

Nursery Crimes

Jennifer Bush seemed a heartbreaking example of bad medical luck. The child had had medical ills since infancy—tough, multi-system problems that tenaciously resisted treatment, crippling her digestive system and urinary tract. She seemed to have immune problems as well, for despite her normal white-blood-cell counts, she repeatedly festered with a variety of bacterial infections in her gut and bladder. By age nine, Jennifer had been hospitalized more than two hundred times and had undergone forty operations, including removal of her gallbladder, her appendix, part of her intestines. And still she did not improve. Her plight was a long-standing mystery—until it was solved, not by her doctors, but by the police.

To begin to understand what had happened to Jennifer Bush, one must confront a vexing question: What things are okay to do to a child? Whom does a child belong to? And should a child belong to anyone?

This issue was at the core of what caused a bunch of my friends to lose religion as adolescents. We would marvel at the injustices of the Exodus story. What about the horses? we would ask. Why should they have been drowned in the Red Sea? And what about the soldiers who got drowned? I bet a lot of them didn't have any choice in the matter.

But the episode most likely to shake one's faith was obvious: And what about the killing of the firstborn, the babies, how'd they get mixed up in this? Our Sunday-school teachers would dutifully fill us

in on how the situation was more complicated than we appreciated. You see, Pharaoh was not just a man. This was a turf war between Yahweh, God of the Israelites, and Pharaoh, God of the Egyptians, with no holds barred. Egyptian cows, horses, crops, loyal servants, even babies, all belonged to Pharaoh and were thus fair game. The ten plagues became just rubouts against the family of this *global parentis* godfather.

This is not the sort of explanation that would still cut it with most folks, the idea of damaging a child to punish or test a parent—these days, if Abraham threatened to slit his son Isaac's throat because he and his god had some issues to work out, a likely result would be a visit from the child welfare authorities. Nevertheless, most people consider children to be partial extensions of adults, and rightly so. Children need their parents to make important decisions about their health care, their diet, and their education—otherwise they would spend entire childhoods eating doughnuts and watching TV. But how much oversight is appropriate? Is a child a mere extension of his or her parents, the school system, the tribe, the state?

These questions have generated some pretty extreme viewpoints, some of which resemble horror stories. At one end of the spectrum are those who argue that adults have no right to impose anything at all on children. An academic version of this is found in the work of Thomas Szasz, one of psychiatry's most persistent nudniks, who spent a career questioning and poking at all sorts of cherished beliefs. He proclaimed mental illness a "myth," a labeling system for the powerful to shunt away troublesome thinkers. He argued that psychiatry could only be carried out with consenting individuals, calling involuntary psychiatric treatment rape of the patient, and that no child could be the consenting equal of an adult psychiatrist, making child psychiatry illegitimate.

As another example, a few years back, a loony reductio of the child-as-free-agent idea was promulgated by the mother of Jessica Dubroff. She was the seven-year-old whose gimmick of becoming the youngest

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person to pilot a plane across the country ended in twisted, fatal wreckage. In the aftermath of the tragedy, the previously exploitative media began its calls for more responsibility by parents and other authorities. Into this breast-beating fest stepped her mother, one Lisa Hathaway, a self-proclaimed New Age healer whose maunderings under the circumstances took America's collective breath away. She, along with her late ex-husband, mangled in the plane crash, espoused a theory that the job of a parent was to stand on the sideline, exhorting the child to explore any and all whims, and that any strictures were abusive, paternalistic, antilife, and so on. "I would want all my children to die in a state of joy," she proclaimed within minutes of her child's death. She vowed to fight the FAA's move to toughen up rules about kids flying airplanes: "You look at Jess and tell me how you can question that. Have you seen a seven-year-old shine like that? She had room to be; she had room to have a life." Well, almost. (Ironically, most came away with the impression that Hathaway and the father had gone about creating and marketing Jessica and her stunt with the crassness and manipulations of old-time stage parents. These ol' hippies could have taught some tricks to the Culkins or to JonBenet Ramsey's folks.)

At the other extreme are cases where parental control of children has extended beyond the realm of what many, or even most, would consider appropriate. For example, courts have tackled the issue of whether Christian Scientists—whose religion rejects medical interventions, even to the point of abhorring the use of a thermometer, in favor of healing prayer—have the right to withhold medical care from their sick children. Some of these cases make for pretty painful reading, these tales of children dying excruciating deaths from readily cured diseases. The court decisions are clear: that may be fine for consenting adults, but parents cannot let a child die for lack of medical care, in the name of their religion.

The courts decided differently, however, when it came to a group of Amish parents in Wisconsin who wanted to keep their children out

of high school—where, for the first time, they would be exposed to non-Amish classmates and so might be tempted to stray from their tight-knit community. The state argued, in part, that if Amish children were to become Amish adults, it should be out of knowledge and choice, not because they were sheltered extensions of their parents. But the U.S. Supreme Court ruled in favor of the parents.

