Disease or deception: Munchausen by Proxy as a weapon of the weak

(Accepted date: 1 April 2002)

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ABSTRACT This paper aims to trouble certain assumptions about the clinical nature of Munchausen by Proxy (MBP), which has been described in the medical literature as a rare “culture bound syndrome” having surfaced at a particular moment, late modernity, and in a particular “place”, Europe and North America and their extensions. At the heart of this disorder is a lie perpetrated by disturbed mothers who masquerade as the concerned and anxious caretakers of one or more long-suffering children who are plagued by fictive or maternally-incited illnesses and, in the worst instance, who are subjected to death by maternal design. MBP is positioned within a broader comparative context as an extreme pole along a continuum of (mal-) adaptive maternal behaviors in response to unrecognized and unmet needs, not all of which are pathological. Second, the locus of the pathology is expanded to include not only the disturbed and troubled mother–child dyad, but also the relationship between mother and her doctors and other caregivers and protectors. In these medicalized transactions—shot through with power, love, and pain—the child emerges as an almost incidental or “transitional object”, a mere pretext that gives voice and substance to the adults’ (mothers’ and professionals’) narcissistic needs. Finally, the social and moral uses of illness as drama, performance, and pageantry, and as a passively aggressive “weapon of the weak”, are identified as a key structure of MBP disease. Based on decades of research on maternal thinking and practice (often under extreme conditions) the paper is an attempt to demonstrate what a “critically applied and cross-cultural medical anthropology” can add to the clinical picture and to a broader social understanding of this seemingly bizarre, rare, and contested syndrome.

Prologue

Are those who lie or deceive the true authors of their lying? Can critical medical anthropologists find out who is responsible for this lying? The major focus of my research is everyday violence, referring to the little daily enactments, rituals and routines of violence that are often normatively practiced on the vulnerable bodies of young people or otherwise relatively powerless people in families,
schools, clinics and various bureaucratic institutions and that can be interpreted as bad faith, false consciousness or as deception.

I want to “trouble” certain assumptions about the nature of Munchausen by Proxy (hereafter MBP) as a rare “culture bound syndrome”, which surfaced at a particular historical moment—late modernity—and in a particular place (Europe, North America and their extensions) and which is expressed in the form of psychopathological relations between disturbed women masquerading as concerned “mothers” and their long-suffering children plagued by fictive or maternally-incited illnesses or even death by design.

First, I would locate MBP within a broader, historical and cross-cultural context, as an extreme pole along a continuum of (mal-) adaptive maternal behaviors in response to unrecognized and unmet needs, not all of which are pathological. Second, I would want to shift the locus of the pathology and suggest that MBP represents more than a sick and troubled dyad. I would situate the pathology of deception in the relations between the mother and her doctors and other caregivers as much as between the mother and her child. For in all these medicalized transactions—shot through with power, love, and pain—the child emerges as an almost incidental or “transitional object”, a pretext that gives voice and substance to the adults’ (including the professionals’) narcissistic needs. The pathological attachments of ‘MBP mothers’ to strong (medical) authority figures who can be mobilized into an exciting but fictive drama of illness, rescue, heroism, and pseudo-life-saving have been duly noted. The pathologies of the doctors and other caregivers who collude and collaborate in the dramatic performances of false rescue and misguided or iatrogenic healing are less well documented or understood. Nor do I pretend to be able to do so here.

Rather, I have asked myself what “critically applied medical anthropology’ (see Schepet-Hughes, 1990; Schepet-Hughes & Lock, 1991) can add to the clinical picture and understanding of this seemingly rare and bizarre syndrome essentially characterized by deception. Anthropological thinking is nomadic and its particular genius lies in the ability to see beyond the specific instance to broader social patterns and related behaviors that may assume a different shape in response to specific social, economic, and historical conditions. Ethnography shares with classical psychoanalysis a strong narrative quality, the art of storytelling, focused on “thickly” described illustrative case studies. Here, I shall draw my primary examples from my long-term—now spanning more than 30 years—intermittent study of maternal thinking and practice among three generations of desperately poor women and their children from a large hillside shantytown, the Alto do Cruzeiro, Crucifix Hill, in the sugar plantation zone of Northeast Brazil.

My own research focus was directed to the pathologies of class and economic relations in reproducing sickness and untold suffering in shantytown households where an ethos of the battlefield and of family triage over-determined the deaths of a great many “angel-babies” (see Schepet-Hughes, 1993). But, as in any human community, there were many variations on the theme and practices
of motherhood. Most of the women I have worked with over these many years were more than just “good enough” mothers in Donald Winnicott’s (1987) sense of the term. They were “hero” mothers with respect to their valiant, uphill struggles to raise to adulthood two or three of the eight or nine children (on average) born to them given the many threats to child survival, including: the lack of clean water and basic sanitation, the inability to breastfeed under the demands of rural wage labor, the reliance on diluted powdered milk, the effects of food shortages, infectious disease, and a lack of adequate medical care.

Among the more than 200 shantytown families studied between 1982 and 2001 (with earlier applied work in 1964–1966 as a community health promoter) there were a small number of mothers who collapsed under the weight of extreme poverty and social neglect and the pressures of their own unsatisfied basic needs. These could not nurture their newborns. Very young and inexperienced shantytown mothers—as well as extremely desperate ones—sometimes approached their newborns as strange objects or as disposable commodities (see Scheper-Hughes, 1987). Mothers at times spoke of and treated their very young babies as competitors or as parasites feeding off their bodies, ruining their health, destroying their beauty, and interfering with their own search for love, support, rescue, and a taste of happiness. The alienation from the infant-as-object was located in desperate need as when, for example, Rosa, a young rural mother of 17, dashed her infant against a tree in order to stop the little “beast” (“bichinha”) from crying for milk.

