Munchausen Syndrome by Proxy (MSBP): An Intergenerational Perspective

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Mental health counselors have a long history of working with abused children. However, only recently have they encountered a new form of child abuse, Munchausen syndrome by proxy. Munchausen syndrome by proxy is a factitious disorder in which the caretaker may induce or exaggerate a medical illness in his or her child; this may lead to illness and even death. Interestingly, there is relatively little information known about the caregivers in such cases. It is vital that mental health counselors become more aware of this form of abuse because of the difficulty detecting it and because of the potential for harm, including death to the child-victim. This article presents new information about Munchausen syndrome by proxy by providing a psychosocial history of the caregiver using an intergenerational model. It also presents a case of Munchausen syndrome by proxy involving three siblings and information regarding the management of these difficult cases.

Although mental health counselors, social workers, psychologists, and other health care professionals have been working with abused children for decades, a new variation, which is by its very nature difficult to detect, is being found with increasing frequency in health care settings. It is essential for mental health counselors to be aware of this new syndrome to protect these children. Munchausen syndrome by proxy (MSBP) was first described by Meadow (1977) as a syndrome whereby a caregiver fabricates information about his or her child's symptoms or illnesses or actively induces an illness in his or her child. Masterson, Dunworth, and Williams (1988) define MSBP

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as "a factitious disorder in which a parent creates the semblance of illness or induces illness in a child who is then presented for evaluation and treatment" (p. 188). For example, caretakers in families with MSBP have been found to poison, suffocate, paint the skin, and alter urine samples of their children to induce or simulate illness. These children are often exposed to unnecessary invasive medical procedures and prolonged, needless hospitalizations, which could be avoided if the appropriate diagnosis of MSBP was made. In fact, Rosenberg (1987) states that approximately 9% of children with MSBP die due to the disorder and many more have long-term disfigurement or impairment. Rosenberg also reports that in 25% of the MSBP cases, the short-term pain or illness was caused solely by unnecessary medical interventions or procedures. Finally, there is relatively little known about MSBP as compared to other psychiatric syndromes or disorders; especially when one considers the death rate in MSBP and the frequency of disfigurement and impairment.

It is important to differentiate MSBP from the more well-known Munchausen syndrome. Munchausen syndrome "refers to adult patients who travel from hospital to hospital fabricating stories of ill health and demanding and subjecting themselves to needless treatments and surgeries" (Stone, 1989, p. 243). Stern (1980) states that a person with Munchausen syndrome demonstrates factitious behavior as a way of obtaining drugs, getting free room and board, or because of a grudge against physicians and hospitals. In contrast, in MSBP the child is a victim of the caretaker's aberrant behavior.

This article is designed to help mental health counselors, especially those working in health care settings, to increase their knowledge of MSBP and to enhance their ability to correctly identify and manage families with this syndrome. Early detection can reduce the risks of serious harm and death, as well as needless hospitalizations and invasive medical procedures.

Following a brief review of the characteristics of MSBP, an illustrative psychosocial history of a caretaker is presented. It is believed that MSBP exists in all three children of this caretaker. This article provides an intergenerational approach to the understanding of the dynamics of MSBP. MSBP appears to be a variation of child abuse transmitted from one generation to the next. This approach has implications for the management of cases of MSBP by health care professionals and mental health counselors.

The case presented here is complicated by the fact that the children involved may have had some real medical problems. As is often the case, it is difficult to discern real symptoms from those induced or exaggerated by the caretaker.

COMMON FEATURES OF MSBP

Rosenberg (1987) reports that only 117 cases of MSBP were reported in the literature from 1966 to 1987. Some of these cases have involved seizures produced through poisoning with phenothiazines, central nervous system depression through the needless administration of drugs (e.g., insulin, barbiturates, aspirin), apnea produced through suffocation or poisoning, and rashes produced by scratching (Rosenberg, 1987). It is estimated that a large number of cases go unrecognized. Table 1 presents an overview of common signs and symptoms of MSBP.

