

Full title: **Munchausen Syndrome by Proxy – A Form of Pathological Play?**

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Abstract

The primary aim of this dissertation was to gain an understanding of the psychopathology present in the perpetrator of Munchausen Syndrome by Proxy (MSP), exploring Jureidini's (1999) notion that this behaviour can be explained as the perpetrator engaging in a form of pathological play. A systematic literature review regarding MSP, with particular foci on psychopathology in perpetrators of MSP and the notion of pathological play was conducted. The notion that MSP is a form of pathological play was critically evaluated through the use of clinical case material. Two cases were selected, both of which met the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) diagnostic criteria for MSP, based on the assessment of a child psychiatrist with expertise in this area. The case material was analysed through the generation of common themes and identification of repetitive patterns which were then systematically analysed and compared with the findings cited in the literature review, with particular reference to MSP as a form of pathological play. Jureidini's (1999) theoretical statement was analysed in the light of the available evidence and the theoretical basis was then revised. Aspects explained by the theory were presented. Aspects not explained by the theory were rejected. Object Relations Theory was proposed as an alternative to understanding the psychopathology present in a perpetrator of MSP.


DECLARATION

This dissertation has not previously been accepted in substance for any degree and is not concurrently being submitted in candidature for any degree

Signed  (Candidate)
Date 20/08/02


STATEMENT 1

This dissertation is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by giving explicit references. A reference section is appended

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STATEMENT 2

Consent is hereby given for my dissertation, if accepted, to be available for photocopying and for inter-library loan and for the title and summary to be made available to external organisations

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University of Cape Town

1. INTRODUCTION

The purpose of this dissertation is to explore the psychopathology present in a perpetrator of Munchausen Syndrome by Proxy (MSP), which can be described as the induction or fabrication of illness in another person. The perpetrator is usually the child's biological mother, although a small number of cases have more recently been recorded where the father is the perpetrator (Schreier, 1997). The average age of the victim is usually less than six years and the mortality rate is approximately nine percent of all cases of MSP (Sapolsky, 1999).

Reliable and valid estimates of the prevalence of this disorder are not available. This could be partly due to the fact that there is a lack of agreement among professionals and professional bodies as to the precise criteria required for making a diagnosis. This has resulted in many cases of MSP going undetected, with grave physical and psychological consequences for the victims of such abuse.

A study conducted over a two-year period (1992-1994) in the United Kingdom and the Republic of Ireland found that the prevalence rates of MSP varied from 0.1 per 100,000 children to 0.8 per 100,000 children under 16 years of age (McClure et al., 1996). The authors attribute this difference partially to under reporting of the disorder (McClure et al., 1996). For children less than a year old there were at least 2.8 cases of MSP per 100,000 children per year (Sapolsky, 1999). According to Eminson and Postlethwaite (1998), on average one occurrence of MSP per health district per annum in the United Kingdom may be a fairly accurate estimation. MSP is now widely described in countries with 'Westernised' medical systems (UK, USA, Canada, Australia, Israel and New Zealand) (Eminson et al., 1998). There does not appear to be any literature documenting the prevalence of MSP in developing countries.

Diagnosing MSP is notoriously difficult in that it is difficult to exclude other diagnoses and a "genuine" physical 'disease' may coexist with MSP. Diagnosis is further complicated because the perpetrator usually appears as caring, concerned and co-operative.

An in-depth understanding of psychopathological factors has important implications for identification, understanding and management of MSP. This dissertation explores Jureidini's (1999) notion of MSP as a form of pathological play as an explanation into the psychopathology present in the perpetrator. According to Jureidini (1999), the perpetrator can be seen as using her baby as a plaything in an attempt to create a relationship with the doctor and thus can be argued as avoiding the real needs of her baby in an attempt to satisfy some need which finds its expression in the form of a narrative. This chapter will outline the purpose of this study and will give an overview of the material to be presented in the following chapters of the thesis.

1.1 Methodology

Aim

The aim of this study was to gain an understanding of the psychopathology present in the perpetrator of MSP, with a particular focus on Jureidini's (1999) notion of pathological play.

Objectives

1. To conduct a systematic literature review regarding MSP, with particular foci on psychopathology in perpetrators of MSP and the notion of pathological play.
2. To critically evaluate Jureidini's (1999) notion of MSP as a form of pathological play through the use of clinical case material.

The methodologies for each of these objectives will be presented separately.

Objective One

Rationale

To place the case study design in a theoretical context, a systematic literature review was conducted regarding the psychopathology present in the perpetrator of MSP, with particular reference to the notion of pathological play. Clinicians in their everyday clinical practice often rely on reviews to offer a summary of the epidemiology,

aetiology, presentation, assessment, treatment and prevention of a condition. A systematic review can therefore be regarded as an attempt by the researcher to ensure that the review is reliable and valid. Explicit decisions about collecting and synthesising data are essential to reduce biases (Barrigan et al., 1997; Nelson, 1998). A systematic literature review “seeks to identify and synthesise all the literature on a given topic rather than only the literature that is easily available or that which agrees with current bias” (Nelson, 1998, p24). Thus through conducting a systematic review of the literature the researcher could help identify what contribution the planned study on MSP could make and how it contributed to existing knowledge as well as how it differed from research that had already been conducted (Katzenellenbogen et al., 1991).

The initial step in conducting a systematic review is to formulate a problem or question which the review will attempt to address. The purpose of the literature review was to help identify previous and current research and theorizing into the psychopathology present in a perpetrator of MSP. A literature review was undertaken with a view to addressing the following topics:

- The history of MSP;
- The definition of MSP;
- The early recognition and diagnosis of MSP;
- Psychopathology present in a perpetrator of MSP;
- The management, treatment and early prevention of this disorder.

These questions were asked because it was felt that any understanding of psychopathology present in a perpetrator of MSP was intimately linked to issues surrounding the recognition, diagnosis and management of the disorder.

Collation of data

The second step in undertaking a systematic review involves locating and selecting studies from the literature which are relevant to the problem or the question the review has been set up to address (Barrigan et al., 1997; Nelson, 1998; White, 1994).

The aim of the review is to not miss important papers on the topic, preventing

potential bias (White, 1994). A literature search needs to include information from both published and unpublished sources as well as dissertations and theses in the area to try and provide a reliable review and to try and reduce the bias that can occur if the researcher exclusively concentrates on published material (Barrigan et al., 1997). Researchers are more likely to report findings that support their argument as opposed to those that go contrary to their research (Barrigan et al., 1997).

The search methods used to locate relevant literature on MSP included conducting a computer keyword search for articles in English from 1984 onwards using the following databases: MEDLINE and PSYCHLIT. Identifying critical terms descriptive of the topic under investigation helps in recalling the maximum number of articles that are relevant to problems that the review has been set up to address (Reed et al., 1994). Keywords thus included a combination of Munchausen Syndrome by Proxy and Factitious Disorder by Proxy.

In an attempt to reduce 'publication bias', both published and unpublished works were referenced (Barrigan et al., 1997). Unpublished works were sourced through discussions with key individuals in the area of MSP. In addition all reference lists from articles used were scanned for further studies. Articles were included into the literature review if they were seen to be relevant to the questions posed by the current research. Unpublished works such as theses and dissertations were collected through conversations with key individuals. These works were also scanned for relevant references.

Data Analysis

Over eighty articles, books and dissertations were located for the literature search. Literature relevant to understanding MSP was included in the review. Common areas of research and theorizing on MSP were identified. These areas were divided up into the following categories:

- Definitions of MSP;
- Diagnosis and Recognition of MSP;
- Psychopathology;

- Management of MSP.

The results of the review were summarised using the above-mentioned criteria (Barrigan et al., 1997). The psychopathology present in a perpetrator of MSP formed the bulk of the literature review in that it was felt to be directly related to the analysis of the case material which made up the second objective of the dissertation.

Objective Two

Rationale

The case study methodology was chosen for this dissertation. The reason that this methodology was selected was that it was believed that an understanding of the psychopathology present in the perpetrators' of MSP would be enhanced through an examination of the cases. Specifically, a critical evaluation of Jureidini's (1999) notion of MSP as a form of pathological play could be grounded in specific features of the cases. Also, it was hoped that this critical evaluation would facilitate theoretical development that would be applicable to MSP in general.

Two cases were selected, both of which met the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV's) (American Psychiatric Association, 1994) diagnostic criteria for MSP, based on the assessment of a child psychiatrist with expertise in this area. All members of the multi-disciplinary team agreed with the diagnoses made by the child psychiatrist. Thus cases that were identified as typical representations of MSP formed part of the dissertation (Kelly, 1999). This is important for both the analysis of the case material and for the generalisability of the findings to other 'typical' cases of MSP.

A psychological case study may be defined as "a scientific reconstruction and interpretation, based on the best evidence available, of an episode (or set of related episodes) in the life of a person" (Bromley, 1986, p.9). The aim of a psychological case study may be to find a solution to a person's problem through an analysis of the difficulties or it may be used to illustrate a condition and demonstrate a typical or representative state of affairs (Bromley, 1986; Stoke, 1994). A case study provides a detailed account of one person and can be used to explore the possible cause,

determinants, factors and experiences, which can be seen as contributing to the outcome (Robson, 1993).

A single case study design is appropriate when the aim of the research is to test a particular theory (Kelly, 1999). According to Stoke (1994) the design adopted in this research may be regarded as an instrumental/collective case study design, in that it aims to provide insight into a particular issue which could then be generalised to understanding other cases, as well as refine theory. The case can be seen as playing a secondary interest, the main concern being to facilitate our understanding.

A psychological case study includes a reconstruction and an interpretation of a major episode/s in a person's life (Bromley, 1986). The value of the case study is dependant upon the extent to which it reveals facts and relationships which make the particular case explicable as well as the extent to which it adds to the theoretical knowledge base of that particular area of research. Thus the case study can be regarded as part of the scientific method in that it adds value in terms of refining theory and suggesting complexities for further investigation (Bromley, 1986; Stoke, 1994). For a case study to be scientific it should give a specific account of a number of issues which inform the research about why people behave in a particular way. It should include a systematic body of knowledge which can be utilised by other researchers and it should include a realistic process of evaluation (Bromley, 1986).

Format

There appears to be very little consensus regarding the specific format that the psychological case study should take, but rather some authors in this area seem to provide broad guidelines as to what should be included in the case study (Bromley, 1986; Huberman et al.; 1994, Kelly, 1999; Robson, 1993; Stoke, 1994). The quasi-judicial approach, based on a jurisprudential process in which there are rules and procedural steps, was adopted for this dissertation (Bromley, 1986; Robson, 1993).

When studying people with severe psychopathology it has been recommended that the case study include a pertinent life history (Bromley, 1986). The quasi-judicial approach includes a study of the critical and culminative incidents in the life history

of people with severe psychopathology (Bromley, 1986). This approach recommends rigorous reasoning and rational argument in the interpretation of empirical evidence which has been systematically collated (Robson, 1993).

Important aspects of the perpetrators' life history were outlined in the presentation of the two cases in order to gain an in-depth understanding of the psychopathology present in the perpetrators' of MSP.

Collation of Data

The two cases referred to above which fulfilled the DSM-IV's diagnostic criteria of factitious disorder by proxy (MSP) which in the DSM-IV falls under factitious disorder not otherwise specified were identified by the researcher in a discussion with the child psychiatrist, who had conducted a comprehensive assessment and intervention of the cases (American Psychiatric Association, 1994). The researcher also attended a detailed case discussion presented by the child psychiatrist on the two cases which formed part of this dissertation. Other professionals who had contributed to the assessment or intervention for these children were also present at the discussion, for example, social workers and nurses.

It was decided early on in the initiation of the research that the 'participants' in the study would not be contacted. This was done because the cases had both been "closed" and it could have been distressing to initiate further contact. Furthermore, the diagnosis had not been made explicit to one of the 'participants' as the child psychiatrist felt that this would compromise future management. The other 'participant' had strongly denied her behaviour.

Written consent to use the case material was obtained from the Head of the Child and Family Unit at Red Cross War Memorial Children's Hospital, Dr C. Ziervogel. The Research Ethics Committee of the Faculty of Health Sciences of the University of Cape Town approved the study. Changes were made to the biographical details of the families to ensure anonymity.

Case researchers seek out what is common and what is particular in a case. Thus information is needed on the nature of the problem, the individual's historical background, the physical setting, other contexts and other cases through which the individual's problem is recognised (Stoke, 1994). It is essential to define what is important in the individual's history as not all aspects of the problem can be studied and covered.

There are some recommendations regarding the content and organization of the psychological case study. For example it has been argued that a psychological case study should include a statement of the general problems under investigation with a detailed account of the evidence to support the assertions being made, a description of the person's life history, present circumstances, future prospects of the subject, material status, physical health and pertinent life events (Bromley, 1986; Robson, 1993). Furthermore, it has been recommended that the psychological attributes of the person need to be explored, for example their characteristic reactions, motivations, attitudes, behaviour, abilities, self-image and life-story (Bromley, 1986). The person's social position, status, social relationships, family relationships and background have also been regarded as being important to the case study (Bromley, 1986).

The above-mentioned recommendations informed the analysis and presentation of the case material in this dissertation.

The case material was read carefully and initially a list of facts relating to the cases was generated. The case material was subdivided into the following main categories:

- Statement of the general problem. This included the following sub-categories: reason for referral, presenting problems of the child victim, history to presenting problems, developmental history of the child victim, child/familial history of illnesses/hospitalisations, current circumstances and parent child relationship.
- Psychological attributes of the perpetrator. This included the following sub-categories: perpetrator characteristics, behaviour, motivations, attitudes and self-esteem.

- Statement of the social position of the perpetrator. This included the following: current familial composition, family background of the perpetrator, relationship history of the perpetrator and the material/social status (Bromley, 1986; Robson, 1993).

Not all of these headings were used because of the specific requirements of the case material. The factual information included in each of the above-mentioned categories was informed by the literature in the area of MSP.

Data Analysis

The case material was analysed through the generation of common themes and identification of repetitive patterns which were then systematically analysed and compared with the findings cited in the literature review, with particular reference to Jureidini's (1999) notion of MSP as a form of pathological play (Robson, 1993). Initially hypotheses were put forward to try and explain the psychopathology present in the perpetrator of MSP. The next step included gathering evidence to support or reject the hypotheses. The purpose of this is to try and select the most likely interpretations possible in comparison with the available evidence (Robson, 1993). Thus Jureidini's (1999) initial theoretical statement was analysed in the light of the available evidence and the theoretical basis was then revised. This was done in an attempt to decrease theoretical bias. The aim of this approach is to search for evidence which supports as well as runs counter to Jureidini's (1999) notion of MSP as a form of pathological play (Bromley, 1986).

Qualitative research has been criticised because it is seen as not complying with the rigours of quantitative approach. Conventional methods used for quantitative research, such as reliability (for example, internal consistency) and validity (for example, external verification) are inappropriate for qualitative material (Robson, 1993).

Robson (1993) and Kelly (1999) propose the implementation of alternative notions to try to enhance the scientific qualities of interpretive research as well as deal with the criticisms aimed at this approach. They argue that the use of the concepts of

generalisability which is related to validity and trustworthiness which is related to reliability enhances the scientific qualities of interpretive research.

The trustworthiness of qualitative data has been questioned (Robson, 1993). For example, the case material used in this dissertation was gleaned from second-hand sources and may have been affected by the perceptions and understandings of the original clinicians involved in this work. There is thus a potential for bias in adopting this procedure, as it is mainly reliant on the human instrument (Robson, 1993). In an attempt to improve the credibility of the case material the notion of triangulation which is the use of multiple perspectives against which to check one's own position was adopted (Kelly, 1999; Robson, 1993). For example, the case material was obtained from a variety of sources, namely: the child psychiatrist, case notes, discussions with key individuals (social workers and clinical psychologists) and attendance of case presentations. This was done in an attempt to gain a multi-disciplinary perspective on the case material used and to deal with investigator bias.

The generalisability i.e. the extent to which interpretive accounts can be applied to other contexts, has also been questioned (Kelly, 1999; Robson, 1993). This is quite difficult to implement because of the contextual nature of the case study design which often puts strong limits on the generalisability of the findings (Robson, 1993). This problem could be addressed by contrasting the current findings of this piece of work with other cases of MSP.

In an attempt to ensure the transferability of the current research approach a detailed description of the research process has been provided including a relatively comprehensive explanation of the different theoretical explanations of the psychopathology present in the perpetrators' of MSP (Kelly, 1999).

This approach is not exhaustive as only selective issues, which highlight the main principles are reported. There is also no standard way of constructing a psychological case study and they vary quite considerably in their construction (Bromley, 1986).

1.2 Contents

Objective 1 (the systematic literature review) is addressed in Chapters 2 – 5, while Objective 2 (the case study) is addressed in Chapter 6.

The results of the literature review are reported in Chapters 2,3,4 and 5 (Objective 1). Specifically, chapter 6 contains a critical evaluation of Jureidini's (1999) notion of MSP as a form of pathological play in the light of the cases and the material gleaned from a review of the literature.

Chapter 2 examines the disputes as to the diagnostic criteria of MSP. An overview of the most widely accepted definitions is presented, including the DSM-IV (American Psychiatric Association, 1994), which defines MSP under the label of factitious disorder not otherwise specified. Each of the definitions is critically evaluated in the light of previous and ongoing research into the disorder.

Chapter 3 explores factors which help with the recognition and diagnosis of MSP. An understanding of factors which help to aid a diagnosis of MSP has important implications for early intervention and management of the disorder. This chapter examines common presentations of MSP and offers practical guidelines into the identification of MSP. The chapter is further subdivided into mother-perpetrator features, child-victim features, and family features, to help aid with identification of the disorder. Schreier and Libow's (1986) classification system of perpetrator characteristics, namely *active inducers*, *help seekers* and *doctor addicts*, can be seen as offering a useful insight into perpetrator behaviour and characteristics. It is essential that professionals gain a clear understanding of MSP. This has important teaching and training implications and involves a challenge to the resistance that 'mothers' are able to carry out such acts against a child.

Chapter 4 examines the psychopathology present in the perpetrator of MSP. This chapter provides an overview of the literature which examines psychopathology, including an exploration of family dynamics. Psychodynamic explanations of MSP are

explored. Most of the literature appears to support the idea that the perpetrator consciously intends to hurt the child but the motivation for the behaviour is unconscious. Many researchers argue that the mother gains a sense of exhilaration and control in taking on and deceiving the medical system, and in this way is able to assert her hostility; that the child's illness prevents her from facing other issues in her life, such as a dysfunctional marriage; and that she seeks the maternal atmosphere of the hospital (Masterson et al., 1987).

Schreier and Libow (1993) offer a more comprehensive explanation. The mother is described as seeking a perverse sadomasochistic relationship with powerful transference figures, such as the doctor, where the infant serves as a "dehumanised regulatory fetishist object" to control this relationship. The doctor serves as a source of nurturance and punishment and can be the focus for both idealization and hostility. The infant is treated as an object rather than a person and the mother is seen as failing to differentiate the infant from the self. Polledri (1996) describes the behaviour as a perversion of the maternal instinct.

The last section of the chapter focuses on MSP as a form of pathological play. Jureidini's notion of MSP as a form of pathological play is explored and critically evaluated.

Jureidini (1999) proposes that MSP is a perversion that can be understood as the perpetrator engaging in a form of pathological play. The real needs of the infant are ignored and the infant is used as a plaything in the enactment of a narrative.

Pathological play is argued to be a distortion of the qualities of play, namely the relationship between play and reality, the subjective experience of the player and the manner in which the player treats the objects of his/her play (Jureidini, 1999).

Healthy play is governed by reality. Access to reality is not lost and the appreciation for what is real is enhanced. In MSP there is a total avoidance of reality and the desire for a satisfying narrative overrides concern for the welfare of the protagonists of that narrative. In healthy play the subjective experience of the player is often of arousal and excitement. If the excitement is too high, the play will stop. In pathological play high levels of arousal may result in play becoming repetitive and compulsive and may result in the player becoming dissociated from feelings or from

other experiences. In MSP the subjective experience of the perpetrator corresponds to that of the playing child. In healthy play the playing child accommodates to the real qualities of the plaything and will most often not damage the plaything. In pathological play living things may be included without consideration for their real needs or their vulnerability. In MSP the victim is treated in a way which is a corruption of the way playthings are treated in healthy play (Jureidini, 1999).

Each theory is critically evaluated in the light of previous and ongoing research into this area.

Chapter 5 explores the management of MSP. In the management of MSP the safety of the child is paramount and must inform all decision-making. The importance of conducting a comprehensive risk assessment is presented. There is a lack of research into psychotherapeutic intervention with perpetrators. Therapeutic success is dependent on the motivation and acknowledgement of the abuse by the perpetrator.

It appears as if a lot more work needs to be conducted into the therapeutic management of MSP. This would have important implications for further management and would also assist in our understanding of MSP.

Chapter 6 explores MSP as a form of pathological play through the presentation of two clinical case examples. Jureidini's contribution to our understanding of MSP is explored and alternative explanations based on Object Relations Theory are presented. Jureidini's (1999) theory of MSP as a form of pathological play is critically evaluated in the light of Object Relations Theory. Material gleaned from Object Relations theorists in the literature on MSP is used to explore the cases. Theoretical concepts derived by Klein, Winnicott and Mahler are used to critically examine the case material.

