On Munchausen’s Syndrome

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MUNCHAUSEN’S syndrome has simultaneously fascinated and vexed general hospital physicians for many years.* Several case reports in the literature reflect pleasurable excitement in recounting the stories of patients who have wandered from hospital to hospital presenting dramatic symptoms and lurid medical histories.10 There is a certain admiration for these patients who cleverly fool admitting and emergency room personnel, and who at times can support the pretense of severe illness by producing factitious lesions in a manner which defies detection. Nevertheless, however strongly the interest of physicians may have been stimulated, the vexation is even more pronounced. Consider the situation of the intern or resident. He has admitted a patient with an intriguing diagnostic problem accompanied by all the excitement of an acute medical emergency. He contributes a great deal of time and energy to the study of the patient and only gradually realizes that he has been victimized by a hoax. When confronted with his fraud, the patient is not contrite or apologetic; instead he invents further cover-up stories or becomes indignant and signs out of the hospital just prior to the time that the physician had planned to present him as a case of Munchausen’s syndrome at Grand Rounds. It is little wonder, then, that these patients evoke a feeling of hostility and contempt on the part of the staff.27 Indeed, this complex of feelings toward the patient with Munchausen’s syndrome has been so intense that some authors15,18,23,28 have suggested setting up a “rogues gallery” of these patients in order that they would not be admitted to hospitals and “use up the valuable time and services.”

With the interest which this syndrome has aroused, it is remarkable that most reports end with a sense of frustration and bafflement. How is one to understand what motivates a man to lead a life perpetually in search of hospitalization and instrumentation? While Asher has offered some tentative explanations, he admits that they are “scanty.” The behavior has been attributed to “psychopathology,” and attempts have been made to classify these patients along conventional diagnostic lines; the motives behind the behavior, however, remain unclear and confusing. One reason for this is that these patients give us little to go on. When the psychiatrist is called in, the patient frequently becomes indignant and signs out. On the few occasions where he “cooperates” with the psychiatrist, the veracity of his statements is always open to question. It is the purpose of this paper to present some ideas about Munchausen’s syndrome which may help make this behavior more explicable. We shall present the case of a patient who appeared at our hospital to illustrate the very familiar pattern shown by these patients.

Report of Case

A 38-year-old white man appeared at the Veterans Administration hospital with a complaint of crushing chest pains. He reported some sweating, shortness of breath, and numbing and tingling of the left arm and fingers. He was described

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* The syndrome was first described in 1951 by Asher. He named it after Baron Munchhausen (1720-1791) who had acquired a reputation as a teller of tall tales about wartime adventures. For interesting comments about the name of the syndrome, the reader is referred to Chapman* and Small.*
as "a good historian with an unfortunate past history." This history, as he gave it, included transurethral resection for prostatitis (non-venerial) in 1947, an operation for a rectal fissure in 1950, an excision of a pilonidal cyst in 1951, a laminectomy for a herniated disk in 1953, hospitalization for treatment of osteomyelitis of the spine in 1953, an acute myocardial infarction in 1954, and an orchietomy for malignant teratoma in 1960 which treatment was supposedly followed by 6,000 roentgens of x-ray therapy to the abdomen and groin. These hospitalizations were reported to have occurred in New York state, Nebraska, Utah, and Texas. In addition, the patient reported that his mother has diabetes mellitus and that he had been told that he has a borderline glucose tolerance test; his father has carcinoma of the prostate; an older sister has recurrent skin infections as does the patient; two uncles died of myocardial infarction and one uncle died of carcinoma of the prostate. Furthermore, the patient claimed to be allergic to "aspirin, Darvon, penicillin, Pyridium, Furadantin, erythromycin, sulfa drugs, Novocaine, tomatoes, and strawberries."

The patient was admitted to the Medical Service with a presumptive diagnosis of myocardial infarction and was treated with bed rest and narcotics. Physical examination revealed a patient who appeared in acute distress and was perspiring; temperature was 99.4° F (37.4° C), blood pressure was 88/60, pulse was 100, respirations were 18. There were multiple abscesses on both hips and buttocks, and the patient had a well-healed appendectomy scar, a scar in the lumbar region, and two right inguinal scars. The right testicle was missing. Other than this, the examination was within normal limits. The x-ray and laboratory examinations which included a wide variety of blood chemistries were all within normal limits. A series of EKG's showed no evidence of abnormality other than the slight tachycardia.

