



THE UNIVERSITY *of* EDINBURGH

Edinburgh Research Explorer

## **Fabricated or induced illness in children: A rare form of child abuse?**

### **Citation for published version:**

Lazenbatt, A & Taylor, J 2011, *Fabricated or induced illness in children: A rare form of child abuse?* NSPCC.

### **Link:**

[Link to publication record in Edinburgh Research Explorer](#)

### **Document Version:**

Publisher's PDF, also known as Version of record

### **Publisher Rights Statement:**

©Lazenbatt, A., & Taylor, J. (2011). *Fabricated or induced illness in children: A rare form of child abuse?*. NSPCC.

### **General rights**

Copyright for the publications made accessible via the Edinburgh Research Explorer is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

### **Take down policy**

The University of Edinburgh has made every reasonable effort to ensure that Edinburgh Research Explorer content complies with UK legislation. If you believe that the public display of this file breaches copyright please contact [openaccess@ed.ac.uk](mailto:openaccess@ed.ac.uk) providing details, and we will remove access to the work immediately and investigate your claim.



## **Fabricated or induced illness in children: a rare form of child abuse?**

Anne Lazenbatt and Julie Taylor

**July 2011**

### **Introduction**

Although child maltreatment due to abuse or neglect is pervasive within our society, less is known about fabricated or induced illness by carers (FII) which is considered to be a rare form of child abuse.

The term FII was introduced in the UK by the Royal College of Paediatrics and Child Health (RCPCH) in 2001 and subsequently adopted by the Department of Health. The terminology is useful in helping to describe and respond to various types of abuse which involve a child being presented for medical attention with symptoms or signs which have been fabricated or induced by the child's carer.

FII occurs when a caregiver (93% of cases, the mother (Schreier, 2004)) misrepresents the child as ill either by fabricating, or much more rarely, producing symptoms and then presenting the child for medical care, disclaiming knowledge of the cause of the problem. Usually this is with the purpose of obtaining an emotional or psychological benefit (Rosenberg, 1987; 2003; Schreier and Libow, 1993). Feldman and colleagues (1997) argue that it is a much wider phenomenon than just "a form of child abuse taking place in a medical setting." Manifestations of FII can be seen in schools, churches, the legal system, child protection agencies, the home, and the community at large. Likewise, physical symptoms are only a part of the

# Research briefing

spectrum of FII, as psychological and mental health symptoms also can be exaggerated, fabricated, or induced.

FII is perpetrated by all social classes, and is not associated with other types of family violence or crime. Nor is it associated with young inexperienced parents or socioeconomic deprivation. Although FII is uncommon, it has high morbidity, and is often not recognised until the child has suffered a great deal, both physically and emotionally. In a recent interview Danya Glaser (a highly renowned child and adolescent psychiatrist) suggested that FII probably occurs more frequently than many would expect, but the variety of presentations makes diagnosis difficult (Griffiths, 2010). Whilst the primary responsibility rests with the abusive carer, health professionals play an integral part in FII's evolution and in the iatrogenic harm caused to the child.

## Key findings

- FII is a form of child abuse with boys and girls equally affected.
- It is perpetrated by those who have care of the child (usually the mother) and usually involves secondary medical services (it may first be manifested, although may be undetected, in primary care settings). Consequently it may be detected first by GPs.
- FII is seen in children of all ages. The reported severe or most dramatic events are usually seen in children under the age of 5 years (newborns in particular are the most likely to be harmed). However, there is a spectrum of significant FII across age groups. Older children may actively collude in the sick role with their parent.

# Research briefing

- Although relatively rare this should not undermine or minimise its serious nature or the need for practitioners to be able to identify when parents or carers are fabricating or inducing illness in children.
- FII is a spectrum of disorders rather than a single entity. At one end less extreme behaviours include a genuine belief that the child is ill. At the other the behaviour of carers includes them deliberately inducing symptoms by administering drugs, intentional suffocation, overdosing, tampering with medical equipment, and falsifying test results and observational charts.
- Recognition of fabricated or induced illness depends, in the first instance, on medical or paediatric clarification of the objective state of the child's health, followed by detailed and painstaking enquiry involving the collection of information from many different sources and discussion with different agencies, for example, social services, general practice, health visitors, schools, and when clearer indications of FII, the police.
- Affected children also live in a fabricated sick role and may eventually go on to somatise or simulate illness themselves and be diagnosed with hypochondria.
- Illness induction can cause death, disability and physical illness. Both induction and fabrication can lead to emotional problems. There are significant risks of re-abuse. Following identification of FII in a child, the way in which the case is managed has a major impact on the developmental outcomes for the child.

