

## Munchausen Syndrome by Proxy: problems of definition, diagnosis and treatment

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### Abstract

Munchausen Syndrome by Proxy (MSbP) is a form of child abuse in which the abuser, usually the mother, fabricates or induces illness in another, usually a child, in order to present the child to the medical establishment for unnecessary examination. Since 1977, when the term was first used in Britain by Meadow, an extensive literature has evolved around the concept, describing cases, delineating indicators and perpetrators characteristics, and recommending strategies for management. While the technicalities of diagnosis have attracted some criticism, there has been much less debate about the validity of the concept itself. This paper raises certain problems associated with the conceptual validity of MSbP, outlines some concerns of current research and puts forward an alternative research programme in order that the concept be understood from the point of view of the suspected abuser and in the wider context of the creation of medical knowledge and sociocultural factors.

**Keywords:** child abuse, Munchausen Syndrome by Proxy, sociology of medical knowledge

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### Introduction

Until 1993 Munchausen syndrome by proxy (MSbP) was a relatively unknown phenomenon outside of the specialist medical and social work press. Then, in May 1993, the case of Beverley Allitt hit the headlines and MSbP came, in the popular mind at least, to be associated with serial murder. The fact that the Clothier Report (HMSO 1994 p. 79) concluded that the term MSbP was unhelpful in this context was not widely reported, and did nothing to dissociate the syndrome from serial murder. This is unfortunate, as any debate surrounding the concept is now clouded by that particular popular conception. However, while 1993 was a year of popular awareness, 1994 brought less favourable attention with the Lancet questioning the validity of the concept in its editorial (Lancet 1994). Although this promoted some response in the letters pages, it did little to generate any great debate and any criticism of MSbP seems to be restricted to the technicalities of diagnosis rather than its conceptual validity. Despite these discouraging precursors, however, it is

debate concerning its diagnostic validity which I want to instigate. It is my contention that MSbP is, at best, a slippery concept which has inherent flaws and contradictions, and if it is to be helpful in managing certain illness behaviours it requires a good deal of clarification and a tightening of its definition so as to avoid misdiagnosis with its subsequent distress to both parents and children. To this end, I wish to examine some of the present problems with MSbP as a diagnostic category and to offer an alternative research programme to that presently undertaken.

### Munchausen syndrome by proxy

MSbP was first coined by Meadow in 1977 to describe two mothers who he suspected were fabricating illness in their children (Meadow 1977). In using the term MSbP he was making reference to Baron Munchausen, an eighteenth century soldier and adventurer who, on his return, regaled his friends with fantastic accounts and stories of his travels (Raspe 1948) and to the

eponymous syndrome created by Asher (1951) to describe those people who deliberately invent medical histories or symptoms in order to gain medical attention.

Initially, MSbP was used to refer to those mothers who fabricated or induced illness in their children. The range of such fabricated illnesses varied widely, a good summary of which can be found in Schreier & Libow (1993, Appendix A). However, over time, further manifestations were added so that today MSbP is used to describe six forms of behaviour:

- (1) pretence of illness,
- (2) fabrication of illness or medical history,
- (3) inducement of illness,
- (4) exaggeration of genuine illness,
- (5) enforced invalidism, and
- (6) false allegations of abuse.

While there is some disagreement in the literature as to whether the last of these is indeed a manifestation of MSbP (Schreier & Libow 1993), it is included here for the sake of completeness and to acknowledge that some sources view this as a manifestation of MSbP (Rand 1989, Barker & Howell 1994).

Similarly, a comprehensive list of MSbP indicators and perpetrator characteristics has been developed as cases of MSbP were diagnosed and reported. These are laid out in tables below.

Until recently MSbP was little known outside of the medical press in which, however, there is a substantial body of knowledge relating to MSbP. Undertaking literature searches through a number of databases I have identified ≈400 references in which MSbP is the sole or

significant part of the subject being reported. The increase in reporting this form of abuse is reflected both in medical and in social work literature, with an emphasis on the multidisciplinary nature of such cases, this being the focus of the first national conference on MSbP and a forthcoming book edited by Howarth.

### Critique

Although there is a large body of work regarding MSbP there are significant problems with the concept which have not been addressed.