As the laboratory evidence was gathered, it became increasingly apparent that the patient had neither the myocardial infarction nor any of the other diagnoses (such as pancreatitis) which had been considered, and the suspicion of Munchausen's syndrome was aroused. This diagnosis was further suggested by the nurses' observations that the patient seemed to be in distress only when people were in the room. It was at this point that letters and phone calls established the fraudulent nature of much of the past history. The testicle had indeed been removed, not for a teratoma but for "neuralgia." The patient had had a long history of hospitalizations and procedures in several areas of the United States, but whatever actual pathology was found had resulted from self-instrumentation. For example, he had caused a urethral stricture which then required dilation. It is noteworthy that during a recent period when he had not been hospitalized for many months, he was receiving periodic urological and colonic examinations in an outpatient clinic. He had also been hospitalized for factitious abscesses and bruises. He had submitted to a variety of diagnostic procedures and had had abdominal and back surgery, both of which revealed virtually no pathology.

As the patient's story became clearer, attention shifted from his chest (the "pain" had now subsided) to the demonstrable lesions—the abscesses. With this shift in emphasis, the patient's story changed and he spoke of the chest pain as an incidental factor. He said that all along he had insisted the chest pain was probably "gas" and not a myocardial infarction; indeed, he had come to New Haven in search of a skin specialist who would help clear up his baffling problem of recurrent infections and easy bruisability. When the diagnosis of Munchausen's syndrome had become apparent, we were asked to evaluate the patient's psychiatric status in preparation for his presentation at Grand Rounds.

This patient was seen for two recorded interviews. He was quite indignant at being interviewed by a psychiatrist but it was apparent that he was equally delighted at the chance to demonstrate and record his voice. The information which the patient gave is so vague and internally inconsistent that it can hardly reflect an accurate history.†

Comment

While we could give greater detail about the wanderings of this patient and the gradual unfolding of the staff's recognition of the deception, there are sufficient cases in the literature4,4,8 which recount the biographical details of patients with this syndrome. The description which is given here should suffice to demonstrate what the author considers the three major features of this syndrome.

The first and most outstanding feature is the dramatic presentation of one or more

† However accurate or inaccurate his stories might be, we have chosen to consider them largely as productions of his fantasy life in the hope that they might illuminate some of the dynamics underlying this syndrome. The "history" which he gave was offered quite freely and probably represents a combination of memory and fantasy. His manner was evasive, alternately ingratiating and boastfully contemptuous, and he constantly attempted to force the psychiatrist to assume the guilt of the "bungling" medical profession. When he was told that he would be given psychological tests, he complained bitterly to the intern, and demanded to be discharged. He was given follow-up appointments at the surgical clinic but failed to appear for them.
medical complaints. These patients present a diagnostic problem and give a long history of numerous hospitalizations and operations. They submit eagerly to painful diagnostic and "therapeutic" procedures.

There is no specific medical complaint which characterizes this syndrome. Originally, Asher attempted to classify the complaints by the organic emergency which they resemble; he spoke of the acute abdominal type, the hemorrhagic type, and the neurologic type—to which list Chapman added a cutaneous type. However, a survey of the literature suggests that the symptoms which are presented may be of an infinite variety and are probably limited only by the patient's intelligence and accumulated medical knowledge and by the symbolic meaning of the choice of organ through which the simulation is expressed. Thus, there are also cases of "malaria" and "porphyria," "fever of unknown origin," and "myocardial infarction." In addition, we have known one case of Munchausen's syndrome which presented as schizophrenia—through which diagnosis the patient elicited a series of shock treatments and various neurological manipulations as he went from hospital to hospital. Clarke and Melnick record a patient who underwent a prefrontal leucotomy for "depression, fear of suicide, and other psychiatric states."

The second feature of this syndrome is that of pseudologia fantastica. These patients falsely elaborate symptoms and histories which intrigue the medical listener. Thus, our patient fascinated the staff with such history as "teratoma" and "borderline glucose tolerance test." Further, when confronted with their falsehoods, these patients rarely admit that they have lied, but they subtly shift their stories to make them more plausible. They seemingly are unaware of the inconsistencies of their stories, and when at last the inconsistencies become so glaring that there seems to be no way out for them, the patients get indignant, angry, and querulous and they leave.

The third aspect of this syndrome is the wandering. Indeed these patients have also been called "problem peregrinating patients." They have no roots, but are impelled to go from hospital to hospital and from city to city. This feature differentiates them from the patients who come to the hospital with occasional factitious illness or minimal organic illness. This latter group of patients use "illness" as an appeal for help in an acute psychosocial crisis; the patients with Munchausen's syndrome have adopted a way of life. They belong nowhere and are well described as "hospital hoboes." Thus, our patient migrated to Texas, to Nebraska, Utah, Connecticut, and to several sections of New York state—and probably has visited many other areas of the country about which we have no knowledge.

