LCC Session 42: Child abuse and mandatory reporting

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CanMEDS Competencies:

Professional - Duty to report child abuse and neglect

Scholar – Child maltreatment definitions, prevalence, associated impairment

Collaborator – Co-ordination and continuity of care; consultation

Communicator – Process of reporting, documenting, using non-leading inquiry

Advocate – Early intervention; child maltreatment prevention

What will happen in this session?

Session Goal: The goal of this session is to discuss the issue of child maltreatment, its assessment in terms of “practice pearls”, and the mandatory duty to report.

Activities:

1) Case Example 1: Query Physical Abuse

2) Case Example 2: Query Sexual Abuse.

3) Listing of Pediatric Clinical Pearls

Problem-based learning will be the means to discuss the approach to one case querying/rule out physical child abuse and one case querying/rule out child sexual abuse well as the process of deciding to report and placing a report. You may chose to pair residents to discuss one case and come together to share discussions. You may find discussing one case as a whole group useful. Clinical pearls may emerge from these discussions and can be identified and noted along the way.

Suggested Time 60 minutes. It may be reasonable to consider 20 min per case and a group discussion of pediatric “pearls” that may have been garnered from resident’s experience to date. If facilitators are interested, email the groups pearl list to wekerc@mcmaster.ca and I will collate these and return the full set of ideas back to the LCC groups.

Readings: Pediatrics in Review articles are highlighted as these provide: (1) brief evidence-based updates from practice leaders and, (2) for self-assessment purposes, brief 4 or 5 item quiz at the end of most articles. Articles on child abuse and neglect assessment generally (Asnes & Leventhal, 2010) and child sexual abuse specifically (Fortin & Jenny, 2012) are required readings.
The Child Advocacy and Assessment Program has drawn from experience and the extant literature in a *Child Abuse and Neglect: The International Journal* article (required) that addresses the “how” aspects of making a report (Pietrantonio et al., 2013).


Managing Child Abuse: General Principles

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Author Disclosure
Drs Asnes and Leventhal have disclosed no financial relationships relevant to this article. This commentary does not contain a discussion of an unapproved/ investigative use of a commercial product/ device.

Objectives After completing this article, readers should be able to:

1. Identify their roles as mandated reporters of child abuse.
2. Discuss the approach to evaluating cases of suspected child maltreatment.
3. Know when to become concerned about possible child maltreatment and when and how to seek help in evaluating cases.
4. Recognize the role of the pediatric practitioner in ongoing care of and advocacy on the behalf of maltreated children.

Introduction
Child abuse is common. In 2007, the year for which the most recent child protective services (CPS) data are available, 3.2 million reports were filed concerning approximately 5.8 million children younger than 18 years of age who were suspected victims of abuse, neglect, or sexual abuse. Also in 2007, 1,760 child deaths were attributed to abuse or neglect. Neglect constituted 59% of all cases of child maltreatment, more than all other forms of substantiated child maltreatment combined. Most maltreatment occurs in children’s homes. In 2007, nearly 80% of the perpetrators of child maltreatment were parents.

State laws mandate that pediatric practitioners report suspected cases of child abuse or neglect to local CPS. The process that begins when the clinician first feels concern about a child’s welfare and ends when he or she makes a report to CPS is one of the most challenging and disturbing that practitioners must undertake. Because child maltreatment is common, it is likely that all pediatric clinicians will care for abused or neglected children and, therefore, will be obliged to report such children to CPS. For this reason, pediatric practitioners should know and employ a careful, systematic, and thoughtful approach to evaluating all suspected cases of child maltreatment to make the right decision about reporting to CPS.

This article seeks to provide a stepwise approach to thinking about and managing possible child maltreatment. Adhering to the proposed steps should help the practitioner make optimal decisions about reporting to CPS, perform difficult tasks (such as telling a child’s parents about a report), and manage the challenging emotions that these cases can generate.

