Lisa Blakemore-Brown says horrifying injustices take place in the name of Munchausen syndrome by proxy, illness induced or fabricated in a child.

False illness in children - or simply false accusations?

A YOUNG MOTHER took her son for one of the routine vaccinations of childhood. That night he developed a dangerously high temperature and soon afterwards started banging his head, soiling and gradually lost all of his language. His behaviour became erratic, he couldn't relate to others and he was difficult to control. Investigations followed, which led to a diagnosis of Asperger's syndrome, a form of autism. Suspecting the vaccination might have been the cause, although nothing could be proven, the mother decided not to have her next three children vaccinated.

As time went on, she kept pestering the social services department for respite care, because she found the eldest boy so difficult to deal with. She came to be seen as a bit of a nuisance. It was suggested, despite the known diagnosis of Asperger's syndrome, that his symptoms might perhaps have been induced by the mother herself. An expert was called in and she was accused of Munchausen syndrome by proxy (MSBP) - deliberately harming her child. Her two youngest children were taken from her into foster care and the youngest was taken from the foster home against the mother's wishes to be vaccinated. Instantly and tragically, the child's behaviour deteriorated in the same way as her eldest brother's had done.

The foster mother had videotapes of the little girl's behaviour before and after the vaccination. Yet the younger children are even now being put up for adoption.

This is just one of many horrifyingly inappropriate instances of 'diagnosis' with MSBP. For what is supposed to be a very rare occurrence of a specific kind of children abuse - and there is no doubting that genuine cases occur - I have now seen details of many cases where children were wrongly taken from their families in the most heartrending of circumstances.

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Where it all started

For a full understanding of what is going on, MSBP needs to be put in context. The term was coined by paediatrician Professor Roy Meadow in 1977 when he described the syndrome in the *Lancet*. Two decades before, physician Dr Richard Asher had introduced, also in the *Lancet*, the term Munchausen syndrome for people who induced dramatic illness in themselves, choosing the name because of the fabled German Baron Munchausen who told tall tales. Professor Meadow suggested the term Munchausen syndrome by proxy to describe the horrifying act of inducing illness in someone else - almost always in a child by the mother. (The purpose, he has suggested, was for the mother to gain attention for herself.[1-5]) He had at that time come across two cases.

He made it very plain that he considered MSBP a form of child abuse, not a psychiatric diagnosis that explained the behaviour. And he stressed that investigations should start with the child, regardless of suspicions. So, if a child presented with pain in the stomach, the gastroenterologist should be called in. If an infant had breathing problems, a neonatologist should assess.

But time has passed and the climate that health and mental health professionals work in has dramatically changed. During the 1980s those at the sharp end - GPs, nurses, health visitors, social workers psychologists, etc - began finding themselves under enormous pressure. The resources were no longer there, and yet they were under pressure to produce results. Parents were better informed and laws were put in place to ensure that they had the right to demand whatever their child needed whilst professionals were told that they could not provide it, as it was too expensive.

Very many professionals worked in a climate of fear. They feared the loss of their jobs if they made recommendations which cost too much, at the same time knowing that it was being made easier for parents to sue them for negligence for not making those recommendations. There was also the stress of knowing that, fundamentally, they were not doing the job they had trained for years to do.

Gradually professionals were being pitted against parents. Increasingly high profile cases of child abuse missed by professionals led to condemnation of many social services departments. Innocent children were openly abused within the families they trusted. It went against the most fundamental need of children - to feel safe within the home. The government demanded better detection of child abuse and the 1989 Children Act shifted the focus from prevention to protection.

Anyone who cared about children could not doubt the importance attached to exposing abuse. Around this time dramatic stories of cases of satanic abuse led to children being snatched at dawn, their parents accused of abusing them, only to be followed by public inquiries, such as the Rochdale Inquiry, in which social workers were severely criticised for a variety of methods which resulted in false accusations of abuse. Some were accused of putting words into children's mouths, for gross misinterpretation of events, for choosing to use information which suited their argument and leaving out information which did not.

