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The Role of Nonperpetrating Fathers in Munchausen Syndrome by Proxy: A Review of the Literature

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Munchausen syndrome by proxy (MSBP) is a psychiatric condition and form of child abuse in which a caregiver, usually a mother, induces illness in a child to gain attention for herself. Because children that are abused by a MSBP perpetrator are likely to be hospitalized multiple times, it is important for the nurse to know warning signs and symptoms of MSBP. Of particular interest is the role of the child's parent that is not involved in the abuse, usually the father. This article presents a review of literature on MSBP, focusing on the role of the nonperpetrating fathers.

MUNCHAUSEN SYNDROME BY proxy (MSBP) is a psychiatric condition and form of child abuse in which a caregiver, most commonly a mother, induces illness in a child to gain attention for herself. MSBP, a relatively poorly understood disorder, was first identified in 1977 (Meadow, 1977). Because children that are abused by an MSBP perpetrator are likely to be hospitalized multiple times, it is important for the nurse to know warning signs and symptoms of this abuse, which may appear in the child or the perpetrating parent. The following review of literature identifies what is known about MSBP and the role of the nonperpetrating father, as well as gaps in knowledge in these areas. This information may aid in diagnosis and prevention of abuse.

A search was done of online research databases, including CINAHL, PubMed, PsychInfo, and Psych Articles. Search terms used were *Munchausen*, *Munchausen syndrome by proxy*, and *factitious disorder*. The search was limited to peer-reviewed journals, research articles, and years 2005 to 2011. This search yielded 73 articles. Only articles in English were reviewed. Articles that were only peripherally related to MSBP were not reviewed. The reference lists of these articles were then used to find additional articles and books. In addition, articles written by Roy Meadow were searched. Thus, for this review, a total of 45 articles were reviewed.

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Literature Synthesis

Richard Asher first coined the name *Munchausen syndrome* in 1951 after the German aristocrat and military man, Baron Karl Friederich von Munchausen, who told tales of his travels and adventures (Holstege & Dobmeier, 2006). His name has since become associated with induced or factitious illnesses (Beard, 2007; Malatack, Consolini, Mann, & Raab, 2006; Smith-Alnimer & Papas-Kavalis, 2003). Munchausen syndrome describes a syndrome of fabricated illness in oneself with the purpose of getting attention (Beard, 2007; Holstege & Dobmeier, 2006). In 1977, Roy Meadow used the term *MSBP* to describe a situation wherein a person induces illness in a child to get attention. MSBP has also been called by other names, including *Munchausen by proxy* (MBP), *parent induced illness*, *factitious disorder by proxy*, and *factitious illness by proxy* (Fraser, 2008; Holstege & Dobmeier, 2006; Schreier, 2004). Because *MSBP* is the name for the condition in the parent, others have described the injury to the child as pediatric condition falsification (Schreier, 2004). Others prefer that the cause of harm be specified, for example, suffocation or poisoning, without any of the above names (Fisher & Mitchell, 1995). The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*) manual of the American Psychological Association (APA, 2000, p. 238) uses the term *factitious disorder by proxy*, which it defines as "the intentional production or feigning of physical

or psychological signs or symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role." There is a great deal of debate about the name of *MSBP*; however, for this article, the more commonly used *MSBP* term will be used.

Diagnosis

There has been some discussion and debate over the diagnosis of MSBP, over such issues as who should diagnose, the name of the diagnosis, and necessary components of the diagnosis. The APA uses the term *factitious disorder by proxy*, a diagnosis which may be made by a psychiatrist. Others posit that pediatricians are best able to detect MSBP-like symptoms, although other members of the health care team aid in detection, and a psychiatric evaluation is encouraged (Siegel & Fischer, 2001; von Hahn et al., 2001). Still, others are convinced that MSBP is a medical diagnosis that cannot be diagnosis by other health care team members, such as psychologists or social workers (Stirling & the Committee on Child Abuse and Neglect, 2007).