Although there has been an increase of reports of MSBP since Meadow's (1977) report, there are still relatively few cases of MSBP. Kaufman, Curry, Pickrel, and McCleery (1989) indicate that the actual incidence and prevalence of MSBP "would seem impossible to conclude from the existing literature" (p. 142). The lack of incidence and prevalence data is partially due to the difficulty that professionals have in diagnosing this syndrome. Furthermore, little is known about this syndrome (outside of the manifested behaviors) due to the caretaker's unwillingness to acknowledge the problem (Waller, 1983) or to participate in psychotherapeutic treatment (Liebow & Schreier, 1986). Little is known about the caregiver's background because he or she typically denies the problem (Waller, 1983).

Invariably, the perpetrator of MSBP is the mother. In Rosenberg's (1987) review of MSBP it is reported that in all of the 117 cases, the mother was the perpetrator. Paradoxically, these mothers have been described as being especially attentive to their children while hospitalized (Jones et al., 1986), cooperative and pleasant to the medical staff (Meadow, 1977), and they have at times adopted the role of exemplary caregivers (Rosen et al., 1983). Lesnick-Oberstein (1986) implies that this may be a response to having their own emotional needs met through involvement in the pediatric ward.

Reports of MSBP have found other common features (Masterson et al., 1988), such as a symbiotic mother-child relationship (Liebow & Schreier, 1986; Masterson et al., 1988), marital discord (Masterson et al., 1988; Waller, 1983), and physicians' overidentification with caretakers (Schreier, 1992). The caretakers have been thought to have a variety of psychiatric disorders. They have been found to have psychoses (Cramer, Gershberg, & Stern, 1971; Fleisher & Ament, 1977), depression (Watson, Davies, & Hunter, 1979), and hysteria (Meadow, 1977; Ries, 1980). They also have been given diagnoses of borderline personality disorder (Outwater, Lipnick, Luban, Ravenscroft, & Ruley, 1981; Ries, 1980) and narcissistic personality disorder (Rosen et al., 1983). Finally, there are some reports of MSBP occurring in more than one

TABLE 1: Common Features of Munchausen Syndrome by Proxy

Medical signs
1. Recurrent illnesses for which no cause is found
2. Repeated hospitalizations with no positive findings
3. Extensive medical workups with no positive findings
4. Fabrication of symptoms
5. Induced symptoms

Pseudo-prosocial caretaker behaviors
6. Overprotective—doting
7. Develops close relationship with physician and nursing staff
8. Overinvolved—becomes part of the "medical team"
9. Exhibits marked interest in child's illness and treatment

Other caretaker characteristics
10. Symbiotic relationship between caretaker and child
11. Psychopathology in caretaker
12. History of abuse in caretaker
13. Disturbed family functioning (e.g., domestic violence)
14. Hostile response when presented with medical facts
15. Denial of involvement in Munchausen syndrome by proxy (MSBP)
16. Resistant to psychiatric involvement
17. Peregrination (doctor shopping)—seeks care in many different medical facilities
18. May have a history of involvement with some aspect of health care (e.g., medical condition, history of hospitalization(s), health care worker)

NOTE: None of these features, in and of themselves, is pathognomonic of MSBP. However, these features should raise the index of suspicion and give rise to the consideration of this diagnosis.

child in the same family (Meadow, 1982). Unfortunately, most of the reports of MSBP do not provide information about the family-of-origin of the caretaker.