What could possibly motivate a person to wander from place to place seeking brief hospital admissions and painful procedures under false pretenses, not as an occasional frantic search for help but as a way of life? Several suggestions have been offered in the literature. The syndrome has been attributed to narcotics addiction, a desire to escape the police or criminal prosecution, a wish for free board or lodging, a need to be the center of attention and interest, and a "grudge against doctors and hospitals, which is satisfied by frustrating or deceiving them." Undoubtedly, these wishes and needs are involved. Our patient admitted intermittent addiction. He also freely described how he enjoys the attention he does not get "on the outside." His anger and contempt for doctors was very much in evidence. He complained that it was "perfectly all right for a doctor to make a mistake or to make a wrong diagnosis, treat a person for a year on the wrong diagnosis and never apologize . . . it's all right for the doctor to lie to the patient . . . but if the patient lies to the doctor, God help the patient!"

However, our patient offered these explanations a little too easily—a little too glibly. When pushed to elaborate, he became anxious and said that addiction was not the "real reason" behind his behavior. "I don't know what the real reason is—there are always reasons and reasons and reasons." If we consider carefully the explanations which are usually offered, we must agree with our
patient that the "reasons" he offered do not suffice. These patients differ from other addicts; their pupils are rarely miotic and we have heard of none who have had withdrawal symptoms. They are clever enough to obtain narcotics without the mutilating procedures they indulge in or submit to. Similarly, they are well aware that one can be hospitalized and cared for on a psychiatric ward for many months. Indeed, hospitalization is not always necessary. Our patient stayed out of hospital for a while, during which time he baffled clinic doctors with a false but intriguing urological problem. In typical fashion, he underwent a variety of diagnostic procedures (such as cystoscopy), and when confronted with evidence of the falsity of his medical history, he became angry and never reappeared at the clinic. What we see, then, is that these usually very clever patients could probably satisfy the needs and wishes mentioned above without resorting to a life of pseudological medical histories, painful procedures, and wandering.

In their search for explanations more pertinent to this bizarre way of life, internists and surgeons have turned to psychiatrists for help. Partly because these patients do not make themselves readily available for meaningful psychiatric investigation, psychiatrists have attempted to classify them diagnostically, but have thus far added little to the dynamic understanding of these patients. Brief examination of some of these diagnostic categories will provide us with a convenient starting point for our dynamic speculations.

Because of the bizarre life pattern, these patients have sometimes been called schizophrenics. Certainly a man who induces a surgeon to perform an orchietomy may well have an underlying psychosis. However, by our usual diagnostic classifications, these patients differ from schizophrenics in that they do not present evidence of thought disorder or affect derangement, and they have a degree of integration and organization which makes it difficult to commit them to mental hospitals.

Often these people are called sociopaths. On examination they present very much like other sociopaths. Our patient was glib, evasive, had a great deal of contempt, gave a history which was quite untrustworthy, and presented what he thought the doctor would like to hear. In the manner of the sociopath, he used language more as a dramatic action than as a realistic communication. Indeed the patient with Munchausen's syndrome does seem to be a type of sociopath but differs from the more usual sociopath who is involved with the law in that he chooses to act out in terms of hospitals, doctors, and painful procedures. Whereas the gains and satisfaction of sociopaths are usually more evident, it is difficult to see what this type of sociopath gets out of his "manipulations."

The third diagnostic label which has been applied is that of hysteria. We differentiate these patients from hysteric on several grounds. Although the choice of organ complaint undoubtedly has a symbolic reference, it is apparent that these patients are much more aware of the false nature of their complaints than is the patient with typical conversions. These patients are rarely bland about their symptoms and the women among them are not particularly seductive—they are truculent. Further, many of these patients are suffering from self-induced illnesses. Indeed it is this feature of willful self-injury and deliberate falsification (pseudologia fantastica) which catches our attention and offers to us a clue to the dynamics of these patients.

