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PERSONAL PRACTICE

Factitious illness: recognition and management

D M Eminson, R J Postlethwaite

Abstract

An analysis of Munchausen syndrome by proxy is proposed, which involves a categorisation of parental behaviour in terms of desire to consult and ability to distinguish the child's needs from parents' own needs. The Munchausen syndrome by proxy case is proposed as one extreme of a much broader and commoner group for which the term factitious illness is used. An outline of assessment and investigation is given, applicable to all degrees of factitious illness, together with a model of collaboration between paediatrician and child psychiatrist. The role of the child psychiatrist is described. Collaboration results in a broader analysis of the situation which facilitates understanding and points the way to appropriate intervention.

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Munchausen syndrome by proxy has received considerable attention recently as it is recognised to take its place among other forms of child abuse.[1] The physical and emotional harm that abuse causes children has been amply demonstrated,[2] and recent work suggests significant co-morbidity in siblings of children suffering Munchausen syndrome by proxy.[3] A vast literature exists of different ways of poisoning, suffocating, or otherwise damaging children in order to produce symptoms for health care professionals to investigate and treat. This literature gives a strong sense of the horror and confusion of paediatricians who patiently pursued what they thought were 'real' symptoms, only to realise slowly that parents were 'tricking' them.

This sense of horror and fury is similar to that which adult physicians first felt when meeting patients with Munchausen's syndrome and was recognised by Asher[4] and discussed by Taylor.[5] It was met again when physical and sexual abuse of children were first recognised. We believe these emotions arise when a transaction occurs that seems to break all the unwritten rules of contact between parents or patients and physicians. Such unwritten rules are, for example, that patients (parents) are telling the truth as they see or experience it or that parents generally do their best for their children. It also happens when doctors have no framework within which to understand the behaviour they see. This paper attempts to provide a framework within which this behaviour can be categorised. It is hoped that this categorisation is a precursor of greater understanding and will lead eventually to better strategies for treatment and remediation, as has occurred with physical and, to some extent, sexual abuse.

Cases in which parents have actively procured symptoms (that is true Munchausen syndrome by proxy) are rare. Far more common are cases where the mother has merely invented an illness story for the child without resorting to direct physical action to procure it.[3] These cases, however, will tend to be presented only with invented histories, thereby making the medical profession carry out physical investigations and arrange hospital admission and further tests. These two groups of patients with illnesses procured and invented form part of the even larger group of children who are presented with very exaggerated symptoms. All these children suffer from what we believe it is helpful to call factitious illness. This term incorporates Munchausen syndrome by proxy within a spectrum of abnormal and excessive health care seeking behaviour.[5 6] We believe this term is more explicable to clinicians and is useful in the categorisation of a wide group of patients. We suggest that it is vital to delineate the parents and children who suffer factitious illness in order to minimise the physical and psychological impact of repeated investigations.

In this paper we suggest that an understanding may be gained if the parent and child behaviour is examined under three headings. First, it is helpful to recognise that in addition to being in the hinterland of child abuse, we are studying a *behaviour*: parents' consultation with professionals. This serves to remind us that professionals' behaviour is not irrelevant (discussed further below). There are two further aspects of parents' behaviour which it is useful to examine. Consultation behaviour may be studied as part of a range of responses that parents make to symptoms in their child: this is discussed in section A and represented diagrammatically in fig 1. Finally, this behaviour may be looked at another way, in terms of parents' ability to distinguish their child's need from their own. Factors affecting parents' abilities are discussed in section B. These two categorisations are then combined in fig 2.

Royal Manchester Children's Hospital, Pendlebury, Manchester M27 1HA, Department of Child and Adolescent Psychiatry
D M Eminson

Department of Paediatric Nephrology
R J Postlethwaite

Correspondence to:
Dr Eminson.

Section A

THE FIRST DIMENSION—APPROPRIATENESS OF PARENTS' DESIRE TO CONSULT

The range of health care seeking by parents for their children is represented in fig 1.