So it's not okay for parents to kill their kids because of a belief system, but it's fine to leave them so uneducated and ill-prepared for the outside world as to give them no choice but to remain in the fold. Thus, Amish children not only "belong" to their parents, but to the Amish heritage as a whole. (And as discussed in the notes after this piece, the court went out of its way to say that this sort of decision only applies to religious heritages of the right sort—cults need not apply.)

A similar belief, in a very different setting, emerges from a story about Gandhi. As appalling violence raged between fanatic Hindu and Muslim nationalists, he commenced a fast to the death for peace. Huge crowds supporting peace converged around him in a vigil. At one point, a bloodstained Hindu fanatic bursts through the crowd to confess his sins to Gandhi: he has slaughtered an innocent Muslim family with his own hands. Gandhi instructs him on his path to redemption. Take a Muslim child, an orphan of this madness, and raise this child with every comfort you can provide . . . as an observant Muslim, as one of your enemies. An immensely moving prescription that made an entire nation sigh, premised on that notion—by dint of birth, this one belongs to the Muslims, and, thus, you must help facilitate his return to them.

Those debates have an abstract intellectual resemblance to the case of Jennifer Bush. But they pale as one begins to comprehend what happened to this child and, unfortunately, to others like her. In April 1996, Jennifer's mother, who had been appealing through the press for help with her daughter's astronomical medical bills, was arrested. Detective work by the police and child-welfare workers in

Florida, where the Bushes lived, showed that the cause of Jennifer's persistent infections was ultimately neither gene nor pathogen. The girl's symptoms, it seems, had been created by her mother. Incredibly, according to the charges, for which she was eventually convicted, Mom had been putting feces into Jennifer's feeding tubes. Plus, there was some major financial fiddling that was added to the charges. It even looked as if a letter to the Clintons, asking for help in a big, childlike scrawl, had been penned by a maternal ghostwriter.

Horrifying, stunning. And a disorder of parental behavior common enough to qualify as a syndrome.

The phenomenon is most commonly called Munchausen's by proxy. In 1951, a psychiatrist named Richard Asher described an odd disorder in which individuals fabricated symptoms to obtain needless medical care. Subspecies of this had already been noted and named, including "laparotomophilia migrans" (fabrication of symptoms resulting in an operation), "neurologia phantastica" (fabrication of neurological symptoms), and "haemorrhagica histrionica" (self-induced blood loss). Asher, emphasizing the common theme, now gave them a single, unifying term, which he termed Munchausen's syndrome (named for Baron Karl von Münchhausen, an eighteenth-century German soldier who was known for telling tall tales about his adventures. For some reason, Asher dropped the second *h* in the name). Then in 1977, a British pediatrician named Roy Meadow, of St. James University Hospital in Leeds, formalized a relative of Munchausen's syndrome in which a parent fabricates symptoms in a child, logically terming it Munchausen's by proxy (MBP).

MBP is stunning, riveting, because of the social complexity of the disorder, the fact that the unimaginable behavior on the part of the parent typically winds up succeeding with the unwitting collaboration of medical authorities. But before delving into that, the mere case reports of what MBP is about are grist for nightmares.

In the less invasive versions of MBP, the parent merely manipulates samples taken from the child. Meadow's original paper described the

case of a six-year-old girl admitted to the hospital with foul-smelling, bloody urine that teemed with bacteria, seemingly due to a massive urinogenital tract infection. Physicians in prior hospitals had seen her and were stumped, referring her to these experts. Oddities began to emerge. In the morning, there would be an infection with one type of bacteria. By the evening, that bacteria would have been vanquished, only to be replaced with an onslaught of a different one. Even stranger, in an afternoon's sample, there might be no bacteria at all. Increasingly powerful medications were given to the child, all for naught—the infection continued. Alert nurses noticed a pattern: there were bacteria in the samples only when the mother was around to help with collecting a urine sample, a pattern documented in Meadow's paper. Eventually, chemical analysis revealed that the blood in the urine was menstrual blood from the mother.

The really horrific quality is seen when a parent manipulates events going on *in* the child's body. Some MBP parents have been found to generate a mysterious rash in their child by rubbing caustic solutions into the skin. In another report, a mother of a two-year-old beat her daughter's ankles severely enough to generate severe inflammation that required incisions and drainage, then kept the area infected by contaminating the incisions with soil and coffee grounds. A pediatric cardiologist at the University of Cincinnati named Douglas Schneider and colleagues reported an even more invasive case. Most parents learn about syrup of ipecac somewhere along the way, the terrible, essential drug needed to purge a child who has swallowed some poison. And this mother was force-feeding her five-year-old son ipecac, triggering violent vomiting and diarrhea. Suspicious nurses found bottles of ipecac secreted in the hospital room, in the mother's coat pocket. The vomiting abruptly stopped after that, and the child recovered, merely with heart damage (a potential side effect of ipecac). The report describes an additional case in which a three-year-old, after vomiting six to eight times a day since birth, died.

