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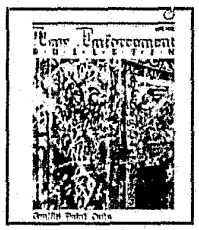

***Cover:*** *Police working with citizens to remove graffiti from neighborhoods strengthens community relations. See article p. 1.*

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# Munchausen Syndrome by Proxy

## Case Accounts

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and
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Hieronymous Karl Fredrich von Munchausen was an 18th century German baron and mercenary officer in the Russian cavalry. On his return from the Russo-Turkish wars, the baron entertained friends and neighbors with stories of his many exploits. Over time, his stories grew more and more expansive, and finally, quite outlandish. Munchausen became somewhat famous after a collection of his tales was published.[1]

In 1794, at the age of 74, Munchausen married Bernhardine Brun, then 17 years old. It is said that on their wedding night, the baron retired early, and his bride spent the night dancing with another. In 1795, Bernhardine gave birth to a son. Following the birth of this child, it was whispered that "the life of the Munchausen child will likely be short." The boy, named Polle, died at approximately 1 year of age under suspicious circumstances.[2]

Almost a century later, an unusual behavior pattern among young men gained recognition in the writings of Charcot. In 1877, he described adults, who through self-inflicted injuries or bogus medical documents, attempted to gain hospitalization and treatment. Charcot called this condition "mania operativa passiva."[3]

Seventy-four years later, in 1951, Asher described a similar pattern of self-abuse, where individuals fabricated histories of illness. These fabrications invariably led to complex medical investigations, hospitalizations, and at times, needless surgery. Remembering Baron von Munchausen and his apocryphal tales, Asher named this condition Munchausen's Syndrome.[4]

Today, Munchausen's Syndrome is a recognized psychiatric disorder. The American Psychiatric Association's *Diagnostic and Statistical Manual of Disorders*

(DSM III-R) describes it as the "intentional production of physical symptoms."

## MUNCHAUSEN SYNDROME BY PROXY

The term "Munchausen Syndrome by Proxy" (MSBP) was coined in a 1976 report describing four children who were so severely abused they were dwarfed.[5] In 1977, Meadow described a somewhat less extreme form of child abuse in which mothers deliberately induced or falsely reported illnesses in their children. He also referred to this behavior as MSBP.[6]

Over the years, alternate terms, such as "Polle's syndrome" and "Meadow's syndrome," have been suggested; however, these terms never gained popularity. In contrast to its adult namesake, the American Psychiatric Association's DSM III-R does not consider Munchausen Syndrome by Proxy a psychiatric disorder.

Tragically, MSBP victims are usually children, and the perpetrators are almost always parents or parent substitutes. If and when victims are hospitalized, they may be subjected to multiple, and at times, dangerous diagnostic procedures that invariably produce negative or confounding results. When the victim and abuser are separated, however, the victim's symptoms cease. When confronted, the abuser characteristically denies any knowledge of how the child's illness occurred.

## CASE REPORTS

In recent years, medical personnel at Children's Hospital in St. Paul, Minnesota, and local law enforcement agencies encountered several MSBP cases, three of which are outlined here. Two of the cases were presented with apnea, a condition where breathing temporarily stops. The third case was presented with recurrent infections masquerading as an immune deficiency.

*Dr. Boros is involved with the Infant Apnea Program at Children's Hospital, St. Paul, Minnesota.*

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### Case #1

*Victim*

MA, a 9-month-old boy, was repeatedly admitted to Children's Hospital because of recurrent life-threatening apnea. At 7 weeks of age, he experienced his first apneic event, and his mother administered mouth-to-mouth ventilation. Spontaneous respiration returned, and MA was hospitalized, treated, and discharged with a home monitor.

During the next 9 months, MA experienced 10 similar events and 7 more hospitalizations. Eight of the events required mouth-to-mouth ventilation. All of these episodes occurred while mother and child were alone, and only MA's mother witnessed the actual events. Two episodes occurred in the hospital.

Unfortunately, despite many tests and surgical procedures, MA's apnea persisted, and his growth slowed. Because of his persistent apnea and failure to thrive, MA received home nursing care. During these home visits, several nurses observed that MA would refuse to eat in his mother's presence. If she left the room, however, he would eat.

