Training Key® #642

Munchausen Syndrome and Munchausen by Proxy

While relatively rare, law enforcement officers should be able to recognize the signs and symptoms of Munchuasen syndrome and Munchausen syndrome by proxy. This knowledge can prove useful when gathering the evidence necessary to criminally prosecute individuals with these disorders.

Munchausen Syndrome

While Munchausen syndrome has been noted throughout history, the condition was first labeled by Dr. Richard Asher in 1951 after the 18th century soldier and adventurer Baron Karl Friederich von Munchausen. Baron von Munchausen was known for the fantastical tales of his exploits, which later became the basis for a popular children's book entitled "The Amazing Travels of Baron von Munchausen."

According to the American Psychiatric Association, the syndrome is officially diagnosed as a factitious disorder characterized by the following: (1) the patient intentionally produces or feigns physical or psychological signs or symptoms; (2) motivation for the behavior is to assume the role of a sick person; and (3) external incentives for the behavior are absent.[1] Munchausen patients intentionally exaggerate, simulate, aggravate, or self-induce an illness or injury for the primary purpose of receiving attention, especially from medical staff.[2] Individuals with Munchausen have faked almost every medical condition, but the most common are persistent rashes, wounds that do not heal, unexplained anemia, and blood in the urine. While it is believed to be relatively rare, the exact frequency of the disorder is hard to determine, since the patients are difficult to identify and often visit several medical practitioners in numerous locations.

The causes of Munchausen are unknown, although it is suspected that the disorder may stem from illness, or illness of a family member, during childhood. Early on, the child is introduced to the psychological and emotional benefits of being sick and uses this knowledge to gain attention later in life. Other motivations may include tension or conflict in the child-parent relationship resulting in the need to be loved or cared for; the need to deceive, feel in control, or feel superior to authority figures, especially doctors;[3] and the feeling that punishment is deserved for some unknown fault. Individuals with Munchausen often have co-occurring psychiatric disorders, such as antisocial and borderline personality disorders, as well as substance abuse problems.

While there is no definitive profile available for an individual with Munchausen syndrome, several characteristics and behaviors are frequently noted as being associated with the disorder. According to research, extreme forms of factitious disorder, namely Munchausen, are generally seen in men, while other, less severe forms tend to occur in females.[4] Three major components[5] of the disorder are as follows:

- *Dramatic presentation of symptoms.* Individuals often arrive at the emergency room or doctor's office with severe cases of infection, extreme variations in laboratory results, and so on.
- *Falsely elaborating symptoms and histories.* This sometimes includes exaggerated claims concerning the individual's personal life, such as relations to famous people or extraordinary achievements (for example, three Ph.D.s, once climbed Mt. Everest).
- *Geographic relocation.* Once one doctor or hospital becomes suspicious, the individual will switch to another health-care provider, sometimes even moving from city to city to avoid detection.

In addition, Munchausen patients usually live isolated lives, with very little contact with people outside the health-care field. They often have extensive medical knowledge, either due to employment in the field or personal research and present themselves with symptoms and illnesses that exactly mimic the descriptions found in a textbook. Individuals with Munchausen are willing, if not eager, to undergo numerous tests and diagnostic procedures, despite the accompanying pain or discomfort. In extreme cases, unnecessary surgeries

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are performed, leaving multiple scars that can be viewed as indicative of the disorder. Often, the patient is harmed more by the doctors' unnecessary procedures than by the original self-induced or fabricated illness. If confronted with their behavior, these patients usually are unwilling to admit that they are causing their symptoms, may become angry or belligerent, and sometimes leave the medical facility rather than consent to a psychiatric evaluation.

Potential Warning Signs of Munchausen Syndrome

The following is a list of characteristics and behaviors that may indicate that an individual is suffering from Munchausen syndrome. However, this list is neither fully inclusive nor exclusive, as individuals with the syndrome vary greatly in their presentation.