... criminal ... MSBP. Whatever the ... problem: a criminal mind, a psychopathic ..., a psychiatric disturbance or a learning difficulty ... the evidence was shocking and went against everything we held sacred. That a mother would intentionally hurt her child, using it to manipulate unwary doctors in order to gain attention for herself and assume the sick role by proxy was at the very least profoundly sick.

Increasingly, and especially after the term was used in association with Beverley Allitt, the hospital nurse who caused the deaths of children in her care (and who herself in fact suffered from Munchausen syndrome), MSBP cases began to emerge. Perhaps it is understandable that attitudes became increasingly punitive. Parents of children hitherto thought to have died of sudden infant death syndrome (SIDS) were at risk of being accused of killing them. In rare cases this may be true, but I believe hysteria has developed and is now affecting the thinking of professionals.

A change of emphasis

Whereas MSBP began from a medical model, where I personally think it should stay, more and more often it is likely to be psychiatrists who are first called in to look at the mother. There appears to be a struggle going on between psychiatry and paediatrics for professional ownership of MSBP. Despite Meadow's insistence that he meant MSBP as a term to describe a kind of child abuse, it is often seen as a suitable psychiatric diagnosis. 'Factitious disorder and factitious disorder by proxy (the American terms for Munchausen syndrome and MSBP) are listed in DSM-IV, the current version of the American Psychiatric Association's guide to the diagnosis of mental disorders, although there are as yet no agreed diagnostic criteria [illegible] by proxy; only research [illegible].

At this point I need to reveal my own background [illegible]. As part of my psychology training in the [illegible] 1970s I worked and did research in prisons for a time. Of course I came across the archetypal psychopaths who lived on the fear of others. I was shocked, however, at how many other men (and women) in prisons had clear learning difficulties and [illegible] disorders.

I wondered how these problems had developed and why they had not been picked up earlier. So, when I qualified I decided to concentrate my attentions on child development, parent-child interactions and the corresponding [illegible] developmental disorders. I am now a specialist in developmental disorders – effectively [illegible] disorder (disorganised behaviour, poor social skills, very difficult behaviour) and [illegible] disorders – with a passion to support early intervention and raise awareness of parenting issues.

The [illegible] disorders include attention deficit disorder (ADD), attention deficit and hyperactive disorder (ADHD), hyperactivity and executive dysfunction. Sufferers act first and think later, don't consider consequences, can't plan or organise, don't [illegible]. There may also be co-existing problems such as [illegible] and conduct disorders. All things which stop sufferers' life chances, frustrate them and make them think of themselves as failures.

I soon realised, however, that offering help was not [illegible]. Even when we knew about [illegible] disorders at a very early age, again policies [illegible] being [illegible] because it cost too much. Of course, later antisocial behaviour soon contributed to the criminal and mental health statistics, and the cost – in psychiatric and prison care. Despite knowing [illegible] more about child development there were fewer and fewer resources to enable early intervention.

Premature babies

Throughout these years, however, we also 'advanced' in that we can now keep very premature infants alive but, alas, we have not properly understood their needs and the consequences of their medical disorders; we have also introduced various [illegible] and significantly increased pollutants in the atmosphere without fully understanding the effects of these on our children's development. This is very important as far as MSBP is concerned.

Many premature babies, for instance, haven't had time for the higher order mental processing areas of the brain to be laid down properly – the frontal cortex. The consequence is a [illegible] risk of attention deficit type disorders and executive dysfunction (inability to plan and organise). Added to this are the medical problems premature babies may have, such as lung problems and brain haemorrhages, which increase risk of minor brain damage and may lead to hyperactivity and social communication problems.

Interestingly we are becoming aware of what I describe as a 'tapestry' of developmental disorders, each person's tapestry being different although they may share threads with others. The concept seems respectful of people and helps us to understand the complex and intertwining threads of genetics and environment.