The striking feature of patients with Munchausen's syndrome is that they are impostors. Michaels et al. referred to this fact when they called their patient a "social . . . and medical impostor." These patients share many features in common with other impostors. Characteristically, the impostor is a peregrinator having no firm roots. He assumes a false identity and resorts to various machinations to support this identity. Our patient used an assumed name as well as a pretended identity—"chronically ill and acutely ill." Indeed, as Deutsch has noted, the denial of the patient's real identity seems very important, and when the imposture must be given up, the patient has a high degree of anxiety. Impostors have high, unattainable ego ideals and use their imposture as
a means of defense against the anxiety associated with feelings of inferiority. Our patient gave a history (or fantasy) consistent with this view. "My cousins were class A students . . . all far more advanced than my sister and I. I remember my mother telling me how much (my cousins) had done—and why couldn't I do that . . . 'look at you, you can't do anything.'” Consistent with Greenacre's 17 view that the inferiority feelings of the impostor stem from fancied defective genital development, our patient spoke of the ridicule he received from his sister when he could not maintain an erection during childhood sexual play.† To the degree that Munchausen's syndrome is an example of imposture, we have some explanation of the incessant demand for the false role and the anxiety which causes the patient to leave when his "defective" true role is exposed. In addition, it may well be that the rootlessness and peregrinations are a way of not assuming a single true identity. These people have left their homes,26 they belong nowhere, and thus they deny a true identity about which they feel inferior.

By this time, the reader must be aware of the serious problem our reasoning has raised. The concept of falsely assuming a glorified role to defend against the anxiety of inferiority feelings may be quite adequate to account for the usual impostors described in the literature.1,11,17 These impostors pretend to be scientists, heroes, and men of influence and affluence. However, patients with Munchausen's syndrome do not assume such masculine roles—on the contrary, they present as victimized, pitiful, and (as with our patient) literally genitaly defective. What is the relationship between this type of imposture and the more usual type? Immediately, the possibility of a counterphobic maneuver is suggested to us. Does the patient, fearing that he is weak, inadequate, and genitaly defective, attempt to master this fear by invoking the very thing he fears and "rising above it"? Listen to our patient who in one of his deceptions induced a surgeon to remove his testicle: "I'm able to have an orgasm three or four times a day even now when I'm 38—even with the—with the removal of one testicle!" If our speculation is correct, we are beginning to traverse familiar ground. Our patient's attitude (an attitude common to patients with Munchausen's syndrome) has in it the elements of the "flight forward" which plays so prominent a role in Reik's 22 discussion of masochism. With his imposture, the patient actively invites that which he fears; at the same time, while he is pretending to submit to the doctor, he is secretly defiant. He may be bloody, but he is unbowed.

It can hardly surprise us to come upon masochism in the imposture of Munchausen's syndrome. Even on the surface, the syndrome suggests a masochistic approach to life. Reik has described two chief forms of masochism—sexual and social.‡ The sexual masochist consciously and intentionally seeks bodily pain, and by being beaten he achieves gratification through orgasm. He is well aware of the sexual and aggressive aspects of the masochistic episode. These elements are largely unconscious in the social masochist. He is unaware that he has provoked his ill fortune (which is usually a social misfortune rather than bodily pain); he attributes his troubles to "bad luck" or fate. There is no culmination in orgasm, and the sexual and aggressive motives underlying his behavior are hidden from his consciousness. The patient with Munchausen's syndrome seems to occupy an intermediate masochistic position. By his imposture, he can actively and consciously seek out pain while presenting himself as the unwilling victim of an unkind fate. Thus, the house staff said that our patient had an "unfortunate past history." While there is obvious bodily involvement, the medical manipulations are not followed by orgasm and the sexual and aggressive motives are not so apparent as they are in the masochist who seeks orgasm through flagellation.

Now, masochism represents a reversal of subject and object.5,22 The sexual and aggressive impulses which were once directed

† Reik's distinction of these types, of course, rests on Freud's 32 discussion of masochism. We prefer Reik's term "social masochism" to Freud's "moral masochism."

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outward are now “given” to the other person to be directed toward the masochist. However, this reversal is not complete, and, as Reik 22 and Brenman 5 have pointed out, the original outward-directed impulses show through the masochistic behavior. The imposture of Munchausen’s syndrome appears as a reversal of the usual imposture. Rather than being the self-assured successful hero, the patient is a “hapless victim.” More specifically, he appears as a person who “unfortunately” is acutely ill and in need of a physician’s services. Can we see the wish for the opposite—the desire to be the physician—through this imposture? Occasionally we can. The patient reported by Michaels 18 had posed as a physician earlier in life. Other patients are drawn from the medical and allied professions.2,20,21 However, it must be admitted that most reports of patients with Munchausen’s syndrome do not include a history of a medical occupation or outright medical imposture. While our patient did not report having posed as a doctor, he did pose as a professional masseur during one period of his life. We suspect that if this point were pursued in interviews with other patients with Munchausen’s syndrome, a large number of these people would prove to have had a medical or paramedical imposture at one time or another.