Lesnick-Oberstein (1986) attempted to provide an understanding of the function and psychodynamics of MSBP in hopes that it would stimulate further research in this area. She speculated that MSBP mothers had childhoods characterized by emotional deprivation. Unfortunately, because few MSBP mothers enter or remain in psychotherapy, there is little known about their backgrounds to support or refute this claim (Chan, Salcedo, Atkins, & Ruley, 1986). Supporting the need for further information, Rosenberg (1987) indicates that little is known about what occurred in these mothers' lives to cause them to disassociate from and harm their children in this pathological and distorted manner. Further, the author states that a necessary first step in understanding MSBP is to describe these mothers rather than categorize them. The case presented here provides such descriptive information about the family of origin of a mother displaying MSBP.

CASE STUDY

This family consists of the mother, Maureen (age 23), the father, Larry (age 21), Lisa (3 years, 9 months), Brenda (2 years, 9 months), and Terry (15 months). All three children are female. The following medical history is based on a review of the medical records, interviews with the family physicians, and interviews with the mother. Many, if not all, of the illnesses of these children are believed to be factitious, induced, or exaggerated by the mother. To protect the confidentiality of all family members, all relevant identifying information concerning the family was changed. This is in accordance with the American Psychological Association's ethical principles (American Psychological Association, 1992).

Medical History

For 4 months following her birth, the oldest child, Lisa, reportedly suffered from pyloric stenosis (a narrowing of the valve at the top of the stomach), and, as a result, vomited frequently. She was hospitalized several times for this condition (Table 1, no. 2). When she was 2 years old, she vomited blood for approximately 2 months. A cause was never determined (Table 1, no. 1). She also has had a myringotomy (tubes surgically placed in ears) for ear infections, and urinated blood for approximately 10 days; a cause also was never determined (Table 1, no. 1). Medical reports do not indicate that anyone besides the mother observed the vomiting or urination of blood of Lisa or her siblings. This type of medical history is not atypical in MSBP families. That is, MSBP children will often have extensive medical histories with multiple diagnoses. Often, these diagnoses are tentative or the result of labeling symptoms when no positive test results emerge from extensive medical workups, as is the case with Lisa. Also, medical intervention (e.g., surgery, use of medications) does not necessarily validate the presence of a medical condition. Many MSBP children have a lengthy history of medical intervention with no underlying medical condition.

The middle child, Brenda, also exhibited some of these same medical problems. She vomited blood for approximately 2 months when she was 17 months old. No cause was determined (Table 1, no. 1). She was hospitalized for dehydration due to vomiting and diarrhea (Table 1, no. 1 and possibly no. 4 and no. 5). She sustained a skull fracture, which, according to the mother, happened when she fell out of a shopping cart (Table 1, no. 5). As far as can be determined, no protective service report was filed. Finally, she gained no weight for about 1 year and weighed 20 pounds when she was 2 years and 9 months old.

The youngest child, Terry, had the most severe medical problems. She had approximately 30 hospitalizations in her first 15 months of life in five different hospitals spanning three states (Table 1, no. 2 and no. 3). During all but one of these hospitalizations, her mother stayed with her. During her most recent hospitalization, the suspicion of MSBP emerged when the referring physician informed the hospital of the child's medical history. In turn, the hospital requested that the mother not stay overnight so that the medical basis of Terry's problems could be determined without possible interference from Maureen. Maureen at first resisted the hospital's request that she leave, but did eventually comply. Medical tests did not support the mother's claim that Terry suffered numerous episodes of apnea (cessation of breathing) each night.

