# MUNCHAUSEN'S SYNDROME OR CHRONIC FACTITIOUS ILLNESS: A REVIEW AND CASE PRESENTATION

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**The psychosomatic disorder termed Munchausen's syndrome has gained official recognition in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* in which it is referred to as a "chronic factitious disorder with physical symptoms." Sporadic case reports have been published over the years. Few patients with this disorder allow themselves to be psychologically evaluated or seek treatment for the disorder itself. We report here an unusual case in which a young woman sought help for her hospital-peregrinating behavior.**

In 1951, Asher[1] described a rare and puzzling psychosomatic disorder he termed Munchausen's syndrome. Patients with this syndrome repeatedly seek admission into medical facilities under apparent physical or mental distress, offering plausible stories supporting the nature of their disorder. Once admitted they may submit themselves to radical medical treatment and then discharge themselves against medical advice, often after exaggerated arguments with the medical staff. They later turn to other facilities with the same or other equally convincing histories for further hospitalization and treatment.

Asher selected the colorful but nondescriptive term "Munchausen's syndrome" because of the similarity between the wanderings and fabrications of these patients and the travels and fantastic anecdotes attributed to Baron Von Munchausen (1720-1791). But here the similarity ends, for the baron never submitted himself to medical operations and procedures as these patients do. Although other names have been suggested since (Table 1), none seems to capture the essence of the disorder as this one does.

Although Asher originally described three varieties of the syndrome, others have been added since (Table 2). A survey of the literature suggests that there may be an infinite variety of symptoms presented. The illness is limited only by the patients' intelligence, imagination, experience, and perhaps by the symbolic meaning of the organ of choice.[2]

Munchausen's syndrome recently has gained official recognition in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM III)* (1980).[3] Here it is referred to as a "chronic factitious disorder with physical symptoms." The essential feature as described in *DSM III* is the patient's

> plausible presentation of factitious physical symptomatology of such a degree that he is able to obtain and sustain multiple hospitalizations. The frequency of hospitalizations will be so extensive that the individual spends the majority of his days either seeking or maintaining hospitalization.

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**TABLE 1. LABELS APPLIED TO CHRONIC FACTITIOUS DISORDER WITH PHYSICAL SYMPTOMS**

| Label |
|---|
| Ahasuerus's syndrome[9] |
| Chronic factitious illness[10] |
| Factitious illness (several authors) |
| Hospital addiction[7] |
| Hospital hoboes[11] |
| Hospital vagrants[12] |
| Metabolic malingerers[10] |
| Munchausen's syndrome[1] |
| Pathological malingering patients[13] |
| Pathomime[14] |
| Peregrinating patients[12] |
| Polysurgical addiction[15] |
| Problem patients (several authors) |
| Professional patients (several authors) |

*DSM III* adds that persons with this disorder have voluntary control over their behavior and that their behavior brings no secondary benefits other than what is gained from playing the "sick role." The controversial issues of volition and obvious secondary gain differentiate Munchausen's syndrome from malingering and somatoform disorders. Malingering is thought to be conscious, volitional, and situationally appropriate where secondary gain is obtained. The somatoform disorders are nonvolitional and unconscious. Table 3 outlines the distinctions among these three disorders with regard to conscious control, volition, and secondary gain.[4]

Other features associated with this disorder, as described by Sussman and Hyler,[5] include pathological lying, extensive knowledge of medical terminology and hospital routines, demanding and disruptive behavior, substance abuse, shifting complaints and symptoms, equanimity regarding invasive procedures and operations, wandering, discharge against medical advice, deception regarding identity, evidence of prior treatment, and intermittent time in jail or psychiatric hospitals.

Psychologically and socially, these patients represent a wide continuum of personality (Table 4) and socioeconomic types. Most authors agree that these patients are evasive, attention-seeking, and to some degree, masochistic. Enoch et al[6] devote a chapter to Munchausen's syndrome in their book on rare psychiatric disorders. In their comprehensive overview of the literature, they found that Munchausen patients differ as much as they are similar. They conclude, as most authors since have concluded, that the disorder is primarily a mental one, requiring psychiatric attention.

Although the precise motivation for Munchausen's syndrome is unknown several explanations have been offered, such as underlying organic problem, substance abuse, resentment of physicians, childhood deprivation and rejection, subintentional death wishes, castration fantasies, relief of aggression and guilt through operations, and seeing the physician as a father figure. It is currently believed that different motives operate in different patients and even in the same patients on separate occasions. Ultimately, the disorder probably represents a final common pathway for predisposed persons.

Modes of treatment have ranged from no treatment at all to leukotomy. Approaches such as electroconvulsive therapy, insulin coma, lobotomy, hypnosis, and various forms of psychotherapy have been suggested, but have not proved successful.[7] Most authors agree that successful treatment rests on early recognition and accurate diagnosis, psychiatric consultation, education of staff as to the seriousness and genuineness of the disorder, and maintenance of the patient in a long-term, preferably closed ward setting where supportive, and later, confrontational, psychotherapy can be conducted (Table 5).

