CASE REPORT

Charles P. McDowell,[1] *Ph.D.*

Suicide Disguised as Murder: A Dimension of Munchausen Syndrome

REFERENCE: McDowell, C. P., **"Suicide Disguised as Murder: A Dimension of Munchausen Syndrome,"** *Journal of Forensic Sciences,* JFSCA, Vol. 32, No. 1, Jan. 1987, pp. 254-261.

ABSTRACT: This case study reports on a suicide made to look like murder. The case highlights the issue of false claims of criminal victimization and suggests the need for a reexamination of the dynamics of factitious allegations of criminal victimization. Factitious complaints of mental or physical illness are typically self-reported to psychiatric or medical authorities. This paper illustrates a different kind of phenomenon: one in which an injury or disorder is brought to medical attention by way of the police, who report the death or injury as arising from criminal victimization.

KEYWORDS: criminalistics, Munchausen syndrome, suicide

The Munchausen syndrome has been widely reported in the literature since the term was coined by Asher in 1951 [*1*]. Even though the problem of factitious illness had been known for many years, before Asher's work, the literature neglected the identification of its correlates and dynamics. As originally described, the syndrome has three central features: one or more medical complaints which are dramatically presented, false but often life-threatening symptoms and histories, and patient itinerancy [*2*].

Munchausen patients present a wide range of factitious symptoms, including fevers, kidney stones, urinary disease, dermatitis, nausea and vomitting, anemia, meningitis, hyposthenuria, seizures, comas, numbness, hemoptysis, hypoglycemia, Bartter's syndrome, and diarrhea [*3*]. After hospitalization and extensive diagnostic workup, when the patient is found to be falsifying his illness, confrontation often leads to self-discharge against medical advice. The pattern may then be repeated at another hospital. These individuals often present very believable (and frequently fantastic) histories. Notably, their dialogues typically reflect a knowledge of pharmacology, anatomy, and medical terminology.

The third edition of The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM III)* recognizes Munchausen syndrome as a factitious disorder typically self-reported to either medical or mental health professionals [*4*]. Yet neither *DSM III* nor the literature recognizes similar cases which arise from the same psychological motivations but which are directed toward a different audience: the criminal justice system. These cases appear to be a special category of the syndrome in which individuals

Received for publication 1 Feb. 1986; revised manuscript received 18 March 1986; accepted for publication 21 March 1986.

[1]Command crime advisor, Headquarters, Air Force Office of Special Investigations, Bolling Air Force Base, Washington, DC.

factitiously present themselves to law enforcement authorities as victims of crime. Reports of factitious criminal victimization extend along a continuum from petty complaints to allegations of very serious crimes, including rape, assault, kidnapping, and murder. The more significant claims may be supported by self-inflicted injuries which are masqueraded as legitimate. These wounds serve as the victim's bona fides and add to the credibility of the complaint.

The key features in factitious claims of criminal victimization include the "victim's" nonculpability, the prior existence of nominally unrelated personal problems, a sense of being trapped, a desperate need for help, and a lack of ego resources that would enable the victim to either solve his own problems or seek appropriate help. The criminal "misfortune" offers secondary gain which simultaneously relieves these individuals of any personal responsibility for the "crime" itself, extricates them from their unrelated problems, grants them a special status, and provides a great deal of supportive attention by law enforcement and medical personnel.

These cases typically come to the attention of medical authorities through the police, thereby lending further authentication to the factitious claim. The police inform medical personnel at the scene (or in the emergency room) that the "problem" is a rape, an assault, or some other crime. The presenting medical complaint is then accepted at face value as a consequence of the "precipitating" criminal act. In the case described below, an individual took his own life but did so under circumstances calculated to make his suicide look like a murder. Although this is an extreme case, it illustrates both the interplay among these variables and the use of secondary gain for manipulation. It also demonstrates the complexity of Munchausen-related events and underscores the real need for complaint validation.

