ORIGINAL RESEARCH

The Delusional Parent: Family and Multisystemic Issues

Thaddeus PM Ulzen, MB, ChB, D Child Psy, FRCP‡, Russell Carpentier, MSW, CSW§

Objectives: To examine the dilemmas for children, family, and mental health professionals posed by the presence of a delusional parent in a family, including someone with induced psychotic disorder (IPD); to identify frequently unrecognized problems; and to propose practical suggestions for professionals.

Method: The pertinent literature on the effects of delusional parents on children, families, and professionals is reviewed. By way of 3 case vignettes, the dilemmas are identified and discussed.

Results: Delusional disorders are underdiagnosed, resulting in poor anticipation of their implications. Unanticipated family factors, such as “pursuit of isolation” and the related heightened risk of violence, contribute to the failure of professional interventions, which has been described as “therapeutic systems paralysis.”

Conclusions: These cases are complex, often requiring multisystemic involvement to reduce the risks of flight, violence, psychosis, posttraumatic stress disorder, and other psychiatric sequelae to children and other family members. The critical features of the innovative collaboration (“therapeutic consensus”) required between professionals for successful therapeutic interventions with these families are described.

(Can J Psychiatry 1997;42:617–622)

Key Words: delusional disorders, children, families, professionals, systemic issues, therapeutic consensus

Paranoid disorders and the spread of delusional ideas to family members have attracted attention in the literature since the 17th century (1). Our literature search produced 387 reports of folie à deux, now known as IPD (2), from 1877 to 1996. Critical reviews demonstrate that most authors have focused on theories of onset and spread of these delusions rather than on the effect of parental delusional disorders on others (3,4). Reports are predominantly descriptive accounts of disorders in the “paranoid spectrum,” with persecutory, grandiose, jealous, somatic, and erotomaniac delusions (5); issues of parenting capacity are not emphasized.

The primary patient in an IPD usually suffers from a delusional disorder (Kraepelinean paranoia) (6). The delusions are not necessarily bizarre and find acceptance in subcultural contexts, for example, as religious or political beliefs. IPD may also result from schizophrenia, major mood disorders, organic states, and associated misidentification syndromes, for example, Capgras’ and Frégoli’s syndromes, which are not addressed in the DSM-IV.

Delusional disorders are largely underdiagnosed because patients retain relatively high functioning in the community, actively denying disability and avoiding help from psychiatrists, who also avoid these patients because of their litigious and confrontational nature (5). These individuals drift between delusional and normal “modes” and confound all but the most experienced clinicians (5), often passing as eccentrics until they cause harm or significant conflict in the family or community, including suicides and murder–suicides. Other medical specialists, nonmedical professionals, and law enforcement officers are likely first contacts (7,8). The inpatient prevalence rate of delusional disorders is estimated at 10% that of schizophrenia, although prevalence in the general population is higher than this figure would suggest (9).

Table 1 shows a summary of some of the literature regarding the risks posed to children of parents with psychotic illnesses, such as schizophrenia and major affective disorders (10–12). In Kaffman’s (13,14) report on a study of family

Manuscript received January 1997, revised and accepted May 1997.
‡Formerly, Psychiatrist-in-Chief, George Hull Centre for Children and Families, Etobicoke, Ontario; Now, Assistant Professor, Department of Psychiatry, University of Toronto, Toronto, Ontario; Associate Professor and Director, University Psychiatric Center, Department of Psychiatric Medicine, East Carolina University School of Medicine, Greenville, North Carolina.
§Clinician, George Hull Centre for Children and Families, Etobicoke, Ontario.
Address for correspondence: Dr TPM Ulzen, Department of Psychiatric Medicine, East Carolina University School of Medicine, Greenville, NC 27958 USA

Can J Psychiatry, Vol 42, August 1997
therapy with delusional families, theoretical issues on the genesis of delusions are raised, but no information on outcome is presented.

Progression of delusional symptoms to a folie en famille is thought to reflect a dramatic attempt by a family to maintain cohesiveness in the presence of a perceived hostile environment (14,15).