However, even in the absence of an actual imposture of the doctor, the wish may be reflected in the patient’s fantasy. Our patient stressed that he knew many doctors socially; he felt he was as good an occupational therapist and psychologist as the professions he had known, and he frequently implied contemptuously that he knew more about medicine than the doctors did. “If you know anything about drug addicts, doctor,” he said to us, “you would know that when an addict is on drugs, sex means very little—if you know anything about drugs.” Indeed, the patient with Munchausen’s syndrome has learned so much about medicine that he can often teach the medical student details about the disease he is simulating. He does not present as a patient coming to the doctor in helpless confusion; he often has a mastery of medical terms and can give a medical history that would rival an intern’s report to the attending physician.

Of course, the impulses which have reversed their objects go much deeper than turning the desire to play the doctor into the desire to play the patient. Evidence of the underlying sexual and aggressive impulses can be observed in the actions and fantasies of these patients, but it is unclear why these impulses take the specific form of playing the role of the medical patient. Simmel 24 has noted that the doctor-patient relationship contains many aspects of the oedipal situation and that there are many physicians who practice their profession as if they were still playing the childhood “doctor-game.” Indeed, the insistence with which the Munchausen patient pursues his imposture suggests a very serious kind of doctor-patient play—and, following Simmel’s analysis, we surmise that the drama is an attempt to cope with poorly resolved oedipal and sadistic conflicts. As with Simmel’s “partial physicians” our pseudopatients appear not to have successfully passed through the oedipal stage and formed firm identification figures. However, here we are clearly well beyond the limits of our data. Thus, we are left with many fascinating questions about the specific choice of the medical field for the drama and the problems of identification underlying the imposture and the direction of the sexual and aggressive impulses.

Treatment of these patients still presents a baffling problem. If our speculations are correct, confronting the patient with his imposture will cause him to flee and there will be no patient to treat. On the other hand, to participate in the perpetuation of the Munchausen’s imposture may be quite dangerous to the patient and it is difficult to imagine medical personnel willing or able to go along with such a plan. Further, while this pretense might keep the patient with us longer, it would not constitute treatment.

In the one case of lengthy treatment of an impostor (not Munchausen’s syndrome) which has come to our attention, Deutsch 11 noted that her patient was driven into treatment when circumstances prevented him

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from running away. The patient was in the military service where a measure of control over his life was available. The anxiety generated when his imposture was exposed could not be relieved by escaping and impelled him to seek help. It is difficult to see how this approach could be applied to the patient with Munchausen's syndrome unless he were committed to the hospital. Inasmuch as the patient is not overtly psychotic, this procedure is unlikely.

Another possible approach is derived from Abraham's description of an impostor who changed his way of life when his narcissistic wishes were gratified. While it is unwise to allow the patient to continue to be the pseudopatient, it might be possible to help him return to the position of pseudodocto by having him use his medical interest to "teach" students, do library work for the physician, or work in a laboratory. Perhaps this would be a way of keeping the patient near psychiatric help. Beyond this, we have no guidelines for therapy other than to avoid too directly forcing the patient to face his real self about which he feels inferior. A corollary to this guideline is that the psychiatrist should avoid concerning himself with the actual history or veracity of the patient's story, and he should make it plain that he is not meeting the patient on the basis of distinguishing fact from fantasy.

As we have not tried the "pseudodoctor" plan, we do not know if it would be of any help; we have never successfully treated a patient with Munchausen's syndrome, nor do we know anyone who has. Perhaps when we understand more about imposture, some other methods of inducing these patients into a treatment situation may emerge.

**Summary**

We have presented a case of Munchausen's syndrome and have speculated on the dynamics of this baffling way of life. While these patients do at times seek attention, drugs, food and lodging, and revenge against doctors, a clue to some of their deeper motivations may be found by considering them as impostors. They defend against the anxiety of their feelings of inferiority and genital defect by running away from their true identities—thus they assume false roles and wander off whenever their real identities are discovered. However, whereas most impostors assume the role of hero, patients with Munchausen's syndrome appear as victims. Their imposture takes a masochistic form; they defend against the anxiety of inadequacy feelings by actively seeking the "defective" position and by defying their physicians. There is evidence that these patients have reversed subject and object and that either through a former imposture or through fantasy life, they gratify a desire to be a physician. The specific mechanisms underlying this reversal and the choice of the medical field as the stage on which to play out the underlying sexual and aggressive impulses must yet be worked out. It is hoped that as we learn more about imposture, we may develop methods of inducing these patients into treatment.

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