At 2 weeks of age, Terry exhibited diarrhea and vomiting, which caused dehydration. A high potassium level was found (Table 1, no. 1 and possibly no. 5). She was diagnosed as having tracheomalacia (softening of the tracheal cartilages) and laryngomalacia (poor muscle tone in the larynx). At 3 months of age, she was reported to have aspirated her formula into her lungs. A nasogastric (NG) tube was inserted for the purpose of feeding her. Also at 3 months of age, she had the first of eight reported surgeries; a feeding tube was placed in her stomach. One week later she had to have emergency surgery due to problems with the NG tube. It is unclear why these problems occurred and no definitive diagnosis or medical problems were found (Table 1, no. 1). She had two surgeries to remove cysts from her throat and two surgeries to remove cysts from her buttocks. Although surgeries for cysts are not unusual, it is important to remember that some degree of judgment by the physician is always involved. In young children, physicians often have to rely heavily on information from parents in making a medical decision. Terry also had surgery to place tubes in her ears for ear infections. Her eighth surgery, at 8 months of age, was to replace a gastric tube (used for feeding), which her mother reported had been pulled out by Terry (Table 1, no. 5). She did not gain weight or grow as would be expected of a child her age. Her mother also reported her as having numerous episodes of apnea each night (Table 1, no. 1 and possibly no. 4 and no. 5). Radiological studies showed possible cerebellar atrophy. However, this is not indicative of apnea. Sleep studies did not support a diagnosis of apnea. She also has had theophylline toxicity (a bronchial muscle relaxant medication often used by asthmatics), which appeared to have been induced (Table 1, no. 5). The mother denied this (Table 1, no. 15).

Psychosocial History

The maternal grandmother of the three children gave birth to Maureen when she was 23 years old. Maureen was uncertain about her father's identity.

However, she believed her father to be one of two men whom she knew. In early childhood the maternal grandmother married. Following this marriage, Maureen observed numerous episodes of domestic violence between her mother and her stepfather, who was an alcoholic. For example, her stepfather hit her mother with a board. In response, her mother stabbed him with a knife in the buttocks. He was arrested and convicted of a crime and was incarcerated. When he was released from prison he told his wife (Maureen's mother) that he had been intimate with a man, and she divorced him. Maureen also reported being physically abused by her stepfather and recalled being chased around the house by him while he was wielding a knife (Table 1, no. 12).

Maureen's mother and stepfather divorced when she was 10 years old. Following this divorce, the grandmother married another man who abused alcohol. When Maureen was 14 or 15, she was violently sexually molested by her new stepfather; he was also physically abusive toward her (Table 1, no. 12). Maureen told her mother about the abuse but the mother did nothing to protect her. Currently, the grandmother is separated from her second husband and is living with another man. Maureen reported not wanting to visit them because she does not trust this new man whom she has not met.

Maureen met her husband, Larry, when she was 18 years old. They were married less than 4 months later. Before they were married, she became pregnant and miscarried. She reported that her husband was the father. One month following the miscarriage, she became pregnant again and in due time gave birth to Lisa.

There is a remarkable amount of domestic violence in this family (Table 1, no. 13). Maureen reported being beaten three to four times a month and having had her hair set on fire. She often fought back and had left Larry several times for refuge in a battered women's shelter. Larry has a history of drug usage. She reported that she currently does not spend much time with him and that she is considering leaving him unless he stops using drugs. Maureen also admitted to drug use before she had her first child, but reportedly has not used any since. Like many battered spouses, Maureen stated that the only reason she stayed with Larry was because she was afraid to be alone. This theme was apparent throughout the interviews with her.

During the diagnostic interviews Maureen presented contradictory information. For example, she reported three different ages for when she last saw her first stepfather. One of these dates was after what would have been the time of his death. When the interviewer subtly queried her about the contradiction, she responded by accusing the interviewer of trying to confuse her.

Periodically during the interviews Maureen became distressed. This was reflected in both her affect (her voice became louder and more tense) and

questions. On one occasion, she demanded to know why these questions were being asked of her. Another time she asked the interviewer if other families are as "weird as hers." When she became distressed, she presented with indications of hypervigilance. That is, she became somewhat guarded and suspicious and seemed concerned about what the examiner was learning about her. She also became upset and hypervigilant when asked to clarify contradictory information.

