APPLYING CRIME SCRIPT ANALYSIS TO FACTITIOUS DISORDER IMPOSED ON ANOTHER:

FINDINGS FROM 45 CASE REPORTS

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Background: Factitious Disorder Imposed on Another (FDIA), previously known as Munchausen Syndrome by Proxy is a rare and severe form of child maltreatment in which a caregiver, predominantly the mother, intentionally fabricates or induces illness in a child to gain attention, validation or control. FDIA is predominantly considered a psychiatric disorder, ignoring the criminal aspect of the abuse with the result perpetrators frequently escape legal accountability. The objectives of this study are to call to attention to the importance of FDIA as a crime, explore how a crime script analysis can be applied to FDIA crimes, and examining the consequences of the failure to consider FDIA a crime. **Method:** Using a crime script approach, 45 FDIA-C cases were analysed to map the sequence of perpetrator behaviour. Behaviour was classified into six sequential scenes: Preparation, Hospital Admission, Worsening of Symptoms, Post-conditions, Exit, and Aftermath. A dataset with 19 variables mapped to the specified scenes was abstracted from 45 case reports. **Results:** By mapping and comparing case reports analysis revealed recurring behavioural patterns, including symptom fabrication, manipulation of medical staff, and continued abuse during hospitalization. **Conclusion:** The study documented that it is feasible to apply a CSA to FDIA crimes, and doing so helped revealed numerous insights and potentially useful interventions that can help improve early detection and limit continued abuse by perpetrators of their children. The study documented very limited legal accountability of FDIA perpetrators, even when they have confessed, suggesting a need for greater emphasis on the criminal nature of FDIA. For this reason, the study coined the term FDIA *crime*, in the hope that this will be a first step towards greater recognition of FDIA as more than a psychiatric disorder.

Keywords: Child abuse, Crime Script Analysis, Factitious Disorder Imposed on Another, Fabricated or Induced Illness, Perpetrator behaviour, Munchausen Syndrome by Proxy.

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1 Introduction

Child maltreatment, physical, emotional and sexual abuse and neglect of children under 18 years of age, is a significant global health problem. It is estimated to affect six in ten children under the age of five years and approximately 400 million children under 16 years of age, every year around the globe (WHO, 2022; WHO, 2024). A rare and severe form of child maltreatment is Factitious Disorder Imposed on Another (FDIA by definition), in which a caregiver, predominantly the mother, intentionally fabricates or induces illness in a child to gain attention, validation or control (Abdurrachid & Gama Marques, 2022; Bass & Jones, 2011). Hornor (2021) estimates that between 0.5 and 2.0 per 100,000 children under the age of 16 are victims of FDIA, but the true rates are likely to be higher because the abuse takes place at home, and the caregiver to the outside world may appear as a caring parent worried about their sick child (Lundin, 2001).

1.1 Diagnosing FDIA is a challenge

Previously known as Munchausen Syndrome by Proxy, FDIA was officially classified in 2013 under the category of "Somatic Symptom and Related Disorders" in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The decision to define a new psychiatric disorder was made to highlight its behavioural basis in contrast to the psychiatric *syndrome* (emphasis added) implied by the previous name (Faedda, 2018). As a first, DSM-5 defines four diagnostic criteria for FDIA (American Psychiatric Association, 2022):

1) Falsification of physical or psychological signs or induction of injury or disease in another
2) Presentation of the victim as ill, impaired, or injured
3) Deceptive behaviour is evident even in the absence of obvious external rewards
4) The behaviour is not better explained by another mental disorder

Despite DSM-5's efforts to define FDIA in practical terms, it remains difficult to diagnose in real-world settings. Even when the abuse is severe enough that the child is repeatedly hospitalized, healthcare professionals may be misled by fabricated or induced symptoms presented by a caregiver who appears attentive, concerned and cooperative (Stirling, 2007).

This may result in early warning signs being overlooked with clinical responses unintentionally reinforcing the false illness narrative, thereby prolonging the abuse (Glaser, 2020; Lundin, 2001). Thus, healthcare staff can inadvertently enable the perpetrator's behaviour and reduce the likelihood of early detection (Hornor, 2021).

Even when FDIA is suspected, confirmation of the diagnosis is difficult because the DSM-5 requires that the falsification is associated with "identified deception" that the "deceptive behaviour is evident even in the absence of obvious external rewards" (American Psychiatric Association, 2013, p. 325). Thus, if deception cannot be clearly proven, the case will not meet the diagnostic criteria for FDIA and is often (mis)classified under a broader psychiatric diagnosis (Ayoub et al., 2000).

1.2 The criminal aspect of FDIA: overlooked and under prosecuted

It is not surprising that the definition of FDIA is subject of continued debate (Stirling, 2007). Even when deception is confirmed, FDIA continues to be treated primarily as a psychiatric disorder, which means the criminal aspect of the abuse is frequently overlooked and the rate of prosecution remains significantly lower than the severity of the offense would warrant. This contrasts with crimes like child sexual abuse which are always prosecuted irrespective of the perpetrator's mental health or psychological background (Stirling, 2007).

Disagreement also persists about how FDIA is identified, diagnosed, reported and prosecuted in practice. Capasso (2025) argues that FDIA should not be recognized entirely as a psychiatric disorder, but as a systemic issue that spans medical, legal and social service domains. These sectors operate with different priorities: medicine aims to treat, justice to prosecute, and child protection to safeguard. Since FDIA falls at the intersection of these domains, diagnosis and responses may be delayed or inconsistent (Ayoub et al., 2002; Hasle et al., 2025).

Because the criminal nature of FDIA is often overlooked, many countries do not treat it as a distinct offense and instead address it, if at all, under general child-abuse. In Denmark, for example, FDIA is addressed under the Danish Penal Code (Straffeloven § 244-249), which criminalizes assault, aggravated assault, neglect and mistreatment, but does not specifically acknowledge FDIA as a stand-alone offense. In contrast, Sweden has recognized FDIA as a form of child abuse in *Barnmisshandel i samhället – en inledning*, an official government report (Regeringskansliet, 2001, SOU 2001:72), which defined FDIA as intentional and provides examples such as suffocation, poisoning, and fabricated illness.

In the United States, individual states are responsibility for the prosecution of crimes, including child abuse and FDIA, committed in their territories, so there is no single penal code to address FDIA (U.S. Department of Health and Human Services [HHS/ACF], 2023). At the federal level, child abuse is defined and addressed administratively under the "Child Abuse Prevention and Treatment Act" (CAPTA, 2023), which provides guidelines for identifying and reporting abuse, but it does not establish criminal penalties (HHS/ACF, 2023) thereby undermining legal accountability and contributing to inconsistent prosecution practices across jurisdictions, mirroring the situation across the world (Capasso et al. 2025).

1.3 Crime Script Analysis Framework

A Crime Script Analysis (CSA) is a criminological approach, originally developed by Derek Cornish (1994) to "generate, organize and systematize knowledge about the procedural aspects and procedural requirements of carrying out a crime" (as cited in Dehghanniri & Borrion, 2021, p. 2). By breaking complex crimes into smaller, manageable stages from preparation, doing to exit, it reveals perpetrator decision-making at each step and establishes a procedural framework that may be used for crime prevention (Wortley & Mazerolle, 2008; Leclerc, 2013).

The concept of CSA is borrowed from cognitive psychology, where Schank & Abelson (1977) introduced the idea of event scripts. A commonly cited example is the 'restaurant script' in which a person enters, sits down, orders, eats, pays, and leaves (Cornish, 1994). Similarly, CSA highlights the sequential flow of behaviours and actions, allowing for a deeper understanding of the crime commission (Keatley, et al., 2020).

Since Cornish (1994) introduced CSA, it has been applied to various offenses such as robbery, vandalism, auto theft, drug dealing, serial sexual offenses and school shootings (Beauregard et al., 2007; Keatley et al., 2020; Sytsma et al., 2021). These applications of CSA demonstrate how it can uncover patterns of criminal activity while identifying critical stages where intervention could have disrupted or prevented a crime. CSA is particularly suitable for analysing FDIA because it maps the perpetrator's behaviours across different stages of the offense, which are otherwise hidden in clinical records.

1.4 Aim and Research Questions

FDIA presents significant challenges for detection, diagnosis, and intervention, partly because the current medical paradigm tends to overlook FDIA's criminal nature. As a result, the abuse often remains unprosecuted, and opportunities for situational crime prevention to prevent and disrupt perpetrators are lost.

The aims of this study are to call attention to the importance of FDIA as a crime, rather than purely as a psychiatric disorder, and to show how a criminological approach can contribute to the existing knowledge and understanding of FDIA crimes – not only to strengthen the legal accountability for the perpetrators, but also of as a means to strengthen efforts to reduce the prevalence and burden of FDIA. To emphasize the criminal nature of FDIA, it will be referred to as a FDIA-crime (FDIA-C), where appropriate, for the remainder of this study.

The study addresses the following research questions:

1. How can a CSA be used to highlight the criminal nature of FDIA?
2. What insights can a CSA of FDIA-C reveal about possible points of intervention to support earlier detection and prevention of FDIA-C?
3. What consequences do perpetrators of FDIA-C face, if any, and to what extent are FDIA-C cases prosecuted as crimes?

2 Previous Research

This section focuses on FDIA studies from a medical perspective because an attempt to identify publications related to the application of CSA or other criminological approaches to FDIA-C yielded no results.

Prior research on FDIA indicates that the phenomenon is predominantly framed within a medical or psychiatric context, with most publications taking the form of clinical case reports that focus on the child-victim and the diagnostic process (Yates & Bass, 2017). Even studies that address perpetrator characteristics tend to do so from a psychiatric perspective, emphasising psychopathology rather than behavioural patterns or intentional decision-making (Bass & Adshead, 2007). Because these accounts focus on symptoms, diagnoses, and treatment, they rarely analyse the abuse as a repeated, concealed, and goal-directed process. This lack of behavioural and procedural analysis makes it difficult to identify systematic patterns or to inform prevention efforts, contributing to mislabelling FDIA-C and cases going unrecognised or unreported (Cording & Carter, 2021; Sheridan, 2003).

A large contributor to this problem is healthcare professionals trusting the reports provided by parents or caregivers (Cording & Carter, 2021). In hospital settings, the healthcare professionals are often "having a tricky issue accusing a parent of harming a child", limiting early identification (Feldman, 2014, para. 14), which can result in long delays between the onset of abuse and formal diagnosis in cases that are eventually identified. Other research suggests that the average time between onset of symptoms and diagnosis of FDIA-C is between 1 and 4.5 years (Cording & Carter, 2021).

These issues further highlight the importance of FDIA awareness and familiarity with the warning signs, such as repeated hospitalizations of the child, symptoms not matching the objective findings, and a caregiver's over-involvement and insistence on invasive procedures (Hornor, 2021). Feldman (2014) argues that this gap in research persists because "the medical community is still uncomfortable with illness deception" (para. 9) and therefore, tends not to recognise where intervention is possible before severe harm occurs. What further complicates identification is that up to 30% of FDIA-C victims already have an underlying medical condition, where the perpetrator initially seeks treatment but later begins to exaggerate, fabricate, or actively induce symptoms (Hornor, 2021).

An important characteristic of the FDIA literature is the virtual absence of information about criminal accountability. A recent systematic review of 108 cases by Abdurrachid & Gama Marques (2022) found that only 11 perpetrators (14%) were imprisoned for their crimes. This review reported that during the investigation phase, the child was typically removed from the perpetrator to secure their immediate safety. Ultimately, most cases end with the permanent separation of the victim from the perpetrator rather than the latter's imprisonment (Riviello & Rozzi, 2024). This reflects how FDIA-C is primarily managed through child-protection and psychiatric pathways instead of legal prosecution, even though criminal consequences do occur in a minority of cases (Abdurrachid & Gama Marques, 2022). In addition, Bass and Adshead (2007) emphasises that there is no simple or direct relationship between psychiatric diagnosis and abusive behaviour, which further illustrates the limitations of relying on diagnostic categories to understand FDIA perpetrators.

The use of CSA has the potential to provide information that could contribute to more effective responses to FDIA-C across healthcare, legal and child protection systems, where the current fragmented approaches often miss critical warning signs. As Dehghanniri and Borrion (2021) emphasizes, understanding how a crime unfolds is essential to design prevention strategies, and CSA facilitates "the identification of a fuller range of possible intervention points for prevention" (Leclerc et al., 2011, p. 212).

2 Materials and Methods

This study applies a CSA to FDIA-C to generate systematic knowledge about the sequential scenes of actions involved in crime to uncover patterns of criminal behaviours and activities that might provide opportunities for situational crime prevention and interventions (De Korte & Kleemans, 2022). A CSA was selected as the method for this study because the aim is to identify behavioural and procedural patterns in FDIA, in which CSA provides a structured framework for mapping perpetrator decision-making across sequential stages of a crime.

