

## ORIGINAL ARTICLES

## Munchausen syndrome by proxy abuse perpetrated by men

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### Abstract

**Fifteen families are described in which one or more child incurred factitious illness abuse as a result of the father's false story and actions. The degree of direct physical harm, and the chance of death, was high in those families in which the father had Munchausen syndrome or marked somatising disorder. Eleven children died and another six survived repetitive smothering or poisoning. Although the extent of the risk to children living with a parent who has marked somatising disorder is unsure, there must be vigilance on behalf of those children.**

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Published reports on Munchausen syndrome by proxy child abuse (factitious illness abuse) emphasise that the perpetrator is nearly always the child's mother.<sup>1–4</sup> It is very rare for the father to be actively involved in the abuse. There are several single case reports of Munchausen syndrome by proxy abuse perpetrated by fathers,<sup>5</sup> but a critical reader might categorise some of these as repetitive physical abuse that was at first unrecognised by paediatricians, rather than typical factitious illness abuse.

Despite involvement with many cases of factitious illness abuse, I did not encounter a male perpetrator in the first 10 years of dealing with these families. However, in the last 10 years I have been involved with 15 cases involving male perpetrators. The clinical features of the abuse, and the relevant issues concerning the perpetrator and the home are described, together with a summary of the ways in which they have been dealt with by the family courts and the criminal justice system.

### Subjects

The cases were encountered during the past 10 years. They were referred to me either by paediatric colleagues, social and legal services, or the police. In most cases all the documented material was made available to me, including records on the child and siblings from the general practitioner, hospital, and health visitor,

and the parents' medical records and social service records. In several cases information was supplemented by transcripts of police interviews and investigations. Usually I had the opportunity to meet separately, and jointly, the child's mother and father, sometimes with grandparents and other relatives, and usually with the key social workers. The accounts of the four fathers who were not seen by me personally are taken from the assessments of colleagues and from the records. By the time of court proceedings additional witness statements were available from many others who knew the child and family, or had been involved in the child's care.

The 15 cases fulfilled the criteria for Munchausen syndrome by proxy child abuse,<sup>6</sup> that is, physical or psychological symptoms or signs intentionally produced or invented by a parent or other carer. The perpetrator, at least initially, denies inventing or causing the symptoms or signs. The symptoms and signs diminish or cease when the living child is separated from the perpetrator.

The additional criterion of the perpetrator acting out of a need to assume the sick role by proxy, or as another form of attention seeking behaviour, was present in 12 of the 15 cases.

Although for three of the families there was an element of secondary economic gain in terms of financial benefits as a result of the child's illness, there was no suggestion that those external financial incentives were a prime reason for the abuse.

### Clinical features

Table 1 summarises the main features. The italicised statement at the end of each case description represents the final clinical conclusion.

In nine of the 15 families the index child or siblings had incurred false apnoea/seizures together with smothering. Usually the infant had been presented to hospital accident and emergency departments on several occasions with the story of being found either not breathing or blue, or shaking, fitting, or unconscious. The father was the person who witnessed the events, or who was present at their start. Commonly the father was involved in resuscitation procedures, which he recounted with avid detail. Sometimes the child was well on arrival at hospital, on other occasions the child was

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Table 1 Clinical features of the index child, siblings and father