- The signs and symptoms of the illness do not improve with treatment. There may be an escalation of symptoms, relapse, or new complaints in an apparent effort to keep caregivers engaged.
- The magnitude of the symptoms consistently exceeds what is usual for the disease, illness, or injury.
- There are a remarkable number of tests, consultations, and treatment efforts to no avail.
- The individual is unusually willing to consent to medical or surgical procedures, including painful or risky ones.
- The individual disputes test results that do not support the presence of an authentic disease or illness.
- The individual's condition regularly worsens before or after discharge from the hospital, emergency room, or doctor's office.
- The individual "doctor shops" and has sought treatment at an unusual number of facilities.
- The individual refuses to allow caregivers access to outside information sources regarding their prior medical care.
- There is the presence of multiple surgical scars, especially in the abdominal area.
- There is a history of so many medical treatments for a variety of problems that the initial impression is that the patient must be extremely unlucky.[6]

Munchausen Syndrome and Bioethics

While individuals suffering from Munchausen syndrome only physically harm themselves, the effects of their actions are widespread, resulting in numerous ethical questions being raised. These questions include

- Are people with Munchausen entitled to medical treatment? Some believe that the answer to this question is no, since these individuals disobey the "unwritten rules" of being a patient, which include that they seek treatment with the goal of recovering, a motivation absent when dealing with Munchausen.
- Should there be civil or criminal penalties for individuals with Munchausen? Since the illnesses are either fabricated or self-induced, these individuals may be committing fraud, costing hospitals and insurance companies large amounts of money.
- Can doctors be held liable for the unforeseen consequences of repeated medical procedures that are unnecessary in actuality?
- Can medical staff search a patient's belongings for evidence of fabrication without his or her consent? Should video surveillance of patient rooms be allowed? What expectation of privacy does an individual have in a hospital setting?

Unfortunately, the courts have differing opinions on the proper resolutions for these problems. With the introduction of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in the United States, the ability of physicians to access existing medical records has become extremely limited, allowing for individuals with Munchausen to jump from provider to provider without fear of their past escapades following them. While a kind of "blacklist" of Munchausen patients is available in some European countries, the creation of such a list in the United States would be considered a gross violation of a patient's privacy rights.

Case Study – Munchausen Syndrome

In one documented case,[7] a 37-year-old man visited the emergency room multiple times and was admitted to the hospital on several occasions. In one two-year period, he underwent partial amputations of all of his fingers and full amputations of all of his toes after wounds caused by self-mutilation became severely infected. In addition, his medical history included a self-inflicted gunshot wound to the lower left leg with reoccurring infections requiring numerous skin grafts. The man also had multiple burns on his arms, reportedly from a car accident. He was known to have substance abuse problems and exhibited drug-seeking behavior.

During one hospital stay, a nurse found a hobby knife and a bag of feces under his mattress. The man was using these materials to infect his wounds, but denied ownership after their discovery. On another occasion, the man went to the hospital emergency room on Christmas Eve with an open abdominal wound, claiming that it was the result of a carjacking and stabbing in Mexico a few days earlier. The staff believed the wound was self-inflicted. He stated that he had undergone surgery in Mexico to repair the wound, although there was no evidence of such a procedure. He demanded narcotics and became verbally abusive to the medical staff when he was refused. The man eventually underwent surgery to close the wound and was released to home care where he once again began demanding narcotics and claiming that he needed to be admitted to the hospital.

He usually visited the emergency room on weekends and holidays when relief staff members who would not recognize him were on duty. He seemed to know the schedules of the resident physicians and would appear in the first few days when a new resident came to the department. Numerous requests for psychiatric evaluations were refused. The man eventually died from a self-inflicted gunshot wound to the chest several weeks after his last hospital admission.

Munchausen Syndrome by Proxy (MSbP) and the Police

Unlike Munchausen syndrome, where the individual inflicts injury or illness on himself, Munchausen syndrome by proxy (MSbP) is characterized by an individual intentionally

causing illness to someone under his or her care, most commonly a child, in order to gain attention. While MSbP is also listed as a factitious disorder by the psychiatric community, it is more commonly thought of as a form of child abuse, rather than a psychiatric disorder. Prior to the identification of MSbP by Dr. Roy Meadow in 1977, families were considered "unlucky," who had numerous children die from mysterious causes. In an extreme case in the 1960s, Marie Noe claimed that all 10 of her children died from Sudden Infant Death Syndrome (SIDS) before they reached 15 months of age. It was later discovered that she had caused the death of her children by smothering them.[8] The medical community is now aware that multiple SIDS deaths in a family are extremely rare, and deaths of multiple children are now investigated further to determine whether abuse, such as MSbP, is occurring.