But in a very few isolated cases, shantytown mothers’ perverse and contradictory dealings with local doctors, nurses, pharmacists, and other care givers produced behaviors that bore resemblance to clinical descriptions of Munchausen by Proxy. In these isolated instances, a quest for therapy and for medical interventions (in various forms) on behalf of a mortally sick or dying child was a substitute for food, love, a sense of purpose, creativity, or stimulation, including a hunger for ritual, drama, and pageantry (see Frankenberg, 1986) in lives that were otherwise impoverished. In these cases the individual pathology was nonetheless still tied to larger social, political, and medical pathologies, so that the Munchausen plot thickens considerably (see also Schreier & Libow, 1993, Chapter 6).

The medical discovery of Munchausen by Proxy

Munchausen by Proxy has been described as a social-psychiatric illness of mothers who are addicted to medical attention, having learned through repeated experience that they can bring drama, richness, and complexity into their lives through fabricating, exaggerating or—in the worst instance—inducing illness emergencies in one or more of their children. Schrier and Libow (1993) and others (see Kaplin, 1991; also see Firstman & Thalan, 1997) see MBP as a “pathology of mothering” in which the infant or small child is reduced to a depersonalized and fetishized object through which the pseudo-mother stakes her claims for medical attention and thereby assumes for herself the “secondary
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"gains" of the sick role: attention, care, nurturance (Parsons, 1972). The fetishized infant is the key token in the mother’s “perverse fantasized relationship with a symbolically powerful physician” (Schrier & Libow, 1993, p. 85). The physician is so blinded by the pseudo-mother’s false admiration that he cannot see the harm that she is visiting upon her child as a perverse byproduct of the doctor–patient relationship.

MBP carries some family resemblances to malingering, but the difference lies in the use and manipulations of the body of a vulnerable third party, a small child, and in the absence of insight or guilt about the pernicious effects on the body of the child or on the naive professionals mobilized into pseudo-helping behaviors. The specificity of the medical diagnosis is contested by some researchers who prefer to see the behaviors as an odd or eccentric manifestation of criminal child abuse, as malicious acts that should not be dignified, explained and thereby possibly excused through the courtesy benefit of a medical-psychiatric diagnosis. Indeed, there is a paradox. In bestowing on these pseudo-mothers the mantle of a medical diagnosis, the perpetrator is rewarded with that which she has been looking for—official recognition as a suffering person and medical legitimacy. From this perspective, Munchausen by Proxy could be labeled a gender-specific form of serial killing.

More recently, critics and detractors of MBP syndrome (see, for example, Allison & Roberts, 1998) have argued that the medical classification of “factitious disorders” is itself a fiction born of a moral panic targeting “bad mothers” as society’s designated scapegoat. Allison and Roberts (1998) argue that MBP is a late modern form of witchcraft hysteria and a trap into which some poor and unsuspecting mothers have fallen, resulting in criminal convictions from court cases in which the accused women have been represented by indifferent, poorly paid, and poorly prepared public defenders. They note the victim-blaming and misogyny that so often accompany perplexing mental disorders, such as the so-called “schizophrenogenic mothers” held accountable for the disturbances of their children in the mid 20th century. Allison and Roberts conclude that MBP is a vague, fluid, socially invented disorder.

While it is important to document the particular social and political context within which MBP took shape as a new diagnostic entity, from a medical anthropological perspective all medical diagnoses—not to mention all conceptions of normal/abnormal “motherhood”, “childhood”, and “infancy”—are socially constructed. The question remains the usefulness or not of the new diagnosis in understanding a cluster of disparate symptoms and behaviors that can alert doctors and other health professionals to serious trouble within a fragile family system within which a child is made to suffer or to carry the wounds and symptoms of the mother’s own distress and neediness.

The Munchausen continuum

Does Munchausen by Proxy exist in the Third World? Yes, but as elsewhere, it exists along a continuum. Where, for example, does one draw the line between
poor women and mothers who use a hastily organized baptism of a dying child to extract social and material support from quickly appointed and well-to-do godparents and those mothers who go to the extremes of neglecting, starving, or mutilating a small child to dramatize their utter desperation?

Meanwhile, one could argue that that there is a little bit of MBP in all mothers whose existence, and whose being and status in the world, is primarily defined in terms of their relationship to a significant “other”, be it a husband, a partner, or a child. Women in many parts of the world who are forced to live and experience their lives vicariously often experience what Nancy Chodorow (1978) called “fluid ego boundaries”, which merge their own self-perceptions and needs with those of their child. My mother/myself has its analog in another classic dyad: my child/myself.

There are many genealogies to consider with respect to Munchausen by Proxy, including the long and complicated history of infanticide, maternal “overlaying” and some forms of SIDS (Sudden Infant Death Syndrome). Meanwhile, there are certain normative aspects of the behaviors in question, insofar as mothers in many parts of the world of necessity fill the role of informal healers and family “doctors” of first resort. Consequently, mothers of all social classes often develop a rich repertoire of ethno-medical knowledge and healing practices. Women are more sensitive to the nuances of patient symptomology (their own and those of family members) and are more likely than men to draw on sickness exemptions (Parsons, 1972). Women—mothers in particular—are more closely tied to the “species life” (de Bouvoir, 1989) and they develop greater empathic skills (Chodorow, 1978; Gilligan, 1982) by virtue of their living vicariously through the bodies (and minds) of their significant and intimate others. There is a great deal of substitution (or projection) that goes on in perfectly ordinary and normative practices of mothering.

In different social milieus (such as rural Northeast Brazil) and in areas where medicine is less readily available, the cast of characters in the MBP drama may be different. Priests and nuns, pharmacists, curandeiros (folk healers) and coffin makers, or even local political leaders may be the ones who are recruited into multiple, heroic, and ultimately false rescues of ‘doomed’ children. But the basic constellation of unmet maternal needs and of intentional manipulations of the health and bodily integrity of the targeted child in a maternal plea for attention is nonetheless identifiable. As I see it, these are the core “symptoms” of “Munchausen by Proxy”.