2. DEFINITIONS

2.1 Historical Background

The name MSP is derived from the original Munchausen Syndrome described by Asher (1951) (Manthei et al., 1988). Asher (1951) used this label to describe patients who consistently produced false stories and fabricated evidence to receive unnecessary medical treatments and investigations (Meadow, 1982). Asher (1951) named the syndrome after an 18th Century German Baron von Munchausen, who was a military mercenary who told fantastical stories of his travels and adventures. Raspe (1785) compiled a literary collection of the fictitious tales of the travels and adventures of Baron von Munchausen. The name Munchausen thus became associated with outlandish story telling (Rosenberg, 1987; Palmer et al., 1984).

MSP has recently been described and most clinicians will only encounter the disorder infrequently and therefore their understanding of MSP may remain limited. In 1977 the British paediatrician Roy Meadow provided the first clinical description of MSP behaviour (Meadow, 1977). He described several cases of mothers who consistently fabricated signs of illness in their children causing them to be repeatedly and unnecessarily examined, hospitalised, tested and treated for a variety of medical problems (Smith & Adern, 1989; Bools, 1996; Schreier, 1997).

There appears to be a lack of clarity about what constitutes MSP behaviour. This ambiguity about MSP is reflected in the variety of terms which have been used to label this disorder. For example, MSP has also been known as Meadow's syndrome, Medea Complex and Polle syndrome. The name "Polle" refers to, Baron von Munchausen's son, Polle, who died in infancy of mysterious causes (Clarke et al, 1984; Leonard et al, 1984). This apparent vagueness regarding MSP also appears to be highlighted by the lack of consistency which surrounds definitions of this disorder. Currently there are numerous definitions of MSP, and disputes exist as to what should comprise its diagnostic criteria. This further complicates the identification, management and treatment of MSP, resulting in many cases going undetected. It is essential that some clarity be gained as to the definition and diagnostic criteria of MSP, which if undetected can have life-threatening consequences.

This chapter will attempt to provide an overview of the most widely accepted definitions for MSP identified from a review of the literature. The reason for this overview is that an attempt to gain greater clarity about the characteristics of MSP may help in the early diagnosis of MSP as well as with treatment and preventative measures. The sections in the chapter are structured as follows: ICD-10 (World Health Organisation, 1992) definition; Rosenbeg's (1989) definition; DSM-IV (American Psychiatric Association, 1994) definition; Kelly and Loader's (1997) definition and a concluding section. Each definition will be critically evaluated in the light of previous and ongoing research.

2.2 Definitions

ICD-10 Definition

The ICD-10 (World Health Organisation, 1992) international classification system adopts a four axes diagnostic system. For example, axis one defines the child's health state, not its aetiology. Axis four (medical conditions) contains a section (T74) for maltreatment syndromes where the extrinsic cause of the illness identified on axis one is coded. Factitious illness is coded in the section on 'injury, poisoning and certain other extreme causes'. Axes two and three are used to code learning and cognitive capacities (Jones et al., 2000).

The ICD-10, (World Health Organisation, 1992) provides a descriptive and atheoretical classification of MSP. Using the ICD-10 to diagnose MSP, the child's health state would be coded on axis one and the extrinsic cause of the illness coded on axis one, for example factitious illness, would be coded on axis four. There is no place for coding the perpetrator's motivation for inducing the illness in the child. The classification system adopts a clear position in relation to the child victim without looking at the perpetrators' behaviour.

This classification of MSP is consistent with Meadow's view that the definition must refer to the nature and the source of the child's illness. "When considering the classification of the perpetrator, MSP abuse or factitious illness by proxy is not included amongst the potential psychiatric diagnoses, thus the confusion between a

behaviour and an illness is avoided” (Jones et al., 2000, p22). For example, the ICD-10 (World Health Organisation, 1992) classification system allows for a wide variety of understandings for the motivation of the perpetrator’s behaviour as well as giving a clear description of the type of abuse endured. It would seem that a classification system would need to provide greater clarity regarding MSP behaviour in order to inform future identification and management of this disorder. For example, the danger of excluding motivating factors for the behaviour is that it makes it difficult to distinguish MSP abuse from other forms of behaviour, such as physical abuse or overanxious parenting, require different forms of intervention from MSP. It would appear that any understanding of MSP would need to include an understanding of what motivates such behaviour.

Rosenberg’s Definition

Rosenberg (1987) attempts to provide an understanding of MSP which allows for psychopathological formulations of the perpetrators’ behaviour. Rosenberg (1987) offers one of the most widely accepted definitions of MSP. “In Munchausen Syndrome by Proxy the following constitute the syndrome cluster:

1. illness in a child which is simulated (faked) and/or produced by a parent or someone who is in loco parentis; and
2. presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures;
3. denial of knowledge by the perpetrator as to the etiology of the child’s illness; and
4. acute symptoms and signs of the child abate when the child is separated from the perpetrator” (548-549).

Rosenberg’s (1987) definition gives a descriptive account of the perpetrator’s behaviour and thus goes further than the ICD-10 (World Health Organisation, 1992) in gaining greater clarity as to the type of behaviour which constitutes MSP abuse. This definition emphasizes the complete denial of responsibility for the illness by the perpetrator and a resolution of symptoms on separation. Rosenberg’s (1987) definition does not specify the nature of the presentation or the denial, particularly the

motivation for the denial. By excluding motivation for the behaviour, this definition allows for individual psychopathological formulations of each case of the disorder. This may be too broad and thus have negative implications for long-term management and prognostic factors.

It would appear that a definition of MSP which includes both a descriptive component (outlining the nature of the child's health state), as well as a motivational component (outlining factors which could account for the perpetrators' behaviour) is essential to gaining a comprehensive understanding of MSP.

DSM-IV (1994) Definition

The DSM –IV (American Psychiatric Association, 1994) classification system attempts to address this issue by including motivating factors for the behaviour as one of the diagnostic criteria for this disorder. MSP forms part of the factitious disorder spectrum described as factitious disorder by proxy by the American Psychiatric Association (1994). It is important to note that the American Psychiatric Association only acknowledged the syndrome in 1994 with the development of the DSM-IV.

MSP is not described as a separate disorder in the DSM-IV (American Psychiatric Association, 1994), but falls under the category of Factitious Disorders. Factitious disorder can be described as “physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role” (American Psychiatric Association, 1994). Of importance is the motivation to assume the sick role which is a psychological need in the absence of external incentives.

In the DSM-IV (American Psychiatric Association, 1994) the inclusion of factitious disorder by proxy is given as an example of “factitious disorder not otherwise specified” and is defined as follows: “This category includes disorders with factitious symptoms that do not meet the criteria for Factitious Disorder. An example is factitious disorder by proxy: the intentional production or feigning of physical or psychological signs and symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role” (American Psychiatric Association, 1994, p727). Of importance in the diagnostic criteria is that “external

incentives for the behaviour (such as economic gain) are absent” (American Psychiatric Association, 1994, p727). This definition appears to go some way in distinguishing MSP from other forms of behaviour such as, physical abuse.

The lack of overall acceptance and recognition of this disorder is displayed by its inclusion in the DSM-IV (American Psychiatric Association, 1994) under the section of disorders requiring further study. This reflects reluctance on behalf of the mental health fraternity to recognise MSP as a diagnosable disorder. Although the disorder is recognised by the psychiatric fraternity it still remains coded under the ‘not otherwise specified’ diagnostic category. According to the DSM-IV (American Psychiatric Association, 1994), further research is required for it to be included as a formal diagnostic category.

The lack of a distinctive diagnostic category for Factitious Disorder by Proxy in the DSM-IV (American Psychiatric Association, 1994) is a reflection of the lack of clarity that exists amongst researchers, clinicians and other professionals alike as to the particular diagnostic criteria to be included under this label.

The DSM-IV (American Psychiatric Association, 1994) definition includes motivation for the behaviour in the diagnostic criteria and therefore helps the clinician to distinguish MSP abuse from other forms of behaviour. Schreier and Libow (1993) state that it is essential to include motivation for the behaviour as one of the diagnostic criteria in order to distinguish it from other cases. Cases that involve over-anxious parents, noncompliant parents of chronically ill children and, parents who attempt to gain benefits from the medical, social, educational or legal systems, do not reflect this diagnosis (Schreier, 1997). Clear specification of the motivation for the perpetrators’ behaviour allows for greater consistency in terms of understanding and management of MSP. Most researchers agree that external incentives for the behaviour must be absent for it to be called Factitious Disorder by Proxy.

Parnel and Day (1998) criticize the use of the label Factitious Disorder by Proxy stating that it incorrectly implies that the disorder is an extension of Factitious Disorder. Furthermore the DSM-IV definition of MSP focuses purely on illness fabrication or induction, without any consideration of psychological or psychiatric

presentations of the illness. This could account for many cases of MSP going undetected, especially if the presentation is of a more subtle nature. According to Schreier (2000), there have been over 300 papers and four books on MSP which focus almost exclusively on medical presentations of the syndrome. For example, a psychiatric or psychological presentation of MSP may involve differing motivational factors for this behaviour from a medical presentation of this disorder. Furthermore, medical presentations of MSP may also differ in nature and thus the motivation for this behaviour may be more complex than the need to 'assume the sick role by proxy'. The motivation of MSP as defined by the DSM-IV (American Psychiatric Association, 1994) to 'assume the sick role by proxy', has been criticised for being superficial and inadequate and not explaining the complexities of the dynamics involved (Parnel & Day, 1998). The DSM-IV's (American Psychiatric Association, 1994) definition of MSP has attempted to narrow down the possible psychopathological formulations of this disorder. It would appear though that other factors which are not considered in the DSM-IV's (American Psychiatric Association, 1994) definition, may account for MSP behaviour.

Kelly and Loader (1997) attempt to address this of complexity surrounding MSP and criticise the DSM-IV's (American Psychiatric Association, 1994) definition of Factitious Disorder by Proxy, stating that the definition is too narrow in scope.

Kelly and Loader's Definition

Kelly and Loader (1997) offer a broader definition that does not specify the perpetrators' motivations or their denial of their role and allows for other explanations regarding the perpetrators' psychopathology and motivations.

Kelly and Loader (1997) define MSP as follows: "the carer will have either exaggerated or fabricated symptoms, falsified investigations, or induced signs and in the process may have directly harmed the child herself" (p116). Any children fulfilling these criteria and requiring mental health involvement are included.

Kelly and Loader's (1997) definition allows for the following motivating criteria to be included in the diagnosis: the parent is excessively anxious; the child has been abused

and the parent is pursuing a medical explanation in order to avoid accusation; the mother believes that their child is genuinely organically ill; the behaviour is an attempt to antagonise somebody; the perpetrator has a misguided belief that medicalisation is in the child's best interests and there is extreme enmeshment of the parent/child relationship.

Schreier (1998) disputes this redefinition stating that it "renders the FDBP (*factitious disorder by proxy*) diagnosis virtually useless for the purposes of perpetrator treatment or child protection, by further confusing categories of child abuse with parental psychopathology" (p2). Schreier (1998) further argues that FDBP is a diagnosis of perpetrator psychopathology and not of child abuse, which has many differing motivations and parental psychopathologies. Furthermore, the specificity of diagnosis is essential in that treatment of an overanxious parent would certainly differ from a parent who has specifically induced an illness in her child. The criticisms lodged at Rosenberg (1987) for allowing for too many understandings of MSP would appear to be applicable to Kelly and Loader (1997).

Kelly and Loader (1998) respond to the criticisms made by Schreier (1998), and argue for subcategories of Factitious Disorder by Proxy, of which MSP could be one. They argue that each of the subcategories would have different motivations and therefore different treatment/management strategies. There appears to be a need to allow for a greater understanding of the possibilities of a continuum of Factitious Disorder Spectrum diagnoses. Kelly and Loader (1998) argue that MSP should form one of the sub-categories of Factitious Disorder by Proxy. They can therefore be seen as broadening our psychopathological and diagnostic understandings of the disorders falling on the Factitious Disorder Spectrum.

Kelly and Loader's (1998) definition allows for other motivating factors to be considered apart from playing the sick role by proxy. This helps to broaden our understanding of the disorder as well as emphasizing that there may be other psychopathological formulations of this disorder. If a continuum of Factitious Disorder Spectrum Diagnoses were to be developed then it would appear to be necessary to develop more specific psychopathological formulations for each of the 'disorders' on the spectrum. This could serve to avoid confusion and to help ensure

that appropriate intervention strategies are adopted. Thus the motivating factors to be included in the sub-category of MSP need to be specified, otherwise the definition could be too broad and result in a lack of clarity in terms of prognosis and management. Furthermore it would seem that a definition of MSP should include the nature of the illness or the psychiatric/psychological presentation as well, as this also has implications for management of the syndrome. A definition which allows for both a descriptive account of the disorder as well as an account which allows for more specific psychopathological formulations of MSP behaviour would appear to be the most comprehensive approach to this disorder.

2.3 Conclusions

The hesitancy in the literature to be explicit about MSP being a form of child abuse results in trivialization of abuse, overinclusiveness in its use, lack of clarity in terms of prognosis and long-term management (Jureidini, 1998). The ongoing ambivalence about how to categorize this disorder has serious implications for treatment and for both the medical and the legal systems. For example, this ambivalence can result in many cases of MSP going unrecognised which can have life-threatening consequences for the victim. Often perpetrators of MSP do not go through the legal system; this can be partly due to the fact that many professionals do not believe that a 'mother' could act in such a harmful manner towards her child.

For the purpose of this dissertation, the DSM-IV (American Psychiatric Association, 1994) definition of Factitious Disorder by Proxy will be used as a guideline, bearing in mind its limitations particularly regarding the nature of the presentation and the limitations in understanding of the motivation for the perpetrators' behaviour.

3. DIAGNOSES AND RECOGNITION

3.1 Introduction

MSP can manifest itself in hundreds of different medical or psychiatric symptoms, modes of abuse and perpetrator and victim dynamics (Folks, 1995; Parnel & Day, 1998; Rosenberg, 1987; Schreier, 1997,2000). Doctors confronted with such a case are faced with an undiagnosable, baffling and unremitting illness that is resistant to treatment (Kaufman et al., 1989).

Since the first reported case of MSP by Meadow, in 1977, over 300 papers and four books have focussed on the syndrome (Schreier, 2000). Most of these describe where there has been a falsification of physical conditions. There has been very little research that addresses the falsification of psychiatric/psychological disorders (Schreier, 2000).

This chapter will look at factors which help with the recognition of MSP and which have important implications for the management of the disorder (Schreier & Libow, 1993; Schreier, 2000). The chapter is structured as follows: presentations of MSP; barriers to diagnosis; identification of MSP; and a concluding section. An overview of factors which aid in the recognition of the disorder has important implications for further training and teaching of professionals in the health, education and social services who are the most likely to encounter cases of MSP.

3.2 Presentations of MSP

The most common presentations of MSP currently identified appear to be medical in nature, but this could also be due to the fact that the disorder has only recently been recognised and psychiatric presentations may be more difficult to detect (Folks, 1995; Rosenberg, 1987; Schreier, 1992). Rosenberg (1987) reviewed 117 cases and found the most common presentations of MSP to be bleeding, seizures, central nervous system depression, apnoea, diarrhoea, vomiting, fever and rash.

Folks, (1995) identified two patterns of presentation of medical symptoms. The first usually presents with apnoea, seizures and cyanosis. The second involves cases with diarrhoea and vomiting, nausea, bone and joint problems. Furthermore, Folks (1995) found that infants may present with failure to thrive, recurrent otitis media or have a history of multiple hospitalisations and repeated medical investigations. Neurological symptoms identified included ataxia, hyperactivity, chorea, weakness, inability to walk, lassitude, and headache and limb paralysis (Folks, 1995).

The most common forms of assault, related to the presentation of medical symptoms, which have been identified include: “suffocation, induced seizures, chronic poisoning with ipecac (which causes vomiting) or phenolphthalein (which causes diarrhoea) - symptoms that lead to frequent invasive investigations and procedures” (Rosenberg, 1987, cited in Schreier, 1992, p42). MSP thus often results in many unnecessary investigations, medical interventions and hospitalisations. For example, unnecessary bone marrow aspirations, surgery, blood transfusions and x-rays are just some of the examples of the results of medical presentations of MSP (Folks, 1995; Schreier, 1992).

There is very little literature describing psychiatric presentation of the disorder (Fisher et al., 1993; Meadow, 1993; Schreier, 1997, 2000). In 1993 Meadow described 14 children in seven families where the mother had made false accusations of sexual abuse and had also fabricated medical illnesses. This does not necessarily appear to be a psychiatric presentation of MSP. Fisher et al. (1993) described the first psychiatric case presentation of MSP. They outlined a single case report describing a young boy who was presented by his mother to be psychotic, but on examination was found to be without any psychotic symptoms (Fisher et al., 1993).

Schreier (1997) offers a more comprehensive description of the psychiatric presentation of MSP. He described 14 cases where the most common presentations included both outpatient treatment and frequent hospitalisations for a range of psychiatric problems, for example: psychotic disorders, multiple personality disorder, attention deficit disorder, temporal lobe epilepsy, Tourettes syndrome and autistic spectrum disorders (Schreier, 1997, 2000). Other presentations identified included learning disabilities, attention disorders, chronic fatigue syndromes and environmental

allergies, and it was argued that these presentations would be the most likely to come to the attention of a broader range of professionals such as teachers and social workers (Schreier, 1997).

3.3 Barriers to Diagnosis

Making a diagnosis of MSP is extremely difficult given the possibility that a true disease may exist (Kaufman et al., 1989; Mart, 1999, Schreier & Libow, 1993). In addition, other diagnoses, such as malingering, conversion disorder and hypochondriasis also need to be considered (Kaufman et al., 1989). Other obstacles to diagnosis which have been identified include staff perceptions of mothers as ideal parents, the perpetrator's denial of allegations and the scepticism of both the psychiatric and legal world that a mother/parent would victimise her child in this way (Kaufman et al., 1989).

Schreier and Libow (1993) argue that MSP is difficult to recognise as the cases often take a long time to unfold. For example, Rosenberg (1987) found that in 67 of the 117 cases studied there was a mean time of 14 months to reporting the diagnosis. Schreier and Libow (1993) found that the average length of time to diagnosis was more than a year in 19 percent of cases and more than six months in 33 percent. This length of time to diagnosis may have grave implications for the safety of the child. This variability in the length of time to diagnosis could be as a result of a lack of knowledge about this disorder.

Furthermore the perpetrators have been found to often give compelling clinical accounts of the illness which are taken by the staff involved to be the true account (Kaufman et al., 1989; Schreier & Libow, 1993, Schreier, 2000). The complex nature of modern medical diagnoses and treatment plans, as well as the fear of lawsuits, also makes diagnosis difficult. Another complication that has been identified is that a real medical problem may coexist with the fabricated symptoms (Kaufman et al., 1989).

There appears to be resistance from professionals to see the mothers, who on the surface appear to be caring, as actually harming their children (Jureidini, 1999). Often doctors embark on a relentless medical pursuit in order to come up with a

diagnosis for the child, missing other factors which could help them identify MSP. This is further confounded by the risk of misdiagnosis in a case where the child may in fact be chronically ill (Jureidini, 1999; Kaufman et al., 1989; Schreier & Libow, 1993; Schreier, 2000).

Schreier (1997, 2000) states that the diagnosis of a psychiatric presentation of MSP is often more difficult to recognise than the medical presentation of the disorder. This could be partly due to the nature of psychiatric presentations in children, for example children often have more than one psychiatric diagnosis and parental reports are often the sole data source when making a diagnosis (Schreier, 1997). The diagnostic process is further complicated by the fact that there is frequently a contrast between the mother's report and the child's behaviour during the evaluation of many psychiatric presentations, especially attention deficit hyperactivity disorder, bipolar disorder, dissociative disorders and Tourette's disorder (Schreier, 1997). The disturbed parent-child relationship, as well as the side effects of previous interventions and medications, may themselves produce symptoms in the child (Schreier, 1997). With the psychiatric presentation of the disorder, it has been found that the victims are older and often involved to varying degrees in a very complex, confusing and pathological relationship with the perpetrator (Schreier, 1997, 2000).

Not all researchers believe that MSP is under diagnosed (Mart, 1999). According to Mart (1999), MSP is prone to being over diagnosed. This results in grave consequences for parents who may have been convicted or jailed for child abuse, only for it to be discovered that they played no part in their children's illnesses. According to Mart (1999), difficulties in accurate diagnosis of MSP and the high probability of false positives make it extremely important to use rigorous procedures for investigating and evaluating this syndrome. Mart (1999) argues that the risk of misdiagnosis is due to the following factors:

- lack of empirical research into the disorder and reliance on clinical judgement in coming to a diagnosis;
- weakness of medical-psychiatric findings which are not necessarily empirical in nature;

- the reliance on weak indicators (such as profile data) in making a diagnosis and not enough reliance on robust indicators (such as laboratory tests or video surveillance);
- the range of behaviour and characteristics attributed to those who have this disorder is too broad to make a diagnosis;
- the lack of adherence to diagnostic criteria;
- the lack of attention paid to alternative explanations for the perceived problem.