Step 1: Understand Mandatory Reporting Laws
The first component to this approach is to know and understand mandatory reporting laws. Such preparation is both necessary and helpful to guide best practice in caring for children who may have been maltreated. The mandatory reporting laws state that once a practitioner has reasonable cause to suspect that a child has been abused or neglected, he or she is obligated by state law to make a report to CPS. In cases of sexual or physical abuse, CPS usually contacts police to investigate a possible crime. Failure to make a report can result in criminal penalty, action against a practitioner’s professional license, or most dire, further injury to or death of a child.

The clinician need not be absolutely certain that a child has been maltreated to make a report to CPS; in fact, waiting for diagnostic certainty can have severe consequences for a child. On the other hand, an investigation by child protection authorities generates significant stress for parents who have not harmed or neglected a child. Taking time to
gather information thoroughly and think through suspected cases carefully can increase the likelihood of appropriate reports and decrease the likelihood of unnecessary ones.

However, when an allegation of child sexual abuse—as opposed to one of suspected physical abuse or neglect—is brought to the attention of a pediatric practitioner, that practitioner is obligated by mandated reporting laws to convey the allegation to CPS.

Although a child may first disclose sexual abuse to a pediatric clinician, it is considerably more likely that the clinician will hear of a child’s disclosure or behavior that led to concern about sexual abuse from an adult caregiver of the child. In this situation, information about what a child said or how he or she behaved should be obtained from the caregiver.

Usually it is not necessary to hear directly from a child about possible sexual abuse. In fact, because what a child says about sexual abuse may be the only evidence that abuse has occurred, it is preferable to refrain from questioning a child until he or she can be interviewed by a professional trained in forensic interviewing techniques. The report of a disclosure of sexual abuse from a child’s caregiver should prompt an immediate report to local CPS, even when the pediatric practitioner is not certain that sexual abuse has occurred. The investigation of alleged sexual abuse is undertaken best by both CPS and police to limit the number of times a child is questioned about alleged abuse and to avoid compromising the investigation of a possible crime.

**Step 2: Understand Risk Factors Associated With Child Maltreatment**

Poverty, family violence, social isolation, and a household that has many children younger than 5 years of age increase the risk of child abuse or neglect. Parents who have a history of maltreatment as children; those who have mental illness, developmental delay, or substance abuse; and mothers who are younger than 19 years of age at the time of the child’s birth are at increased risk of maltreating their children. In addition, children born of undesired pregnancies, those born of multiple gestation (twin) pregnancies, and disabled children (including children who have behavioral and learning problems) are at higher risk of being maltreated.

Taking the time to obtain, update, and document detailed family and social histories with all parents and patients provides a foundation from which to evaluate worrisome physical findings, growth and developmental failures, or other issues of concern that may present during health supervision visits. Gathering such information also allows for identification of high-risk families to initiate support services and prevention efforts and help prevent the occurrence of abuse.

Certain patterns of parental behaviors and feelings about children increase the risk of abusive or neglectful behaviors. An example is parents who have inappropriate developmental expectations of their children, such as expecting a newborn not to cry or an 8-month-old infant to be toilet trained. All parents can become frustrated by an infant who cries for hours each day or a toddler who is learning toileting skills. When parents cannot understand their children’s behavior as age-appropriate, their frustration may escalate and result in child abuse.

Another example of worrisome parental behavior is a failure of empathy between parent and child or the inability of the parent to understand and participate in the child’s emotional experience. It is likely that parents who were not treated with empathy and understanding as children may be at particularly high risk of an inability to show understanding to their own children. Another parental attitude that increases the risk of child maltreatment is the assignment of inherent value to the use of physical punishment. Some families believe that children cannot be brought up successfully without the use of regular spankings or beatings and that to spare such actions will lead to harm.

Finally, parents who reverse parent-child roles and see children as a major source of family comfort are likely to be frustrated and disappointed when faced with the persistent neediness and dependence of children. This mindset also can lead to child maltreatment. Using health supervision visits to learn of parents’ feelings about and attitudes toward their children can provide useful information that can be accessed when concerns about a child’s welfare arise and can prompt the clinician to implement important family support and prevention services.