## CASE REPORT

Ms. M. reported to the emergency room early one morning with the chief complaint of increasing nervousness following a threat of eviction from her apartment following a heated argument with a neighbor. A mental examination at that time noted paranoia, suicidal ideation, flight of ideas, and concrete thinking.

Ms. M. was a slender, 30-year-old white woman with boyish features. She dressed casually in masculine clothes, had short hair, wore glasses, and smoked cigarettes. Her face had numerous acne

**TABLE 2. VARIETIES OF MUNCHAUSEN'S SYNDROME**

*Acute abdominal type* (laparotomaphilia migrans), distinguished by repeated abdominal symptoms and laparotomies; alleged to be the commonest type[1]
*Hemorrhagic type* (hemorrhagica histrionica), characterized by alarming episodes of bleeding from various orifices[1,16]
*Neurological type* (neurologica diabolica), in which patients present with acute neurological symptoms[1,17,18]
*Cutaneous type* (dermatitis autogenetica), characterized by self-inflicted skin lesions or rashes[12]
*Cardiac type* characterized by various symptoms associated with cardiovascular distress[19-21]
*Repeated ingestion of foreign bodies,* sometimes involving request for surgery for their removal[22,23]
*Psychiatric type,* characterized by mimicking of psychotic behavior and often voicing of suicidal ideation[24,25]
*Munchausen's syndrome by proxy,* in which the symptoms of the presenting disease are fabricated by some person other than the patient[26-29]
*Factitious fever and self-induced infection,* characterized by factitious fevers of unknown origin, or infections/fever caused by the ingestion of drugs, or self-inoculation of contaminated material[30-33]
*Feigned bereavement* (pseudologia phantastica), characterized by false sorrow for the death of another[34,38]
*Mixed and polysymptomatic types*
*Unusual types*

**TABLE 3. DIFFERENTIAL DIAGNOSIS OF MUNCHAUSEN'S SYNDROME**

*Authentic physical disorder*
*Malingering:* conscious, volitional, situationally appropriate behavior aimed toward clear secondary gain (conscious and volitional, with secondary gain, and no organic basis)
*Somatoform:* nonorganic illness in which the signs and symptoms are nonvolitionally simulated and secondary to unconscious drives and for which there is no apparent secondary gain (nonvolitional and unconscious, with no secondary gain)
*Munchausen's or factitious illness with physical symptoms:* conscious and volitional "addictive" behavior, which leads to repeated hospitalizations andmultiple treatments for illnesses which may have an underlying, organic cause (volitional, conscious, with no secondary gain, and possibly related to real organic illness)

scars and both arms were heavily marked with scars and recent sutures. Her abdomen also had extensive scarring, apparently due to many laparotomies.

During her hospitalization she complained of sharp abdominal pain, and later admitted to having swallowed glass prior to admission.

The medical history offered by the patient revealed numerous hospitalizations for a variety of mental and physical complaints. She admitted to having been hospitalized over 60 times, not including numerous emergency room, clinic, and office visits. She also claimed to have moved at least 16 times over the past 10 years. She reported being suicidal since age 15, and having received electroconvulsive therapy (ECT).

Attempts at suicide were evidenced by the patient's statements and by scars covering both arms. She once threw herself from a second-story parking deck, sustaining a broken wrist, pelvis, leg, and ankle. She also had two cornea operations for congenital ocular keratoconus, an appendectomy, a thyroidectomy, a thoracotomy, and a hysterectomy. The patient had had several laparotomies due to her habit of swallowing foreign objects. She claimed to suffer from a seizure dis-

**TABLE 4. PERSONALITY CHARACTERISTICS REPORTED IN MUNCHAUSEN'S SYNDROME**

Aggressiveness
Ambivalence
Antisocial nature
Anxiety
Attention-seeking behavior
Brillance
Childishness
Cleverness
Deficient sense of reality
Depression
Drama
Egocentricity
Emotional lability
Evasiveness
Ability to act
Histrionics
Intellectualizations
Disturbance of identity
Impulsiveness
Inadequate social functioning
Intensity of affect
Loneliness
Manipulativeness
Masochism
Nomadic behavior
Paranoia
Pathologic lying
Restlessness
Self-destructive behavior
Suspiciousness
Unruliness
Lack of stability in interpersonal relations

**TABLE 5. DIAGNOSIS AND TREATMENT OF MUNCHAUSEN'S SYNDROME**

Early recognition and accurate diagnosis from various clues:
- Multiple surgical scars
- Lesions or injuries of improbable character and distribution
- Variety of hospital cards and insurance certificates
- Marked hospital garments
- Possession of sharp objects or medical instruments
- Inconsistencies in complaints and history
- Stories of similar emergencies
- Odd attitude or "la belle indifference" towards the illness
- Better than average command of medical terminology and understanding of hospital procedures
- Desire to impress medical staff

Inpatient hospitalization
Referral to psychiatrist
Long-term psychotherapy

order, amnesia, severe chronic stomach pain, nausea, anorexia, insomnia, constipation, anemia, arthritis, and polydipsia. She also said she became addicted to narcotics during one of her hospitalizations. Various documented psychiatric diagnoses she has carried are shown in Table 6.