Kelly and Loader (1997) state that research indicates the prevalence of the disorder is greater than has been generally estimated. From a review of the literature the overall impression given is that there is an underestimation of the disorder and that this could be partly due to professionals' reluctance to believe that a parent could intentionally harm his or her child (Eminson et al., 1998, McClure et al., 1996).

It would appear that reliance on purely 'robust' indicators, as suggested by Mart (1999), would make prevention of harm to the child almost impossible. Mart's (1999) argument also appears to negate the possibility of there being a psychiatric presentation of MSP. A misdiagnosis of MSP could have hefty implications for the alleged perpetrator whilst not recognising the syndrome could have serious implications for the child. A thorough systematic investigation with clear guidelines for coming to a diagnosis may help to alleviate the complexities involved in diagnosing and managing MSP. For example, indicators such as profile data could be helpful in the identification of a suspected case of MSP (Parnell, 1998).

3.4 Identification of MSP

Parnell and Day (1998) offer a guideline for the identification of MSP which divides the framework into mother-perpetrator features, child-victim features and family features. This system will be used to look at factors which help with the identification of MSP.

3.4.1 Mother-Perpetrator Features

As mentioned previously, a review of the literature reveals that the perpetrators of this form of abuse are generally women and usually the child's mother (Parnell & Day, 1998; Rosenberg, 1987; Schreier & Libow, 1993). For example, Rosenberg (1987) found that out of 117 cases, 98 percent of the perpetrators were the child's biological mother with two percent being the child's adoptive mother. Schreier and Libow (1993) state that a small number of fathers have been identified as the perpetrators. Meadow (1998), reports on 15 families in which one or more of the children incurred factitious abuse as a result of the father's false story and actions. According to Meadow (1998), when the perpetrator is a male then he himself will generally be suffering from Munchausen Syndrome or a significant somatising disorder. Male perpetrators are treated more harshly by the legal system in the United Kingdom than women. The reasons for this are uncertain, but could certainly relate to a societal reluctance to regard women as perpetrators. Overall, it appears as if women are much more likely to be the perpetrators of this form of abuse.

Schreier and Libow (1986) compiled a classification system to help identify perpetrators of MSP. They identified the following categories:

Active Inducers

Here the perpetrator is seen as actively inducing an illness or injury in the child through suffocating, poisoning and injecting noxious foreign substances into the child's body (Schreier & Libow, 1986). The perpetrator is seen as being devoted, calm, trustworthy and co-operative. They may respond with denial and anger if confronted with their behaviour and frequently abscond before any intervention can take place. Schreier and Libow (1986) argue that the mother has a mutually dependent relationship with the child. Disturbed marital relations are common. The use of the defensive mechanisms of denial and projection predominates the picture. They argue that the behaviour may be motivated by the secondary gain of being appreciated as a good mother (Schreier & Libow, 1986, 1993; Schreier, 1997, 2000).

Help Seekers

According to Schreier and Libow (1986) “help seekers” will present with fictitious child illness. They differ from the “active inducers” in terms of the severity and the frequency of the symptom presentation and their motivation for the behaviour. Schreier and Libow (1986) describe their motivation as being related to a need to communicate exhaustion, distress or feelings of inadequacy whereas “active inducers” may be trying to receive nurturance for themselves by presenting the child as sick. The mother’s behaviour is thus seen as being more under her conscious control and usually falls away once the underlying need for outside involvement has been met (Schreier & Libow, 1986).

Doctor Addicts

According to Schreier and Libow (1986), doctor addicts are seen as seeking treatment for non-existent illnesses in their children. They present with an inability to acknowledge their behaviour or their motivation even when help has been offered. They tend to relentlessly pursue diagnostic and medical procedures (Schreier & Libow, 1986). Their behaviour is characterised by falsifying history and symptoms. They tend to lack insight, refuse to accept contradictory medical evidence and often appear to be less co-operative and more angry and suspicious than the “active inducers” (Schreier & Libow, 1986). Confrontation of this behaviour will often result in anger and denial. According to Schreier and Libow (1986), the victims tend to be older. The mothers tend to over-react to the child’s “medical” condition, whilst under-reacting to the child’s emotional state.

The categories of “active inducers” and “doctor addicts” could be useful from a descriptive perspective and for recognition of MSP. The category of “help seekers” is more likely to be applicable for overanxious parents who respond to intervention and do not show such a strong attachment to the medical system (Schreier & Libow, 1986).

Other Perpetrator Characteristics

- The above categories may be helpful in the identification of MSP behaviour. The following additional perpetrator characteristics may help in recognising the disorder (Bools, 1996; Feldman, 1994; Folks, 1995; Jureidini, 1999; Leonard & Farrel, 1992; Marcus et al., 1994; Parnell & Day, 1998; Polledri, 1996; Schreier, 1997, 2000; Yorker & Kahan, 1990):
 - Denial of any responsibility;
 - medical experience or training;
 - prevalence of personality disorders, particularly histrionic, borderline, narcissistic and paranoid personality disorders;
 - history of self-harm and substance abuse;
 - an absence of the mother's expression of concern for her child;
 - details of the child's illnesses being copied from cases receiving media attention;
 - over attachment on the part of the perpetrator on the medical system, hospital or;
 - medical staff;
 - The perpetrator having medical problems similar to those of the child; and
 - fabrication of other aspects of the perpetrators life.

The perpetrator characteristics can aid professionals in the identification of MSP. However, a diagnosis of the disorder cannot be made on the basis of perpetrator characteristics alone. Consideration should also be given to the child-victim characteristics.

3.4.2 Child-Victim Features

The victim is usually the biological child of the perpetrator (Parnell & Day, 1998; Rosenberg, 1987; Schreier & Libow, 1993). The average age of the victim has been found to be less than six years (Sapolsky, 1999). Rosenberg (1987) found that the mean age at diagnosis was approximately 32.1 months. There is no gender differential in the choice of victim (Rosenberg, 1987; Schreier & Libow, 1993). Rosenberg's (1987) study found that 46 percent of the victims were girls, 45 percent were boys and nine percent were of unknown gender.

- From a review of the literature child-victim features have been identified which could be helpful in the recognition and diagnosis of MSP (Leonard & Farrel, 1992; Folks, 1995; Parnell & Day, 1998; Schreier, 1997). The following child-victim features have been identified as being important in alerting clinicians to the possibility that they may be dealing with a case of MSP (Leonard & Farrel, 1992; Folks, 1995; Schreier, 1997; Parnell & Day, 1998).
- Baffling, unremitting illness which is undiagnosable and resistant to treatment;
- illness is multisystemic, prolonged, unusual or rare;
- signs and symptoms are inappropriate or incongruent (for example the child is presented as being dyslexic but does well on achievement and cognitive tests);
- signs and or symptoms disappear when the parent is absent;
- the child shows a poor tolerance to treatment;
- the general health of the child clashes with the results of laboratory tests; and
- the father is usually absent.

Researchers into MSP have found that the difficulties involved in recognising a presentation of MSP makes careful observation and gathering of information from other sources who are familiar with the child absolutely vital in the assessment process (Leonard & Farrel, 1992; Schreier & Libow, 1993; Schreier, 1997, 2000). For example, it is common for there to be inconsistencies in behaviour with children who have been diagnosed with Tourette's or bipolar disorder and therefore there

should not be a hasty diagnosis of MSP (Schreier, 1997). A child who has been diagnosed with bipolar disorder may display no signs of the disorder during the assessment process. The mood disorder may only become apparent following a careful collation of data from multiple sources familiar with the child's behaviour over a long period of time. Furthermore it is essential to differentiate MSP from other forms of illness fabrication and other situations that may resemble but are not the disorder. For example, it is important to distinguish between a concerned parent, a delusional parent and MSP (Schreier, 1997). This differentiation is essential as it will inform the treatment and intervention strategies adopted by the professionals involved.

3.4.3 Family Features

- Under family features the following factors have been identified to help with recognition of the disorder (Bools, 1996; Feldman, 1994; Folks, 1995; Jureidini, 1999; Leonard & Farrel, 1992; Marcus et al., 1995; Parnell & Day, 1998; Polledri, 1996; Schreier, 1997, 2000; Yorker & Kahan, 1990).
- Emotional neglect and psychological abandonment in childhood, not necessarily active abuse, although some authors have found a history of sexual abuse in the backgrounds of the perpetrator;
- unexplained and recurrent childhood illnesses which some of the literature sees relating to an earlier history of factitious or somatising disorders;
- an absent marital partner;
- marital discord;
- disturbed family relationships;
- unexplained illness or death of a sibling or another child in the perpetrator's care; and
- familial pattern of illness presentation.

Research into the siblings of MSP victims indicates that they are at greater risk for unexplained illness or death (Booles et al, 1992, Meadow, 1984, Rosenberg, 1987, Schreier & Libow, 1993). For example, Meadow, (1984), in a study describing 32

children who presented with factitious epilepsy, found that of 33 siblings there were seven sudden infant death syndrome cases. Meadow (1990b) reported on 27 young child victims of MSP who had been repeatedly suffocated by their mothers. They had 15 live elder siblings and 18 who had died suddenly and unexpectedly in early life. Schreier and Libow (1993) conducted a survey of paediatric gastroenterologists and paediatric neurologists and found that a sibling was believed to be involved in 120 (25.8 percent) of the 465 possible cases (273 confirmed and 192 suspected). Booles et al. (1992) reported on siblings of 56 victims of MSP, 11 percent had died in early childhood and 39 percent had illnesses fabricated by their mothers.

A large number of siblings of victims of MSP are or have been at risk of being victims of MSP. Knowledge about siblings could aid in the diagnosis of MSP and could also help to alert the clinician to the possible risk posed to siblings. The fact that several of the siblings die under mysterious circumstances could alert clinicians to other cases of MSP that have gone unrecognised in the past (Booles et al., 1992).

The above features may help with a psychopathological understanding of the perpetrators' behaviour and may thus inform the management of this syndrome.

Both robust and profile data, for example, may assist in the diagnosis of MSP (Mart 1999; Schreier & Libow, 1986, 1993; Schreier, 1997, 2000).

3.5 Conclusion

In conclusion, MSP may have a medical, neurological and psychiatric/behavioural presentation. Difficulties in recognising and accurately diagnosing this disorder may result in unnecessary and preventable harm to children which are carried out through the health and mental health systems. It would appear that rigorous attempts need to be made to assist all professionals who work with children in the recognition of the disorder, so that professionals may refer patients/clients for a specialist assessment, diagnosis and management.

4. PSYCHOPATHOLOGY

Most of the literature on MSP looks at ways of explaining this behaviour by focusing on perpetrator characteristics, psychodynamic explanations of the perpetrator's behaviour, and familial and sociological perspectives. Single case reports form the bulk of the literature dealing with psychopathology (Bools, 1996; Feldman, 1994; Griffith, 1988; Kelly & Loader, 1996; Masterson et al., 1988; Polledri, 1996; Rosenberg, 1987, Sanders, 1995, 1996; Schreier & Libow, 1993; Schreier, 1992; Sheridan, 1989; Sigal et al., 1989; Weldon, 1988; Yorker & Kahan, 1990).

The disadvantage of using a single case report as a basis for speculation about psychopathology is that concepts which are exemplified by a particular case are likely to receive the focus of attention at the expense of other factors which could explain the behaviour. It is also difficult to generalise theoretical concepts derived from a single case report to MSP in general (Schreier & Libow, 1993). Authors may present a particular case of MSP in an attempt to find support for their own theoretical perspective, thus not allowing for contradictions or challenges to this perspective (Rosenberg, 1987; Schreier & Libow, 1993). In spite of these disadvantages, the use of single case studies has led to a considerable enhancement of our understanding of MSP.

Basing explanations of MSP on several cases allows for the emergence of themes that are common across cases. It also provides greater credibility to the particular theoretical perspective adopted by the author/s (Meadow, 1993; Rosenberg, 1987). Examples of authors who have based their explanations of psychopathology on more than one case report include Meadow (1993), Rosenberg (1987), Schreier & Libow (1993) and Schreier (1997).

This chapter will provide an overview of the literature which focuses on the psychopathology of MSP. The sections in the chapter are structured as follows: family dynamics; psychodynamic explanations of MSP, with an introductory section on Object Relations Theory to locate the psychodynamic formulations of this disorder; and MSP as a form of pathological play. Each theory will be critically evaluated in the light of previous and ongoing research into this area. The

psychodynamic section of the chapter includes a general introduction to the work of Klein, Winnicott and Mahler. This will be followed by some psychopathological explanations of MSP which will draw on the theoretical work reviewed. Jureidini's (1999) notion of MSP as a form of pathological play will be reviewed separately. One of the main purposes of the dissertation is to critically evaluate Jureidini's (1999) notion of MSP as a form of pathological play. This theory offers an alternative explanation of MSP and will be critically evaluated in the context of the case material.

4.1 Family Dynamics

A number of researchers argue that familial factors are essential in the precipitation and maintenance of MSP abuse (Griffith, 1988; Sanders, 1995, 1996). For example, Griffith (1988) argues that MSP behaviour is maintained by the family system as a whole and not by the autonomous behaviour of the perpetrator alone. He argues that the behaviour stabilizes the family system by avoiding marital conflict, regulating intimacy in the marriage, avoiding unresolved familial losses and maintaining the familial myth (Griffith, 1988). He describes the perpetrator/mother as dominating and controlling, and the father as absent or weak. There is a blurring of parent-child boundaries. Intense family group loyalty predominates. The autonomous needs of the children to develop their own separate identities are ignored and the family is socially isolated (Griffith, 1988). This explanation, whilst focusing on systemic factors, does not appear to explain why the perpetrator will engage in MSP abuse to maintain the family system. There is a need for a sound psychopathological understanding of the perpetrator's behaviour which maintains the system.

Narrative therapy has been used to explore the family dynamics in MSP (Sanders, 1995, 1996). Sanders (1995, 1996) offers a systemic narrative explanation of MSP. She argues that the family creates an illness story. MSP is based on cultural factors (role of women), familial background experiences (abandonment, feelings of neglect), and the current family situation (birth of a child, child illnesses, absent partner), which all interact to produce a dominant story of illness. She argues that this illness story produces strong feelings of sympathy and care from others, particularly the doctor, (a powerful societal figure), who unwittingly co-authors this story. The perpetrator is

rewarded for posturing as a good mother and thus has her own contradictory needs met (Sanders, 1995, 1996).

Sanders (1995), adds to our understanding of MSP by looking at the participation of other family members in the presentation of false symptoms. She argues that the collusion of the child and other family members in illness induction or fabrication is on a continuum. The child or family members may be naïve, i.e. unaware that the illness is being induced; passively accept, i.e. be aware of the deception/abuse but not point this out; or actively participate in the presentation of symptoms. Through a case study analysis, Sanders (1995) concludes, “the more congruent and consolidated the family is in illness presentation, the less likely its members are to endorse feeling stressed (despite extreme external evidence of stressors) and the more likely they are to report coping and help-seeking behaviours” (p436).

This analogy has important implications for understanding the complicated interaction between parental pathology and familial factors in the presentation and maintenance of this disorder. It also has important implications for the assessment of the role of each family member in the presentation of symptoms. Family approaches contribute to the understanding of factors which maintain MSP behaviour. This approach does not focus on factors which could help to explain the origins of this disorder. An approach which looks at intrapsychic factors could help in gaining a more in-depth understanding of the psychopathological origins of MSP. An understanding of how the psychopathology present in the perpetrator interacts with the system at large to induce and maintain this form of abuse could be seen as addressing some of the complexities involved in understanding MSP behaviour.

4.2 Psychodynamic Explanations of Perpetrator Behaviour

It is apparent from a review of the literature that most of the psychodynamic explanations of MSP have their origins in Object Relations Theory, especially the work of Klein, Winnicott and Mahler (Bools, 1996; Polledri, 1996, Schreier & Libow, 1993, Schreier, 1997, 2000; Sheridan, 1989; Sigal et al., 1989, Weldon, 1988).

Kleinian notions of projection, splitting and projective identification form the foundation of many of the arguments put forward to explain the psychopathology present in a perpetrator of MSP (Bools, 1996; Polledri, 1996, Schreier & Libow, 1993, Schreier, 1997, 2000; Weldon, 1988). Furthermore MSP involves a complex interaction between the perpetrator, the child-victim and the system at large which brings into focus the importance of object relations in the aetiology and maintenance of this disorder. This section of the chapter will focus on the theoretical aspects of Object Relations Theory, with reference to Klein, Winnicott and Mahler. This will be followed by an exploration of psychodynamic formulations of MSP in particular. The application of these theoretical approaches to MSP will be discussed in subsequent sections of the dissertation.

4.2.1 Object Relations Theory

Klein

Psychodynamic theorists use the defence mechanisms, which develop in the paranoid-schizoid position, to explain the genesis and maintenance of MSP (Bools, 1996; Polledri, 1996; Schreier & Libow, 1993; Schreier, 1997, 2000; Weldon, 1988). Klein's conceptualisation of the nature of the drives can be seen to situate her as a transitional figure between the classical/drive structure model, (in which the entire motivational system is dependent on drives) and the relational/structural model, (in which the drive model is completely abandoned). Klein thus uses both a biological as well as an object-relations approach. "She does this by combining a severe instinctual bias with a subtle account of psychological development through periods marked by the relative disintegration or integration of ego-object relationships" (Frosh, 1987, p13).

Klein argues that the defense mechanisms of projection, splitting and projective identification predominate during the paranoid-schizoid position, which occurs in the first three months of life (Klein, 1952). She adopts the term "position" to emphasize that "the phenomenon she was describing was not simply a passing 'stage' or 'phase'; her term implies a specific configuration of object relations, anxieties and defences which persist throughout life" (Segal, 1964, pxiii). The paranoid-schizoid position is

dominated by part object-relations, for example the infant's relationship with the breast, as opposed to whole object relations where the mother is perceived as a whole (Klein, 1952).

The early ego, according to Klein, is present from birth and is able to experience anxiety and employ defence mechanisms with which to cope with this anxiety. This early ego is also capable of forming object relations in phantasy and reality (Frosh, 1987). Klein regards unconscious phantasy as "a mental expression of the instincts which exist from the beginning of life" (Segal, 1964, p13). As there is a definite link between the instincts and the objects, phantasy "is also the arena in which the child's object relational drama is experienced" (Frosh, 1987, p117). Therefore any experience of an instinct by necessity must be attached to a phantasy of an object which is appropriate to that instinct. "Phantasy is not merely an escape from reality, but a constant and unavoidable accompaniment of real experiences, constantly interacting with them" (Segal, 1964, cited in Frosh, 1987, p117). An unconscious phantasy is thus constantly influencing and altering the perception and interpretation of reality, whilst reality also impinges on unconscious phantasy (Segal, 1964). The outside world is perceived and related to through the screen of the individual's drives and phantasies, which may alter the impact of external reality considerably (Frosh, 1987). Phantasy can also be regarded as a mechanism of defence against external reality, thereby fulfilling instinctual drives regardless of reality as well as acting as a defence against the internal world (Segal, 1964).

The early ego is largely unorganised and right from the beginning can be seen as having tendencies towards integration and fragmentation (Klein, 1952). This is largely due to the co-existence of the life and death instinct which are in conflict with one another. Thus the earliest anxiety to which the ego is exposed is the fear of annihilation.

The ego is argued to have a number of defence mechanisms at its disposal in order to protect itself from the anxiety caused through the fear of annihilation (Segal, 1964). The main anxiety in the paranoid-schizoid position is persecutory. The ego is exposed to the impact of external reality from the beginning. According to Klein, the death instinct is converted into aggression, which is then projected (Segal, 1964).

Klein argues that the ego splits itself and projects the part that contains the death instinct outwards onto the external object which initially is the breast (Klein, 1952). The breast can be experienced as bad and threatening and give rise to feelings of persecution.

Part of the libido can also be projected externally, hence creating an idealised object. She argues that the ego has a relationship with two objects, the breast which is split into two parts, an ideal breast and a persecutory breast (Segal, 1964). Phantasies of ideal objects are confirmed by gratifying experiences in the real world, whilst phantasies of persecution are confirmed by similar experiences in reality (Segal, 1964).

To ward off persecutory anxiety the defence mechanisms of projection, introjection, splitting and projective identification are used (Frosh, 1987).

Introjection and projection can be used in conjunction to protect the ego and the ideal object from annihilation. Introjection can be defined as the “phantasised taking in of material that lies outside” (Frosh, 1987, p121). Projection can be defined as the “phantasised insertion into the external world of impulses that originate in oneself” (Frosh, 1987, p121). Projection can be seen to lead to persecutory anxiety, in which it is feared the object will retaliate. It is also possible that the good object be projected in order to protect it from persecution by bad persecutory internal objects. Projection of the good could lead to anxiety over being depleted of all goodness (Segal, 1964).

The defence mechanism of splitting also predominates during the paranoid-schizoid position (Klein, 1952). From the beginning the child in phantasy is argued to introject the mother’s breast and constantly splits it into good and bad aspects, with aim of introjecting a good breast and projecting and annihilating a bad one. Through the defence mechanism of splitting, the object is divided into good and bad components in an attempt to protect the good from the bad (Yorke, 1967). Thus initially the breast may be split into an ideal breast which the child desires and a persecutory breast which the child fears. Through splitting the ideal object (breast) is perceived as being protected from the persecutory object (breast). The split between the ideal and the bad is increased and can result in excessive idealisation.