Moreover, there is much discussion in the literature of the intent of the abuse and whether an understanding of intent is necessary for a diagnosis. The APA requires motivation as one of the components for diagnosis. Schreier (2004, p. 131) wrote that "the intent of the perpetrator is essential to differentiate MBP abuse from other forms of illness falsification, because that will affect the outcome for the child and the prognosis for the treatment of the perpetrator." At the same time, Schreier (2004) wrote that intent may not be completely understood, but that sufficient information can be derived from commonalities between presentations of MSBP intent. Likewise, in a 2002 article, Shreier wrote that a diagnosis, which requires knowledge of motivation, is necessary to protect the child. However, there are others who find that motivation is not necessary for diagnosis. Stirling & the Committee on Child Abuse and Neglect (2007, p. 1028) wrote, "The motive of the caregiver, although useful to the therapist, is unimportant in making the diagnosis of abuse. In no other form of child abuse do we include the perpetrator's motives as a diagnostic criterion." Rather, intent is important when related to "incarceration, treatment, or reunification" but is not important when describing what happened to the child or making a medical diagnosis (Stirling & the Committee on Child Abuse and Neglect, 2007, p. 1028). Furthermore, as described by Rosenberg (2003), undeniable knowledge of intent is difficult to determine and cannot be inferred or observed.

The *DSM* also includes in the definition the idea that external gains, such as economic gain, are not present. Meadow (2002) disagrees with this part of the diagnosis, finding it naive to think that some perpetrators may receive considerable gain as a result of abusing their child. "However, *DSM-IV* would have been wiser to suggest that external incentives for the behavior were not the *prime* reasons for behavior," wrote Meadow (2002, p. 504).

With this degree of debate, there are a multiple definitions of MSBP. The APA (2000, p. 238) uses the term *factitious disorder by proxy*, which it defines as "the intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role." In contrast, Meadow (2002, p. 506) proposed four criteria for MSBP diagnosis:

1. Illness fabricated (faked or induced) by the parent or someone in loco parentis
2. The child is presented to doctors, usually persistently; the perpetrator (initially) denies causing the child's illness
3. The illness goes away when the child is separated from the perpetrator;
4. The perpetrator is considered to be acting out of a need to assume the sick role by proxy or as another form of attention seeking behavior.

This definition does not require that secondary gain is absent but requires that the child be presented to doctors and that the victim's condition improves with separation from the perpetrator. Rosenberg (2003) wrote of ways to diagnose MSBP by inclusion and by exclusion. This requires frequent presentations for medical care, tampering with the child or the child's medical situation that is caused by the perpetrator, and that no other explanation for the situation is present (Rosenberg, 2003). Furthermore, the child's condition improves with separation from the perpetrator (Rosenberg, 2003). If the child is dead, autopsy reveals that the cause of death is not accidental, natural, or suicidal (Rosenberg, 2003). Thus, Rosenberg's definition requires tampering. Like Meadow (2002), Rosenberg (2003) also requires that the child's condition improves with separation.

Hence, there is a great deal of discussion on how and who can diagnose MSBP and on the components necessary for diagnosis. For simplicity, the definition provided by the APA *DSM-IV-TR* manual will be used for this article: "the intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role" (p. 238). In practice, it is important to recognize that in the absence of clear defining criteria, the nurse should be attentive to how their observations match with all possible symptoms of MSBP.

Forms of Abuse

MSBP abuse may be chronic or episodic, with periods of relative peace between abuse instances (Beard, 2007). The severity occurs on a continuum between relatively

mild events and lethal abuse. Mild abuse should not be dismissed because it can escalate (Fulton, 2000). Seventy percent of abusers continue to induce symptoms in the hospital after bringing children in for symptoms (Fulton, 2000). The siblings of the child may experience abuse as well. It is possible that some cases of sudden infant death syndrome (SIDS) can be due to MSBP (Craft & Hall, 2004). The timing of abuse can vary and may carry over to or from the child's sibling(s).