In summary, many of the features commonly found in MSBP are present in this family's history, including an overly involved mother (Table 1, no. 6 and no. 7), domestic violence (Table 1, no. 13), a caretaker who was abused as a child (Table 1, no. 12), numerous unexplained illnesses (Table 1, no. 1), and indications that the caretaker directly fabricated or caused some of the medical problems (Table 1, no. 4 and no. 5). Other features include peregrination to numerous hospitals (Table 1, no. 17) and denial when confronted with the possibility of causing some of the medical problems (Table 1, no. 15). The lack of additional psychiatric or psychological evaluations on Maureen, her husband, and her children is not uncommon in MSBP given the fact that they often resist psychiatric or psychological involvement (Table 1, no. 16). Overall, the information known about this family indicates that a diagnosis of MSBP is warranted and that all three children may be victims.

DISCUSSION AND IMPLICATIONS

The psychosocial history obtained from the mother is more extensive than is usually available (Rosenberg, 1987) and illustrates some of the dynamics of MSBP. As a child, Maureen experienced profound emotional deprivation and abuse, supporting Lesnick-Oberstein's (1986) hypothesis that mothers with MSBP had their needs for warmth, affection, and attention ignored or neglected. This mother is attempting to fulfill her own unmet needs by projecting these onto her children. In turn, she places her children at risk, thereby enabling her to enter a safe and nurturing environment—the hospital or health care setting. Further, the mother's need for attention and approval is met directly by being involved with the caring and supportive medical staff. Her role as a caring and supportive mother is also affirmed by having a sick child in need of assistance.

The hospital also provides Maureen with a sense of safety that she does not experience at home. Because she knows how to function in a hospital and gives the impression of being concerned about her child (whether genuine or not), it may be the only place where she feels safe, respected, and competent. This dynamic also increases (reinforces) the likelihood that Maureen will

continue to engage in MSBP (if left untreated) and display the peregrination often found in MSBP families.

Maureen's projection of her own needs onto the children also serves as a defense mechanism. This projection, which developed as a response to anxiety (McElroy & McElroy, 1989), allows her to deny having any problems or unmet needs by experiencing gratification vicariously through her children. Simply put, the children, through the use of MSBP, are a means of avoiding her own multiple problems, that is, deteriorating marriage, physical abuse, history of sexual abuse, her impaired relationship with her mother, and her fear of men. Also, clinical data from Maureen and from observing her interactions with Terry suggest that there was also a strong symbiotic relationship between them. For example, she reported writing a book to give her about their life together.

Finally, the question arises as to why Maureen displays this type of abuse, rather than the physical abuse or sexual abuse her caretakers displayed. The most plausible answer is that Maureen meets many of her own needs by exhibiting the behaviors of MSBP, which would likely not be met if she physically or sexually abused her children. By displaying MSBP, Maureen gains nurturance and a sense of personal competence, while avoiding and denying multiple personal and interpersonal problems.

Diagnostic or Management Issues of MSBP

Children of MSBP are difficult to diagnose because they masquerade as medical problems or combine real medical problems with those that have been induced or exaggerated by the caretaker. Often, the exemplary behavior of the mother makes such a diagnosis the most unlikely of possibilities. At times, those health care providers closest to the problem have the most difficulty recognizing and accepting a diagnosis of MSBP. As a result, health care professionals need to have an increased index of suspicion when caretakers present with a child having symptoms described in Table 1.

There is some danger of MSBP being misdiagnosed so that real physical problems go untreated. However, given the limited awareness of this syndrome, there may be a much greater danger in diagnosing and treating a medical condition when the condition has been induced by the caretaker. The severe potential harm of misdiagnosing MSBP as a medical condition, or diagnosing a known medical problem as MSBP, demonstrates the importance of heightening the awareness of mental health counselors, social workers, and psychologists to this syndrome. It also raises some ethical and legal issues. For example, given the consequences of a misdiagnosis of MSBP, how much "proof" is needed to make a diagnosis of MSBP? Related to this