Case	Clinical presentation and cause†	Siblings	Father
1	Boy, living. Recurrent apnoea with near-miss death episodes from age 3 weeks to 3 months. <i>False history and smothering</i>	One brother—died suddenly at age 6 months having had similar history of recurrent apnoea	Munchausen syndrome since age 19
2	Boy, living. Recurrent apnoea age 1 to 4 months. Unexplained haematemesis. Failure to thrive. <i>False history and smothering</i>	One sister—died aged 16 months after 4 month history of recurrent apnoea	Somatising disorder—presented mainly to family and employers since age 17. Minor fraud and much fabrication
3	Boy. Died age 21 months following history of recurrent apnoea since age 2 weeks; also haematemesis, rectal bleeding, and ingestion of unusual foreign bodies. <i>False history, smothering, and physical abuse</i>	Two elder siblings had fictitious epilepsy and were receiving inappropriate anticonvulsant treatment	Munchausen syndrome since age 14
4	Girl. Died age 6 months following 3 months history of recurrent apnoea. <i>False illness and smothering</i>	None	Munchausen syndrome since age 16
5	Newborn boy. Concerns about deaths of siblings. <i>False history and smothering (of siblings)</i>	One sister died age 4 months following bouts of recurrent apnoea from age 5 weeks. One brother died age 4 months following history of recurrent apnoea from day 4; also haematemesis	Somatising disorder since age 21
6	Boy, living. Recurrent apnoea age 4 to 7 months. Unexplained fractures of femur and ribs. <i>False history, smothering, and physical abuse</i>	None	Fantastic story teller, but only a few unexplained illnesses
7	Boy, living. Recurrent apnoea age 2 weeks to 6 months. Haematemesis. <i>False history and smothering</i>	None	Mild somatising disorder
8	Girl. Died age 6 months following one previous episode of apnoea. Failure to thrive. Unexplained fractures. <i>False history, smothering, physical abuse and neglect</i>	None	No unusual medication or psychological features
9	Newborn girl. Concerns about deaths of three previous siblings. <i>False history and smothering (of siblings)</i>	Unexplained deaths of two boys and one girl at ages 3 months, 5 months, and 16 months. The deaths were preceded by concerns about care	Record of criminal convictions. No unusual medical features
10	Girl, living. Recurrent illnesses from 1 to 5 months, at which age she had marked hypernatraemia and high urine sodium. <i>False history and salt (NaCl) poisoning</i>	None	Mild somatising disorder
11	Boy, living. Recurrent unexplained illnesses age 1 week to 13 months when he had acute hepatic failure. Investigation revealed high blood levels of warfarin, paracetamol, and caffeine. <i>False history and repetitive poisoning</i>	One sister age 6 years—well	Munchausen syndrome since age 22
12	Boy, living, age 3 years. Pains, haematemesis, and haematuria. <i>False history and fabrication of samples</i>	One healthy brother	Munchausen syndrome
13	Girl, living, age 4 years. “Severe epilepsy” causing her to miss regular education. Girl adopting chronic illness role. <i>False history</i>	One healthy brother	Unexceptional medical record. Since divorce 6 years before, father had been sole carer of the two children
14	Boy, living, age 4 years. Marked behaviour disturbance. Being investigated and treated by his father for alleged bowel disorders, allergy, and anaemia. <i>False history, disordered perception, and physical abuse</i>	One brother died age 10 years. One brother in custody	Somatisation disorder and self injury
15	Boy, living, age 9 years. “Uncontrollable epilepsy.” Previous genuine congenital bowel disorder and genuine seizures at time of viral meningitis at age 2. Father insisted that major seizures were still occurring and that the boy continued to need anticonvulsants. <i>False story and disordered perception</i>	Five healthy siblings, but social services concerns about standards of care. Allegation of sexual abuse	Mild somatisation disorder leading to invalidity benefit

†Italicised statements represent final clinical conclusions.

collapsed or had abnormal respiratory signs. The children had all had the usual range of investigations seeking a cause for bouts of apnoea,<sup>7</sup> without a natural cause being found. Two fathers were observed by staff to be smothering their child in hospital, another two were revealed by covert video surveillance. Three in the course of criminal proceedings confessed to injuring their child to a limited extent, which was less severe and less repetitive than suggested by the clinical findings. It is not known how many times the reported episodes of apnoea were merely a false story, rather than an episode of smothering. (My experience is that most episodes are a false story and that a

minority, which includes those occasions when the child is observed to be moribund or collapsed by medical staff, are ones that have been associated with deliberate obstruction of the airways.<sup>8</sup>) The features of the children who incurred repetitive smothering were similar to those that have been reported previously as a result of being smothered by their mothers.<sup>9–11</sup> Thus it was common to find a history of other previous unexplained disorders in the child, previous unexplained disorders in siblings, and other unexplained deaths of children in the family. However, compared with the frequency with which a child smothered by the mother dies in the afternoon or evening after being

discharged following a period of hospital observation, no child in this series died within 36 hours of discharge from hospital.