Induced symptoms come in a variety of forms, encompassing many body systems. About half of child victims of MSBP have central nervous system disorders, which may include sedation, coma, seizures, and gait disturbances (Denny, Grant, & Pinnock, 2001; Fulton, 2000; Meadow, 1982, 1995; Rosenberg, 1987). Some have ineffective epileptic therapy because of induced seizures (Fulton, 2000). Symptoms may be induced by the use of sedatives, insulin, salt, smothering, or a fabricated history. Gastrointestinal symptoms include diarrhea and vomiting, brought about by emetics (ipecac), salt, phenolphthalein, laxatives, or a fabricated history. Respiratory symptoms, like apnea, are cause by suffocation or poisoning or are fabricated. Bleeding can occur as hemoptysis, hematuria, hematemesis, hematochezia, or epistaxis. The perpetrator may add his or her own blood or that of the child to the specimen or give the child warfarin or phenolphthalein to cause symptoms. The caretaker may also cause a rash by applying a caustic or dye to the skin. Often, there are multisystem disorders. Salt poisoning can cause metabolic disturbances, lethargy, and seizures. Intravenous line contamination by urine or feces or another nonsterile agent can cause sepsis (Meadow, 1982; Rosenberg, 1987). Often, the bacteria present are *Escherichia coli*, also found in feces (Fulton, 2000). Finally, the perpetrator may cause a false temperature reading by putting the thermometer in something warm and claiming that was the child's reading (Moldavasky & Stein, 2003). In short, child victims of MSBP may present with many symptoms or a history of many complex symptoms.

Instead of causing actual harm to a child, some perpetrators seek to gain the attention and sympathy of doctors or health care providers by exaggerating or lying about symptoms (Moffatt, 2003). Thus, the child may have to endure painful blood tests, procedures, and surgeries (Moffatt, 2003; Schreier, 2004). In one case, a child endured 40 unnecessary surgeries and 200 hospitalizations for symptoms feigned by his mother (Schreier, 2004).

Death occurs in the most severe cases. An estimated 6% to 10% of MSBP victims are killed. Although mothers are the more common perpetrators, fathers may perpetrate abuse as well. Male perpetrators are more likely to kill their children than female perpetrators (Meadow, 1982, 1998; Rosenberg, 1987; Schreier, 2004). Some children die of supposed SIDS, 10% of which may actually be the result of suffocation (Schreier, 2004). One mother was found to have suffocated five infants before MSBP was diagnosed (Moffatt, 2003).

Thus, abuse is complex and not easy to detect. Symptoms may include many body systems. The perpetrator may simply claim false symptoms or induce symptoms in the child. Normally, no independent observer is present at the onset of the event (Southall, Plunkett, Banks, Falkow, & Samuels, 1997). MSBP involves as least two parties, perpetrator and victim. Often there is a nonabusing parent residing in the home while the abuse is occurring. Understanding the characteristics of all of these parties is important in fully understanding MSBP.

Characteristics of the Child Victim

The child victim of MSBP is usually younger than 2 years and is rarely older than 6 years. However, cases with victims up to the age of 16 years have been identified (Denny et al., 2001; Fulton, 2000). The average age at diagnosis is 39.8 months or about 3 years (Fulton, 2000). The time from the onset of the signs and symptoms has been recorded, on average, to be between 7 and 23 months, with earlier diagnosis being related to the involvement of child protective services (Denny et al., 2001). In cases involving older children, the child also tends to be involved in the conspiracy as a way of receiving acceptance (Fulton, 2000). There is no gender preference among the victims of MSBP abuse (Malatack et al., 2006). The incidence of MSBP is unsure, largely because MSBP is difficult to diagnose and there is a good deal of controversy about who can diagnose, who is diagnosed, and what are the diagnostic criteria (Denny et al., 2001; Moldavasky & Stein, 2003). However, the United Kingdom and Ireland estimate cases of nonaccidental suffocation and nonaccidental poisoning at 2.8 per 100,000 children younger than 1 year and 0.5 per 100,000 for children younger than 16 years (McClure, Davis, Meadow, & Sibert, 1996). The prevalence of cases of MSBP among children younger than 16 years was 2 per 100,000 children in a New Zealand study (Denny et al., 2001). MSBP is a rare condition that tends to occur among young children, and a significant period may pass between the onset of signs and symptoms and diagnosis.

