# THE ABUSED CHILD

"A child is considered to be abused if he/she is treated by an adult in any way considered as unacceptable in a society, at a given time".

(Meadow)

# OVERVIEW

Today, child abuse is divided into 4 distinct categories: physical abuse, sexual abuse, neglecting, and emotional and psychological abuse. Obviously, there is interference between these categories.

There are some common features of the different types of child abuse:

- The child abuse is present in all the countries, in all the societies, and in all the economical classes;
- Although the abused child can be of any age, the most affected are the small children, who cannot talk and complain, or if they do, nobody believes them;
- Many of the children abused by a family member do not accuse the guilty person because they love him or because they believe they themselves are guilty for the abuse;
- Any kind of abuse may be present inside a family or in different institutions (schools, camps, and shelters).
- There is a tendency for repeating the abuse upon children of consequent generations (the false heredity of the abuse), as well as the iterative abuse upon the same child.

# RISK FACTORS

- The risk for abusing and neglecting a child can be enhanced by factors related to the parents, as well as to the children. Among the factors related to the adults are the poor economical and social status, social isolation, drug addiction, violent environment, family history of abuse, and failure of communication.
- The children born in very poor families are considered to be extremely vulnerable (Wolfner). One can observe some other factors, such as: promiscuity, early pregnancy, and an unemployed father.
- Violence is frequently focused not only on the child, but also on other members of the family. The children who witness violent scenes between their parents may suffer not only emotional and behavioural distress, but they may be themselves victims of physical abuse.
- One of the most important predictive factors for the use of physical punishment by parents is that themselves were physically abused as children. Many of the children accept the physical punishment as a right of their parents, so that punishing a child in any way represents an important risk factor for using the same kind of treatment upon one's own children.
- Among the factors related to the child can be included: children with special needs, children with behavioural problems and multiple pregnancies. Hyperactivity and behavioural disorders are simultaneously causes and effects of the abuse.

# PHYSICAL ABUSE (SILVERMAN SYNDROME)

**External lesions**

**Bruises and haematomas**

- are frequently the most obvious physical signs, although their presence in a large number isn't necessarily a sign of abuse.
- We can suspect a non-accidental cause when the ecchymosis are situated on parts of the body usually covered with clothes, or anatomically protected (trunk, the lumbar region, buttocks, the medial side of the thighs, the scalp etc).
- Suggestive ecchymosis caused by hand or fingers are located on the buttocks, on the neck (in cases of asphyxiation) or on the limbs.
- Grouped ecchymosis, round or oval in shape, suggest grabbing, the signs of the fingers being present especially on the trunk and arms.
- "Eyeglasses ecchymosis" (bilateral peri-orbital haematomas) may occur after a violent hit to the face or at the base of the nose.
- The presence of injuries of different ages is a good indicator for abuse, especially when they cannot be explained by iterative accidents.
- Bleeding and diseases with vascular fragility can cause ecchymosis-like lesions. Diagnosis errors are extremely dangerous, because they can accuse innocent parents of abuse.
- bruises can frequently offer information about the object that caused them - shape or texture (e.g. multiple, linear bruises caused by caning or whipping).
- Signs around the ankles and wrists may be observed, in cases of struggle, as well as circular bruises in the same sites, in cases of tying the limbs.
- injuries of the lips, gums and oral cavity can be caused by forcing the entry of a spoon or by the hot food. The rupture of the frenulum of the upper lip is usually associated to a non-accidental trauma.
- After punishing a child for enuresis or masturbation, injuries of the scrotum may occur; genital injuries are suggestive in both sexes for sexual abuse.

# PHYSICAL ABUSE (SILVERMAN SYNDROME)

**Wounds**

- The injuries may consist in LACERATIONS, cuts, stab wounds and many other forms of deliberate mutilation. All of these are rare, representing the pinnacle of child abuse methods, and frequently leading to death.