Two children had incurred repetitive poisoning. Three of the other four children (cases 12, 13, and 15) were considered most unlikely to have been directly harmed by their father, though they all suffered needless medical investigation and treatments as a result of their father's false story and one had blood smeared about his body and in his samples to simulate bleeding.

Cases 13 and 15 involved the common problem of fictitious epilepsy; one of these children had had genuine seizures at the time of viral meningitis, as well as a genuine bowel atresia at birth. The unusual feature of case 13 was the way in which the father conducted a crusade on behalf of his daughter, seeking ever more opinions from experts throughout the country—he was the active seeker of further hospital investigation and referral rather than the consultant paediatrician, who in most factitious illness is the person to refer the child to another centre. In case 14, the father was even more proactive in that he took it upon himself to consult medical books, and perform tests with equipment which he purchased. He then devised treatments for the supposed alimentary disorders, which include bizarre diets and the administration, by him, of enemas. His investigations included taking blood from the child which he “analysed” using a microscope which he had purchased.

There was a significant incidence of other physical abuse, and two children had severe fractures. The father of one child claimed that a fractured femur had been caused by a small monitor falling on the child's thigh. In one family there had been concerns about possible sexual abuse. In another family the elder teenage brother was subject to a life sentence for the murder of a young girl. In all, the series contains 16 abused children, 11 who have died and eight for whom there was no evidence of abuse.

### The home

All except two fathers were living with their partner. The length of that partnership (median 16 months) was less than three years in all except five families. Four fathers had previously been married or had been in a long relationship.

In eight homes the mother was the main child carer, in four the father, and in three there was shared care.

The mother, who was invariably either one or two years younger than her partner, was the meeker and less forceful partner. One wife with severe learning difficulties was being investigated and “treated” by her husband. In five cases the mother's caring capabilities for the child were sufficiently suspect for social services to consider her an unsafe carer.

There was no evidence of active collusion by the mother in either the creation of false illness or the killing of a child. In three cases there were concerns that, because of apparent lack of care from the mother, and some malevolence to

the child, there might have been an element of passive collusion. Three mothers were proved to have lied about circumstances in order to protect their partners, including one case in which the mother lied and fabricated evidence to implicate herself as the perpetrator of abuse, apparently to protect her partner, until police investigation eliminated her as a possible abuser (because of the timing of events and her lack of opportunity to cause them), and identified the male partner as the perpetrator. It was not thought that the mother had colluded in the child abuse in the first instance.

### The fathers

The fathers were of average intelligence and, in two cases, above average intelligence. All had attended normal schools, and two had received further education after leaving school. One was in regular employment in the armed services, but was currently on sick leave. None of the others was in regular employment or had been in long term employment before.

Five were receiving a disability allowance. Six had previously encountered psychiatrists, who had not identified mental illness but had commented on features such as “hypochondriacal nature,” “aggressive personality,” “hysterical amnesia,” “neurotic panic attacks,” and “personality disorder with schizoid features.” It should be noted that the psychiatrists at the time of those assessments did not have all the information that was available subsequently at the court hearings. Usually they were relying on information given to them by the fathers without the benefit of accounts of their behaviour from others.