Treatment outcome for families with delusional members is unknown. When patients consent to treatment, which is uncommon, some have been successfully treated with pimozide (16–22) and antidepressants (23,24) when delusions are associated with affective and obsessional symptoms.

The community’s attempts to address the needs of delusional patients and their families are often confounded by legal issues. The law attempts to balance individual civil liberties against community safety (25,26), and when therapeutic interventions are met with either aggressive denial leading to violence or a maladaptive coping mechanism causing families to flee (which we call “pursuit of isolation”), professionals find the legal statutes vague.

These problems contribute to well-founded concerns about the safety of children in such families and heightened anxieties in mental health professionals. Safety concerns and the patient’s and/or family’s resistance to treatment often result in strong countertransference feelings among therapists, ranging from overprotectiveness to feelings of rejection. These feelings contribute to coercive and poorly planned or executed interventions, which we call “therapeutic systems paralysis.” Because the literature offers little guidance on these practical clinical issues, we present the following 3 case vignettes, which illustrate the dilemmas that arise for mental health professionals, children, and adult family members of the paranoid patient. The case vignettes provide an overall guide to the therapeutic and systemic impasses. Two of the cases involve parents with an IPD.

**Case 1: The “Y” Family**

Mr and Mrs Y were immigrants with 4 children: 3 sons, ages 17, 16, and 13, and a 7-year-old daughter. Concern about this family developed when school personnel from the 13-year-old’s school began inquiring about his frequent absences, apparent overtiredness, and fainting at school. The youth’s teacher and principal took a firm position with the parents to ensure that their son attended school. The boy was the third child in the family whose school attendance and performance had fallen off drastically at adolescence. This firm approach to managing the problem did little to improve matters. Enter the school social worker, who was able to engage with Mrs Y to arrange for the involvement of a local public health nurse, the family physician, and a psychiatrist at a local hospital. While the public health nurse had concerns about Mrs Y, she was not alarmed by her mental state. The psychiatrist, by contrast, viewed Mrs Y as psychotic and in need of immediate treatment.

By the end of the school year, the school social worker had become increasingly anxious about the need to involve other professionals. Once school was out for the summer, the social worker would no longer be able to monitor this youth. Having become convinced that he was at risk and likely in need of protection, the social worker made a referral to the local child protection agency. Initially, the agency questioned the grounds for a protection investigation. When the social worker obtained a letter from the psychiatrist, however, who indicated that Mrs Y was “deeply psychotic” and that there was “great concern about the well-being of the children,” the child protection agency agreed to contact the Y family. On the authority of the psychiatrist’s letter, the school social worker immediately referred the family to a counselling agency for therapy.

The “handover” from the school social worker to the child protection agency and the counselling agency resulted in decreased monitoring of the family. In family therapy, however, which included a psychiatrist, it was confirmed that Mr Y was also delusional and could not be seen as a resource to his children. He believed, among other things, that the neighbours were pumping noxious gases into his home, causing his family to feel unwell. He believed these activities had caused his impotence. A folie à deux of long standing existed between the parents. None of the children was deemed delusional.

<table>
<thead>
<tr>
<th>Source</th>
<th>Basic design</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthony 1969 (10)</td>
<td>Clinical case study; sample size not reported; Identification of vulnerabilities in children for involvement in folie à deux</td>
<td>No suggestions for professionals</td>
</tr>
<tr>
<td>Anthony 1986 (11)</td>
<td>Quantitative measures of risk, vulnerability/resilience, coping, and competence in children of schizophrenic and manic-depressive parents</td>
<td>5-year, 10-year, and 15-year follow-up; Prediction of outcome</td>
</tr>
<tr>
<td>Lander and others 1978 (12)</td>
<td>N = 141 children (45 families with parents with schizophrenia and manic-depressive illness); Measurement of childhood vulnerability by 8-item vulnerability rating scale</td>
<td>Childhood psychopathology significantly greater in “vulnerable” children of psychotic parents; No suggestions for professionals</td>
</tr>
<tr>
<td>Kaffman 1981 (13)</td>
<td>Clinical study of 34 families with one or more delusional members</td>
<td>Reality basis of delusions often present; Authentic past transactions maintain and amplify delusions</td>
</tr>
<tr>
<td>Kaffman 1983 (14)</td>
<td>Conceptual paper—clinical study N = 34; 29 families with one delusional member; 5 families in IPD</td>
<td>Identifies paranoid family style of communication; Identifies therapeutic impasse; Family treatment discussed; outcome not reported</td>
</tr>
</tbody>
</table>
Recognizing the existing split in opinions about how serious Mrs Y’s mental health problems were and the uncertainty about what impact these problems might have on the children, the workers from the protection and counselling agencies endeavoured to coordinate their contact with the Y family. In the rush by the professionals to mobilize and respond to the reported serious concerns about this family, however, the parents became alarmed and defensive.