**Burns**

- The different types of burns (especially with hot water) are usually seen in cases of beaten child syndrome, and the infections secondary to these are also frequent. Lesions can be located on the hands, as well as on any extremity, caused by introducing them in hot water. The injury has a glove-like or sock-like shape, with a precise delimitation at the upper part and without the typical injuries caused by splashing.
- Burns on the buttocks or on the perineum, caused by forced contact with hot water or an electrical machine are frequently used for punishing the enuresis (Fig.1). There are not unusual the cigarette burns, which can be complicated with infections. Accidental hot water burns are usually situated in the upper part of the body, on a convex surface, with an irregular shape and associated with splashing injuries. The accidental contact burns are usually superficial, because the injured part is retracted by reflex. The burns of the dorsal side of the hands are suggestive for a physical abuse.

**Bites**

- A bit mark may associate ecchymosis, bruises, contusions or any combination of these. A bite that produces visible signs is usually strong, painful, and different of the so-called “love bite” (in fact this is an injury produced by sucking a part of the skin, which comes in contact with the tongue, teeth and palatine vault). This injury, as suggested by its name, is usual in a sexual context, though inappropriate at this age.

**Violent hair loss**

- The irregular shaped areas on the scalp without hair must be differentiated from fungal infections of the skin and from *trichotilomania*. The abusive extraction of the hair determines a larger defect and a *subepitelial* haematoma, associated with a more intense pain than that produced by the extraction itself.

# PHYSICAL ABUSE (SILVERMAN SYNDROME)

**Internal lesions**

**Subdural haematoma**

- The subdural haematoma is an intra-cranial haemorrhage between the dura mater and the arrachnoid membrane. As known, the large majority of the subdural haematomas are traumatic, and the force that produces them can be direct or indirect. The traumatic subdural haematomas are found especially in children between 2 and 6 months of age, and in 80% of these cases, the lesions are bilateral.
- The characteristic neurological symptoms include focal or general convulsions, loss of conscience and motor deficit. When the subdural haematoma is suspected, it can be confirmed by examining the anterior *fontanela*, which is large and tensioned. The examination of the retina may find perivascular haemorrhages and retinal oedema. MRI can offer more sensitive and specific data than computed tomography, being able to detect small parenchymal and subdural haemorrhages.
- The subdural haematomas can be caused not only by trauma, but also by meningitis (frequently caused by Haemophilus influenzae) or a severe dehydration. The subdural haematoma can follow a singular trauma episode, but most frequently is a result of repeated traumas. Therefore, a slow developing, progressive haematoma is extremely suggestive for child abuse. The prognosis of subdural haematomas is usually severe, this being one of the main death causes, in cases of child abuse.
- A typical example of child abuse is the “shaken baby syndrome”, described by Caffey in 1974. This syndrome occurs when the child is violently shaken back and forth, usually in order to make it stop crying (Roussey). At this age, when the muscles of the neck cannot sustain the weight of the head, violent shaking acts like an aggressive factor determining the rupture of the cortico-dural blood vessels, with haemorrhage and subdural haematoma. Relatively frequent bone injuries are associated.

# PHYSICAL ABUSE (SILVERMAN SYNDROME)

**Visceral lesions**

- represent the second most frequent death cause in cases of physical abuse on children.

The following represent the typical visceral lesions:

- Thoracic contusions associated with hemo- or pneumotorax;
- Abdominal injuries - liver or spleen rupture, injuries of the mesentery, or pancreatic lesions;
- Renal injuries, complicated with *haematuria* or even fatal retroperitoneal haemorrhage;
- Duodenal wall haematoma, small bowel perforation or, rarely, mesentery rupture, when the vertebrae perforate or compress the soft tissues

**Bone trauma**

- Linear, spiral or oblique fractures located on the long bones diaphysis (similar to accidental fractures);
- Metaphysis and epiphysis fractures (extremely suggestive for child abuse);
- Forming of periostal tissue. An untreated diaphysis or metaphysis fracture may determine sub-periostal haemorrhage, and consequently a deposit of calcium that compresses the diaphysis. The periostal reaction can appear even without any bone lesion, determined by a direct trauma or by a violent torsion of the limbs;
- Radiological modifications. A careful radiological examination helps dating the lesions. The oedema of the soft tissues appears in the first few days, and they heal in 4-10 days. The periostal reaction is observed in approximately 10 days after the trauma, and the callus is formed in 14-42 days. The complete healing appears in about 1 year;
- Cranial fractures are always determined by a direct trauma. Whilst the subdural haematomas may appear without any bone injury, skull fractures are always associated with cerebral lesions. The forensic meaning of a skull fracture is that it represents the local effect of a severe force, by impact or increased pressure;
- The fractures of the ribs are extremely suggestive for abuse;
- Nasal fractures (bones, cartilage) can be complicated with infections, followed by permanent deformities – suggestive for a non-accidental cause;
- Vertebral traumas can be located at the antero-superior regions of the vertebral bodies. They are not frequent and reflect the action of a powerful static or dynamic force. Due to these, cardiac or neurological injuries may occur.