## Background

Whilst FII is a recognised form of child maltreatment with the UK Government producing guidance on *Safeguarding Children in whom Illness is Fabricated or Induced* (DH, 2002; HM Government, 2009), it is a form of abuse that has been subject to debate regarding its prevalence and indeed its very existence. The guidance does however, highlight that the task for key professionals is to distinguish between the over anxious carer who may be responding in a reasonable way to a very sick child and those who exhibit abnormal behaviour. Potential for confusion exists because the behaviour results in fabricated or induced illness in the child, but may be associated with various types of disorder in the abuser.

The Department of Health (2002) uses 'fabrication or induction of illness in children', although 'Munchausen syndrome by proxy' (MSbP) is still widely used in other countries. In the USA, DSM-IV recognises 'factitious disorder by proxy' (American Psychiatric Association, 1994). More recently the term *Medical Child Abuse* has been used in a book published by the American Pediatric Association (Roesler and Jenny, 2009), suggesting MSbP should be retired for good.

The growing body of literature on FII reflects the lack of clarity amongst professionals as to what constitutes FII, the difficulties involved in diagnosis, and the lack of research into psychotherapeutic intervention with perpetrators (Meadow, 1985; Rosenberg, 1987; Parnell and Day, 1998; Schreier, 1997, 2000). This lack of clarity further complicates the identification, management and treatment of children suffering from FII and may result in many cases going undetected, with potentially life threatening consequences for children. Despite the controversies and complexities, the RCPCH has acknowledged how much we have learned over the last 10 years about the spectrum of FII and has issued updated guidance to encourage earlier identification by paediatricians and other health professionals (RCPCH, 2009).

The RCPCH helpfully offer five examples across the spectrum of FII:

1. Simple anxiety or over-interpretation of trivial symptoms.
2. Child's symptoms are misperceived, perpetuated or reinforced.
3. Carer actively promotes sick role by exaggeration, fabrication or falsification.
4. Carer suffers from psychiatric illness.
5. Child has a genuine and unrecognised medical problem.

The extremes are useful to note and should be borne in mind throughout.

## Prevalence

A hierarchy of evidence now exists, which ranges from detailed accounts by victims to the confessions of perpetrators and published case series (Davis, 2009). Epidemiological studies used to demonstrate prevalence rates are fraught with methodological difficulties. Current estimates suggest that more than 700 cases of FII in 52 countries have been reported (Siegel and Fischer, 2001), but this is likely to be a substantial underestimate of the true prevalence of the disorder (Schreier, 2004). A decade ago, McClure *et al* (1996) reported that the combined annual incidence of FII, non-accidental poisoning and non-accidental suffocation in the UK and Ireland in children under-16 years of age was 0.5 per 100,000. Sapolsky (1999) found that for children less than a year-old there were at least 2.8 cases per 100,000 children per year. It is likely that this is an underestimate as not all cases are detected, especially those that involve false accounts of symptoms or fabricated symptoms (such as reporting episodes of apnoea or tampering with a child's specimens at home). The largest case series includes 451 cases from many different countries (Sheridan, 2003).

# Research briefing

The increased risk of unexplained death in siblings of children identified as having FII (Sheridan, 2003) shows that the syndrome may be under-detected and current methods for identifying it are underdeveloped (Rogers, 2004). A study on the attribution of cause of death in a hospital setting concluded that systems are just 'not in place to collect information relevant to furthering our understanding of the relationship between child death and child maltreatment' (May-Chahal et al., 2004). The British Paediatric Surveillance Unit (BPSU) epidemiological study in UK in the early 1990s included new cases which had been confirmed at least at the level of a Child Protection Case Conference. Most had also been confirmed in Family Courts. There were 97 new cases of FII in two years which means that a large teaching hospital will only see one or two new cases per year and the average paediatrician will only manage one or two cases in their entire career.

However, it has been suggested that there is a national under reporting of fabricated or induced illness (Schreier, 2004). In practice these cases are encountered more frequently due to the chronic nature of the presentations, the large number of professionals who may be involved and the broad spectrum including milder cases which may not all require a formal child protection response (Davis, 2009). Watson et al (quoted in Eminson, 2000) asked professionals in one health district to identify cases in the previous two years where excessive health care had caused them to have concerns of significant harm to a child. They found a prevalence rate of 89 per 100,000 children over two years, almost three quarters of whom had not been identified as being 'at risk'. This indicates that the prevalence of FII concerns in children is substantial, although many cases do not immediately enter the child protection arena.