Meadow, in his original paper, described another case, this time of

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a toddler whose salt balance was dramatically, incessantly out of balance, with far too much sodium in the bloodstream, a problem also there since birth. As per the usual pattern, the problem disappeared whenever the mother was kept away from the child. A trained nurse who was skilled at using a gastric feeding tube, she was apparently force-feeding salt to her son. He died as social services personnel were planning his protective custody. And in a truly horrifying case, a University of Chicago pediatrician named Edward Seferian reported on a six-year-old boy whose body had been invaded by a menagerie of bacteria. This was rare, puzzling—one seldom sees a child who is so immunosuppressed that the body festers with polymicrobial sepsis. But the mystery deepened—the child's immune system wasn't suppressed, it was functioning just fine. Yet wave after wave of bacterial infection occurred in the blood, accompanied by sustained high fevers, all resistant to a pharmacy's worth of antibiotics. Eventually, the staff became suspicious, and the father supplied some corroborating details that pointed to the mother, the mother who had become enough of a regular on the ward to help with the intravenous feeding of the child, the mother who had earlier worked as a medical technician and knew her way around a hospital, the mother who was ultimately found to be introducing feces into her child's bloodstream.

Here are the techniques available to the MBP parent: Bleeding can be fabricated by adding outside blood or can be induced with enough anticoagulants to turn a scratch into a river. Seizures can be provoked by repeatedly pressing down on the carotid arteries in the neck. A torporous state of central nervous system depression can be induced by insulin injections. Apnea severe enough to be convincingly recorded on a breathing monitor can be induced with smothering. Diarrhea can be induced with laxatives or salt poisoning, vomiting with emetics like ipecac.

And here are the most common drugs and poisons force-fed to the children to generate symptoms: anticonvulsants, opiates, tranquilizers, antidepressants, salt, antihistamines, and, of course, laundry bleach.

The average perpetrator is, overwhelmingly, the mother (and this is sufficiently so that I will write throughout as if this were solely the case—this is just an expository convenience). The average victim is under six years of age, certainly in no position to tell anyone that when no one is around, Mommy injects a finely suspended filtrate of dog shit into her child. The average lag time between the child's entrée into the medical system and discovery is fifteen months, ample time for those serious and recalcitrant symptoms to generate plenty of tests and scans, for a round of medication, for a more powerful second medication, for that new experimental third medication, for feeding tubes, drainage lines, transfusions, urinary catheters, enemas, IV lines, and endless injections, even for repeated anesthetizations and surgeries. And the mortality rate approaches 10 percent.

One gropes for a way to understand this, to tie these obscenities to some sort of explanation, as if MBP were a maddened extension of something remotely familiar. But many of these potential links are severed because of what MBP is not. This is not child abuse in the (tragic that the following word will be understood) "everyday" sense of, say, beating the child. That typically involves active effort on the perpetrator's part to avoid prying medical authorities, in contrast to the situation with MBP. This is not some maternal anxiety disorder, a mother so pathologically worried about her child's health as to fabricate problems so that the child can remain safely ensconced in the medical system. There appear to be no such anxieties. Nor is this something called "mothering to death," where the maternal anxiety about the child's health involves a dread avoidance of the medical system. It is not "masquerade syndrome," in which a mother will lie about a child's health to keep her out of school—in such cases, the motive is to extend the mothering, delay the child's independence, and there is typically complicity between the mother and child, and no actual illness induced.

As also defined, MBP cannot involve a delusional but sincere belief on the part of a parent that the child is sick. The parent

doesn't believe that the baby repeatedly manages to swallow some poison, necessitating ipecac eight times a day. The parents don't believe that bleach, an occasional smothering, and feces under the skin drive out Satan. There are no whispering voices in the head insisting that they provoke seizures in their child.

And as a final version of what MBP is not, its manipulativeness cannot be for the goal of material gain—the mother tearfully begging the landlord to be understanding about the late rent check because, after all, her child is sick again. Insofar as there might be any material gain, it is a secondary motive, at best.

So what is the disease about? In MBP families, the husband is typically nonexistent or at least distant, and Meadow speculates that the fabricated drama, in the latter cases, is partially meant to pull in that disinterested husband. Another clue: as hinted at in the case reports, about half of MBP perpetrators have had some medical training. This is a prerequisite for the technical skill and the familiarity with hospital culture needed to pull off some of the fabrications. And Meadow noted a pattern subsequently reported by others: most of those mothers with medical backgrounds had *failed* at their medical careers; they had been nursing students who didn't cut it academically, physician's assistants fired for their emotional instability. Meadow writes, "It could be suggested that some [of the MBP mothers] were determined to defeat the system that had defeated them."