**Step 3: Obtain a Careful History and Perform a Thorough Physical Examination**

When a child presents with a concerning injury or the clinician begins to suspect neglect, a critical step is to obtain a thorough history and physical examination. In addition to the history of the present illness and past medical history (which may reveal past injuries or evidence of neglect), a complete family and social history should be obtained to provide a framework or context that may explain the injury or suspected neglect. Gathering historical data is particularly important in urgent and emergent settings, when the examining practitioner...
does not have the benefit of long-term knowledge of a patient and family that the primary care practitioner has.

When evaluating an injury in a child, it is best for the practitioner to hear exactly what occurred from the parents and witnesses (if possible and only if they were present at the traumatic event). It is imperative to avoid interrupting parents as they relate the history of an event, so their report about what happened is not influenced by the clinician’s words or perspective. Once a story is obtained in full, questions for clarification and requests to demonstrate or re-enact events may be useful. However, such questioning should occur only after listening to an initial full explanation.

Crucial additional information may be obtained simply by performing a full physical examination with the child disrobed. Consider an 18-month-old child who presents with a fractured humerus and whose parents report that they have not witnessed a traumatic event. A fully disrobed examination may reveal bruises or other cutaneous manifestations of trauma for which explanations must be sought. Conversely, failing to complete a fully disrobed examination could leave clear signs of physical abuse undetected.

Step 4: Seek Out and Use Additional Data
The fourth component of a useful approach to evaluating possible maltreatment is to seek out and use additional data that can aid in establishing the degree of concern about an individual child’s presentation. Other sources of data may include an additional interview of an injured child’s parents by a different clinician or a social worker, a conversation with the child’s primary care practitioner, an examination by an expert (such as a pediatric ophthalmologist), laboratory data (such as coagulation studies), and radiographic studies (such as computed tomography scan of the head).

Consider a 3-month-old infant who has a femur fracture and whose father reports that she rolled from a bed. A radiologic skeletal survey may reveal multiple healing rib fractures. In this case, the decision to report the child to CPS is clear. An interview of the father by a social worker may generate a significantly different history of the child’s fall that prompts increased concern for possible physical abuse. A review of a child’s medical record (or of his or her sibling’s medical records) or a conversation with a primary care clinician may identify a pattern of multiple missed visits or documented social concerns that also may push the practitioner toward a decision to report a questionable presentation.

Step 5: Know When to Become Concerned and Use a Clear Approach to Decision-making
Most often, concern about physical abuse is generated by an unexplained or less-than-adequately explained injury rather than by the mere presence of a specific injury. Examples include a 5-month-old infant presenting with unexplained bruises and a 2-month-old infant who has multiple rib fractures and reportedly fell from a mattress 1 foot from the floor. Certain presenting or incidental physical findings always should prompt a consideration of physical abuse. These findings include bruises and oral trauma in children younger than 6 months of age and fractures in nonambulatory infants. Bruising can occur in the setting of a bleeding diathesis, and fractures may be accidental, but abuse must be considered and ruled out carefully when very young children have signs of trauma.

Similarly, the clinician must consider neglect in children who fail to thrive or are developmentally delayed while simultaneously considering other medical explanations for the growth failure. In addition, recognition of a child’s developmental abilities is crucial to approaching injuries that may be accidental. Active toddlers who run and play can sustain fractures in many ways. Five-month-old infants who cannot sit alone, crawl, or “cruise” are much less likely to sustain fractures under their own power, but can be injured if a parent falls while carrying the child.

After performing the examination, obtaining an explanation for an injury, and gathering additional data, the practitioner must answer questions related to the mechanism, severity, and timing of injury. First, does the history obtained from parents include a reasonable mechanism to explain the child’s injury? For example, a 3-month-old child who presents with bruises and multiple fractures and whose parents report a single fall from a bed 2 feet from the floor raises concern about the adequacy of the stated mechanism of injury to explain the child’s physical findings.

Second, does the history obtained from parents make sense in terms of the severity of the injury? When parents state that a 7-month-old who has seizures, a subdural hematoma, and retinal hemorrhages banged his head on the side of his crib, the history is insufficient to explain the severity of the child’s presentation and should cause significant worry.