3.1 Search Strategy

With a CSA requiring a great deal of information at each scene, it is not easy to obtain the data needed for the analysis. Since primary data collection was beyond this study, it relies on secondary data from published case reports about individual perpetrators of FDIA-C. PubMed and Google Scholar were searched to identify potential case reports that could be used to operationalize the crime script. These databases were chosen as they contain a large number of publications on topics of criminology, psychiatry and mental health research, increasing the likelihood of finding studies with the needed information. Using these databases ensured consistency and guaranteed that the materials met scientific standards.

Although two databases were used, the searches were not conducted identically. PubMed served as the primary database, while Google Scholar was used as a supplementary search to obtain additional case reports. Because PubMed and Google Scholar operate as two different search systems, it was not possible to create an equivalent search string for both. PubMed supports built-in filtering and MeSH terms, whereas Google Scholar does not (National Library of Medicine, 2025).

To align with current terminology, the initial search strategy used the term, "Factitious Disorder Imposed on Another". Although the official name, related cases are still reported under older terms like "Munchausen Syndrome by Proxy", "Medical Child Abuse", "Fabricated Illness" and "Paediatric Condition Falsification". Studies referring only to older terms were excluded unless FDIA was explicitly reported, because those terms lack official diagnostic criteria, making the cases incomparable and potentially weakening the validity of the analysis. To narrow the search to paediatric cases, the term "child" was then added. Since the DSM-5 was published in 2013, the sample was limited to studies published between 2013 and 2025. In addition, the search was limited to articles published in English only.

As this study focuses on perpetrator behaviour, three filters were applied: case reports, interviews, and legal cases. These filters were selected because they may provide detailed description of perpetrator behaviour in FDIA-C cases, insights from a perpetrator perspective, involved healthcare professionals, and legal outcomes. This ensured that all retrieved articles were FDIA-C related case reports, while allowing for the inclusion of studies containing either interview-based material or legal elements.

The initial search in both databases was conducted using the basic search interface. The exclusion stages in the screening process were different across the databases. In Google Scholar, a title and abstract screening was conducted. Exclusions at this stage were made when an article was not written in English, was not a case report or was a format without real case material (e.g., books, reviews, monographs), involved an adult victim, or described factitious disorder imposed on self (FDIS). In PubMed, which produced a manageable number of 57 records, no title/abstract screening was necessary, and all articles were assessed in full text.

The full-text screening stage was applied in both databases, and exclusions were made when articles that initially appeared relevant involved FDIS, reported unrelated diagnoses, or contained insufficient or unavailable case information.

3.1 Screening and Selection Process

3.1.2 PubMed

The initial search on PubMed with search string “factitious disorder imposed on another” produced 838 results. After applying the time frame 2013–2025, this was reduced to 171 results. Adding the term “child” led to the search string being “factitious disorder imposed on another” AND “child”. In PubMed, “child” automatically maps the MeSH heading “Child”, which also includes narrower terms such as “Infant” through PubMed’s Automatic Term Mapping (National Library of Medicine, 2025). This reduced to 117 results.

After applying the article-type filters, “case reports”, “interview”, and “legal Case” which is applied by selecting tick-boxes in the PubMed database, 57 records remained. Of these, 28 articles were excluded due to FDIS (n = 10), adult victim (n = 7), unrelated diagnoses (n = 5), and not in English (n = 6). This resulted in 29 PubMed articles being included in the CSA.

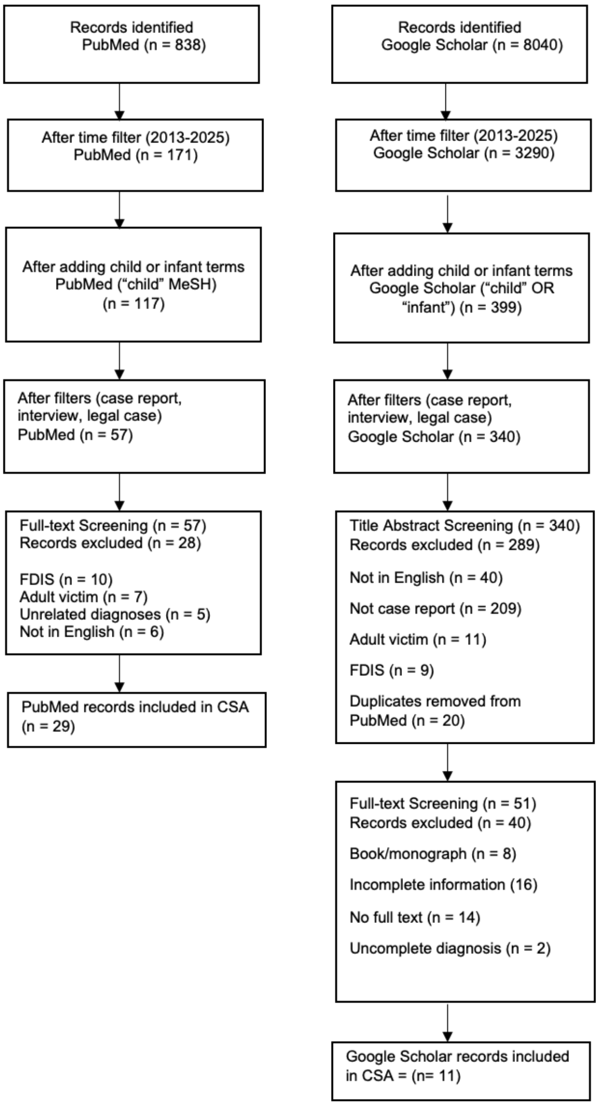
3.1.3 Google Scholar

The initial search on Google Scholar with search string “factitious disorder imposed on another” produced 8,040 results. After applying the time frame 2013–2025, this was reduced to 3,290 results. Because Google Scholar does not use MeSH or automatic term mapping, the terms “child” OR “infant” were added manually to the search string: “factitious disorder imposed on another” AND (“child” OR “infant”), resulting in 399 records. To mirror the

PubMed filtering process, the same three filters ("case report", "legal case", and "interview") were applied manually by including them into the search string. The final search string was therefore: "factitious disorder imposed on another" AND ("child" OR "infant") AND ("case report" OR "legal case" OR "interview"), which produced 340 records.

All 340 Google Scholar articles were screened by title and abstract, and 289 were excluded due to not being case reports (n = 209), not in English (n = 40), adult victim (n = 11), and FDIS (n = 9). During the title/abstract screening, 20 records were identified as duplicates from PubMed and removed at this stage of screening. This resulted in 51 articles which were full-text assessed where records were excluded due to book/monograph (n = 8), incomplete case information (n = 16), unavailable full-text (n = 14), or unrelated diagnoses (n = 2). This resulted in 11 Google Scholar articles being included in the CSA. A complete visualization of the search strategy and selection and exclusion process is presented in the PRISMA flow diagram (see Figure 1).

Figure 1 *PRISMA flow diagram*



The total sample consisted of 40 articles, which contained a total of 45 separate FDIA-C cases for analysis. Because this study used published etiological case reports as source of data, the dataset may be selective as the studies tend to focus on clinical detail rather than perpetrator behaviour, meaning that information relevant to CSA may be incomplete. These limitations originate from the material and need therefore to be considered as part of the study's methodological limitations.

Some articles reported more than one case. To maintain transparency in the dataset, the following cases originate from the same article: case 4, 5, and 6 were reported within the same article, case 9 and 10, case 29 and 30, and finally case 37 and 38 were reported in the same article. All other cases are individual single-case reports.

3.2 A Generic Crime Script Scheme

This study analysed FDIA-C at a script level of abstraction (Cornish, 1994). Cornish (1994) original crime script approach was used as a template to assess and analyse the content of the case reports, to uncover regularities of sequential behaviour, and served as an initial analytical framework. The first step of a CSA is the development of a crime script scheme that reflects the actual scenes in the crime commission of FDIA-C. In his development of a generic crime script scheme, Cornish (1994) presented nine standard categories of scenes. Figure 2 presents the nine generic scenes, their purpose, and provides an example of graffiti "Tag writing" (Cornish, 1994).

Figure 2. Generic crime script scheme and application to the crime of "tag writing" graffiti

Scene/function	Script Action	Sample script action for the crime of" tag writing" graffiti
1. Preparation	Planning phase	Buy a spray-can Find a good setting
2. Entry	Entering the crime scene setting	Enter setting
3. Pre-condition	Awaiting or establishing the conditions to commit the crime	Loiter
4. Instrumental Pre-condition	Critical or goal-oriented actions needed to carry out the crime	Select target
5. Instrumental Initiation		Approach target
6. Instrumental Actualization		Reach target
7. Doing	Perpetration of the crime	Spray graffiti
8. Post-condition	Actions immediately following the perpetration of the crime	Get away quietly
9. Exit	Perpetrator exits the scene	Leave setting

Source: Adapted from figure 5 in Cornish (1994).

It is important to note that an actual crime script scheme will need to reflect the scenes of the crime in question. As a result, the actual number and categories of crime script scenes will depend on the specificities of the crime.

3.3 Structuring the Crime Script for FDIA-C

Borrion (2013) emphasises the importance of quality assurance in crime scripting. For the CSA to be used for intervention and crime prevention, the sequence of actions must be consistent. In addition, the value of the script comes from its grounding in real cases and its ability to show the recurring choices perpetrators make (Chainey & Berbotto, 2021). In line with Borrion's (2013) checklist for crime script development, this study constitutes a performed script based on real FDIA-C cases. Because the crime script is based on events which have already occurred, the script also functions as a potential script, meaning it can be applied to anticipate how FDIA-C may develop in future cases to inform prevention and intervention (Borrion, 2013).

There are no strict rules regarding how a crime script must be structured (Borrion, 2013). Scripts are meant to guide our understanding of behavioural processes, but their stages can be adjusted based on the nature of the crime and the available data (Borrion, 2013). Authors have often modified the number and type of scenes to fit a specific crime and reduced Cornish nine stages, excluding irrelevant scenes to the crime under study (Leclerc et al., 2011).

The development of the FDIA-C crime script followed a mixed deductive–inductive process, consistent with Ekblom and Gill's (2016) argument that crime scripts draw on both prior knowledge and observations from the data. The initial structure was deductively informed by Cornish (1994) generic crime script scheme and previous CSA literature (De Korte & Kleemans, 2022), as well as established knowledge about FDIA behaviours such as repeated hospital visits, symptom fabrication and worsening of symptoms during treatment (Abdurrachid & Gama Marques 2022; Hornor, 2021; Cording & Carter, 2021), which provided the starting framework of scenes. The final FDIA-C crime script (see Figure 3) was deductively constructed based on prior theoretical and empirical FDIA knowledge before the case material was analysed.

As the 45 FDIA-C cases were examined, additional behavioural patterns emerged that were not included in the original scenes (e.g., single mother, absent father, social isolation of the perpetrator, or that the perpetrator has been diagnosed with psychiatric illness). These inductive insights led to adjustments of the script and the alteration of scenes to accurately reflect the behavioural sequence specific to FDIA-C. Thus, the final FDIA-C script presented below is grounded in both existing CSA theory and empirical patterns identified across the case material.

Figure 3. Crime script scheme for FDIA-C	
Scene / function	Script action(s)
1 Preparation (Preparation)	Preparation to enable FDIA-C in a hospital setting
2. Entry/Pre-condition (Hospital Admission)	Admission to the hospital / ensures continued hospital admission by exaggerating symptoms
3. Doing (Worsening of symptoms)	Direct harm or abuse of the child while in hospital and worsening of the symptoms
4. Post-condition	There are two options i) FDIA-C remains undiscovered (deception continues) ii) FDIA-C is or suspected and child is separated from perpetrator
5. Exit	The child is discharged with or without the perpetrator depending on the outcome of scene 4.
6. Aftermath	1) The child returns home with perpetrator, abuse is not discovered 2) The child returns home with perpetrator, and abuse is subsequently discovered 3) Perpetrator loses custody of child 4) Perpetrator is prosecuted
Source: Author	

3.4 Narrative Description of the FDIA-C Crime Script

The *Preparation* scene captures background information about the perpetrator, either personality traits, living conditions, or life circumstances. In the context of FDIA-C, it is also highly relevant if the victim has experienced other hospitalizations for the same conditions or symptoms, and/or if there have been other child deaths in the family.

The *Hospital Admission* scene corresponds to the *Entry/Pre-Condition* scene. This marks the point where the child's symptoms are considered serious enough to be hospitalized by an outpatient healthcare professional. This is where the perpetrator and the victim enter the hospital setting.