But the central, defining motivation in MBP is a desire to be utterly enveloped in the medical system. "Hospitals can be a strong (and dangerous) addiction," as Meadow puts it. MBP mothers devote themselves full-time to the child's illness and go weeks without leaving the ward. The medical staff initially views them as self-sacrificing saints. In return, they reap a sense of comfort and security, the almost sensual pleasure at the attention, the intertwining of nursing and being nursed, the acceptance into a rich, structured social community.

This insertion into the hospital setting is not merely presented as

an energetic vigil for a sick child. The mother quickly inveigles her way into the community of the staff. Becoming a model "civilian" on the ward requires a manipulative social expertise that is even greater than the medical expertise that many of these MBP mothers have. The typical MBP mother is effusively complimentary of the staff, grateful, appreciative, trying gamely to be diplomatic about how much more capable everyone here is than those incompetents in that previous hospital. Within days, she is showing up with brownies for the night crew (in a high-brow version of this, one MBP mother turned out to be a primary fund-raiser for the hospital's pediatric ward). Soon, the mother has found out everyone's birthday, arrives with gifts that are just barely on the right side of being too personal. She becomes a confidante, hearing about nurses' romantic problems, the shared heartaches of parenthood. She figures out the politics and conflicts of the house staff, quietly letting someone know whose side she is on—theirs, of course. She understands. She understands the abuse nurses have to often put up with from the doctors, she understands the strain and insecurities the young doctors have to work under, so impressive in her ability to hear about other people's problems when she has so many of her own—"Do you know whose kid is hers? Yeah, the really sick one; it's amazing how strong and giving this woman is. . . ." She becomes more than an undefined ward mascot. Half the female staffers suspect they have found a new best friend; half the male staffers think they'll be in bed with her soon. An entire medical unit is seduced, ready to go the extra mile to help her mysteriously ill child, ready to accommodate the mother's desire to be in the thick of virtually every medical procedure, ready to suspend the slightest whisper of suspicion as absurd and unworthy.*

*This style of social manipulateness shares many traits with "borderline personality disorder." Borderlines are notorious for chewing up inexperienced clinicians for breakfast. Grizzled mental-health elders, overseeing the training of young psychiatrists or psychologists, talk about the need for their young'uns to become "borderline-proof," hoping that the first such patient they encounter merely teaches them

This complex edifice of manipulation, that ability of the MBP mother to work her way into the social community of the staff, becomes a vicious spring trap when someone begins to suspect that the pieces aren't adding up. The features of the kid's illness begin to raise suspicions. Or maybe it's that the perfect mother never seems as concerned about her child as is the staff. Perhaps someone finally notices how the vomiting, the bacteria, the fever only seem to occur when the mother is around. Or maybe someone walks into the child's room and catches the tail end of the mother doing something behind closed curtains to the sobbing, agitated child. The sleuth is probably going to be a senior nurse, maybe the head nurse, who has some experience and jadedness about patients and their families. It's going to be someone who is distinctly borderline-proof, who is not looking for a best friend at work to pour out her heart to. It's going to be a no-nonsense type who is not prone to the touchy-feely and is probably not the most popular staffer.

The skeptic airs the suspicions, and the ward explodes into dissent, as most staffers turn on the skeptic. These are accusations against their new friend, against the most devoted mother any of them have ever

indelible clinical lessons, rather than destroying their career or personal life.

In mental-health lingo, *borderline* can be a hideously active verb: "Christ, I have to go waste the afternoon in a trumped-up disciplinary hearing for Smith, the second-year resident. Poor kid. He had this patient, smart, young professional, totally seductive style, gets Smith to start prescribing tons of Demerol for her for no reason. He finally figures it out, tries to stop her meds, and now she's got half the board convinced that he was trying to get into her pants during therapy sessions. And, naturally, turns out she's done this Demerol stunt at four other training clinics, but it's not admissible at his hearing because she keeps countercharging them into chickening out of putting it in her records. So now it's hit the fan for Smith. Poor kid, he got totally borderlined." The infamous Glenn Close character in *Fatal Attraction*, before she went postal with the knives and the bunny, had many borderline traits. Masters of manipulation, emotionally labile, capable of grandiose suicidal gestures (but rarely of true suicidalism), functioning in a black-and-white world of villains or idealized heroes, with relationships that are usually transient and superficial because they can't survive that sort of dichotomizing, borderlines possess an all-consuming surface persona of control and duplicity that makes one wonder who, if anyone, is inside.

seen. Terry Foster, clearly a battle-wearied senior nurse, writes in the nursing journal *RN* about how manipulative individuals such as these can "split" an entire staff. Most nurses are unaware of these sorts of disorders, find it unimaginable that such a thing can exist, as it runs counter to the core of the caregiving of their profession. Doctors, who are usually as psychologically sophisticated as an adolescent candy striper, find the accusations by some abrasive, unpopular nurse against this personable, committed individual to be ludicrous. Foster writes about how the doctors don't even show up at the staff meetings called about the matter.