Such children are difficult to rear and have a vulnerable neurological status. They don't know how to give out the right cues and fail to become sociable. If an infant has these difficulties, then the mother's important non verbal signals, such as facial expressions and smiles, are not responded to or reciprocated by the infant. The mother, in turn, is then likely to lose her natural inclination to relate to her baby in a non verbal manner and she may possibly become more prone to depression. A depressed mother will even less easily stimulate her unresponsive infant who needs carefully planned cycles of stimulation and

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[illegible] Developing [illegible] Skills, a group organised by [illegible] psychologists who belong to the British Psychological Society.

pauses to assimilate information. Combine the problems faced by the children and the mother's depression and you are increasing the risk factors for a difficult relationship. But we must understand that, even in the best situations, children with such prenatal traumas and/or inherited neurological disorders are at higher risk for hyperactivity disorders and developmental delay in certain skills.

Accusations of emotional abuse

The shock about to descend on me personally was that MSBP experts were dismissing these disorders, instead accusing mothers of intentional emotional abuse to cause their children's difficult behaviour. Possibly because of the association with Allitt, I have heard mothers described as potential murderers, probably psychopaths unable to change.

I first became aware of this dangerous interpretation when I was asked to see twins born so prematurely over 10 years previously that no one thought they would live. They went on to suffer massive head injuries through brain haemorrhages, so their survival was nothing short of miraculous. As expected, the twins did not develop normally. By the time I saw them, the social services were already involved and suspicion was being directed towards the mother. Because the children clearly had difficulties relating to others, this was regarded as arising from emotional abuse on the mother's part, rather than from the disorders they were suffering.

This mother had sought help for the twins' difficult and unpredictable behaviour for many years, to no avail. Now, in her desperation to prove she was not intentionally harming her children, she had offered to be videoed covertly in her home or to be taught new parenting skills if her own behaviours were to blame. After seeing a QED programme in which the Parent Child Game was featured, a means of improving parent-child interactions being used at the Maudsley Hospital at the time, she even contacted the Maudsley for help, but the hospital had been inundated with requests for support for their children and the Parent Child Game programme was closed shortly afterwards anyway. The twins' mother did, however, receive a very helpful letter suggesting investigation into hyperactivity disorders. But the local services interpreted her contact with the hospital as just another attention-seeking criterion for MSBP.

Many incidents were viewed with suspicion and the temperature between local services and the mother clearly rose. At one point the mother threatened to sue if it was found that the social services had missed the real reason for her children's behaviour. In the end one of her twins was taken into care and she fought passionately to get her back. Unfortunately all the natural instincts of a mother deprived of her young were interpreted as impulsivity and borderline behaviour. She was accused of MSBP and eventually lost all four of her children, the younger two of whom were perfectly normal.

So the evidence of a typical history of a child with the tapestry of developmental disorders threaded through with ADHD and coexisting with an autistic continuum disorder was totally dismissed, as were the professionals - myself and a paediatric specialist in ADDs - who had established the existence of these problems. Despite the appalling head injuries and prematurity of the twins, the mother was blamed for their behaviour in its entirety. When I asked how it was that her other two children had developed normally, I was told that they would also become like the twins!

Why is this happening?

I think it is partly because of the current climate of fear that cases like this are occurring. A child is brought to a GP or paediatrician with symptoms they do not recognise. Maybe the child is obsessional, has poor social skills, is very difficult to manage, perhaps not toilet trained by age four or five. The mother may also appear to be very difficult (because there is a genetic component in some of these disorders and the mother may be mildly affected). So she rings everyone up all of the time, describing all the awful things her child does, demanding action, making threats and, understandably, gets on everyone's nerves. Because of fears about their own position and about potential negligence suits, the professional perhaps ceases to see clearly. Can they justify ordering expensive invasive investigations but can they afford not to?

> *It is a straightforward neuropsychological phenomenon that, when emotion comes in the front door, rationality goes out the back.*

Perhaps, if they are aware of MSBP, they will have heard that mothers often tell 'exciting' or exaggerated stories and this parent is more agitated and excitable than most. Perhaps someone on staff has just seen a documentary or read something about MSBP. It seems sense - and, initially, it's cheaper - to focus attention on the mother instead of the child. And so the crucial initial stage, assessment of the child by the appropriate medical person, is sidestepped. If a health professional calls in someone who has developed a reputation for expertise in MSBP, that expert will not, of course, even be looking for a disorder in the child.