The existence of a continuum of MBP behaviors means that it may be difficult at times to distinguish ordinary, good enough mothers with flexible (and sometimes confused) ego boundaries from the very small number of dangerous and pathological pseudo-mothers for whom the child is merely a convenient object of primary or secondary gain. Some individual behaviors ripped out of their social context can seem extremely pathological. Conversely, many social pathologies that endanger vulnerable individuals are hidden within perfectly “normal” and normative social scripts. What is lacking in most clinical discussions of MBP is any consideration of the larger social context and social
dynamics within which the behavior takes place. In the following analysis I want to introduce into the discussions of deception such as it appears in MBP three fairly common social phenomena that play a role in MBP as they do in other more normative—though no less problematic—social interactions: sacrificial violence, somatization, and reification/commodification.

**Sacrificial violence: maternal thinking and practice in the shantytowns of Brazil**

One way of understanding the maternal behaviors associated with Munchausen by Proxy is through the lens of scapegoating and sacrificial violence. As described by the social philosopher Rene Giraud (1987), ritual sacrifice demands a collectively agreed upon surrogate victim, the generative scapegoat, if you will, whose suffering and/or death is used to resolve unbearable social tensions, conflicts, dilemmas and difficulties of all kinds. While Giraud is primarily interested in this phenomenon from a theological perspective, linking it to the origin of sacrificial-based world religions, like Judaism and Christianity, one can also apply his insight to more mundane situations as in family pathologies where the sacrificial victim is often a child.

For example, in the economically strapped small farm households of mountainous West Kerry, Ireland the surrogate family victim was normally the ungainly, shy, “left over” bachelor son—the “last of the litter”, the “runt”, and the “scraping of the pot”—who was chosen in his youth as the designated farm heir and thereby sacrificed to a life of celibacy, relative poverty, and self-abnegating service to the “old people”. He was constantly reminded that he was less talented than his older siblings and judged “good enough” for the farm at a time when both farming and the village were seen as dying institutions. A set of contradictory and double-binding injunctions lead to a good deal of drinking and depression among the young men, leading for the more fragile to “mad house” of Killarney or to young adult suicide (see Schepers-Hughes, 2000). While the premature deaths of these sacrificed family scapegoats are mourned in the village, the basic injustice and the violence of the family and social systems that demand such a sacrifice of some of its children goes unrecognized and uncorrected.

In the desperate shantytowns of Northeast Brazil other forms of sacrificial violence predominate in the form of indifference to infant hunger, sickness and death that allows some shantytown mothers and their co-conspirators—clinic doctors dispensing in bad faith inappropriate “surplus” medications to malnourished babies—to casually dispatch a multitude of “angel-babies” to the afterlife. These given up/offered up/given up on babies—identified locally as *crinaças condenadas*, condemned children—are sacrificed so that others—their mothers, her partner, and her older children—can live. Insofar as the sacrifice of the supernumerary infant made possible the survival of another child (or made life more bearable for the mother herself), the passive infanticide could be viewed,
as a tragic survival strategy and the pathology can be firmly located in the social and economic system. Maternal thinking and practice in a hungry and desperate world produces a moral philosophy compatible with these perverse social conditions. While it is possible to envision a universal maternal ethos characterized by emotional warmth and responsiveness, empathy, nurturance, and protective custody, the maternal thinking and practice that evolve in the context of hunger, scarcity, and infant death is based on delayed attachment and “letting go”. An ethic of the battlefield where triage, thinking in sets, and ideas of magical replacement (one new child, like one new recruit, replaces the one lost) predominate along with the idea of acceptable death.

“Our babies die”, Brazilian shantytown mothers say, “so that the rest of us can live”. “They die because they were meant to die. If they were meant to live it would happen that way as well.” Dona Terezinha evoked Rene Girard’s notion of the “generative scapegoat” when she said at a meeting of a liberation theology-based mothers club of the Alto do Cruzeiro: “Jesus takes our babies to save us, their mothers, from suffering. They die, just like Jesus died, to save us from pain.” Another mother, Luiza, added, “I only know that I kept giving birth and they kept on dying. Maybe the first nine had to die so that the last five could live.” Dona Rosalva expressed her relief at the death of her two-year-old son when she was overwhelmed with the care of a new baby girl: “When my precious little cacula [last-born] fell sick, I prayed to God to take her older brother, Edinaldo, and to leave me my favorite one, instead. God is good, and that’s what He did”.

While the moral thinking that guided these mothers in, as they themselves said, “helping’ their children to die” is understandable under the harsh conditions of shantytown life, the ‘bad faith’ medicine that would substitute medications for food (see below, the cases of Mercea and Gil-Anderson) was more difficult to accept uncritically. And while it was possible to rescue infants and toddlers from premature deaths from diarrhea and dehydration by using a simple sugar, salt and water solution (ORT, although even Coca-Cola worked in a pinch) it was far more difficult to enlist some shantytown mothers in the rescue of a child they perceived as fated or destined to die, and therefore as better off dead.

Consequently, a great many Alto babies “successfully” rescued and treated again and again and again in the hospital rehydration clinic or hospital were sometimes dead before the next follow-up house call. Alto mothers learn to differentiate among those infants thought of as ‘thives’ and as ‘keepers’, and those thought of as born “already wanting to die”. The “doomed” infants were allowed to die “a minguia”, of neglect. Mothers would passively step back and “allow nature to take its course”. These mortally neglected infants and babies were often prettily kept: washed, such hair as they have combed, and their emaciated little bodies dusted with sweet-smelling talcum powders. When they died, they did so with a candle propped up in a tiny hand to light their way to the afterlife.
Grief and mourning were attenuated by means of “delayed attachment”, estrangement, and a failure to anthropomorphize the infant held at arm’s length and pitied as a “poor little creature” or received as a temporarily visiting stranger in the cradle or hammock. “Infants are like birds”, Biu would often say. “Here today, gone tomorrow. They don’t have that certain attachment to life that we [i.e. real people] have.” The reification (objectification) and depersonalization of the infant were normative in these contexts born of material scarcity defensive fatalism and a reasonable pessimism. Mothering under adverse conditions like these entails a great ability to “let go”. A reification and fetishization of the infant or child in pathological Munchausen by Proxy cases derives however from a different source, an intentional use of the sick child for one’s own gain.