## Mothers who harm their children by FII

There is a paucity of systematic research regarding what motivates mothers to harm their children by means of illness falsification (Siegel and Fisher, 2001). The issue of motive has, in the past, been a major cause of debate among workers in this field. Now, though, it is recognised to be of importance primarily at the later point of planning intervention and assessing future risk, rather than as a means of recognising FII.

Meadow's (1977; 1982) original contention was that the mothers carried out this behaviour to draw attention to their own needs. Some later examples have been noted where mothers have fabricated illness in order to claim welfare benefits (RCPCH 2009). Schreier and Libow (1994) have suggested that the mothers form disturbed relationships with healthcare professionals that replicate disturbed past relationships with carers. Although there is no clear relationship between any specific mental disorder and abusive behaviour towards children (Adshead *et al*, 2004), it is common to see mothers who fabricate illness with somatising and 'borderline' personality disorders, as well as symptoms of anxiety and depression.

Some case series have revealed that many of these mothers themselves experienced childhood abuse (Gray and Bentovim, 1996; Adshead and Bluglass, 2005), had a previous history of self harming, drug or alcohol abuse, or had experienced the death of another child (Bools *et al.*, 1994; Bools, 1996). Adshead and Bluglass (2005) have examined attachment models in mothers who had fabricated or induced illness in their children and found high levels of insecure attachment and unresolved bereavement, compared with established norms. Gray and Bentovim (1996) go on to suggest that finding unresolved bereavement reactions in these mothers might sensitise them to see dependent others as more ill than they really are, or to dread that a potentially fatal illness may be missed. Later disturbed relationships with a child may begin in the womb, as is evidenced by the high rates of

reported antenatal and obstetric complications in women who carry out this behaviour (Jureidini, 1993). Although mainly mothers, fathers are also known to abuse in this way, and there are cases where the couple have colluded jointly (RCPCH, 2009).

## Risks to the child

It is also important to be clear that some parental behaviours connected with illness in children do not constitute FII. International research findings suggest that up to 10% of children in whom illness is induced die and about 50% experience long-term consequent morbidity (HM Government, 2009). In the UK, McClure et al (1996) found that 8 out of 128 (6%) children died as a direct result of illness induction. Many of the children who do not die suffer significant long-term consequences including long-term impairment of their physical, psychological and emotional development (DoH et al 2002; DoH, 2000). Bools *et al.* (1993) found a range of emotional and behavioural disorders, and school-related problems including difficulties in attention and concentration and non-attendance. There has been little research undertaken on the longer-term outcomes for children exposed to FII.

Although the induction of illness usually carries a greater risk of causing serious physical harm to the child, children can also suffer harm as a result of repeated inappropriate investigations, such as lumbar punctures, which are administered as a result of false accounts of symptoms or fabricated symptoms. One of the most problematic aspects of this behaviour is that general practitioners, emergency department staff, paediatricians and any doctors working with children (for example, surgeons, CAMHS) may be unwittingly involved in causing potentially dangerous iatrogenic complications (Eminson and Postlethwaite, 2000). It is important to recognise the emotional harm felt by professionals when they find that they may have contributed (in all good faith) to the abuse (Horwath and Tidbury, 2009). Furthermore,

affected children may live in a fabricated sick role and eventually go on to simulate illness themselves (Sanders, 1995; Sanders and Bursch, 2002). Three-quarters of index children are affected by other forms of maltreatment, neglect, further fabrications or inappropriate medicating (Bools *et al*, 1992).

## Recognition of fabricated or induced illness in a child

Diagnosis of fabricated disease can be especially difficult, because the reported signs and symptoms cannot be confirmed (when they are being exaggerated or imagined) or may be inconsistent (when they are induced or fabricated). Researchers may differentiate between exaggeration and fabrication or induction of symptoms, but **action taken by the clinician must be determined by the perception of harm or potential harm to the child**. This is the most crucial point and is perhaps one sometimes forgotten in clinical practice. Regardless of the exact nature of the duplicity, health care professionals can be seduced into prescribing diagnostic tests and therapies that are potentially injurious. There are some warning signs which may suggest that a child is being subjected to FIL. Examples are:

- The child has repeated and unexplained illnesses or symptoms.
- The child has unexplained multiple illnesses or symptoms.
- The child's supposed symptoms only occur when the mother is present.
- The mother appears to know a lot about medicine.
- Although the mother stays with the child all the time while he/she is in hospital and attends to him/her well, she may not appear as concerned about the child's well being as the health care professionals who are providing treatment; in contrast she may appear overly concerned.
- The father is not involved in the care of the child, or his involvement is minimal. Note however that fathers are sometimes involved in FIL.