In table 1, the term “Munchausen syndrome” is used to denote fathers who had major factitious disorder; in four cases it was associated predominantly with physical signs and symptoms, while in one it was associated with combined psychological and physical signs and symptoms. The given age of onset of Munchausen syndrome is the first appearance of an obvious factitious disorder. It was common to find the term “Munchausen syndrome” being used or questioned in the medical records of the perpetrators, usually by a physician or surgeon to whom they had been referred for a supposedly genuine physical complaint. The term “somatising disorder” has been used to indicate that in retrospect the father displayed either DSM IV somatoform disorder,<sup>12</sup> or a factitious disorder, but neither the duration, persistence, nor severity of those disorders was as great as those categorised as Munchausen syndrome, and for several of their illness episodes it was not possible to be sure retrospectively that they were a somatoform or factitious disorder. The detailed reasons for this usage were explained in a previous publication.<sup>13</sup>

In the men displaying features of Munchausen syndrome or somatising disorder, it was common to find that bouts of personal false illness behaviour had gone into abeyance at the time that they were inventing or causing false illness for their child, and then re-emerged when the child was healthy or dead. Thus

chronologically there was a pattern of either father or child displaying false illness. For example, one man had an annual average of 16 attendances at accident and emergency departments for new conditions and for surgical operations, and merely had two accident and emergency attendances and a moderate excess of general practitioner consultations during the two years in which his children incurred fictitious seizures/apnoea and smothering.

The hospital staff caring for these children and parents did not enjoy dealing with the fathers. Although the fathers took a prominent role in the care of their child, and often stayed with their child in hospital, they were perceived as being overdemanding, overbearing, and unreasonable. Even those who initially seemed to behave reasonably were found to lose their temper easily and become irritated with staff. The fathers were quick to make formal complaints and to seek legal redress for the perceived failure of the health care system to provide either satisfactory service or care for their child. Five families, at the instigation of the father, were involved in formal litigation against a hospital.

### Other features

#### FIRE

In four homes there had been one or more unusual fires, requiring help from the fire brigade. The fires were not the result of household accidents but were said by the father to have been caused by either strangers, burglars, or neighbours setting fire to the house. Investigation suggested that the father was the fire raiser.

#### PETS

In four homes dogs or cats died in unusual circumstances. From one home a dog, and from another home three dogs, were presented to a veterinary surgeon with recurrent illnesses which the father said were the result of poisoning (by a neighbour or by ingestion of a dangerous substance in the road). The story and the pets' condition led to them either being destroyed or dying. In one home the pets appeared to have been poisoned with the same drug that was later used on the child.

### Examples of paternal behaviour and false stories

(A selection of some of the false claims made by the fathers, and the bizarre occurrences with which they were involved.)

#### ACHIEVEMENTS

- South of England sailing champion.
- Amateur Athletic Association junior champion, 800 metres.
- Fighting alongside Prince Andrew in the Falklands war; showing photograph of Fleet Air Arm passing out parade, claiming to identify himself.
- "Academic achievement—nine GCSE grades, mainly A and B" (but the school head confirmed that on the first day of exams he turned up at school with his arm in a sling, "unable to write," and had achieved no grades).

- Devised poster campaign for national election victory, also invented British Telecom TV advertisement.

- Writer of two novels, one of which has been adapted for film.

- Writing screenplay for film. He spent much time on the telephone at home speaking to Steven (Spielberg), convincing his wife to the extent that she agreed to dress up in her best clothes to accompany him to the studio to meet the cast—but "the chauffeur driven Rolls Royce broke down" on the way to their house.

- Manager of transport depot supervising 58 employees.

- Senior security position for prestigious London office block.

#### HOME EVENTS

- Many robberies. Burglars vandalising the house or stealing money (particularly when child was in hospital).

- Stranger abducted child, who had to be rescued by father.

- Inadequate or dangerous gas/water supply leading to formal complaints and litigation.

- Deliberate cut of face, followed by successful claim against firm marketing a safety razor.

- Insertion of foreign body into confectionery, followed by successful claim against supplier for damages to mouth.

- Missing money, or valuables, from family or friends' houses.

#### ILLNESSES AND INJURIES

- Father bandaged himself from head to foot and claimed to have 90% burns.