Pathology within the pathology: identifying Munchausen by Proxy in situations of extreme poverty

The essential task here is to distinguish ordinary, good enough mothers who are challenged to the extreme by inhuman social circumstances to make choices that no mother should have to make from deviant mothers who actively manipulated and provoked states of sickness, malnutrition, and extreme wasting in an infant so as to incite a final dramatic crisis and/or to elicit support and sympathy from doctors, political leaders, or wealthy patrons. Some shantytown mothers evidenced a kind of “addiction” to bad medicine in a constant cycle of visits to public clinics, hospitals, pharmacies, and to the offices of political leaders and political patrons who often dispense free and even harmful drugs from the drawers of overstuffed file cabinets. Here I am responding to Marilyn Nations and Linda-Anne Rebhun’s (1988) and to Marijke Stegeman’s (1997) uncritical descriptions of desperately poor women of Northeast Brazil, continuously involved in medical rescues of infants and children who, nonetheless, unexpectedly die later at home. Studies of what is essentially covert maternal behavior cannot be made while based in the clinic or hospital setting or as an identified doctor or nurse–practionier. It is necessary to position oneself as an ethnographer–companheira, one who is both knowledgeable of, and at least initially non-judgmental toward, the alternative social ethic in use (see Schepere-Hughes, 1995) and the observations must be based in the home.

The point of some shantytown mothers’ constant search for medications was not the treatment offered. For the medical advice dispensed was rarely followed, the medications were tried once or twice and then discarded, used for barter, or turned into ornaments prettily arranged on a shelf like a home altar. Meanwhile, the medications distributed were often perverse drugs, including tranquilizers to silence the cries of hungry babies (see Schepere-Hughes, 1988). Rather, the quest for therapy had another source. The clinics, the hospitals, the pharmacy, the mayor’s office linked poor women to a social world, a network of support
and of attention, something beyond the misery of the shantytown. The clinic and pharmacy visits were valued as a time out of ordinary time during which women could share the tragedy and the drama of their lives with seemingly empathic others. (Obviously the distribution of free drugs by political leaders had nothing to do with real empathy.) The dramatic moment when a mother unwrapped and publicly displayed a “skeleton” child was an aggressive challenge to the medical, social or the political system: “See where you have brought us! See how we have suffered!” The fear of casting aspersions on the majority of poor women struggling to survive as best they can in the shantytown causes some hesitation in describing a very few cases of disordered mothering that bear some resemblance to Munchausen by Proxy. For even in these few pathological instances, the real culprit remains the effects of material scarcity within the context of economic globalization (see Scheper-Hughes, 1993, Chapters 1–5). The following fragments of longer narratives of lives, far too complex to render adequately here, can however illustrate the dynamic and the problematic.

**The condemned child syndrome: Doença de Criança**

The ethno-medical folk category of *doença de criança* (child sickness) was used by mothers to distinguish between babies worth keeping and those to be “let go”. *Doença de criança* was a fluid, elastic, and non-specific diagnosis. It is altogether ambiguous. How can a mother be certain that her infant was suffering from a non-treatable “gasto” (mortal wasting) as opposed to an ordinary case of pediatric diarrhea? How was a mother to discriminate between ordinary teething and the more dreaded and potentially fatal symptoms of “trapped teeth”? When was a *susto* just a bad fright, a mere startle reflex in an infant, and when was it likely to knock the soul right out of the infant’s body? Sometimes, the attribution of the pediatric folk illness was a projective device.

During a drought in 1990 a desperate family arrived from the countryside in search of work and food in the interior market town of Bom Jesus da Mata. The mother, father and two surviving babies found lodging in a small lean-to behind the larger shack of another resident of the shantytown of Alto do Cruzeiro. The mother, a grim woman in her early 40s, sat impassively holding a weak and listless infant, extremely pale, almost white, with eyes that were deep and vacant. Her husband, a younger man in his late 20s, sat on a straw mattress next to his wife. They were expecting the baby to die soon, the man said, “God willing”. While the father said that he knew about oral rehydration therapy (“soro”) according to the local formula—a glass of boiled water, a beer cap of sugar and a toothpaste cap of salt—he and his wife had decided not to give this to the baby. The following dialogue was recorded:

“Is the infant being fed?”
“No, she is very sick with *gasto*” [a severe, wasting diarrhea, one of the ‘untreatable’ illnesses according to the folk ethno-medical system]
“Not even rice water?”
“No, nada, nothing.”
“Is she baptized?”
“We will baptize her on Sunday.”
“She may not live until Sunday.”
“Como Deus quise—As God wishes, then.”

Outside the door a small knot of neighbor women commented in lowered voices on the miserable situation of the drought victims. “Péssimo, abysmal”, said one woman whose own family had suffered hunger so many times herself. Plans were made to get emergency rations to the household.

“What about the baby?”

There was silence until an older woman spoke out:

“They are letting the baby go. The father says it has the ‘ugly disease’ for which there is no cure. It was better, he said, to let the baby die.”

On the following day the situation unchanged and the following exchange was recorded:

“How is the baby?”
“There’s no hope. It’s aquele mesmo.” [it’s that [awful] thing/disease]
“How do you know?”
“It has the red marks on its body.”
“Show me.”

Gingerly the mother lifted the infant’s tiny little shirt and cloth diaper to reveal a very wasted and pale, but unblemished, body.

“There are no marks!”
“They have retreated inside the baby”, the father intervened to explain.
“What do men know about these diseases. This is something that concerns only women.”
“You are wrong. Many men know about this [evil] sickness. I was a little boy this high when I buried my baby brother in the fields.”

The infant died, unfed and untreated, later that same day and by dawn the pair, perhaps fearing another invasive series of questions, had packed their few belongings and returned to the drought-plagued countryside.

