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PSEUDO-BEREAVEMENT IN THE MUNCHAUSEN SYNDROME

DEAR SIR,

In their paper on Feigned Bereavement (*Journal*, July 1978, **133**, 15–19) Dr J. Snowdon *et al* describe twelve cases of a relatively common variant of the Munchausen Syndrome. Fifty per cent of my series of 12 cases of the Munchausen Syndrome described a feigned bereavement. The characteristic pseudologia phantastica of the Munchausen is only likely to be either noticed or effective when it deals with emotionally gripping topics, and personal danger or loss is a most suitable theme, both in relation to its reliable effect on the audience's sympathy and in reducing the likelihood of especially searching questioning, such is our usual social embarrassment when faced by grief. So it is tactically useful.

Pseudo-bereavement was a notable feature of three of the four in my series whom I was able to investigate and treat over a significant period of time. In each case, their 'bereavement' was especially poignant: in one, his young wife had died of breast cancer while in bed with him, on their first wedding anniversary, after suckling their new-born child; in another, while on holiday abroad, he'd returned to his hired car only in time to see it struck by a drunken driver, when it burst into flames cremating his mother while he watched; the third had recently suffered the death from leukaemia of his young wife. In each of the four cases studied in detail, real bereavement or loss of a major relationship had been a significant factor in relation to the start of their hospital addiction. The true and lasting sense of loss was embellished so as to affect others comparably to the depth of the patient's own feelings. One persistently referred to his lies as 'exaggerations'. His lies often convince us because he has first convinced himself; although the facts are wrong, the emotional tone is usually correct.

The Munchausen behaviour is definitely not consciously determined or even fully consciously formulated. Those who have entered therapy confirm their frustration with the compulsion to behave as they do, which interferes with other, consciously-formed plans. They describe episodes of 'finding' themselves in hospital again, without full awareness of how they got there. External documentation confirmed that they had had a very disturbed childhood, with separations and abandonment by parents. They showed several features of the personality disorder described in relation to the Borderline Syndrome, and were similarly sensitive in relation to the Borderline Syndrome, and were similarly sensitive in response to rejection and abandonment.

I see no reason why the presence of depression should in itself lead to the slightest doubt that these patients are cases of the Munchausen Syndrome. The Syndrome does not confer immunity to depression, and the circumstances of their childhood and adult life are such as to make the development of a depression not only possible but even likely. Depression is often a real concomitant of the Munchausen Syndrome, and treatment of the depression may be important in helping the patient control his maladaptive behaviour. Of course, psychiatric symptoms themselves may be simulated, as in one of my series, but this is less common than might be expected. (The two cases of Cheng and Hummel, *Journal*, July 1978, **133**, 20–1) certainly do *not* confirm their claim that 'many . . . present with psychiatric symptoms').

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NECROPHILIA, MURDER AND HIGH INTELLIGENCE

DEAR SIR,

Dr Lancaster's lucid case report Necrophilia, Murder and High Intelligence (*Journal*, June 1978, **132**, 605–8) raises interesting points in both legal and clinical areas.

Psychiatrists with a forensic concern particularly might have welcomed a fuller account of the legal aspects of this case. Notwithstanding the comments on 'Defect of Reason', 'Disease of the Mind' and 'Nature and Quality' it would be illuminating to know why the defence chose to plead insanity under the McNaughton Rules rather than diminished responsibility under the Homicide Act, 1957. As Dr Lancaster says, 'once the defendant admitted to the stabbing there was little chance of his not being convicted of murder'. Quite so; Walker (*Crime and Insanity in England*, Vol. 1. Edinburgh 1968) states: 'it is surprising that Counsel should still think the defence of insanity worth attempting . . . If it is easier to show on the evidence that the client is suffering from diminished responsibility, why embark on the more difficult task of convincing a Judge and Jury that he did not know the nature and quality of his act, or did not know that it was wrong?'.

Consideration of the evidence introduces the clinical aspects. Dr Lancaster establishes evidence of