Those who had the most significant contact with members of the family (for example, the school social worker) were not available to continue involvement once school had ended. The inadequately coordinated activity of the professionals contributed to a hopelessly incomplete understanding of the dilemma. The Ys successfully avoided professional intrusion by convincing the protection worker that no danger to the children existed and by respectfully declining any counselling or family therapy. The family moved to another jurisdiction by the beginning of the next school year. While the parents could not be legally compelled to receive psychiatric treatment, their children were in need of some protection, at least in the form of an Order of Supervision.

Discussion of Dilemmas for Professionals

Prediction of Dangerousness. The risk of potential acts of violence by paranoid patients and the implications for their families, particularly children, are of concern to professionals. The responsibility for making a prediction of dangerousness is often a source of stress for professionals who are unqualified to make such judgements. Therapists vary greatly in their ability to tolerate potentially violent situations, which contributes to erratic decision making in such circumstances.

Conflicting Rights of Parents and Children. Inexperience and lack of skill in identifying and eliciting paranoid phenomena leads professionals to accept delusionally based reasons for patients’ actions as rational if they are not immediately bizarre. Delusional patients often do not meet criteria for involuntary treatment, leaving professionals with few opportunities to remove children from potentially harmful situations. Guidelines for the involuntary commitment of adults are often in conflict with child protection legislation.

Confidentiality. Many professionals are unaware of the legal limits of confidentiality and do not consider the safety of other individuals in the decision-making process. When a patient’s dangerous plans or ideas are not shared between professionals providing service from different vantage points (for example, mental health agency and child protection agency), the safety of family members may be compromised.

Threats of Litigation and Harassment. Paranoid patients are often litigious and make threats when issues of the safety of their children are raised. They feel persecuted and sometimes make delusionally based threats against professionals that they actually act upon. This causes professionals to approach such situations with extreme caution.

Differing Mandates of Professional Agencies. Institutions providing service for such families may have different standards of intervention or mandates (for example, public health nurses and social workers). This results in role-boundary diffusion and interagency conflicts that impede progress and can result in the dangerous situation worsening.

Physical Separation of Child from Parents as an Intervention. It is generally accepted, particularly in IPD, that separation from the primary patient is an essential part of treatment. Where children are involved, this prescribed separation is difficult to effect. The delusional parent is ill as opposed to malicious (for example, in abusive situations), and conflicts about the deleterious effects of the separation on the development of involved children complicate decision making. This is especially so because parental resistance to treatment often lengthens the parent–child separation once it has been effected.

Case 2: The “C” Family

Mr C was a 35-year-old father of 2 daughters, ages 9 and 6. The parents had separated several years previously following a violent assault by Mr C on the girls’ mother, Mrs V. He was convicted and incarcerated. The girls moved to a distant city with their mother and had no contact with their father until 5 years later, when Mrs V contacted Mr C and requested that he care for the girls temporarily to enable her to receive treatment for substance abuse problems.

Mr C, who was married at the time of the request, separated from his wife and hired a live-in nanny to care for the girls. Soon after arriving, the girls confided to the nanny about a number of sexual experiences they had while in their mother’s care. Despite being informed that the sexual abuse had been previously investigated and that counselling had been provided for the mother and daughters, Mr C became angrily determined to stop his daughters from returning to their mother. He insisted that any further contact would result in the revictimization of his children. Through persistence, he had the sexual abuse thoroughly reinvestigated in both jurisdictions. He concurrently initiated custody proceedings to vary an existing order to ensure all future contact between the girls and their mother would be supervised.