is the issue of what mental health counselors should do when they believe MSBP is present in a family but the family continues to receive treatment from physicians. The converse also poses an ethical dilemma. Mental health counselors may find themselves in a situation where they feel MSBP is not present, but a physician refuses to treat a victim because the physician believes the symptom is faked or induced. Another dilemma is whether or not hidden video cameras should be used to obtain information necessary to make a diagnosis. For example, Epstein, Markowitz, Gallo, Holmes, and Gryboski (1987) present a case where a hidden camera was placed in a child's hospital room for the purpose of assessing whether or not a mother induced diarrhea in her child. Although Epstein et al. acknowledged that a hospital must preserve the privacy of their patients, they also felt that using the above method was acceptable even though it might lead to a lawsuit. Given the potential consequences of the failure to diagnose MSBP, these issues need to be addressed from an ethical and legal standpoint and they highlight the importance of multidisciplinary collaboration.

The assessment process is complicated because the caretaker, on whom professionals rely for much of their information, is often dishonest. This runs counter to the usual presumption that a caretaker will provide accurate data about his or her child's illness. Further, it is often difficult to differentiate between induced (and/or exaggerated) medical problems and naturally occurring medical problems. When MSBP is suspected, siblings should be evaluated because several reports have indicated that siblings may be at increased risk for MSBP (Jones et al., 1986; Rosenberg, 1987). If the child is deemed to be in immediate harm, or if the caretaker seeks to remove the child from the hospital once confronted with the diagnosis, protective custody may need to be taken (if state law permits) and protective services involved.

The complexity of these cases requires a multidisciplinary approach for diagnosing, managing, and treating MSBP. Mental health counselors can play a vital role in the multidisciplinary team in the diagnosis and management of these cases. Aside from providing and coordinating services (e.g., individual therapy, family therapy, medical care, protective services), they can serve as consultants to the physician(s) to help them understand the psychosocial complexities of MSBP.

The most challenging job of mental health counselors is to educate protective service agencies and the courts about MSBP. Often, protective service agencies do not want to become involved in these cases and may indicate that there is not enough proof to warrant their involvement or to bring the case to court. If protective service agencies do get involved, these cases may prove difficult to prosecute because of the caretaker's denial and the often ambiguous medical findings. A concerted effort is needed by mental

health counselors, social workers, and psychologists to educate protective service agencies, and the legal and judicial systems to the existence of this insidious form of child abuse.

In addition to identifying and diagnosing MSBP, mental health counselors may be asked to engage these families in psychotherapy. These families present many challenges because they are highly resistant and deny having the disorder. Issues of dependency, lack of personal competence, denial, avoidance, and resistance often need to be addressed as part of the psychotherapeutic process. It is likely that a combination of family therapy and individual therapy for the caretaker(s) will be necessary. A more precise protocol for therapy cannot be made at this time due to the limited number of reports of successful therapy with these families; more data are needed on cases entering treatment.

Although a precise protocol for therapy cannot be developed at this time, an intergenerational approach for conceptualizing MSBP cases is a useful guide for mental health counselors. The very nature of MSBP includes two generations. This cannot be ignored from a theoretical or treatment perspective. Many of the MSBP caretakers had problematic childhoods, which likely affect their functioning as parents. Specifically, treatment should address issues of what parents received as children from their parents (e.g., nurturance, discipline, emotional support) and how this affects their own child-rearing methods. Their understanding of this, and their willingness to change their behavior, is vital to treatment. Finally, if children with MSBP are more likely to be perpetrators of MSBP as parents, then treatment for these children may be a preventative measure. Unless an intergenerational perspective is used, there may be greater risk that the syndrome will continue to be perpetuated through the generations.

Concerning the management of these cases, it is extremely helpful to differentiate the roles of those involved in reporting and working with protective services from those who will be required to develop a therapeutic alliance with the caretaker and the family. The treating mental health counselor must be seen as an ally of the family and generally should not be involved in the protective service aspect of the case. Therapy is often made impossible because caretakers evade treatment (Liebow & Schreier, 1986). Court-supervised counseling may be required for resistive caretakers. This further highlights the need for the mental health counselor to remain a helping figure in the eyes of the family.