Professionals recognise a range of normal consultation behaviour by parents (points 4, 5, 6). Sometimes (commonly) parents and professionals are in almost complete agreement

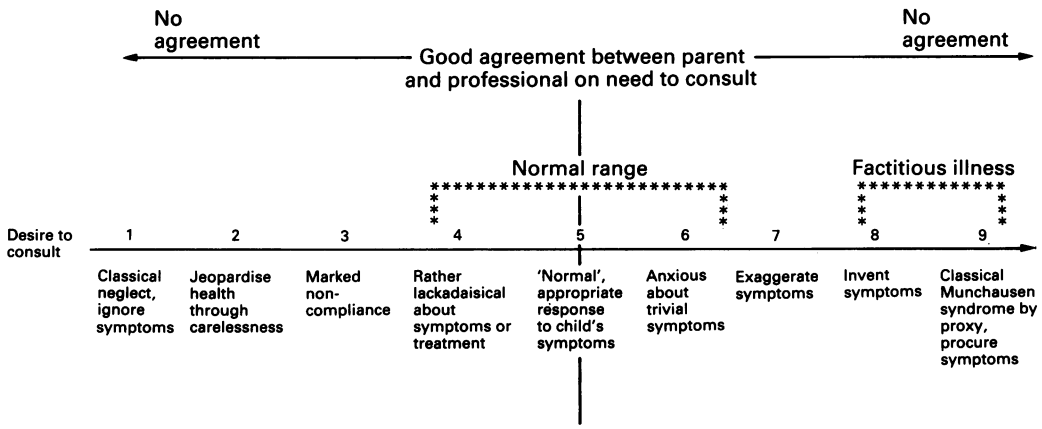

Figure 1 Parents' desire to consult for their child's symptoms.

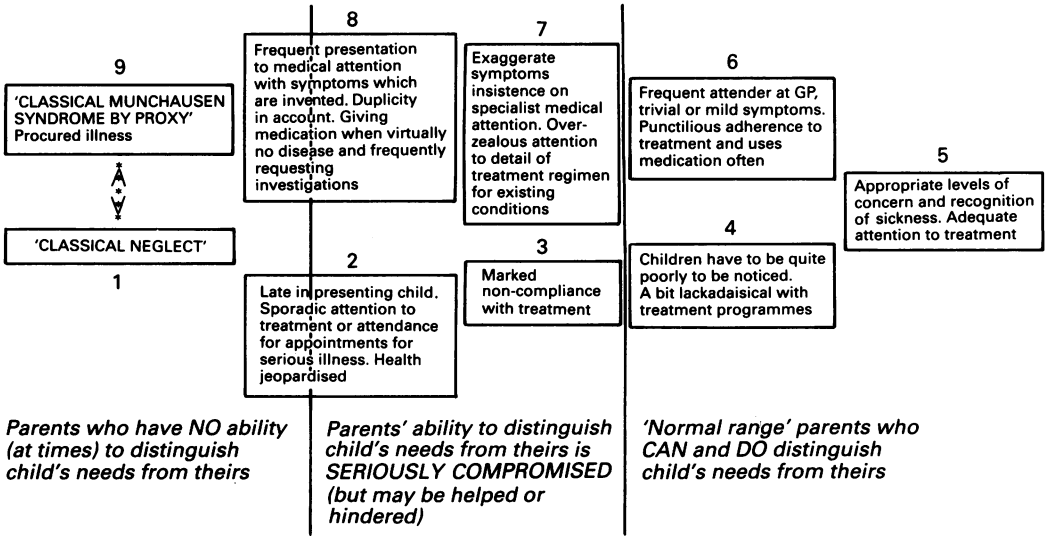

Figure 2 The spectrum of health care seeking by parents for their children.

about the need to consult (point 5). A 'normal range' of health care seeking, however, also encompasses a group of parents who exhibit more anxiety than their doctor. This might manifest itself as frequent attendance at general practice for trivial or mild symptoms, punctilious adherence to treatment, and frequent use of medication (point 6). Another variety of normal health care seeking behaviour describes parents who are less anxious than the doctor. These parents will tend to present their children later in an illness than is ideal and are a little lackadaisical with treatment programmes (point 4).