- Several examples of unusual road accidents.

- Wounds incurred "fighting off burglars."

- Wounds incurred "while rescuing a girl being gang raped."

- Injured by debris from Lockerbie air crash.

- Shaving off hair and eyebrows to substantiate story of chemotherapy for testicular cancer; aggressive requests for medical appointments with general practitioner or hospital and subsequent failure to keep appointments.

- Journeys to London for "leukaemia treatment."

- Father knocked on door of home in country in the middle of the night, collapsing inside. The elderly lady living there cosseted him, wrapped him in a blanket, and paid for a taxi to take him home.

- Escalation of symptoms and self mutilation of leg, leading to amputation, for which father ostentatiously shaved his own leg so that the acquaintance who was present felt "physically sick" because "this young man was very calm and collected about his leg being amputated; I felt he was showing off."

### Legal proceedings

All the children who survived were subject to proceedings in the family courts under the provisions of the Children Act 1989. Thirteen were made the subject of a care order, one the subject of a supervision order, and the other was not placed under a legal order because the parents separated and the child went to live



with the mother. Three children were adopted outside the family because of social service concerns about the adequacy and safety of the mother's care.

Investigation by the police occurred in 12 cases and in seven there was a criminal prosecution in which the father was convicted of a criminal offence—usually cited as either manslaughter or grievous bodily harm with intent to injure. The sentences ranged from a custodial sentence of five years to unlimited sentence in a maximum security hospital (Broadmoor). None was given the benefit of a suspended sentence with probation order and treatment conditions.

### Discussion

Munchausen syndrome by proxy abuse is associated with an extraordinary gender disparity, which is not found in other forms of child abuse. Though boys and girls are similarly abused, the perpetrator is nearly always female and is the child's mother. The 1992–94 epidemiological survey of the United Kingdom and Ireland disclosed 128 cases of Munchausen syndrome by proxy abuse, non-accidental poisoning, and suffocation.<sup>2</sup> Although there were six children who were definitely abused by their father, only one of those was characteristic of factitious illness abuse, the others being examples of deliberate poisoning or smothering outside the context of repetitive or persistent factitious illness.

These cases came to my attention in the last 10 years, whereas in the previous 10 years I encountered no case involving male perpetrators. In part that is the result of many more cases of Munchausen syndrome by proxy abuse being identified in recent years. In earlier years the abused children were identified after multiple and repetitive illnesses and hospital admissions; with improved recognition diagnosis occurs at an earlier stage<sup>2</sup> and sometimes at the first occasion of serious abuse, before there is the opportunity for repetition. Another possibility is that the emphasis in published reports on the perpetrator being the child's mother may have dissuaded some from identifying male perpetrators. Our research clarifies the current position in the United Kingdom: the perpetrator of Munchausen syndrome by proxy abuse is nearly always the child's mother and rarely the child's father. When it is the child's father he is likely to be a man with either Munchausen syndrome or significant somatising disorder.

Several hypotheses have been proposed to explain why it is mothers rather than fathers who are the usual abusers. Sometimes it is suggested that it is merely because the young child is predominantly in the mother's care and therefore it is she who has the most opportunity to abuse. But that does not seem to prevent physical abuse being perpetrated equally by fathers and mothers. Nevertheless, to provide a consistent story of false illness to a succession of different doctors and hospital staff does require that the parent has prolonged care of the child, responsibility for the child, and a role for that child in hospital. From that point of

view, cases 12, 13, 14, and 15 can be said to be examples where fathers, who in each case were the main carers of the child, acted in the same way as some female carers. One of the cases reported by Gray and Bentovim was similar.<sup>14</sup> The four fathers of cases 12 to 15 appeared convinced that their child had particular illnesses and perceived, exaggerated, or invented symptoms—and sometimes signs—to substantiate their conviction. One of the fathers appeared very unhappy and genuinely worried about the child; another saw his role as a crusader for better care for his child and thrived on the business and importance of his task; another, who had a more marked personality disorder, had a misplaced belief in his own medical knowledge and skill and acted very inappropriately and harmfully to the child. All four were older men (aged 31 to 50 years) with partners who were either absent, inadequate, or failing. Though the local authorities and family courts took steps to safeguard the children, it is not surprising that the Crown Prosecution Service did not proceed with criminal charges.