The Presenting Event

The event took place in the early morning hours in the first part of March 1984 on an Air Force base. A 27-year-old Air Force Security Police staff sergeant radioed his dispatcher stating, "I'll be checking out a red GMC pickup truck at the north gate. I can't see the license or tags. . . . I can't see anybody around the vehicle." When asked by the dispatcher if he needed a backup, the sergeant replied, "Negative backup at this time." Another Security Police unit overheard the radio traffic and drove to the Sergeant's location. Upon arrival about 10 min later, the backup unit discovered the sergeant lying on his back in the middle of the road between his patrol car and the gate. The Sergeant's patrol car had its headlights and spotlight aimed at the gate. There were fresh tire tracks on the other side of the gate. The sergeant had a single fatal gunshot wound to the chest (see Figs. 1 and 2).

The sergeant's pistol, which was on the ground underneath his right hand had been fired once. A pair of handcuffs was found 2 ft. 8 in. (0.8 m) from his left hand with one ratchet open (see Fig. 3). A steak knife was found near the body (see Fig. 4). Nothing else of significance was found at the crime scene. The gate itself is located in an isolated area of the base and was closed and unattended from 5 p.m. to 6 a.m. Lighting in the area during hours of darkness was poor.

The deceased was wearing a standard military uniform and black leather gloves. He had a small bullet wound 1½ in. (4 cm) above the sternum and was purging pink froth from the mouth and nose. Officials at the crime scene believed he had intercepted an intruder carrying the steak knife, whom he disarmed. It appeared the sergeant was in the process of placing handcuffs on the intruder when the intruder managed to get the Sergeant's pistol and shoot him in the chest.

The Autopsy

Postmortem examination disclosed a single gunshot wound. The bullet entered the victim's chest through the third left intercostal space and went through the heart and left lung,