**Ocular and ear injuries**

- Up to 70% of the abused children have ocular injuries, including retinal, vitrous haemorrhages, dislocation of the lens and retinal detachment. The ophtalmological examination is necessary in all the suspect cases of child abuse, because missing an ocular injury may lead to temporary or permanent blindness. A violent blow to the face may lead to the rupture of the tympanum.

# SEXUAL ABUSE

*Behavioural indicators of sexual abuse:*

- Acute answer:
  - Recent behaviour changes;
  - Nervousness in young children;
    - Regressions:
  - Loss of sphincter control;
  - Sucking the fingers;
- Sleep disorders:
- Nightmares;
- Somnambulism;
- Enuresis;
- The child cannot sleep alone.
  - Feeding disorders:
    - Difficulties in feeding small children;
    - Nervous anorexia;
    - Overfeeding.
      - School problems:
        - Affecting the school abilities;
        - Lowering of concentration capacity.
- Social problems:
  - Anger and inadequate reactions;
  - Altered activity levels (hyperactivity, depression, inactivity);
  - Small number of friends;
  - Poor social life.
    - Behavioural sequels:
      - Diminished self-respect;
      - Depressions;
      - Guilt;
      - Suicide attempts;
      - Inappropriate sexual behaviour;
      - Excessive interest for masturbation;
      - Increase of juvenile delinquency;
      - Runaway;
      - Drug abuse;
      - Prostitution;
      - Psychosomatic disorders;
      - Gynaecological and gastrointestinal disorders.

# SEXUAL ABUSE

- *Medical indicators for sexual abuse:*

Girls and boys:

- Ecchymosis, bruises, bite marks;
- Sexual transmitted diseases;
- Blood spots on the underwear;
- Genital ecchymosis and tumefaction;
- Pains of the perineum, abdomen, pelvis;
- Genital lesions;
- Lips injuries, *petesii* on the hard palate (Fig.3);
- Signs of constraint, finger-shaped bruises;
- Enuresis, encompresis (uncontrolled emission of urine, faeces).

Boys:

*Disuria*;
Tumefaction of the penis;
Various penile secretions.
Girls:

Vaginal secretions;
Inflammation of the urethra;
Lymphnodes inflammation;
Pregnancy;
Atypical, recurrent abdominal pain;

# SEXUAL ABUSE

- It is a lot easier to obtain information from the adolescent victims, because they can be asked more questions. There are some very important aspects that need to be known:
  - Who, what, when, where;
  - Which orifices were penetrated;
  - Use of force and/or threatening;
  - Pain, bleeding, *disuria*;
  - Ejaculation, use of condoms;
  - Other non-genital lesions;
  - Known risk factors related to the assailant;
  - Last sexual intercourse (if case);
  - After the rape: shower, urination, defecation, changing the clothes;
  - Personal history and information about the sexual activity.
- Because visualising the hymen is difficult in pre-puberty some techniques were developed in order to facilitate the examination, i.e. the delicate separation and lateral traction of the labia. A redundant hymen is easily observed if some warm sterile water is put over it.
- Examining a supposed sexual abuse in a teenager requires a lot of attention for the needs of the victim and for understanding the emotional impact of the entire experience. There are two ways of obtaining the samples: clinical and laboratory exams.
- The laboratory exams include all the samples needed in forensic medicine and, eventually, cultures for sexual transmitted diseases. The DNA type is important for identifying beyond any doubt the assailant, but the procedure requires a lot of attention in selecting, working on, preserving and examining the samples. The presence of the sexual transmitted diseases represents a certain evidence of a sexual intercourse.
- The use of colposcopy and of the photographic documents has enhanced the number of cases with real-positive results, and represented the basis for the study of normal and posttraumatic anatomy (associated with the sexual abuse in children). The main value of the photographic documents in the cases of sexual abuse is the permanent recording of the lesions at that time, thus eluding the re-examinations, which are physically and psychologically traumatic.