The main group of 11 families (cases 1–11) included more violent abuse and a different type of perpetrator. Within those families, 10 children died and another eight suffered severe factitious illness abuse, of whom six incurred smothering or poisoning. The circumstances of the recurrent apnoeas, near-miss cot deaths, and sudden deaths were similar to those in which the mother is the perpetrator apart from the fact that there were no examples of children dying within a few hours of being discharged from hospital after a period of investigation (a circumstance that is common among female perpetrators).

The clinical histories and the features of smothering were similar to those previously described for mothers, and to the clear account by Makar and Squier of a male perpetrator.<sup>15</sup>

Thirteen of the 15 cases presented in this paper are typical of factitious illness abuse. Two (cases 8 and 9) are less typical in that the length of factitious illness preceding death was not extensive. But the histories of the others would be familiar to anyone accustomed to dealing with factitious illness abuse perpetrated by mothers.

At first sight it might be thought that there was rather more associated physical abuse and neglect than is usual in factitious illness abuse, but previous work has shown that other forms of abuse also occur in children whose mothers have caused factitious illness abuse,<sup>16</sup> and there are too few cases involving male perpetrators to allow one to conclude that the incidence of other forms of abuse is necessarily higher.

Unusual illnesses and deaths of pets have also been observed in families in which the mother is the perpetrator of factitious illness abuse. Similarly, an unusual frequency of home fires has been noticed with female perpetrators. Complaints about the health service and instigation of litigation have also been features of cases involving female perpetrators—so much so that I am aware of two cases in which formal litigation, and the despatch of the hospital records to an outside specialist for the assess-

ment of the competence of care, led to that outside specialist being the first person to identify that the child was incurring abuse rather than natural illness. (The specialists notified the relevant social services department.) Nevertheless, a minority of female perpetrators are perceived by staff to be aggressive, overbearing, and difficult to deal with, whereas these descriptions were applied to nearly all the male perpetrators. There were no examples of male perpetrators who were considered model fathers, or who formed close relationships with hospital staff or parents of other ill children.

Whenever Munchausen syndrome by proxy abuse occurs, there is concern that the perpetrator's partner is someone who, by their personality and role in the partnership, contributes to the abuse. In these cases the apparent weakness, inadequacy, passivity, or unloving nature of the mother appeared to allow the abuse to continue undetected too long.

An intriguing aspect of Munchausen syndrome by proxy abuse is that it usually occurs in a household in which there are two parents; a mother living on her own is less likely to abuse the child in this way. The fathers of cases 1–11 were living in a partnership but, in relation to their personal needs and their abnormal social behaviour, they are the sort of men who would be unlikely to have care of a child if living on their own, or be in a position to abuse children. The sort of factitious illness abuse which would be perpetrated by a single father would be the type shown by fathers of cases 12, 13, 14, and 15, two of whom were sole carers and two of whom had grossly inadequate partners. While the presence of an unsatisfactory father may be an important reason for the mother to invent factitious illness in her child, it is unlikely that the same psychosocial factor is operating to the same extent when the father is the perpetrator.

The perpetrators were a memorable group of men, as the anecdotal details make clear. However, the nursing and medical staff dealing with them at the time of the child's illness usually had only a few of the background details. The fathers were not popular with the staff, but they were not recognised as villains nor (with the exception of case 14) as very disturbed persons. To the staff they merely seemed a bit unusual; and hospital staff are trained to cope with and to help unusual people. The extent of their unusual nature became clear on investigating their past health, family, personal, and employment records, and on talking to members of the family and other acquaintances. Many of them were, and are, considerable dissemblers who are able to present an impressive front that hides their problems and the risks that they pose.