Third, does the history offered adequately explain the injury with respect to timing? A 2-year-old child who is brought for medical attention after a reported fall down stairs but is found to have fractures in various states of
healing has evidence of older, unexplained trauma that must be investigated for suspected abuse.

Lack of an appropriate explanation for serious injury in a child always must raise the practitioner’s concern for possible child abuse. In addition, when different parents or witnesses offer significantly inconsistent histories of a reported traumatic event or when individuals offer multiple descriptions of a single traumatic event, child abuse must be considered. Keep in mind, however, that inconsistencies in histories can occur when different people ask questions in various ways and when parents have less than a full understanding of what is being asked. Use of interpreter services with non-English-speaking families is crucial, as is a sense of any cognitive limitations in parents that may affect their understanding of the questions asked.

Employing a framework to help evaluate the child’s presentation is helpful when considering an injured child or a child who may have been abused or neglected. All clinical presentations fall along a continuum between those presentations consistent with abuse or neglect and those that can be explained by accidental mechanisms, medical problems, or birth injuries. Graphically, this can be represented by Leventhal’s Triangle (Fig. 1). Each side of the Triangle represents a continuum between: 1) an abusive injury and an accidental or medically explained injury, 2) neglect and an accidental or medically explained injury, and 3) an abusive injury and an injury that occurred through neglect. A line can be drawn through the Triangle that represents the point at which an injury or presentation suggests maltreatment and warrants a report to CPS. If a child’s presentation along one side of the Triangle falls below the line, a report to CPS is indicated. If the presentation falls above the line, referral is not necessary.

Each injury can be located along the side of the Triangle. For example, a 9-year-old child wearing a bicycle helmet presents to the emergency department (ED) with a fractured wrist after a fall from his bike. The child is verbal and describes what happened: “I took the turn too fast and fell off of my bike.” With this history, the child’s presentation on the Triangle (Fig. 2) does not warrant a report to CPS.

The injury suffered by a 9-month-old child who has a linear parietal skull fracture after a witnessed fall from a bed falls along the continuum between an accident and neglect (Fig. 3). A report to CPS is not indicated. More careful supervision likely would have prevented the injury. Although it does not reach a level of reporting for neglect, this injury offers an opportunity for the clinician to educate the caregivers about supervision and injury prevention.

The Triangle may be helpful when the clinician evaluates possible neglect by placing a single injury in the context of other child and family factors. When considering a diagnosis of neglect, the practitioner must take into account a pattern of parental behavior. If history-taking for the 9-month-old child who experienced a witnessed fall from a bed and a fractured skull reveals that the child has been injured in two previous falls from the bed, the same injury could be represented differently (Fig. 4), and a report to CPS should be made.

Other factors in the history might influence the placement of the injury along the line. For example, if the mother of the 9-month-old infant who sustained the skull fracture has alcohol on her breath at 8:00 AM when the child is being evaluated, the clinician would be more worried about neglect (or abuse). In this instance, the injury is placed well below the reporting line, and a report to CPS should be made. It is important to remember that injuries happen in a context, and the context influences both how clinicians evaluate an injury and where the designation of the injury should be placed on the Triangle.
Many pediatric practitioners struggle with how to handle parental use of physical punishment. Although the American Academy of Pediatrics is clear in its evidence-based opposition to the use of physical punishment, most states allow for some degree of physical punishment within legal limits. The Triangle may be adapted slightly to help the clinician determine whether a child has been physically disciplined or has been abused. If Accident/Medical Problem at the top of the Triangle is replaced with Acceptable Parental Behavior, the Triangle may be used to consider whether a child has been treated within the spectrum of acceptable behavior. For example, a 2-year-old child who has been spanked lightly on clothed buttocks for playing with the stove may be placed in the triangle as in Figure 5. No report is made. In contrast, the same 2-year-old child who has been punched in the stomach for having a toileting accident would be represented differently (Fig. 6) and a report to CPS made.