There is an expression found in many peasant societies, from Eastern Europe to this part of rural Brazil—“You cannot fight with Death”—that translates into actions that, in fact, actively collaborate with the grim reaper. As Primo Levi (1988) might say, here we have entered “the Grey zone”, the space where victims begin to behave like victimizers.
Biu and Mercea: the pageantry of birth, sickness, and death

The life of “Biu” and the death of several of her children as infants and babies exemplifies the mix of economic, social and psychological pathologies that can lead, in some instances, to the manipulation of the sickness and death of a child to give meaning to a tragic, impoverished, and stunted adult life (see Schepel-Hughes, 1991). Even by Brazilian shantytown standards Biu’s life was judged hard and brutish, an example of all that could go wrong, of how bad and mean life can be for Alto women. Despite all, Biu was hardworking, independent, and uncompromising. Her adamant refusal to marry, or to be “beholden” to any one man or to any one boss, contributed to her grinding poverty. She took her first serious partner at the age of 15 and remained with Valdimar, off and on, for almost as many years. Although she left him several times it was never to take up with another man. And it was only after Valdimar’s death that Biu formed a second and, again, long-term, relationship with another common-law husband. Although Oscar ultimately proved unfaithful, Biu remained loyal to him and she still dreams of being buried next to him “in the end”.

Full of initiative and survivor spirit that allows her to pick herself up and try again and again, Biu was particularly susceptible to pregnancy as a demonstration of her spirit of survival, her will to life and to replenish the earth, even though she more often replenished the pauper graves of the municipal cemetery with the bodies of her angel-babies. What motivated Biu to get pregnant again and again and again despite a string of tragic infant and childhood deaths and despite her own self-admitted inability to care for her young children? Even those that survived—her neighbors would say—did so not because of Biu but in spite of her. Biu defended herself: “I adore being pregnant! I love the richness of it. I adore the roundness of my belly and the drum-tight fullness of it.”

Pregnancy was Biu’s answer to her chronic hunger-anxiety, an answer to the emptiness and the feelings of loss and abandonment. Pregnancy was a solution of sorts to the father who walked out on her as a child, to the suicide of her first lover and to the humiliation she suffered at the hands of Oscar, who left her on the feast of Sao Joao’s day, taking the couple’s stove, their lumpy straw-filled mattress, and the two strongest male children with him in order to live with a new woman, one (he said) who still had her teeth and was not the “toothless old hag” he said Biu had become by her early 40s.

But it was the warm, full, pregnant belly, and not the screeching real babe in arms that Biu wanted. Biu often admitted that she had no patience with babies. But she relished the pageantry of sickness and the carnivalesque drama of infant and child death that linked Biu—even if only fleetingly and most unsatisfactorily—to hospitals, clinics, the civil registry office, the church, the municipal coffin maker, the cemetery. The flowers, the candles, and the pretty little white dress that her barefoot, last-born child, three-year-old Mercea, was finally buried in—the only dress that ever graced her famished little, scabby body—was all part of a myth—like story, an aesthetic, and a moment in her life that Biu
would visit and revisit many times over with a certain bitter sweet nostalgia. “Aye! Que Saudades!” (“Oh, what sad memories and longing!”)

Over the course of her three miserable years, Mercea, who never spoke and could not balance her bloated belly on her spindly legs, was left alone for long stretches of the day, rarely washed and rarely fed. She was often found sitting cross-legged on a stool in a corner of Biu’s shack crying softly and scratching at her endless infected bug bites. Mercea was rescued several times via ORT, oral rehydration therapy. She was brought to local clinics and treated on dozens of occasions for a variety of illness complaints—from infantile nervousness to lack of appetite. But perhaps the mytho-poetic diagnosis of “acute infantile suffering” recorded on Mercea’s official death certificate was the truest statement of the meaning of her brief life and death.

Mercea’s death came during the four-day celebration of Carnival when Biu and her older daughters were out dancing in the streets. On the first night of Carnival everyone tried to ignore Mercea’s hacking, convulsive coughing. Her breathing was shallow and rapid, and her tiny, bony chest jumped along with the fast beat of the frevo music that blasted from every transistor radio on the Alto. When asked what her Carnival costume would be, Mercea whined and crawled away, dragging her wasted legs behind. Her skin was hot and as dry as parchment. The excitement was too much for the sick little girl and she began to cough violently, throwing up into the eroded and rocky ravine that separated the two sides of her hillside niche.

But Biu did join the revelers, though her attempt at wringing some small pleasure out of life was foreshortened by Mercea’s abrupt death at home, alone. Biu was in shock. She barely had time to change out of her makeshift costume. Her older sister, Antonieta, took over the preparations of the angel wake, carefully washing and dressing Mercea’s wasted little body. She had suffered so much, everyone said, surely the little girl was already in heaven, and more than an angel, more like a little martyr. At Antonieta’s insistence there would be a proper purchased coffin for their little saint.

Biu’s estranged husband, Oscar, arrived with Biu’s other children. He sat in a corner, quiet and shame-faced, his head down and his thin arms folded across his chest. He could not get himself to gaze at the dead child. The question that was foremost on everyone’s mind that day was: “Why did Mercea die?” Was it because Mercea’s older sister, Xoxa, was away from her small charge? Was it because Oscar had abandoned part of his family? Was it because the child was never “well attended” in the local hospital and municipal clinic? Was it because the prayers of the local healer were “weak”, or because the medicines purchased at Feliciano’s pharmacy were the wrong ones? Was it because the municipal ambulance arrived too late, the driver still groggy from “playing Carnival’ the night before? Or was it because Mercea, as old as she was, never really had a knack or a “taste” for life?

At least no one tied to blame poor Biu for dancing in the streets during Carnival. Everyone affirmed Biu’s right to play and to take some small pleasure in the life of the festival. The family members would spend the next several
months puzzling over this death, Xoxa in particular. The child of 10, Mercea’s designated sister–caretaker, knew that much of the blame would be laid on her shoulders, and she carried it as best she could. Severino, Mercea’s uncle and godfather at the dead child’s post hoc wake/baptism, sprinkled holy water over the still little body, as somber in death as in life, while he prayed: “Mercea, I don’t know whether you were called (chamada), taken (tirada) or thrown out (jogada) of this world. But look down on us from your heavenly home with tenderness, with pity, and with mercy.” Amen.