How can any of these mothers get away with it, often for such fatally long periods? The borderline style is obviously a big part of it. Moreover, in most pediatric wards, parents are encouraged to spend as much time there as possible, and to be active participants in health care—generally a good thing, but open to the depredations of wolves in mother's clothing. Part is because physicians are suckers for exotic, complicated cases that challenge them, and they lose the forest for the trees—a medical system that is "specialized, investigation-oriented, fascinated by rare conditions, often ignorant of abusive behaviors, and too accepting of reported histories," according to Terence Donald and Jon Jureidini, two Australian pediatricians who have written about MBP.

But there is a darker reason too. By the time the first jaundiced accusations emerge, every health-care professional has been complicit, albeit unwillingly and unconsciously, in what was done to that healthy child. The injections, the blood draws, the drainage incisions, the enemas, the surgeries. The restraining of the sobbing, frightened child for a procedure. The pain. "All for the child's own good." All for nothing.

Donald and Jureidini write about the "systems" aspects of MBP with particular insight. Throughout the literature, there is confusion about whether the MBP label describes the perpetrating mother or the victimized child—many in the field write as if the diagnosis somehow

floats between the two actors. Donald and Jureidini take that floating sense a step further. MBP “best describes a complex *transaction* among at least three persons—a parent, her or his child, and the physician” (their emphasis). The formal definition of MBP requires the needless treatment on the part of the medical system. Given the gradual process by which suspicions typically emerge, it seems impossible for the most caring of practitioners not to feel sullied and guilty. And, as such, MBP is probably the diagnosis that everyone is most invested in not making.

The strangest and most fascinating aberrancies of human behavior are the perversions of our strongest emotions. We all have our moments of imagined violence, spittle-flecked fantasies of explosive, visceral aggression. Thus, it becomes that much more incomprehensible when some murderer kills with an affectless, reptilian coldness. We all know something about the warm, limbic glow of love. Thus, Jeffrey Dahmer becomes that much more boggling when, in addition to murdering, dismembering, and cannibalizing his victims, he spoke of “loving” them as well.

And we all know something about maternalism, and here is the most boggling inversion of that imaginable. How could they do it, how could they do it to their own flesh and blood?

And here is where we return to how this piece began, an exploration of what boundaries there are, if any, to parents’ concept of “their own.” In some MBP cases the perpetrators seem to be sheer, brutal exploiters. Such people have an intense need for the attention of the medical system and have discovered that a sick child is a wonderful entrée to it. If the rewards of attention were the same, that kind of MBP mother would just as readily lie to a veterinarian about the symptoms of her goldfish, or to the people at Sears about the clock radio that stops working. Child as object, child as pawn. In these cases, the criminality of the acts seems to vastly outweigh the implied illness behind the acts.

But in some cases, something much more complex is going on. A number of studies have reported that in most MBP mothers, there is also Munchausen's on the part of the mother herself. Maybe the mother was cured of her Munchausen's once the child was born and the MBP began. Maybe the Munchausen's began only when the MBP was discovered and prevented. Maybe they are concurrent, beginning with the mother damaging both of them when one was pregnant and the other a fetus. Meadow writes about cases where there is virtual "transmission" of fabricated symptoms between mother and child.

That picture is completely different from the one that sees the child as clock radio. Here is a vastly sick, intimate intertwining of mother and child, with a complete failure of ego boundaries, a pathological view of the child as an extension of the parent, a confusion as to what constitutes, literally, one's own flesh and blood.

And it is that intertwining that is ultimately the most disturbing thing about MBP, because it contains a glimmer of familiarity. Both Meadow and Marc Feldman, a psychiatrist at the University of Alabama, draw parallels between MBP and the subtler ego-boundary problems that all parents have, this quandary of how much a child is a vessel for your values and beliefs, hopes and disappointments. There is an invitation to irrationality when you hold your child for the first time, when you realize that this is someone who will likely be there long after you are gone, and whose person will someday, you believe, constitute a partial biography of you.

~ NOTES AND FURTHER READING ~

This piece has had a strange emotional pull for me. I had been fascinated with Munchausen's syndrome for years and had only vaguely been aware of MBP—oh, yeah, sometimes people fabricate symptoms in their kid instead of in themselves, weird. Then my first child was born, and about five days later, drifting back to sleep after the umpteenth awakening in the middle of the night, I was suddenly cat-

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apulted into utter alertness with the thought *My God, there's a disease where a parent intentionally generates illnesses in a child, where they intentionally hurt their baby*. I instantly had a frantic need to read everything available on the subject and, ultimately, to write and write about it—it's that professorial instinct of thinking that if you cogitate on a subject long enough, if you lecture on it sufficiently, it will eventually give up and go away. Thus, this will be a particularly long stretch of notes reflecting, in part, how much verbiage I forced myself to cut out of the piece itself.