Perpetrator Characteristics

Most perpetrators of MSBP abuse are women at an estimated 90% to 98%. Mothers account for 85% of all perpetrators (Fraser, 2008; Fulton, 2000; McClure et al., 1996; Schreier, 2004; Shaw, Dayal, Hartman, & DeMaso, 2008). Other female perpetrators are female guardians or nurses (Fulton, 2000). About 10% of all perpetrators are fathers (Malatack et al., 2006; Shaw et al., 2008). Some cases have involved abuse by both the mother and the father, who conspired together to harm the child (Schreier, 2004). Some

researchers report that most perpetrators are of White descent, upper class, and educated (Smith-Alnimer & Papas-Kavalis, 2003). Other researchers report no ethnic or economic class differences in perpetrators (Chiczewski & Kelly, 2002). Many perpetrators are knowledgeable about medicine due to some medical or nursing training or employment (Beard, 2007; Fulton, 2000).

Female perpetrators usually develop a good rapport, even close friendships, with hospital staff (Beard, 2007; Fulton, 2000; Shaw et al., 2008). Malatack et al. (2006) report that these relationships are usually with junior health care staff. Health care staff members may become unwitting participants in the abuse as they do multiple tests and procedures aimed at diagnosing and treating the child (Fulton, 2000). Scarcely leaving the bedside, female MSBP caretakers appear to be devoted, selfless, and compliant in public (Fulton, 2000; Malatack et al., 2006; Schreier, 2004; Shaw et al., 2008).

Male or father perpetrators do not often form these tight bonds with the health care staff. They may be demanding, overbearing, and litigious (Shaw et al., 2008). Male perpetrators brag about their accomplishments to the staff (Schreier, 2004). Although mothers may seem to be superb caregivers, the fathers do not appear to be so caring (Schreier, 2004).

Behind closed doors, perpetrators of both genders do not see the child as having his or her own rights and feelings (Beard, 2007). Rather, MSBP caretakers have more concern about the hospital staff and illness than the child (Fulton, 2000). They appear comfortable and even to enjoy the hospital setting (Beard, 2007; Fulton, 2000). Even a disturbing diagnosis does not affect their level of calm (Beard, 2007). They may be happy about additional testing and giddy when describing near-death situations of their child, from which they may have rescued the child (Beard, 2007; Southall et al., 1997). They thrive on attention, sympathy, recognition, and admiration (Beard, 2007; Fulton, 2000).

MSBP perpetrators may also have concurrent psychiatric diseases (Bools, Neale, & Meadow, 1994). They seem to lie often (Moldavasky & Stein, 2003). There is some debate about the presence of Munchausen syndrome in the life of the MSBP perpetrator. Craft and Hall (2004) state that the minority have Munchausen syndrome, whereas Fulton (2000, p. 36) claims, "Many of these mothers have had Munchausen syndrome," which they then transfer to the child. Likewise, Schreier (2004, p. 141) wrote, "Up to 75% of MBP mothers had somaticizing problems when younger, and as many as one third will have factitious disorders themselves." Others find that caretakers have some personality disorder, such as antisocial, border, histrionic, or narcissistic personality disorders (Fulton, 2000). Malatack et al. (2006) reported that MSBP is not as closely associated with borderline personality disorder as is Munchausen syndrome. Nevertheless, personality disorders are not always known. Only 20% of people with personality disorders have a diagnosis and are receiving treatment (Fulton, 2000). Other related conditions include psychotic illnesses and hysteria. Many others have fantasies, obsessions, and worries about causing harm to their child (Craft & Hall, 2004; Fulton, 2000). Schreier (2004, p. 141), however, claims that these assumptions are not always true because "there is no particular psychological profile or checklist of symptoms that definitively confirms or excludes the diagnosis of M[S]BP." The incidence of psychiatric conditions among abusers is debatable, which may be perpetuated by those who lie to or deceive psychiatrics, psychologists, and the general public. Perhaps, Schreier's (2004) advice of having an expert consider each case individually is worth following in these cases.