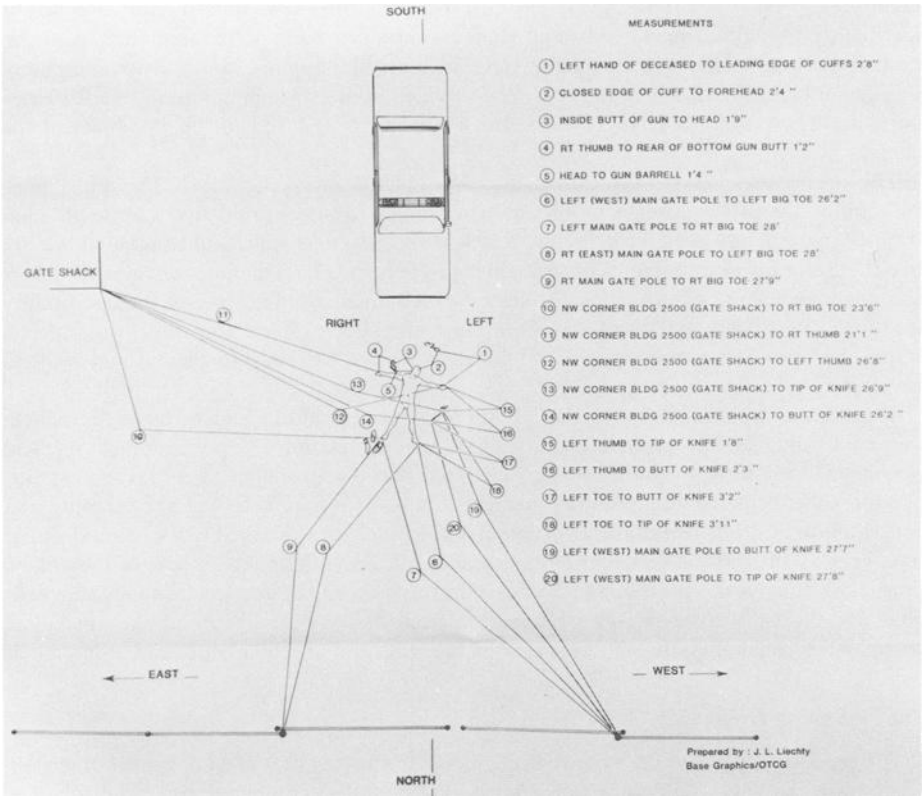

FIG. 1—*Diagram of crime scene (1 ft = 0.3048 m; 1 in. = 25.4 mm).*

exiting the chest through a fracture of the posterior aspect of the eighth left rib. Direction of the bullet was front to back with a right-to-left deviation. Autopsy finding was gunshot wound of chest, heart, and lung with hemothorax and hemopericardium. There were no physical signs of a struggle nor did the deceased have any apparent defense wounds. Subsequent laboratory examination of the powder residue on deceased's jacket revealed a pattern consistent with a shot fired within 12 in. (30 cm) (muzzle-to-garment). Residue tests on the deceased's gloves were inconclusive; although no residue was found, the possibility that the deceased fired the pistol could not be ruled out.

The Investigation

The investigation initially focused on identification of the suspected intruder. At the same time, the facts and circumstances of the deceased's life were examined to see if they could shed light on the incident. It was this latter effort that brought the true picture into focus.

A search of the deceased's quarters revealed, among other things, medical supplies subsequently identified as having been taken during a burglary on base. Police records for the date of the burglary showed that the deceased had been discovered in the supply warehouse. Other officers, seeing his police car parked outside the building, investigated and found him in the building. He told them he had been driving by when he noticed the building had been entered. He said he stopped to investigate. At the time, he was not suspected of committing the burglary.