The initial phases of the Jennifer Bush case were covered in *Newsweek*, April 29, 1996. The story of her mother's conviction by a jury in Broward County, Florida, after a mere seven hours of deliberation, is covered in the October 7, 1999, *Sun-Sentinel* of South Florida.

Thomas Szasz's thinking is summarized in books of his such as *The Myth of Mental Illness* (2nd ed., New York: Perennial Editions, 1984) or *Ideology and Insanity* (New York: Anchor Books, 1970).

The death of Jessica Dubroff, and the quotes from Lisa Hathaway, came from both *Time* and *Newsweek*, April 22, 1996.

The definitive case regarding the rights of Christian Science parents is *The People v. Rippberger*, 231 CalApp 3d 1667: 283 Cal Rpter, July 1991. Eight-month-old Natalie Middleton-Rippberger contracted bacterial meningitis, complete with apparent high fever (estimated, since her Christian Science parents would not use a thermometer) and heavy convulsions. The parents sought no conventional medical care, instead seeking assistance from a Christian Science nurse, who advised the parents to keep the child warm and nourished as well as to notify a Christian Science committee that prayers for the child were not working as quickly as should be expected. After Natalie's apparently excruciating death, which could readily have been prevented, her parents were charged with felony child endangerment.

The Supreme Court decision regarding mandatory schooling requirements for Amish children is found in *State of Wisconsin v.*

Yoder, 70-110, 1972. Based on their desire to shield their children from the influences of non-Amish culture in high school, a couple named Yoder kept their kids out of school. They were cited and fined. Just to show how much everyone involved knew this was about principles, the fine was \$5, and the Yoders appealed; the case eventually landed in the Supreme Court.

The attorney for Wisconsin emphatically expressed respect and admiration for the Amish, but argued that the state had a vested interest in making sure kids got educated, and that eight years of school did not equal the required ten years. He emphasized high school as an ideal place for socialization and choice, exactly the things the parents feared. The attorney for the Amish, in turn, discussed how successful the Amish were, what natural educators they were with their approach of teaching by doing, and how sending kids to two years of high school would destroy this fragile minority culture. The wise black robes deliberated and came up with a ruling that strikes this legal neophyte as weird as hell.

In the majority opinion, the justices started off by praising the Amish educational system: "The evidence showed that the Amish provide continuing informal vocational education to their children designed to prepare them for life in the rural Amish community." They then said that Wisconsin's argument about eight years of education leaving a child ill-prepared to deal with the outside world was weakened by the fact that the Amish didn't leave the community much anyway. They didn't seem to note a tautology: of course few leave the Amish community when their education has only prepared them to be Amish. There was no discussion about what happened to the people who did leave the community. Nor of what the kids in this particular case wanted. None raised the question of whether a minority culture that was so fragile as to be destroyed by two years of secular high school deserved to be preserved as a museum piece. Concepts like "rights of children" or "freedom of choice" were notably absent in the majority opinion.

As noted, the court came down in favor of the Amish—their kids could be kept out of school past the eighth grade—and in a truly odd way. First, the court explained why two fewer years of schooling wouldn't harm the kids. Keeping the kids out of school "will not impair the physical or mental health of the child" . . . nor get in the way of such children discharging "the duties and responsibilities of citizenship." Furthermore, in case Amish children did happen to leave the community at some point, "There is no specific evidence that . . . upon leaving the Amish community, Amish children . . . would become burdens on society . . . or in any other way materially detract from the welfare of society." Cool criteria. I'd definitely be satisfied if my children got only enough schooling to be ensured of not being mentally ill or driving down the gross national product.

The justices then carefully limited the boundaries of their decision. First, they stated that you couldn't keep your kids out of school based on a minority philosophy, only a minority religion—they explicitly said that Thoreau couldn't have gotten away with this. Next, they made it clear that they weren't talking about all religions deserving this protection. This was 1971, and they went out of their way to warn hippie cult religions not to even think of starting any tomfoolery. "It cannot be overemphasized that we are not dealing with a way of life and mode of education by a group claiming to have *recently* discovered some '*progressive*' or more *enlightened* process for rearing children for modern life" (my emphases). So the Moonies and Krishnas can't keep their kids from going out for the cheerleading squad.

The incident with Gandhi is described in Collins L and Lapierre D, *Freedom at Midnight* (New York: Acacia, 1997).