The patient described herself as having been a hyperactive child with complaints of insomnia, claustrophobia, and paranoia. She said she was seen by a psychiatrist at the age of 12 because of disruptive behavior in school. She said she was adopted and that her adoptive parents reside in a different state. She described her adoptive mother as domineering and emotionally abusive, and her adoptive father as passive. She related several different stories concerning her natural parents. To one of the authors, she contended that her natural parents were serving prison terms for the murder of her younger sister. To another author, she stated that her parents were killed in an automobile accident. However, a social worker's report stated that both the patient and her brother were removed from the home because of neglect.

The patient stated that she graduated from high school and had minimal college training as an x-ray technician. She said she has held a variety of unskilled jobs, has few close friends, and does not participate in sex.

The patient was very verbal, with rapid, articulate, coherent speech, mostly directed at the mistreatment she suffers in the hands of medical institutions. She seemed quite intelligent but also braggadocian, stating that it was difficult being so smart. The patient had a very good command of medical terminology and procedures and was able to relate various complaints in technical terms. Overall, she appeared rather arrogant and conveyed an "above-it-all" attitude. Nursing notes stated that the patient could be hostile, demanding, and manipulative.

**TABLE 6. PSYCHIATRIC "DIAGNOSES" ATTRIBUTED TO ONE PATIENT WITH MUNCHAUSEN'S SYNDROME**

| |
|---|
| Anxiety reaction |
| Conversion reaction; borderline personality disorder |
| Depression with postoperative psychosis |
| Manic-depression |
| Munchausen's syndrome |
| Schizophrenia, character disorder, chronic depression |
| Schizophrenia, paranoid type |
| Schizophrenia, schizoaffective type |
| Severe antisocial character disorder |
| Suicidal neurosis |

Administration of the Wechsler Adult Intelligence Scale (WAIS) yielded a verbal IQ score of 114, a performance IQ score of 123, and a full scale IQ score of 119. This places Ms. M. within the uppermost limits of the "bright normal" range of intelligence (110 to 119), according to Wechsler norms.

When given the Bender Gestalt Visual Motor Test, the patient reproduced the figures adequately. There were no distortions and the gestalt of all the figures was maintained. No organic involvement, as manifested within the visual-motor area, was evidenced based on the results of this test.

Personality data suggest a distress syndrome marked by anxiety, depression, and nervousness. She is likely to attenuate somatic and emotional complaints through histrionics. She is sensitive and distrustful of others. Projection, somatization, and acting out are her preferred defense mechanisms. Impulse control is likely to be deficient and ineffective. Her expressions of hostility and depression may form a cyclic pattern in which expressions of hostility lead to feelings of guilt which lead to greater depression—anger then recurs more intensely because of resentment for the guilt feelings. She appears to have an exaggerated need for affection and emotional dependency. Sexual difficulties and suicidal themes were noted. Furthermore, she appears withdrawn and lonely. She is resentful towards her parents and distrustful of authority figures in general. She seems to feel that life offers little in the way of happiness, and maintains a pessimistic outlook in line with this world view.

The patient became the center of attention among medical students, staff, and faculty. She appeared to enjoy this attention and offered us a unique opportunity to document her hospital-peregrinating behavior. She provided a list of her hospitalizations, her diagnoses when known, and other information concerning her hospitalizations. Medical release forms were obtained and most of her acclaimed hospitalizations were documented. She asked for help in understanding and changing her hospital-peregrinating behavior. The treatment plan described below was devised and enacted.

The patient remained hospitalized for 12 days. She was maintained on a drug regimen of anti-anxiety and antidepressant agents. In addition, she was given medication for the pain caused by her glass swallowing prior to admission. The patient participated in daily ward activities and was discharged to the Comprehensive Health Center for follow-up.

The patient was assigned a social worker to whom she could turn any time of the day or night. She also participated in group activities at a local community mental health center. Her attraction to the hospital was dealt with by providing her with volunteer work within the hospital. She seemed to improve briefly. However, when last seen she was wearing a cast on her left leg after surgery to repair a ligament she claimed was causing chronic pain.