**Step 6: Know When and How to Get Help**

Even after careful consideration and application of the decision-making tools described previously, the clinician may not yet be clear about whether to make a report to CPS. For this reason, the sixth step is knowing when and how to get help. Such help may be obtained from key support staff such as social workers or nurses. Obtaining a careful family and social history in the setting of a busy ED is a challenge; working with a social worker may allow the gathering of important information to help the practitioner decide whether to report an injury. Information should be gathered in four key areas: exposure to violence, substance use or abuse, mental health, and previous CPS involvement. Nurses may witness parents attempting to “get their stories straight” and should be asked about what they have observed; nurses often make important observations about parent-child, parent-sibling, and parent-parent interactions.

When available, a pediatric child abuse expert can be a valuable resource for cases in which a decision to report to CPS is particularly difficult. Such experts may be available for telephone consultation, to review photographs and radiographs, or to evaluate children personally. They can offer extremely useful input in difficult cases.

![Figure 3](image1.png)

Figure 3. Child has a linear parietal skull fracture after a witnessed fall from a bed.

![Figure 4](image2.png)

Figure 4. Child has third witnessed fall from a bed.

![Figure 5](image3.png)

Figure 5. Two-year-old child who has been spanked lightly for playing with the stove.

![Figure 6](image4.png)

Figure 6. A child punched in the stomach for having a toileting accident.
Confronting possible child maltreatment can generate multiple emotions in the clinician, including anger, sadness, disgust, and anxiety. It may be helpful for the practitioner to discuss worrisome cases with a trusted partner or senior clinician, so that such emotions may be identified, supported, and managed. Consultation with another person can provide support to the clinician and may prevent difficult emotions from interfering with his or her ability to act in the best interest of the children for whom he or she cares.

**Step 7: Consider Hospital Admission**
Arranging an inpatient evaluation for a child who appears to have been abused or neglected may be especially helpful. Admission may allow the input of pediatric specialists (including child abuse experts, orthopedists, hematologists, and trauma specialists) and simultaneously provide immediate safety for the child while a decision about reporting to CPS is made. In situations in which a practitioner is especially concerned, transportation by ambulance may be arranged from the primary care setting to the hospital. If parents refuse to comply with a suggested evaluation in the ED or inpatient unit, local law enforcement may need to be notified. If the practitioner does not opt for hospital admission, careful follow-up must be assured and current contact information for the family confirmed in addition to mandatory CPS notification about possible abuse.

**Step 8: Remember That a Child May Have Siblings**
Hospital admission may secure the safety of an individual child, but that child may not be the only one at risk. The eighth component of a successful approach is to remember that an abused child may have siblings or live in a household with other children, a circumstance that may accelerate the timing of a report to CPS in less clear cases. When a child is an only child, time may be taken during a hospitalization to gather and weigh facts before making a report. When a child has siblings who remain in the care of possibly abusive or neglectful parents, however, an immediate report of suspected maltreatment is warranted.

**Step 9: Tell Parents When a Report is Made**
Once the clinician decides to report a child to CPS, the next challenge is when, where, and how to tell the child’s parents. Many practitioners identify the act of telling a child’s parents that a report to CPS has been or will be made as being among the most difficult tasks they face. However, the person making a report (or causing a report to be made) is the best person to inform a child’s parents about it. It may be helpful to recall the mandatory reporting laws when communicating with parents about a report to CPS. Remembering that a legal mandate goes into effect when concern for a child is raised (and communicating that legal obligation) may help the practitioner face the challenging task of informing parents of his or her suspicion of abuse.

It is acceptable and advantageous to assure a child’s safety first, but there should be no additional delay in telling parents about a report beyond the time that a child’s safety is assured. Hospital admission (Step 7) may be employed best in this setting. For example, an infant presenting with multiple bruises may be safest if sent directly to the ED or inpatient unit before his or her family is informed about a report to CPS. The conversation may take place in the hospital with the support of available hospital services, such as on-site social workers and security personnel.

Deciding how to tell parents that the report will be made is a particular challenge to primary care or subspecialty practitioners who have longstanding relationships with the children and families. A CPS report is likely to be perceived as a severe threat to a partnership between the clinician and the family that may have been built over a period of years. Remembering the mandated reporting law once again may be helpful. The practitioner should recall that the law must guide his or her actions, which can be stated to parents.