In general, the biological mother is usually the perpetrator of the abuse, although there have been cases involving fathers, grandmothers, aunts, and babysitters. In very rare cases, a medical practitioner may be involved, miraculously "saving" the child during a medical emergency. Overall, the common factor among all perpetrators is that they are the child's primary caregiver. Research has shown that MSbP perpetrators have a high likelihood of suffering from Munchausen themselves. In all cases, the caregiver is inflicting the abuse in order to garner attention from authorities, including medical, child services, and law enforcement personnel. MSbP perpetrators are effectively described by the following:

> *She may appear on the surface as caring, concerned, and eager to assist in her child's diagnosis and treatment. She may constantly remain at her child's bedside, demonstrate keen interest in his or her progress, follow instructions, and keep medical appointments…A great deal of satisfaction is obtained when the health team admires her care…Her gratification comes from the sympathetic medical staff admiring her care and providing for her psychological needs.*[9]

MSbP offenders will go to extraordinary lengths to cause or mimic illness in their victims. Mothers have been accused of suffocating their children with plastic bags and pillows; poisoning their children with caffeine diet pills, bleach, ipecac syrup (to induce vomiting), cough syrup, carbon monoxide, drugs, and insulin; causing infections by putting feces in their children's intravenous and feeding tubes; causing cardiac arrests; blowing, spitting, or putting fingernail polish into medical tubes; and attempting to drown their children. It is estimated that as many as 30 percent of MSbP victims die, and that 2 to 10 percent of deaths attributed to SIDS each year are actually the result of child abuse.[10] Once one child becomes too old to continue the abuse, the perpetrator will often turn to a younger sibling. For this reason, it is important for investigators to collect as much information as possible regarding the medical history of all the children in a family in order to identify a pattern of abuse.

Profile of MSbP Perpetrators

The following is a list of common characteristics shared by many MSbP perpetrators.[11] However, not all MSbP abusers will perfectly fit this profile, and it should not be used as the sole basis for suspicion. MSbP perpetrators

- are most often biological mothers of the victims;
- are often upper class, well-educated persons;
- remain uncharacteristically calm in view of the victim's perplexing medical symptoms;
- welcome medical tests that are painful to the child;
- praise medical staff excessively;
- appear to be very knowledgeable about the victim's illness;
- have some medical education – either formal or through self-initiated study/experience;
- might have a history of the same illness as the victim;
- typically shelter the victim from outside activities, such as school or play with other children;
- allow only selected persons close to the victim; and
- seem to find emotional satisfaction when the child is hospitalized because of the staff's praise of their apparent ability to be a superior caregiver.

Potential Warning Signs of MSbP

Once again, any single warning sign should not be viewed as proof that MSbP is to blame for a child's illness. In these cases, a conclusion of MSbP should be made only after carefully reviewing the totality of the circumstances.

- Unexplained and prolonged illness that puzzles experienced doctors who may state that they have "never seen anything like it before"
- Repeated hospitalizations and extensive medical tests that fail to produce a diagnosis
- Symptoms that do not make medical sense
- Persistent failure of the victim to respond to therapy
- Signs and symptoms that dissipate when the victim is removed from the suspected offender's presence
- Caregivers who do not seem worried about the child's illness but are constantly at the child's side while in the hospital
- Caregivers who have an unusually close relationship with the hospital's medical staff
- A family history of sudden infant death syndrome (SIDS)
- Caregivers with previous medical or healthcare experience who have a history of the same type of illness as the child
- A caregiver who welcomes medical testing of the child, even if painful
- The caregiver attempts to convince the staff that the child is still ill when advised that the child will be released from the hospital
- A model family that normally would be above suspicion
- A caregiver with a previous history of Munchausen syndrome
- A caregiver who adamantly refuses to accept the suggestion that the diagnosis is nonmedical[12]

Investigating MSbP

Much like individuals with Munchausen syndrome, MSbP is very difficult to identify, since perpetrators may frequent numerous doctors and hospitals. If MSbP is suspected, law enforcement officers should be vigilant in documenting the number of times they have visited a particular home or accompanied a child and/or parent to the hospital. A multidisciplinary team should be formed as soon as possible including physicians, nurses, social workers, psychologists, and law en-

forcement officers to encourage information sharing, resulting in a complete record of abuse.

If at all possible, investigators should avoid interviewing the victims of MSbP, as they are usually very young and will not be able to provide much useful information. If they are old enough to assist in the investigation, the trauma associated with learning that their caregiver has been causing them harm often outweighs any benefit. Since the abuse is most likely all the victim has ever known, he or she will probably believe that the situation is normal. The victim may sincerely believe that the offender is an ideal caregiver, even if the abuse is blatantly obvious. In some instances, the victim may think that the abuse is a punishment for some wrongdoing and is therefore deserved.