Through the process of projective identification impulses and parts of the self which are in phantasy are projected into the object (Segal, 1964). Klein argues that the aims of projective identification are as follows: an attempt to get rid of unwanted parts of the self or an attempt to control an object (Segal, 1964). The result of projective identification is the identification of the object with the projected part of the self (Segal, 1964).

Projective identification can involve the projection of the good parts in an attempt to avoid separation or in order to idealise the object (Segal, 1964). This may also occur when the inside is felt to be full of badness and the good parts of the self may be projected into the object for safe-keeping (Segal, 1964). This could lead to excessive idealization of the object and devaluation of the self.

Kleinians regard defense mechanisms as playing an essential role in the normal healthy development of the infant (Segal, 1964). "Projective identification is a primitive bases for empathy, splitting for discrimination" (Yorke, 1967, p137). For the normal development of the infant to occur, it is essential that good factors predominate over bad ones, internal and external situations taken into consideration. This will enable the ego to identify more closely with the ideal object, thereby developing a belief in the goodness of the object and the goodness of the self (Segal, 1964). As the ego identifies more with the good object, it is likely that there will be a decline in the fear of persecutory objects, a decrease in the use of the defence mechanisms of projection and splitting and a decline in the fear of its own aggression will enable the ego to integrate good and bad parts of the self more easily. Thus the pathway towards to depressive position has been paved. If the paranoid-schizoid position is not overcome in a normal way, this will be characterised by the predominance of bad experiences over good and is the basis of adult pathology, often of a psychotic nature (Segal, 1964).

Before any explanation of the depressive position can be given, it is important to explain Klein's notion of envy. Envy needs to be distinguished from jealousy and greed. Jealousy is based on love and occurs in the context of a triangular relationship. Envy is a two part relation whereby the subject envies the object for some possession

or quality (Klein, 1952). Greed occurs when the aim is one of possession of all the goodness of the object, regardless of the consequences. This normally results in the destruction of the object, although this is not initially the aim (Segal, 1964). For example, the infant may envy the breast as it is the source of all goodness and love and the infant wishes to be as good as the object. This can result in feelings of envy and the aim may become to spoil this object which is the source of the envious feelings. Thus envy involves spoiling of a good object as opposed to a bad object, towards which most other aggression is directed (Segal, 1964). Envy operates mainly through the defence mechanism of projection. For example, the infant may spoil the envious breast by projecting all the bad parts into it.

If envy is very intense it can interfere with the process as splitting. The infant will be unable to split the good from the bad, as the good has been spoiled. Introjection of an ideal object is also severely impaired and on the whole the development of the ego is hampered (Segal, 1964).

Envy can also be dealt with through idealisation, although in the long run this just intensifies the envy. It can also be coped with through the splitting off of the painful aspect. None of these mechanisms is wholly effective (Yorke, 1967).

The depressive position follows a successful negotiation of the paranoid-schizoid position (Klein, 1952). As a result there can be a decrease in the use of the defence mechanisms of splitting and projection and the drive towards integration is seen to predominate (Segal, 1964). It is a time of development when the infant recognises the whole object and relates him/herself to the whole object. The infant thus becomes increasingly aware of the mother as a person, possessing both the sources of goodness and badness which is no longer split off. As the infant is increasingly able to integrate objects so his/her ego begins to integrate as well (Segal, 1964).

The mother is now seen as possessing good and bad aspects as well as being the person towards whom all the infant's love and hate is directed. This requires that the infant come to terms with the conflicts of his/her own ambivalence. The main anxiety of this position is depressive anxiety i.e. the child fears that his/her destructiveness

may have damaged or destroyed the object of his/her love and dependence (Yorke, 1967).

During the depressive position, the infant feels an increasing need to introject the good object and to protect it from its own destructiveness. There is a fear that the infant's destructiveness will destroy the good internal and external object (Segal, 1964). As the good object is the core of the ego's internal world, there is also a fear that the infant's own destructiveness will destroy the whole of the infant's internal world (Segal, 1964). As a result the infant will be exposed to new feelings of "mourning and pining for the good object felt as lost and destroyed and guilt, a characteristic depressive experience developed through a sense that the infant has lost the good object through its own destructiveness" (Segal, 1964, p57).

The infant feels that it has destroyed the mother it loves and that she is no longer available in the external world. The infant also feels that he/she has destroyed the mother as an internal object which is now felt to be in bits. Loss and feelings of hopelessness characterise the early phase of the depressive position (Yorke, 1967).

The experience of depression encourages the infant to try and repair the damage he/she has done to his/her internal and external objects. Thus the infant develops a belief in its ability to restore the object through its love and care. The depressive conflict revolves around the infant's destructiveness and its wishes to express love and reparative impulses (Segal, 1964). A successful working through of the depressive position is likely to result in the infant becoming more aware of him/herself and his/her objects as being separate from him/herself, of his/her impulses and phantasies and is more likely to be able to distinguish between phantasy and reality (Segal, 1964). Conflicts relating to this phase are likely to be neurotic in nature (Segal, 1964).

Kleinian notions of projection, splitting, projective identification, envy and greed and the experience of the infant as a part-object have been used by psychodynamic theorists in an attempt to explain MSP and will be explored later on in this chapter (Bools, 1996; Polledri, 1996; Schreier & Libow, 1993; Schreier, 1997, 2000; Weldon, 1988).

Winnicott

Winnicott (1965, 1986, 1990) argues that the development of the self is based on relational experiences with specific maternal provision. This is central to the understanding of the psychopathology present in a perpetrator of MSP, particularly the notion that the behaviour represents a re-enactment of an early parent-child relationship (Bools, 1996; Polledri, 1996; Yorker & Kahan, 1990). Furthermore, Winnicott's notion of transitional phenomena and play have also contributed to theorists understanding of how the perpetrator treats the child-victim in MSP (Jureidini, 1999; Schreier & Libow, 1993; Weldon, 1988).

Winnicott places Object Relations Theory firmly within the relational/structural model (Greenberg & Mitchell, 1983). The focus is on the mother-child unit and there is no such thing as a baby alone, only a 'nursing couple' (Greenberg & Mitchell, 1983). Winnicott thus stresses the importance of the emotional interaction between the mother and infant in the development of the self (Winnicott, 1986, 1990). He can be seen as establishing Object Relations Theory on a footing that is autonomous and separate from instinctual processes (Greenberg & Mitchell, 1983). Winnicott firmly established the move from classical drive theory where object relations are regarded as being derivatives of the "vehicles for drive gratification and defence" to an approach where the earliest object relations are regarded as consisting of interactions between the developmental needs of the child and the maternal provisions offered by the mother, this being an entirely separate process from drive gratification (Greenberg & Mitchell, 1983, p200). Winnicott's major contribution is located in his exploration of the conditions which make it possible for the child to become aware of his/her separateness from others (Winnicott, 1990).

The infant's shift from infantile dependence to independence is based on the mother providing 'good enough mothering' (Winnicott, 1986). The mother is seen as providing a holding environment for the infant who starts life in a state of unintegration. Winnicott (1986) described the devotion of the mother to the child as the primary maternal preoccupation. He argues that the mother brings external reality to the infant. According to Winnicott (1986, 1990) the infant initially feels omnipotent and believes that he/she creates the breast that feeds him/her, thus the

infant hallucinates the breast that feeds him/her (Greenberg & Mitchell, 1983). It is important that the mother resonates with the baby's functions and needs and this in turn is seen as enabling the baby to become attuned to his/her own bodily functions and is regarded as being the basis for the slowly evolving self. If the mother initially fails to respond empathically to the baby's needs this undercuts the baby's sense of hallucinatory omnipotence and can affect the person's belief in his/her own creativity (Greenberg & Mitchell, 1983).

Once hallucinatory omnipotence has been firmly established, it is time for the infant to learn about external reality and the world that is outside of his/her control as well as to experience the limits on his/her powers (Winnicott, 1990). This occurs through the mother's failure little by little to shape the world according to the infant's demands. This process is seen as beginning the push towards separation and allowing for increasing differentiation in terms of the child's relationship with the mother (Greenberg & Mitchell, 1983).

According to Winnicott (1990) maternal failure occurs when the mother does not actualise the hallucinatory creations and needs of her infant when he/she is in an excited state and also when she interferes with the infant's state of unintegration when he/she is in a quiescent state (Greenberg & Mitchell, 1983). This is seen as resulting in a split of the self into the true self and the false self (Winnicott, 1990). The true self which is the source of spontaneous needs and gestures goes into hiding and becomes detached from the self and the false self, which gives an illusion of personal existence develops on a compliant basis and is based on maternal expectations and claims (Winnicott, 1986, 1990). Through the development of the false self the child becomes the mother's expectation of him/her. The false self also comes into being in an attempt to take over some of the care-taking functions which the environment has failed to provide (Greenberg & Mitchell, 1983).

Transitional objects/phenomena are used in the development of the infant from a state of hallucinatory omnipotence to the recognition of objective reality (Winnicott, 1990). Transitional objects, for example a piece of blanket, are created by the infant and supplied by the external world (Winnicott, 1965). The emergence of the individual involves a movement from a state of hallucinatory omnipotence where the infant,

through the facilitation of the mother, feels that he/she controls and creates his/her world, to a state of objective perception, where the infant becomes aware of the limits on his/her powers and develops an awareness of the independent existence of others (Greenberg & Mitchell, 1983). The relationship with transitional phenomena can be seen as facilitating this process. Transitional objects enable the child to withstand frustrations and deprivations and to deal with new situations. Transitional phenomena can be seen as standing between the world of subjective objects over which the infant has total control and the world of independent and separate others (Greenberg & Mitchell, 1983).

Winnicott's (1971) theory of play adds to our understanding of the development of the self and is utilised by Jureidini (1999) to explain the hypothesis that MSP is a form of pathological play. Winnicott's (1971) understanding of play will be explored so that it can be contrasted with Jureidini's (1999) conceptualisation of play.

Melanie Klein (1952) used play in the psychoanalysis of children and was primarily concerned with the use of play, whereas Winnicott (1971) was interested in playing itself as a concept.

According to Winnicott (1971) play can be conceptualised, as an activity on its own which is supplementary to the concept of the sublimation of the instinct. If there is too much instinctual involvement the play will stop or will become spoiled (Winnicott, 1971). According to Winnicott playing occupies a space which is neither 'inside' nor 'outside'. It occupies a potential space between the baby and the mother and this space varies according to the life experiences of the baby in relation to the mother figure. This potential holds the tension between the inner world and the outer world which lies outside this boundary. Winnicott (1971) argues that playing is made up of the following features: play is universal, play belongs to health, playing facilitates growth and health, playing leads to group relationships, playing can be a form of communication in psychotherapy and psychoanalysis has been developed as a highly specialised form of playing.

It is important to gain an understanding of where play fits in the developmental process of the individual. According to Winnicott (1971) initially the baby and the

object are merged. The baby's view of the object is subjective and the mother is oriented towards making actual what the baby wants to find. The "object is repudiated, reaccepted and perceived objectively" (Winnicott, 1971, p.47). The mother therefore alternates between "being that which the baby has the capacity to find and being herself waiting to be found" (Winnicott, 1971, p.47). This allows for the baby to experience a sense of omnipotence which is described above. A playground develops between the mother and child. This playground is argued to be a potential space between the mother and the baby or joining mother and baby. Play is exciting in that it occupies this space which is made up of components of personal psychic reality and components of external, objective reality (Winnicott, 1971). Initially the mother fits into the child's play activities but with development the mother introduces her own playing into the picture. This can be seen as paving the way for playing together in a relationship.

Preoccupation characterises the playing of the young child where the content of the play doesn't matter. Playing is characterised by a 'near withdrawal' state which cannot be easily left or intruded upon (Winnicott, 1971). Playing is not inner psychic reality it is outside the individual yet it is not external reality. In playing the child gathers objects from external reality and uses them in the service of 'some sample derived from inner reality' (Winnicott, 1971). According to Winnicott (1971) playing involves the body because it involves the manipulation of objects. If the instinctual excitement involved in playing becomes too much, the play will become threatened. This could result in a climax, a failed climax which is characterised by a sense of confusion and physical discomfort, or an alternative climax which may involve the provocation of parental anger.

Playing is exciting and precarious because it belongs to the interplay "in the child's mind of that which is subjective (near hallucination) and that which is objectively perceived (actual/shared reality)" (Winnicott, 1971, p. 52). It is through playing that the adult is allowed to be creative. There is a development from transitional phenomena to playing and from playing to shared playing to cultural experience. Playing can be seen as contributing to creative activity and the search for the self. It is through playing that the individual is able to be creative and use the whole

personality and it is only through being creative that the individual discovers the self (Winnicott, 1971).

Winnicott (1965, 1986, 1990) offers an explanation of development which is firmly rooted in the child's early object relationships. The development of a separate self is dependent on the provision of good enough mothering and is assisted by use of transitional phenomena and the healthy development of play. Thus the emergence of a healthy, creative self is dependent upon certain environmental provisions.

Winnicott's theory of development underpins many of the arguments used to explain MSP (Jureidini, 1999; Polledri, 1996; Weldon, 1988)

Mahler

Psychodynamic theorists have also used Mahler's concept of separation-individuation to explain the psychopathology present in a perpetrator of MSP, particularly the notion that the perpetrator is symbiotically involved with the child-victim (Weldon, 1988; Polledri, 1996). Mahler's perception of development is that the child begins in a state of symbiotic fusion with the mother out of which independent selfhood develops (Greenberg & Mitchell, 1983). In MSP, the theorists argue that there is a failure in the process of separation-individuation in the perpetrator's early object relations as well as in the way the perpetrator relates to the child victim (Polledri, 1996; Weldon, 1988).

Mahler's formulation of development of the self describes a movement from autism to individuation (Greenberg & Mitchell, 1983). The normal autistic phase is present in the first few weeks of life. During this phase of development the infant functions as a closed system, "autistic" and is totally removed from reality. The existence of the infant is based on the maintenance or disruption of physiological homeostasis (Greenberg & Mitchell, 1983). At the age of about three to four weeks the infant starts to show greater sensitivity to external stimulation and the stage of normal symbiosis is ushered in. It is during this stage of the development that the infant experiences the self and the mother as existing in a dual unity. There is no differentiation between the two individuals' which comprise the symbiotic unit (Greenberg & Mitchell, 1983). The infant does not see his/her needs as being met

from the outside, but as being generated by the symbiotic fusion. During this stage of development good experiences, which are pleasurable to the infant become split off from bad experiences, which are experienced as being painful to the infant (Greenberg & Mitchell, 1983). This is a stage of primary narcissism and there is no idea that the infant's needs are provided from the outside.

The phase of differentiation can be seen as heralding the process of separation-individuation. This begins at the age of about four to five months and continues until the age of approximately ten months (Greenberg & Mitchell, 1983). It is during this phase that the infant becomes aware of the difference between mother and other and this period is often characterised by stranger anxiety. During the practicing subphase, the infant begins to differentiate more and more from the mother. This is characterised by the infant learning to crawl and later to walk. During this phase of development the infant is more aware that his needs are being met from the outside. The infant still treats the mother as a home base and frequently returns to her for emotional refuelling (Greenberg & Mitchell, 1983).

It is during the rapprochement subphase which occurs in the middle of the second year of life that the infant becomes increasingly aware of his/her separateness from the mother. Mahler described this phase as being characterised by 'ambivalence' (Greenberg & Mitchell, 1983). The infant is seen as alternating between periods of intense neediness and powerful desires for separateness. "The child fears loss of the mother's love following his separation from her, on the one hand, and reengulfment in the symbiotic orbit resulting from his need for her, on the other" (Greenberg & Mitchell, 1983, p278). Mahler regards the successful resolution of the rapprochement subphase as being a central developmental requirement for the avoidance of the development of severe psychopathology. "Mahler stresses repeatedly that the mother's reaction at all subphases, and particularly during rapprochement, decisively influences the final outcome" (Greenberg & Mitchell, 1983, p279).

One of the main aims of development, which is regarded by Mahler to be an ongoing process, is the achievement of libidinal object consistency which starts in the third year of life. It is only when this process has occurred that the child can develop a stable concept of self and of the other. This is also an important step in the attainment

of individuality and enables adequate functioning in the absence of the other.

“Separation refers to the emergence from symbiotic fusion with the mother, while individuation ‘consists of those achievements marking the child’s assumption of his own individual characteristics” (Greenberg & Mitchell, 1983).

The above exploration of Klein, Winnicott and Mahler’s contribution to Object Relations Theory will serve to place the subsequent psychodynamic explanations of MSP in context.

4.2.2 Psychodynamic Explanations of MSP

Most of the authors agree that the perpetrator consciously intends to hurt the child but the motivation for the behaviour is unconscious (Bools, 1996; Feldman, 1994; Polledri, 1996; Schreier & Libow, 1993; Schreier, 1997, 2000; Sheridan, 1989; Sigal et al., 1989; Weldon, 1988; Yorker & Kahan, 1990). Many authors argue that the mother gains a sense of exhilaration and control in taking on and deceiving the medical system and in this way is able to assert her hostility (Kelly & Loader, 1996; Schreier & Libow, 1993; Schreier, 1992; Sheridan, 1989). Furthermore the child’s “illness” prevents her from facing other issues in her life, such as a dysfunctional marriage, and she is seen as seeking the maternal atmosphere of the hospital (Masterson et al., 1987).

From a review of the literature, the following psychodynamic explanations predominate:

- The behaviour is motivated by the mother’s own needs
- The behaviour represents a re-enactment of an early parent-child relationship
- The behaviour is characteristic of a perversion
- The relationship with the medical system is essential in understanding the dynamics of the syndrome
- The victim is treated like an object (Bools, 1996; Feldman, 1994; Kelly & Loader, 1996; Polledri, 1996; Schreier & Libow, 1993; Schreier, 1992, 1997, 2000; Sheridan, 1989; Sigal et al., 1989; Weldon, 1988).

Each of the above psychodynamic explanations will be explored separately.

Perpetrators Need for Nurturance

According to Sheridan (1989), the perpetrator of MSP believes that by parenting a sick child she will be able to solve personal conflicts, be socially rewarded or may, from her experience of mothering associate illness with love. The medical system is thus seen as providing a nurturing and warm environment.

Yorker and Kahan (1990) expand on this argument and state that MSP behaviour is motivated by the mother's own need for caring which has been split-off and repressed because of the anxiety these feelings engender in the mother. This explanation can be seen as drawing on Kleinian notions of splitting, whereby the 'good' and 'bad' aspects of self and other are split off in an attempt for the 'good', in this case the mother's neediness, to be protected from the 'bad' and hence from annihilation. Through "caring" for others, she projects her own needy self onto the child and has difficulty differentiating herself from the child. The relationship between mother and child is described as being symbiotic and the mother's needs for care are vicariously met through the child's illnesses (Yorker & Kahan, 1990). This explanation draws on Mahler's concept of symbiosis, whereby the infant and the mother are seen as a dual unity and the needs of the mother and the needs of the infant are regarded as being fused.

Feldman (1994) supports this argument and agrees that pervasive denial of responsibility is characteristic of MSP behaviour. In an attempt to explain the denial, Feldman (1994) relates that through deceiving health professionals the perpetrator is able to deceive herself into the belief that the attention and care she is receiving is warranted. According to Bools (1996), through the use of the defense mechanism of projective identification, the mother projects her unconscious longings for nurturance onto the child and thus the child receives the nurturance she so wants. Thus in accordance with Kleinian theory, parts of the perpetrator's self, i.e. her longing for nurturance, are projected into the child-victim. The result of the projective identification being that the child-victim identifies with the projected part of the self, namely the need for nurturance (Segal, 1964). This can be seen as enabling the

perpetrator to get rid of unwanted parts of the self i.e. her feelings of vulnerability and fragility, as well as control the child-victim (Yorke, 1967).

These explanations appear to give greater insight into the motivation for this behaviour although they do not appear to adequately explain the hostility present in this behaviour. The defense mechanisms of denial, repression and projection explain some of the motivations for this behaviour. They do not fully explain all the possible underlying unconscious motivations. The importance of the relationship with the doctor is not given adequate consideration.

Re-enactment of the Parent-Child Relationship

Sigal, Gelkopf and Meadow (1989) focus on the relationship the perpetrator develops with the doctor. They state that the patient-doctor role can be seen as an early re-enactment of the parent-child relationship where the doctor is seen as the authoritative, caring parent as well as the rejecting, punitive parent. This argument appears to be consistent with Klein's theory whereby it is assumed that in the analytic relationship, through the mechanism of transference, the analyst (doctor) comes to represent the split between the good, nurturing parent and the bad, punitive parent (Frosh, 1987; Segal, 1964). The child allows the mother to receive attention from the medical setting as well as being a receptacle of intrapsychic and/or parental conflict.