# Research briefing

- The mother talks to the medical team a lot and tries to develop a friendly relationship with them. However, if anything related to her views on what's wrong with the child are challenged she becomes aggressive, confrontational, and may become abusive. The parent is keen for the child to undergo tests which most parents would only agree to if they were absolutely necessary. She will even encourage doctors to perform tests and procedures which may be painful for the child. However, the parent may not agree to the child being admitted for observation or investigation of the reported symptoms.
- Documents or other sources indicate that the mother has changed doctors frequently, and/or has visited different hospitals for her child's treatment.

The NICE guidance on when to suspect child maltreatment (National Collaborating Centre for Women's and Children's Health, 2009) also adds:

- An inexplicably poor response to treatment or medication.
- As soon as old symptoms are resolved, new ones appear.
- Normal daily activities for the child are compromised more than would be expected for a particular medical activity (for example, confinement to a wheelchair).

Further examples can be found in the practice guidance on FII issued by the RCPCH (2009).

**It is important to recognise that children may have genuine significant illnesses or medical conditions in addition to ones that are fabricated and/or induced.**

It is not only health professionals who have a role in the detection of FII. Social workers play an important part and may struggle because they have little knowledge about FII, or when they suspect FII, they may not be able to convince the GP (Griffiths, 2010). Griffiths suggests specific points for social workers to bear in mind:

# Research briefing

- Being honest about suspicions from the start may scare off the parent (making it difficult to gain evidence), attract undue media attention, or worse, can lead to an increase in harmful behaviour in an attempt to be more convincing.
- Consider motivation. For example, the family might be having financial trouble and fabricating or inducing an illness may entitle them to extra welfare benefits.
- Verify the personal histories of family members, as lies may have been told (for example, that one of the parents has a medical background).
- Remember that some parents may be extremely manipulative and convincing. They may be middle class and they will know how to invoke complaints procedures.

Although Griffiths offers cautionary advice, the point for social workers is ultimately the same as for health professionals: it is crucial to do the detective work.

The Royal College of Paediatrics and Child Health, and the Department of Health, both recommend the use of the controversial diagnostic method, covert video surveillance (CVS), **only** if there are concerns about child abuse that cannot be resolved in any other way (Foreman and Farsides, 1993). There are stringent protocols for implementing such surveillance. For example, it must be police-led and instigated with permission of the Trust's Chief Executive. The use of CVS is governed by the Regulation of Investigatory Powers Act (Home Office, 2010). Doctors or other professionals should not independently carry out covert video surveillance. If the suspicion of child abuse is high enough to consider the use of such a technique, the threshold must have been passed to involve the police and Social Services.

Primary care sees families where FII is diagnosed and they have a history of frequent presentations to the GP, and often extensive involvement of Health Visitors (Davis,

2009). Children in this group may present with premature birth or have a past history of both genuine and perceived feeding difficulties, faltering growth and reported allergies (Bools et al, 1992). Psychological care and social support for the whole family may also be necessary. Early communication will lessen the extent of iatrogenic harm and speed up the diagnosis of abuse in these cases.

For healthcare professionals there still remains confusion about who should make the diagnosis of FII: a psychiatrist or paediatrician? Is it a diagnosis applied to the parent or the child? Is it a paediatric or a mental health diagnosis? These ambiguities become especially important when medical personnel present their diagnosis to other professionals or to juries in seeking to protect a child victim. To remove confusion, the American Professional Society on the Abuse of Children has made a more explicit distinction between the abuse [*paediatric falsification*] and the presumed motive behind most such cases [*factitious disorder by proxy*] (Schreier, 2002). Regardless, it is important to remember that harm incurred when a caregiver exaggerates, fabricates, or induces symptoms of a medical condition may still simply be termed “child abuse, which happens to occur in a medical setting.” The focus of any intervention should always be to identify and minimise harm to the child regardless of the motivation of the perpetrator.