When interviewing the suspect, investigators should present themselves as having an open mind and avoid showing any suspicion towards the individual. He or she will probably provide very rational explanations for the events in question, or place the blame on someone else entirely. If the perpetrator is confronted, he or she may cause the victim's symptoms or illness to worsen in an effort to "prove" that the child is genuinely sick. Alternatively, the abuse may stop for a brief time period until the caregiver believes the suspicion has passed. In extreme cases, the suspect may move the entire family to another geographic location where officials are unaware of the potential abuse. However, the abuse will continue because the perpetrator is addicted to the attention that results from the child's illness.

Since MSbP abusers very rarely admit to their actions, it is important for law enforcement to rely on statements from other individuals, rather than the individual herself, for evidence. Evidence in court cases most often comes in four forms: statements made by the suspect as to the condition of the victim; statements made by the victim; hospital records; and testimony of hospital personnel.[13] Since very little physical evidence exists, officers must be painstakingly thorough in collecting statements from anyone who might have information concerning the abuse.

One concern voiced by critics of the MSbP diagnosis is the possibility of false accusations. Many of the "warning signs" for MSbP, such as overprotectiveness and extensive knowledge of the child's medical condition, can be seen in parents of children who are genuinely ill. If authorities mistakenly believe that the child is being abused, he or she may be removed from the care of innocent parents, causing unnecessary stress and leaving the parents with the stigma of being accused. It is this possibility of misidentification, coupled with the difficulty in proving legitimate cases, which makes MSbP such an investigative challenge.

MSbP and the Courts

MSbP cases are incredibly difficult to prosecute and therefore are not common. This is due in large part to the fact that there is very little direct evidence of the crime. In addition, the length of time between the onset of the abuse and the point at which suspicion is raised, followed by the inevitable delay before appearing in court, severely hinders any chance of a successful prosecution. To further complicate matters, the courts are generally disinclined to allow prosecutors to introduce expert testimony on MSbP as an explanation for the perpetrator's actions, as well as any evidence of previous abuse involving older children. Defense attorneys are quick to argue that MSbP is junk science and that the diagnosis actually stems from doctors' unwillingness to admit that they are unable to effectively treat the child or frustration with a persistent parent.

In situations involving suspected MSbP, the primary goal is to prevent any additional harm to the child. The courts often remove the child and any siblings from the perpetrator's care and from the care of anyone who maintains that the perpetrator is innocent (for example, the child cannot stay with his or her father or grandparents if they believe the mother is not responsible for the child's illness). In extreme situations, a baby may be taken away immediately after birth when the mother is suspected of MSbP involving her other children. If visitation is allowed, it is usually strictly monitored to ensure that no harm comes to the child. Children should not be returned to the custody of an MSbP perpetrator at any point, as the condition is not treatable.

Possible criminal charges for MSbP abusers include first-degree murder, aggravated murder, and homicide by child abuse if the victim dies and attempted murder, reckless endangerment, cruelty to a child, and aggravated battery of a child if the victim is only injured.[14] Illustrating the inconsistency among MSbP cases, sentences for abusers have ranged from a life sentence to probation, depending largely on whether the perpetrator confessed, pled guilty, or accepted a plea deal.

While there is very little case law governing MSbP prosecution, two court cases have specifically addressed the issues hampering the prosecution. First, the Supreme Court of West Virginia, discussing the appropriate weight to be placed on circumstantial evidence in MSbP cases, stated "we may accept any adequate evidence, including circumstantial evidence, as support for a conviction. Circumstantial evidence…is intrinsically no different from testimonial evidence…In both instances, a jury is asked to weigh the chances that the evidence correctly points to guilt against the chances of inaccuracy or ambiguous inference." In 1998, a Texas appeals court held that research on MSbP meets the standard of admissibility required of scientific expert witnesses and is "sufficiently reliable and relevant to help the jury in reaching accurate results." California appeals courts have held similarly. In the same case, the court allowed the admission of evidence regarding a past pattern of medical abuse and testimony about the deaths or near-deaths of children of an accused MSbP mother since "the extraneous offense is useful in reducing the possibility that the act in question was done with innocent intent."[15]

Case Study – Munchausen Syndrome by Proxy

By the time she was eight years old, Jennifer Bush of Fort Lauderdale, Florida, had spent 640 days in hospitals and had undergone more than 40 surgeries. Her appendix, gall bladder, and part of her intestines were removed and feeding tubes were implanted in her stomach and intestines due to what doctors believed was a gastrointestinal disorder. Nurses who treated Jennifer noticed that her condition often worsened following visits from her mother. Furthermore, they observed that "Jennifer's feeding tubes 'mysteriously' sped up to more than seven times the level they were set at, found toxic levels of drugs in Jennifer's blood, and saw that someone may have tampered with urine samples."