Kelly and Loader (1996) expand on this argument and state that previous explanations have focused on the psychopathology present in the perpetrator without giving enough consideration to systemic factors. Kelly and Loader (1996) see MSP in terms of a life story. They state that MSP provides the perpetrator with satisfaction for two contradictory unmet childhood needs, namely for love/affirmation and for revenge/anger. Thus through inducing/fabricating illness in their child, the perpetrator is able to receive the longed for love/affirmation from the doctor who represents a powerful parental figure. Furthermore they are also able to express their own anger/hostility towards their own parents for not meeting their needs by ensuring that the doctor's attempts to treat their child fail. MSP is described as the mother/perpetrator's attempt at self-therapy. The perpetrator is thus able to be powerful and repeats her own experience of abuse onto her child. The medical

context is seen as being an essential component in this narrative. They argue that the doctor replaces the absent husband and thus the dysfunctional family system becomes the dysfunctional medical system. This argument reiterates that MSP represents a re-enactment of an earlier parental relationship (Kelly & Loader, 1996).

Although Kelly and Loader (1996) wish to offer a more systemic understanding to MSP, they appear to offer an explanation of the psychopathology present within the perpetrator which appears similar in content to the explanation offered by Schreier and Libow (1993). The description of the behaviour as a life story is very similar to the psychodynamic understandings of this pathology which also focuses on the mother's unconscious unmet needs.

MSP as a Perversion

Schreier and Libow (1993) look at MSP in terms of understanding the dynamics that exist in the complex relationship between the mother/perpetrator and the doctor. They argue that the relationship with the doctor is paramount to the development and continuance of MSP and that the mother's need for this relationship is grounded in her own sense of early abandonment, particularly paternal abandonment.

“The mother becomes a “perfect” mother in a perverse fantasized relationship with a symbolically powerful physician, and the harm that she does to her child is but a by-product of that relationship” (Schreier & Libow, 1993, p.85).

According to Schreier and Libow (1993) MSP represents a perversion of mothering in that the mother develops a perverse, sadomasochistic, distant and ambivalent relationship with the doctor, who is seen as a powerful paternal figure, who is powerfully loved and feared. Kleinian notions of splitting of the object into ‘good’ and ‘bad’ parts, to protect the ‘good’ idealised figure from annihilation, become re-enacted in the analytic situation whereby the analyst, in Schreier and Libow's (1993) formulation, the doctor becomes both nurturing and punishing. Schreier and Libow (1993) state that a perversion does not necessarily refer to particular sexual functioning but can be understood as “a mode of mental functioning in which reality and fantasy coexist, though their distinction is blurred” (p85). Schreier (1992) argues

that a perversion relates to a “non-psychotic mode of mental function” (p422). The aim of a perversion is to try and rectify and revenge, whilst keeping out of consciousness the traumatic experiences they had as a child. Thus the perversion keeps traumatic events out of consciousness and therefore has to be compulsively repeated to keep anxiety at bay (Schreier & Libow, 1993).

According to Schreier (1992), pregnancy and the birth of a child offers vulnerable mothers the attention and caring they so crave from a powerful paternal figure. The mother is also able to express her feelings of hostility towards the powerful paternal figure, the doctor, by ensuring that he is devalued in his relentless search for a diagnosis. The doctor needs to be devalued in order for the mother to feel secure, but insofar as he unwittingly plays along, he does not provide the mother’s bereft sense of self with the protection and love she craves. The doctor serves as a source of nurturance and punishment and can be the focus for both idealization and hostility. An underlying theme is that feelings about the mother’s own parent/parenting are transferred onto doctors. It is argued that there is a re-enactment of a past trauma. The mother thus develops a sadomasochistic relationship with the doctor which can be best described in terms of a perversion (Schreier & Libow, 1993).

Schreier and Libow (1993) and Schreier (1997, 2000) offer extensive insight into one psychodynamic understanding of MSP. This approach does not allow for other psychodynamic formulations of the syndrome. For example, inadequate attention is given to the perpetrators’ early object relationships, particularly the mother-child relationship, and how this could account for the MSP behaviour in the present.

Furthermore, there is a paucity of articles focussing on male perpetrators of this behaviour which once again results in limitations in our knowledge and understandings. Makar and Squier (1990) give a case report of a male perpetrator of MSP. Their paper is descriptive in nature but no explanation is given as to the psychodynamic factors which play a role in men who perpetrate this form of child abuse.

Currently psychodynamic literature’s focus is on the pre-oedipal phase of development which is seen as being largely responsible for the development of

perverse behaviour in both men and women (Polledri, 1996; Weldon, 1998). Focus on the pre-oedipal phase of development appears to give a more comprehensive explanation of perversion of motherhood.

In order to understand perverse mothering, it may be helpful to gain an understanding of what is meant by a perversion. Traditionally psychoanalytic explanations of a perversion focused on the Oedipal phase of development. According to Freud, material that is repressed in the unconscious is predominantly of a sexual nature. Freud regarded repressed sexuality as being different from what is considered to be normal sexuality, i.e. genital and heterosexual (Segal, 1964). Repressed sexuality “is bisexual, and of a markedly perverse polymorphous kind, including sado-masochistic, oral, anal, urethral, voyeuristic, exhibitionistic impulses corresponding to what, in adult sexual activity, would be perversions” (Segal, 1964, p12). In normal adult sexuality the genital aim and instinct predominate. Freud argued that sexual instincts undergo development. Pre-genital instincts become repressed during the Oedipus Complex as genitality becomes dominant (Segal, 1964). According to Freud, the first sexual object, the breast, is abandoned and the infant becomes auto-erotic. Autoeroticism gradually progresses to narcissism, whereby the infants own body is experienced as an object. During the phallic stage of development, the parents become the objects of desire and this heralds in the Oedipus Complex (Segal, 1964). This occurs at about the age of five years. According to Freud, the boy begins to desire his mother as a sexual object as well as becoming aware of the sexual relationship that exists between his parents. His desire for his mother is seen as leading to a violent jealousy of his father which makes him hate his father and wish that he were dead. These desires are seen as conflicting with both the fear and the love that he has for his father. His fear being that his father will castrate him as a punishment for his sexual wishes (Segal, 1964). This fear of castration results in the boy repressing his sexuality towards his mother and his aggression towards his father with whom he identifies. This is seen as forming the basis of future heterosexual relationships.

According to Freud, the love the boy has for his father also has a strong sexual component. The boy may desire his father sexually and see his mother as a rival. He may want to be penetrated and possessed by his father but this would lead to

emasculatation (Segal, 1964). If this desire is not repressed, Freud argued that it could lead to the development of homosexuality in adulthood. Freud's explanation of the girl's working through of the Oedipus Complex can be regarded as being based on purely a male model of sexuality, which has at its core penis envy. It is through the development of a heterosexual relationship and ultimately the birth of a child that the woman is seen as getting the penis she so desires.

A perversion has thus been traditionally explained as any form of adult behaviour in which heterosexuality is not the preferred goal (Rycroft, 1968, cited in Weldon, 1988). The person is seen as suffering from an unresolved Oedipus complex which has castration anxiety, as it's central and main component. It has been argued that when the Oedipal male reaches adulthood he is unable to reach genital primacy with a person of the opposite sex since his mother still lies in his unconscious mind. He feels extreme anxiety about being castrated by his father and therefore denies differentiation of the sexes and creates a phallic mother. Laplanche and Pontalis (1973, cited in Weldon, 1988) see a perversion as accompanying all psychosexual behaviour which is associated with any atypical means of obtaining sexual pleasure. A perversion can be seen as relating to pre-genital expressions of sexuality where a part-object (i.e. the breast), auto-eroticism or narcissism predominates. Although this explanation may partly explain perversion in men it does not address the possibility of perversions in women.

Traditional psychoanalytic explanations are based on a purely male-model and have seen sexual perversion as always including the body/penis (Weldon, 1988). This has resulted in the erroneous conclusion that women cannot have perversions because they don't have a penis. Thus fantasies about perverse actions have not traditionally been labelled as perverse. The fact that women's bodies are completely taken over in the course of their inherent functioning by procreative drives, sometimes accompanied by perverse fantasies whose outcome materializes in their bodies, has largely been ignored (Weldon, 1988). There do not appear to be any clear conceptualisation or acknowledgement of female perversions in the literature.

According to Weldon (1988), perversions differ for men and women. For men the aim of the act is aimed at an outside part-object and for women the act is aimed

towards themselves, their bodies or against objects, which they see as their own creations, their babies. This could explain the MSP mother's behaviour towards her own baby, who is not treated as a separate being with his/her own needs, but rather as an extension of herself. This notion is consistent with both Klein's notion of part-object relations which predominate during the paranoid-schizoid position and Mahler's conceptualisation of symbiosis, which is intimately linked to an unawareness of separateness.

The perverse person is described as not having experienced a sense of her own development as a separate person with her own identity (Weldon, 1998). Thus she has not experienced herself as a whole being but as a part-object. Very early on she has felt unwanted, ignored, an important, but an unidentifiable part of her parents' lives (Weldon, 1988). It has been argued that this experience generates extreme vulnerability and insecurity and results in an intense hatred for the person who inflicted this upon them, on whom they were most dependant. This explanation focuses on the early mother-child relationship in the genesis of this disorder as opposed to Schreier and Libow's (1993) explanation which ignores this very important pre-oedipal phase of development. Thus the perpetrator's relationship with the doctor and her treatment of her infant is argued to be more rooted in the early mother-child relationship than the paternal relationship (Weldon, 1988).

Polledri (1996) utilizes Weldon's conceptualisation of a perversion of the maternal instinct to explain MSP behaviour. "These mothers have, deep in their maternal object world, an aspect of their relationship with their own mothers which involves a sense of being bad, malignant, defective, dangerous, suffocating, poisonous and rejecting, in a corrosively pernicious mix" (Polledri, 1996, p553).

Polledri (1996) argues that these early experiences become split off and encapsulated only being reactivated when the adult becomes a mother or takes on a maternal role. These mothers are argued as being psychotic at the core. The infant is experienced as a part-object, a thing, not as a separate individual. The mother projects her early experiences of mothering onto her own children. Klein's notion of projection and projective identification, in this case of the bad parts of the self into the child victim, who is seen as identifying with the projection and who is not experienced as a whole

and separate individual, can be seen as informing Polledri's (1996) conceptualisation of MSP. This split-off mother-child object relations set is activated with the birth of a child. Thus the need for a relationship with the doctor can be seen as being rooted in a sense of early abandonment.

This explanation appears to give a more comprehensive account of the nature of the projective identification. It also explains more adequately the treatment of the infant as an object. Furthermore, motivation for the relationship with the doctor is given a wider conceptualisation than being motivated by a need for a relationship with a 'paternal' figure as described by Schreier and Libow (1993). Schreier and Libow (1993) and Schreier's (1997) explanation focuses on the perverse relationship the perpetrator develops with the physician. Weldon (1988) and Polledri (1996) see the perversion as being a failure in the separation-individuation process and thus the treatment of the infant is described as perverse. Again notions from Object Relations Theory appear to form the basis of this argument, in this case Mahler's notion of separation-individuation.

Relationship with the Medical System

The medical system can also be regarded as playing an essential role in the genesis and maintenance of MSP (Jureidini, 1999; Kelly et al., 1997; Parnell et al., 1998; Schreier & Libow, 1993, 1997). The medical system is seen as exacerbating and perpetuating MSP behaviour. The medical personnel can be seen as playing an actively abusive role, albeit it unwittingly. This may be as a result of the defence mechanism of projective identification, whereby the perpetrator is able to rid him/herself of unwanted (abusive) parts, which are then projected into the doctor who is seen as identifying with these projections and behaving in an abusive manner. This formulation of the problem would need further exploration.

The doctor-patient relationship lies at the heart of all medical practice. In MSP it is this relationship which is exploited by the mother. Schreier and Libow (1993) state that there is a desire by physicians to believe the reports of the mother about her child's illness. This is further complicated by the fact that most physicians are not

equipped to spot the mother's deception and they are fully reliant on her reports to gain a full history of the illness.

Schreier and Libow (1993) state that doctors are susceptible to being taken in by the MSP perpetrators' manipulations. They state that people in the caring profession are particularly susceptible in that they are used to denying their own narcissistic needs and to identify themselves as helpers (Schreier & Libow, 1993). The MSP perpetrator can be seen as encouraging an empathic identification as well as feeding the ego of the professional. When things are not going well clinically and the doctor is left feeling incompetent, there is likely to be an increasing pressure on the doctor to find a solution and thus miss the MSP behaviour.

The more uncertain the medical situation, the more investigations the physician orders. MSP mothers are seen as being demanding and supportive of doctors and often manage to persuade doctors to pursue more tests, consultations and procedures. Given the ability of these mothers to falsify the child's symptomatology and to convince the doctors, an understanding of the psychodynamic issues present in the parent-doctor relationship could help in the detection and management of this disorder. Schreier and Libow (1993) offer a tentative explanation of certain doctors who might be susceptible to this form of manipulation. Jureidini (1999) further proposes that there may be specific characteristics of particular doctors that 'predispose' them to becoming involved in a case of MSP. This argument needs to be explored in more detail, but is beyond the scope of this dissertation.

Treatment of the Infant

According to Schreier (1992), the infant is dehumanised and turned into a fetish-like object in order for the mother to sustain a relationship with the child's doctor. The masochism is present in the message "do anything to my child, but don't leave me". The infant is treated as an object rather than a person and the mother is argued as failing to differentiate the infant from the self.

Object Relations Theory expands on this explanation. The early infant-mother relationship is essential to understanding the kind of defence mechanisms the baby

uses at the time and which thus persist throughout the life of the individual (Greenberg & Mitchell, 1983). Motherhood is seen as offering vulnerable individuals the opportunity to satisfy their perverse attitudes through their babies, who are seen as an extension of themselves and not as separate individuals with her or his own needs and desires. Weldon (1988) uses the theories of Margaret Mahler and Donald Winnicott as well as Melanie Klein to explain perverse mothering. A perversion is seen as a disturbance of the separation-individuation process and maintenance of a symbiotic relationship between mother and child. In a perversion of mothering, the child is used as a transitional object and as such can be idealized, devalued, dehumanised, identified with and symbiotically related to (Weldon, 1988). The child can thus be seen as being a transitional object in that the child is created by the mother whilst at the same time remaining a part of the external world (Winnicott, 1990). The child can thus be seen as standing between the world of subjective objects and the world of independent and separate others. This is similar to Schreier and Libow's (1993) conceptualisation of the infant as a fetishistic object. It differs in that the child is not seen as a fetish, which usually has sexual implications and can therefore restrict our understanding of this behaviour.

These women treat their babies as part-objects, as extensions of themselves. Such mothers try and conquer their own childhood traumas through exploiting their own babies and in such way try and convert "childhood trauma into adult triumph" (Stoller, 1974, cited in Weldon, 1988 p74).

MSP has been explained as a re-enactment of the early pre-oedipal mother-child relationship (Polledri, 1996; Weldon, 1988). The perpetrator of MSP is regarded to have experienced her relationship with her own mother as being a part-object, there to satisfy her mother's needs (Polledri, 1996). Thus the perpetrator was not related to as a whole person with her own separate needs, but rather as an extension of her mother. Object Relations theorists (Klein, Winnicott and Mahler) agree that the adult regresses to earlier traumas in times of crisis in an attempt to resolve earlier conflicts.

According to Polledri (1996) and Weldon (1988) vulnerable mothers regress to a pre-oedipal phase of development, where part-object relations predominate as well as the defence mechanisms of splitting, projection and projective identification, following the birth of a child. The child-victim thus becomes treated as a part-object. Through

the use of projective identification, the mother's own vulnerability becomes split off and projected into her child, who is regarded as an extension of the self. The child identifies with these split off projected parts and comes to represent the mother's own neediness (Polledri, 1996). The early parent-child relationship becomes reversed and the mother is able to move from a position of victim to victor. According to Weldon, (1988) this sexual acting out can be seen as a defense against fears which are related to a fear of losing a mother and thus a sense of her own identity. This argument still does not appear to explain what induces the mother to actively harm her child, because it does not appear to give a thorough account of the aggression inherent in MSP.

Conclusions

Schreier and Libow (1993), Weldon (1988) and Polledri (1996) appear to offer useful psychodynamic understandings of MSP which focus on perversion and the treatment of the infant as an object. Weldon's (1988) and Polledri's (1996) attention on the early mother-child relationship appears to offer a more comprehensive understanding of this behaviour. MSP is a complex disorder and pre-oedipal explanations can be seen as contributing to our understanding of this form of abuse. Schreier and Libow (1993) and Schreier (1997) offer an important understanding of the dynamics which exist between the perpetrator and physician.

Jureidini (1999) can be seen as expanding on some of the arguments put forward by Schreier and Libow (1993). Jureidini (1999) argues that MSP is a form of pathological play. Jureidini (1999) draws on Winnicott, Piaget and Narrative theory to develop his conceptualisation of MSP as a form of pathological play.

4.3 MSP as a form of Pathological Play

This section outlines Jureidini's (1998, 1999) notion of MSP as a form of pathological play. This will be done by focusing on Jureidini's notion of a 'perversion' followed by an explanation of the theory of pathological play which includes: the relationship between play and reality, the mental experience of play and the relationship between the player and the objects of play.

Jureidini (1998, 1999) expands on Schreier and Libow's (1993) conceptualisation of the psychopathology present in a perpetrator of MSP and offers a narrative explanation of the disorder which sees the syndrome as a form of pathological play. According to Jureidini (1998, 1999) play becomes pathological when something goes wrong with play. MSP is argued to be pathological in the sense of which the play causes damage.

Jureidini (1998) describes peek-a-boo as a form of play that might contribute to our understanding of and theorising about MSP. Peek-a-boo is a non-verbal game which is highly exciting and is underpinned by a fearful phantasy which is not articulated, but which can be seen as being related to loss, death or separation (Jureidini, 1998). The game is dominated by the disappearance and reappearance of an object.

Initially the mother needs to modulate the amount of separation experience in the game to make it pleasurable for the child without overwhelming the child with anxiety. The relationship between the parent and the child in the game of peek-a-boo can be seen as promoting cognitive development, affective attachment and the management of anxiety (Jureidini, 1998). In active peek-a-boo the child is able to control both the dose of separation and the timing and the nature of the experience. Jureidini (1998) uses the concepts developed from an analysis of the game of peek-a-boo to comment on a mother who repeatedly asphyxiated her infants to the point of unconsciousness, almost to the point of death, before resuscitating them. The baby is rendered a plaything and ruthlessly commandeered in the enactment of a phantasy. The child is seen as a focus of attack and or as a sick child needing care. The actual needs of the child are not accounted for.

Perversion

Jureidini's (1998,1999) conceptualisation of MSP as a form of pathological play needs to be understood in terms of the relationship between a perversion and pathological play. MSP is described as a perversion in the mother which can be understood as the mother engaging in a form of pathological play. The mother enters into the state of mind characteristic of a perversion, which enables the "infant to be

treated as a plaything and ruthlessly commandeered to the enactment of a narrative, often with the unwitting participation of family and medical professionals” (Jureidini, 1998). Traditional psychoanalytic explanations of perversion describe all perversions as having a sexual component. Jureidini (1998, 1999) disagrees with this conceptualisation and argues that any behaviour that disavows the real needs of self/other can be described as perverse. Through the use of disavowal, the real needs of the infant are avoided and the mitigating function of the individual’s total belief system fails, allowing the perpetrator to hurt her child without apparent concern. Jureidini’s (1998) conceptualisation of a perversion as being pathological in the way it avoids reality is consistent with Schreier and Libow’s (1993) explanation.

Schreier and Libow (1993) see the perversion in MSP as existing in the relationship the perpetrator has with the doctor, whereas Jureidini (1998) sees all perversions as a form of pathological play. Pathological play is regarded as psychopathology in its own right.

In order to understand Jureidini’s (1999) notion of MSP as a form of pathological play it is important to explain his conceptualisation of play.

Play

Jureidini (1999) claims that pathological play is a specific kind of psychopathology that can help professionals understand MSP. In order to understand pathological play it is essential to explore the constructs, which constitute healthy play.

To explain pathological play Jureidini (1999) draws on Piaget’s constructionist and Winnicott’s psychoanalytic conceptualisations of play.

Jureidini (1999) argues that the following qualities constitute play: the relationship between play and reality, the subjective experience of the player and the way in which the player treats the object of his/her play. According to Jureidini (1999) distortions in these three qualities of play can manifest in psychopathology.

Relationship between Play and Reality

Piaget's views about the development of play with particular reference to the concepts of symbolisation, pretence and narrative, inform Jureidini's (1999) conceptualisation of play.

Piaget's constructs of assimilation and accommodation are used to understand the relationship between play and reality (Jureidini, 1998). In accommodation there is a modification of internal schemes to fit experience. In an infant's first encounter with an object the task is to accommodate to the new phenomenon. Once this has been achieved then play can commence and the infant can gain pleasure in the mastery and feelings of power associated with play (Jureidini, 1998). In assimilation there is an attempt to make sense of the environment by making things fit into existing structures. In order to assimilate something it must be recognised as being appropriate to some pre-existing scheme. According to Piaget play is represented by the domination of assimilation over accommodation. "The tendency to override the real properties of the object to fit into an existing pattern of thought dominates the capacity to modify patterns of thought to take account of those real properties" (Jureidini, 1998).