First, MSbP has become a somewhat nebulous and inconsistent concept, which allows it to be used as a 'dustbin' term for otherwise inexplicable factors. In order to argue this point I collated all the identifying features of MSbP from across the literature. Thus from available case descriptions, it is possible to draw up lists of indicators of MSbP, perpetrator characteristics, manifestations of MSbP, management actions after a diagnosis of MSbP and methods of determining whether such abuse is taking place. While such tables are a frequent occurrence in the literature there has been no systematic overview. By collating this information, and also by drawing on case study materials from four families, it has been possible to point to the ever widening catchment area of MSbP (see above), the substantial contradictions between indicators (compare Tables 1 and 2), the generalized nature of the perpetrator characteristics (Table 3) and to some of the difficulties in diagnosing and opposing MSbP.

Secondly, MSbP lies within the 'disease model' of

**Table 1** Indicators of Munchausen Syndrome by Proxy\*

1. Persistent or recurrent illnesses for which a cause cannot be found or which are very unusual
2. Discrepancies between history and clinical findings
3. Symptoms and signs that do not occur when a child is away from the mother
4. Unusual symptoms, signs or hospital course that do not make clinical sense, causing experienced physicians to say they have "never seen a case like it before"
5. A differential diagnosis consisting of disorders less common than MSbP
6. Persistent failure of a child to tolerate or respond to medical therapy without clear cause
7. A parent less concerned than the physician, sometimes comforting the medical staff
8. Repeated hospitalisations and vigorous medical evaluation of mother and child without definitive diagnoses
9. A parent who is constantly at the child's bedside, excessively praises the staff, becomes overly attached to the staff, or becomes highly involved in the care of other patients
10. A parent who welcomes medical tests of her child even when painful
11. Doctor shopping or hospital peregrination (Libow and Schreier 1986, Meadow 1989)
12. Unusual or unexplained illness or death in previous children (Samuels and Southall 1992a)
13. Patient has multiple allergies (Leonard and Farrell 1992)
14. Parent or caretaker is overattached to the patient (Leonard and Farrell 1992)
15. In children, one parent (usually the father) is absent during hospitalisation (Leonard and Farrell 1992)

\* Adapted from Jones *et al* (1986).

**Table 2** An extended list of MSbP indicators

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1. Presentation at hospital (Leonard and Farrell 1992)
  2. Non-presentation for medical attention (Money *et al.* 1985)
  3. Overconcern about the child's health in the form of extreme exaggeration of symptoms (Masterson, Dunworth and Williams 1988)
  4. Not as concerned about the child's health as the medics (Meadow 1985)
  5. Cooperation with the medics (Meadow 1985)
  6. Non-cooperation with the medics e.g. seeking alternative medical opinions which counter the diagnosis or conflictual relationships with the medical staff (case notes, Robins and Sesan 1991)
  7. Confession (Rees 1987)
  8. Denial (Leonard and Farrell 1992)
  9. Medical knowledge on the part of the mother (Leonard and Farrell 1992)
  10. Medical ignorance on the part of the medics (Meadow 1985)
  11. Symptoms that only begin in the presence of one parent (usually the mother as the absence of the father is also indicative) (Samuels and Southall 1992a)
  12. Collusion of father or other family if symptoms start in the presence of more than one person (case notes)
  13. A poor intellectual relationship with the husband (Meadow 1980)
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child abuse (Parton 1985) and is thus open to the general criticisms of that model as well as having its own peculiar failings. By examining the general characteristics and criticisms of such a model it is possible to situate MSbP within it as focusing on individual pathology. However, it is necessary to point to the paradoxical nature of MSbP in this respect. On one hand it can be argued that MSbP falls clearly within such a model. On the other hand, MSbP can only be understood in social and relational terms. There are two points which help explain this apparent contradiction. First, because of the predominance of the disease model of abuse in research, policy and practice, by describing itself within these terms MSbP seeks to gain credibility by association. Secondly, by drawing social factors and relationships into this model, MSbP links in with the discussion of the medicalization of society. In addition, there are questions as to the a-historical

and a-social nature of MSbP which suggest that its development as a diagnosis is not as objective as its proponents would have us believe.