Characteristics of the Nonperpetrating Spouse

Although much has been written to describe the perpetrator of MSBP, comparatively, little is known about the child's parent, usually the father who does not have MSBP (Fulton, 2000; Malatack et al., 2006; McClure et al., 1996). Often, the literature does not mention the spouses or partners of the perpetrators or only does so in passing (Astuto, Minardi, Rizzo, & Gullo, 2009; Carter, Izsack, & Marlow, 2006). What is known is usually placed in contrast with the role of the perpetrator of the abuse. The experiences and perspectives of the fathers are seldom explored. The following is a review of what is currently known about these nonperpetrating fathers.

Rarely do articles mention the demographic characteristics of nonperpetrating fathers. In the case studies of Martinovic (1995), the men were between the ages of 37 and 43 years. In one case, the father was 37 years old, and the mother was 3 years younger. Most commonly, these men are married, usually to the perpetrator of the abuse (Schreier, 2004; Senocak, Turken, & Buyukpamukcu, 1995; Sheridan, 2003). Of the 10 mothers in the work by Lacey, Cooper, Runyan, and Azizkhan (1993), 9 were married. Some cases mention single mothers with the father of the child having occasional visits (Moldavasky & Stein, 2003). A study in Japan found that 28.6% of perpetrators were single parents (Fujiwara, Okuyama, Kasahara, & Nakamura, 2008). In other cases, the parents were divorced (Klebes & Fay, 1995; Lacey et al., 1993; Martinovic, 1995). However, most are married.

Fathers of child victims of MSBP tend to be distant, uninvolved, and emotionally and physically detached from the family system (Beard, 2007; Fulton, 2000; Schreier, 2004; Senocak et al., 1995). Some authors describe the men as tentative or as having a passive role and taking a low profile (Malatack et al., 2006; Sanders, 1995; Schreier, 2004). Gray and Bentovim (1996) found the men to be peripheral or, contrastingly, very intense. Of the men involved in the cases

studied by the researchers, 70% of fathers were either absent or peripheral to the family prior to abuse identification (Gray & Bentovim, 1996; Schreier, 2004). The aloof personality of these men is reflected across the literature and summarized well by Awadallah et al. (2005, p. 937), who stated, "The rather absent father…is typical."

Although many of the parents live together, these relationships are not pictures of marital bliss (Meadow, 1982). Rather, fathers may have insecurity in their commitment to their spouses (Southall et al., 1997). In a literature review, Sheridan (2003) found that at least some marriages were not happy. Specifically, in the work by Gray and Bentovim (1996), 40% had serious marital problems, which may have been denied or minimized previously. In another research sample, all 10 cases showed "evidence of current disruption in the parent's martial relationships and support system" (p. 830). In 1977, Meadow found that one father was an "undemonstrative husband" (p. 344). In another case, the perpetrator found that after the long-awaited birth of their daughter, her husband seemed to be more interested in their daughter than in her (Meadow, 1977). Some men may be sexually assaultive in their marriages (Feldman, Christopher, & Opheim, 1989). In other cases, there are signs of infidelity. One author described a case in which "the father had illegally married another woman (the patient's mother) without divorcing his first wife" (Senocak et al., 1995, p. 1733). It is not clear if the marital strife tends to occur before or after the onset of abuse or the time of hospitalization (Gray & Bentovim, 1996). These marital problems affect the stability of the family as a whole.

Nonperpetrating fathers seldom visit the hospital, usually due to claimed work conflicts (Fulton, 2000; Malatack et al., 2006; Schreier, 2004). One father held two jobs during the child's hospitalizations (Feldman et al., 1989). One perpetrator described her husband as a workaholic who took little interest in the care of their child (Awadallah et al., 2005). The father is often the "traditional breadwinner" of the nuclear family who seems to be "somewhat uninvolved and immersed in his work" (Castiglia, 1995, p. 79).

Work may not be the only detractor from good marital and parental relationships. One perpetrator claimed to be neglected by her husband, who chose instead to spend time with his male friends (Martinovic, 1995). Fathers may have little part in home chores and their children's education and care (Awadallah et al., 2005; Martinovic, 1995). Other fathers may abuse alcohol and act aggressively toward their family (Feldman et al., 1989; Martinovic, 1995). Work, social engagements, and alcohol use may pull the father from family obligations.