After being placed in foster care, Jennifer's condition remarkably improved, and she has not been in the hospital since she was removed from her mother's care. Mrs. Bush claimed that her daughter's symptoms disappeared because she had outgrown a genetic disorder and that the same outcome would have resulted if Jennifer had remained under her care. Mrs. Bush was convicted of fraud and aggravated child abuse and, in January 2000, was sentenced to five years in prison and five years probation.[16]

Endnotes

[1] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revision (DSM-IV-TR) (Washington DC: American Psychiatric Association, 2000).

[2] James C. Hamilton and Marc D. Feldman, "Munchausen Syndrome," http://emedicine.medscape.com/article/295127-overview (accessed June 18, 2010).

[3] Allen R. Dyer and Marc D. Feldman, "Factitious Disorder: Detection, Diagnosis, and Forensic Implications," Psychiatric Times 24, no. 4 (April 2007): 17–19.

[4] Hamilton, "Munchausen Syndrome."

[5] John B. Murray, "Munchausen Syndrome/Munchausen Syndrome by Proxy," *The Journal of Psychology* 131, no. 3 (May 1997): 343–353.

[6] Dyer, "Factitious Disorder: Detection, Diagnosis, and Forensic Implications."

[7] Donna R. McEwen, "Recognizing Munchausen's Syndrome," *AORN Journal* 67, no. 2 (February 1998): 440–443.

[8] Melissa A. Prentice, "Prosecuting Mothers Who Maim and Kill: The Profile of Munchausen Syndrome by Proxy Litigation in the Late 1990s," *American Journal of Criminal Law* 28, no. 3 (Summer 2001): 373–412.

[9] Abdul-Kader Souid et al., "Munchausen Syndrome by Proxy," *Clinical Pediatrics* 37, no. 8 (August 1998): 497–503.

[10] Prentice, "Prosecuting Mothers Who Maim and Kill."

[11] Kathryn A. Artingsall, "Munchausen Syndrome by Proxy," *FBI Law Enforcement Bulletin* (August 1995): 5–11.

[12] Ibid.

[13] Deborah Chiczewski and Michael Kelly, "Munchausen Syndrome by Proxy – The Importance of Behavioral Artifacts," *FBI Law Enforcement Bulletin* 72, no. 8 (August 2003): 20–24.

[14] Prentice, "Prosecuting Mothers Who Maim and Kill."

[15] Ibid.

[16] Susan Candiotti, "Mother Found Guilty of Child Abuse, Fraud for Making Daughter Sick," *CNN.com*, http://www.cnn.com/US/9910/07/munchausen.verdict/

questions

The following questions are based on material in this *Training Key®*. Select the one best answer for each question.

1. Munchausen syndrome is characterized by the intentional infliction of illness or injury on another person, usually a child, in order to receive attention from medical staff.

(a) True
(b) False

2. Which of the following is not a typical reaction when an individual is confronted with the suspicion that they suffer from Munchausen syndrome or MSbP?

(a) Deny any signs or symptoms of the syndrome.
(b) Willingly agree to a psychiatric evaluation and counseling.
(c) Leave the hospital or other healthcare setting against medical advice.
(d) Move to a different geographic location where doctors are not familiar with his or her medical history.

3. Which of these factors contribute to the difficulty in successfully prosecuting MSbP offenders?

(a) The victim is often too young to provide any valuable information concerning the abuse.
(b) The abuser presents herself or himself as the perfect caregiver, thereby avoiding suspicion for an extended period of time.
(c) Abusers are careful to mimic the symptoms of legitimate illnesses.
(d) All of the above.

answers

1. (b) False. Munchausen syndrome involves the self-infliction of illness or injury, while MSbP involves harming another person.
2. (b) Only in rare cases will an individual with Munchausen syndrome or MSbP voluntarily admit that he or she suffers from the disorder.
3. (d) All of the above.

have you read…?

"Dealing with the Mentally Ill" and "Investigation of Child Abuse," *Training Keys®* 487 and 396, respectively, International Association of Chiefs of Police, 515 North Washington Street, Alexandria, VA 22314-2357.

These *Keys* provide additional general knowledge on the topics of mental illness and child abuse.