FIG. 2—*Closeup of deceased at crime scene.*

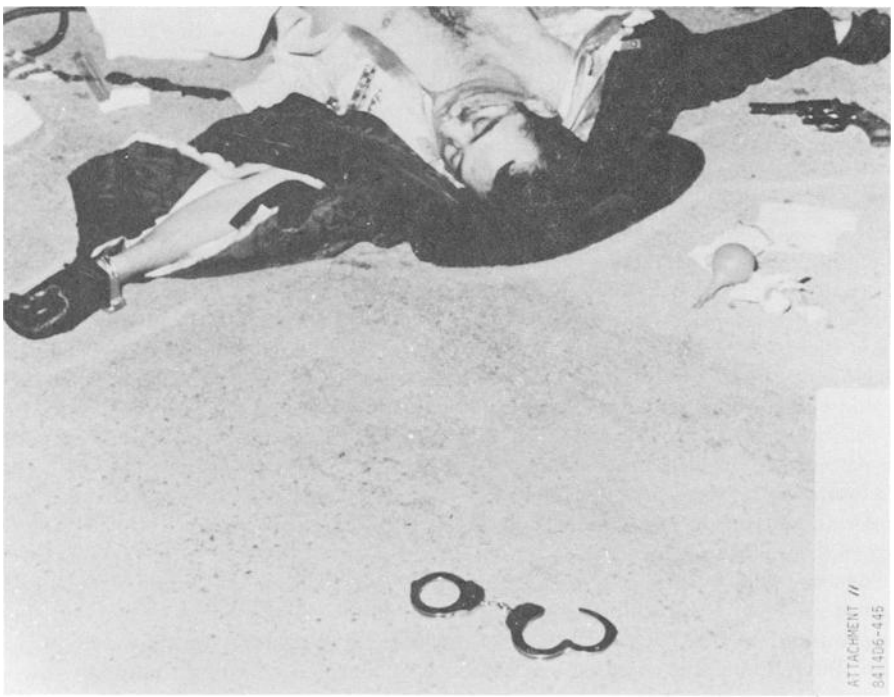

FIG. 3—*Location of handcuffs in relation to the deceased.*

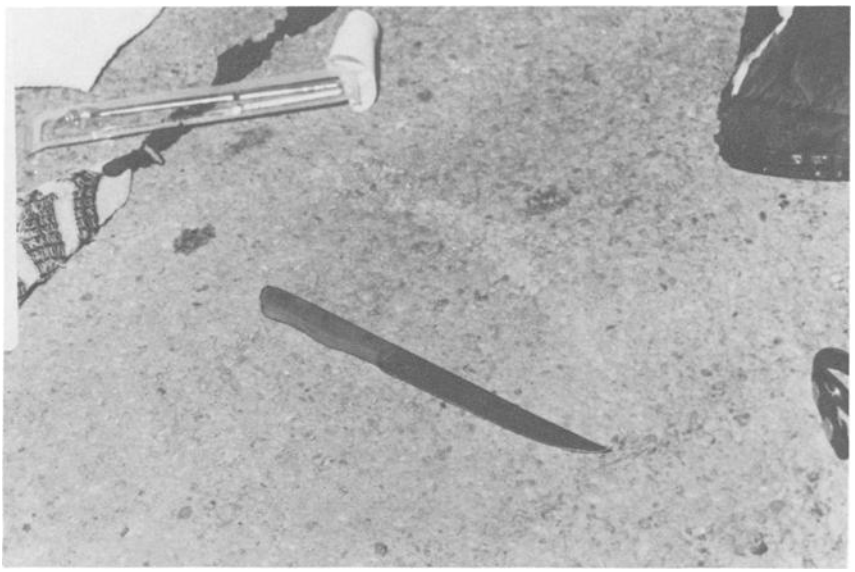

FIG. 4—*Detail showing steak knife.*

The deceased had been on base for a month, having been recently reassigned from an overseas location. He had been divorced once. His second marriage was of three years' duration, although during that time he had only lived with his wife for a total of eight months. They were reportedly separated because of his overseas assignment; however, he maintained an extramarital affair during that period and was ambivalent about with whom he wished to live. His wife stated that the deceased had served a previous four-year tour of duty in the Air Force, which he terminated to become a civilian police officer. It was not long before he lost that job as a result of becoming the prime suspect in a series of burglaries. He then reenlisted in the Air Force and completed two assignments (including the overseas tour) before arriving at his present duty station. His wife called him a "liar and a kleptomaniac," saying he would repeatedly bring home items he stole. She said he had "expensive tastes," and she suspected that he obtained money for stereo and photography equipment by selling things he stole.

They were together the preceding Christmas, at which time he showed her a medical report indicating he had been referred to the base Mental Health Clinic for treatment for a "nervous breakdown." This report cited numerous traumatic experiences, including accidents where people died in spite of his efforts to save them. It further referred to a shooting in which he was almost killed (and which he was later accused of precipitating). Another entry recounted an unsuccessful attempt to save the life of a little boy who had been struck by a vehicle, while yet another notation claimed somebody had tried to kill him but was shot by his partner, and the deceased "had to save the suspect's life." Perhaps the most remarkable disclosure was his secret assignment to a classified combat mission where he served as a team leader and medic and was credited with saving two wounded servicemen while taking the lives of three of the enemy.

Subsequent investigation disclosed this medical report to be a sham, evidently prepared by the deceased and used by him in an effort to manipulate his wife, whom he had told about the extramarital affair. The report was not only a fraud; its contents were complete fabrications. Interestingly, the deceased was trained as an emergency medical technician and apparently had a strong interest in emergency medicine. He also had a history of hospitaliza-

tion for dizziness, hypertension, and tachycardia. He was known to self-medicate for these symptoms and had a history of substance abuse.

His superiors considered him a very good police officer who took his duties seriously and performed at a high level of efficiency. He was always willing to provide counsel to fellow police officers and to talk about his civilian police experience. For example, he "lectured" on the advisability of wearing protective garments, recounting an incident from his civilian police experience. He explained that he had encountered two gunmen during the course of an armed robbery. During the ensuing shootout he was slightly injured, his life being saved because he was wearing his bulletproof vest. He normally did wear a bulletproof vest on duty, but was not wearing it on the night of his death. The knife found at the crime scene did not belong to the deceased but had been taken from a friend's room.