Despite official guidance (HM Government, 2010; RCPCH, 2009; National Collaborating Centre for Women’s and Children’s Health, 2009), there has not been any systematic evaluation as to adherence in practice or effectiveness in assisting with detection, management or treatment.

## Management

The management of diagnosed FII is just as complex and is done on a case-by-case basis. Whatever is in the best interests of the child (and any siblings) is paramount

# Research briefing

and takes precedence over criminal prosecution of the carer. For instance, psychological care and social support for the whole family might be all that is necessary.

The management of FII is more challenging than simply recognising the possibility that a parent has fabricated or induced an illness in the child. As soon as suspected, a complete record of the medical history of the family should be undertaken, including detailed health chronologies of all children in the family. Whilst possibly tedious, this can be the most telling piece of evidence (Bütz et al, 2009). Records and photographs of all symptoms and physical signs should be kept for evidence in court. Professionals have a very difficult task balancing confidentiality and raising concerns and questions when there is uncertainty. Maintaining a balance between the child's and family's needs versus the risks of harm is difficult and uncomfortable. Health professionals have to clarify reported medical problems, checking with any other medical professionals involved and balance their questions about whether further investigations are needed to avoid missing a genuine health problem versus continuing to do unnecessary things to a child. Once sufficient evidence has been collected, the parent should be confronted, although many will deny it.

Government guidelines (HM Government, 2008) state that where a criminal offence might have been committed against a child, the police should be involved at the earliest opportunity. The guidelines also note that, "there is sometimes a reluctance on the part of doctors to involve the police, but it must be remembered that all professionals should be working towards the same goal i.e., securing the safety of the child". Multi-agency collaboration and communication is crucial in diagnosis and management of any form of child maltreatment, including FII. Social Services have lead responsibility for investigating safeguarding issues in children. Health and social care professionals should comply with all reasonable requests for assistance and should seek to work in close partnership. This is especially important in suspected FII cases because of the uniquely medical nature of the concerns.

Although professionals may worry about confidentiality, it is legitimate for the GP and other health professionals to disclose information about the parent if it is in the child's interests, but this should be limited to that information which is relevant and proportionate. The General Medical Council (2009; 2011) have issued guidance on confidentiality. It is also important that the GP does not assume the role of advocate for the carer, as it is the welfare of the child that is paramount.

When FII is recognised in a child, this leads to child protection procedures in order to determine whether the abusing parent should continue to care for the child and this may include care proceedings. In most cases, the protection plan or the courts will place the child in the care of the non-abusing parent (if separated), grandparents or the local authority. Abusing parents may or may not have contact or access, depending on individual circumstances (Bass and Ahead, 2007). Reunification is not usually an option for parents who continue to deny FII (Bütz et al, 2009) and recidivism is common. Children's services and GPs should monitor siblings for signs of FII. The child who has been subject to FII will need an integrated plan of therapeutic intervention.

## Treatment

Most FII cases meet criteria for involvement of a child and adolescent mental health service (CAMHS) service. The extent of their involvement will depend on the individual case, what resources are available locally and whether the child and carer are still together. Again it is important for the CAMHS psychiatrist to be well informed about the paediatric evidence. CAMHS will likely take the lead in offering therapeutic interventions.

Elements of therapeutic interventions include:

1. Protection of the child from further illness fabrication or induction.
2. A truthful narrative for the child and the siblings about what has been going on, without undue denigration of the parents.
3. Helping the child to resume normal life and activities and adjusting to a view of themselves as healthy or less ill (many of the children also have a genuine illness).

The parent too can benefit from therapeutic intervention, which will focus on assessing the parents' capacity to accept the child as well or less ill and recognising/acknowledging the parents' action in misreporting the child's health (whether due to anxiety, misconstruing minor symptoms in the child or for other reasons).

## Implications for practice

FII is a child protection issue and cannot be treated by the NHS alone. Medical professionals who suspect FII is taking place should liaise with social services and the police. Clinicians and professionals who specialise in caring for children are little equipped to diagnose the psychiatric state of the child's caregiver. Determining if and how a child has been abused should be their first concern; others can then focus on the motivation of the perpetrator. Cases of FII can range from moderate to severe. Previous case reports have uncovered evidence of:

- Mothers lying about their child's symptoms (for example, 'he keeps having fits', 'she suddenly stops breathing') or exaggerating symptoms, causing professionals to undertake unnecessary investigations and treatments which may be invasive and may cause secondary physical problems.