In time, both medical and nursing staffs became increasingly suspicious that Mrs. A was somehow responsible for her child's apnea. To better observe mother-child interaction, MA was moved to a hospital room equipped for covert audio-visual surveillance.[7]

On the sixth day, the video clearly recorded Mrs. A bringing on the apnea by forcing the child into her chest, which caused him to lose consciousness. MA became limp and experienced a falling heart rate. Mrs. A then placed the baby back on the bed, called for

help, and began mouth-to-mouth resuscitation.

The hospital immediately informed child protection services and police authorities, who reviewed the recording. Shortly thereafter, a team consisting of a physician, nurse, social worker, and police officer confronted the parents. At first, Mrs. A expressed disbelief at the suggestion that she smothered MA, but when she was informed of the video, she made no comment. She was then arrested.

*Family History*

Mrs. A was a 36-year-old occupational therapist and the mother of three boys. Late into her pregnancy with MA, she worked in an early intervention program for developmentally delayed children. During many of MA's hospitalizations, she appeared caring and concerned, but emotionally distant. Clearly, Mrs. A was the dominant parent, who made all decisions regarding medical treatment.

*Followup*

Mrs. A subsequently pled guilty to felonious, third-degree assault. At the time, she stated: "The only time I ever caused MA to stop breathing was in the hospital." She received 3 years' probation during which she was to receive psychotherapy. If she successfully completed psychotherapy, the felony charge would be reduced to a misdemeanor. She also had to live apart from her children and could only visit them in the presence of two adults.

MA had no further apnea, and at 24 months of age, he appeared vigorous, healthy, and normal. Eventually, the family was reunited.

**Case #2**

*Victim*

CB, a 10-month-old girl, was admitted to a hospital because of recurrent life-threatening apnea. CB was born in another State and was sexually assaulted at the age of 3 months by an acquaintance of her father. After the assault, local child protection services closely monitored the family.

At 6 months of age, CB experienced her first apneic episode. Her father shook her vigorously, then administered mouth-to-mouth ventilation. She was subsequently admitted to a local hospital. After examination and treatment, she was discharged with a home monitor. During the next 2 months, CB experienced six apneic events and three hospitalizations. The family then moved to Minnesota.

During her first month in Minnesota, CB experienced four apneic episodes and three more hospitalizations. All required vigorous stimulations to restore spontaneous breathing. Other family members observed the child immediately following the events. However, only CB's father ever witnessed all of the

## Help for Investigators

Investigators assigned to work child abuse cases should investigate cases of MSBP as they do similar cases of abuse. In general, however, when confronted with possible cases of MSBP, investigators should:

- Review the victim's medical records to determine condition and illness
- Determine from contact with medical personnel the reporting parent's concerns and reactions to the child's medical treatment
- Compile a complete history of the family to determine previous involvement with law enforcement agencies, medical facilities, and social and child protection services
- Compile a detailed social history of the family, including deaths, injuries, and illnesses
- Interview family members, neighbors, and babysitters
- Use video surveillance in the hospital in accordance with State law, and
- Use a search warrant for the family's residence when collecting evidence of the assaults.

actual events. CB was eventually referred to Children's Hospital.

While in the hospital, CB had no clinical apnea or monitor alarms. And, most of the time, she appeared happy and playful. However, when anyone attempted to touch her face, she became hysterical and combative. Over time, both the medical and nursing staffs began to suspect that CB's parents were responsible for her apnea.

Local police and child protection services were notified, and CB was placed in a room with covert audio-visual surveillance.[8] On the third day of video monitoring, the video recording clearly showed CB's father producing an apneic event by smothering her. Mr. B was viewed picking up the sleeping child, placing her prone on the bed, and forcing her face into the mattress. CB awoke and struggled to escape, wildly kicking her legs. Mr. B continued until CB's struggling stopped and she appeared limp and unconscious. Then, he repositioned her on the bed and called for help. A nurse entered the room, stimulated her, and administered supplemental oxygen.

CB's parents were confronted by a physician, nurse, and police officer. Mr. B adamantly denied smothering CB. He was subsequently arrested and removed from the hospital.

*Family History*

Mr. B. was a 27-year-old, unemployed, semi-literate laborer in good health. He was actively involved in CB's day-to-day medical care and was clearly the dominant parent. He also became very knowledgeable of the mechanics of the various county and hospital welfare systems. Officials described him as "demanding and manipulative." During CB's hospitalizations, the family lived in a hotel adjacent to the hospital with room, board, and radio pagers provided by the hospital. Throughout CB's hospitalization, Mrs. B was passive and deferred all medical decisions to her husband.