The source of the *Munchausen* in Munchausen's syndrome, and MBP: It all started with the eighteenth-century Baron von Münchhausen (who came with two *h*'s, in contrast to his namesake disease). A nobleman soldier, he fought the Turks in the Russo-Turkish war of 1737 before spending his remaining years entertaining guests at his

estate with tales of war ventures and sportsmanship. The standard story is that Münchhausen was a tiresome blowhard with his stories, and that someone ultimately published a collection of them that came to be viewed as the epitome of confabulatory, impossible tales of self-congratulatory derring-do. According to one revisionist historian bent on clearing the name of the poor baron, the guy's stories were actually factual, and the anonymous author—some powdered-wig ex-houseguest with a grudge, intent on embarrassing the baron and apparently succeeding—was the one who conflated. (Small-world department: Münchhausen was apparently cuckolded in his later years by a younger wife, who was able to escape to her trysts thanks to her skills at faking a chronic illness, necessitating convalescing at a spa.) All this is described in Haddy R, "The Münchhausen of Munchausen syndrome: a historical perspective," *Archives of Family Medicine* 2 (1993): 141.

Meadow's original paper on MBP is Meadow R, "Munchausen syndrome by proxy: the hinterland of child abuse," *Lancet* 2 (1997): 343. The case involving beating of ankles is found in Bryk M and Siegel P, "My mother caused my illness: the story of a survivor of Munchausen by proxy syndrome," *Pediatrics* 100 (1997): 1. The ipecac case is found in Schneider D et al., "Clinical and pathologic aspects of cardiomyopathy from ipecac administration in Munchausen's syndrome by proxy," *Pediatrics* 97 (1996): 902. The case involving feces in the IV line: Seferian E, "Polymicrobial bacteremia: a presentation of Munchausen syndrome by proxy," *Clinical Pediatrics* (July 1997): 419.

The characteristics of the MBP parent and child, and the range of symptoms induced in MBP, can be found in McClure R, Davis P, Meadow S, and Sibert J, "Epidemiology of Munchausen syndrome by proxy, nonaccidental poisoning, and nonaccidental suffocation," *Archives of Diseases of Children* 75 (1996): 57; Rosenberg D, "Web of deceit: a literature review of Munchausen syndrome by proxy," *Child Abuse and Neglect* 11 (1987): 547; Meadow, "Munchausen syn-

drome by proxy"; and Feldman M, Rosenquist P, and Bond J, "Concurrent factitious disorder and factitious disorder by proxy. Double jeopardy," *General Hospital Psychiatry* 19 (1997): 24. Reliable statistics on MBP are not available, and indeed, the precise criteria for making a clinical diagnosis are still evolving. Along with the growing awareness and diagnosis of this tragic disorder, there is also the tragic circumstance of false accusations of MBP.

What MBP is not is discussed in Meadow R, "What is, and what is not, Munchausen syndrome by proxy?" *Archives of Diseases of Children*, 72 (1995): 534; also, Feldman, Rosenquist, and Bond, "Concurrent factitious disorder."

The social manipulations and borderline features of MBP mothers run throughout the MBP literature cited. Foster's writing about how MBP mothers can divide an entire medical staff is found in Foster T, "Munchausen's syndrome? We've met it head on," *RN*, August 17, 1996. The vulnerability of medical staffers to MBP deception, and the triadic nature of MBP, is written about in Donald T and Jureidini J, "Munchausen syndrome by proxy: child abuse in the medical system," *Archives of Pediatric and Adolescent Medicine* 150 (1996): 753.

The co-occurrence of MBP and Munchausen's syndrome was first discussed in Meadow R, "Munchausen syndrome by proxy," *Archives of Diseases of Childhood* 57 (1982): 92, and has been noted in many of the other papers cited.

One of the most ornate and horrifying of MBP cases, too lengthy to put into the main essay, is that of Waneta Hoyt and Alfred Steinschneider, covered at length on May 5-7, 1996, in the *Syracuse Post-Standard*. A young woman living outside Syracuse, New York, in the 1960s and '70s, Hoyt had suffered the indescribable pain of having a series of her infants die of sudden infant death syndrome (SIDS). A young pediatrician at Upstate Medical Center at Syracuse, Steinschneider was on the rise as a researcher for his advocacy that SIDS was caused by apnea, a mysterious cessation of breathing. Hoyt had been

sent to his clinic with her fourth child. The three previous had died from SIDS, and the fourth was already in trouble—Hoyt reported the same pattern emerging at home at night, the child having terrifying episodes of apnea, requiring resuscitation, vigorous stimulation to get her breathing again. This seemed strongly confirmatory of Steinschneider's theory about the critical role played by apnea in SIDS, namely that the neurons in the brain stem that regulate automatic breathing during sleep can be immature in their function in some infants, can cease working for long, fatal periods. Such immaturity was viewed by Steinschneider as having a biological flavor to it—an intrinsic flaw in the system—and that SIDS could run in a family such as Hoyt's seemed to support his idea. These poor children carried an inborn biological weakness that made a peaceful night's sleep chancing death.