Thirdly, medical presentation with real or imagined illness is an unsurprising spin-off of a medicalized and 'hypochondriac' culture for which the medical establishment is primarily responsible. It is thus possible to situate the development of MSbP into wider processes of medicalization of society and the increasing concern with 'health'. By looking at the medicalization of childhood, clinical and social iatrogenesis and the creation of a society obsessed with 'health' and its concomitant illness, it is possible to identify factors other than individual pathology that might explain unnecessary presentation to the medical establishment.

Fourthly, by focusing on the mother as abuser, MSbP can be seen as another case of a predominantly male medical establishment defining a problem which

**Table 3** Profile of the 'Munchausen mother'

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1. Appears as the 'perfect parent', nurturing, loving and caring (Leeder 1990)
  2. Has had some medical training or has been active in health service affairs eg officer of the hospital league of friends (Meadow 1984)
  3. Father is absent for long periods of time (Meadow 1982) or is inconspicuous (Jones *et al.* 1986)
  4. The mother comes from a higher social background or seems much more intelligent than her husband (Meadow 1985)
  5. Similarities between the medical histories of the mother and child (Jones *et al.* 1986)
  6. May have features of Munchausen syndrome herself (Jones *et al.* 1986)
  7. Characterised by severe emotional deprivation (Leshnik-Oberstein 1986)
  8. Has previously worked with children in some capacity (Meadow 1980)
  9. Has a previous history of hysterical illness (Meadow 1980)
  10. Parents who have a history of unusual illness or themselves have suffered physical, emotional or sexual abuse in childhood (Meadow 1980)
  11. Parent who have a history of conduct or eating disorders (Meadow 1980)
  12. Has a history of marital discord (Leonard and Farrell 1992)
  13. Denies involvement in deception (Leonard and Farrell 1992)
  14. Has suicidal ideation or attempt before disclosure or after discovery (Leonard and Farrell 1992)
  15. Is lonely and isolated (Leonard and Farrell 1992)
  16. Previous criminal record (case notes)
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blames women. Virtually every reported case of MSbP has involved the mother as perpetrator. As such, the question arises as to what explanations other than female pathology could be found for this outcome. Although it seems obvious that MSbP is presented as 'another women's disorder', there is surprisingly little debate about its diagnostic bias. Even those authors sympathetic to the gender issues involved (Robins & Sesan 1991) seem to resort to individual or family therapy as a means of treatment, and do not consider the wider issues of gender and medicine. In examining MSbP within the wider context of the history of medicine and the medicalization of society it can be argued that MSbP is best understood as an outgrowth of factors other than individual pathology. Following the arguments of Ehrenreich & English (1973a, 1973b, 1978), it is possible to argue that MSbP fits into the misogynist history of medicine by bringing together the two historical views of women as sick and sickening. In MSbP these two views can be seen in the diagnosis of an individual. As such, and in combination with the argument about the medicalization of society, it can be argued that MSbP can be seen as a cultural symbol.

In every culture there are acts, concepts and artefacts which are regarded as symbolic. These symbols encapsulate either those things which that culture regards as significant or express the *Zeitgeist*. I would like to suggest that MSbP can be seen as a symbol of the latter kind. MSbP can be seen as an outgrowth and extension of the medicalized culture, expressing itself as an accumulation of indicators from medicine's historical subjugation of women. As such it probably tells us more about the state of society than the pathology of any individual.

Fifthly, the consequences of allegations or diagnosis of MSbP can be disturbing in terms of future medical treatment and family life. Drawing on case study materials it is possible to illustrate the sense of confusion and distress that families experience upon being accused of MSbP abuse. Given the variety of contradictory indicators and the catch-all nature of the perpetrator characteristics, it is not surprising that families express upset and confusion, it seeming to them that no matter what they do their actions can be used against them. Indeed, one family was caught into MSbP by simply following the advice of their doctor and another by being referred to a number of hospitals by doctors without any pretence or deception on their part. The most distressing case is one in which the child died and the mother was accused of smothering her. It was only six months later, after a good deal of investigation, that the pathologist's report stated a medical diagnosis and reason for the child's death

which the original doctors had failed to detect. If this was the case here, it is interesting to ask how many more cases of genuine illness have not been detected because a diagnosis of MSbP has already been made.