Once in the setting, the scene transitions into the *Worsening of symptoms* scene corresponding with *Doing* scene, where further abuse is carried out. Thus, in the FDIA-C script, scenes 4-6 and the *Doing* scene in the generic crime script presented in Figure 1 have been combined to better reflect the nature of the FDIA-C in the hospital where the abuse is often hidden and where isolating the child becomes a necessary condition for the abuse to take place (Cornish, 1994).

The *Post-condition* scene represents the outcome immediately following the abuse. There are basically two options: 1) The FDIA-C can remain undiscovered (deception continues) or 2) the deception has been revealed or is suspected, and the child is separated from the perpetrator. In Cornish (1994) terminology, the latter corresponds to a so-called *script failure*, which would not normally be included in a script scene, because it is developed from the perspective of the perpetrator and presumes that they succeed in advancing from one scene to the next. However, the unique characteristic of FDIA-C, is where detection can occur at multiple stages, and suggests the importance of including two options before the Exit scene.

The Exit scene which is consistent with Cornish (1994) exit scene. However, as described above two options exist: the perpetrator may exit with the child (because the crime has not been discovered) or they may withdraw without the child, if the crime has been discovered.

The Aftermath scene describes the post-hospital outcome, which may involve the perpetrator returning home undetected, being suspected but escaping accountability due to insufficient evidence, the child being separated with custody removal but without legal consequences for the perpetrator, or separation followed by formal legal liability.

3.5 Coding Procedure

To operationalize the CSA, it was necessary to assess the full text of the 40 articles (representing the 45 FDIA-C cases) selected for inclusion in the study and to identify the data elements needed to carry out the systematic analysis. The analysis enabled detection of important patterns across the cases for each of the script's scenes, so that possible intervention points might be identified. As the only coder, I acknowledge the risk of coder bias and limited inter-rater reliability, which must be considered when interpreting the results.

To code the material systematically, each case report was read in full, and all descriptions of actions, behaviours, and events were extracted, and assigned to the correct scene, using the scenes of the crime script as building blocks. Relevant information was then entered into a coding template (see Appendix A1) structured around the scenes and allowed for interpretation and comparison across cases, with a case number and the author of the case report. Each event or behaviour was assigned to the scene that reflected its function in the progression of the case. As new behavioural patterns emerged inductively during the reading process, the template was adjusted accordingly, and earlier cases were revisited to ensure consistency in coding. Once all 45 cases had been coded, the dataset was analysed to identify recurring patterns within each scene.

These behaviours were later summarized in an interpretative overview to illustrate the frequency of selected inductive behavioural and situational variables across cases, see Table 2 under Results. Each variable was coded using categorical responses (Yes, No, or N/A), which allowed for the calculation of percentages of how often a specific feature appeared across the 45 cases.

3.6 Variable Construction

The data needed for the CSA analysis was abstracted using a template that defined the different data elements required to create the variables needed to populate the script scenes. The development of the variables and the needed data elements was informed in part by the findings of prior research regarding risk factors for FDIA, including sex of the perpetrator, presence of psychiatric illnesses or disorders, extensive medical knowledge, as well as information about the victim such as prior hospitalizations, and in part by the information that would be needed to complete the different script scenes. In addition, variables were included if they were necessary for completing the different script scenes, for example the perpetrator's behaviour to exacerbate the symptoms during the hospitalization. For example, sex of the perpetrator was included because the study focuses on perpetrator characteristics, and previous research reports that FDIA-C is overwhelmingly committed by mothers/women (Abdurrachid & Gama Marques, 2022; Cording & Carter, 2021). The final set of variables included in the analysis were necessarily limited by the information available in the selected articles.

The data abstraction template coded the variables as yes (Y), no (N), or not available (N/A), with a few exceptions (age of the victim, the number and types of exacerbating symptoms during the hospitalization). In total, information was collected for the creation of 19 variables for the 45 cases. Despite the relatively large number of variables and cases, missing data turned out to be a very minor problem, with more than 75% of the cases missing data for either none or one of the 19 variables. The situation was slightly different when examining the individual variables. A few variables had a higher percentage of missing data, which increased the uncertainty of the information they provided. However, the vast majority had only a small number of missing cases. The results presented in Section 5 include information about the extent of missing data for every variable.

Appendix A1 contains the full qualitative CSA coding for all 45 cases. Each case is presented in narrative form and organised according to the FDIA-C script scenes. Appendix A2 contains the quantitative dataset used for the cross-case analysis and includes all 19 variables coded for each case (Y, N, or N/A). For the calculation of percentages, Y and N values were converted to 1 and 0, respectively. Both appendices provide the foundation for the results presented in Section 5.

4 Ethical considerations

This study utilizes secondary data from publicly available case reports. Because this study is based exclusively on anonymised and secondary data, the ethical risks associated with primary data collection do not apply. Since the data is publicly available and contains no personal or identifiable information, neither the General Data Protection Regulation (GDPR) nor the Swedish Ethical Review Act applies to this study. Hence, ethical approval is not needed.

The absence of a formal approval process does not remove the researcher's ethical responsibility in the way the study is designed and carried out. Methodological and interpretive choices still carry the risk of bias, and it therefore remains important to consider how objectivity, fairness, and accountability are maintained throughout the research process.

However, in this study, the empirically informed methodological design follows a standard crime-theoretic approach. The selection of data and cases is based on objective criteria whose relevance has been documented in the literature, and the data abstraction methods are established based on objective criteria rooted in both theory and empirical evidence. The one area of potential subjectivity that remains is the fact that I was the sole researcher and data abstracter. However, a database has been developed with a detailed qualitative summary of each case that other researchers can use to verify the coding of the variables.

5 Results

The results presented in this section are divided into two parts. The first section presents the analysis of the background characteristics that are not part of the crime script itself but are important for the overall analysis. The second part displays the results of the CSA as applied to FDIA-C in the study's 45 cases.

5.1 Analysis of Background variables

The results shown in Table 1 present the perpetrators in this sample as being almost universally the mother (all but one perpetrator was the mother), which is very consistent with what other studies have reported (Abdurrachid & Gama Marques, 2022). Furthermore, just over 1/3 of the perpetrators have a diagnosis of a psychiatric illness or disorder (aside from FDIA). In cases 3 and 9, for example, the perpetrators were undergoing psychiatric treatment and had a history of depression and anxiety. Similarly, more than half of the perpetrators (54%) were living under socially isolated conditions, in part contributed by the absence of a husband or the father of the victim (69%). Both conditions may facilitate the abuse by making it easy to hide it from others.

Table 1. Background information about the perpetrator and the victim

Characteristic		Missing data
1. Share of perpetrators who are the mother (n)	98% (44)	0%
2. Share of perpetrators with a diagnosis of psychiatric illness (N)	35% (14)	11%
3. Share of perpetrators living in social isolation (n)	54% (15)	38%
4. Share of perpetrators who are single mothers or have absent father (n)	69% (25)	20%
5. Age distribution of victims: 4 hours to ≤ 1 year: 5 children (n= 15) 13 months to 3.5 years: 16 children (n = 16) 4 years to 8 years: 10 children (n = 10) 8.7 years to 12 years: 11 children (n = 11)	Average age: 4.7 years Median age: 3.0 years	7%

Source: Author

Collectively, these findings indicate that both perpetrators and the victims in this study closely resembles those in the other FDIA studies (cf. Stirling 2007; Abdurrachid & Gama Marques, 2022), suggesting that the findings of the CSA analysis presented below may be more broadly representative of the population of FDIA-C victims than what might otherwise be expected given the source of the data and the number of cases included.

5.2 Preparation Scene

Although only three variables were available to describe the preparation scene—prior child death(s) in the family, multiple prior hospital visits, and the perpetrator's possible extensive medical knowledge, the results are enlightening. Previous child deaths were reported in seven cases, but in case 5 there had been *six* prior unexplained infant deaths in the same household, suggesting a possible history of unrecognized FDIA-C. Even so, the fact that seven households (18%) had experienced at least one prior child death is unusually high because global estimates indicate that 1 in 27 children under the age of five die (Our World in Data, 2022). In this sample it is almost 1 in 5.

While the numbers are small and the estimates are therefore surrounded by much uncertainty, the results nonetheless indicate that a prior child death in the family is a major risk factor and red flag for FDIA-C. Also surprising is that the *entire* sample reported frequent and repeated hospital visits prior to the hospitalization being studied. In an extreme case (no. 24) the perpetrator reported bringing the child to the hospital over 700 times, although this number seems absurdly high. In another case (no. 17) 48 medical consultations were documented. Again, these findings clearly point to the importance of these variables as potentially predictive of FDIA-C.

Table 2. Summary of quantitative CSA data by scene			
Scene			Missing data
I. PREPARATION			
1. Perpetrators with prior child death(s) in the family (N)	18%	(7)	11%
2. Multiple hospital visits or doctor shopping (for victim)	100%	(45)	0%
3. Perpetrator has medical knowledge	44%	(14)	29%
II. ENTRY / PRE-CONDITION – CHILD IS ADMITTED TO HOSPITAL			
4. Number of hospitalized children		45	0%
5. Symptoms witnessed only by mother	95%	(42)	2%
III. DOING - WORSENINIG OF SYMPTOMS			
6. Perpetrator appears very caring	80%	(33)	9%
7. Victim's symptoms are exacerbated during treatment	100%	(45)	0%
8. Types of symptoms persisting during treatment - Poisoning (P) - Active physical abuse (A) - Fabrication (F)	 P: 36%* A: 38%* F: 47%*	 (n=17) (n=18) (n=21)	0%
IV. POST-CONDITION – PRIOR TO DISCHARGE			
9. Perpetrator is arrested before FDIA diagnosis is made (prior to discharge)	9%	(4)	0%
10. Perpetrator deceit is discovered, and victim is removed (before discharge)	52%	(23)	2%
V. EXIT – CHILD IS DISCHARGED FROM HOSPITAL			
11. Child is discharged to home with perpetrator	23%	(10)	4%
VII AFTERMATH – CONSEQUENCES AND LEGAL ACCOUNTABILITY			
12. Perpetrator confessed	27%	(12)	2%
13. Child removed from custody of perpetrator	68%	(27)	11%
14. Perpetrator prosecuted	31%	(12)	13%
Note. Percentages do not add to 100 because some cases report more than one type of symptom			
Source: Author			

The third characteristic frequently reported is the fact that in 44% of the cases the perpetrator demonstrated medical knowledge or a high degree of comfort within the medical setting, often through previous professional experience. This familiarity with medical procedures enabled perpetrators to engage confidently with healthcare professionals and, in some cases, to influence or request specific treatments. Their credibility often came from being perceived as caring and devoted caregivers.

The three variables collectively point to a very high early-stage risk of FDIA in a person at a very early stage in the crime commission process. If mechanisms could be found to reveal these risk factors early in a hospital admission, it might be possible to alert the hospital staff early enough to prevent the exacerbation of symptoms and continued abuse during the hospitalization.

5.3 Hospital Admission Scene

In the Hospital Admission scene, the 45 cases were brought to the hospital to be admitted for symptoms that could not be verified for 95% of the cases. This finding, combined with the above-mentioned finding that all the children had been hospitalized before or in frequent contact with medical providers, again points to an established pattern of continual medical contact, strongly suggestive of undetected longer-term abuse preceding the hospitalization.

Even though there are few data to describe this scene, it is important because this is the point the perpetrator secures access to the medical system by convincing healthcare staff that the child requires admission. The Entry scene therefore marks the initiation of FDIA within a healthcare setting and represents the place where the perpetrator begins actively seeking to meet their psychological needs through medical manipulation.

5.4 Doing - Worsening Symptoms Scene

From the perpetrator's perspective this is the most rewarding part of the hospitalization, and the data clearly reveal that they all actively pursue exacerbation of the child's symptoms while presenting themselves as a concerned and caring parent. Indeed, 80% of the perpetrators were described as having appeared very caring and concerned, all the while they were actively poisoning or physically abusing their child or fabricating additional symptoms (or some combination of the above). Fabrication of symptoms was the most prevalent (47%), followed by physical abuse (38%), and poisoning (36%).

Some of the perpetrators fabricated illness by manipulating medical tests or seeking unnecessary treatments, despite normal clinical findings. In case 18, the perpetrator tampered with urine samples and deliberately injured the child's ear canal to mislead healthcare professionals. In case 11 the perpetrator gave the child a substance that, when vomited, resembled blood, leading to a false impression of internal bleeding. In case 15 the perpetrator insisted the child was ill despite negative findings and later planted blood on the child’s clothing to support their claims. These deceptive actions led to unnecessary medical interventions before laboratory results eventually ruled out genuine illness.