# SEXUAL ABUSE

- Regarding the anal abuse, the special structure of the anus makes the diagnosis of anal sexual abuse more difficult, the recent lesions being different from the chronic ones. Also the period of time between the sexual abuse and the forensic examination has a role. At this level, there is a lot of elastic tissue and it usually stretches without any lesion and heals quickly. Especially in children, the anatomical types and the unspecific abuse signs must be considered. The specific terms is extremely important:
- The fissures can be associated with the abuse, but also may occur in constipated children;
- The anal folds are usually located on the median line;
- The polyps are small tissues masses with a pedicle, consequent to anal fissures and ruptures;
- Plain, soft areas at 12 and 6 o'clock appear both in abused and non-abused children;
- Reflex anal dilation is associated with the presence of faeces in the rectum;
- Losing faeces is usual in some children, especially boys;
- Venous dilations may be observed in some children, when examined in a position that obstructs the blood flow in the anal plexus.
- The anal region will be examined with the child in left-lateral position or on the knees and elbows. The buttocks will gently be pulled apart, and the anus will be observed for 30 seconds in order to notice any dilation. The anal folds must be symmetrically arranged around the anus, but frequently there is a redundant anterior fold, especially in boys; this fold can be easily mistook for a polyp or a healed fissure. Any dilated veins must be considered as important signs of abuse. In the cases when the abuse is accused it is necessary to put a finger towards the anus, in order to test its tonus. In some cases the digital exam of the anus is necessary, asking the patient to try and compress the finger.
- In the anal region rarely one can find certain proofs of penetration, except in the examinations within hours (or days) from the abuse. A recently penetrated anus may be opened, with one or more recent fissures, on the median line or around it. It is possible that the fissures bleed. Some fissures and ecchymosis may be found inside the anal canal. Such fissures can heal in some days, usually without any signs; a scar or an excrescence may appear in some cases. After repeating anal penetration for years the anal skin is soft and thickened, without folds and with a low sphincter tonus. In some cases no signs can be found.

# SEXUAL ABUSE

**Differential diagnosis of genital lesions**

- The hymeneal membrane has some anatomical types that can be observed both in abused and in non-abused children, so that they cannot be considered as specific for sexual abuse.
- On the margin of the hymen there are frequently some excrescences which must be very attentively examined. Also, in newborn children, some indentations of the hymen can be observed, especially in the anterior half; hymeneal excrescences are usual at this age. Although these indentations were supposed to be caused by violence, these exist also in newborn and in non-abused children. Some vaginal signs are usual in non-abused children, but they cannot be considered specific for sexual abuse. These signs may include:
- Subcutaneous follicles in the fossa navicularis;
- Labial adherence;
- Urethral dilations;
- External hymeneal excrescences.
- The neutral lesions affect the periurethral tissue, the labia and the mount of Venus. The accidental vaginal penetration with an unsharpened object can determine lesions similar to those found in sexual abuse. If a cutting object is inserted into the vagina, the lesions are located at the periphery of the hymeneal membrane. Generally, the majority of the neutral lesions affect the anterior half of the hymen, and the penetration generates lesions of the posterior half. Very rarely the children produce themselves lesions or pain in the genital area. Touching their genitalia produces a nice sensation, and consequently they are frequently touching their penis or clitoris.