For example, consider a 4-month-old child found to have bruises over her face and ears during a health supervision visit. Bruising in this age group is never normal, and although it may be the presenting sign of a bleeding diathesis, the bruising may have been caused by trauma. This infant may be sent to the ED for simultaneous evaluations of a possible bleeding problem and possible abuse. Because abuse is suspected, a report to CPS should be made. Once the child’s safety is assured, her parents may be told that because her bruising could represent possible child abuse, state law mandates a report to CPS.

The practitioner may say something such as, “Whenever we see bruises like this in an infant, we have to worry about possible abuse. When that happens, I am mandated by state law to make a report to child protective services.” Parents then can be assured that the practitioner will maintain contact with the family and continue to be a source of support while the CPS investigation progresses: “I will stick with you throughout this process and answer any questions along the way.”

Parents also can be assured that other, possibly medical, causes of a child’s presentation will be ruled out.
Step 10: Continue to Advocate and Care for the Child and Family After Making a CPS Report

Although making a report to CPS for a child may feel like the final step in an assessment process, it should not be. The practitioner should make every effort to continue to advocate for children and families after making a report to CPS. This action comprises the tenth and final step in a successful approach to managing suspected child maltreatment. An understanding of what is likely to happen after a CPS referral can help the practitioner provide support to families.

The pediatric clinician provides and interprets medical data to CPS personnel and to the investigating law enforcement officers. Police detectives and prosecutors who seek to determine if a crime has been committed may have particularly challenging questions. They may request an ironclad diagnosis of abuse, ask the practitioner to explain exactly what mechanism led to a child’s injuries, or ask the clinician to “time” the injuries definitively. It is important to remember that the answers to these questions may not be available immediately (because a medical evaluation is ongoing) or that they may never be available (identification of an exact mechanism of injury and specific timing of injuries may not be possible).

When speaking with law enforcement personnel, the clinician should be guided by adherence to what can be said with certainty and avoid speculation. Medical terminology also should be explained carefully to both law enforcement and CPS personnel. The practitioner should take time to explain a child’s medical findings in clear, jargon-free language to CPS personnel as they work to determine a safe disposition for the child and to law enforcement personnel as they seek to identify, investigate, and prosecute possible crimes.

Only a fraction of CPS reports result in removal of a child from his or her home. Removal is most likely to occur in cases of suspected serious injury or serious neglect. Even when removal occurs, reunification is always a goal and is considered in every case. Many families who are reported to CPS do not lose custody of their children; instead, they receive services through the auspices of CPS. For example, the infant of a depressed mother who has failed to thrive because of caloric restriction may remain with his or her parents if intensive services, including mental health care, can be provided. Removal is an option of last resort and is used only when a child’s safety cannot be assured.

When CPS decides that a child’s safety is in imminent danger because of suspected abuse or neglect, the agency has two means by which to obtain custody of a child. The first is a temporary custody order. To obtain a temporary custody order, CPS must present evidence to a judge in court (called juvenile, family, or dependency court in different states) that a child’s safety is at continued imminent risk. If the temporary custody order is granted, CPS takes temporary custody of the child, and a future court date is specified, at which time the judge hears additional evidence and reevaluates whether to continue custody with CPS or reunite the child with his or her parents (with or without specified services). At the hearing, evidence is presented by a CPS attorney and attorneys for the individual parents and the child. In some states, the child is assigned a guardian ad litem who tries to understand the child’s situation and advises all involved parties about what would most benefit the child.

The second option is used on weekends, holidays, or after work hours, when a judge is not available. In this situation, CPS still may take temporary custody of a child for several days under what usually is called a “hold.” In Connecticut, this period is 96 hours, but the duration of the hold may vary from state to state. Within whatever time frame a given state prescribes for a hold, CPS must go to court to provide evidence about the reason the hold was invoked and the necessity that the child not be allowed to be cared for by his or her parents.