Sixthly, certain aspects of MSbP and its management would seem to be contrary to the spirit of the 1989 Children Act. In recent months there has been a great deal of debate around the methods used to confirm or detect a diagnosis of MSbP. Most of these have centred around the issue of covert video surveillance (CVS) and, in particular, the work of Samuels & Southall (1992b), Samuels *et al.* (1992), Morley *et al.* (1992) and Morley (1992). Proponents of MSbP argue that it is the interests of the child that must come first, and if this involves covert video surveillance then so be it. However, not only does this raise ethical questions, and those of civil rights, but also legal ones. Given that the Children Act requires a working partnership between local authorities and families it is difficult to see how this can be maintained when professionals are required to systematically lie to parents in order to undertake CVS (O'Hagan 1994).

#### **Current research into Munchausen syndrome by proxy**

Current research, however, is not addressing these questions. In this section the thrust of current research into MSbP is outlined and an alternative research programme suggested.

The main thrust of current MSbP research is to further our understanding of this phenomenon and move it closer to clinical validity (cf. Kendell 1989). This point is important as, despite the inclusion of 'factitious illness by proxy' in the Diagnostic and Statistical Manual IV (DSM IV) MSbP does not, as yet, meet the criteria for clinical validity. Kendell outlines these criteria.

- (1) Identification and description of the syndrome, either by 'clinical intuition' or by cluster analysis.
- (2) Demonstration of boundaries or 'points of rarity' between related syndromes by discriminant function analysis, latent class analysis, etc.
- (3) Follow-up studies establishing a distinctive course or outcome.
- (4) Therapeutic trials establishing a distinctive treatment response.
- (5) Family studies establishing that the syndrome 'breeds true'.
- (6) Association with some more fundamental abnormality: histological, psychological, biochemical or molecular. (Kendell 1989, p. 47.)

Current mainstream research into MSbP falls within the above categories. For example, Meadow's (1977)

current research is geared to follow up studies looking at the outcome regarding the child and the management of the case. The work of Jureidini (1993, personal communication) on parenting skills would seem to fall within the fourth category of establishing a treatment response. The work of Schreier & Libow (1993) would seem to fall within the sixth category, where they look at possible psychological factors in MSbP perpetrators and the most recent publication by Bools, Neale & Meadow (1994) focuses solely on the psychopathology of perpetrators.

Given that much of the published literature can be filed within one of these categories it is of little surprise that MSbP has been used as a clinical diagnosis for some time before it received official acknowledgement in DSM IV. However, it is somewhat debatable that the above criteria have been satisfied within the existing literature. Certainly the vast majority of writings seem to fall within the descriptive criteria without any systematic overview of the development of the concept. Kendell (1989) outlines the difficulties within the criteria of clinical validity and suggests four forms of research in order to address these problems: prospective follow-up studies based on serial interviews; therapeutic trials involving a broad spectrum of diagnostic categories; family studies; and twin studies involving alternative definitions of syndromes. While some of the published MSbP literature might go some way towards addressing these problems, it is difficult to imagine how twin studies could be undertaken in the case of MSbP.

Whatever the difficulties involved regarding the validation of MSbP as a clinical diagnosis, it seems certain that the increasing body of literature is establishing it as a valid diagnosis. Certain deliberate steps are being taken to fill some of the gaps left in its development, although it is unlikely that any serious questioning of the concept will occur despite the Lancet's (1994) opening volley.

### **Munchausen Syndrome by Proxy: An Alternative Research Programme**

In opposition to this trend in MSbP research an alternative research programme is suggested, based upon some of the above criticisms and divided into the different processes involved in the creation and establishment of MSbP as a clinically valid diagnosis. Four areas for such research are suggested.

#### **The Creation of MSbP**

Almost from the outset, MSbP has been accepted as describing some form of deviant behaviour that exists

in the 'real' world of medical practice. As such it has connotations of objectivity, of scientific status. However, there is much work done on the socially constructed nature of scientific and medical knowledge and it would appear that such an approach is well suited to examining MSbP. Prior to 1977 (or 1976, depending on whom you believe: Meadow 1977, Money & Werlwas 1976, Money 1986, Sneed & Bell 1976, Sneed 1989), MSbP did not exist. There were no references to it in any textbook, no-one talked about it, and it was impossible to diagnose, although there is reference in the literature to cases in which MSbP could have been diagnosed but was missed. Seventeen years on, it has the status of clinical validity and monies are being made available to further our knowledge of this phenomenon. Consequently, the starting point for any alternative research programme is to examine the processes whereby MSbP became established in the medical literature and in medical practice. This involves examining citation networks and the creation of a body of literature; the differentiation of MSbP from other diagnoses and the creation of its conceptual unity; the establishment of MSbP as a 'social problem'; and the creation of the 'Munchausen mother'.