The physical abuse perpetrated against the victim included case 12, where the perpetrator sprayed deodorant on the child, causing cold-induced lesions, while in case 25, the mother suffocated her infant by blocking the child’s airways, deliberately provoking cyanosis. In other cases, the perpetrator administered poisonous substances or intoxicated the child. In case 19, for instance, the child’s fever did not respond to treatment, and it was later discovered that a toxic chemical had been given to provoke the symptoms.

The widespread and serious abuse of the victims while surrounded by hospital staff points to the strong psychological need for attention even when the risk of discovery is great.

5.5 Post-condition scene

In this scene the perpetrator’s abuse risks being discovered and the child removed from the perpetrator. In four cases (9%) legal authorities were contacted during the hospitalization and an arrest was made, thereby separating the victim from the perpetrator. This was done based on direct evidence such as surveillance footage as in cases 12 and 25 where the abuse was directly documented by surveillance, leading to immediate intervention, toxicology reports or direct observations as in case 4, where another patient witnessed the perpetrator abusing her child.

However, in another 22 cases (53% of the sample), the child was separated from the suspected perpetrator prior to confirmation of FDIA-C, following increasing suspicion, persistent or unexplained symptoms, or inconsistent results from medical findings. In many of these cases, the child's health improved noticeably shortly after the separation.

Given the severity of the abuse perpetrated on the victims during their hospital stay, it is not surprising that 60% of the children were separated from the perpetrator while still in the hospital.

5.6 Exit Scene

In the last stage of the crime script, 23 % of the perpetrators managed to leave the hospital with the victim, despite the significant abuse imposed on the victim. In case 3, despite confirmed fabrication of illness through synthetic insulin, the child remained with the mother. In case 8 although the child's condition improved during the perpetrator's absence, the child was discharged with the mother. In case 9, the child remained in the mother's custody due to the absence of an alternative caregiver. Lastly in case 15, the perpetrator self-discharged, with no option for the healthcare professionals to follow up or intervene.

5.7 Aftermath Scene

The aftermath of the abuse perpetrated in the hospital again their child could take different forms. In 27% of cases, the perpetrator confessed to having harmed, fabricated or induced the child's symptoms, although in one case (no. 11), it was the child who confessed that the perpetrator had fabricated the symptoms. The most frequent result of the FDIA-C was the perpetrator losing custody of the child, either to a relative or Child Protection Services. In 68% of the cases did the perpetrator lose custody of the child, typically to another family member like a grandmother as in case 36. However, legal action was on taken against the perpetrator in 31% of the cases. In case 12, the mother was sentenced to four years in prison, while in case 29 the mother was charged after toxicological evidence confirmed deliberate poison administration. It is noteworthy that only 25% of the perpetrators who confessed were prosecuted, although virtually all of them lost custody of their child.

5.8 Crime Script Failure

Based on the results a CSA makes it possible to construct 'script failures' to make interventions points for FDIA-C (see Figure 4). Figure 4 summarises how FDIA-C typically fails, and which situational controls could interrupt and prevent the abuse from happening. The table represents the intervention points based on the crime-commission process of FDIA-C.

Figure 4. Crime script failure / situational control	
Scene	Function / Component
1. Preparation	A coding system triggered by multiple or unexplained hospital admissions
2. Entry	Review admission history/ doctor shopping Require independent observation
3. Pre-conditions	Short separation where healthcare professionals observe the child independently to verify reported symptoms Controlled visitor/access policies and strict medication access and logging Surveillance
4. Doing	Increased observation Surveillance Education for healthcare professionals on FDIA-C perpetrator behaviour
5. Post-conditions	Independent reassessment before discharge Structured follow-up plan
6. Exit	Stronger multidisciplinary communication between hospitals to prevent “starting over” in a new setting.
7. Aftermath	Improved legal accountability The criminal aspect of FDIA-C should carry as much weight as the medical/disorder aspect of FDIA.

6 Discussion

6.1 Opportunities for Early Detection

Although FDIA is classified as a psychiatric disorder, it entails the perpetration of serious child abuse potentially leading to death. The purpose of this study was to examine FDIA-C as a criminal process, to identify behavioural patterns across cases using a CSA - and to explore what insights could be gained from applying a criminological method to FDIA-C. Overall, the CSA demonstrated that the 45 cases followed similar behavioural patterns, revealing a consistent, almost standardized script of offending that can be mapped as a sequence of perpetrator decisions. By emphasizing that FDIA is a form of criminal behaviour, this study sought to increase recognition of the criminal nature of FDIA. For this reason, the term FDIA crime (hereinafter FDIA-C) was used in the hope that future studies will also seek to incorporate the criminal aspects of FDIA. By using a criminological approach like a CSA, this study challenges the existing literature, which predominantly considers FDIA within a medical or psychiatric context, often neglecting the procedural and criminal aspects of the abuse (Yates & Bass, 2017).

Breaking FDIA-C into six sequential scenes allowed for prevention and intervention which aligns with broader CSA research arguing that scripts make hidden perpetrator decision-making processes visible (Leclerc et al., 2011; Dehghanniri & Borrion, 2021). The similarity of crime commission across cases further suggests that FDIA-C perpetrators act intentionally and strategically rather than impulsively, reinforcing criminological perspectives centred on rational, goal-directed offending (Cornish & Clarke, 1986; Wortley & Mazerolle, 2008).

The Preparation scene showed that multiple previous hospitalizations and prior child deaths are strongly consistent with well-known warning signs in the FDIA literature (Hornor, 2021). In many countries, healthcare professionals can only access information on prior hospitalizations within the same hospital or network as broader medical record systems may not be well established. This difficulty in linking patient histories across institutions, as Feldman (2014) argues, creates fragmented medical information that allows FDIA-C abuse to remain undetected. This is further worsened by the fact that healthcare professionals may not receive information about prior child deaths during an admission, even though that is a key risk indicator for FDIA-C. Countries with national identification systems like Denmark can more easily confirm this information, whereas in countries without such systems, detection becomes much harder.

In the Entry scene, 93.3% of symptoms were only witnessed by the perpetrator, which supports earlier findings that caregiver-reported symptoms without objective verification represent a critical diagnostic red flag (Cording & Carter, 2021). Social isolation among perpetrators was also common in 54% of the cases. Bass and Adshead (2007) note that isolation can be part of the environment in affected families, which may increase opportunities for abuse by reducing external oversight. The absence of a partner meant that many perpetrators spent nearly all their time alone with the child, creating an unhealthy dependency and continual access to commit abuse that further delayed detection (Bass & Adshead, 2007).

The Doing scene further demonstrated the severity and deliberateness of the abuse: all victims experienced poisoning, fabricated symptoms, or physical harm. This escalation is consistent with Hornor (2021), who notes that FDIA typically involves active induction once initial medical attention is secured. Despite a high risk of detection during hospitalization, perpetrators harmed their children to maintain hospitalization to receive attention and validation. This reflects strategic awareness and calculated decision-making, suggesting that emotional rewards outweighed the risk of being caught (Wortley & Mazerolle, 2008).

That only 24.4% of perpetrators had a psychiatric diagnosis challenges earlier literature that FDIA is primarily driven by mental illness and instead supports the view that it constitutes deliberate and organised abuse (Feldman, 2014; Yates & Bass, 2017). This aligns with Bass and Adshead's (2007) argument that fabrication or induction of symptoms is best understood as an offending behaviour towards children, and that psychiatric diagnoses alone do not explain why the abuse occurs. While certain personality disorders may occur more among FDIA-C perpetrators, it would be misleading to suggest that these personality disorders are the cause of the abusive behaviour, since most individuals with such diagnoses do not abuse their children (Bass & Adshead, 2007).

6.2 Systemic Vulnerabilities

The Post-Condition and Exit scenes highlight how systemic fragmentation facilitates continued offending. Almost a quarter of victims were discharged home with the perpetrator, demonstrating that FDIA-C may remain unrecognised even when strong clinical evidence or concerns are present.

With many previous hospital visits, it is very likely that the perpetrator had "doctor shopped" in different hospitals prior to admission, which was discovered in many cases. This aligns with Glaser's (2020) observation that perpetrators move between hospitals to avoid recognition. This finding points to differences how variation in healthcare infrastructure across countries affects detection: the absence of coordinated systems indirectly allows such abuse to persist and go undetected. Similarly, Isaac et al. (2016) found that inconsistent staff assignment prolongs the time to detection. In hospital settings, continuous oversight by the same healthcare professional is not possible due to shift changes and staff rotation. The disruption of continuity between patient and staff significantly delays the recognition of FDIA-C in practice (Isaac et al., 2016)

The Aftermath scene showed that although 68% of perpetrators lost custody, only 31% were prosecuted which is higher than the 14% reported by Abdurrachid & Gama Marques (2022), but it still confirms that legal consequences are rare in FDIA-C cases. These results support Riviello and Rozzi's (2024) argument that FDIA-C cases typically go through child-protection systems rather than criminal courts. The finding that 27% of perpetrators confessed, but only 31% of the entire sample were prosecuted, further illustrates the classification challenges that make FDIA-C difficult to recognize and treat as intentional abuse.

6.3 Methodological reflections

Although CSA offered a structured way to map the sequences of the FDIA-C, the method has limitations as it risks simplifying complex actions into linear or fixed stages. This is because the CSA framework can only reflect the stages that can be observed in the available and provided material, meaning from a medical or physiological perspective. Because etiological case-reports only document what happens within the healthcare setting, parts of the preparatory phase, such as what happens at home before hospitalization, remain absent from the script due to data limitations. Previous CSA research emphasizes that scripts can only be as detailed as the material on which they are built, and missing information can give a false sense of completeness (Borrion, 2013). This means that a CSA can overlook both behavioural variability and the deliberate, strategic planning of perpetrators (Beauregard et al., 2007). Thus, this study acknowledges that the FDIA-C script is a partially reconstructed model rather than a complete representation of perpetrator decision-making.

These patterns emphasize a significant gap between medical recognition and legal accountability. Despite clear evidence of deliberate harm in many cases, FDIA-C is still rarely prosecuted, revealing systemic weaknesses in how it is viewed and managed. This is further exacerbated with weak communication between healthcare systems, Child Protection Services, and legal authorities.

As long as FDIA continues to be primarily framed as a psychiatric disorder, responsibility for intervention will mainly fall on Child Protective Services, which do not have authority to prosecute the perpetrators. Legal authorities may not be involved because the behaviour is not recognized as intentional abuse (Lundin, 2001). The findings of this study emphasize the need for stronger classification procedures, standardized ways of reporting abuse, and better collaboration and coordination between institutions. This should be done to ensure that FDIA-C is recognized as intentional abuse rather than an issue of psychiatric concern. Improved communication between hospitals, child-protection agencies, and prosecutors is therefore essential to bridge the gap between clinical detection and legal response. By reframing FDIA as an intentional and organized form of maltreatment, this study expands criminological understanding of child abuse and demonstrates the value of CSA in a context which traditionally is dominated by a medical and clinical perspective.

7 Strength and Limitations

7.1 Strengths

To the best of current knowledge, this is the first study to apply a CSA to cases of FDIA and is the first to systematically map the crime-commission process of FDIA-C. This study introduces a way to apply a structured criminological approach to a field typically examined through a psychological and clinical lens. It demonstrates that the crime script approach can be adapted to child abuse driven by psychological rewards.

A particular strength of the study is the relatively large number of cases included in the analysis and the extensive amount of detailed information that could be used to populate the different scenes in the crime script scheme developed for FDIA-C. Furthermore, the consistency of many of the findings, particularly, the risk factors with those found in the literature suggests that the sample is more representative than what one might otherwise expect from this type of a study. In addition, the study was able to use CSA to identify several ways in which efforts could be made to improve early detection and the limitation of continued abuse in the case of hospitalizations.

7.2 Limitations

These strengths notwithstanding, there are some limitations that should be acknowledged. Descriptions of events, motivations, and interactions are subject to the authors of the case reports' interpretations, norms, and diagnostic framing. This creates a potential bias, as the narrative reflects the medical professionals' understanding of what occurred rather than the perspectives of the perpetrator, victim, or other parties involved.

A known limitation of the crime script approach is that it is inherently interpretive, and the abstraction of the perpetrator behaviour put into sequential scenes relies on the researcher's judgement about what constitutes a relevant action (Chainey & Berbotto, 2022). Because case reports are already a filtered and summarized version of reality, the script is based on second-hand reconstruction rather than raw behavioural data, which other researchers therefore cannot access directly. It is also important to acknowledge that the findings are shaped by the limitations of case-report data and the CSA method, which may not capture all procedural details of FDIA-C.

A related, but different challenge concerns the issue of data abstraction from the case reports that inform this study. Since the coding was carried out by a single coder, there is no way to test the reliability of the coding done. However, Table A2 in the Annex, which contains qualitative summaries of each study, provides a measure of information against which to compare the abstracted data.