The events of his last day were unusual. Earlier in the day he called his roommate asking that he be picked up at the local civilian jail. Upon the friend's arrival at the jail, the deceased told him he had been arrested because of a dispute with a store clerk. The roommate thought the charge was drunk and disorderly conduct; in reality, the deceased had been arrested for shoplifting. According to the arresting police officers, he was extremely agitated. He told them the arrest would cause him to lose his job. Interestingly, he was not scheduled to work on the night of his death because he was supposed to take a promotion test the next morning. He showed up for duty anyway, claiming the test had been canceled (which was not true). That evening, before reporting for duty, he told his roommate he was going to work in the hope he could make the "jail check" at the local police department. This was a regular procedure to see if any military members had been arrested by civilian authorities during the previous 24 hours. He hoped that by doing so he could conceal the fact of his arrest and thereby save his job.

After learning he could not intercept his police report, he volunteered to work a patrol post. It might be supposed that at this point, the deceased was overcome by a sense of impending disaster and decided to stage the presenting event to make his suicide appear to be a murder. Such a dramatic scenario would enable him to escape from his marital/girlfriend problems and his indebtedness ($15 000), and to avoid disgrace at work. It would also afford him a hero's death. There is reason to believe, however, that he contemplated suicide even before reporting for duty on the fatal evening. A note addressed to his wife was found in his room. It bore a notice that it was to be opened only in the event of his death. The note said, among other things, that he "died as he had lived."

Discussion

Careful examination of this case reveals dynamics that conform to Munchausen syndrome. Its features meet the diagnostic criteria of *DSM III* (Axis I Code 301.51, Chronic Factitious Disorder with Physical Symptoms). The deceased's military medical records show 41 instances in which he presented himself to military hospitals or clinics over a 35-month period. His records further indicate additional treatment by civilian physicians before his entering the Armed Forces. Although his complaints centered around hypertension, they also included tachycardia, shin splints, bruises, a broken nose, assault, dizziness, foot pain, minor accidents, and eye irritation. His hypertension was episodic and did not respond well to prescribed treatment. This may be important in light of the deceased's technical knowledge of medicine which went beyond that of the average layman—a characteristic often found among Munchausen patients [5].

The deceased's pseudologia fantastica is seen most clearly in the sham mental health report he left with his wife, but is also evident in the tall tales he told his coworkers. Interestingly, in the report he gave his wife he suggested a post-traumatic stress disorder. Sparr and Pankratz have reported other cases of factitious post-traumatic stress disorder [6]. By link-

ing his current problems with factitious past events (especially those of a spectacular nature), the deceased not only shifted responsibility for his actions from himself to events outside his control, his "traumatic" claims also enabled him to maintain continuity with his ongoing, dramatic biography. His grandiose, spectacular, and extremely macho references to his own gallantry have an almost counterphobic quality to them, suggesting that his career choice (police work) and avocational interest (emergency medicine) may have been efforts to gain mastery through a kind of imposture. These interests may have also been vehicles which enabled him to act out the role of an exaggerated ego ideal, thereby protecting himself from a self-image of inadequacy and incompetence. This would also provide him with a distorted sense of entitlement in which he could view himself as deserving praise and public esteem because of his humanitarian efforts at rescue. This would enable him, as Grinker notes, to search for a new identity while denying his actual, unwanted identity [7]. Seen in this light, his medical complaints may have been self-punitive, used to assuage feelings of guilt, and simultaneously used to enable him to manipulate his environment.

A central feature of Munchausen syndrome is patient itinerancy. These patients tend to be travelers who repeat their performances at different hospitals. The military offers an especially rich opportunity for peregrination because of the frequency of reassignments. Deceased did avail himself of military hospitals and clinics at every location where he was stationed. He was thus able to capitalize on normal military routine to achieve itinerancy.