Finally, more reports of the psychosocial histories and psychotherapy with MSBP caretakers are needed so that mental health counselors, as well as health care providers, can begin to understand and treat these families more effectively.

REFERENCES

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*(12), 1597-1611.

Chan, D. A., Salcedo, J. R., Atkins, D. M., & Ruley, E. T. (1986). Munchausen syndrome by proxy: A review and case study. *Journal of Pediatric Psychology, 11*(1), 71-80.

Cramer, B., Gershberg, M. P., & Stern, M. (1971). Munchausen syndrome. *Archives of General Psychiatry, 24*, 573-578.

Epstein, M. A., Markowitz, R. L., Gallo, D. M., Holmes, J. W., & Gryboski, J. D. (1987). Munchausen syndrome by proxy: Considerations in diagnosis and confirmation by video surveillance. *Pediatrics, 80*, 220-224.

Fleisher, D., & Ament, M. I. (1977). Diarrhea, red diapers and child abuse. *Clinical Pediatrics, 17*, 820-824.

Jones, J. G., Butler, H. L., Hamilton, B., Perdue, J., Stern, P., & Woody, R. (1986). Munchausen syndrome by proxy. *Child Abuse and Neglect, 10*, 33-40.

Kaufman, K. L., Curry, D., Pickrel, E., & McCleery, J. (1989). Munchausen syndrome by proxy: A survey of professionals knowledge. *Child Abuse and Neglect, 13*, 141-147.

Lesnick-Oberstein, M. (1986). Letter to the editor. *Child Abuse and Neglect, 10*, 133.

Liebow, J. A., & Schreier, H. A. (1986). Three forms of factitious illness in children: When is it Munchausen syndrome by proxy. *American Journal of Orthopsychiatry, 56*(4), 602-611.

Masterson, J., Dunworth, R., & Williams, N. (1988). Extreme illness exaggeration in pediatric patients: A variant of Munchausen's by proxy. *American Journal of Orthopyschiatry, 58*(2), 188-195.

McElroy, L. P., & McElroy, R. A. (1989). Psychoanalytically oriented psychotherapy with sexually-abused children. *Journal of Mental Health Counseling, 11*(3), 244-258.

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

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

Outwater, K. M., Lipnick, R. N., Luban, N.L.C., Ravenscroft, K., & Ruley, E. J. (1981). Factitious hematuria: Diagnosis by minor blood group typing. *Journal of Pediatrics, 98*, 95-98.

Ries, R. K. (1980). *DSM-III* differential diagnosis of Munchausen syndrome. *Journal of Nervous and Mental Disease, 169*, 629-632.

Rosen, C. L., Frost, J. D., Bricker, T., Tarnow, J. D., Gillette, P. C., & Dunlavy, S. (1983). Two siblings with recurrent cardiorespiratory arrest: Munchausen syndrome by proxy or child abuse? *Pediatrics, 71*, 715-720.

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

Schreier, H. A. (1992). The perversion of mothering: Munchausen syndrome by proxy. *Bulletin of the Menninger Clinic, 56*, 421-437.

Stern, T. A. (1980). Munchausen syndrome validated. *Psychosomatics, 21*(4), 329-336.

Stone, F. B. (1989). Munchausen by proxy syndrome: An unusual form of child abuse. *Social Casework: The Journal of Contemporary Social Work, 70*(4), 243-246.

Waller, D. A. (1983). Obstacles to the treatment of Munchausen by proxy syndrome. *Journal of the American Academy of Child Psychiatry, 22*, 80-85.

Watson, J.B.G., Davies, J. M., & Hunter, J.L.P. (1979). Nonaccidental poisoning in childhood. *Archives of Disease in Childhood, 54*, 143-144.