# Research briefing

- Mothers deliberately contaminating or manipulating clinical tests, such as adding blood to urine samples or heating thermometers to suggest the presence of fever.
- Poisoning their child with unsuitable medicine.
- Infecting their child's wounds with dirt or faeces
- Inducing unconsciousness by suffocating their child.
- Claiming a psychological illness in a child.
- Forcing caustic ingestion, for example making the child drink bleach (Postethwaite, 2010; Chin et al, 2009).

**Case example:** Baskin et al (2003) reported the case of a five month old infant who first visited the emergency department with 'swollen eyes'. She was diagnosed with bilateral viral conjunctivitis. The next day and on four more occasions she attended, each time with a worsening temperature, discharge and swelling to the eyes, and latterly ulcerations around her mouth and some respiratory distress. She was admitted to hospital and during a three week stay underwent a battery of diagnostic tests, including two endoscopies, skin biopsy, skeletal survey and daily eye examinations. On discharge from hospital all had healed, but she was soon back as an in-patient for more tests with worsening encrustations and scabs. A punch biopsy was performed, and pathology showed that the injuries were consistent with exogenous injury. Upper endoscopy also showed injuries consistent with ingestion of a caustic agent. The mother admitted inflicting the injuries, although never revealed how.

Safeguarding and promoting the welfare of children depends crucially upon effective information sharing, collaboration and understanding between agencies and professionals. These relationships may become strained where there are concerns that illness is being fabricated or induced in a child and there are differences in

opinion about how best to safeguard the child's welfare or indeed if the child is being abused. Multi-agency collaboration and communication is crucial in diagnosis and management of FII. This practice has been explicitly detailed in the government guidelines (HM Government, 2008), which are based on *Working together to safeguard children* (HM Government, 2006). As with all guidelines, they can only be implemented effectively when embraced wholeheartedly by all professionals involved.

## Recommendations for policy

- Whilst FII diagnoses remain relatively rare, complex and can be controversial (Bütz et al, 2009), it can also be objectively diagnosed. Such cases are best managed by individualised approaches that always put the best interests of the child at the forefront.
- It is important to note that communities, parents and professionals remain justifiably nervous of both failures to protect children from abuse and incorrect accusations of child abuse and of unnecessary infringements on the right of children and parents.
- It is the responsibility of health and social care professionals to protect and promote the welfare of children in partnership with parents, with adequate resources and a knowledge base that protects all concerned.
- The NSPCC believes there is clearly a need for better data to make the most vulnerable children more visible.

## Further resources

*Incredibly Caring* (DCSF, 2008) is a multi-disciplinary training pack designed to provide learning opportunities to promote best practice in relation to safeguarding children in whom illness has been fabricated or induced by a carer (FII). The materials comprise training exercises and handouts, PowerPoint presentations, filmed scenarios, a reader and trainer's guide, all presented on an easy-to-navigate DVD.

The Royal College of Paediatrics and Child Health (RCPCH, 2009) guidance provides useful case examples and a practical guide for health professionals.

The NICE guidance on when to suspect child maltreatment (National Collaborating Centre for Women's and Children's Health, 2009) has an extremely helpful section on FII, containing a useful overview of evidence from systematic reviews.

## Acknowledgements

Thanks to our two peer reviewers: Danya Glaser from Great Ormond Street Hospital and Anne Livesey, Consultant community paediatrician from Brighton General Hospital.

## References

Adshead, G. and Bluglass, K. (2005) Attachment representations in mothers with abnormal illness behaviour by proxy. *British Journal of Psychiatry*, 187(4): 328–333.

Adshead, G., Falkov, A. and Gopfert, M. (2004) “Personality disorder in parents: developmental perspectives and intervention”. In: M. Gopfert, J. Webster and M. Seeman (eds.). *Parental psychiatric disorder: distressed parents and their families*. 2nd ed. Cambridge: Cambridge University Press. pp.217–238.

American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders* 4th ed. Washington, D.C.: American Psychiatric Association.

Baskin, D.E., Stein, F., Coats, D.K. and Paysse, E.A. (2003) Recurrent conjunctivitis as a presentation of Munchausen syndrome by proxy. *Ophthalmology*, 110 (8):1582–1584.

Bass, C. and Adshead, G. (2007) Fabrication and induction of illness in children: the psychopathology of abuse. *Advances in Psychiatric Treatment*, 13(3): 169-177.