Fortunately, Steinschneider was on the cutting edge of his science, and Molly Hoyt became the first child cared for at home with an apnea monitoring machine, newly developed by the doctor. The idea was that no parent could spend all of each night standing vigil, in case the child stopped breathing. The machine would, instead, stand watch, sounding an alarm at each episode of apnea, so that the parent could rush in and resuscitate the child. It worked flawlessly for Molly, documenting that she had apneic episodes virtually nightly, just as Waneta Hoyt had reported. Hoyt would use the machine as an indicator of when to stimulate Molly and would bring her to the hospital at times when the clusters of episodes became too much for her to handle. Aided by the machine, she was able to keep the child going for some months until the terrible weakness of those breathing centers in the brain finally triumphed: Molly died at home at close to three months of age, as her mother worked frantically to jump-start her breathing reflexes with mouth-to-mouth resuscitation. A year later, Hoyt and her husband had a fifth child, Noah, and had to endure the unbearable cycle again—an infant prone to severe clusters of apnea, the middle-of-the-night panic of resuscitation as the monitor's alarm

signaled yet another breathing crisis, until, finally, the biology won again, another dead child at two months of age.

The cases of Molly and Noah were the centerpieces of Steinschneider's landmark 1972 paper and subsequent career. For about a decade after that, sleep apnea became the dominant paradigm for understanding SIDS, and Steinschneider was its most acclaimed champion. He rose in the professorial ranks, was eventually lured to a more prestigious university, eventually even had his own institute funded by grateful donors. During that ten-year stretch, Steinschneider received nearly one-quarter of all the funds spent by the federal government for SIDS research, something on the order of \$5 million—this is a staggering dominance of a research field by a single investigator. And amid documentation by Steinschneider that his apnea monitor had cut the SIDS death rate in the Syracuse region since its introduction, sales flourished.

But, naturally, something was not quite right.

As usual, it began with a perceptive nurse attuned to human behavior rather than to medical reports. Something just didn't seem right about Waneta Hoyt. She was gregarious enough with the staff, but she was cold, aloof from the children, seemed far less concerned about them than did the nurses. Steinschneider later defended Hoyt, writing that her distancing was a protective mechanism. But there were more problems. The home-monitoring machine clearly did not work well, and it was impossible to distinguish between true apnea and one of the frequent false alarms due to glitches in the system. Maybe these babies weren't really having such frequent episodes of apnea? Most important, staff soon keyed in on the critical indicator that something was wrong: Molly and Noah never had apnea in the hospital. No apnea, no need to resuscitate, no need to stimulate to get the breathing started again. It was only at home. When Noah was sent home, nurses wept openly, predicting that Hoyt would kill him. And he was dead the next day.

Hoyt was not heard from again on that ward. Meanwhile, Stein-

schneider's theory was the dominant explanation for SIDS throughout the 1970s. But by the mid-1980s, things were shifting. Blue-ribbon panels of pediatricians—one organized by the American Academy of Pediatrics, another by the National Institutes of Health—concluded that the home monitors were useless for preventing SIDS. And it became apparent that Steinschneider's oft-repeated proclamation about his monitor cutting the SIDS rate in Syracuse was nonsense—the SIDS rate had dropped in many other cities without the use of Steinschneider's monitors.

In 1994, an eager, skeptical district attorney in New York State decided to pursue the Hoyt case. Within hours of being picked up for questioning, Waneta Hoyt confessed to murdering all five by smothering.

At her trial, medical records were introduced showing that there had never been any apnea requiring resuscitation for a Hoyt child in the hospital; any such episodes were exclusively reported by Hoyt at home. Nurses said that there had never been any apnea in the hospital. Steinschneider, testifying for the defense, insisted that such episodes had occurred, just as he had reported in his 1972 paper. When did those supposed episodes occur, who were the attending nurses? He couldn't remember. Did he know of any records that indicated that there were episodes of apnea in the hospital? He couldn't recollect any, but noted that things occurred that may not have been noted in the charts. As reported in the *Syracuse Post-Standard*, after the jury convicted Hoyt, Steinschneider "suggested her confession was coerced."

Waneta Hoyt's motives remain a bit murky. At her confession, she claimed she had smothered the children because they would not stop crying. Were that the case, such impulsive violence would not qualify as MBP. However, the placid personality of the children, as reported by nurses, the pattern of repeated smotherings during a night, the gravitation toward the attention of medical authorities (rather than the nervous avoidance of it), all argue against that motive. Nurses who observed Hoyt at that time emphasized, instead,

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how she seemed to crave the attention she got because of the unique,
tragic nature of her situation, suggesting that the actual deaths were
due to smotherings that had gone too far—a definitive MBP profile.
And naturally, one wonders whether Steinschneider's motives had
something to do with the power and prestige this landmark study
gained him in the medical community. And thus, in Dr. Stein-
schneider, we contemplate here the possibility of a supremely rare case
of Munchausen by proxy by proxy.