild depression" for the 6 months before admission. He had not seen her for the past month when she left his care to be admitted to another major medical center. While under his care she had been to more than 20 physicians specializing in neurology, internal medicine, psychopharmacology, and neurovirology despite his recommendations against such efforts. He suspected that over the past 3 years the mother had visited more than 100 physicians and had had dozens of admissions to major medical centers all over the country. He had seen the daughter several times and noted a similar pattern of multiple physician contacts. He also indicated that the husband had always accompanied his wife during inpatient admissions, and that during several past episodes the physician son had provided case histories to admitting physicians.

Up to that point the mother's evaluation, which included a physical examination, screening blood tests, a fever curve, an EEG, a lumbar puncture, nerve conduction velocities, an electromyogram, and a computed axial tomography scan, was completely normal.

The daughter's evaluation, like her mother's, showed a completely normal physical examination and laboratory profile except for an iron deficiency anemia.

The mother was seen again on the 5th hospital day by the psychiatric consultant. After confrontation she admitted to having her first episode of unexplained illness while she was a college student, after her roommate contracted polio and had to be placed in an iron lung. She remembered developing weakness and muscle pain and visiting a series of doctors. However, no organic etiology for her symptoms could be found. She dropped out of school, but eventually graduated. She subsequently admitted to numerous other episodes of unexplained symptoms during periods of significant stress. These episodes most usually involved fatigue and muscle pain, with literally hundreds of visits to physicians and medical centers. Significantly, the current bout of unexplained symptoms and doctor visits occurred in the setting of her failure to pass a professional licensing examination 3 years before admission to the hospital.

The mother provided the names of several other physicians who had treated her and her daughter in the past. They were contacted by phone. The mother was diagnosed as having had "hysterical paralysis" at a large medical center 6 years before admission; a diagnosis of "hypochondriasis" was made by another psychiatrist 1.5 years ago. The daughter had presented to several medical centers over the past 2 years with similar complaints; the only positive finding had been an iron deficiency anemia.

The psychiatric consultants recommended that no further tests be done on either patient until they both provided the names of, and allowed the neurologists to contact, all previous treating physicians.

On the evening of the 6th hospital day, the neurologists requested the list of treating physicians from both patients. They initially refused, but stated that they would consider the request. They also demanded further tests, including a nuclear magnetic resonance scan to "rule out brain infection."

On the morning of the 7th hospital day, the family suddenly remembered an urgent business appointment and left the hospital precipitously. They refused to sign a standard "against medical advice" form. The psychiatric consultant was contacted by the mother later that morning from the airport with a request for a list of psychiatrists who "take care of patients with undiagnosed illnesses."

Discussion

The mother, with her history of hospitalizations at numerous medical centers, many outpatient physician contacts, multiple medical procedures, medical sophistication, demands for specific procedures, and disruption of ward routine, presents as a classic case of Munchausen syndrome (or chronic factitious disorder

with physical symptoms), as defined in the DSM-III (American Psychiatric Association, 1980, pp. 288–290). The daughter, with her own several-year history and current presentation, is clearly beginning a similar course.

Although the DSM-III requires that the criteria for paranoid disorder be met in order to diagnose folie à deux (APA, 1980, p. 197), descriptions of the condition have included patients with clearly schizophrenic or affective conditions (Gralnick, 1942a, b). Gralnick, who wrote the comprehensive review of the subject, defined several "important factors" associated with the disorder: a close and long association, the dichotomy of dominance and submission between the two actors, a blood relationship present, and women being usually affected (Gralnick,1942a, p. 235). Thus, two patients with Munchausen syndrome would meet classic clinical criteria for folie à deux.

Classic psychodynamic formulations of folie à deux have emphasized identification as the predominant psychological process (Brill, 1920), whereas more recent formulations have noted the dependent and ambivalent love-hate relationship between the two actors (Enoch and Trethowan, 1979, p. 153). Although both patients in this case were quite guarded about their relationship with each other, clearly the passive daughter's identification with her more dominant mother was evident in the daughter's choice of the same career as her mother.

Perhaps even more remarkable in this case is the seemingly willing participation in the deception by the husband and physician son. Clearly the son's referral notes have facilitated both patients' continued readmission to hospitals, and subsequent repeated diagnostic procedures. Perhaps a more appropriate name for the syndrome in this case would be folie à famille, a term which has been used in the literature in the past (Enoch and Trethowan, 1979, p. 134).

This case also illustrates the extreme difficulty in treating patients with Munchausen syndrome. Current literature notes that psychotherapy and somatic therapy have proven ineffective treatments and that psychiatry's main role may to educate the treatment staff and keep the patient from undergoing further procedures (Hyler and Sussman, 1981). Unfortunately, because of current pressure to shorten the length of hospital stays, both patients had been prescheduled for, and had undergone, many invasive procedures before the diagnosis of Munchausen syndrome was entertained. Thus, the risk of iatrogenic injury to patients with Munchausen syndrome has intensified. This risk can only be minimized by including Munchausen syndrome in the differential diagnosis of patients who present with appropriate histories. Perhaps it should be mandatory for patients with a complex medical history and numerous past hospitalizations to provide records of all past hospitalizations before their elective admission to hospital.

Conclusion

Munchausen syndrome can present as a variant of folie à deux. Munchausen syndrome should be suspected in patients who have histories of multiple treatments at multiple hospitals, whose past histories cannot be verified, who exhibit unusual medical sophistication, and who demand multiple medical tests and procedures.

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