Once the infant/child has 'accommodated' to the new phenomenon, the interaction with the object can become playful. The activity is no longer an effort to learn and play becomes associated with the exercise of mastery and is associated with feelings of power. In healthy play a healthy attitude to reality predominates which is characterized by an awareness that play is unreal and by an ability to accommodate itself readily to the salient features of reality (Jureidini, 1998). A pathological attitude to reality characteristic of a perversion transgresses reality in a way that avoids and disavows the truth. Through the process of disavowal the playing child is able to allow things to be other than what they seem (Jureidini, 1999).

According to Jureidini (1999) our total belief state determines our behavioural responses which are seen to follow from a given subset of beliefs. In MSP the ability of the perpetrator to carry out damaging acts could be argued as resulting from a

failure in the 'mitigating' function of the total belief state. For example, the belief that it would be satisfying to have a sick child would usually be mitigated against by beliefs that the child's welfare is of primary importance (Jureidini, 1999). Through the process of disavowal, i.e. "not letting reality stand in the way of a good story", the mitigating function of the total belief state is blocked. Disavowal can be understood in terms of the tension, which exists between accommodation to, and assimilation of reality (Jureidini, 1998). Jureidini (1999) argues that Winnicott's conceptualisation of transitional space offers a play space where this tension can be resolved.

Psychoanalytic conceptualisations of play, where play is seen as a product of the inner world of the player and the objects that the player finds to play with, forms part of the basis for this approach. Jureidini (1998, 1999) expands on Winnicott's notion of transitional space to develop his theory of pathological play.

According to Winnicott the tension between internal and external reality is not resolved by complete dominance of one over the other, but with a preservation of an intermediate space, which is neither inner experience nor outer objective reality, but transitional between them. Through play the child's understanding of internal experience and external reality is enhanced and healthy play is strongly influenced by reality. In play, the child can be seen as using objects (toys/others) from external reality to fulfil some sample derived from inner reality.

Pathological use of this transitional space through the use of disavowal can be seen as blocking the mitigation function of the total belief state of the individual thus enabling the perpetrator to act without apparent concern for her child (Jureidini, 1999). MSP "transgresses reality in a way that disavows its real destructiveness and facilitates reality avoidance" (Jureidini, 1999). This enables the mother to 'harm' her child without displaying concern about her behaviour.

Mental Experience of Play

Both healthy and pathological play are characterised by "preoccupation and excitement and by the active control of what may have been a passive experience"(Jureidini, 1999). Play is characterised by high levels of arousal. The

excitement associated with play might arise out of the nature of the playful acts themselves and not be related to sexual arousal (Jureidini, 1999).

If the instinctual arousal is too high, the play itself may stop, the play may end in climax, or there may be a failed climax resulting in mental confusion and physical discomfort, or an alternative climax such as parental provocation may occur (Winnicott, 1971). In pathological play, high levels of arousal do not stop play but are likely to result in repetitive/compulsive play and the excitement of the play may be pursued in an attempt to distract the player from painful memories or experiences. Thus through harming her child, the perpetrator is able to avoid painful memories and experiences and will thus be compelled to repetitively engage in this behaviour.

This fits in with Winnicott's (1971) notion of one of the functions of play which is to master anxiety or ideas and impulses that result in anxiety. According to Winnicott (1971) if the anxiety is too great then the play becomes repetitive, compulsive, dominated by pleasure seeking or may result in pure exploitation of sensual gratification. Pathological play is therefore rigid, repetitive, less amenable to intrusion and not easily ended by the player.

Relationship between the Player and the Objects of Play

Jureidini (1999) utilizes the notion of symbolism to explore the relationship between the perpetrator and the victim in MSP. The child's objects of play are described as symbolic in that it contains significant hidden or underlying meaning.

In MSP the child is a psychological symbol who has hidden meaning for the mother. "The baby is a prop in the production and execution of the Munchausen By Proxy Syndrome narrative" (Jureidini, 1998, p.150). According to Jureidini (1999), the child is a prop, not a fetishistic object which is an inanimate object used for sexual gratification. The child is thus a plaything used in a game which is played in the medical arena with doctors who unwittingly contribute to the MSP behaviour because of a desire to solve an 'unsolvable' illness or from their own motivations. The medical setting provides the ideal setting for the enactment of the narrative (Jureidini, 1999). According to Jureidini (1999) the perpetrator of MSP disavows the essential

qualities of her infant and treats her infant ruthlessly. Jureidini (1999) draws on Winnicott's account of ruthlessness in play in which the needs of the other are not taken into account. The infant/child itself has no meaning. The child stands for a sick child and the meaning is seen as coming from the narrative that is created around the baby by the perpetrator and is influenced by the psychological symbolism of that baby for the mother. Healthy play allows for the representation of hidden meaning to be communicated and therefore be available for psychotherapeutic work. In pathological play, the symbolic aspect is not communicated and the play becomes repetitive, rigid and the child is used as a pathological symbol with underlying meaning.

The symbolic meaning of the play is seen as coming from the play narrative and from the hidden meaning to the player of the playthings. The development of a narrative is based on elements of early experience influencing later behaviour making a contribution to an organizing phantasy that might shape a perversion. Jureidini (1999) mentions the importance of early attachments in determining the nature and content of the narrative. Difficulties in attachment might result in the person seeking out aversive experiences in that these experiences correspond to their only kind of being with the others that the individual believes is desirable or attainable (Jureidini, 1999). It seems that Jureidini (1999) could have expanded on this notion. Early object-relations could contribute to our understanding of the psychopathology present in the perpetrator by highlighting the importance of early attachments and the subsequent development of a perversion of mothering.

Jureidini (1999) argues that through play the child gains an awareness of the independent existence of others (Jureidini, 1999). Play can be seen as running parallel to the process of separation-individuation (Winnicott, 1971). Play moves through solitary play to social play to cultural interest (Winnicott, 1971). Successful completion of the developmental progression of play/separation-individuation is largely dependent on the early mother-child relationship. In MSP this process is flawed and the awareness of the needs of others is denied.

In conclusion, the key elements of pathological play include:

- Cruelty and ruthlessness

- A pathological relationship to reality
- Disavowal and narrow-mindedness
- A pathological narrative
- A system in which a perversion occurs, particularly MSP.

Jureidini's (1999) notion of MSP as a form of pathological play will be critically evaluated following the presentation of the case material in chapter six.

4.4 Conclusions

This chapter has provided an overview of some of the theoretical explanations of the psychopathology present in a perpetrator of MSP. Most of the formulations rely on psychodynamic principals to explain MSP (Jureidini, 1999; Schreier & Libow, 1993, Polledri, 1996; Weldon, 1988). An overview of the theories of Klein, Winnicott and Mahler places these explanations of MSP in context. Jureidini's (1999) theory of pathological play was presented in detail. One of the aims of this dissertation is to critically evaluate this theory of MSP as a form of pathological play through the lens of previous research and the presentation of cases. Given the complex nature of MSP an ongoing evaluation of the psychodynamic factors involved in conceptualising MSP behaviour could help with the understanding of this disorder. The above explanations give some insight into the motivating factors underlying this behaviour.

The management of MSP is largely based on professionals' understanding of the psychopathology present in the perpetrator of this abuse. Psychopathological issues provide insight and guidelines into the interventions needed both for the perpetrator and the child/victim. The success of any therapeutic process is dependent on the extent of the existing psychopathology. Intervention strategies will be critically evaluated.

5. MANAGEMENT OF MSP

In the management of MSP the child's safety is of paramount importance. From a review of the literature most authors agree that as soon as MSP is identified, the child must be immediately separated from the perpetrator (Jones et al., 2000; Lyons-Ruth et al., 1991; Meadow, 1985). Intervention should begin with a thorough and comprehensive risk assessment.

5.1 Risk Assessment

Once a case of MSP has been identified, the child must immediately be referred to a child protection agency. In the United Kingdom a Child Protection Conference will draw together the professional network to evaluate the risk of further harm to the child and formulate a plan to reduce this risk to an absolute minimum (Jones et al., 2000). Immediate removal of the child from the perpetrator is vital and the absence of signs and symptoms on separation of the child from the perpetrator should inform the risk assessment and the management of MSP (Jones, et al., 2000; Lyons-Ruth et al., 1991; Meadow, 1985). The absence of signs or symptoms on separation is often an indication that illness induction may be the cause of the child's symptoms. It is often difficult to elicit a response from the protective services management in a case of MSP resulting in the child not always being removed from the perpetrator (Lyons-Ruth et al., 1991). There appears to be a resistance from many professionals to acknowledge MSP which results in many cases going undetected. This is reflected in the legal system's resistance to prosecute in cases of MSP (Jones et al., 2000). Resistance and lack of knowledge about the disorder by professionals can result in disastrous consequences for the victim of this disorder.

A thorough risk assessment that considers the current risk factors and long-term prognostic indicators needs to be completed (Jones, et al., 2000). The initial focus of all risk assessments should be based on the appropriateness of the child's placement within the family home. Thus the possibility of the child being re-united with his/her family must be thoroughly assessed.

The child can be regarded as being at greater risk when (Meadow, 1985):

1. The abuse is severe
2. The child is younger than five years old
3. Where there is a history of unexplained sibling deaths
4. Where the mother/perpetrator has a negative attitude towards receiving help
5. Where the perpetrator has Munchausen Syndrome
6. Where there is substance abuse
7. Where there is persistence on fabrication even after the perpetrator has been confronted.

Bearing these risk factors in mind, a review of the literature revealed that a thorough risk assessment would need to include the following:

1. An assessment of the nature of the abuse. This would include an assessment of other forms of child maltreatment (Jones et al., 2000).
2. A multi-disciplinary approach to the medical, psychological and legal issues involved. Some authors recommend an in-patient admission to allow for a multi-disciplinary assessment (Masterson et al., 1988).
3. An assessment of the child's behaviour whilst separate from the perpetrator. Such an assessment would give greater insight into the mental health and physical needs of the child (Meadow, 1985; Parnell & Day, 1998).
4. A thorough assessment of the child's psychosocial adaptation (Masterson et al., 1988).
5. Assessment of the level of parental acknowledgement. It is essential that the perpetrator is able to acknowledge the harm done, take responsibility and have a genuine appreciation of the child's experience of the abuse and their accompanying parenting problems. If there is pervasive denial, this in itself is prohibitive of embarking on any treatment plan. Where there is a denial of the behaviour, the likelihood that the abuse will re-occur is extremely high. Jones et al. (2000), state that depending on whether the symptoms were fabricated or induced may have different implications for re-unification. In cases of fabrication the extent of the possible harm being done to the child must be thoroughly assessed. Access to all school, medical, psychiatric and social records relating to the case is essential and must be comprehensively reviewed.

6. Assessment of the level of parental response to improved illness management and the potential for co-operation in treatment and social case-work (Jones et al., 2000).
7. A comprehensive assessment of the parent-child relationship must be undertaken with a focus on attachment issues. All family relationships need to be thoroughly assessed, with the focus on improving parental sensitivity and competency. It is essential to assess the problems in the parent-child relationship to establish whether attempts at intervention would be successful.
8. Examination of the availability of support structures which might be supportive in case management and risk reduction (Jones et al., 2000).
9. Exploration of whether a focus for psychological work emerges and is feasible.

Following such an assessment a recommendation can be made regarding the appropriateness of the child's placement in the family home. The future safety of the child must inform all decisions and recommendations. Successful outcome for treatment is defined in terms of securing a safe and stable upbringing for the child (Jones et al., 2000). If the child is to be returned to the parents there needs to be long-term planning approach which aims at maintaining a healthy relationship as well as assessing any relapse in behaviour (Jones et al., 2000).

An in-patient assessment allows the family to be assessed and treated across a whole range of daily activities. It allows for opportunities for intervention to occur in an informal setting and can therefore be regarded as therapeutically beneficial (Jones et al., 2000). This process although comprehensive is a largely costly procedure and the family's behaviour in an in-patient setting can be seen as being different to that in their own natural environment.

If the risk is assessed as being too great then substitute care needs to be arranged, whilst at the same time evaluating the risk to current and future siblings (Jones et al., 2000).

Following a risk assessment it is essential to assess the likelihood of successful intervention. In the process of doing this it is important to develop a time-scale for

change sensitive to the age and needs of the individual child. It is essential that an assessment for psychotherapy be conducted to assess the appropriateness of this form of intervention.

5.2 Assessment for Psychotherapy

Limited literature is available on the therapeutic work with perpetrators of MSP. This is largely due to the unwillingness of perpetrators to engage in therapeutic work. Long-term work with these patients is usually court-ordered or results from the perpetrator going through an acute psychiatric crisis (Schreier & Libow, 1993).

For any therapeutic intervention to be successful, it is essential that the perpetrator show a willingness to acknowledge his/her behaviour and to express a desire to engage in psychotherapeutic work. The success of the therapeutic intervention is based on the motivation of the perpetrator. He or she needs to be of at least average intelligence and not beset by familial or social problems (Nicol et al., 1985).

MSP is often characterized by a lack of motivation to understand behaviour and by a strong use of the defense mechanism of denial, which makes any therapeutic intervention tenuous (Schreier & Libow, 1993). Where there is total denial of MSP behaviour, therapeutic intervention would not be indicated.

MSP perpetrators evoke strong countertransferential feelings in the therapists that work with them, which makes it difficult for therapists to maintain their therapeutic objectivity (Schreier & Libow, 1993). Thus the skill and the knowledge of the therapist working with the perpetrator of MSP is also a vital factor in the possible success of the intervention. To ensure therapeutic objectivity and effectiveness knowledge of the syndrome is essential as well as ongoing supervision and consultation (Schreier & Libow, 1993). In cases where the perpetrator is able to work through his/her issues, a psychoanalytically informed approach appears to be the most appropriate intervention. In instances where denial remains pervasive and the child remains at risk, it is essential that child protection issues come to the fore and the case is managed appropriately.

5.3 Psychotherapeutic Intervention

If psychotherapy is identified as being appropriate, psychoanalytically oriented approaches offer the most insight into the complex dynamics of MSP. Some authors argue that psychotherapy should include individual therapy, mother-child therapy, observation and treatment in formal and informal settings and direct work with the child (Jones et al., 2000).

There are two possible approaches to the management of MSP. First, Schreier and Libow (1993) argue that individually oriented interpretative therapy for the perpetrator, in which the motivation for her behaviour is understood in the context of severe neurotic conflicts, is the most appropriate psychotherapeutic intervention. Second, Lyons-Ruth et al (1991) argue for an approach which focuses on working with the mother and child together (Lyons-Ruth et al., 1991). They feel that this is essential in enabling the mother to be able to separate out her own needs from that of her child's (Lyons-Ruth et al., 1991). At times it might be counterproductive to conduct mother-child therapy, especially if the needs of each do not allow for a collaborative approach to be adopted.

A thorough assessment of the psychodynamic factors prevalent for both the perpetrator and the child should inform the nature of the therapeutic intervention. It is also important to consider that family therapy may be an important adjunct (Schreier & Libow, 1993).

Individual therapeutic work with the perpetrator would include: exploration of current and early feelings of neglect; exploration of how relationships with staff are a re-enactment of their earlier parental relationship; and exploration of current relationship issues and an exploration of alternative ways of expressing needs more articulately (Schreier & Libow, 1993). Some therapists argue that individual psychoanalytic approaches for the perpetrator can only take place in the structure of an inpatient setting that can offer the containing environment for "holding and evolution of conflictual states of mind" (Coombe, 1995, p.205). Attention is drawn to the perpetrator's use of projective identification and the strong countertransferential

feelings evoked in the therapist by such patients. Considerable experience and support and a personal and intellectual framework for support are essential when working with perpetrators of MSP (Coombe, 1995).

The paucity of literature on therapeutic work with MSP perpetrators affects the level of knowledge and understanding of this disorder. It is essential that research into the nature and outcome of psychotherapy in MSP continue to inform future theory and practice.

5.4 Outcome-Based Studies

Timely identification and management of this disorder is vital particularly given the results of research into the long-term effects of abuse which goes untreated. Research has shown that the abused child who does not receive any form of intervention is likely to re-abuse, will have poor outcomes for behaviour and emotional problems and is likely to experience educational difficulties (Booles et al., 1993). There is very little research on the long-term prognosis following treatment and intervention in MSP (Booles et al., 1993). The literature that is available indicates that where the outcome has been successful, the perpetrator has been able to take responsibility for her actions and has thus been amenable for psychoanalytically-oriented psychotherapy (Jones et al., 2000). Gray and Bentovim (1996), state that outcomes are successful where there is a balanced combination of therapeutic input for the mother and the family and child protection work.

Jones (1994) appears to offer one of the most comprehensive assessments of treatment outcomes after psychiatric intervention in MSP. Seventeen children from 16 families, selected for admission to the Park Hospital family unit in Oxford from 1992 to 1996, were followed up after 27 months. Thirteen of the children and their carers were interviewed. All had been severely abused and in all cases the biological mother had been the abuser. Of these 13 children, 10 were reunited with their families. On follow-up a minority of the children were suffering from mental health problems (mainly anxiety and depression). Overall the children had done well in terms of their development, growth and adjustment. "Family reunification is feasible for certain

cases, but long-term follow-up is necessary to ensure the child's safety and to identify deterioration in parent's mental health" (Jones, 1994, p 465).

Although much more research is required to look at the long-term prognostic factors, the above example shows the importance of early intervention and management of MSP. This is important for both therapeutic and preventative reasons.

The notion of MSP as a form of pathological play will now be critically evaluated with reference to two clinical case examples. Jureidini's (1999) contribution to our understanding of MSP will be explored and alternative explanations offered.

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6. CASE MATERIAL

The psychopathology present in the perpetrator of MSP will be explored through the presentation of two cases that were recognized as meeting the DSM-IV's (American Psychiatric Association, 1994) criteria for factitious disorder by proxy. The difficulties associated with recognizing the disorder will be explored. This chapter addresses objective 2, to critically evaluate Jureidini's (1999) notion of MSP as a form of pathological play through the use of clinical case material.

The case study methodology was selected to explore the psychopathology present in the perpetrators' of MSP. The reason that this methodology was selected was that it was believed a critical evaluation of Jureidini's (1999) theory of MSP as a form of pathological play could be gained through an exploration of the case material. The case material was subdivided under the following main headings: statement of the general problem, psychological attributes of the perpetrator and statement of the social position of the perpetrator. The case material was then analysed through the generation of common themes and identification of repetitive patterns. These were then systematically analysed and compared with findings cited in the literature review. Hypotheses were generated to try and explain the psychopathology present in the perpetrator of MSP. The most likely interpretations were selected in comparison with the available evidence.

6.1 Case One

Statement of General Problem

Reason for Referral

An eight-year old boy, John, was referred to a child psychiatrist to assess whether he was a victim of MSP.

Presenting Problems of the Child Victim

John was referred following an admission to a paediatric ward to investigate unexplained episodes of drowsiness and coma. This was John's fourth admission for

similar complaints. A toxicology screen showed high levels of anti depressant medication and opioids in his blood during one of the coma episodes. This episode had occurred whilst John was in the ward and his mother was in constant attendance. John's mother was found administering milk to him through a nasogastric tube, which on removal was found to be heavily laced with anti-depressant medication.

History of Presenting Problems

Developmental History of Child Victim

John appeared to have been the focus of his mother's destructive behaviour. He was born as a result of an unplanned and unexpected pregnancy. John's mother, Jane, had to remain in hospital for most of her pregnancy. While pregnant she suffered from kidney failure and required a blood transfusion for anaemia. When she was five months pregnant Jane had to have an operation for bladder and kidney problems. John was born prematurely by emergency caesarean section because of suspected heart problems. He was placed in an incubator for the first three months of his life and was visited regularly by his mother. According to Jane, although he progressed well, the paediatrician was not sure whether John would survive. Initially John was tube-fed and later breast-fed until the age of one year two months. Jane described him as a healthy baby.

Childhood History of Illnesses/Hospitalisations

From the age of one year, John had frequent admissions to hospital. At one year old he was admitted to hospital with meningococcal meningitis. He had frequent subsequent admissions for pneumonia. As a child he allegedly suffered a head injury and was concussed. Jane stated that since this episode he had suffered from headaches and that she had frequently given him medication for this.

Family History of Illnesses/Hospitalisations

Jane had to care for her ten year old epileptic son and her twelve-year old asthmatic daughter. Her son was reported to have one or two fits per week and had regularly attended the neurology clinic. Her daughter was also reported to have attended the hospital for allergic conditions. Jane reported that she had been required to administer

Relationship History of the Perpetrator

Jane described an abusive marital relationship where she had had to get a restraining order against her ex-husband. She stated that she had been divorced for the past three years. Jane explained that the chronic illnesses of her children, John's problematic behaviour and the demands placed on her by her own parents where she resided had placed her under considerable stress.

Material Status

Jane also missed her work which was in the health profession. She had given up her work of nine years in order to take care of her extended family. In the course of her work and in managing her family's medical problems, Jane expressed considerable medical interest and knowledge. She also stated that she had found the doctor she had worked for very caring and sympathetic. Jane stated that her mother was very ill and needed constant care. She explained that her father criticised her and felt she did not do enough around the home. This also appeared to be related to Jane's frequent absences from the home due to frequent clinic visits. Jane stated that she found it hard to fight against her parents.

Outcome

The child psychiatrist stated that the case did fall into the category of MSP. It was concluded that Jane was a likely perpetrator of abuse, which placed John at severe risk for physical harm and even death. Jane's personality was described as being of such a nature that she was considered capable of perpetrating severely disturbed and dangerous acts.