For both a temporary custody order and a hold, CPS usually requests that the practitioner caring for the child or consulting on the case provide documentation (often in the form of an affidavit) describing, in lay terms, the child’s medical condition, the types of injuries seen, and the reasons that abuse or neglect is suspected. In addition, the documentation states that the child’s safety is at imminent risk if he or she is allowed to return to the home.

Many practitioners identify a concern about what may happen to children after a CPS report is made as a reason for choosing not to report suspected maltreatment. Concerns about the CPS underreacting (failing to substantiate a report) or overreacting (seeking removal of a child not believed by the clinician to be at high risk) often are cited as barriers to reporting to CPS a worrisome injury or behavior. It is helpful to remember that CPS investigators often have
far more information at hand than the medical practitioner. For example, the parents of an infant suspected of being a victim of neglect may have had other CPS reports in the past that resulted in out-of-home placements of children. The parents may not share this information with the primary care practitioner. Similarly, CPS investigators routinely perform home visits that can offer a wealth of information. Odd mechanisms of injury that may prompt practitioner concerns may be confirmed when the parent re-enacts the event at the site where the injury occurred. On the other hand, home investigations may reveal inadequate resources to care for children far beyond what the practitioner may have imagined.

A particular challenge occurs when a clinician is extremely concerned about a child and makes a report, but CPS fails to substantiate abuse or neglect and closes the case. This outcome may occur for a variety of reasons. A child who disclosed sexual abuse may retract the disclosure in the face of family pressure. An infant who has missed many continuity appointments but has no specific medical problem may not be judged to be at risk by CPS investigators. An unsubstantiated report to CPS does not mean that abuse or neglect did not occur. When a report is unsubstantiated and the degree of worry is high, the practitioner should be reminded that additional reports may be filed in the face of new or ongoing concerns.

In addition, a concerted effort on the part of the practitioner to speak directly with a CPS investigator or supervisor about concerns is likely to make a powerful contribution during an investigation. Many practitioners feel that the only call possible is the initial report to CPS; in fact, continued discussions with the CPS personnel investigating alleged maltreatment are both possible and extremely useful.

Similarly, when a practitioner believes that CPS has overreacted in its handling of a report, continued advocacy is possible. The practitioner may reach out to CPS in an effort to share observations about a parent’s strengths that may encourage authorities to consider keeping a child in the care of his or her family, perhaps with additional support. In either case, the practitioner may serve the children in his or her care best by continuing to provide advocacy long after making a first report to CPS.

If a child is placed in foster care as a result of a CPS report, the practitioner may continue to advocate for that child and offer the services of a medical home if he or she continues to provide primary care to the child and the foster family. Even if this arrangement is not possible, as is the case when a child is placed with a family who lives too far away from the practitioner’s office, the practitioner can ease a child’s transition by making medical records available to the newly identified clinician.

Although the foster care system offers safe haven for abused and neglected children, it is not a perfect solution. Even children who have been maltreated suffer consequences from being removed from their parents’ custody. Unfortunately, some children may suffer harm, including abuse and neglect, in foster care. The ongoing care of a concerned pediatric clinician can offer continuity to children who may benefit greatly from it.

Summary

- The management of child maltreatment is never easy, but considering and reporting suspected cases of child abuse and neglect are important clinical skills and obligations of a pediatric clinician.
- Use of the stepwise approach and the conceptual framework set forth in this article is likely to help the pediatric practitioner move from concern to action in a way that assures children’s safety and also serves families best.
- The clinical approach described in this article is based not on research evidence, but rather on the practical experience gleaned from years working as pediatric experts in child abuse.

Suggested Reading

PIR Quiz
Quiz also available online at http://pedsinreview.aappublications.org.

1. Which of the following statements regarding the reporting and investigation of suspected child maltreatment is true?
   A. Allegations of child sexual abuse should be reported to the police and CPS only if physical evidence of abuse is present.
   B. If a health-care practitioner suspects child maltreatment but does not report it to CPS, his or her medical licensure could be at risk.
   C. In cases of suspected child sexual abuse, the family, rather than the health-care practitioner, is responsible for filing a report with the police.
   D. Investigators should interview children for whom parents allege sexual abuse as many times as possible to be sure to get an accurate history.
   E. To be protected by the law, health-care practitioners should wait until they are certain that child maltreatment has occurred before reporting it to CPS.