After the case with the twins and through contact with other professionals, I began to hear of many other cases in which children had been taken from their mothers. (In some they were eventually returned to them after real causes had been exposed, in most cases a treatable disorder.) When a case gets as far as a Family Court, even if specialists appear who testify to the existence of an organic disorder, the expert in MSBP may easily override them. The issue of child abuse is, naturally, an emotional one. But it is a straightforward neuropsychological phenomenon that, when emotion comes in the front door, rationality goes out the back.

Other cases

One child who was removed from his mother for years was eventually returned, at last recognised as suffering from a rare genetic disorder of the mitochondria affecting breathing and present from birth.

In another case a child who became highly allergic after vaccination was described as normal by an expert in MSBP. He wanted the child to be challenged by

...es, to prove this, and said that, if the mother ...l, he should be taken into care. The child had ...l subjected to challenges earlier in his life which ...ad sent him into anaphylactic shock. These reactions had been witnessed at school and the GP, the school, the social services and the local psychologist all disagreed with the MSBP diagnosis. The allergy specialists in this case wrote about their great concerns and their intention to report the case to the GMC should a challenge go ahead which could kill the child.

In a few cases, a child has begun to soil, throw tantrums and head bang after MMR vaccination (against mumps, measles and rubella). Whilst in some cases the child may have had subtle signs of autism prior to the vaccination, there now appears to be some evidence that a rare bowel disorder linked with autism may be triggered in certain vulnerable children. The final insult to these families is to blame the mother for creating the problem, with a charge of MSBP.

In yet another case, four puppies died from strangulation in a family home. The vet, understandably concerned, called an MSBP expert, as he had heard that if someone abused their pet they were likely to go on to abuse their children. The children were taken into care and the totally shocked mother found herself facing the charge of strangling the puppies and of MSBP. During the court case, however, the father, an ex policeman who had suffered from a nervous breakdown, stood up and admitted to strangling the dogs. He was allowed to return home with his wife and children (the family has since broken up). But if the mother had been found guilty of the crime, the children would have been removed and the mother probably told she must admit to the abuse if she wanted treatment. If she refused, her denial would be seen as further evidence of MSBP and she would be unlikely to get her children back.[3]

I am aware that, in America, women have found themselves in chains in prison and that currently two women are facing the prospect of enforced sterilisation. A child was recently removed from a hospital bed and extradited to Britain.

In my opinion, we must ensure that very clear methods are put into place before MSBP is investigated, to avoid false allegations. Absolutely the first requirement is to establish whether a disorder is real or not. Shona Craig[4] refers to this within the Delphi project, an Auckland-based audit of research criteria for MSBP. She states: "It is necessary to first eliminate all somatic possibilities of true physical illness so there will not be a misdiagnosis of MSBP with irreversible repercussions". Meadow states in a letter to a referrer: "In the diagnosis the essential step is to differentiate between natural and genuine problems and artefactual ones. One does not suggest factitious disease without excluding genuine disease. Therefore the most important step in the diagnosis is in ensuring that the child is assessed by a paediatric specialist who is experienced and skilled in the particular disorder which is being alleged. ... Although the mothers who perpetuate this form of abuse may have certain characteristic features and personalities, one does not identify the abuse by examining the mother. It comes from assessment of the child by an appropriate expert."[5]

I would like to suggest that the Internet could offer a cheap and efficient means of finding an appropriate expert, whatever symptoms are presented. So, if a child is brought into a surgery or clinic apparently suffering from something which is completely unfamiliar to the doctor and he can't find an appropriate specialist, it should be possible to tap into the Internet, describe the symptoms in detail and ask if anyone else has come across a similar case. It could be that someone in Greece has had three such cases and can easily advise. Specialists could perhaps also use this method to describe unusual symptoms or cases that have an unusual pattern to them.

