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### BOOK CHAPTER

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themselves to have been the recipient of deficient mothering in their early years, as will have their own mothers before them through at least three generations. Perverse mothers use their babies as "transitional objects" or actually as fetishes to gain relief from sexual tension and anxiety. Such pathological intimacy is a special form of abuse that has far-reaching transgenerational consequences.

## CHAPTER FOUR

### Is Munchausen Syndrome by Proxy another case of female perversion?

Notwithstanding my large clinical experience of dealing with mothers who exhibit the most damaging and perverse attitudes towards their children (Welldon, 1988), I found myself in a state of disbelief and shock when I was asked to prepare a psychiatric court report on Mrs H. Such was the horror of Mrs H's actions that they left me astounded, confused, and unable to think. Mrs H was suspected of pulling and removing, from birth, her two babies' finger- and toenails. At the time of the enquiry, they were aged 21 months and 10 months. A case of Munchausen Syndrome by Proxy (MSBP) was suspected, and an assessment of her parenting abilities with the confirmation of this diagnosis and her suitability for psychotherapy was needed.<sup>1</sup>

During psychiatric assessments, mothers usually display strong emotions about the possibility of their children being taken away and try very hard to give a "good impression" of their maternal abilities. This was not the case with Mrs H, who appeared throughout all our meetings to be completely devoid of any feelings—flat in her affects, detached and dissociated. Not even when she said "the most important thing in my life are my children and I want them back with me" did she show any signs of affection.

Another unusual feature in this case was that the removal of her children's toe- and fingernails appeared to be a cold, planned revenge, showing a strong sadistic quality. In contrast, previous cases involved mothers who had become impulsive, out of control, and aggressive

during the course of their mothering duties. There were no precedents of this kind of behaviour, except in acts of torture.

Whereas at the beginning she denied harming her children, she eventually told me that not only had she done so, but that also, while harming them, she was effectively able to convince all professionals involved—GPs and paediatricians—that the children's suffering was the result of skin diseases. I consider that, in some ways, she must have felt seriously distressed about being able to deceive all the professionals, because she *knew* that those actions were extremely harmful to her children and to herself because she was getting away with it when she was in urgent need of professional help.

These actions, which could easily and vividly evoke the Medea complex, cannot be solely and simply explained as a vengeful strategy against an "uncaring" husband. I believe that her strong sense of revenge was born in early infancy and was directed, symbolically speaking, first against her own mother for abandoning her at age 4 months and later against her father for sexually abusing her from the age of 6 years. These explosive negative feelings had been enacted in a combination of neglect and abuse towards her own children from their birth, culminating in the most unthinkable sadistic behaviour.

Compulsions to enact as opposed to experience feelings are linked to early traumas where mother-baby bonding breaks down at early stages of the baby's emotional development.

Being the receptacle of much early neglect and abuse had seriously impeded her mothering function. It looked as if a challenge of disbelief had been created within her when she was confronted with the evidence of being able to produce healthy babies. She could not accept any intrinsic goodness because it would have implicitly implied a recognition that she was intact despite the injurious psychological harm inflicted by her own mother. It was then that she proceeded to inflict on her healthy babies endless suffering and serious bodily damage. When I began to regain my capacity for thought, I speculated that by taking away growing and protective structures such as nails, leaving fragile, raw skin exposed to continuous physical harm, it might be the way she experienced herself: a raw object exposed to so much suffering that she had to rigidly protect herself with detachment and strangeness to avoid experiencing her own unbearable pain. I have described female perversions as either self-abuse or child abuse, which then becomes a dual process involving mother and baby. When I first encountered MSBP, I questioned its inclusion in my definition of female perversion, since it appeared at first sight to involve three persons: mother, child,

and medical practitioner whose clinical judgement is being corrupted or perverted by the mother's persuading him (usually it is a he) that her baby's physical ill health is caused by fictitious illnesses.