Marital friction, among other things, may provide an impetus for some women to perpetrate MSBP. Parents "tend to come together around a sick child," and an otherwise indifferent father may be likely to become more involved in a sick child's life (Castiglia, 1995, p. 79; Meadow, 1982, p. 96). Thus, the mother may find that the child's illness may provide a "reprieve" from marital conflict or a distraction from personal and home difficulties (Castiglia, 1995, p. 79). By seeking to reengage the spouse in family life, she attempts to maintain their relationship or even to draw closer to her spouse (Gray & Bentovim, 1996; Southall et al., 1997). Others have proposed that she may use the physician as a way to replace a missing or weaker partner (Awadallah et al., 2005, citing Schreier, 2004). Yet, the perpetrators' intentions are not uniform. As Meadow wrote in 1982, perhaps "it would be naive to seek a single cause for the harmful behaviour of these mothers" (p. 96); however, the uneasy relationships between the fathers and mothers may influence a woman's decision to perpetrate MSBP on her child.

The literature indicates some differences between the mothers and fathers in the areas of intelligence and aggression. In 10 of 15 cases studied by Meadow (1982), the fathers' and mothers' families had a "greater than usual discrepancy between the social or intellectual grade of the parents," with the mother being more intelligent or of higher status than the father (p. 94). However, in some cases, the mother is not as intelligent (Meadow, 1982; Senocak et al., 1995). In general, the literature has described the father as less intellectually adept than his spouse (Malatack et al., 2006). For example, Moldavasky and Stein (2003) describe, "The mother told the staff that the husband did not want to be involved in [the child's] medical care, and that he would not be able to feed him through the gastrostomy" (p. 413). Moldavasky and Stein speculate that, in this case, the mother appeared to push away her spouse from caring for the son, which may have been because of what she believed to be his lack of commitment or ability to provide care.

In the area of aggression, the perpetrating mother tends to be more dominant than the nonperpetrating father (Martinovic, 1995). During an interview, one mother dominated the conversation by answering questions directed at the husband (Awadallah et al., 2005). As discussed previously, the father tends to play a peripheral role, but the father may even display passive–aggressive personality traits (Martinovic, 1995).

The distance between the mother and the father is evident in the relationship between the father and the child. In one case, a father and daughter did not make efforts to connect following the divorce of the father and the mother (Sanders, 1995). In another case, the father had only scheduled visits with the child (Osterhoudt, 2004).

Moreover, the distance between the father and the child carries over into his presence at the hospital. Studies state that the fathers "kept a low profile" (Meadow, 1982, p. 94), were "never involved in the presentation of the illness" (Sanders, 1995, p. 431), or "were typically not very involved in the child's illness of hospitalizations (Feldman et al., 1989, p. 830). Others have said the father rarely, if ever, visited. Of 11 men in one study, 6 had jobs that kept them away from home for long periods or in the evening (Meadow, 1982). In the same study, 2 other fathers were "considered extremely unsupportive to their wives for other reasons" (Meadow, 1982, p. 94). One father did not visit the child much,

although it was noted that he lived in the home (Sanders, 1995). This distance is notable because of the severity of the child's illness and in how it contrasts with the proximity of the mother and the child. Moldavasky and Stein (2003) wrote about one case, saying that the child's "mother stayed with him day and night, in striking contrast to the very rare and short visits of his father" (p. 413). These men are shown in many cases as uninvolved men who rarely visit their ill children.

Likewise, some fathers appear to be oblivious to the partner's abuse and to the child's illness (Fulton, 2000; Sanders, 1995). In one study, none of the fathers questioned why the mother was the only one to observe the child's symptoms nor asked their wives about the child's illness. Rather, the men supported their wives' assertions (Gray & Bentovim, 1996). It is unclear if these men were merely ignorant or actually avoided conflicts to sustain their distance from their spouses (Meadow, 1977; Rosenberg, 1987). Some fathers may be in denial or trust their spouses. Some fathers may facilitate the abuse without colluding in it, a situation which "is frequently the case" (Awadallah et al., 2005, p. 937). "One father," notes Schreier (2004), "paid enormous doctor bills for years for a completely healthy son without questioning what was going on" (p. 128). The way these men avoid knowing what is going on with their child is "quite profound" (Schreier, 2004, p. 937). The role of the men in the abuse may not be in practicing the abuse but in facilitating it by not realizing what is going on and not asking questions about their children's conditions.