Previously we have studied the psychopathology of female perpetrators of Munchausen syndrome by proxy abuse.<sup>15</sup> There is a characteristic subgroup with histrionic personalities who display dramatic and emotional behaviour, exaggeration, and marked personal somatisation. Most of the male perpetrators who harmed their children directly by smothering or poisoning (cases 1–11) were similar to that

type of female perpetrator. Even though they were young (all but one was under the age of 30, and their median age was 22), four of them fulfilled the criteria for "Munchausen syndrome," and another four had significant somatisation disorder.<sup>12–17</sup> As has been seen from the descriptions of some of their lives and stories, at least six of them would have vied with Baron Munchausen himself in terms of dramatic and untruthful stories.

The way in which the men's somatising behaviour so often decreased or went into abeyance at the time that they were inventing and causing false illness for their children has been seen frequently with women perpetrators as well. Therefore it can be helpful when investigating these families to draw up a chronology of the illness events for father, mother, and each of the children, because so often periods of most active fabrication and induction of illness follow sequentially and alternate between perpetrator, child, and sibling. Similarly, times when the perpetrator is arousing interest as a result of legal proceedings or media attention may be linked with a decrease or absence of both personal somatisation and Munchausen syndrome by proxy abuse.

It is clear that male perpetrators of Munchausen syndrome by proxy abuse have been more likely to incur criminal prosecution than female perpetrators. The sentences for male perpetrators have also been more punitive than for women. A typical judgment in a United Kingdom criminal court in relation to a woman found guilty of smothering her child has been that it was "a cry for help" and that such help should be given: a custodial sentence is rare, and a suspended sentence involving three years probation linked with treatment conditions is more usual. Several of the criminal cases in this series initially involved a charge of murder, but during the course of legal arguments and pragmatic plea bargaining, it was common for charges to be reduced to manslaughter or grievous bodily harm, charges which do not lead to a mandatory life sentence; nevertheless several of these men incurred lengthy prison sentences and the one who was confined to a maximum security hospital was sent there for life.

The difference in dealing with male and female offenders may now be changing since there have in the last two years been examples of female perpetrators being given lengthy custodial sentences. It is difficult to understand why men should have been dealt with more punitively than women for similar abuse of their own children. There is no evidence to suggest that such men are likely to be a danger to the community, or to children other than their own. It may be that the negative reports of psychiatrists and psychologists in relation to treatment options—and the unlikelihood of altering their personalities and behaviours—has led to a more punitive approach.

By common usage, the term "Munchausen syndrome" has tended to be used much more for men than for women. Published reports suggest that two thirds of patients with Munchausen syndrome are male, whereas in

the more common non-Munchausen forms of factitious physical disorders, females outnumber males by three to one.<sup>18</sup> In the past, men with Munchausen syndrome have been considered a danger to themselves but not to others. There was nothing to suggest that the fathers reported in this paper had harmed children outside their family, but we now have to accept that such men may be a danger to their own children. It is not certain that men with Munchausen syndrome are more dangerous to children than women with the syndrome, who on rare occasions have been known to harm children other than their own.<sup>19</sup> The difficulty is that, until there have been comprehensive surveys of the children of men and women with Munchausen syndrome, one cannot predict the likelihood of someone with the syndrome, or a major somatising disorder, being harmful to their child. Nevertheless, the appalling mortality and morbidity for the children reported in this paper must influence current advice and practice. There were only three homes in which other siblings had not incurred severe abuse or death, and in one of those the child received most care elsewhere. There may be slight reassurance from the fact that, for the children incurring major abuse or death, there were usually clear warning episodes of unexplained illness or unusual events before the fatal or most damaging incidents. Therefore, if a father has Munchausen syndrome or significant somatising disorder, doctors, health visitors, and social workers need to be vigilant for any unusual illness or event involving a child in that home.

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