As for Biu, she endured. Later on, the same evening following Mercea’s burial, Biu was on her feet and outside shouting and gesturing to passersby along a high path of the hillside shantytown. Biu’s ravaged grief and rage earlier in the day was real and thoroughly exhausting. Antonieta had forced a strong tranquilizer on her sister after which Biu fell into a fitful sleep. But a few hours later, a seemingly fully recovered Biu was bounding down the rocky path of the Alto do Cruzeiro, laughing and teasing and making demands on those around her. She wanted some pretty gifts to ease her most recent loss. After all, material objects often outlasted the more fragile human relationships they came to represent. This kind of symbolic substitution was part of the survivor resilience of Alto life. It made living at all possible. But where was Biu going now in such a hurry? “Oscar”, she said, with evident delight, “has just sent for me!”

The next day the newly reunited couple were holding hands like newlyweds. Biu smiled cooly into the eyes of her long estranged partner. Her long, brown hair was shaken loose and hung fully and thickly around her thin face, neck and shoulders. Oscar seemed a changed man from the day before when he was so cowed and laid low by his daughter’s death. “Life is hard, brutal”, said Oscar philosophically. “It is over now for Mercea. Who dies never comes back. But for us still here and living on this earth, it is a case of keep going straight ahead, and never look back. We have to believe there was a reason for Mercea’s death. Maybe she died to bring us back to our senses, to make us a united family again.”

Biu’s story illustrates the extent to which the birth and death of a tiny child—a death that was altogether avoidable even in the shantytown—played a formidable role of “substitution” in Biu’s life on the margins of survival. Mercea, Biu said later, was not meant to live. She was only a messenger. She was an “angel child” which is why she never learned to speak. “Angels are mute”, Biu said with reference to the poor, stunted, half-starved little toddler. The story also illustrates the difficulty in determining just where the ‘pathologies’ fall as in so many other child deaths in the shantytowns of Northeast Brazil.

Maria das Prazeres and Gil-Anderson: a case of MBP in the shantytown

In one instance, however, despite the intervening and confounding variables of abysmal poverty and social neglect, a diagnosis of MBP seems appropriate. In the midst of the considerable scarcities of favela life, there are also scenes that give reason to pause and doubt, scenes—as the Brazilian anthropologist, Alba
Zular, once described it—of “strong, well-fed mothers sitting side by side with famished and skeletal babies and small children”. Such was the case of Maria das Prazeres (Mary of the Pleasures, her real name) and her skeleton child, Gil-Anderson.

In the hovel of an old water-carrier, Dona Dalina, a skeleton of a toddler, Dalina’s great grandson, was cradled in the arms of an older child. When asked what was the child’s problem Dalina replied that he was very sick because he did not like to eat. Food, she said, disgusted him. The child’s mother, a heavy-set and stocky 17-year-old named Maria dos Prazeres, went on to explain that Gil-Anderson, although 11 months old, “accepted” only a tablespoon of skimmed powdered milk in a baby bottle of polluted tap water a day. She displayed Gil’s food supply: a battered dirty can of Nestle’s powdered milk, all but empty. The boy weighed no more than 10 or 12 pounds and looked startlingly like E.T. Yet Gil showed no signs of fever, pain or diarrhea. Surely, he was just hungry. Starved babies often lose their appetites and become “fussy feeders”.

But Prazeres insisted that Gil was definitely sick. Hadn’t she taken him to the clinic on many occasions as well as to several pharmacies on town? And each had given her medicines to cure him. In her tiny lean-to behind Dalina’s hut, Prazeres showed, with pride, a shelf with more than a dozen bottles and tubes of prescription drugs, all partly used, and displayed like saints on a home altar. The boxes were arranged carefully, even artfully, by size and color. In the collection were antibiotics, painkillers, tranquilizers, sleeping pills, and an appetite stimulant. Gil was being fed medicines (including one to make him hungry) while being systematically denied food.

Prazeres refused to allow the boy to be interned in a good pediatric hospital in Recife for intensive care and careful feeding. Her new boyfriend would “kill” her, she said. Instead, I negotiated to bring special foods to her hut to feed Gil—thick purees of cooked vegetables and mashed fruits, and plenty of fresh whole milk. At first, Gil spit out what was given him (thinking perhaps that here was other bitter medicine to swallow), but then he began to eat, tentatively at first and then greedily. Prazeres laughed and said she was “amazed” that Gil could even eat such things. Each day, however, the foods provided for Gil and meant to last the little fellow for two or three days would disappear. When questioned Prazeres and Dalina confessed to eating the foods that Gil “didn’t like” or that “disagreed” with him. Once again, Gil was excluded from the family circle. “Such good food could not be wasted”, said the elderly great grandmother.

The failure of Maria Prazeres and her kin to recognize Gil’s hunger—so preoccupied as they were with their own—is perhaps understandable. Prazeres’ and Dalina’s hunger went far deeper than the flesh. But the turning away of the doctors and pharmacists who gave or who sold Maria painkillers and sleeping pills to quiet her fussy starving son is less easily swallowed. Death, after all, is the ultimate soporific and the perverse medical practitioners need not have bothered. Clinic doctors had diagnosed Gil-Anderson’s state of wasting from
starvation as "infantile nervousness", a fancy-sounding diagnosis that agreed with Prazares, who often repeated it to neighbors. The real mental disorder was located in the disordered *pas de deux* that linked Prazares, her grandmother and her doctors in a carnivalesque dance of induced death and of false, medicalized rescue. If there is a tragedy of false (and desperate) mothering embedded in these sad favela tales there is also a tragedy of pseudo-doctoring that contributed to the iatrogenic over-medication of little Mercea and of Gil-Anderson in the face of their 'simple' misery. The "not so good enough" mother requires the collusions of a not so good enough doctor to complete the cycle.