Summary

As Cavenar and Maltbie have noted, "The Munchausen syndrome is a descriptive diagnosis only and, while it is a colorful term, fails to define the dynamics or psychopathology of the patient" [8]. Even so, the concept is a convenient vehicle for evaluating certain kinds of behavior. However, as this case illustrates, the concept may be too narrow in its current definition. By focusing on cases involving factitious conventional physical or mental illnesses, the present definition of Munchausen syndrome stresses the means of deception while ignoring its central feature: the use of a factitious problem to generate secondary gain which thereby enables the individual to avoid responsibility for other, unrelated problems. The particular manifestation of the factitious illness or trauma is of less importance than the fact that a factitious problem is used to manipulate the "victim's" personal and social environment. Moreover, the "problem" need not necessarily even be of a medical or psychiatric nature, although that will often be the case. Members of the medical and mental health professions become unwitting dupes because they are care-givers who typically assume "responsibility" for the management of the patient's problem (at least to the extent that it appears to be medical or psychiatric). Indeed, this is part of the "therapeutic alliance." It may make the patient's problem appear more credible if it comes to medical authorities through the police, but the basic dynamic remains the same.

The victim in this case manipulated his spouse, coworkers, and even the law enforcement and medical systems in the service of his pathology. This case suggests that the conventional description of Munchausen syndrome may be overly narrow in its focus and that the phenomenon of factitious claims of negative experiences—medical, psychiatric, criminal, and others—may need to be given greater scrutiny and perhaps a broader definition. From the perspective of the forensic science specialist, this case illustrates the critical need for objectivity, complaint validation, and the importance of a carefully developed patient history.

Many of the characteristics frequently found in suicides (disturbances in intimate relationships; a sense of isolation; a feeling of powerlessness or the inability to control one's life, and so on) also describe many Munchausen patients. In most suicides the victim becomes trapped in a downward spiral of depression, alienation, and estrangement without becoming increasingly manipulative, ultimately losing control. The Munchausen patient, on the other hand, maintains control through manipulation. Although the victim in this case was virtu-

ally an exact match to the Air Force profile of active-duty members who commit suicide, the construction of his suicide scenario was unique. The investigators' willingness to explore all possibilities and the commitment to a thorough investigation ultimately led to a successful resolution of this case. The manner of death was ruled as a suicide by the medical examiner.

The phenomenon of false allegations of criminal victimization requires a systematic examination in its own right. Research into this unexplored realm might shed a great deal of light on the problem and at the same time suggest effective approaches for identifying false positives. This is more than a theoretical issue since it is not inconceivable that a person could structure his or her suicide to look like a murder, thereby implicating an innocent party.

References

[1] Asher, A., "Munchausen's Syndrome," *The Lancet*, Vol. 1, Jan. 1951, pp. 339-341.
[2] Nadelson, T., "The Munchausen Spectrum: Borderline Character Features," *General Hospital Psychiatry*, Vol. 1, 1979, pp. 11-17.
[3] Shafer, N. and Shafer, R., "Factitious Diseases Including Munchausen's Syndrome," *New York State Journal of Medicine*, Vol. 80, 1980, pp. 594-604.
[4] *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed., American Psychiatric Association, Washington, DC, 1980.
[5] Pankratz, L., "A Review of Munchausen Syndrome," *Clinical Psychology Review*, Vol. 1, 1981, pp. 65-78.
[6] Sparr, L. and Pankratz, L., "Factitious Posttraumatic Stress Disorder," *American Journal of Psychiatry*, Vol. 140, Aug. 1983, pp. 1016-1019.
[7] Grinker, R., "Imposture as a Form of Mastery," *Archives of General Psychiatry*, Vol. 5, Nov. 1961, pp. 53-56.
[8] Cavenar, J. O. and Maltbie, A. A., "Munchausen's Syndrome," *Military Medicine*, Vol. 143, May 1978, pp. 349-352.

Address requests for reprints or additional information to
Charles P. McDowell, Ph.D.
Command Crime Advisor
HQ AFOSI/IVIS
Bolling AFB, DC 20332-6001