During this period, a request for counselling was made. While the stated reason for counselling involved providing help for the girls to deal with their sexual abuse, Mr C’s unstated wish was for professional allies who could testify on his behalf about custody. When he realized that this help would not be forthcoming, he abruptly ended contact with the counselling agency.

Approximately one year later, Mr C phoned in distress to the counselling agency. He explained that his daughters had been ordered by the court to visit their mother for the summer holidays. Mr C described how, since returning to his care and that of a new partner, the girls had become increasingly and continually disobedient and openly challenged his authority. It was his opinion that the girls had been “brainwashed” by their mother as her way of taking out revenge on him through their children. Mr C sought help to “reprogram” his daughters. He was now doubly determined to disallow any further contact with the mother. He insisted he “knew” the girls’ mother was continuing to abuse alcohol and drugs and was permitting...
lesbians to have the free run of her home. As a result, he believed his children would be perverted if permitted contact with their mother. He refused to acknowledge the many documented changes for the better that had occurred in Mrs V’s life. The children became afraid to ask for visits with their mother or to express any concern for her.

At the same time, he accused his live-in girlfriend of being a lesbian and, at other times, on returning from trips, insisted she had brought in a variety of lesbian and male sexual partners. He also would force his daughters to “confess” that she had been unfaithful.

On numerous occasions, he physically assaulted his girlfriend on the basis of these ideas. She made this disclosure in an individual interview. She was constantly perplexed by Mr C’s behaviours, never being sure if he was sick or not.

Our evaluation was that, on the basis of morbid jealousy, Mr C was physically and psychologically terrorizing his family. We presented our concerns to the child protection agency. The agency’s investigation resulted in the documentation of one incident of physical discipline that was reported to be an exception.

Soon after, Mr C severely assaulted his partner, who finally broke her silence about his continual intimidation, violence, and unmanageable suspiciousness. Eventually, she was also able to encourage the girls to speak openly. Following a subsequent assault by Mr C on his partner, the girls were removed from his care and returned to their mother. Mr C viewed himself as a victim.

Discussion of Dilemmas for Children

Contradictory Belief Systems. Children in families such as Mr C’s vary in their involvement in the delusional system. They struggle with their loyalties to 2 divergent belief systems: the delusional, based at home, and that of the larger society. This psychological struggle results in overt symptomatology and poor functioning in a number of areas (10).

Parental Coercion. Paranoid parents tend to demand secrecy and loyalty, interrogating their children (as Mr C did) to confirm their beliefs. The children present with internalizing symptoms, which they develop to prevent open conflict with the dominant delusional parent. Emotional withdrawal, constriction of affect, and silence are commonly observed in these children. They do not challenge the beliefs because they fear the parent’s anger and retaliation, which in turn awaken separation and abandonment fears. A similar situation exists for children who are victims of parental incest, whose obligation to secrecy is necessary to preserve their abnormal relationship with the parent (27).

Isolation and Physical Danger. On the basis of parental delusions, children may be restricted to their homes, foregoing school and contact with peers. This isolation increases the risk of physical danger to children in such families. They could be subjected to dangerous rituals, otherwise terrorized, or fatally attacked by the psychotic parent (15). Attacks may lead to a variety of responses if the child survives the physical assault (11).

Psychological Sequelae. Outcomes noted include post-traumatic stress disorder response in children predisposed to anxiety. They may be engulfed by the psychotic process, as in an IPD, or become psychotic years after the terrorizing episode (11). Ten percent of the children exposed to severe adversity are identified as resilient, having a good outcome in spite of the stressors. Both good and bad outcomes seem to persist for years after the original event (28,29).

Case 3: Mr “K” and Family

A report appeared in local newspapers that a black family of 4 were living in their car with their dog to protest poverty and that they had launched a suit against the government for failing to provide a minimum standard of living for them. They were originally parked in front of city hall. Threats of eviction from the city caused them to move to a suburban park, where they were again threatened with eviction because they were deemed an embarrassment to the local mayor, who was campaigning for reelection.