> ***"...MSBP victims are usually children, and the perpetrators are almost always parents or parent substitutes."***

When they first arrived in Minnesota, the family received emergency financial assistance and was closely monitored by local social service agencies. Four years earlier, Mrs. B was allegedly assaulted and raped. Two months prior to CB's monitored episode, Mrs. B was evaluated at a local emergency room for a "hysterical conversion reaction."

*Followup*

Following the incident at Children's Hospital, Mr. B was taken to the county jail, and upon viewing the video, he admitted to smothering CB. He also was charged with felonious, third-degree assault. The judge ordered a psychiatric examination. Mr. B also received a 10-month sentence in a local workhouse and 5 years' probation. Also, he is to have no contact with his daughter or unsupervised contact with any child in the future.

**Case #3**

*Victim*

JC, a 2 1/2-year-old boy suffered from asthma, severe pneumonia, mysterious infections, and sudden fevers. He was hospitalized 20 times during an 18-month period. Doctors were even concerned that he may have AIDS. However, they soon began to suspect that the mother may have caused the child's problems. Finally, when the boy complained to his mother's friend that his thigh was sore because "Mommy gave me shots," the authorities were called.

Upon searching the residence, investigators seized medical charts and information and hypodermic needles. It was also believed that material also entered the boy through a catheter doctors surgically inserted in the arteries near his heart to give him constant medication.

*Family History*

JC's mother was a 24-year-old homemaker and part-time fast-food restaurant worker. When the mother was 7 years old, an older sister died of a brain tumor at Children's Hospital. During her sister's prolonged illness, JC's mother, by necessity, spent long periods of time at the hospital. Although this occurred long ago, JC's mother remembered the experience vividly.

During JC's many hospitalizations, the mother seemed almost

## MSBP Warning Signs

- Unexplained, prolonged illness that is so extraordinary that it prompts medical professionals to remark that they've "Never seen anything like it before."
- Repeat hospitalizations and medical evaluations without definitive diagnosis.
- Inappropriate or incongruous symptoms and/or signs that don't make medical sense.
- Persistent failure of a child to tolerate or respond to medical therapy without clear cause.
- Signs and symptoms that disappear when away from the parent.
- A differential diagnosis consisting of disorders less common than MSBP.
- Mothers who are not as concerned by their child's illness as the medical staff, who are constantly with their ill child in the hospital, who are at ease on the children's ward, and who form unusually close relationships with the medical staff.
- Families in which sudden, unexplained infant deaths have occurred and that have several members alleged to have serious medical disorders.
- Mothers with previous medical experience and who often give a medical history similar to the child's.
- Parent who welcomes medical tests of the child, even if painful.
- Increased parental uneasiness as child "recovers" or approaches discharge.
- Parental attempts to convince the staff that the child is more ill than what is apparent.

obsessively involved in medical matters and hospital routines. She spent hours in the hospital library reading medical texts. She had few friends outside the hospital, and the medical and nursing staff described her as an isolated person.

JC's father was a 24-year-old church janitor, afflicted with many health problems—the most notable being severe insulin-dependent diabetes. During JC's many hospitalizations, his father appeared distant and only marginally involved. JC's 7-year-old sister was in good health and was named after her mother's deceased sister.

*Followup*

Since JC was removed from his home, he has been healthy. As in previous cases, only Mrs. C was present when the boy became ill, and until investigators showed evidence linking her to her child's illnesses, she denied any wrongdoing. Assault charges were filed, and Mrs. C's case is pending.

## CONCLUSION

Today, the consensus is that MSBP is not rare, is notoriously resistant to parental psychotherapy, and carries a very grim prognosis. Approximately 10 percent of MSBP victims die.

Unfortunately, more police agencies and medical professionals will be confronted with this form of abuse in the future. Hopefully, the information discussed here will alert law enforcement officers, especially those who deal with cases of abuse, to the warning signs of MSBP and will assist them in identifying the perpetrators and helping the victims. ✦

**Endnotes**

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[7] R. Fiatal, "Lights, Camera, Action: Video Surveillance and the Fourth Amendment," *FBI Law Enforcement Bulletin*, January 1989, 23-30. See also *Sponick* v. *City of Detroit Police Department*, 211 N.W.2d 674, 690 (Mich. Ct. App. Div. 1, 1973).

[8] Ibid.