# SEXUAL ABUSE

| TYPE OF ABUSE | INITIAL ASPECT OF THE LESIONS | AFTER HEALING ASPECT |
|---|---|---|
| Touching the genitalia, finger penetration | Normal aspect or small bruises | Usually normal aspect; small scars may be present |
| Sexual act simulation | Posterior bruises | Usually normal aspect; occasionally posterior median scars or on the vestibule mucous. |
| Vaginal penetration (hymeneal rupture) | Prepuberty: ecchymosis, bruises, erosions; possibly positive lab tests.<br>Postpuberty: vaginal wall erosions, ecchymosis, uterine bruises. | Hymeneal ruptures or scars with tissue loss. |
| Anal penetration | Normal aspects, especially when lubricants are used; a careful examination may lead to positive lab tests. | Normal aspects (over 90%); scars, tissue proliferation and alteration of the anal sphincter tonus. |

***The aspect of the genital lesions associated with sexual abuse***

# SEXUAL ABUSE

| | Pre-puberty abuse | Post-puberty abuse |
|---|---|---|
| Acute lesions | • Large defects, extended to the base of the hymen, anywhere between 3 and 9 o'clock;<br>• Loss of hymeneal tissue;<br>• Lesions of the posterior part of the vulva;<br>• Bruises, erosions, haematomas;<br>• Anal fissures, alteration of the anal tonus. | • No lesions;<br>• Bruises or haematomas;<br>• Partial or total hymeneal ruptures;<br>• Excoriation, bruises, haematomas;<br>• Anal fissures, alteration of the anal tonus;<br>• Bruises or ruptures of the vagina or uterus |
| Healed lesions | • Ruptures extended to the base of the hymen;<br>• Loss of hymeneal tissue;<br>• Normal anatomical aspects, rarely anal scars. | • Normal anatomical aspect;<br>• Ruptures extended to the base of the hymen;<br>• Normal hymeneal aspect. |

***The lesions associated to penetrating sexual attacks***

# SEXUAL ABUSE

- **Collecting samples**
- In any suspect cases of sexual abuse, the legally agreed procedures must be exactly followed, in order to protect the evidence. It is recommended that the victim should undress on some sheets, to collect any hair or textile fibres. The clothes the victim wore during the attack must be retained as evidence (including the shoes). If the clothes were changed, the underwear must be considered as possible evidence.
- The victim is later asked to comb the pubic hair with a special comb; after that the scalp hair must be combed with another comb. A special instrument is used to collect any material from under the victim's nails, as those may come from the assailant.
- The next step consists in identifying the lesions of the external genital organs and of the inferior part of the vagina. Afterwards all the secretions must be collected; an examination with the speculum is recommended only in non-virgin women, in order to detect the internal lesions (of the vagina). Any anal lesions must be documented and associated with collecting samples from the anal area, the anal canal and from the rectum, in order to confirm or infirm the ejaculation or the use of lubricants. When severe anal or rectal injuries are present a rectoscopic examination is required.
- When sperm cells are present, they can be used to identify the DNA profile of the aggressor.
- After the sexual contact, semen can be discovered after 24 hours in a proportion between 25 and 100%. Extremely rare is the identification of immobile sperm cells until the $17^{th}$ day after the contact.
- Significant levels of the acid phosphatase are difficult to detect after 12 hours from the contact, but if the samples are correctly preserved, this analysis may bring important information. The acid phosphatase normally has low levels in the adult women vagina; thus this enzyme is very important in verifying an eventual ejaculation. The p30 protein is specific to the sperm cells and it is not found in the normal vaginal secretions. Determining the p30 protein is one of the most specific and sensitive methods for diagnosing an ejaculation into the vagina. The specific protein for the seminal vesicles is, also specific for the presence of sperm.

# CHILD NEGLECT

This term refers to different circumstances that lead to neglecting various needs of the child. Child neglecting is also physical or emotional and can have many different forms, starting from inadequate care, feeding, education or medical treatment, and culminating with total absence of affective and cognitive stimulation.

