patients with TLE due to alien tissue lesions, but neglects other factors which appeared to play an equally prominent role in Taylor's series, viz., sinistrality and femininity (Taylor, 1975). While the discrepancies in prevalence of schizophrenia between alien tissue lesions and mesial temporal sclerotic lesions may be attributed to differences in the likelihood of misconnections following these two lesions, other explanations cannot be ignored. These include differences in the topography of the two types of lesions. Moreover, temporal lobe alien tissue lesions may be accompanied by similar lesions in other brain regions. The latter could account for the psychopathology. A more provocative explanation for the alien tissue/mesial sclerosis discrepancy – that mesial sclerosis arising from perinatal lesions *protects* against schizophrenia – may not be acceptable to proponents of the aetiological role of obstetric trauma in schizophrenia (Murray *et al*, 1988).

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Unreliable urine samples

SIR: I was very interested to read the results of Gossop *et al's* follow-up of opiate addicts after treatment (*Journal*, March 1989, **154**, 348–353). I am, however, a little unhappy about their use of urine specimens to support claims of abstinence, as in my experience such testing is not sufficiently reliable for such inferences to be drawn. It is difficult, without undue strain to the doctor-patient relationship, to be sure of the origins of a proffered sample. I feel that urine drug screening is often a test of uncertain accuracy, performed on a sample of dubious antecedents, provided by a population noted for the deviousness of their behaviour. It has a place in the assessment of drug use, but added little to Dr Gossop *et al's* study.

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Munchausen's syndrome by proxy

SIR: Munchausen's syndrome by proxy has been called the "hinterland of child abuse" (Meadow, 1977) and there have been numerous, and sometimes quite bizarre, case descriptions. The parents are known, by using fabrication and manipulation, to cause their children to receive unnecessary and potentially harmful investigations and treatment. The presenting problems can vary widely and include neurological symptoms, haematuria and bacteriuria, recurrent diarrhoea and bloody stools, vomiting, dehydration, drowsiness, and urticaria. The management of this disorder can present quite a challenge to health professionals (Nicol & Eccles, 1985; Rosen *et al*, 1983). I report a case with an unusual presentation of self-induced vomiting, anorexia, and weight loss in a 3-year-old girl.

Case report: A 3-year-old girl was admitted to the paediatric ward via her general practitioner, after having been ill for 5 days with an upper respiratory tract infection and perhaps a mild chest infection, for which she had been treated with amoxycillin. This would not in itself have merited admission, but the girl's mother complained that the girl was refusing to eat or drink, and was making herself vomit by "sticking her finger down her throat", hence becoming dehydrated. The girl had been admitted to a hospital in Leeds nine months before this admission and had presented with "vomiting and food refusal". Her mother was very concerned about the child's condition, and repeatedly asked the doctors to set up a drip as she felt her child was "very dehydrated".

Child psychiatric opinion was sought, and it soon became clear that the child's mother was suffering from bulimia nervosa. She gave clear descriptions of bingeing and self-induced vomiting since she was a teenager. Her life had been unsettled and her relationships short-lived. Her child's father left before the child was born, and the mother then lived with another man with whom she had another child. He also left, after much conflict at home, and took their two-year-old girl with him. Now the mother is seeing another man and is pregnant again.

She described her own childhood as "terrible", as her own mother died from "not eating" and she and her sister were brought up from an early age by her maternal grandmother, who was very strict and would beat the children "until they stopped crying". The mother left home as soon as she could and tried to pass examinations in nursing but was unsuccessful. She worked as an auxiliary nurse before having her first baby. She has had numerous admissions into various hospitals for short spells with "non-specific" problems, leaving the child in voluntary care or with friends. Her last admission was for suspected ectopic pregnancy after she collapsed on the paediatric ward while visiting her daughter, who had been readmitted with self-induced vomiting. The mother was discharged after a short period of observation.

We encouraged the mother to attend for individual psychotherapy, with a view to helping her cope with

her chaotic life and improve the relationship with her daughter.

In Munchausen's syndrome by proxy the children do not have a good prognosis, especially if the parents themselves suffer from Munchausen's syndrome. Markantonakis & Lee (1988) suggested a central register of Munchausen's syndrome patients which could prove to be a cost-saving exercise (Jones, 1988). I would like to suggest the same for Munchausen's syndrome by proxy, as this may be a way of alerting clinicians in different parts of the country which would lead to early recognition of the problem.

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Sorcery and psychiatry

SIR: Keshevan *et al* (*Journal*, February 1989, **154**, 218–220) describe how psychiatric illness is attributed to sorcery in the predominantly Hindu culture of southern India.

In our child psychiatry practice among Moslem Bangladeshi clients we found a similar pattern. A wide variety of physical and emotional disorders are thought to be caused by sorcery. This can be of two types: *Kunni*, when someone who envies their victim casts a spell; and *Ufri*, when a chance circumstance caused by somebody leaving the house causes possession. Bhattacharyya (1986) describes a similar pattern in Hindu Bengal. In Bangladesh, clients consult a local religious healer, a Mullah, as well as practitioners of western medicine. He may use hair or leaves to create an alternative spell to counteract the initial spell or possession. Alternatively, he may treat the patient with an amulet containing verses from the Koran to be worn round the neck or arm, or give the patient holy water or holy mustard oil over which Koranic verses may have been read or into which paper with Koranic verses on may have been dipped.

The commonest symptoms which we found described to sorcery are conversion disorders or psychosomatic symptoms.

Case report: An 11-year-old Bangladeshi girl who had spent all her life in England had been given an injection at the age of 5, and following this the family described a personality change in which she became much more shy. The Mullah suggested she had been possessed, and she had been given holy water to drink. She was diagnosed as having epilepsy at the age of 9 and had both grand and petit mal fits which were controlled with sodium valproate.

Her sister had died in Bangladesh at the age of 11 after a 2-year illness characterised by odd behaviour. The father's side of the family accused her mother and uncle of casting a spell on her, but the mother thought that the illness had been caused by her standing under a tree at an inauspicious time.

The patient was a shy girl who had been teased about her fits at primary school. A few weeks after starting secondary schooling at a large comprehensive school she had a "florid fit" and did not return to school that term. The paediatrician thought that her frequent fits were hysterical, and referred her to a psychiatrist.

She was having attacks in which for no apparent reason she would look scared and thrash around. Sometimes she would attack the younger children in the house, trying to strangle them or try to pick up a knife, or at other times she would try to bite people. When she came out of the 'fits' she would cry a lot and say she "hurt everywhere". Her mother thought that she had been possessed by going outside alone during the school lunch hour and sitting on the grass. They were concerned that she would die like her older sister. They had consulted a Mullah, who had given her holy water to drink.

In addition to the stress of starting a new school, she was missing her father. He had gone to Bangladesh just prior to the onset of these attacks. He was staying with his mother who was dying and had no plans to return to England. The family had housing problems and their son was in trouble with the police.

The family were reassured both by the paediatrician and by the psychiatrist that the fits were not epileptic. They knew that the fits were precipitated by situations where she felt stressed. For example, one of the attacks had occurred when she was talking about her sadness in her father's absence. The family followed the psychiatrist's advice and ignored the attacks. The attacks ceased when they were positively connoted as her way of trying to solve family problems in the absence of the head of the household and to provide a reason for him to return to England. She was slowly reintroduced to her school and had no fits there.

This family accepted the concepts of western medicine: they attended appointments punctiliously, followed the tasks set by the psychiatrists, and gave the patient her medication regularly. Her mother, however, also told us that the Mullah had told her that