For a time, I considered the possibility of including MSBP as a type of maternal perversion since the process is symbolically a dual one, as the mother is in complete identification with the image of a seriously ill baby. I even thought that despite protestations about the adequacy of the term "by proxy", it was wittingly or unwittingly the most accurate way to designate this extremely severe psychopathological syndrome. At the time of the publication of *Mother Madonna Whore* (1988), awareness of MSBP was limited, and there were some doubts in my mind as to whether this was yet another manifestation of what I had defined as perverse mothering. After years of clinical experience, I had to acknowledge the existence of feelings and activities among women that could or must be called perverse, even if the mental mechanisms are different from those found in men. In brief, in both genders the reproductive functions and the organs attached to them are those used for perversion: the man has the penis to carry out his perverse activities, the woman the whole body. In general, the hypothesis is that female perversion is very different from male perversion, because the aim is directed towards themselves, their bodies, or what they perversely regard as an extension of themselves, their babies (Welldon, 1988). This is in contrast with men, where the target for the sadistic action is directed to an outside object. The object in women is highly cathected physical and emotional attachments. This characteristic, again, is in contrast to men who do not experience emotional or physical investment.

In fact, I believe that the important differences between males and females could help us in the prediction, assessment, and management of female dangerousness. These could be used in a positive way to promote further understanding and prevention of these particular conditions.

From my clinical observations, I have identified distinctive features that differentiate MSBP and perverse mothering (Welldon, 1988). There are some common traits in the mothers' histories, but the differences in the mothers' attitudes and actions are important. The perverse mother may neglect or physically or sexually abuse her child. She is concerned and experiences anxiety, but she is secretive about her actions and scared of being caught.

Instead, cases of MSBP always require a third party (a professional), are always premeditated, cold-blooded, and show complete

detachment, and are always presented as seeking help. Another significant difference is the mother's complete denial of the harm inflicted on the child. The mother will also commit at least one of four actions: smothering, poisoning, fabrication of seizures, or fabrication of other symptoms. Perverse mothers are often young mothers with a history of eating disorders and/or self-harm. In contrast, MSBP mothers tend to be older and present with somatizing behaviours and/or a history of illness. The ways in which the babies are treated also differ: the actions of perverse mothers usually involve older babies, who may present in future with serious personality disorders. In cases of MSBP, the babies are usually much younger, and they may in future have physical illness, sometimes leading to death.

The professional attitudes are also different: in maternal perversion, the patient is usually completely isolated; her problems are met with disbelief and lack of awareness. The patient is usually amenable to treatment, if offered; the assessment of parenting abilities is relatively easy in long-term assessments. Cases of MSBP usually involve many medical staff and hospitals, with the focus placed on the baby's physical illness. The mother usually resists treatment, and assessment of parenting abilities is difficult.

Perversion of motherhood is the end product of serial abuse or chronic infantile neglect. This condition involves at least three generations in which faulty and inadequate mothering perpetuates itself in a circular motion, reproducing a cycle of abuse.

#### Note

1. Munchausen Syndrome by Proxy is also now referred to as Fabricated and Induced Illness (FI) or as Factitious Disorder by Proxy (FDP).

## CHAPTER FIVE

### Bodies across generations and cycles of abuse

This chapter explores women's specific struggles in the fulfilment of the function of mothering after having been the receptacle of much early abuse, at times going back many generations. The long-term consequences can in the first instance lead to acts of self-harm such as eating disorders, substance abuse, self-cutting, and self-burning. Later on these can be superseded by sadomasochistic relationships with violent men, whose attacks might come to represent the women's own self-hatred towards their female bodies. This perpetuates and reiterates the early abuse. Some of these women might get pregnant and have babies, and then a process of identification with the aggressor can take place in which the victims may become victimizers of their own children.

Having a baby gives a unique reassurance to some women that their bodies and their reproductive functioning are still intact. Also, having babies may be the only way for some to communicate and express their own emotional needs, which have not previously been properly addressed nor recognized in themselves. The complexities of the body-mind relationship become crystal clear in observing the female *body* responding adequately to the physical demands of the pregnancy, but there is *emotional* inability to respond adequately to the newly born or growing baby's demands.

I wonder at the paradoxical and somewhat unfair position that young girls with most deprived and abused childhoods have to face. That is, whereas they are able with their bodies to produce babies, they