- **4.1. Neglecting in feeding the child**
- Because the child is totally dependent of its caretakers, an inappropriate feeding rapidly affects the physical development. When elder children are not fed properly, the economical status of the family must be evaluated, because this may be the real cause of malnutrition. The absence of an well-equilibrated diet can be attributed to the parents' beliefs. For example, a rigid vegetarian diet, with no animal aliments is absolutely inappropriate for a small child.
- **4.2. Neglecting in medical care**
- The parents can influence the medical care of the child by refusing to see a doctor or by not administrating the prescribed treatment. These parents can be extremely attentive with their children, but they can act in a wrong way only when they consider that spiritual well being compensates the physical needs. No court of law will ever accuse a doctor who does not consider the parents' religious beliefs; contrary, the parents can be accused if interfering with the treatment.
- **4.3. Neglecting in supervising the child**
- The parents can neglect the safety of their children. A child in a house determines changes in that environment, adapting it to its needs.
- The accidents are more frequent in boys with at least one alcoholic parent, as well as in girls with psychological problems or with social disabilities at an age of 4 or 5 years. A number of hospitalisations for one child suggest neglecting.
- **4.4. The mother behaviour during pregnancy**
- In time, the mother behaviour during pregnancy was considered a form of abuse. Antenatal alcoholism can induce the born of underweight, with developmental problems, mental retardation, facial, bone and visceral malformations children. Although children with drug addicted parents have a significant risk for physical or emotional abuse; it is very difficult to prove whether maternal misbehaviour during pregnancy had a certain role in abusing.
- Besides these determining factors, an important role is given to the negative aspects of the child's hygiene, alcoholism and drug addiction. The free access of children, in some families, to alcohol or drugs may be considered as educational neglecting, with possible severe consequences.
- **4.5. Cases of fatal neglecting and abusing**
- The number of fatal cases is underestimated, as well as the accidental injuries are difficult to differentiate from the non-accidental ones. The autopsy and the post-mortem radiological examination should clarify the unexplainable or suspect deaths. MRI helps identifying brain injuries that later can be examined on the conserved brain. Conserving the brain in suspect abuse cases is compulsory, because the hystological examination of the fresh brain, especially that of young children is valueless.

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# EMOTIONAL AND PSYCHOLOGICAL ABUSES

The main issue here is whether the emotional and psychological abuses are synonyms, or at least, partially intersect.

There are different terms for each of them:

- **Emotional abuse** represents the repeated inappropriate answer to the child's needs, with a particular behaviour;
- **Psychological abuse** represents the repeated, sustained inappropriate answer that leads to the destroying of the creative and developmental potential of some faculties in the child, including memory, recognition, perception, attention, imagination and moral development.
- The "psycho-social dwarfism syndrome" is revealing for this situation, this syndrome resulting from emotional abuse, as well as from neglecting.
- The emotional abuse includes psychological neglecting, verbal abuse, sarcasm, threatening behaviour, punishments, exaggerated requests from the child, corruption of emotional sensitivity. Hart and Brassard described in 1987 six types of active psychological abuse:
- Rejecting the child;
- Diminished attention for the child;
- Terrorising the child;
- Isolating the child;
- Indifference for the child's affective needs;
- Corruption of the child.

In 1984, Miller described as "poisoning or toxic pedagogy" the education of children using dangerous rules; for example, the parents are always right, love comes from a sentiment of duty, a high degree of self-respect is vicious, and powerful feelings (hate) can be pushed away.

Diagnosing the emotional or psychological abuses can be done directly (observing the children and their relation with the parents and by interviewing the children) or indirectly by observing the developmental consequences of abuse. The emotional abuse is always present in cases of sexual abuse in children. A known person commits more than ¾ of the sexual assaults in children (family member, caretaker, teacher, and neighbour). Although children, teenagers or parents report some sexual abuses, most frequently the diagnosis is suspected in front of the psychosomatic or psychological problems (Nathanson).

# THE MÜNCHAUSEN SYNDROME

The Münchausen syndrome is an unusual and dangerous type of child abuse, relatively recently defined and admitted by the medical community. This syndrome was first described as a unique pathological situation, when the patient, usually a boy, gets hospitalised, accusing series of severe symptoms, that need numerous examinations or treatments, including surgery (Asher).

In 1984, Rosenberg had established four diagnosis criteria, important for identifying this syndrome:

- Real and/or pretended sickness, affirmed by one of the parents;
- Repeated requests for medical assistance for a child, multiple investigations;
- The parent denies any knowledge about the causes of the symptoms;
- The regression of the symptoms when the child is isolated from its family.