One pole in this dimension, well outside the normal range, is characterised by a gross discrepancy between parental and professional views; this is Munchausen syndrome by proxy (point 9). In Munchausen syndrome by proxy parents seek health care where an objective professional view would suggest this is quite unnecessary. The difference between the parents' desire to consult and the objective professional view of their child's health is so huge that the parents have to procure illness, in order to force doctors to investigate and treat it.

One step back towards 'normal' are families where symptoms are invented or grossly exaggerated by the parents (point 8). These and the Munchausen syndrome by proxy groups both fall into the category of factitious illness. Between this group and normal but punctilious health care seeking behaviour (point 5) lie parents who are insistent on specialist medical attention and show over zealous or intrusive attention to detail of treatment regimens for existing conditions (point 7). These parents are distinguished from those of factitious illness by virtue of the symptoms being neither invented or grossly exaggerated, but dwelled upon and taken round many different specialists.

The other pole of the dimension concerns parents who also show a great difference in the level of concern that they show, compared with a 'professional's' view. These parents (point 1) show classical neglect of their children's health, ignoring obvious ill health. Those with a slightly greater desire to consult (point 2) include a group of parents who jeopardise the health of their children because of late presentation with serious illness or sporadic attention to treatment. More common again (point 3) are various forms

of non-adherence with treatment regimens which shade in to the 'normal range' (points 4, 5, 6). It is likely that community paediatricians see more of this end of the spectrum than do hospital paediatricians, except where children have a serious chronic illness that should bring them to clinics and should receive treatment.

SECOND DIMENSION—ABILITY OF PARENTS TO DISTINGUISH THE CHILD'S NEEDS FROM THEIR OWN

In paediatrics, children are seen whose parents' behaviour is at all points of the spectrum in fig 1, but specialists are more likely to see an excess of children and parents from points 6 upwards. Though this analysis is helpful in examining the parents' desire to consult and the degree of discrepancy from the 'objective' professional view, further elucidation may be gained if the links between the two ends of the spectrum are made. This involves analysing the behaviour along the dimension of the parents' ability to distinguish the child's needs from their needs. For ease, three groups can be identified.

(a) Parents who cannot distinguish their needs from the child's and who will satisfy their own needs first (point 1, neglect and point 9, Munchausen syndrome by proxy).

(b) Parents whose ability to distinguish their child's needs is severely compromised, so that the child's needs will be heeded variably and inconsistently (points 2, 3, 7, 8).

(c) Parents who can adequately, though variably, distinguish their needs from the child's (points 4, 5, 6).

Expressed diagrammatically (fig 2), the result of applying this categorisation to the previous figure is to demonstrate the similarity between the two ends of the spectrum.

Section B

FACTORS AFFECTING THE PARENTS' PRESENTATION OF THEIR CHILDREN AT MEDICAL FACILITIES (CONSULTATION BEHAVIOUR) AND THEIR ABILITY TO DISTINGUISH THEIR CHILD'S NEEDS FROM THEIR OWN

All clinicians are aware that factors in parents are significant in affecting which children are presented to paediatricians in their clinics. Maternal mental health has been shown to affect attendance rates in outpatients.[7–9] In all situations, several other factors may affect the parent and child dyad in altering their likelihood of seeking health care in response to symptoms in the child or anxieties in the parent.

Many of the factors in parents will affect both their consultation behaviour and their ability to distinguish their child's needs. It is likely that the same factors affect *all* parents and children and result in their occupying different points on the spectrum at different times. It seems intuitively unlikely that any parent would move though *many* 'points', but this merits much further research.

Factors in the child:

(a) The child's tendency to experience somatic symptoms, and other aspects of mood and temperament (anxiety, depression, histrionic traits).

(b) The history of the child: previous or coexisting illness in that system or a serious illness earlier in the child's life.

(c) Learning that physical symptoms elicit parental attention better than other signals.

Factors in the parent:

(a) Intellectual ability: inability due to low intelligence to recognise the importance of the physical symptom in the child.