> ***Even if you commit suicide there will be no sympathy, as this can be another sign of MSBP.***

Reasons for accusing the mother

Another major concern I have relates to controversial profiling of the MSBP mother, using particular criteria. The use of predictive profiles for identifying abusive parents has resulted in "unacceptably high false positives and was a disaster" according to Howitt.[7] Cambridge paediatrician Dr Colin Morley clearly outlined his concerns regarding MSBP in the *Archives of Disease in Childhood*.[3] He wrote that the criteria, if fulfilled, which Meadow suggested[8] warranted the use of the term MSBP, are very non-specific and could be misinterpreted. These are: illness fabricated by the parent or carer; a child presented to doctors, usually persistently; the perpetrator (initially) denying causing the child's illness; and the illness clearing up after the child is separated from the perpetrator.

Morley also expressed concern about the additional 'diagnostic pointers' suggested by Southall and Samuel.[7] These include: inconsistent histories from different observers (but consistency could depend upon how the history was obtained and whether the same questions were asked in the same way); parents being unusually calm for the severity of illness (but they could be suffering inner turmoil) and parents fitting in contentedly with ward life and attention from staff (but this is common in a ward where the child is well known and the staff are caring and compassionate).

He stated: "I urge caution about some of the criteria for this diagnosis and concern about the accuracy, sensitivity and ethics of some of the techniques being used. I urge doctors to take detailed histories and talk to the mothers in a caring way about their concerns. It is important to protect a child who is being harmed by his mother. It is equally important not to harm the child by falsely accusing his mother of Munchausen by proxy and thereby breaking up the family."

Particularly deserving of caution in regard to MSBP is the criterion that the illness clears up when the child is away from the mother. "Outcome is an important aspect of the epidemiology of a condition."[9] In other words, after the children have been removed from a mother, the 'acid test' is seen to be the improvement of their children. But we have no robust evidence of outcome as yet. Morley[3] makes the point that many of the childhood illnesses such as apnoea and vomiting which may lead to a child being taken

into care usually clear up at the end of the first year. If the child had remained with the mother the condition would have cleared up anyway. Instead the fact that it cleared up after removal from the mother is seen as proof that the mother was inducing the illness.

In ADHD impulsive and hyperactive behaviours abate as the child grows, particularly in girls, to the extent that we used to believe that it no longer existed once the child approached adolescence. We now know that it simply changes in its presentation. Lack of motivation is a strong feature whereas overly impulsive behaviour prevails particularly pre school.

I fear that, once the albatross of an MSBP diagnosis has been placed on a woman's shoulders, it cannot be removed.

It can be difficult, once children have been taken into care, to find out what has happened to their illnesses and behaviours. In one case, a mother undergoing an acrimonious divorce, after she found her husband had been unfaithful to her, was accused of MSBP as a tactic by her husband's lawyer, so that the husband could gain custody of the child. Her husband, it emerged, was only too willing to say that his child was no longer ill once away from his mother. In fact, he remained the same as he had been previously. In another well publicised case a child died of the undetected disorder whilst his parents were away from him in custody accused of MSBP.

"Child normal"

The criteria some experts use to determine outcome, once mother and child are parted, is unacceptably vague. For instance, in one case, the MSBP expert just stated "child normal". So the massive efforts that were involved in scouring files of mothers and children stop, the huge magnifying glass placed over the family before the children were taken is suddenly removed, the excitement is gone, and an unsubstantiated comment of "child normal" is sufficient to satisfy the criterion of the illness clearing up when mother and child are separated.

Meadow's original criteria for MSBP have now been added to quite considerably and there is no consensus about them. The Delphi project, in feedback to its questionnaire answered by international MSBP experts, found wide disagreement even about the basic research criteria listed in DSMIV (meaning the four criteria offered have not yet been validated as diagnostic criteria). These four were: the intentional feigning or production of physical or psychological symptoms in another person; the motivation for the behaviour by the perpetrator being to assume the sick role by proxy; no external incentives for the behaviour; and the behaviour not better accounted for by another mental disorder. Only the first of these was generally agreed to.