A psychiatrist was asked to evaluate the family and report to the child protection agency, which was concerned for the well-being and safety of the children, aged 13 and 10. They had been living in their car for 144 days up to that point. At the park, Mr K received the doctor as one would someone entering a living room. He offered the doctor a spot on a park bench and proceeded to inform him about the issues at hand. He also provided a 6-page typewritten statement, which he had circulated to various government officials.

Mr K had a university education and his wife was a performer. He felt that his difficulties were the result of a policy in Canada whereby people were being “graded by their external differences” and that blacks were being made second- and third-class citizens. He insisted that “people were treasures, not commodities.” He had his children on what he called a “home-school program” to avoid their being streamed into nonacademic, dead end courses. He claimed he spent 3 hours a day “attending to their academic needs” but could not describe a curriculum.

He was unwilling to consider medical treatment for his children because he opposed all “theories of duality.” He compared himself to Ghandi, Martin Luther King, and others, saying his message was to attend to their academic needs” but could not describe a curriculum.

He saw nothing wrong with their living situation and felt that everyone from the federal government down had been “abusive to the family, turning them into economic paupers and social outcasts.” His wife shared his beliefs completely, and his son, aged 13 years, although he agreed with his father, felt “the protest” would end in a few months. His daughter, aged 10 years, agreed with everyone and seemed quite passive.

Attempts by authorities to intervene included an offer of housing and employment. Mr K and his family fled the scene in midwinter to an unknown location, however, depriving their children of schooling, the possibility of associating with
other children, and the comforts of a home, and continuing their exposure to the elements and unsanitary conditions.

This was a case of a folie à deux based on the grandiose delusions of Mr K. It is of interest that Mr K had moved from jurisdiction to jurisdiction for 3 years, presenting as a new problem each time until the reported contact was made.

Discussion of Dilemmas for Parents

Psychotic Induction and Other Psychological Sequelae. The risk of the second parent becoming delusional is significant (for example, cases 1 and 3). Other emotional responses in the second parent include anger, perplexity, protective feelings, help-seeking behaviour, or withdrawal. The girlfriend of Mr C (case 2), for example, showed bewilderment and was not sure whether Mr C was ill or not.

Physical Danger. If the psychotic parent acts on his or her delusions, children are endangered, especially if the other parent cannot protect the children (case 3). This is a major concern when the delusional parent is violent towards the other parent (case 2). Delusional content and the degree of systematization are added risk factors.

Conflict with Authorities. Delusions bring the parents in conflict with authorities who attempt to rescue the children. This fuels the persecutory delusional beliefs, and authorities are seen as provocateurs by the ill parent(s), who feel undermined and may flee (cases 1 and 3).

Implications for the Larger System

The Family and the Macrosystem

The initial therapeutic tasks include identifying the primary patient (if an IPD), arriving at a diagnosis, and attempting medical intervention with psychotropic medication. Treatment is usually resisted by the patient on the basis of delusional beliefs (cases 1, 2, and 3).

The failure of mental health intervention often leads to withdrawal of the family from helping agencies. This precipitates a referral to child protection agencies because of professional anxiety about the safety of children.

Child protection agencies, school authorities, public health nurses, and mental health professionals become involved with varying degrees of investment. These patients, though clearly ill, are often deemed not certifiable, and the use of child protection and educational (truancy) legislation to bring attention to the plight of the children is common. This often results in potentially violent confrontations with the family, precipitating their departure from the jurisdiction (cases 1 and 3) in “pursuit of isolation.”

Numerous studies have suggested that immigrants are overrepresented in samples of patients with paranoid disorders (30,31). Ethnocultural factors are a consideration in deciding if thoughts expressed by the patient are delusional or are consistent with his or her cultural norms. Conflict between the professionals’ cultural beliefs and those of the patient may result in incorrect assumptions about the presence of delusions. Knowledge that assists in establishing the failure of “cultural logic” helps resolve this conflict (32). This understanding is achieved by greater reliance on information from relatives or professionals who share ethnocultural features with the patient or understand the patient’s culture and any alternative explanatory models for understanding the presenting phenomena (32,33).