Some fathers, however, doubt the truthfulness of their wives. In a case of invented seizures, one father overtly expressed to the physician his disbelief in the existence of the seizures. He thought his wife was controlling their son and preventing him from being involved in activities, such as playing with other children (Martinovic, 1995). One case mentions that the father had been concerned about this wife's neglect of the children and desire to put the children through unnecessary testing (Moldavasky & Stein, 2003). Despite disbelief, a father may remain supportive of his spouse even when he knew of her inclination toward exaggeration (Sanders, 1995). Thus, men may convey doubt in the believability of the situation but not intervene.

Emotions run high when the men are made aware of the abuse. In some cases, the father had to be informed of the abuse (Martinovic, 1995). Some spouses may express shock, surprise, and dismay (Lacey et al., 1993; Senocak et al., 1995). Some, then, have "difficulty in believing" the fabrication when told (Meadow, 1982, p. 94). Oftentimes, the spouses' initial strong support of their wives will give way to belief in the diagnosis. After this, he is usually amenable to treatment (Fulton, 2000).

Others, however, do not believe in the abuse. Some deny the existence of a factitious illness as well as the allegations against their wives (Mehl, Coble, & Johnson, 1990). These reactions may be the case even when the man is confronted with irrefutable evidence or when their ignorance is highly improbable (Mehl et al., 1990; Schreier, 2002). In the case of Jennifer Bush, Mr. Bush "staunchly" supported his spouse, even when his daughter had 200 hospitalizations, 40 surgeries and a dozen infections (Schreier, 2002, p. 547; Schreier, 2004). Another man appeared protective of his spouse even when he seemed to have knowledge of her prior exaggerations (Sanders, 1995). Some men defend their wives even in the face of logic and evidence.

Nevertheless, most men end up agreeing with the diagnosis, with some even leaving the spouse. One man separated from his spouse when he had to choose between marriage and being able to see his child. Little is known about the treatment and long-term effects of MSBP on the family unit. Men tend to respond well to treatment, and some men maintain custody of the child (Osterhoudt, 2004). In the work by Lacey et al. (1993), only 1 child in 10 cases was disposed to the father; in this case, the mother was in a psychiatric hospital. In other cases, the child is placed in foster care (Carter et al., 2006; Moldavasky & Stein, 2003). These case

Table 1 Characteristics of the Perpetrator

Characteristics	Source
Most commonly women, child's mother	Data from Fraser (2008), Fulton (2000), McClure et al. (1996), Schreier (2004), Shaw et al. (2008)
May have concurrent psychiatric conditions (diagnosed or undiagnosed)	Data from Craft and Hall (2004), Fulton (2000), Malatack et al. (2006), Moldavasky and Stein (2003), Schreier (2004)
Often well educated, particularly with regard to medical issues	Data from Beard (2007), Fulton (2000), Smith-Alnimer and Papas-Kavalis (2003)
Develop rapport of close relationships with health care staff	Data from Beard (2007), Fulton (2000), Malatack et al. (2006), Shaw et al. (2008)
Rarely leave the child, appear to be caring and attentive	Data from Fulton (2000), Malatack et al. (2006), Schreier (2004)
Thrive on attention, sympathy, recognition, admiration	Data from Beard (2007), Fulton (2000)
Perpetrators of both genders do not see the child as having his or her own rights and feelings	Data from Beard (2007)
Have more concern about the hospital staff and illness than the child	Data from Fulton (2000)
May have concurrent psychiatric disease	Data from Bools et al. (1994)
They seem to lie often	Data from Moldavasky and Stein (2003)

studies do not mention reasons for the placing the child with one set of caregivers or another.