Bools, C.N. (1996) Factitious illness by proxy: Munchausen syndrome by proxy. *British Journal of Psychiatry*, 169(3): 268-275.

Bools, C.N., Neale, B. A. and Meadow, S. R. (1992) Co-morbidity associated with fabricated illness (Munchausen syndrome by proxy). *Archives of Disease in Childhood*, 67(1): 77-79.

Bools, C.N., Neale, B. A. and Meadow, S. R. (1993) Follow up of victims of fabricated illness (Munchausen syndrome by proxy). *Archives of Disease in Childhood*, 69(6): 625-630.

# Research briefing

Bools, C.N., Neale, B. A. and Meadow, S. R. (1994) Munchausen syndrome by proxy: a study of psychopathology. *Child Abuse and Neglect*. 18(9): 773-788.

British Paediatric Surveillance Unit (BPSU) (2008) [BPSU 22<sup>nd</sup> annual report 2007-2008](#), London: Royal College of Paediatrics and Child Health (RCPCH).

Bütz, M.R., Evans, F. and Webber-Dereszynski, R. (2009) A practitioner's complaint and proposed direction: Munchausen syndrome by proxy, factitious disorder by proxy, and fabricated and/or induced illness in children. *Professional Psychology: Research and Practice*, 40(1): 31-38.

Chin, O., Ferrant, C., Dupont, A. and Papin, C. (2009) Recurrent caustic esophagitis: a clinical form of Munchausen syndrome by proxy. *Child Abuse and Neglect* 33(5): 293–295.

Davis, P. (2009) Fabricated or induced illness in children: the paediatrician's role. *Paediatrics and Child Health*, 19(11): 498-508.

Department for Children, Schools and Families (DCSF) (2008) *Incredibly caring*. Milton Keynes: Radcliffe Publishing.

Department of Health (2000) [Assessing children in need and their families: practice guidance \(PDF\)](#). London: The Stationery Office.

Department of Health, Home Office, Department for Education and Skills, Welsh Assembly Government (2002) [Safeguarding children in whom illness is fabricated or induced: supplementary guidance to working together to safeguard children](#). London: Department of Health.

# Research briefing

Eminson, M. (2000) "Background." In: M. Eminson and R.J. Postlethwaite. *Munchausen syndrome by proxy abuse: a practical approach*. Oxford: Butterworth Heinemann. pp.17-70.

Eminson, M. D. and Postlethwaite, R. J. (eds.) (2000) *Munchausen syndrome by proxy abuse: a practical approach*. Boston: Butterworth- Heinemann.

Feldman, M., Rosenquist, P. and Bond, J. (1997) Concurrent factitious disorder and factitious disorder by proxy: double jeopardy. *General Hospital Psychiatry*, 19(1): 24–28.

Foreman, D.M. and Farsides, C. (1993) Ethical use of covert videoing techniques in detecting Munchausen syndrome by proxy. *British Medical Journal*, 307(6904):611-3.

Gray, J. and Bentovim, A. (1996) Illness induction syndrome: paper I: a series of 41 children from 37 families identified at the Great Ormond Street Hospital for Children NHS trust. *Child Abuse and Neglect*, 20(8): 655–673.

General Medical Council (2009) [Confidentiality: guidance for doctors](#). London: General Medical Council.

General Medical Council (2011). [Protecting children and young people: the responsibilities of all doctors: draft for consultation](#). London: General Medical Council.

Griffiths, J. (2010) [The social worker role in cases of fabricated illness](#). *Community Care*. 1822: 16-17.

# Research briefing

HM Government (2006) [Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children \(PDF\)](#). London: TSO (The Stationary Office).

HM Government (2008) [Safeguarding children in whom illness is fabricated or induced: supplementary guidance to Working together to safeguard children](#). Nottingham: DCSF Publications.

HM Government (2010) [Working together to safeguard children. a guide to inter-agency working to safeguard and promote the welfare of children](#). Nottingham: DCSF Publications.

Horwath, J. and Tidbury, W. (2009) Training the workforce following a serious case review. *Child Abuse Review*, 18(3): 181-194.

Home Office (2010) [Covert surveillance and property interference: revised code of practice pursuant to section 71 of the Regulation of Investigatory Powers Act 2000](#). London: TSO (The Stationary Office).

Jureidini, J. (1993) Obstetric factitious disorder and Munchausen syndrome by proxy. *Journal of Nervous and Mental Diseases*, 181 (2): 135–137.