## DISCUSSION

Ms. M. presents an unusual case of polysymptomatic Munchausen's syndrome, meeting several of the clinical requirements necessary for this diagnosis. Her physical complaints are plausible and stated articulately, with medical sophistication. Her symptoms seem to be under voluntary control and are of a vague, nonlocalized, and migrating nature. She has a history of drug abuse, has received numerous medical treatments, exhibits wandering, disruptive, and demanding behavior, and shows a lackadaisical approach to medical interventions.

Clinically, she presents signs of depression, ambivalence, insecurity, and emotional immaturity. Projective testing revealed depression, feelings of rejection, suspiciousness of authority figures, and the use of somatization, denial, and projection as her main defense mechanisms. Intelligence testing revealed cognitive ability in the "bright normal" range, with higher performance than verbal scores.

Her psychosocial history is consistent with the diagnosis of factitious illness. Her natural parents, she stated, have been absent since she was four years old. She resided in several foster homes before finally being adopted by parents for whom she has never developed love or trust. Her hospital-peregrinating behavior began early, at the age of 15, when she was hospitalized for depression, and given ECT. Since that time she has wandered from Ohio to Florida staying at various psychiatric and general medical facilities. She presents a history of swallowed foreign objects, laparotomies, appendectomy, thyroidectomy, and thoracotomy. She has acquired multiple surgical scars and an extensive knowledge of medical procedure and terminology.

Several mechanisms motivating the peregrinating behavior in this patient have been proposed: First, she claims that the hospital is a harbor of refuge. She appears to thrive on the attention, care, and pleasant surroundings provided in the hospital environment. Significant, perhaps, is her rendition of an earlier deprived childhood. Second, she has had some hospitalizations for real physical conditions that required medical attention. Third, she admits to having abused narcotic drugs to the point of addiction at least once. The hospital undoubtedly provided a readily available source of drugs. Fourth, as happens to many persons who have been raised in foster homes and finally been adopted, she appears to view herself as unloved or unlovable. It is speculated that unconsciously she is attempting to destroy or remove that part of her which she perceives as being defective (eg, via surgical intervention, such as the appendectomy, thyroidectomy and various laparotomies). Finally, the patient related that as time passes an overwhelming "pressure" builds up within her. She confided that by swallowing sharp objects this pressure is released. Her confession is strikingly similar to Menninger's formulation of self-induced punishment for unconscious guilt.[8]

The patient has shown marked improvement in her behavior. She no longer wanders across the country seeking hospitalization, even though she has become very well known to the emergency room personnel in the local hospitals. She has developed several longstanding interpersonal relationships within her age group and visits a social worker regularly. She has not, to our knowledge, swallowed any more foreign objects, cut herself, or in any other way physically abused herself. She no longer abuses drugs, and physically she is a much more attractive young lady than she was one year ago. The progress that had been made has proved tenuous yet significant for a person with this reportedly chronic disorder.

## THERAPY

Patients with Munchausen's syndrome present a difficult therapeutic challenge. Often they have no knowledge of the emotional or psychologic aspects of the illness, have an antipathy for psychiatrists, and refuse psychiatric evaluation and care. Frequently, they sign out of the hospital against medical advice before long-term treatment approaches are conceptualized. Finally, they seem to have no desire to change their hospital-peregrinating behavior.

As a treatment approach, we suggest that once the person is identified a health provider develop a trusting relationship with the patient. This person would not necessarily have to be a physician or mental health professional, but would probably have to be seen as an advocate of the patient whom he would trust and see regularly for support, care, and advice. We feel that once a trusting relationship is developed, the patient would transfer some of his needs for dependency and attention to this significant other. Treatment could be accomplished through this significant other under the tutelage of a mental health expert on an "as needed" basis.

Second, it is important that the treatment plan include long-term psychiatric care. This does not necessarily imply traditional psychotherapy and it certainly is not intended to mean prolonged hospitalization. What is needed is a "psychosocial, environmental plan," within which the true psy-

chosocial and medical needs of the patient can be addressed.

Third, it is imperative that the patient's total psychologic, social, familial, environmental, and other needs be evaluated. Once this information is obtained, it is possible to devise a treatment plan for the patient based on individual needs. Helping the patient gain a vocational or professional skill, if there is desire and sufficient ability, could be an important part of the plan. Efforts should be made to improve family relationships if there are problems. If there are problems in housing, social activities, physical exercise, or any other areas of psychosocial functioning, which seem to be hampering the patient's ability to enjoy a full life, these should be addressed in a positive manner. In essence, the care team can assist the patient in making appropriate choices and decisions, and can provide him with sufficient support and guidance in accomplishing the goals which he sets for himself.

The hope is that by providing the patient with a comprehensive medical, psychiatric, social, and environmental program of rehabilitation, the patient will gain sufficient self-esteem that it will not be necessary to continue the hospital-peregrinating behavior.

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