Professional Macrosystemic Issues

A large number of agencies can rapidly become involved in such cases as creative interventions are sought to break the therapeutic impasse. These include the police and the courts, as well as community and religious groups who naively take up the “cause” of such families, completely unaware of the delusional basis of the expressed beliefs.

Systemic problems contributing to the risks for children of delusional parents include 1) role boundary diffusion resulting from poorly coordinated multiple agency involvement in an anxious search for a solution to the therapeutic impasse, 2) assessments by professionals from many disciplines with different areas of expertise, 3) battles over “ownership” of the case, 4) excessive professional attention to parental symptoms at the expense of developmental needs of children, 5) rapid front-line staff turnover at social agencies, and 6) lack of available expertise on child development (34).

The solutions to these problems include the routine involvement of supervisory staff in these cases and collaboration between professionals, referred to as “therapeutic consensus.” Such a consensus is especially important when:

- The decision is made which individual or agency is trusted the most.
- The time frame for therapeutic engagement is discussed. These cases often require a commitment of one or more years.
- Goals are set for therapeutic engagement, for example, restriction of children’s activities or school attendance, homicidal or suicidal threats, and the prevention of the “pursuit of isolation.”
- Testing or monitoring of interventions occurs, for example, at what point to offer medication or to introduce safety concerns.
- Interventions are tested or monitored. Participating agencies’ systems have to adopt role flexibility, for example, a school counsellor could see the family frequently at home and use a psychiatrist as a consultant.
- Talks between agencies occur, that is, pragmatic information is shared between agencies to reduce safety risks and fragmentation of services.
- Teaching about the illness takes place: psychoeducational efforts are required to help family members understand that the patient’s actions stem from his or her illness, not a wilful desire to do harm.

Summary

The delusional context of paranoid patients evokes strong feelings, both positive and negative, in professionals, and can lead to unsuccessful outcomes because objectivity is compromised. The diagnosis is often missed or its implications woefully underestimated. This may partly account for the scarcity of written accounts of treatment outcomes in such
situations, even though the literature is rich in descriptive and phenomenology-based accounts of IPD.

Mental health professionals should be guided by the principle of the least detrimental alternative for a child in a given situation, and indicators of parenting capacity should be borne in mind at all times during the process (35).

In the circumstances described, treatment choices are complicated by the competing forces of danger, impeding object loss, and the defence of family integrity on behalf of the child. Objectivity, continuity, and safety are important hallmarks of the therapeutic consensus.

Therapeutic consensus also includes mutual support and improved communication among caregivers. This ideally results in more realistic goal setting and avoids therapeutic systems paralysis in the interest of children in such families.

Psychiatrists should function as active educators of other professionals on the features and prognosis of paranoid-spectrum disorders to help improve awareness of these disorders and of the risks inherent to children and families as a result of misdiagnosis. The economic loss to society in terms of resources applied with inadequate returns can be overwhelming in these situations.

Clinical Implications

- Increased awareness of missed diagnoses of delusional disorders.
- Awareness of dangers to family and community.
- A focus on practical suggestions for mental health professionals treating delusional parents.

Limitations

- Existing data on wider implications of delusional disorders in child psychiatry are sparse.
- Proposed “therapeutic consensus model” not systematically tested.

References


Résumé

Objectifs : Examiner les dilemmes qui se posent aux enfants, aux familles et aux professionnels de la santé mentale en présence d’un parent en proie au délire dans une famille, notamment une personne atteinte de trouble psychotique induit, identifier des problèmes qui échappent souvent au diagnostic et proposer des suggestions pratiques aux professionnels.

Méthode : On a examiné la littérature pertinente sur les effets provoqués par des parents délirents sur les enfants, les familles et les professionnels. Au moyen de 3 vignettes de cas, on décrit les dilemmes, qui font l’objet d’une discussion.


Conclusions : Ces cas sont complexes et exigent souvent l’apport de nombreux systèmes pour réduire les risques de faute, de violence, de psychose, d’état de stress post-traumatique et d’autres séquelles psychiatriques chez les enfants et les autres membres de la famille. On décrit les caractéristiques essentielles de la collaboration novatrice (consensus thérapeutique) qui s’impose entre les professionnels en vue de la réussite des interventions thérapeutiques auprès de ces familles.