The prevalence of this syndrome is difficult to be calculated, because many cases are undiagnosed. It is probable that the victims have brothers or sisters with complex medical history. This can be either secondary to real sicknesses or to abuse or neglecting. The symptoms may be induced or falsified by the parents, including the repeated declaration of false symptoms, such as adding blood in the urine. The real physical signs may be real or false. The symptoms, the simulation or producing the illness methods, as well as the diagnosis methods are presented in table III.

*Salt poisoning* represents a severe form of Münchausen's syndrome (Meadow). The children suffer from extreme thirst, vomiting sometimes diarrhoea or neurological signs (sleepiness, convulsions, rigidity, and coma), interfering with the development. The level of the sodium in the blood reaches 200 mmol/L and the urinary level 150-360 mmol/L.

Although the characteristics of the inductors of the Münchausen's syndrome are well known, the reasons of this behaviour are not. The mother may be a nurse, a social assistant or a doctor's wife, and frequently has enough medical knowledge. Usually she is very "helpful" in making the medical team understand the problems of her child. She stays permanently in the hospital, feeling well in this environment, that others find depressing.

# THE MÜNCHAUSEN SYNDROME

| Symptoms (frequency) | Methods of simulation or induction | Methods of detection |
|---|---|---|
| • Bleeding (44%); | • Intoxication with anticoagulants;<br>• Phenolphthalein poisoning;<br>• Bleeding induced by the mother;<br>• Bleeding with other causes. | • Toxicology exams;<br>• Examination of the stool;<br>• Determining the blood group;<br>• Supervising the mother |
| • Convulsions (42%) | • Pretended;<br>• Teophilin, insulin, psychotropic drugs intoxication. | • A particular context, interviewing other members of the family;<br>• Toxicology. |
| • Depression of the central nervous system (19%) | • Intoxication with Valium etc. | • Toxicology (blood, urine).<br>• Bruises at the base of the neck. |
| • Apnoea (15%) | • Intended asphyxiation; | • Stool analysis;<br>• Blood and urinary levels of the sodium. |
| • Vomiting (10%) | • Laxative poisoning;<br>• Salt poisoning. | • Measuring the patient's temperature; |
| • Fever (10%) | • Pretended or induced;<br>• Bacterial infection due to the IV line. | • Positive identification of unusual bacteria.<br>• Toxicology exams; |
| • Rash (9%) | • Intoxication;<br>• Scratching injuries. | • Stopping the child from scratching. |

***Symptoms, methods of simulation/producing illnesses and the diagnosis methods***

# THE DIAGNOSIS OF THE ABUSED CHILD SYNDROME

**1. History**

- Although the doctors are not asked to show the proofs of the abuse, they must be able to suspect and evaluate abuse. Whenever possible, the children must be examined without their parents, because the behaviour can be very important. The doctor has to pay attention to the developmental status of the child and to adapt himself to his level of comprehending and communicating.
- The younger children are asked simple, alternative questions, with multiple choices of answering. "Why" should be avoided, because the child does not know how to answer questions such as "Why do you think mom did this thing?", "Why do you think you didn't sleep well recently?". It is recommended that the parents should not be accused during such an interview, because the children are usually very loyal to them. The first conversation with the child has a crucial importance, in many cases this being the most revealing.
- The doctors must be objective and professional. They are not allowed to accuse the parents, but they have to explain to them that protecting their children is important, and that they must co-operate.

**2. The physical examination. Evaluating and reporting the abuse**

- A correct physical examination is acquired with the child completely undressed. A written report is compulsory, for this can become a legal document.
- Evaluating an abuse is a teamwork result, because no specialist can evaluate by himself all the aspects of an abuse. The team must include a paediatrician, a psychologist, a social assistant and a forensic examiner.

**3. The prevention of child abuse**

- The main purpose is represented by the eradication of child abuse. Although it is unreal to think about the complete elimination of violence, no actions are sufficient to achieve this aim.
- Pre-natal talks have an important role, offering information about a child's needs for a harmonious development; these can lead to identifying parents in need of help. After birth, the bond between mother and child must be encouraged.
- Another prevention method requires an intervention in the families considered having risk factors for abuse or neglecting (Leventhal). The risk factors should be identified during pregnancy or immediately after birth (the end of the first week). An important risk factor is an early mother depression.