8 Conclusion

This study set out to apply a criminological approach to highlight the criminal nature of the FDIA-C and to explore what insights could be gained from applying a CSA to FDIA crimes. The study not only showed that it is feasible to apply a CSA to FDIA crimes, but by doing so has revealed numerous insights and potentially useful interventions that can help improve early detection and limit continued abuse by perpetrators of their children. This includes a variety of initiatives across the different script scenes, ranging improved surveillance, to greater sensibilization of healthcare providers, to better coordination among the key actors in this field (medical, social, and legal spheres).

The study is also among the first to analyse the consequences, or lack thereof, for perpetrators of FDIA-C. The very limited legal accountability of FDIA-C perpetrators, even when they have confessed, suggests a need for greater emphasis on the criminal nature of FDIA. For this reason, the study introduced the term FDIA crime, in the hope that this will be a first step toward greater recognition of FDIA as more than a psychiatric disorder. While this study has generated both interesting and useful information, much remains to be done. Hopefully, this study can serve as a foundation for future efforts to reduce the burden of FDIA-C.

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Appendix A1.

Crime Script Analysis of 45 Factitious Disorder Imposed on Another Cases

PROTOSCRIPT: CHILD MALTREATMENT

SCRIPT: FDIA

TRACK: FDIA IN A HOSPITAL SETTING

Note: Scene categories are adapted from Cornish' (1994) framework Crime Script Analysis.

Author	Pre-offense Scene (Preparation)	Hospital Admission (Entry to setting)	Worsening of Symptoms Scene (Instrumental actualization, Doing)	Post-condition/ Script Failure	Exit	Aftermath
1 Alkhattabi et al., 2023.	Child had been hospitalized multiple times before FDIA was suspected. Mother was recently divorced and socially isolated.	An 18-month-old child was brought to the hospital with seizures and low blood sugar.	All symptoms were only witnessed when the mother was present. Mother insisted on unnecessary surgery despite no medical indication. Staff observed the child was unusually calm with needles; needle marks and swelling were visible on the body.	Symptoms ceased entirely after separation from the mother. After confrontation by social services, the mother confessed to administering insulin injections for more than six months. She later explained her motive was to gain the attention of her ex-husband.	Child was discharged with her grandmother. Custody was officially transferred under the supervision of Social Protection Services, with the father's agreement.	No arrest or legal prosecution was reported.

2 Alkhattabi et al., 2023.	The child had prior a long hospitalization history of 9 months. Mother had a psychiatric history, low socioeconomic status and was socially isolated. Mother was one of many wives. Two other daughters had died under unknown circumstances.	A 15-month-old child was brought to the hospital with severe bleeding mouth ulcers and feeding/breathing difficulties.	Medical evaluation concluded ulcers were likely made intentionally. Bleeding episodes reoccurred when discharge was mentioned.	The child was separated from the mother, in rotating rooms with a sitter. Bleeding stopped within three weeks.	Mother was briefly hospitalized for psychiatric care but discontinued treatment. Custody was removed and transferred to father/aunt under Social Protection Service supervision.	No arrest or legal prosecution was reported.
3 Arabi, et al., 2022.	Child had prior to investigation repeated medical contact with 29 ER visits and 23 admissions. Mother was on psychiatric medication and had a history of depression and past	A 2-year-old was hospitalized repeatedly from 6 months of age for unexplained seizures and low blood sugar.	Despite treatment, symptoms persisted. The mother positioned herself as a concerned caregiver. All symptoms were only witnessed by the mother. Healthcare staff came suspicious when the child	The child was separated from the mother. No seizures occurred in mother's absence.	Despite confirmed fabrication of abuse, the child remained with the mother under monitoring by SCAN team, home health care, and family therapist.	No arrest or legal prosecution was reported.

	domestic violence from the father. Two older siblings had similar unexplained symptoms.		improved during mothers' absence. Lab results confirmed the presence of synthetic insulin, supporting deliberate induction of hypoglycaemia.			
4 Asan, et al., 2025 Case 1	Prior to investigation the perpetrator brought the child three times to the hospital before she turned 7 months.	A 7-month-old girl was brought to the hospital by her mother, four months after her last admission due to swelling in her arms and legs. The child had been admitted before with urinary tract infection, bruising, blood in stool, Nosebleeds, umbilical bleeding, cranial bleeding. In addition, while being hospitalized, the perpetrator left the bed rail open, and the child feel down.	Another admitted patient witnessed the perpetrator remove the child's diaper and proceed to pinch and squeeze the child's swollen arms and legs, likely aggravating existing injuries and contributing to inflammation or tissue damage.	The mother was removed from the child. No diagnostic separation was conducted. Within two weeks all symptoms disappeared. The mother confess- ed and admitted responsibility. The mother confessed during interviews that she had pricked the inside of her daughter's mouth with a syringe needle and made incisions with a razor blade on various parts of child's body. A comprehensive psychiatric evaluation concluded that the mother was mentally stable, fully aware of her actions, and	The child placed under protective custody with father/family.	The mother was charged with attempted homicide of a child.

				not suffering from a mental illness that impaired judgment or self-control.		
5 Asan, et al., 2025 Case 2	In a span of eight years six previous children died from unexplained illness. The mother left school in third grade and was married at age 14. The mother reported long-term emotional and physical abuse by her husband. Her mother-in-law was a diabetic living with the mother and her husband and child.	The mother's last and seventh child was brought to the hospital due to being unusually sleepy and unresponsive. Blood tests showed the child had low blood sugar.	The child's condition worsened under medical care due to the mother's interference. Severe symptoms continued even during treatment, nearly leading to unnecessary surgery.	During surgical preparation, the child was separated from her mother. The child's health rapidly improved and blood sugar levels stabilized.	Child removed from family and placed in protective state custody. The mother later confessed to administering insulin to the child, which she had taken from her mother-in-law, as well as to her other children, contributing to their deaths.	Mother was charged with six counts of murder and one count of attempted murder. She was found fully criminally responsible.

6 Asan, et al., 2025 Case 3	The mother's three children had repeated hospital admissions for cyanosis (blue skin due to lack of oxygen), respiratory distress, and sudden unresponsiveness. Two of her children had already died from similar unexplained episodes. The mother herself had a history of childhood neglect and physical abuse, was socially isolated, and estranged from her family after marrying without their approval. She received brief psychiatric treat-ment during her first pregnancy.	The third child, a 1-year-old girl was brought to the hospital by her mother reporting that she also had cyanosis. Despite extensive testing, no organic cause was found during a month-long admission.	While under her mother's care in the hospital, the child suddenly turned blue and became unresponsive. She suffered a 15-minute cardiac arrest, resulting in severe hypoxic brain damage and permanent disability. Two years later, she died in the care facility due to complications from the incident.	Given the deaths of her previous two children and the sudden worsening of the third while in maternal care, hospital staff grew suspicious.	Authorities were notified, and the child was removed from the mother's custody and placed in institutional care. While the third child remained in care, the mother gave birth again. Due to the ongoing investigation, the fourth child was immediately placed under protective custody.	The mother was charged and found fully criminally responsible.

7 Bensaghir, et al., 2025.	Since the child was three months old, the mother had repeatedly claimed that the child suffered from various illnesses and conditions, yet she was unable to provide any medical documentation to support these claims.	A 3,5-year-old child was brought to the hospital for a wound on his left leg.	Multiple new wounds appeared during at night when only the mother was present. The mother gave misleading explanations, delaying accurate diagnosis. The mother framed herself as engaged.	No new wounds appeared once the mother was separated from the child. The mother confessed during psychological interviews that she had been intentionally inflicted the wounds on the child.	Child was placed under CPS.	No arrest or legal prosecution was reported.
8 Bertrand, et al., 2022.	The mother exclusively spoon-fed the child and intentionally limited feeding interactions to herself, excluding others. Mother had a history of anorexia and had anxiety and controlling behaviors. Medical records showed that the child had previously been evaluated for	An 8-year-old child was brought to the ER with joint paint in a wheelchair, reportedly unable to walk, with weight loss and bruises. He was undernourished and weighed 16 kg. The child complained of joint pains, which disappeared when distracted. Healthcare professionals sensed that she liked the	All symptoms were only witnessed by the mother. Healthcare staff grew suspicious when the child improved during the mother's absence. The mother manipulated the child's eating behavior and fed him outside hospital supervision. The mother consistently presented herself as a highly involved and concerned. She coached the child on	The mother's resistance to intervention raised suspicion of FDIA. However, no immediate protective actions were taken at this stage.	After two months of hospitalization, the child was discharged home. He was placed in psychiatric day care with his mother twice a week under close monitoring. Foster care placement was considered if compliance failed.	No arrest or legal prosecution was reported.

	seizures and hypoglycemia, with extensive but inconclusive investigations.	attention of her son being chronically ill.	how to answer clinicians' questions. When the hospital denied discharge in a wheelchair, the child began walking again.			
9 Faedda, et al., 2018. Case 1	Prior to investigation the mother took the child 9 times to the hospital since the child was 15 months. The mother had anxiety and was treated with psychiatric treatment. She had limited social support and was isolated after the father abandoned the family when the child was three. Described as manipulative and emotional detached,	A 9-year-old child was brought to the hospital with symptoms such as seizures, sleep issues, developmental delays.	All symptoms were only witnessed the by mother. The mother showed over-concern and was very caring for the child. When her narrative was challenged, she became defensive and hostile. The mother insisted on medical investigations and surgeries (including brain surgery and circumcision). All tests (EEG, MRI) came back normal. Teachers confirmed the child was socially and cognitively well. The mother reported speech	A child psychiatrist noticed contradictions between the mother's reports and medical observations. No diagnostic separation was conducted.	The mother was referred to psychiatric evaluation. The child remained with his mother because she was the child's only caregiver after the father's abandonment.	No arrest or legal prosecution was reported.

	she also had good medical knowledge.		delays and neurological problems that were never observed by school or during medical evaluations. A cracked tooth, blamed on the school, was later admitted by the child to have happened at home.			
10 Faedda, et al., 2018. Case 2	Prior to investigation the child had undergone repeated hospitalizations over four years, with 18 admissions across six different hospitals. The mother was isolated with little social life, spending most of her time with her daughter and mother-in-law. During the periods of the child hospitalizations, the mother was prioritizing the	A 12-year-old girl was brought to the hospital from Adolescent Psychiatry. Mother reported multiple symptoms like migraines, fainting, stomach pain, and leg weakness. .	Despite extensive testing (EEG, MRI, CT, EMG), no cause was found. Despite showing a caring attitude, the mother was emotionally detached from her daughter and showed limited empathy. Symptoms persisted despite treatment. The child stopped walking and began using a wheelchair, despite normal findings. Over time, the child began to internalize the role of being sick, shaped by long	The child was removed from her family for six months during a psychiatric hospitalization. During the separation, doctors observed how her symptoms changed, and her behavior improved.	The child remained with the mother. The mother had parent training interventions sessions.	No arrest or legal prosecution was reported.

	opportunity of networking with other people. She appeared passive and lacking in self-confidence.		hospitalizations and her mother's behavior.			
11 Gehlawat, et al., 2015.	The father and paternal uncle were primary caregivers. Both unemployed and insisted on repeat-ed medical tests. He had been hospitalized multiple times over three years, always accompanied by his father and uncle. Family conflict and financial stress occurred in their home.	A 9-year-old boy was brought to the hospital with reported seizures and vomiting blood. The child went through unnecessary invasive procedures.	Vomiting blood was fabricated, saliva mixed with Betadine. Lab tests confirmed no real blood. Both father and uncle was over-involved and concerned about the boy.	Upon suspicion, the child was separated from the father and uncle and placed with the mother. After one week, no symptoms were observed. The boy disclosed his father, and uncle, who gave him a substance before the supposed episodes of vomiting blood. Father and uncle denied accusations.	Child was placed in the mother's custody under the supervision of Social Protective Services.	No arrest or legal prosecution was reported.
12 Guez, et al.,	The child had a long history of	A 17-month-old girl was brought to the	Lesions were limited to the body (not face, hands, or	No diagnostic separation was performed; confirmation	Following confirmation of abuse, the mother	The mother was sentenced to four

2024.	hospitalizations. The mother was socially isolated.	hospital with skin lesions repeatedly appearing and healing since 2 months of age. The mother appeared concerned and engaged in the child's condition, though her emotional responses were detached with the severity of the child's condition.	feet), and the child was otherwise healthy. Skin tests revealed high aluminum levels, consistent with a deodorant spray found with the mother. Hidden camera footage confirmed external injury, mother was seen spraying deodorant directly onto the child's skin.	came through toxicology and video surveillance.	was arrested, and custody of the child was removed.	years in prison for child abuse.
13 Gupta, et al., 2022.	The mother experienced emotional distress following a miscarriage, the death of a son and grief over not having a surviving male child. She falsified her own medical records, claiming a diabetes diagnosis during pregnancy that was later disproven.	A 4-year-old girl was brought to the hospital with symptoms of excessive urination, thirst and weight loss suggesting diabetes.	Home and private lab tests reported high blood sugar levels. However, hospital tests showed normal results. Altered documents raised suspicion	No diagnostic separation from the caregiver was conducted. The diagnosis was obtained through hospital observation and comparison of test results.	The child's symptoms resolved during hospital observation, and no diabetes was confirmed. After psychological evaluation of the mother, the child was discharged home under counseling and follow-up.	No arrest or legal prosecution was reported.