(b) Extreme youth.

(c) Social circumstances and stresses: distractions, difficulty with partner, finance, job or the parent's or family's health, bereavements.

(d) Mental health: anxiety, depression, or other psychological or psychiatric problems including psychotic illness.

(e) Early experience combined with personality and social factors. In general, the evidence suggests that having one's own needs met in childhood makes a parent more likely to be able to meet their child's needs, but individual parents' histories are not easy to analyse categorically.

These issues figure prominently in the explanations for the behaviours of the Munchausen syndrome by proxy mother.[10] Though the mechanisms and personal histories require much further study, it is evident that a group of women derive gratification from the medical and nursing attention gained when their children are in hospital or under medical investigation. Research, though anecdotal, suggests these women have a history of abusive experience in their own childhoods, have abnormal illness behaviour themselves, possess a variety of unusual personality traits, and are single or in unsupportive relationships (C N Bools, personal communication).[10] These mothers seem to adopt this pattern of behaviour as a result of a combination of inherent personality characteristics, early experiences, a later personal predicament, and the demands/availability of children as a source of vicarious satisfaction. There is a suggestion that once this pattern of behaviour has developed, it is very difficult to dislodge.

Factors in the wider family:

(a) The general tendency to somatise or to be stoical.

(b) Different cultural groups have been shown to vary in relation to frequency of presentation at clinics.

Factors in society:

(a) Factors increasing general anxiety about health, for example, a recent meningitis outbreak.

(b) Factors resulting in a decrease in presentations, for example a recent scandal such as media attention to doctors' 'reporting' of parents to social workers.

It will be obvious that all the factors interact with each other to alter the likelihood of any

particular parent and child consulting for, ignoring, or inventing any symptom.

We shall now turn to the management of those children where presentation to the paediatrician suggests that a diagnosis of factitious illness may be considered; in other words, where parental concern for their children's health is very excessive, and illness may be invented or procured. It should be emphasised that this is an analysis that concentrates upon understanding parental behaviour. Children may or may not have organic illness of varying degrees of severity, whatever their parents' behaviour.

Characteristics of children presented with factitious illness

(1) The initial presentation which alerts the paediatrician is a child whose mother describes numerous physical complaints: usually more than five, often more than 10. These complaints are often presented in a confused picture including both physical and behavioural symptoms and not conforming to any easily recognisable condition.

(2) The child will be presented with symptoms which are unusual or serious, but also are either: (a) by their nature unverifiable, for example sudden pain in the penis or (b) though striking, not corroborated, for example red motions, blood in the urine.

(3) The history given by the parent is justified in an unusual way: (a) the explanations for symptoms are often bizarre or (b) after repeated discussion these explanations are tenaciously retained. In order to continue to hold to this belief supposed witnesses will be advanced in support. These 'witnesses' often have status to emphasise their reliability (friends or neighbours with medical, nursing, or paramedical training, general practitioners).

(4) The children show few if any physical signs and those found are incidental to the presenting complaints.

(5) There are extensive claims of serious illness that has been identified at other hospital(s).

(6) The patients are usually accompanied only by their mothers, rarely by their fathers. Mothers often give a history of illness themselves, usually with little detail that can be verified.

Despite the striking and extensive histories that these patients produce, the factitious origin of the symptoms frequently goes unrecognised. A number of factors contribute to this.

(1) Few patients exhibit all the features.

(2) The possibility of factitious illness is not considered, medical training tending to place emphasis on a rather narrow form of information and history gathering.

(3) The parents hide from the paediatrician the complex pattern of previous medical care. Superficially, an innocuous history of contact with other professionals is given; in a busy clinic this can easily elicit the further investigations the parents seek.

(4) A trivial positive finding or abnormal result, either on history or with investigation, can mislead the paediatrician who focuses on this. Such a focus obscures the overall picture.

(5) It is only with attention to detail and corroboration of the history that the complex picture emerges and this usually requires a number of assessments.