Other 'pointers' suggested by some include tendency to complain, run away, approach lawyers or the media. Even if you commit suicide there will be no sympathy as this can be another sign of MSBP.

I am personally concerned about the way in which even the one research criterion for MSBP for which there is most consensus can be used. The idea of 'fabricating' or 'inducing' the problem certainly covers most possibilities and ensures that, if a woman cannot be accused of the one, then she can be accused of the other. The mother in the premature twins case was accused of fabricating a story about a neighbour's baby which had died. It was claimed that she had invented the tale that the mother of the infant rushed hysterically into the street and pushed the baby, which had already been dead for 12 hours, into her arms. What had happened was that, tragically, the baby had managed to gets its head caught between the struts of a home-made cot and hanged. The mother, when she found the child in the morning, rushed screaming with it in her arms into the street, calling for help. The twins' mother ran out, as did many others, and the child was thrust into her arms, and then other women's, arms in the hope they could resuscitate it, as the woman hysterically refused to believe it could be dead.

When this was found to be a true story, it was claimed by the twins' mother's accusers that she had killed it! Fortunately the Coroner's office was able to confirm that the baby had been dead for 12 hours and the judge threw the accusation out. But when such information is written down and produced in court, relevant or not, it soon has an effect on the nervous system of any normal person.

Many of us would run a mile

As the President of the Medico-Legal Society, His Honour Arthur Mildon QC, said to Professor Meadow after his talk in 1995, printed in *The Therapist* in 1996 (vol 3, no 3): "I find it a most appalling subject. I am glad there are chaps like you who are prepared to do something about it. I think many of us would run a mile and prefer to do something else."[9]

He is right, we would. From my experience, when people are presented with the amassed detail of MSBP cases, all trussed up in huge bundles, dismembered to release a sickening stench, with details which make the mind reel, they effectively do run a mile. Rational thinking deserts them as they struggle to understand how a woman could possibly do such things to her children. Resistance sets in, defences go up and, from that point on, the woman is damned.

But what if the details are wrong? What if the idea of MSBP was based on a rumour? Or on the focus on the mother? What if the expert who diagnosed a real disorder had been ignored? What if the MSBP experts had left out the bits which didn't fit their hypothesis and just left in those which did, possibly grossly embellished? In the same talk at the Medico-Legal Society, Professor Meadow was asked about the theories put forward in *Hurting for Love*, a book by Shreier and Libow, MSBP experts in America.

He said: "I know them and their book and they actually invited me to write anything I wanted after I had read their manuscript, and I did so, and I was a bit critical of their hypothesis. They just abstracted the bits that praised their work and left out my critical bits from the book. I have never had that done to me before."[10] Professor Meadow was clearly upset that he should be misrepresented, especially as it became the preface to the book, sold the world over, and he was the man who had coined the term MSBP.

Selective evidence

It ought to worry us enormously that experts in child abuse can choose which information they want to leave in and which they want to take out, as the Rochdale inquiry Judge exposed. In one case, 13 witnesses speaking in favour of an accused woman were some of the 'left out' bits. In another, the fact that a child who was found to have ingested prescription medication had been with his psychiatrically disturbed grandmother when he became drowsy, was missed out and the mother was accused of administering 'poison' to him - a deliberately emotive word in itself.

I fear that once the albatross of the diagnosis of MSBP has been placed on the shoulders of a woman it cannot be removed. All exit routes are blocked and women find that, despite our so called democracy, their democratic rights are curtailed. They are in a terrible Catch 22 situation. Denial is a pivotal feature in MSBP, so if they deny abuse, this may add to suspicions. If they become angry that their child's real disorder has been missed, this may be claimed as another pointer to MSBP. If they decide to seek an alternative opinion they will be accused of 'doctor shopping', another possible pointer for MSBP. If, in absolute desperation, they write letters of complaint or approach lawyers, this 'busy in litigation' procedure is yet another pointer. Daring to approach the media is seen as a clear sign of MSBP. If they flee to another country, this is a very bad sign, and they will be tracked down and extradited if possible or the systems in that country rapidly informed about this 'dangerous' person.