14 Houas, et al., 2019.	The mother had taken both of her 2-month-old twins at the time, to the hospital many times for various symptoms. She left school at the age of 15 and was forced by her parents to marry a 45-year-old man. She seemed to have a great interest in medicine.	A mother brought her 2-month-old son to the hospital with trouble breathing, low blood pressure and blue nails.	Scans revealed multiple needles in his heart, lungs, and diaphragm. A week later, his twin brother was brought in. An X-ray revealed that he also had a needle inserted, but in his liver. She insisted on giving her children treatment herself, showing over-involvement.	Due to suspicion of FDIA and the mother being the only caregiver, CPS were contacted. She denied responsibility and accused medical staff. Both children were kept in the hospital while a custody decision was pending. During this period, their health remained stable.	The second twin died suddenly in the hospital; since all visits were super-vised, the death was classified as SIDS. Custody of the surviving twin was awarded to the grandparents.	Criminal charges were filed against the mother.

15 Kairys, et al., 2024.	The child had been hospitalised several times over four months, each time. As a teenager, the mother spent a long time in hospital, possibly associating illness with attention. She claimed a medical background, later revealed to be only three years of medical school. She was active on social media, where she received attention and financial support. She developed close relationships with healthcare staff. Frequent changes of home address made tracking medical	A 3-year-old boy was brought for fever and symptoms, including joint pain, coughing up blood, and blood in urine.	All symptoms were only witnessed by mother. Healthcare staff described the mother as a "heroine mother,' always there for her child, so attentive and kind all the time". Blood values remained normal, contradicting the mother's claims. Fresh blood was suspected to have been placed on the boy's clothing. She avoided sending consent forms for genetic testing, raising further suspicion. The mother presented photographic "evidence," which was never verified by medical staff.	Doctors began to suspect FDIA and stopped engaging with the mother. Once staff distanced themselves, symptoms disappeared, and previously symptoms and diseases resolved within five days. The mother returned hours after discharge claiming internal bleeding, which tests disproved. CPS was contacted.	The mother and the child withdrew from the hospital and stopped seeking treatment.	No arrest or legal prosecution was reported.

records difficult.

16 Kelley & Curran, 2019.	For eight years, the child had multiple hospitalizations and diagnostic procedures for unexplained bleeding, with no cause identified. She was adopted at six months of age. The mother, a former hospital clinic manager, had medical knowledge and access to health systems.	A 12-year-old child was brought to the hospital with a history of recurrent episodes of heavy menstrual bleeding and developmental delay due to fetal alcohol syndrome.	All symptoms were only witnessed by mother. The mother showed over-involvement and presented herself as a responsible parent. Despite treatment, symptoms persisted. The mother exaggerated and fabricated bleeding episodes, claiming saturation of pads every 20 minutes and bleeding from eyes, navel, and palms, none of which were observed clinically. On direct examination, the physical findings were inconsistent with the reported severity.	Suspicion of FDIA led to protective separation from the mother. After separation, all symptoms ceased. It was later revealed that the mother had coerced the child into providing a false history.	The child was placed in foster care. Further investigation showed the mother continued attempts to harm the child even after placement.	Parental rights were subject to termination proceedings by the state, after which the family voluntarily surrendered custody .
17 Khalil, et al., 2022.	The mother was socially isolated and lived in poor conditions with limited support.	An infant was brought to the hospital with episodes of seizures and a 3-week history of worsening of his left	All symptoms were only witnessed by mother. The mother appeared involved and emotionally	The child was immediately put under custody of CPS. After separation, his symptoms	The child was left permanently blind. Grandmother was granted custody.	A no-contact order was placed against the m was referred for psychiatric treatment.

	The child had been treated over 14 months by multiple specialists for on-going eye infections and seizure-like episodes, based entirely on the mother's reports. One of the boy's eyes had already been surgically removed months earlier due to same unexplained symptoms.	eye with swelling and discharge.	invested, even offering to donate one of her eyes to save her son's vision. Despite treatment, symptoms persisted. Due to the lack of improvement, suspicion of FDIA was raised. Continuous EEG and CCTV monitoring was arranged. Surveillance revealed the mother blocking the camera a few seconds before the child experienced a seizure-like episode.	stopped. The mother confessed to suffocating the child and repeatedly injuring his eyes.		No arrest or legal prosecution was reported.
18 Kuhne, et al., 2019.	The child had been hospitalized multiple times, since the child was five months old. The mother had previously lost a 7-year-old daughter, allegedly to cSLE and claimed her husband had the same illness.	A 9-year-old boy was brought in with symptoms including facial rash, sensitivity to sunlight, hair loss, pain in the left knee, high blood pressure, visible blood in urine, seizures, delays in development, and a positive test for autoimmune disease.	Symptoms reported by the mother lacked clinical evidence. Twice, doctors found toxic levels of medication in the child's body, suggesting he had been poisoned. Signs of induced harm included ear canal injuries	The child was separated from the mother. All symptoms resolved within a week. The mother confessed to giving anti-seizure medicine to the child.	The mother was referred for psychiatric care but never followed up. Custody was given to the child's father.	No arrest or legal prosecution was reported.

			and fabricated urine infections (samples contaminated with multiple bacteria, but no actual infection in the body).			
19 Mwaba, et al., 2022.	Over 4 years, the child was admitted 11 times, mostly for seizures. The mother was the only caregiver and consistently present at all hospital visits. At one incident, the mother said a seizure had lasted for 10 hours before they went to the hospital. The child was the fourth of five children, with a history of three unexplained infant deaths.	A 7-year-old girl was admitted with seizures reportedly unresponsive to medication. The mother also described extreme tiredness, abdominal pain, vomiting, and swelling of one leg. She had been discharged from hospital only three weeks earlier.	All symptoms were only witnessed and reported by the mother. The mother was constant at bedside with the child and even wanted to leave her newborn baby to be with her. Healthcare staff came suspicious when the child improved during mothers' absence. Lab tests revealed a high concentration of pesticide in the girl's body. Given the toxic nature of the chemical, deliberate poisoning was suspected.	The child was separated from the mother. All symptoms resolved, and she had no further seizures.	The child recovered physically, though she was left with cognitive impairment requiring special education. She was initially placed in a home for girls and later reunited with her father and extended family.	The mother was prosecuted for the abuse.

20 Noqueria-de-Alemeida, et al., 2017.	The mother attended 48 consultations with her son. She was a single mother; her husband had left during pregnancy. A psychologist reported that she used the child's illness to gain attention and benefits. The child's teacher noted anxiety during meals, explained by the boy as pressure from his mother to eat large amounts. The mother, a nursing assistant, was fluent in medical terminology and often challenged healthcare staff.	A 4.5-year-old boy was admitted for severe obesity, weighing 42 kg.	All symptoms were only witnessed by the mother. The mother was caring and concerned. The mother demanded extensive testing and reacted aggressively when questioned. The mother was persistent in medical seeking for her son, even though she denied treatment. Lab tests and investigations consistently returned normal, indicating no underlying organic disease. The mother reported highly unlikely dietary behavior: saying the child ate very little despite severe obesity	Separation was considered but deemed unfeasible due to the chronic nature of obesity and the lack of an alternative caregiver. Psychological support was proposed to the mother, but she rejected it.	The mother and child withdrew from medical follow-up. No further contact was possible.	No arrest or legal prosecution was reported.

21 Oppan & Otupri, 2024.	The child lived with a caregiver, as the biological parent worked away from home and was not present during hospital care. The caregiver presented with concern over multiple unexplained symptoms and consistently wanted medical attention.	A 2-year-old girl was brought to the hospital with ongoing fever, swollen liver and spleen, back pain and kidney inflammation.	Despite treatment, the symptoms persisted.	Caregiver admitted to giving the child Pyrogenal, a drug that provokes fever, by mixing it in food.	The case was referred to CPS.	No arrest or legal prosecution was reported.
22 Sirka et al., 2018.	The child had been repeatedly hospitalized since she was six months old.	A 15-month-old girl was brought to the hospital with history of recurrent blisters and ulcers over the body.	All symptoms were only witnessed by the mother. The father reported smelling oils (coconut oil) on the child's scalp and noticed that new injuries appeared only when the child was alone with the mother. It was discovered that the mother was intentionally burning the child with hot oils.	The child was hospitalized and separated from the mother for 20 days. During separation, no new blisters or injuries appeared, confirming that the mother had been burning the child with oils.	The father agreed to move the child to his brother's home.	No arrest or legal prosecution was reported.

23 Swonke, et al., 2019.	Prior to investigation, the mother went to the hospital multiple times. She consistently reported unusual nasal injuries without clear explanation.	A mother brought her 8-month-old son to the hospital reporting that he had hit his nose while crawling which resulting in picking, causing irritation.	Despite surgery and ongoing treatment, the boy's nasal destruction worsened over two years. Extensive biopsies, imaging, and specialist referrals showed no medical cause. Lesions often worsened around clinical visits. Later, the younger half-brother developed the same rare destructive sores, further indicating FDIA	The child was separated from the mother. Although FDIA was suspected, CPS initially found no evidence of deception.	Both children were removed from their home and placed in foster care. They improved after separation, though they were left with permanent nasal deformities requiring future reconstruction.	No arrest or legal prosecution was reported.
24 Takher & Cosme, 2023.	The mother had a long history of bringing her daughter to the hospital with over 700 documented visits. The mother was previously investigated and suspected for FDIA four times by CPS.	A 12-year-old girl was brought to the hos-pital by her mother with symptoms such as vomiting, head-aches, stomach pain and refused to eat for two days. The child showed symptoms of catatonia a condition where a person stops moving or	The child developed symptoms of catatonia, a condition characterized by mutism, rigidity, and immobility. The mother showed patterns of over-involvement and fabricated or exaggerated the child's medical symptoms. She also withheld proper care, worsening the child's condition by	The child was separated from the mother. Once separated, the child's physical and emotional state improved significantly. Suspicion of FDIA was supported by her rapid improvement when properly treated	Her mother lost custody. The girl was put in protective custody.	No arrest or legal prosecution was reported.

		speaking.	omission.			
25 Unal et al., 2017.	The mother married without her family's permission and moved to another city with her husband's family. She had three children - the first, a 30-month-old girl with a hip deformity, later died. The second, a 6-month-old girl, was hospitalized for two months with unexplained symptoms including fever and cyanosis. After being discharged without a diagnosis, the mother suffocated her, leading to death.	The mother's third child, a 3-month-old infant, was admitted to the hospital with medical issues since birth. She had already been hospitalized for 15 days and was readmitted for recurrent episodes of turning blue.	While hospitalized, the mother was caught on surveillance camera suffocating the infant by closing her nose and mouth.	The abuse was directly documented by hospital surveillance, leading to immediate intervention. The infant was protected within the hospital setting.	The mother was arrested and confessed to suffocating her first-born on two occasions, leading to her death, and admitted to suffocating the second child who also died. Psychiatric testing revealed no active psychopathology; she was found criminally responsible.	The mother was prosecuted for attempted murder of the third child and held accountable for the deaths of her first two children.