The case was referred to the Child Protection Services with the recommendation for legal proceedings and psychiatric observation of the mother. Jane underwent psychiatric observation. She continued the denial of her abusive behaviour. Legal proceedings were not carried out and John remained in the care of his grandparents.

Statement of the General Problem

Reason for Referral

A seven year old boy, Peter, was referred to the child psychiatrist because of severe and ongoing medical problems which were suspected to have been fabricated and induced by his father. The main problem was identified as Peter's frequent urination and wetting. After extensive investigations, it was concluded that the urination was psychogenic in origin.

Peter's father wanted to identify an intervention which would 'cure' his problems. Peter's father, Rudolph, appeared anxious and contacted the child psychiatrist on three occasions before attending the initial interview. He sent a facsimile which provided a comprehensive chronology of Peter's problems and previous interventions. The letter included a detailed description and history of Peter's urinary problems highlighting Rudolph's attempts at resolving them. This included medical consultations, behavioural interventions and psychological and educational input.

Presenting Problems of Child Victim

Peter's parents gave different perspectives and understandings of the presenting problems. Peter's mother, Mary stated that his main problems related to his poor attention and concentration, underachievement at school and poor self-esteem. Peter had been prescribed medication and his concentration had improved.

Rudolph felt that most of Peter's problems were of a medical nature and he presented a detailed list of Peter's medical problems over the years. He stated that a couple of years prior to the psychiatric consultation he had consulted an urologist who had suggested that Peter required surgery for his urinary problems. This had angered Peter's father who had sought the opinion of numerous other professionals in this regard.

The pediatrician stated that the parents needed to defocus from Peter's urinary functioning as this had exacerbated the problems and created anxiety. The pediatrician's advice appeared to be related to the vigorous behavioural programme that his parent's were adopting with Peter to control his bladder function which included timers, bladder emptying to the clock, rewards and punishment. Medication was also being used to control the problem. Peter was called upon at regular intervals to empty his bladder in the presence of his father who would measure the urine and chart it. Peter's father indicated that the pediatrician's comments had precipitated the referral to the child psychiatrist. Peter's father produced a flow chart he had constructed on how he saw and understood Peter's problems with his bladder and bowel. The child psychiatrist reported that the chart was very involved and complex in nature and had taken many aspects of Peter's behaviour into account.

History of presenting problems

Peter's urinary problem dated back to infancy when at seven, eight and nine months he had three episodes of unexplained temperature. Urinary infection was suspected and Peter was put on constant antibiotic treatment. Rudolph did most of the care taking tasks as Peter's mother was involved in part-time study and was focusing her attention on her work.

As mentioned, Peter had numerous medical investigations and treatments from the age of nine months. At the age of nine months old he was treated with antibiotics for a period of six months following three urinary tract infections. At 11 months of age the antibiotic medication was stopped and Peter received weekly urine tests for a period of six weeks. From 15 months of age the parents, particularly Peter's father, started to introduce a programme with Peter to control his bladder functions which involved timers, bladder emptying to the clock, rewards and punishment. Peter was introduced to a two hourly toilet routine which was reduced to one and half hourly when it was noticed he had wet his nappy in-between.

When Peter was two, a two-hour toilet routine was introduced. At the age of three and half years Peter was given imipramine for bedwetting for a period of five months. From the age of three years his father would measure the amount of urine he would

expel into his trousers at the time his bladder became full or before urinating. He was then subjected to urinating for 15 to 20 minute intervals until his bladder was regarded to be empty.

At four and a half years he was treated with imipramine for frequent urination and daytime wetting for a period of five months. At five years old he was prescribed medication for frequent urination and daytime wetting for a period of eight months.

A psychologist saw Peter in play therapy. The nature of this intervention was uncertain. Peter was also referred to an educational psychologist. His cognitive functioning on the date assessed placed Peter in the superior range. His difficulties were seen as being related to attention deficit hyperactivity disorder and Peter was prescribed Ritalin.

Peter was also seen by a pediatrician for constipation and was prescribed medication to restore normal bowel functioning. The pediatrician suspected that Peter may have had an over-developed muscular sphincter of his bladder neck due to withholding of his urine and that he had reflux which had resulted in some renal involvement. Peter was subjected to many tests and invasive investigations.

Peter's father had taken him to many professionals to seek advice on how to manage Peter's alleged urination problems. He had not appeared to be as concerned about Peter's attentional problems. He appeared to have been very involved in caring for Peter. A lot of time and attention had been given to Peter's performance with regard to urinating with the resultant emphasis on his bodily functions and his penis.

Developmental History of Child Victim

Peter was a planned and wanted baby. He was born two years after his parents had decided to have children. Peter's mother, Mary, was taking treatment for infertility when he was conceived. Peter's father was concerned that the baby may be born with a learning disability or a physical deformity. His mother, although excited to be pregnant, did not enjoy the pregnancy itself. She was anxious about delivery. His mother stated that she had not felt well during the last months of the pregnancy and

that he had been a very active foetus. Following a five-hour labour which terminated in foetal distress, she was induced.

She stated that she was not able to breast feed for very long as she was unable to produce enough milk. She stated that she was relieved when the paternal grandmother, who had medical training, started Peter on a supplement and it was following this that he appeared to thrive and was reported to be a happier child. Peter was described as a demanding and difficult baby. Peter's father stated that he had felt that the discontent may have related to Peter having had a wet nappy and it was at this stage that he had started to check his nappy regularly. He had normal developmental milestones, but was described as demanding, restless and wakeful. His father stated that he was a discontented and unhappy child.

Psychological Attributes of the Perpetrator

He described his personality as one of extremes. He described himself as moody, but when unable to express his emotions, particularly when he was upset. He stated that he avoided expressing his feelings in relationships. He described himself as passionate, energetic and sensitive and was close to tears for much of the interview. Peter's mother described herself as outgoing but not always as that affectionate.

Statement of the Social Position of the Perpetrator

Current Familial Composition

Peter had a younger sister of three years old. The family lived together in their own home.

Family Background of the Perpetrator

Peter's father was the second eldest son in a large family. His father was described as strict, conservative and critical and had high aspirations for his son. He had a difficult and conflictual relationship with his father and would receive regular beatings. He was able to avoid some of the beatings by using his intellect, but had to observe his

siblings being beaten. His parents had a conflictual relationship. He was closer to his mother who was in the medical profession. He described her as strong, but rather unemotional and more rational and concrete in her way of thinking.

He described his adolescence as lonely and stated that he felt depressed for much of the time. He was not allowed to go out much and felt trapped at home. He tried to fulfill his father's aspirations by taking on a career that his father had wanted to follow himself.

Relationship History of Perpetrator

Peter's parents had been married for over 10 years. They had met through a church function. Peter's mother had felt that Rudolph was a kind and affectionate man. He had been attracted to his wife's personality and good looks. Since the marriage they had both suffered from stress and had argued a lot more since the birth of the children. They had especially disagreed over the handling of Peter. They both reported that they became ill after Peter's birth. His mother became tired and felt ill and was extremely irritable. She did not have much time for Peter as she was studying at the time.

When Peter was three years old his mother recommenced fertility treatment. This had resulted in sexual tension and conflict in that she no longer wanted sexual contact with her husband.

Material Status

Peter's father, a professional man, had a chequered occupational career. He had embarked on one profession, changed direction only to return to his old profession. One profession required a relatively high level of psychological training. His mother had also been involved in part-time study for her own career advancement.

Outcome

Peter presented as an anxious child. He was initially avoidant in the interview situation. He liked to draw during the sessions, at times became anxious and appeared to have wet himself slightly.

The child psychiatrist concluded that the case fulfilled the criteria for MSP. It was decided to increase Peter's mother's involvement with him. It was also decided to take father and Peter into play therapy sessions in an attempt to get father and son to develop a different relationship which would defocus from Peter's urinary functioning. Father and son, mother and father and the family attended a number of sessions.

During the play sessions the following themes emerged: The play between father and son appeared competitive and hostile in nature, with boundaries and space for each individual being diffuse and unclear. Issues of power and control emerged, with the son at times being afraid to partake in the play for fear of maybe not being as 'good' or as 'powerful' as father. Father on the other hand was not always able to set clear limits and boundaries for his son, allowing his behaviour to become chaotic at times. Both father and son appeared anxious in the sessions.

Peter's father was encouraged to try and develop a more positive relationship with his son which defocused from his urogenital system. The case was not referred to the Child Protection Services and Peter remained in the care of his mother and father. The therapy sessions at the clinic were terminated.

6.3 Discussion of Cases

The first part of the analyses involved the comparison of findings cited in the literature review with regard to the recognition of MSP with common themes and repetitive patterns identified in the case material.

The discussion of the findings is presented as follows: Barriers to Diagnosis (Recognition of MSP) and Factors which aid with the identification of MSP (Perpetrator Features, Child-Victim Features and Family Features).

6.3.1 Barriers to diagnosis

Recognition of MSP

A diagnosis of MSP is difficult to make because a true disease may exist or may coexist with the fabricated symptoms and the cases often take a long time to unfold. In both case one and case two, the children had a long-standing history of medical complaints and illnesses and the diagnosis of MSP slowly unfolded. In John's case, his mother was caught administering medication to him, which precipitated his coma episodes. In Peter's case a pediatrician became concerned about his father's preoccupation with his urinary functioning and referred the family for a psychiatric evaluation.

Professionals often find it difficult to comprehend that a parent would behave towards their own child in this manner, again making diagnosis difficult. This could be surmised from both of the cases presented in that suspicion of the disorder took such a long time to unfold. This may further be accounted for by the fact that professionals rely on parental accounts of their child's illnesses/behaviour. In case one, John's mother had considerable medical expertise and training and as such could give compelling accounts of his illness. In case two, Peter's father had comprehensive psychological understanding and training and gave compelling and detailed descriptions of Peter's illnesses. It was only after numerous consultations with other professionals in the medical arena that these two cases were referred to a child psychiatrist.

John's case was referred to the Child Protection Services. It is clear that for the safety of the child, he would have needed to be removed from home. This did not occur and legal proceedings were not carried through. This reluctance of professionals to identify and respond to a case of MSP was highlighted in the case of John. He remained at risk of further abuse, particularly given that his siblings had a history of medical illnesses and complaints, his mother had possible Munchausen Syndrome and she continued with the denial of the abuse even after she had been confronted (Jones et al., 2000). John's mother underwent a psychiatric assessment. Her pervasive denial and lack of motivation would make therapeutic intervention with her difficult.

Peter continued to remain in the care of his parents. Peter's father was competitive with his son. He appeared to need large amounts of affirmation and control and this would preclude him gaining an awareness of the psychological and emotional needs of his son. His concern about Peter's urogenital functioning declined and other aspects of a relationship with his son were encouraged. Peter could be regarded as being at less of a risk of re-abuse than John. His father was able to work towards developing another relationship with his son, so at some level there appeared to be some awareness of his own behaviour. Furthermore his sibling was not regarded as being at risk and Peter's mother could be regarded as being a protective factor in Peter's relationship with his father.

6.3.2 Factors which Aid Identification:

Table 1 outlines the findings of the part of the analysis which refers to factors that aid with the identification of MSP.

Table 1: Factors aiding the identification of MSP

Perpetrator features	Case 1	Case 2
Actively induces illness	+	-
Seeks treatment for non-existent illnesses	+	+
Falsify history and symptoms	+	+
Refuse to accept contradictory medical evidence	+	+
Appears devoted, calm, trustworthy	+	+
Respond with denial or anger if confronted with their behaviour	+	Unclear
Disturbed marital relations	+	+
Use of denial as a defence	+	+
Projection of negative feelings	+	+
Medical experience and training	+	+
Prevalence of personality disorders	+	+
Expression of concern for the child absent in actions towards the child	+	+
Overattached to the medical system	+	+
Perpetrator has medical problems similar to the child	Problems but not similar	-
Child-Victim features	Case 1	Case 2
Biological child	+	+
Baffling unremitting illness, undiagnosable and resistant to treatment	+	+
Symptoms disappear when parent is absent	+	N/A
Health of child clashes with laboratory tests	+	+
Father is absent	+	Mother is absent
Family features	Case 1	Case 2
Emotional neglect or abandonment in childhood	+	+
Recurrent childhood illnesses in the perpetrator	+	-
Absent marital partner	+	+
Marital discord	+	+
Disturbed family relations	+	+
Family discord	+	+

Mother-Perpetrator Features

Under perpetrator features, John's mother fulfills all of the criteria identified in the literature review whilst Peter's father fulfills 11 of the 14 criteria identified in the literature review (Table 1). Schreier and Libow's (1986) classification of perpetrator

behaviour is useful in understanding the cases. In case one John's mother may be regarded as an **active inducer**, in that she actively induced episodes of coma and drowsiness by administering anti-depressant medication to him. In case two Peter's father could be regarded as being more of a **doctor addict** in that he pursued treatment for what appeared to be non-existent illnesses in his son. This often resulted in conflict with medical professionals and Peter's father often consulted many professionals for alternative opinions. In both cases the children were subjected to unnecessary medical and psychological investigations and treatments.

Both parents had medical/psychological knowledge, training and experience and appeared to be overattached to the medical system. In case one John's mother appeared to suffer from illnesses herself, which is again a perpetrator characteristic (Bools, 1996; Leonard et al., 1992; Parnel et al, 1998).

Child Features

John's mother fulfills all of the child victim features identified in the literature review and Peter's father fulfills 3 of the 5 criteria identified in the literature review (Table 1). Both John and Peter presented with a long history of a baffling and unremitting illness, which had resulted in numerous medical investigations and also at times hospitalization. Both parents appeared to be more concerned about the physical state of their children, without much apparent concern for the psychological and emotional impact of the illnesses and subsequent investigations. Again this has been found to be a common characteristic of MSP (Leonard et al, 1992; Folks, 1995; Parnell et al., 1998).

Family Features

Under family features, case 1 (John) fulfills all of the criteria identified in the literature review whilst case 2 (Peter) fulfills 5 of the 6 criteria identified in the literature review (Table 1). In both cases the parents presented with a history of emotional neglect, psychological abandonment and abuse in their childhood, which is common in MSP (Bools, 1996; Parnel et al., 1998; Schreier, 1997, 2000; Yorker et al., 1990). John's mother described her father as having been physically abusive and

critical. Her mother appeared to be emotionally unavailable to her and in need of care herself. Peter's father had a similar experience in that his father had very high expectations of him. He was exposed to episodes of violence in his home, which he managed to escape through the use of his intellect. His mother also appeared to be emotionally unavailable to him and not able to protect him from his father.

In both cases the marital partner was absent. John's mother had been abused by her ex-husband and was divorced. Peter's father had to take on the main role of caretaker, as his wife was involved in her own studies. There was also a history of marital discord. This is a common characteristic in MSP.

In case one John's mother had a history of recurrent childhood illnesses, for example epilepsy. A familial pattern of illness presentation was also common with her mother suffering from a severe and debilitating illness. Furthermore, a pattern of disturbed familial relationships could be identified in case one, with John's mother stating that she was conflicted about being with her parents and caring for them, but being unable to express her distress or to leave the family home. Furthermore, the conflictual relationship with her father had left her without support in the familial home. The above difficulties have been identified as common patterns in MSP (Bools, 1996; Folks, 1995; Parnel et al., 1998, Yorker et al., 1990).

Both parents present with characteristics which have been found to be common in perpetrators of MSP. It is important to try and understand these characteristics by exploring the psychopathology present in the perpetrator of MSP.

6.3.3 Themes

The second part of the analyses involved the identification of themes and repetitive patterns across the two cases which were systematically analysed and compared with findings cited in the literature review, particularly Jureidini's (1999) notion of pathological play. Hypotheses were generated to explain the psychopathology present in the perpetrator of MSP and the most likely interpretations were identified in comparison with the literature. The results of the analyses are presented in Table 2.

Table 2: Themes identified across the two cases

Treatment of Child Victim			Perpetrators' Family Background			Personality			Relationship History			Relationship with Medical System		
Themes	C 1	C 2	Themes	C 1	C 2	Themes	C 1	C 2	Themes	C 1	C 2	Themes	C 1	C 2
Lack of concern about the psychological and physical sequelae of their behaviour	+	+	Critical and absent father	+	+	Inadequacy	+	+	Absent marital partner	+	+	Baffling, unremitting illness, undiagnosable and resistant to treatment	+	+
Diffuse boundaries	+	+	Abusive relationship with father	+	+	Low self-esteem	+	+	Abuse Present	+	-	Involvement of numerous professionals in the medical system	+	+
Lack of awareness of separate needs of the child	+	+	Absent mother	+	+	Inability to express emotions	+	+	Inadequate	+	+	Conflict with medical professionals regarding the management of the child's illnesses	+	+
			Need to take on caretaking tasks of other family members	+	+	Use of denial	+	+				Medical training and experience	+	+
			Isolated and lonely adolescence/ childhood/ adulthood	+	+	Wish to be cared for by others	+	+						
						Inability to express feelings in relationships	+	+						

C1= Case 1

C2= Case 2

From Table 2 it can be seen that the following themes were identified within and across the two cases:

1. **Treatment of the child victim** (Lack of concern about the psychological and physical sequelae of their behaviour; diffuse boundaries; lack of awareness of the separate needs of the child)
2. **Perpetrators family background** (Critical and absent father; abusive relationship with father; absent mother; need to take on caretaking tasks of other family members; isolated and lonely childhood and adolescence)
3. **Personality** (Inadequacy; low self-esteem; inability to express emotions; use of denial; wish to be cared for by others; inability to express feelings in relationships)
4. **Relationship history** (Absent marital partner; abuse present; inadequate)
5. **Relationship with the medical system** (Baffling and unremitting illness; undiagnosable and resistant to treatment; involvement of numerous professionals; conflict with medical professionals regarding the management of the child's illnesses; medical experience and training).

The case material will be discussed under the following two headings: treatment of the child victim and perpetrators' family background. A discussion of the themes identified under personality features, relationship history and relationship with the medical system will be included under these two main headings.

Treatment of the Child Victim

A predominant theme across the two cases was the parent's apparent lack of concern about the psychological and physical consequences of their behaviour towards their children. Both parents exposed the children to numerous intrusive and unnecessary investigations and hospitalisations. The children were presented as sick and in need of treatment. Numerous professionals became involved in an attempt to diagnose and treat non-existent illnesses.

John's mother intentionally harmed him by actively inducing episodes of coma. He appeared to have been the focus of his mother's destructive behaviour from the time

of his birth. John had a complex medical history and had suffered from numerous illnesses and had frequently been admitted to hospital. Peter's father had exposed him from the time of his birth, to numerous intrusive investigations and procedures, all relating to his urogenital system, without apparent concern about the consequences of his behaviour on his son.

Another theme that was identified was both parents' lack of awareness of the separate needs of their children. The boundaries between parent and child were diffuse. Jane displayed a lack of awareness about John's feelings. She showed no understanding of why John had allegedly threatened suicide in the past in spite of all the care she felt she had given him. Peter's father was not able to set clear limits and boundaries for his son. This was demonstrated in the play therapy sessions where boundaries and space for both Peter and Rudolph were diffuse and unclear. These dynamics were further highlighted in the parent-child relationship whereby both the children were perceived as being ill and defective. Furthermore both the children were vulnerable from birth and allowed the perpetrators to develop a relationship with the medical system.

The whole notion that the separate needs of the child are not accounted for in MSP and that the child comes to represent a sick child who allows the perpetrator to develop a relationship with the medical system is supported by researchers of MSP and is a dominant theme in the cases presented in this dissertation (Jureidini, 1999; Polledri, 1996; Schreier & Libow, 1993; Schreier, 1992; Weldon, 1988; Yorker & Kahan, 1990).

Jureidini's (1999) notion that MSP is a form of pathological play is partially supported by the case material. The behaviour of both the parents can be seen as pathological in that the child can be seen as representing a pathological symbol with underlying meaning. John and Peter represent 'sick children' needing care. The actual needs of John and Peter are not accounted for. According to Jureidini (1999) they can be regarded as being props/playthings ruthlessly commandeered to the enactment of a narrative in a game played in the medical arena. John and Peter were treated ruthlessly without any concern being given to their physical and emotional well-being.

Through the use of disavowal which involves a failure in the mitigating function of the total belief system, the perpetrators were able to treat their children ruthlessly (Jureidini, 1999). Jureidini (1999) regards this failure of the mitigating function of the belief system as being related to the perpetrator's pathological relationship to reality. Jureidini (1999) regards this pathological relationship to reality as a pathological form of play. In healthy play a transitional space exists where the tension between internal and external reality is resolved without the dominance of the one over the other, which is neither inner experience nor outer reality, but transitional between them. In MSP Jureidini (1999) argues that there is a pathological use of this transitional space where inner reality predominates. Both parents could be argued to be treating their children in a way in which their own inner reality predominates over the objective reality of the potential harm they are causing their children. Thus the tendency to override the real properties of their children to fit into an existing thought pattern or narrative can be seen as predominating the picture. In healthy play internal experience and external reality are enhanced. In MSP there is no accommodation to external reality, there is a pathological relationship to reality.