Assessment and management

Rarely will a firm diagnosis be established at the first assessment and factitious illness is likely to be only one of a number of more or less likely diagnoses. Several steps are necessary in the painstaking process of establishing the diagnosis, and both parents must be invited to appointments.

STAGE ONE

First, a very detailed history is required of the child's illness past and present. This would seem a routine element in any paediatric assessment but when factitious illness is considered in the differential diagnosis, the details need to be much more precise. It must be established exactly who is supposed to have seen what, when and where; both the details and parents' agreement to these details should be recorded in the notes. Despite the account being carefully agreed, contact with the 'witness' often fails to verify the story. Exactly the same precision is required in gathering the history of contact with other medical services.

Second, a detailed history of illness in siblings and parents is required. The family's current social circumstances, stresses, and supports merit inquiry.

Third, the child must be examined and the appropriate preferably non-invasive investigations performed to exclude truly likely physical explanations.

Fourth, the previous medical records of child and siblings and, where necessary, parents must be pursued and scrutinised. This is time consuming but crucial if a full picture of the family's pattern of illness and health care seeking behaviour is to be understood. It is this process that reveals the complex pattern of contact with medical services. Previous contacts might have been suppressed, unremarkable events may have been embellished by the parents, completely false stories may have been given or addresses of fictitious hospitals given. Parents may try to frustrate the search by suggesting it is fruitless, for example 'the hospital has now been burnt down', or transferred elsewhere, 'Dr X had already tried to obtain the records but they were not available'. The unwary might take these apparently helpful suggestions at face value.

Permission to seek records from other agencies should be sought.

STAGE TWO

Equipped with the detailed history and records, the clinician may now have a high level of suspicion that he or she is dealing with factitious illness. The management is still no different from any other unusual or puzzling presentation.

It is essential to see the child when the symptoms are present. It may be obvious at this

visit that some significant organic disease has been overlooked in which case the child will present with the appropriate symptoms and signs.

With factitious illness, the parents show great ingenuity at evading this contact. The symptoms will occur at a time when it is judged inappropriate to attend the hospital (for example in the early morning). Problems with transport will be used as an excuse, or the child will be taken to another facility (general practitioner, another department of one's hospital, a laboratory, another hospital) with the symptoms. Many of these excuses can be forestalled by making sure the parents have transport to the hospital, a letter of introduction, and know exactly where to attend in the hospital.

Despite obsessive attention to the detail of these arrangements, with factitious illness a number of outcomes is likely. The child will not present at the hospital despite continuing symptoms because the symptoms will have been judged to have failed to reach an arbitrary threshold which the parents feel would have justified attendance at the hospital. Sometimes, often after repeated requests, the child will be presented with dramatic symptoms but no abnormal finding is identified on physical examination or with investigation.

A final possibility is that the child is not presented to the hospital with the symptom that was the focus of the previous consultation, but the excuse given at the next appointment is that a different symptom has been troublesome. (Doctor: 'He hasn't been troubled by the red motions since I last saw you, then?' Mother: 'No, but he's gone yellow . . . but you didn't tell me to bring him up if he went yellow'.)

In the course of a number of outpatient consultations, the typical mother will introduce new complaints and symptoms and will not appear reassured or enlightened by:

(a) Careful explanation that her child shows no significant ill health.

(b) Offers of benign explanations for previous symptoms.

(c) Reopening and explaining patiently the history of a previous medical contact which has shown no significant illness, but which the mother thinks has demonstrated one.

(d) Constructive refusal to carry out further investigations because the child is well.

STAGE THREE

At this point the paediatrician is under serious pressure to admit and reinvestigate the child on the grounds of vague maternal complaints, exposing the child to interruption of normal routine and schooling, painful tests, and possible risks from radiography etc. The threat is always present somewhere in the paediatrician's mind that he or she might be 'shown up' by missing a rare illness, or, that greater humiliation, an opinion will be sought from another colleague who will reveal this unusual condition. We suggest that if this aspect of medical thinking is recognised and if the possibility that the sickness might be present in the form of factitious illness has been entertained, then the paediatrician should give careful consideration to the parents' health care seeking behaviour in the dimensions outlined previously: their ability to distinguish their child's needs from theirs, and their level of concern compared with 'objective' professional appraisal. When thinking about the psychological make-up of parents reaches this level of complexity, it is suggested that the most fruitful investigation to undertake is a consultation with a child psychiatric colleague. If conversation with these colleagues suggests an assessment by the child psychiatrist should be made, this recommendation is made to the parents by the paediatrician.