**Pathologies of doctoring**

The medical and psychiatric literature on Munchausen by Proxy literature is replete with cases of small children exposed to hundreds of repeated clinical visits and to scores of painful and intrusive, and unnecessary examinations and treatments with no attention to why this is possible. The attention seeking on the part of MBP mothers is matched by the narcissism and self-deceptions of the attending doctors who sometimes seem more infuriated by their manipulations at the hands of the pseudo-mothers than concerned about the role they themselves played in further victimizing and harming the child.

In some published scenarios the collaborating doctors, nurses, and lab technicians are presented as if they themselves were the *real* victims of MBP. Like the Brazilian doctors and pharmacists who callously refused to see what was so graphically before their eyes in the cases of malnourished Mercea and Gil-Anderson, the doctors in more classical clinical cases of MBP bear some of the blame and responsibility for what is more than a pathological dyadic relationship between mother and child.

In asking why Munchausen by Proxy is so often overlooked by medical professionals and social workers (not to mention by a great many medical anthropologists) we need an answer that goes beyond the deviousness of the mothers and beyond the doctors' cautiousness and fears of rejecting, questioning, or over-stigmatizing nervous mothers. Between three and four children die each day in the United States because of child abuse and neglect. It is not known, of course, exactly how many other children who die of "accidental" falls, burnings, poisoning, drowning were also intentional victims of criminal caretakers. But thanks to the dogged work of Jill Korbin (1998) we do know something about the family histories and social and professional networks of convicted child-killers, most of them women, and all of who claim that they were good mothers. While that is not surprising, the fact that the murders' relatives, friends, co-workers and professionals—pediatricians and social workers—also tended to defend the accused woman as a good mother is a profoundly disturbing finding of Korbin's research. These collaborators and bystanders to the child's eventual murder either denied outright or minimized the early warning signs of serious abuse in the mother's relations to their children. The
fatality was rarely the first incident of child abuse, but tends to follow a trajectory of misread signs and underestimated risks.

In following a small sample of women who killed their children, Korbin noted the characteristic failure of those around them to attend to a plethora of signs indicating the mothers’ malevolent intent, including their personal confessions to their doctors, social workers, mothers and sisters as well as to friends. And so, grandmothers assured their daughters that they are good mothers, telling them that even the best mothers can “lose” their patience and let loose toward a child from time to time. Social workers tended to side with mothers seen as victims rather than as perpetrators of violence within disturbed homes. And pediatricians could not bear to accuse a mother of intentional injury or deception.

The failure to identify a mother’s risk to an endangered child is, in part, the result of conventional wisdom about motherhood and sentimental images of mother love. The idea that mothers are born and not made contributes to considerable blindness to pathologies of mothering. An alternative understanding of motherhood as an “accidental” condition and as a socially constructed role is still generally resisted, even in progressive quarters, along with the idea that mother love, like any other human emotion, is always conditional and contingent. The ideology of mother love remains a great impediment to the recognition of child endangerment at the hands of the few extremely disturbed women who also happen to be mothers. The notion of unconditional mother love has allowed some women to get away with murder, literally.

**Munchausen by Proxy, somatization, and other weapons of the weak**

Finally, it is important to recognize the role of embodiment and of “somatization” in the drama of MBP. Embodiment concerns the ways that people come to “inhabit” their bodies so that they become, in every sense of the term, habituated, dwelled in, taken for granted (see Bourdieu, 1977). Somatization, the manufacture or amplification of bodily symptoms, is more characteristic of certain cultural subgroups and social classes (see Boltanski, 1984) and is more characteristic of women than of men. Manual laborers, for example—those who make their living with their bodies—are often more prone to using bodily complaints and symptoms as a medium of self-expression, creativity or resistance.

In somatization the body is called upon to produce an explosion of chaotic symptoms—fictive, factitious (i.e. frankly deceptive), or psychosomatic—in attempts (most of them semi-conscious) to demonstrate one’s goodness through suffering, to solicit help and/or sympathy, or to express one’s secret indignation, frustration, or anger at those in a more privileged or superordinate position to oneself. Somatized illness can be seen as another weapon of the weak (see Kleinman & Kleinman, 1985; Ong, 1987; Scheper-Hughes & Lock, 1991; Taussig, 1980).

Illness is never just an unfortunate brush with nature. Ever since Talcott
Parson’s classic essays on the role of sickness in the American family, critical social theorists have understood that illness is more than a naturally produced phenomenon. Illness symptoms are social facts in the Durkheimian sense, and they constitute a “social role” through which sickness and healing as well death and dying are performed and staged. Ways of being ill disabled and of suffering are habituated bodily expressions of dynamic social and political relations. Sickness is not just something that “happens” to people but also something that people do in uniquely personal and creative ways. Illness is, in other words, a form of bodily praxis. While the body can be used to express a sense of belonging and affirmation, it can also be used to express negative, conflictual sentiments—feelings of distress, alienation, frustration, anger, resentment, sadness and loss. These two modes of bodily expression exist in a dialectical relationship, an expression of the tensions between belonging and alienation that characterize human social life everywhere. In societies characterized by a great deal of institutionalized inequality and class, racial or gender exploitation, feelings of oppression, frustration and rage are common, but disallowed, social sentiments. Most subordinate classes, including women, have rarely been afforded the “luxury of open, organized political activity” (Scott, 1985, p. xv).

However, those who are relatively powerless and aggrieved do put up a remarkable assortment of resistances, including, as Scott (above) has pointed out, “foot dragging, dissimulation, desertion, false compliance, pilfering, feigned ignorance, slander, arson, sabotage, and so on” (1985, p. xvi). To this list we could add some forms of illness, somatization, malingering or feigned and provoked symptoms, as in Munchausen by Proxy, which can be seen as inchoate acts of protest and defiance against oppressive roles and/or feelings of inadequacy, frustration, or failure. Of all the options for expressing dissent, the production of illness symptoms is perhaps one of the most common, yet also one of the most problematic strategies of redress.