McClure, R. J., Davis, P. M., Meadow, S. R. and Sibert, J. R. (1996) Epidemiology of Munchausen syndrome by proxy: non-accidental poisoning and non-accidental suffocation. *Archives of Disease in Childhood*. 75(1): 57-61.

May-Chahal, C. and Cawson, P.. (2004) Measuring child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect. *Child Abuse and Neglect*, 29(9): 969–984.

# Research briefing

Meadow, R. (1977) Munchausen syndrome by proxy: the hinterland of child abuse. *Lancet*, 2(8033): 343-345.

Meadow, R. (1982) Munchausen syndrome by proxy. *Archives of Disease in Childhood*, 57(2): 92-98.

Meadow, R. (1984) Fictitious epilepsy. *Lancet*, 2(8393): 2-28.

Meadow, R. (1985) Management of Munchausen syndrome by proxy. *Archives of Disease in Childhood*, 60(4): 385-393.

Meadow, R. (1997) "Fatal abuse and smothering." In: R. Meadow (ed.) ABC of child abuse. 3rd ed. London: BMJ Publishing Group. pp. 27-29.

National Collaborating Centre for Women's and Children's Health (2009) [When to suspect child maltreatment \(PDF\)](#). London: RCOG Press.

Parnell, T. F. and Day, D. O. (1998). Munchausen by proxy syndrome: misunderstood child abuse. Thousand Oaks, Calif.: Sage Publications.

Postethwaite R.J. (2010) Fabricated or induced illness. *Paediatrics and Child Health*, 20(12): 561-565.

Roesler T. and Jenny C. (2009) Beyond Munchausen syndrome by proxy. Elk Grove Village, Ill.: American Academy of Pediatrics.

Rogers R. (2004) Diagnostic, explanatory, and detection models of Munchausen by proxy: extrapolations from malingering and deception. *Child Abuse Neglect*, 28(2): 225-38.

# Research briefing

Rosenberg, D. (1987) Web of deceit: a literature review of Munchausen syndrome by proxy. *Child Abuse and Neglect*, 11(4): 547-563.

Rosenberg, D. (2003) Munchausen's syndrome by proxy: medical diagnostic criteria. *Child Abuse Neglect*, 27(4): 421–430.

Royal College of Paediatrics and Child Health. (2009) [Fabricated or induced illness by carers \(fii\): a practical guide for paediatricians \(PDF\)](#). London: Royal College of Paediatrics and Child Health (RCPCH).

Sanders, M. and Bursch, B. (2002) Forensic assessment of illness falsification, Munchausen by proxy, and factitious disorder, NOS. *Child Maltreatment*, 7(2): 112-124.

Sapolsky, R.M. (1999) What kind of a mother poisons her child to fake an exotic illness, then enlists an unsuspecting medical system to treat it? *The Sciences*, 39(3): 20–25.

Schreier, H.A. (1997) Factitious presentation of psychiatric disorder: when is it Munchausen by proxy? *Child Psychology and Psychiatry Review*, 2(3): 108–115.

Schreier, H.A. (2000) Munchausen by proxy defined. *Pediatrics*, 110(5): 985–988.

Schreier, H.A. (2002) On the importance of motivation in Munchausen by proxy: the case of Kathy Bush. *Child Abuse and Neglect* 26(5): 537–549

Schreier, H. (2004). Munchausen by proxy. *Current Problems in Pediatric and Adolescent Health Care*, 34(3): 126–143.

# Research briefing

Schreier, H. A. and Libow, J. A. (1993). Hurting for love: Munchausen by proxy syndrome. New York: Guildford Press.

Schreier H.A. and Libow, J.A. (1994) Munchausen syndrome by proxy: diagnosis and prevalence. *American Journal of Orthopsychiatry*, 63(2): 318-321.

Sheridan, M. (2003) The deceit continues: an updated literature review of Munchausen syndrome by proxy. *Child Abuse Neglect*, 27(4): 431-51.

Siegel, P.T, Fischer, H. (2001) Munchausen by proxy syndrome: barriers to detection, confirmation, and intervention. *Children's Services: Social Policy, Research, and Practice*, 4(1): 31–50.

Watson, S., Eminson, D.M. and Coupe, W. (1999) quoted in: M. Eminson (2000) "Background." In: M. Eminson and R.J. Postlethwaite. Munchausen syndrome by proxy abuse: a practical approach. Oxford: Butterworth Heinemann. pp.31-32.