26 Walters, et al., 2019.	Over six years, the mother repeatedly brought her son to numerous specialists across different fields. Most examinations and tests came back normal. The family had recently relocated. The mother used advanced medical terminology, presented misleading medical histories, and falsely claimed her son had leukemia.	A 2-year-old boy was brought to the hospital for unexplained fevers. The child was prescribed various medications, including stimulants, morphine, and psychiatric drugs.	The mother repeatedly exaggerated symptoms and falsely claimed serious diagnoses such as leukemia. The mother was frequently verbally aggressive with staff and insisted on escalating investigations despite normal results. The child's development was affected by constant medical visits and treatments.	Although child protective services were contacted twice, no separation occurred, and the boy remained with his mother. The mother was arrested and incarcerated for trafficking prescription medications, many of which she had obtained through her son's medical treatment.	No custody outcome for the child was specified.	The mother was imprisoned for drug trafficking, but there was no legal case pursued for FDIA.
27 Wittkowski, et al., 2017.	Prior to investigation the mother brought the child to the hospital up to 12 times a month.	A 3-year-old boy had been brought to the hospital regularly since the age of five months for symptoms including bloody urine, diarrhea, nosebleeds, and high fevers every two weeks lasting one to three	Skin wounds appeared at spots where the child received injections or vaccines. The symptoms became more severe during or after medical treatments.	The child was immediately separated from the mother and admitted to the hospital with his father. Within two weeks, all symptoms disappeared. The mother provided a written confession admitting	No resolution is disclosed in the article.	No long-term custody outcome.

		days. Over time, he developed painful skin ulcers, facial swelling, an unevenly dilated pupil, and blisters on his hands and feet.	The mother consistently reported new issues and was always by the child's side during hospital visits.	she had caused many of the child's symptoms. Her actions included: falsely reporting symptoms such as fever or denied medications, tampered with test samples, such as adding blood to urine or using a thermometer to fake a fever, or directly causing symptoms by irritating the skin with applying substances like saliva or stool to create infections.		
28 Ashraf & Thevasagayam, 2014.	Prior to investigation, the mother repeatedly brought her son to the hospital over an eight-year period, beginning when he was five years old.	A 5-year-old boy was brought to the ENT clinic by his mother after she had raised concerns about the boys hearing. The boy was also being assessed for possible ADHD.	Over several years, the mother insisted on ongoing hearing problems despite repeated normal examinations and audiograms. The mother coached her son to perform poorly on hearing tests, reinforcing the idea of disability.	Suspicion increased when the child's hearing remained normal despite the mother's claims. After custody shifted to the father, it became clear that the boy had been coached to fail hearing tests. Without the mother's influence, his results normalized.	The child was removed from the mother's care and placed with his father.	No arrest or legal prosecution was reported.

29 Basilicata, et al., 2025. Case 1	Prior to investigation, the mother repeatedly brought her son to the hospital, with at least two emergency room visits and one full admission within six months. The mother owned a glucometer because her daughter had diabetes - she had often checked the boys blood sugar at home, finding low values.	A 7-year-old boy was brought to the hospital by his mother with symptoms such as with pale skin, sweating, and low blood sugar.	All symptoms were only witnessed by the mother. The mother appeared attentive and medically informed showing responsibility towards her son. During hospital monitoring, the boy still showed low blood sugar. A special 72-hour fasting test confirmed the results: his insulin was very high, but other markers were normal. This pattern proved the insulin came from outside his body, meaning he had been given insulin rather than being sick with a natural illness.	Doctors concluded the child was receiving insulin from an outside source. The focus turned to the mother, who was suspected of deliberately administering insulin to her son	The article does not specify the boy's later custody or medical outcome	The mother was legally charged after toxicological evidence confirmed deli-berate insulin administration.

30 Basilicata, et al., 2025. Case 2	Prior to investigation, the mother repeatedly brought her son to the hospital with episodes of sudden coma. Over several years he had been hospitalized numerous times, but each time doctors found no organic cause and concluded he was healthy.	An 8-year-old boy was brought to the hospital room his mother after becoming very sleepy, increasingly weak, and eventually unresponsive.	All symptoms were only witnessed by the mother. The mother always appeared very affectionate and attentive towards her son. Despite normal test results, the boy remained in a critical state. Her behavior raised concern that she might be giving substances to her son.	Under suspicion, the medical team arranged for blood and urine samples to be collected without the mother present. Toxicology tests revealed the presence of phenobarbital, a sedative drug that explained the child's comatose state	The discovery confirmed that the child's condition was caused by drug administration rather than natural illness. The article does not provide further details about the boy's long-term outcome or custody.	The mother was charged
31 Benhachem et al., 2024.	Prior to investigation, the mother repeatedly brought her son to the hospital for recurrent bleeding episodes starting when he was 7 months old. He had already undergone multiple consultations and hospitalizations,	A 19-month-old boy was brought to the hospital looking pale but otherwise healthy. Clinical exams showed bruising around his nose and traces of blood near his mouth. Despite repeated blood tests, endoscopy, and other exams, no	During admission, the mother reported several new bleeding events, such as nosebleeds, vomiting blood, blood in the urine, and blood in diapers. Tests did not confirm presence of blood. Later, the child suddenly had a seizure.	Doctors found that the child's high potassium was caused by potassium gluconate he had swallowed. The medicine was found with his mother, showing she had given it to him.	A psychiatric consultation was requested for the mother.	No arrest or legal prosecution was reported.

	requiring blood transfusions and medications, but no cause was ever identified.	bleeding source could be found.				
32 Çakmaklı et al., 2024.	Prior to investigation, the mother repeatedly brought her son to hospitals since the age of 14 months. Within only two weeks, he had already been admitted four times. Histrionic personality disorder was noted in limited psychiatric evaluation because the mother was defensive.	An 18-month-old boy was brought to the hospital with his mother with an unusual tendency to bleed from nose, ears, and rectum. He had been hospitalized in at least two different hospitals for the same complaints, but no medical cause was ever found.	All symptoms were only witnessed by the mother. The mother presented herself as a concerned. Despite extensive testing no bleeding disorder was confirmed. During hospitalization, the mother continued to report new bleeding. Healthcare staff noticed inconsistencies in how the blood looked unusual in color and texture, sometimes with bacterial shapes under the microscope. This raised suspicion that	The child was kept under strict inpatient monitoring, with healthcare staff controlling all drugs and blood samples. When new bleeding occurred, samples were collected and DNA analysis showed the blood belonged to the mother, not the child. This confirmed that the symptoms were fabricated.	After discharge, the child was removed from the mother's custody and placed in institutional care, where all bleeding episodes stopped immediately	The case was referred to the prosecutor's office.

			the blood was not from the child himself.			
33 Gomila et al., 2016.	Prior to investigation, the mother repeatedly brought her 3-year-old son to the hospital over several months, reporting seizures, tremors, speech problems, and walking difficulties. Despite multiple admissions and tests, no clear medical cause was found.	A 3-year-old boy was brought to the hospital with seizures and nerve problems. Tests including brain scans, EEG and blood work showed no abnormalities. He was hospitalized several times, but symptoms returned whenever he was discharged.	All symptoms were only witnessed by the mother. The boy continued to have seizures, loss of coordination, and difficulty speaking. Doctors became suspicious as the clinical picture was inconsistent, and tests did not explain his symptoms.	Toxicology tests revealed the presence of alimemazine (a sedating antihistamine not declared by the mother) in his urine, blood, the liquid around his brain and stomach - and later in hair segments. Hair analysis confirmed repeated exposure for at least eight months. After he was separated from his mother, all symptoms disappeared, and his condition improved.	Custody was given to the maternal aunt. The boy recovered completely after separation.	The case was reported to SSP. A restraining order was issued against the mother. The article does not specify criminal charges.
34 Özdemir, et al., 2020.	Prior to investigation the child had been admitted to the hospital a dozen of times.	An 11-year-old-girl was brought to the hospital with her mother, with symptoms of vomiting blood.	Symptoms were only witness by the mother. The mother portrayed herself as devoted mother, (constant presence) goes to bathroom	The healthcare staff team proposed restricting the mother's presence, but the mother refused and demanded discharge.	In the end they were discharged with recommendation for child and adolescent psychiatry follow-up.	No arrest or legal prosecution was reported.

	The mother was forced to marry at the age of 16 years. Her husband was absent and had anger problems. The mother was satisfied to take her daughter to the hospital, so she could escape their home and her husband.	with the child and insists because “she (e.g. the girl) cannot go without me”). Eager to manage care. The mother was satisfied with the attention received through her child’s illness and her relationship with the hospital environment. The child bit on the inside of her mouth to create real blood. The mother exagger-ated the symptoms and pressured medical teams to pursue more invasive investigations. Both the mother and child rehearsed identical narratives, speaking in similar phrasing, which staff interpreted as coached or mirrored language.	

35 Muckensturm, et al., 2020.	Prior to investigation, the mother had her child admitted 13 times and have had 32 emergency visits, despite the child only being 16 months old.	A 16-month-old child was brought to the hospital for seizures, digestive and ENT troubles and neurological signs such as trembling and abnormal movements.	All symptoms were only witnessed by the mother. Despite treatment, new seizures occurred, but the seizures were atypical. Toxicology revealed toxic blood levels of lamotrigine, a drug prescribed to the mother.	All medication was stopped, and no recurrence took place. The child recovered.	The child was placed in foster care.	No arrest or legal prosecution was reported.
36 Ibrahim, et al., 2018.	The mother was a 19-year-old student and the second wife in a poly-gamous family. The mother had a history of self-harm, depression, and borderline personality disorder. The marriage was unstable, and she was separated from her husband. The father described	A baby boy was first admitted 4 hours after birth for respiratory distress and foaming from the mouth. The mother provided inconsistent histories during multiple readmissions and transferred between hospitals. At each presentation, she claimed new and severe symptoms, such as seizures and difficulty breathing.	The mother exaggerated and possibly induced symptoms to ensure repeated hospitalizations. Each time the baby was admitted, no abnormalities were observed by staff. The symptoms only occurred under the mother's supervision and resolved during hospitalization, suggesting deliberate fabrication.	The baby's symptoms disappeared when placed in the grandmother's care but reappeared once returned to the mother.	Psychiatrists diagnosed the mother with severe depression and borderline personality disorder. She refused psychiatric admission and left the hospital against medical advice.	The infant was discharged to the grandmother's custody and remained healthy during follow-up. Despite clear evidence of fabricated illness and risk of harm, no legal action or child protection intervention could be enforced due to the lack of functional

	her as manipulative and neglectful toward the baby. Her motive appeared to be gaining financial and emotional attention from her husband and family through her child’s illness.					child protection services in Nigeria.
37 Akpinar, et al., 2021. Case 1	The mother had experienced chronic stress, isolation, and depressive symptoms linked to single parenting and lack of social support. She had been in a prolonged state of “learned help-lessness,” suffering constant depressive episodes over six months prior to detection.	A 4-year-old girl was brought to the hospital by her mom for unexplained worsening of her diabetic condition.	During the hospitalization, another patient reported that the mother had secretly fed her diabetic child chocolate at night, deliberately worsening her condition. Healthcare staff described the mother as desperate for attention and to be seen taking care of her daughter. The next morning, the child’s blood sugar was unstable, and her hospital stay was extended.	When confronted, the mother admitted her actions, expressing regret and emotional exhaustion. She stated she was desperate, had no one to care for her daughter, and felt overwhelmed balancing work and childcare. A psychiatric evaluation was conducted, diagnosing her with depressive disorder.	The mother began antidepressant treatment and received frequent psychiatric follow-ups. Over a one-year monitoring period, both the mother and child improved significantly. The child had no further diabetic crises or hospitalizations for at least 18 months.	No arrest or legal prosecution was reported.

38 Akpinar, et al., 2021. Case 2	The mother lived with her husband and their children and her mother-in-law. The marriage was arranged, and the mother reported experiencing ongoing physical and verbal abuse from her husband. She had no social network or family support.	A 2-year-old boy was brought to the hospital for growth retardation, spasms and prolonged fainting, with no clear medical diagnosis. The child had spent approximately 14 months in the hospital since birth. The husband was uninvolved and unsupportive.	The mother appeared attentive and cooperative, forming relationships with nurses, though many of them perceived her as mentally unstable. It was discovered that the mother was administering medications that were not prescribed to the child. When these substances were confiscated and the child's medication was administered by the healthcare staff, the child's condition improved rapidly. Upon confrontation, the mother reacted violently, striking her child on the hospital bed. Her actions demonstrated deliberate symptom induction and physical aggression toward the child.	After this incident, psychiatric consultation was requested. Although the mother refused treatment, testing was conducted under supervision.	Following the investigation, hospital legal authorities and police were notified. Social services initiated legal procedures. The mother never returned to the hospital after discharge, and the case was closed.	No arrest or legal prosecution was reported.

39 Assoc, et al., 2020.	The mother had limited social support, living in a large extended family household with her husband, in-laws, and two sons. She described her life as stressful, with constant domestic respons-ibilities and little personal autonomy. The father was largely uninvolved, and her mother-in-law was described as controlling. She had no prior psychiatric history but later showed signs of depression.	An 18-month-old boy was admitted to the hospital due to infection, for vomiting and diarrhea. Initially, his test results were normal, but after several days of fluid therapy, he suddenly developed persistent high fever.	The child's condition worsened despite strong antibiotic treatment. The mother stated she felt more comfortable in the hospital seeing it as a place where she could rest and be alone and spend time with her son. The mother frequently requested medical supplies such as syringes and needles and resisted allowing anyone else to stay with her son, showing unusually high involvement and control over his care. The mother appeared calm and unconcerned, even as her son's condition worsened.	Doctors became suspicious when the infections continued despite treatment and no infection source was found. When the mother was replaced by another caregiver, the boy's fever stopped, and the blood cultures became normal within days.	The mother was hospitalized in a psychiatry clinic, where she admitted to causing the infections, by injecting fecal material into his intravenous line to induce infections.	The child remained safe under supervision, and no reports of further abuse. No legal prosecution was mentioned, but long-term psychiatric and social monitoring were continued.