Implications for Nursing Practice

Despite the grim nature of MSBP and the difficulties associated with diagnosis and treatment, favorable outcomes have been reported (Klepper, Heringhaus, Wurthmann, & Voit, 2008). One of the most important roles of all health care professionals is identifying abusive situations as early as possible. The nurse should be alert to signs of possible abuse, including MSBP, in all members of the family and the ill child. Summaries of characteristics of the mother and father can be located in Tables 1 and 2. Knowing the characteristics of the child and both parents, which may indicate possible MSBP, allows the nurse to assess vulnerability and make an informed referral (Shaw et al., 2008). As with all forms of child abuse, when MSBP is suspected, immediate reporting must be completed. Keeping the child safe is the first priority.

Often, those caring for children rely heavily on the health history provided by the parent or primary caregiver. When the parent or caregiver is a perpetrator, the health history provided loses credibility.

Klepper et al. (2008) warn against health care professionals becoming unwitting contributors to abuse of the child by ordering expensive and/or invasive tests that may not be needed. Any incongruity between physical assessment findings and parental reports of injuries or illnesses should serve as a "red flag" to the nurse. Thorough and careful physical and psychosocial examinations should be conducted and documented to identify possible abuse. Effective and clear communication between health care professionals of careful assessment findings is an important element of intervention in cases of MSBP (von Hahn et al., 2001).

Conclusion

Most journal articles published on MSBP review research were conducted in the 1970s and 1980s. Many include suggestions for health care personnel to discover the warning signs and appropriately intervene in cases of MSBP. Prospective experimental studies are difficult, if not impossible to conduct; thus, much of the new information on MSBP is based on case studies. Because of these limitations in the field of study, it is difficult to determine what has changed since original articles were published, and new knowledge based on large enough sample sizes may be lacking.

However, there is a fair amount known about MSBP at this time, especially about the types of abuse that occur and characteristics of the child and the female perpetrator. There are data on rates of abuse, the most common symptoms, the age of the child, and the personalities of the perpetrator. The parent who is not the perpetrator, usually the father, is known to be distant from the hospital and to be surprised at the abuse. After confirmation of diagnosis of his spouse is made, the father is likely to be amenable to psychological treatment. The father may or may not obtain custody of his abused child. Most of what is known, however, is not about the father but about the mother and the child.

There is still much to be learned about nonperpetrating fathers. Perhaps, after diagnosis is confirmed, the father is able to review the past and identify some warning signs of abuse, both in his spouse and child. In addition, more research is needed to determine if MSBP would be less likely if the father was more devoted to his relationship with his wife and the medical care of his child. Details about his relationship with his spouse are missing; little is known about the onset of marital conflict, the nature of conflict, and the actions taken to resolve conflict. Through decades of research on MSBP, there is some known about the condition

Table 2 Characteristics of the Nonperpetrating Father

Characteristics	Source
May or may not reside in the same household	Data from Klebes and Fay (1995), Lacey et al. (1993), Martinovic (1995), Senocak et al. (1995), Sheridan (2003), Schreier (2004)
Distant, uninvolved, emotionally detached, often facilitate abuse without colluding in it. Seem to actively avoid knowing what is going on with the ill child	Data from Awadallah et al. (2005), Beard (2007), Fulton (2000), Schreier (2004), Senocak et al. (1995), Shaw et al. (2008)
Defer health care decisions to the mother, seldom visit the hospital	Data from Awadallah et al. (2005), Castiglia (1995), Fulton (2000), Lacey et al. (1993), Malatack et al. (2006), Meadow (1982), Sanders (1995), Schreier (2004), Senocak et al. (1995)
High level of denial, appears to be supportive of spouse	Data from Fulton (2000), Lacey at al. (1993), Martinovic (1995), Meadow (1982), Senocak et al. (1995)
Evidence of disrupted marital relationship, if married to the child's mother	Data from Gray and Bentovim (1996), Meadow (1977), Meadow (1982), Sheridan (2003), Southall et al. (1997)
In contrast with perpetrating mothers, tend to be demanding, overbearing and litigious with health care staff	Data from Schreier (2004), Shaw et al. (2008)

and participants, but more investigation is needed into the insights on nonperpetrating fathers.

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