Some women who have had their children returned have found themselves silenced by injunctions. In one case a child had a rare breathing disorder but the mother was accused of MSBP and all three of her children were taken into care. At the Appeal Court she was vindicated and six paediatricians backed up the diagnosis of the breathing disorder. Her children were returned but she and her entire family have had injunctions placed upon them to stop her speaking to the media. She was told by the judge that she could spend seven years in prison if she spoke about her experience.

The classic witchhunt is with us again. If you drown you are innocent but if you float you are a witch and will be burned at the stake. Women are being demoralised and denigrated, demonised and damned. I am appalled at the control which is threatening basic human freedoms and the extraordinarily inhumane treatment of women once they are accused of this disorder.

The court fiasco

Criminal proceedings are opted for "in most if not all cases of MSBP abuse."[4] If only we had such a tight system for mass murderers, paedophiles, serial rapists, drug pushers, stalkers and fraudsters. It seems that resources in relation to MSBP are unlimited. Each case can involve numerous professionals - one woman faced 27 when she went to pick up her child in hospital. The court costs are breathtaking (the one in which I was involved cost over a quarter of a million pounds but there were no resources when the mother asked for help when the twins were little) and the amount of paperwork is gargantuan.

It seems the more paperwork which can be created the more likely that we will assume guilt. I often wonder whether it all gets read. Let's face it, professionals do not have the time, we are overloaded and overworked. If we are faced with thousands of sheets of paper and a convincing argument from an MSBP expert, is it not just a little bit possible that we might not read every detail, finding ourselves overwhelmed, and take the line of least resistance - agreement? What happens to those who dare not to agree once the machinery is rolling? They are likely to be maligned or dismissed out of hand, at the very least. If our reasoning affected by terrible stories of abuse apparently undertaken by the accused, confused by masses of detail and the convincing argument, under pressure to conform to the prevailing thinking, we are faced with the prospect of possibly leaving a child in an abusive situation, most of us would opt for removing the children.

It is interesting to reflect on the similarity between MSBP procedures and the effects which excitable mothers are accused of creating to meet an apparent underlying need for attention. Once the first gossamer breath of a whisper of MSBP has been uttered, our systems can rapidly draw together many people, including the police over here or the FBI in America, vast amounts of material and, in cases of covert surveillance, cameras, ringing bells, dashing nurses and police cars with flashing lights. A recent *Primetime New York* (November 1997) gave us a flavour of the behind the scenes activity. If I didn't have such concerns about the use of the MSBP label it would make me wonder if some of those who designed the procedures didn't have it. Only joking!

In my work with people with impulse disorders, obsessions and problems of empathy, I expect to find that they will have a fascination for certain types of stimuli, and indeed need this to trigger their sluggish neurotransmission system. One child I saw would run after ambulances and he already knew at age 10 that he wanted to work in an emergency ward when he left school. Another was fascinated by police cars and ended up being arrested for getting in one and looking around. Another leapt into a builder's skip after dogs chased him and told his mum that it was the most 'exciting night' of his life!

I would urge caution before making assumptions about the 'personalities' of women from the style in which they talk about their children's problems. It may well be that some, suffering from a mild form of their children's disorder themselves, have to tell a dramatic story in order to put their point across, as their cognitive processing prevents them from communicating effectively in any other way. In the case of others, many mothers feel anxious when with professionals and may feel they have to make their case strongly, in desperation for help for their child.

What now?

I have raised many issues of concern. Could I make a plea for openness, honesty and balance in the diagnosis of MSBP? I believe that specialists in particular disorders, MSBP experts, lawyers and politicians need to get together and thrash through these issues properly, to see exactly where error has occurred and how to move forward and put things right. I wrote to Princess Diana about this and was about to embark on discussions with her when she tragically died. Unless some equally powerful influence is brought to bear, I fear for the futures of wrongly accused mothers and their vulnerable children. ■

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