Illness, as Frankenberg (1986) noted, is theater and pageantry, especially in parts of the Mediterranean world, Eastern Europe and Latin America where both the liturgical and the public calendars center around the birth, suffering, death and resurrection of Jesus and the maladies and miraculous healings of the saints. Indeed, in much of the folk Catholic world there is a strong association between goodness and sickness, reinforced by the ubiquitous images of the Mater Dolorosa, Our Lady of Sorrows, the mature Mother of God standing at the foot of the cross or sitting with her dead Son in her arms. Religious images of suffering are far more common than images of the nativity or the resurrection.

For an example rather uncomfortably close to home, the author, despite an otherwise unproblematic childhood in New York City in the early 1950s, was invited with her older brother to produce a kind of seasonal stigmata—oozing patches of exema on arms, feet, legs, and face, especially during Holy Week. A devoutly Catholic, first generation Czech-American mother interpreted this visible distress as a sign of Divine grace and election. The Virgin Mary, she said,
always loved those who suffered most. The author was keenly aware that her seasonal “wounds” made her more dear to her beloved human mother as well. With age she learned to shed the unconsciously elicited dis-ease, recognizing it as a *folie a trois* uniting mother, son and daughter in which one’s candidacy for sainthood hinged on a sacred pageantry performed on the canvas of one’s own skin. Here, Munchausen-like behaviors represented a confused, but devotional act of simple faith rooted in a belief in the value of suffering, characteristic of Eastern European peasant cultures, both Jewish and Catholic. The experience contributed to the author’s sensitivity to the social, political *and* spiritual meanings of somatization and somatization by proxy (see Scheper-Hughes, 1994).

In all, a greater familiarity with illness and with its creative uses has perhaps biased women in many parts of the world toward the uses of somatization and other forms of body tactics which can also be transferred to one’s intimate surrogates and proxies, especially to children. Women are the petite doctors of every household and village, the *curanderiras*, the *rezadeira*, the everyday healers of the sick within family, neighborhood and village. And women—far more often than men in any of the societies medical anthropologists have studied—use suffering and illness creatively.

Their insertion into the social world teaches women in many societies to privilege the body and to pay attention to the physical senses and to the language of the body as expressed through physical symptoms. One thinks, for example, of Alice James (1964), the less famous and celebrated sister of William and Henry James, writing her diaries in her neurotically invented sickroom, using her body as an instrument of revenge *and* creativity. But in the case of Munchausen by Proxy the displaced and malignant uses of somatization to dramatize the needy self are almost criminal.

Biu and Maria das Parzeres, for example, used the sickness and deaths of their own children to carve out a space of resistance and protest in a world that allowed them few, if any other, options for survival. Obviously, there is a dangerously thin line between either exempting or blaming women for malignant behaviors born of lives so constrained and so meager that advancing the sickness and death of one’s children could be become a creative solution. It was the death of Mercea, Biu and Oscar insisted, that brought about their reconciliation.

**Munchausen by Proxy and mother love**

Obviously, mother love is anything but natural and everywhere maternal thinking and practice are a complex matrix of images, meanings, sentiments and practices that are suffused with social, cultural, and political meaning. All mothers are “adoptive” or “fictive” mothers in the sense that they must chose whether or not to accept a baby or a child into the circle of protective custody and care. A small number of deviant mothers use the “sickness strategy” to project onto their babies their own frustrated wishes and needs, the central and
determining feature of Munchausen by Proxy. Hence, mother love is best understood as (m)other love.

Just as mothers sometimes project onto their babies their own frustrated wishes and needs, so do medical professionals and other caregivers project onto women their fantasized and naturalized images of “motherhood” and “mother love”, which make it difficult to see harmful behaviors that are occurring right before their eyes. A commitment to an ideological formation of “natural” or biological motherhood and to the universality of “maternal bonding” and mother love obscures the real dangers that mothers can pose to their own children (see, for example, Weiss, 1994).

Behaviors conforming to the symptoms of Munchausen by Proxy exist along a continuum of maternal behaviors, from normative to deviant. Munchausen by Proxy syndrome is rooted in conventional roles that isolate women, make them overly responsible for the physical care of vulnerable family members, and thereby prone to the social uses and abuses of somatization and the sick role, and especially to the drama and pageantry of fictive illness and heroic (though false) medical rescue. Here we can see that lying and deception (or self-deception) in a context of bad faith become strategies with a deeper meaning than simple pathology and falsehood.

Whenever we try to pierce the meanings of lives very different to our own, we face two interpretive risks. On the one hand, we may be tempted to attribute our own ways of thinking and feeling to “other” mothers. To describe some poor women as aiding and abetting the deaths of certain of their infants can only be seen as “victim-blaming”. And to describe a small number of those women as “deceiving” can be seen as an a priori moral judgment. But the alternative would be to cast women as passive “victims” of their fate, as powerless, without will, agency, or subjectivity. Certainly, part of the difficulty lies in the confusion between causality and blame. There must be a way to look dispassionately at the problem of disordered mothering and child survival. By being attentive to the conditions that underlie what is being called MBP, and by being aware of the role played by naïve and self-concerned doctors in producing the drama, and thereby looking beyond “the lie”, we are able to see it as a social constellation, a form of everyday violence which is a destructive weapon of the weak solicited to resolve otherwise unbearable personal and social suffering.

Unfortunately, there are many hidden violences and pathologies in mothering and family life as in medical care and the healing in addition to the more visible and transparent acts of generosity, altruism, self-sacrifice, and tenderness that we would like to think of as more characteristic and common, if not as altogether “natural” and universal.

Acknowledgements

An earlier version of this paper was presented at the National Institute of Health, Division of Rare Disease, International Conference on Munchausen by
Proxy Disease, Stockholm, 1–2 August 1998. The revised paper benefited greatly from many discussions with Herb Schrier and with D. Michael Hughes.

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