The most important determinant of whether or not the parents will accept this is the conviction the paediatrician has that the consultation will be helpful. A mother who senses that the paediatrician has listened to her carefully and has her child's welfare at heart seems able to accept his assurance that referral to a child psychiatrist, which she might not particularly welcome, can be helpful. The paediatrician must convey with confidence that he is not trying to dispose of a problem, and that psychiatry is neither unnecessarily stigmatising nor unhelpful.

The role of the child psychiatrist

The training of child psychiatrists involves acquiring a combination of skills that are relevant to this situation. Initially their training is with the adult psychiatrically sick and only subsequently with children. Earlier generic medical training (often, also as junior paediatricians) equips child psychiatrists to understand and have a physician's view of organic sickness in children and adults. Subsequent postgraduate clinical work in child psychiatry involves constant assessment of interactions between parents and children, so that a vocabulary to describe relationships is readily available. As a result, the child psychiatrist can make a contribution as follows:

(1) In assessing the degree of psychological disturbance suffered by the child and forming a view of the aetiology of this and planning management.

(2) Examining the parent(s) and assessing their mental well being, personality functioning and current relationships, stresses, and supports.

(3) Examining current interactions between parents and child (and other family members where possible) and giving consideration to the likelihood of this family responding to intervention.

These assessments will be made through routine child psychiatric history taking, which involves systematic examination of the child's history, development, and family background. This includes re-examining the parent's own history in some detail with careful attention to issues (such as parental illness and illness behaviour, psychiatric illness including depression, a history of physical and sexual abuse, child rearing and relationship difficulties) that may be highly relevant to the aetiology of factitious illness. In addition, if not established earlier, the viewpoints of independent sources,

such as the child's school, health visitor, and other parents and grandparents will be looked for.[11]

In summary then, the child psychiatrist presents an understanding of the child's symptoms in the context of his predicament.[12] Both the history of parent and child, the way in which it is given, and the relationships seen in the interview, will enable the child psychiatrist to present a view of the issues relating to the child's symptoms, and a view of factors affecting parental health care seeking behaviour.

Further management

On meeting after the child psychiatric assessment, paediatricians and child psychiatrists may agree the child is at serious risk of preventable physical or emotional harm where a parent is damaging the child's health through procuring sickness, or endangering it through repeated hospitalisation, investigations, and time away from normal life. The local authority may need to be consulted with a view to calling a case conference. Consulting Professor Meadow's outline of management is useful.[13]

In these very serious cases, any legal action is taken against a background of assessment of a broad range of physical and emotional capacities in child and parents. If subsequent events result in permanent separation of parent and child, professionals may have later involvement with the child if (as often occurs), he or she has had a mixture of mild physical illness with factitious illness, or because of psychological illness resulting from the emotionally abusive environment.

We have experience of several other outcomes. In the most optimistic cases the psychiatric assessment enables the mother to feel accepted and her predicament understood, perhaps in a more profound way than has happened before. If such trust develops, any necessary psychiatric treatment for parent and child may be possible using individual and family treatment approaches that will not be detailed here.[10 14] A psychiatric social worker, play or other individual therapist may have a role. Physical complaints rarely disappear however, and close monitoring of health care seeking with regular physical examination and reassurance is necessary. The child psychiatrist's medical qualification is helpful here in allowing regular limited examination at the psychiatric appointments as well as containing anxiety between paediatric visits.