This argument does not appear to adequately explain what causes this failure in the mitigating function of the total belief system for both Jane and Rudolph. According to Jureidini (1999) the nature of the play narrative is dependent on the perpetrator's early experiences, particularly difficulties in attachment which can be seen as influencing later behaviour. Jureidini (1999) does not expand on the nature of the experiences which inform the narrative. This could inform our understanding of the psychopathology present in the perpetrator of MSP. This will be expanded on later in the discussion.

Jureidini (1999) does not explain why there is a lack of differentiation between self and other in the perpetrator's treatment of the child. Both John and Peter's parents failed to differentiate their children from themselves and could be seen as treating their children as extensions of themselves. Schreier and Libow (1993) argue that there is a lack of differentiation between self and other and the perpetrator treats the child as a fetish-like object, not a person, in order to sustain a relationship with medical system. The notion of the child being a fetish does not appear to be

appropriate in that it has sexual connotations and traditionally a fetish has been seen as relating to inanimate objects.

The argument that the children are treated as part-objects, as things, not as separate individuals with their own needs and desires appears to more adequately account for the lack of differentiation between self and other which is present in the pre-oedipal phase of development where part-object relations predominate (Polledri, 1996).

Most theorists agree that the child is 'dehumanised' and treated like an 'object' where there is a lack of awareness of the separate needs of the child; who is used to develop a relationship with the doctor (Jureidini, 1999; Polledri, 1996; Schreier & Libow, 1993; Schreier, 1992; Weldon, 1988; Yorker & Kahan, 1990). They differ in their understanding regarding the manner in which the child is objectified. Jureidini (1999) argues that the child is a prop in a game; Schreier and Libow (1993) argue that the child is a fetish-like object and Polledri (1996) argues that the child is a part object. Furthermore, theorists appear to disagree regarding the reasons for why the child is treated like an object without his/her separate needs being accounted for (Jureidini, 1999; Polledri, 1996; Schreier & Libow, 1993; Schreier, 1992; Weldon, 1988; Yorker & Kahan, 1990). This will be expanded on in the next section which looks at the perpetrator's family background.

Family Background

Both Jane and Rudolph can be seen as vulnerable individuals. 'Motherhood' could have offered them the opportunity to satisfy their perverse attitudes through their children who are seen as extensions of themselves and not as separate individuals with their own needs. An exploration of the themes identified in their family background's will help to explain why Rudolph and Jane are likely perpetrators of MSP.

Both the perpetrators' experienced emotional neglect, abandonment and abuse in their own childhood. Paternal and maternal abandonment dominate the picture. The perpetrators experienced a relationship with their own fathers which was dominated by the themes of abuse, neglect and criticism. The maternal relationship was

dominated by the absence of the maternal figure and her apparent lack of awareness of the separate needs of either of the perpetrators. For example, Jane described her father as abusive and critical. Her mother had a long-standing history of illnesses and Jane had to take on most of the care-taking tasks in her family at the expense of her own needs. Her own need for love and nurturance was expressed in her desire to be taken care of by one of her siblings. Furthermore, her mother criticised her management of John and this intensified her feelings of anger and inadequacy. She demonstrated a difficulty in separating herself from her family's demands.

Rudolph described his father as strict, conservative, critical, abusive and with high expectations. He received regular beatings from his father and was able to avoid some of these beatings through the use of his intellect. He attempted to satisfy his father's expectations of him by embarking on one career, only to take on another. Rudolph's mother was distant and emotionally unavailable. She tended to rely on her son for support.

Jureidini (1999) sees Jane and Rudolph's behaviour towards their children as a compulsive and repetitive form of play, where the destructive behaviour/play needs to be repeated in an attempt to avoid earlier traumatic experiences and feelings which were conceived in the perpetrators' early object-relations experiences. Jureidini (1999) argues that the behaviour of Rudolph and Jane represents pathological play in that high levels of arousal do not stop the play (behaviour) but result in repetitive play. The excitement of the play is pursued to distract the player from painful memories and experiences. Thus the mental experience of play is seen as being essential in the genesis and maintenance of this disorder. The high levels of anxiety related to earlier experiences could be seen as having resulted in a repetitive and compulsive need in both of these parents to continue acting in potentially harmful and threatening ways towards their children.

This appears to be more characteristic of the nature of a perversion as opposed to being a form of pathological play. Furthermore Jureidini (1999) does not give an account of the nature of these early experiences which lead to this 'pathological form of play'.

Schreier and Libow's (1993) argument that the perpetrator's relationship with the doctor, which is essential to the development and continuance of MSP, is rooted in the perpetrator's own sense of rejection and abandonment, particularly paternal abandonment, is partially supported by the case material. As mentioned above, both the parents had a relationship with their own fathers which was dominated by abuse, criticism and a sense of inadequacy in relation to paternal expectations. Thus their behaviour could be regarded as a perversion of mothering, whereby both Rudolph and Jane developed a perverse, sadomasochistic, distant and ambivalent relationship with the medical system, a powerful paternal symbol that is both loved and feared. This is demonstrated by their dependence on the medical system, as well as their attempts to fail the medical system. Rudolph and Jane's behaviour can be regarded as a perversion in that the abusive behaviour can be seen as an attempt to rectify and revenge, whilst at the same time keeping out of consciousness the traumatic experiences they had as children (Schreier & Libow, 1993).

Schreier and Libow (1993) see the perpetrator's behaviour as being rooted in the Oedipal stage of development and as relating to a non-psychotic mode of functioning where fantasy and reality coexist. This could account for Peter's father's preoccupation with his son's urogenital system and may relate to Rudolph's own fears of castration anxiety during the Oedipal phase of development. Exposing his son to repeated intrusive investigations can be seen as a re-enactment of his relationship with his own father, where castration anxiety was a prominent feature.

Although this partially explains the treatment of the child in MSP, it does not appear to account for the extent of the disturbance which can be seen as being more rooted in pre-oedipal relationships where the relationship with the mother is paramount (Polledri, 1996; Weldon, 1988). In Jane's experience of being mothered she was not treated as a separate person with her own needs, she was treated as a part object, as an important (involved in taking care of her sick mother), unwanted yet unidentifiable part of her parent's lives. Jane was unable to experience herself as being separate from her parents' lives and her own attempts at separation had failed. Rudolph's mother did not protect him from his father's attacks and Rudolph needed to support his mother at the expense of himself. This could have resulted in feelings of inadequacy as well as an intense hatred for the people who had inflicted this on them

and on whom they were so dependent. This is consistent with Polledri's (1996) and Weldon's (1988) conceptualisation of MSP as a perversion of mothering whereby the act is aimed towards the self, their own bodies or objects which they see as their own creations, namely their babies.

In conclusion Jane and Rudolph's early experiences of mothering involved a sense of being bad and defective, yet needed. This early object relations set was reactivated when they were required to take on the maternal role (Polledri, 1996). The defense mechanisms of projection, projective identification and splitting dominate the picture. This is evidenced in both of the parents' behaviour whereby the children come to represent ill children and are presented as in need of care. The parents' own personality style is dominated by the themes of inadequacy, low self-esteem, inability to express emotions, a wish to be cared for by others and an inability to express emotions or feelings in relationships. Furthermore both marital partners were absent and they had both experienced a sense of inadequacy in their own relationships. Through the use of projection the children came to represent unwanted parts of themselves, namely their own vulnerability and neediness (Polledri, 1996). The children were initially forced to identify with these projections in that they were actively made ill or presented as sick. In Jane's case, John can be seen as complying with his mother's behaviour and thus as identifying with her projections.

These defense mechanisms characterise the paranoid schizoid phase of development where part-object relations dominate (Klein, 1952). Klein's theory is useful in understanding MSP. For normal development to occur it is important that good experiences predominate over bad experiences (Klein, 1952). This will enable the ego to identify with the ideal object and develop a belief in the goodness of the self and the goodness of the object. Jane and Rudolph's early object-relations experiences were characterised by a predominance of negative experiences. This resulted in the maintenance of the primitive defence mechanisms of splitting, projection and projective identification and their behaviour towards their children is psychotic in nature (Polledri, 1996).

The notion that MSP is a form of perversion, which involves a re-enactment of an early parent-child relationship, where inner reality dominates, is supported by most of

the theorists and by the case material presented in this dissertation (Jureidini, 1999; Polledri, 1996; Schreier & Libow, 1993; Schreier, 1992; Weldon, 1988; Yorker & Kahan, 1990). Differences relate to the depth of the disturbance, with some authors seeing MSP as a non-psychotic mode of functioning and being related to paternal relationships (Schreier & Libow, 1993) whilst others argue that MSP is related to a psychotic mode of functioning with its genesis in early pre-oedipal relations where part-object relations predominate (Polledri, 1996; Weldon, 1988). Polledri's (1996) and Weldon's (1988) conceptualisation of MSP as a perversion of mothering which has its roots in pre-oedipal relations where part-object relations dominate, appears to more adequately account for the parents treatment of their children.

6.4 Critique

Jureidini's (1999) notion of MSP as a form of pathological play makes a valuable contribution to our understanding of the reality avoidance present in the perpetrator, the repetitive nature of the behaviour and the use of the infant/child as a prop in the development of a relationship with professionals and in the satisfaction of a narrative.

According to Winnicott (1971), children play for pleasure, to express aggression, to master anxiety, to gain experience, to make social contacts, for personality integration and to communicate with people. It appears as if the whole notion of play has been extended to fit into the conceptualization of pathological play. Jureidini (1999) appears to have re-phrased theoretical concepts and understandings, which appear to be better accounted for by Object Relations Theory.

The notion that internal reality predominates without any adaptation to external reality is useful in understanding MSP. Jureidini (1999) uses Winnicott's (1971) conceptualization of play to explain the reality avoidance present in the perpetrator of MSP. According to Winnicott (1971) playing occupies a potential space, which is not inner psychic reality, it is outside the individual, but it is not the external world. This highlights the precariousness of any form of play in that it occupies the space between that which is subjectively perceived and that which is objectively perceived. In MSP inner reality predominates without any access to objective external reality and

according to Winnicott (1971) the perpetrator of MSP would not be perceived as 'playing' or as having access to his/her creativity.

According to Winnicott (1971) one of the functions of play is to allow for external objective reality to impinge on the internal psychic reality of the child. Furthermore the development of play is dependent on the nature of the early mother-child relationship. The good-enough mother is seen as being able to introduce external reality to the child in a way which parallels the development of the child from a state of absolute dependence through to independence (Winnicott, 1990). It is through play that reality impinges on the inner world of the child. It seems as if Jureidini (1999) has confused one of the functions of play, which is to introduce external reality to the child, with the nature of play itself which is described as being pathological with regards to its relationship with reality. MSP could thus be regarded as being characterized by a failure in one of the functions of play, namely the introduction of external reality to the individual. MSP would thus appear to be closer to a psychotic form of functioning rather than being related to a failure of the mitigating function of the total belief system of the individual.

Although Jureidini's (1999) theory offers a useful insight into the perpetrator's relationship with his/her child/victim and the medical system it appears to extend the notion of play as described by Winnicott (1971). Winnicott (1971) regarded the early mother-child relationship as the initial playground for the child in that it provides a potential space between the mother and baby or joining mother and baby. This early relationship is paramount in determining the nature of the child's play as well as the child's ability to play. Initially the mother is careful to fit her playing into the child's playing and with development she is later able to introduce her own play (Winnicott, 1971). Disturbance in the area of play between the mother and child could result in an inability for the individual to play together in a relationship.

The development of play can be seen as running parallel to the process of separation-individuation. The nature of the early mother-child relationship in the genesis and maintenance of MSP does not form an important part in Jureidini's (1999) theory of pathological play. This lack of emphasis on early object-relations and how these

impact on later development of object relations appears to be pervasive throughout Jureidini's (1999) explanation of pathological play.

The notion of aggression in play may be helpful in understanding MSP. The mother's responses to the child can also be seen as modulating the child's expression of aggression. "The child values finding that hate or aggressive urges can be expressed in a known environment without the return of hate and violence from the environment to the child" (Winnicott, 1971, p.149). In a good-enough setting the child will learn appropriate and acceptable means of expressing aggression which is again highly dependent on early object-relations. Although aggression can be felt as pleasurable it is usually tempered by the real/imagined hurting of someone. In healthy situations modulated through play the reality of the object predominates. In MSP there appears to have been a failure of play and hence of early object relations to provide opportunities for aggression to be appropriately and acceptably expressed.

Jane's early object-relations experiences resulted in her associating anger with violence. Her own anger was not expressed and her aggression towards her parents was acted out with the medical system. The reality of the 'abuse' towards her son did not modulate her behaviour. Peter's father was able to act out his feelings of hostility towards his own father through his son. Again early object-relations and hence early play experiences did not result in either of the perpetrator's learning appropriate and acceptable ways of expressing their hostility.

Another vital function of play is the integration of the personality. According to Winnicott (1971) playing facilitates health and growth and contributes to the development of the self. "Play can easily be seen to link the individual's relation to inner personal reality with his relation to external or shared reality" (Winnicott, 1971, p.151). To be creative in the world the individual is seen as being able to function in a place which allows for elements from both inner reality and outer reality to coincide with one another. Thus play is seen as enhancing the integration of internal and external reality and hence the personality. In MSP there appears to be a failure in this function of play and hence in the integration of the personality and the perpetrator is unable to distinguish between objective external reality and inner reality. Jureidini (1999) appears to be confusing the functions of play with actual play in adulthood.

MSP can alternatively be argued to be as a result of a failure to adequately master the functions of play.

Play is rooted in the infant's early relationship with the mother, which if good enough allows for the development of a place where there is an interplay between personal psychic reality and external objective reality. Winnicott's (1965) notion of the development of the self being based on relational experiences with specific maternal provision appears to more adequately explain MSP. MSP can be seen as being rooted in the early mother-child relationship which disallows for the contribution of healthy play to the development of the personality. Winnicott's (1990) main contribution is rooted in his exploration of the early mother-child relationship which is argued to provide the necessary conditions for the child to become aware of his or her separateness. It is the mother that brings external reality to the infant. MSP could be conceptualized as the development of a false-self, based on maternal expectations and impingements (Winnicott, 1990). The false self can be seen as taking over some of the care-taking functions that the external environment has failed to provide (Winnicott, 1990). The infant can be regarded as being a transitional object, i.e. a part of the mother's creation yet part of the external world. Thus the child could help the perpetrator to deal with frustration as well as try and get some of his/her needs met.

Play can be regarded as being integral to the development of the self and as running parallel to the process of separation-individuation. MSP could be argued as being located in the failure of the functions of play as opposed to being pathological play in and of itself.

The perpetrators' (Rudolph and Jane) early object relationships, which included a sense of being a hated, needed, yet unidentifiable part of the mother-child union, was split off and encapsulated only to be reactivated with the birth of the infant (Polledri, 1996). The perpetrator's early object-relations will determine the way in which he/she perceives him/herself and the other objects in his/her world. This focus on the early mother-child relationship emphasizes the importance of early object relationships in the genesis of MSP which can be regarded as a perversion of mothering. This corresponds with Mahler's theory of development where the infant moves from symbiotic fusion with the mother through the process of separation-

individuation. In MSP the perpetrator remains symbiotically fused with the child. Furthermore the perpetrators' experiences with their own mothers were dominated by a lack of appreciation of their own separateness.

Initially the mother and child are merged in symbiotic union. There is no such thing as a baby alone; there is always a baby in relation to a mother (Winnicott, 1971). The mother initially adapts herself to the demands of her infant. At this stage the infant may be regarded as experiencing a sense of omnipotence. Through the process of separation-individuation the infant develops a sense of his/her separateness and of the fact that his/her needs are met from the outside world. Through this process, the importance of accommodating to the reality principle is paramount. According to Winnicott (1971) the holding function of the mother will determine the internalized images the child has of him/herself and the objects in the world with whom he/she interacts.

Confidence in the mother allows for this experience of initial omnipotence and a "potential space between the mother and baby or joining mother and baby" (Winnicott, 1971, p55). The nature of this space between mother and child is dependent upon the life experiences of the child and the life experiences of the mother. In MSP it may be argued that the perpetrator perceives her infant subjectively and therefore responds and acts in a way which is determined by her own inner reality without any awareness of the objective or external reality. Whether this can be regarded as a form of play is debatable. It appears to be more akin to a failure in the separation-individuation process which in itself can be seen as facilitating an avoidance of reality.

Part object relations dominate pre-oedipal relations and the defense mechanisms of splitting, projection and projective identification predominate. This is consistent with Klein's description of the paranoid-schizoid phase of development. Through splitting the object is divided into good and bad components in an attempt to protect the good from the bad (Yorke, 1967). Splitting dominates the relationship the perpetrator develops with the doctor who is both idealized and devalued in his attempts to diagnose and treat untreatable illnesses. Projective identification dominates the perpetrator's treatment of the child victims who are initially forced to identify with

the perpetrator's projections. The children thus come to represent ill children in need of care. The argument that the perpetrator gets some of her needs met vicariously through presenting her children as sick is evidenced in the case material presented in this dissertation.

In MSP the anxiety arising from unconscious ideas or impulses can be regarded as being too overwhelming and therefore resulting in a repetitive need to engage in MSP behaviour in an attempt to master anxiety. Whether this behaviour can be related to a form of play is questionable. It is through play that the child learns to master anxiety and therefore MSP can be regarded as being rooted in the failure of one of the functions of play, i.e. to master anxiety. The behaviour is motivated by a need to avoid painful memories/ideas, probably conceived in the mother-child relationship. This is consistent with Schreier and Libow's (1993) notion of MSP as a perversion whereby the behaviour has to be repeated to keep traumatic experiences out of consciousness. The perpetrators in the cases presented had experiences in their own parental relationships which were dominated by abuse, abandonment and rejection.

Jureidini's (1999) explanation that the compulsion to play is to avoid pain fits in with other psychodynamic explanations of a perversion. The child's early object relations would affect the way in which the child and later the adult would treat the objects in his/her life. Jureidini's (1999) notion of play can be seen as placing all play in the object relation's arena. Jureidini (1999) can thus be seen as conceptualizing all relationships as a form of play.

The use of the child as a prop appears to be a good way of expressing the nature of the relationship the perpetrator develops with the professional system. Jureidini's (1999) notion does not take into account that the motivation for this relationship is grounded in the perpetrator's early parent-child experiences. The nature of this relationship highlights the perpetrator's fear of intimacy and ability to express hostility and needs for nurturance through the relationship they develop with professionals. The treatment of the child as a part-object, where the primitive defense mechanisms of projection, projective identification and splitting predominate appears to more adequately account for the perpetrator's treatment of the child (Polledri, 1996).

In MSP the perpetrator's ability to respond empathically to her infant/child is impaired. Thus it could be argued that the capacity for concern/guilt is not developed in the MSP perpetrator (Winnicott, 1986). This may account for the ruthlessness with which both the parents in the above-mentioned cases were able to treat their children. This appears to be a more appropriate explanation than Jureidini's (1999) notion of disavowal. Through this attack on her child the real needs of the infant are denied. It would also appear that the impact of her behaviour on the child is not of concern to the MSP mother. In healthy play there is a balance between ruthlessness and concern. This ability to act ruthlessly towards the child victim is rooted in the early mother child relationship where there is a lack of differentiation between self and other.

6.5 Conclusions

Jureidini's (1999) notion of MSP appears to adapt understandings of play to fit into the notion of pathological play. The child's ability to play is dependent on early object relations. Through play the child is seen as learning to master anxiety, appropriately express aggression and form social relationships. Object Relations Theory, with its emphasis on pre-oedipal relations where there is a failure in separation-individuation and part object-relations predominate, offers a more adequate explanation of MSP. MSP can be regarded as a failure in the 'functions' of play as opposed to pathological play. Early object-relations are important in the development of play, the integration of the personality and the overall process of differentiation between self and other. Jureidini's (1999) theory of pathological play does not expand on the importance of these early object relations. The work of Klein, Winnicott and Mahler more adequately explains MSP and informs current psychodynamic conceptualisations of MSP. From an analysis of the case material MSP appears to be more rooted in maternal failure. Motherhood can be seen as resulting in a regression to pre-oedipal functioning where symbiotic fusion predominates.

Primitive defence mechanisms, part-object relations, lack of differentiation and a perversion of mothering appear to more adequately account for MSP as opposed to Jureidini's (1999) theory of pathological play which adapts concepts borrowed from Object Relations Theorists.

This dissertation has gone some way in highlighting some of the psychological processes inherent in MSP. The use of 2 cases as opposed to 1 can be seen as potentially enhancing the generalisability of the findings to other cases of MSP. Future research could look into the psychopathology present in the perpetrator with reference to a larger caseload so that themes identified in one case could be generalized across cases.

The use of second-hand sources in compiling the case material used in this dissertation could be biased in that the interpretation of the material was partially based on the researcher's collation of the data and additional information may not have been identified. The use of multiple sources in the collation of the data can be seen as reducing some of the potential bias in the procedures adopted.

Furthermore our understanding of MSP could be further enhanced through the presentation of case material, which explores the psychotherapeutic assessment or intervention with a MSP perpetrator. Much more research is required into the long-term impact on a victim of MSP. Do victims of MSP abuse present with MSP behaviour in adulthood? It is essential that we gain an in-depth understanding of the long-term psychological/psychiatric sequelae of MSP abuse. This may have implications for developing treatments for MSP as well as informing strategies for the prevention of MSP.

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