Case 40 Huang, et al., 2021.	Prior to investigation, the mother had taken the child to many hospitals and pushed for several unnecessary surgeries. The mother controlled the child's medical care and seemed to enjoy the attention from healthcare staff.	A 9-year-old girl was brought to the hospital because she suddenly could not walk and needed a wheelchair. The girl was fully dependent on intravenous feeding (TPN) because her mother claimed she could not tolerate food. She also had repeated episodes of very high lactic acid and bleeding problems. Doctors thought these were caused by infections, but all tests were negative.	Tests showed that the girl had a severe vitamin deficiency, especially thiamine (vitamin B1), even though it was part of her prescribed nutrition. It was discovered that the mother had withheld the vitamins, making her daughter seriously ill and keeping her hospitalized.	A multidisciplinary team became suspicious of abuse and contacted child protection services. After the child was separated from her mother, her symptoms disappeared completely, and she was able to eat normally again.	The child fully recovered and did no longer need TNP. The mother received psychiatry follow-up.	No arrest or legal prosecution was reported.

Case 41 Manerkar, et al., 2025.	The family lived in a small village, and claimed their daughter sickness came from the house they lived in. Both parents were well-educated professionals.	An 11-year-old girl was repeatedly brought to the hospital by both of her parents with photos showing spontaneous gum bleeding. During dental visits, the child's gums appeared completely healthy, and no bleeding was ever witnessed by staff.	Later, the parents sent new photos showing supposed bruises and nosebleeds. The blood in the images looked like pinkish paint and not real blood. When asked for a live video call to confirm bleeding, the parents refused.	Soon after being questioned, the parents claimed that all symptoms stopped when the child stayed at their inherited home. The false reports and refusal to cooperate confirmed suspicions of fabricated illness.	The family later told the dental team that they had moved to an urban area. The motive appeared to be gaining justification to move homes, suggesting parental fabrication rather than illness in the child.	No follow-up mentioned. No arrest or legal prosecution was reported.
Case 42 Lee, et al., 2025	The mother had severe childhood trauma, including sexual abuse by her father and brother, which contributed to her distorted perceptions of her son's behaviour.	The mother frequently presented her 7-year-old son to the hospital with fabricated medical histories and false symptoms, claiming unexplained illness. Medical staff conducted multiple investigations without finding a clear cause.	The mother secretly injected her son with insulin, causing dangerous drops in his blood sugar. She altered diagnostic results and misled doctors to keep attention focused on the child's supposed illness.	Her deception was uncovered after repeated episodes and inconsistent test results led to suspicion. A multidisciplinary investigation confirmed deliberate insulin injections. She was separated from her son and referred for psychiatric evaluation.	Partial improvement was reported under psychiatric care, and the child was safeguarded from further harm.	The mother was charged with attempted murder.

Case 43 Lin & Chan, 2021.	The mother actions led to repeated and unnecessary hospitalizations for her child, some lasting up to 10 months The mother had a history of postpartum depression, domestic violence, and family conflict. She developed chronic depressive symptoms and borderline-type personality traits. She often sought medical attention for herself and her son.	Over several years, the mother brought her son to hospitals hundreds of times with various unexplained illnesses such as seizures, infections, and injuries.	The mother exaggerated her son's symptoms, including using a hot towel to fake fever and worsening his wounds intentionally. The mother frequently rejected discharge, requested further testing and moved between hospitals when doctors questioned her claims.	Medical staff eventually suspected fabricated illness and separated the child from his mother. The boy's condition improved steadily after 15 months of treatment, and he was later reunited with his extended family.	Before discharge from another hospital in 2019, the mother unexpectedly died from hypovolemic shock after a fall.	No arrest or legal prosecution was reported.

Case 44 Lanzarone, et al., 2017.	The mother had a history of anxiety and major mood disorder. Family tensions and possible neglect were present.	A 6-year-old girl was hospitalized several times for epileptic episodes. Despite repeated medical tests and changes in medication, doctors could not confirm any neurological disorder.	During the last hospital stay, the child became unusually drowsy. Toxicology revealed extremely high levels of Clobazam, incompatible with prescribed doses, indicating deliberate poisoning. The mother was the only person with access to the medication.	When the girl was separated from the mother and placed in a Recovery Unit, the child's symptoms resolved rapidly.	The mother received psychiatric care, and child protection authorities took responsibility for the family's follow-up.	The mother received psychiatric care, and child protection authorities assumed responsibility for the family's follow-up.
Case 45 Isaac, et al., 2016.	A divorced mother, socially isolated and financially supported through community donations, portrayed her son as medically fragile. She liked and gained sympathy within her community and among medical professionals.	Over several years, the mother brought her 6-year-old son multiple times to the hospital. The boy was diagnosed with numerous complex conditions such as seizures and feeding intolerance.	The mother exaggerated and fabricated symptoms, restricted the boy's diet and kept him to a wheelchair and feeding tube. Their illnesses persisted only under her supervision.	When the mother got hospitalized due to illness, volunteers observed the boy improving rapidly with normal feeding and play. After CPS removed the boy, hospital teams re-evaluated his conditions, all medical diagnoses were dismissed.	The boy recovered fully, had the feeding tube removed, and began normal a life with his father.	The mother was charged with injury to a child.

APPENDIX

Table A2

Interpretations of Crime Script Analysis results. Note. Y = Yes; N = No (none/absent); N/A = No answer.

	Background						
Case number	**1. Sex of perpetrator**	**2. Perpetrator has been diagnosed with psychiatric illness**	**3. Perpetrator lives in social isolation**	**4. Single mother**	**5. Father is absent**	**Age of victim in months**	**Age of victim in years**
1	F	N	Y	Y	Y	18	1,5
2	F	Y	Y	N	N	15	1,3
3	F	Y	N/A	N	Y	24	2,0
4	F	N	N/A	N	N	7	0,6
5	F	N	Y	N	Y	N/A	
6	F	Y	Y	N	N/A	12	1,0
7	F	N	N/A	N	N	42	3,5
8	F	N	N	N	Y	96	8,0
9	F	Y	Y	Y	Y	108	9,0
10	F	Y	Y	N	Y	144	12,0
11	M	N	N/A	N	N	108	9,0
12	F	N	Y	N/A	N/A	17	1,4
13	F	N	N/A	N	Y	48	4,0
14	F	Y	Y	N	Y	2	0,2
15	F	N/A	N/A	N	Y	36	3,0
16	F	N	N	N	N	144	12,0
17	F	N	Y	N	N/A	N/A	
18	F	N	N	N	Y	108	9,0
19	F	N	N	Y	Y	84	7,0
20	F	N	N	Y	Y	54	4,5
21	F	N	N	Y	N/A	24	2,0
22	F	N	N	N	N	15	1,3
23	F	N	N	N/A	N/A	8	0,7
24	F	N	N/A	N/A	N/A	144	12,0
25	F	N	N	N	N	3	0,3
26	F	N	N	N/A	N/A	24	2,0
27	F	N	N	N	N	36	3,0
28	F	N	N/A	N	Y	60	5,0
29	F	N	N/A	N/A	N/A	84	7,0
30	F	N/A	N/A	N/A	N/A	96	8,0
31	F	N	N/A	Y	N/A	19	1,6
32	F	Y	N/A	N/A	N/A	18	1,5
33	F	N	N/A	N/A	N/A	36	3,0

34	F	N/A	N	N	Y	132	11,0					
35	F	N/A	N/A	Y	Y	16	1,3					
36	F	Y	Y	Y	Y	N/A						
37	F	Y	Y	N	Y	48	4,0					
38	F	Y	Y	N	Y	24	2,0					
39	F	Y	Y	N	N	18	1,5					
40	F	N	N/A	N/A	Y	108	9,0					
41	M/F	N	N	N	N	72	6,0					
42	F	Y	N/A	N/A	N/A	84	7,0					
43	F	Y	Y	Y	Y	N/A						
44	F	Y	N/A	Y	N/A	72	6,0					
45	F	N/A	Y	Y	Y	108	9					

	Scene											
Scene	**Preperation**			**Entry/Pre-Condition**	**Doing**	**Post-Condiiton**			**Exit**	**Aftermath**		
Case number	**1. Prior child deaths in family**	**2. Multiple hospital visits / doctor shopping (for victim)**	**3. Perpetrator has medical knowledge**	**4-5. Symptoms only witnessed by perpetrator**	**6. Perpetrator appears to be caring**	**7-8. Symptoms persisted during treatment: (P) Poison, (A) Active physical abuse, (F) Fabrication**	**9. Perpetrator arrested before diagnostic separation scene**	**10. Diagnostic separation**	**11. Child remained with perpetrator**	**12. Child remained with perpetrator**	**13. Removed custody**	**14. Perpetrator prosecuted**
1	N	Y	N/A	Y	Y	P	N	Y	N	N	Y	N
2	Y	Y	N/A	Y	Y	A / F	N	Y	N	N	Y	N
3	N	Y	Y	Y	Y	P	N	Y	Y	Y	N	N
4	N	Y	N/A	Y	N	A	Y	N	N	N	Y	Y
5	Y	Y	N/A	Y	Y	P	N	Y	N	N	Y	Y
6	Y	Y	N/A	Y	Y	A	N	Y	N	N	Y	Y
7	N	Y	N/A	Y	Y	A	N	Y	N	N	Y	N
8	N	Y	N/A	Y	Y	F	N	N	Y	Y	N	N
9	N	Y	Y	Y	Y	F	N	N	Y	Y	N	N
10	N	Y	N/A	Y	Y	F	N	Y	Y	Y	N	N
11	N	Y	N	Y	Y	F	N	Y	N	N	Y	N
12	N	Y	N	Y	Y	A	Y	N	N	N	Y	Y
13	Y	Y	N	Y	N	F	N	N	Y	Y	N	N
14	N	Y	Y	N/A	Y	A	N	Y	N	N	Y	N
15	N	Y	Y	Y	Y	F	N	N	Y	Y	N	N
16	N	Y	Y	Y	Y	F	N	Y	N	N	Y	N
17	N	Y	N	Y	Y	A	N	N	N	N	Y	N
18	Y	Y	N	Y	Y	P / A / F	N	Y	N	N	Y	N
19	Y	Y	N	Y	Y	P	N	Y	N	N	Y	Y
20	N	Y	Y	Y	Y	F	N	N	Y	Y	N	N
21	N	Y	N	Y	N/A	P	N	Y	N	N	Y	N
22	N	Y	N	Y	N/A	A	N	Y	N	N	Y	N
23	N	Y	N	Y	N/A	A	N	Y	N	N	Y	N
24	N/A	Y	N/A	Y	Y	F	N	Y	N	N	Y	N
25	Y	Y	N	N	N	A	Y	N	N	N	N/A	Y
26	N	Y	Y	N	N/A	F	Y	N	N	N	N	Y
27	N/A	Y	N/A	Y	N	A / F	N	Y	N	N	N	N
28	N/A	Y	N/A	Y	Y	F	N	N	N	N	Y	N/A
29	N	Y	Y	Y	Y	P	N	N	N	N	N/A	Y
30	N/A	Y	Y	Y	Y	P	N	N	N	N	N/A	Y
31	N	Y	Y	Y	Y	P	N	N	N/A	N/A	N/A	N/A
32	N	Y	N	Y	Y	F	N	Y	N	N	Y	N/A
33	N/A	Y	N/A	Y	Y	P	N	Y	N	N	Y	N
34	N	Y	N	Y	Y	A / F	N	N	Y	Y	N	N
35	N	Y	Y	Y	Y	P	N	N	N	N	N	N/A
36	N	Y	N	Y	N	A / F	N	N	N	N	Y	N
37	N	Y	N	Y	Y	A / F	N	N	Y	Y	N	N
38	N	Y	N	Y	N	P	N	N	N/A	N/A	N/A	N/A
39	N	Y	N	Y	Y	P	N	Y	N	N	Y	N
40	N	Y	Y	Y	N	P / F	N	Y	N	N	Y	N/A
41	N	Y	N	Y	Y	F	N	N	Y	Y	N	N
42	N	Y	N/A	Y	Y	P / F	N	N/A	N	N	Y	Y
43	N	Y	N	Y	Y	F / A	N	Y	N	N	Y	N
44	N	Y	Y	Y	N	P / F	N	Y	N	N	Y	Y
45	N	Y	Y	Y	Y	A/F	N	Y	N	N	N	Y