In these cases, flurries of new physical symptoms are often related to new life stresses and the family may start to recognise and acknowledge this. The pattern is described to the family and accepted by both paediatrician and psychiatrist; it is not criticised or rejected; improvement does not depend on the mother achieving insight. The general practitioner needs to understand the pattern and hold the mother's anxiety by encouraging her to phone for reassurance and not to seek new referrals. A period of several months or years of continued paediatric and psychiatric attendance (without unnecessary investigations and admissions) is usually required and continued intermittent surveillance may prevent further episodes. Junior staff need careful supervision to prevent their interrupting the treatment process with an unnecessary admission, perhaps after a call from a locum or deputising doctor who does not know the family, but not all such crises can be prevented.

In other cases, the psychiatric assessment is permitted and some greater understanding of aetiology and current dynamics is gained, but the mother cannot be engaged in treatment either on behalf of her child or herself. Sometimes she will continue to attend the paediatrician and through liaison meetings the psychiatrist may continue to have a role in ensuring and promoting the child's emotional development. Collaboration with other professionals and careful containment of new consultations is necessary, as above.

A further outcome occurs when parents depart from attendance at paediatric and psychiatric clinics simultaneously and restart the process of consultation for factitious illness through their family doctor with a new set of specialist appointments. Pointing out the pattern to the newly recruited professionals is usually fruitless, unless they have some experience of factitious illness and understanding of the dynamics of parental health care seeking and consultation behaviour.

Further work may involve setting up good communication with general practitioners, health visitors, and community services where attendance at hospital appointments is sporadic but where the risk of a new bout of seeking specialist opinions remains. The general practitioner serves as an excellent gatekeeper but may need support; health visitor and community services monitor the child's school attendance and normal physical development. A number of children have mild chronic illnesses (constipation, an occasional urinary tract infection, mild asthma) that can become the kernel of a new bout of factitious symptoms unless viewed objectively in terms of severity.

Characteristics of mothers

The mothers we have engaged in psychiatric treatment, themselves only a small percentage of those who are seen by the child psychiatrist, are a disturbed group of women in terms of parenting abilities (in the broadest sense), personality functioning, and ability to form relationships. All have had early experience that was abusive at an emotional or physical level, although on occasion this is suggested rather than actively acknowledged. Although these mothers' capacity to cope with current difficulties without presenting their child for paediatric care can be supported, their own concurrent psychiatric difficulties treated, their child helped to independence of maternal symptom production, and they themselves helped to find ways in which some personality maturation may take place, they remain highly vulnerable to using this method of meeting their own needs.[2 3] Even so, we believe strenuous efforts to engage these families in treatment are worthwhile in terms of the quality of life for the children, even

before considering the savings in unnecessary hospital stays and investigations.

The children who stay within families where factitious illness is common have not been studied extensively. Retrospective studies of adults with abnormal illness behaviour would suggest that this may be one of the outcomes.[15] The extent to which it is proper to generalise from less unusual health care seeking parents (for example parents with psychosomatic illness or anxiety) to examine the results for families with greater parental health care seeking behaviour and less ability to distinguish their child's needs is unknown.

Conclusion

We have presented a model of collaborative working in assessment and treatment of parents and children where factitious illness is considered a likely part of the differential diagnosis. We would emphasise that a known ordinary physical illness explaining *part* of the symptoms is common, and this only increases the need for collaboration because of the complexities. A two dimensional spectrum categorising parental behaviour is advanced, which requires validation clinically. Collaborative research between child psychiatrists and paediatricians will elucidate this area further. The strength of the collaboration rests on the understanding, achieved jointly, of the child's physical and emotional state, the parental capacities and their predicaments. This is in contrast to a sequential model in which referral to the child psychiatrist follows exclusion of a physical cause for symptoms and is usually a transfer of care. (Of course this sequential model may also be appropriate in straight forward cases of hysteria, or psychiatric illness presenting with physical symptoms—for example anorexia nervosa, depression presenting with abdominal pain.) It is generally accepted with recurrent symptoms in children that the dialectic of physical versus psychological be rejected in favour of more complex categorisations.[16] The pattern of paediatric and child psychiatric cooperation we have evolved to meet the extreme challenge of factitious illness in children offers a paradigm of paediatric–child psychiatric cooperation adaptable for a much larger area of paediatric practice.

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