#### **The process of diagnosis**

Obviously linked with the above is an examination of the processes involved in diagnosing MSbP. The differentiating factors which suggest MSbP rather than any other diagnosis and the negotiation of the diagnosis of MSbP with the supposed perpetrator must be described. Essentially, MSbP concerns differing definitions of illness and appropriate illness, or help-seeking behaviour, which have to be negotiated in the interactions between professionals and laity and between different professions. It is my contention that through close examination of case study documents and interviews with both families and professionals it should be possible to identify the processes whereby it is the professional definition of the situation that comes to be predominant. By laying bare the processes involved in the diagnosis of MSbP, and how these processes are then used to validate the concept, it should be possible to account for the inherently contested nature of MSbP and thus come closer to understanding both the creation of MSbP and the effects of its diagnosis.

#### **The Effect of Diagnosis**

While the literature is replete with accounts of the effects of certain behaviours on the children concerned (morbidity or death), what is substantially missing

from the literature is the voice of those accused. Because MSbP is an essentially contestable diagnosis rather than an 'objective' disease the absence of this voice is disturbing. The only voice that seems to be heard is that of the diagnoser. Given also that there are substantial problems with MSbP which can lead to frequent misdiagnosis, the lack of research into the effects of diagnosis and misdiagnosis on those concerned is an important part of understanding the processes of diagnosis and management. Although the literature has many accounts of the difficulties in diagnosing MSbP and then managing it, and accounts of the effects of such a diagnosis on professional staff, there is a singular absence of parallel accounts from those who have been accused.

### The Relationship between MSbP and other related theories

MSbP holds a paradoxical position within the medical model of child abuse, but the medical model is not the only model available. Consequently, further study of how MSbP fits into the spectrum of such models, its points of contact and points of divergence is required. Taking a somewhat wider view of the theoretical situation of MSbP might clarify the management of cases.

Similarly, MSbP will also need to be situated within theories of help-seeking and illness behaviour. While initial work has been done on this by Eminson & Postlethwaite (1992), they did not cover the whole spectrum of help-seeking behaviour, for example they omitted any discussion of the 'worried well'. Similarly, they focused on the behaviour of the 'patient' and omitted any discussion of what role the medical establishment had in promoting, encouraging or maintaining various behaviours. MSbP essentially concerns the negotiation of acceptable illness or help-seeking behaviours and as such is inter-personal. Therefore, investigation must involve relational processes rather than a monologue by the medical establishment on MSbP behaviour.

Furthermore, there are significant problems within the literature on the issue of causation or motivation. For some it would seem to be an extreme form of attention seeking. For others, it represents a form of atonement for previous 'wrong-doing'. For others yet, it represents an attempt to seek revenge for previous abuse. Each of these motivations needs to be examined within the range of motivations for other forms of abuse and help-seeking or illness behaviours.

### Conclusion

With the move towards researching the processes whereby professionals come to the diagnosis of MSbP,

and individuals become labelled as MSbP perpetrators, there will be a shift in the form of research required from the present positivist and quantitative methods to qualitative research focusing on the essentially negotiated character of an MSbP diagnosis and, in particular, a focus on the meanings, intentions and attitudes held by the supposed perpetrator.

This proposed research would be useful in several ways. It would provide a fuller understanding of the process of diagnosis and of MSbP in particular, which might hopefully improve the practice of diagnosis and management by drawing attention to the hidden biases and difficulties inherent in the concept. It would clarify certain aspects of the concept of MSbP and attempt to tighten the definition into a more meaningful concept, thus facilitating better operationalization. Finally, it would contribute to the debate surrounding MSbP and thus help clarify its further development. As such it is expected that the research would be useful to medical professionals involved in diagnosis, social workers in managing cases and individuals accused of MSbP in making sense of the above processes.

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