2. Which of the following conditions always should prompt the health-care practitioner to strongly consider child maltreatment or abuse?
   A. Bruises on the abdomen of a 5-month-old girl who has no reported history of trauma.
   B. Bruises on the anterior legs of a 2-year-old boy who has normal development.
   C. Failure to thrive in an infant who has large, bulky stools and noisy respirations.
   D. Fracture of the tibia in an 18-month-old girl who just learned to walk.
   E. Linear skull fracture in a 10-month-old girl who was dropped from her parent’s arms in a fall.

3. You are evaluating an 11-month-old boy for decreased right arm movement. His mother is extremely upset and reports that he fell from her bed after a nap that morning. Except for bruising and pain over his right upper arm, his physical examination findings are normal, and his development is consistent overall with that of a 7-month-old. He is just beginning to support his weight on his legs. A skeletal survey reveals an acute fracture of his right humerus and two healing fractures of the left ribs. His mother states that she is unaware of the rib fractures and denies previous trauma. Which piece of information is most likely to prompt an additional evaluation and report to CPS?
   A. Acute injury inconsistent with the history given by the mother.
   B. Developmental delay of unclear cause.
   C. Fracture of an extremity in an infant younger than 1 year of age.
   D. High distress level in the mother.
   E. Presence of old healing fractures.

4. You suspect neglect in one of your clinic patients, who has severe failure to thrive and some unexplained bruises, and you file a report with CPS. Which of the following techniques for disclosing this report to the family should be employed?
   A. Admit the child to the hospital and ask the hospital social worker to tell the family.
   B. Advise the family that you are unable to participate further in the child’s care.
   C. Refer the child to a child abuse specialist so that he or she can explain the process to the family.
   D. Tell the family that you are obligated by law to report the case but that you will fully investigate other causes for the child’s symptoms.
   E. Wait to tell the family about the report until all organic causes have been ruled out.
Managing Child Abuse: General Principles
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Sexual Abuse

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Objectives After completing this article, readers should be able to:

1. Understand the definition and epidemiology of sexual abuse.
2. Know when to suspect sexual abuse, and know which behaviors are normal and which are suggestive of abuse.
3. Recognize that a sexually transmitted disease may be an indicator of sexual abuse.
4. Be aware of the recommended methods for taking a history when there is concern about sexual abuse.
5. Know the proper techniques for examining a child when sexual abuse is possible, and how to interpret physical findings. Be aware that a normal physical examination does not rule out sexual abuse.
6. Be familiar with techniques for collecting forensic evidence and the value of laboratory testing.
7. Know the psychological and legal aspects of sexual abuse, and be aware of treatment plans and methods for prevention.

Introduction
It is almost certain that pediatricians will encounter child sexual abuse over the course of their careers. Sexual abuse is prevalent. Sexually abused children present for medical care in a variety of clinical contexts. The evaluation and treatment of child sexual abuse involves multidisciplinary collaboration. The health professional’s role includes addressing the physical and mental health consequences of abuse. Physicians are mandated to report suspected abuse to authorities.

In this article, history taking, physical examination, forensic evidence collection, laboratory testing, sexually transmitted infections (STIs), interpretation of clinical findings, psychosocial outcomes, legal considerations, and treatment will be discussed. Pediatricians might choose to consult with a health professional specializing in the management of child sexual abuse, depending on the clinical context, the physician’s level of ease with components of the evaluation, and local resources.

Background Information
Child sexual abuse occurs when a child is engaged in a sexual situation. Some cases of sexual abuse involve physical contact between the victim and the perpetrator, with or without oral, anal, or vaginal penetration. In other cases, there is no touching (eg, a child is made to watch sexual acts or pornography). In the majority of cases, perpetrators are not strangers, but are known to the victim through relationships such as being relatives, family friends, neighbors, or community volunteers. (1)(2)(3) In many instances, perpetrators “groom” their victims and use threats, manipulation, or coercion as opposed to physical force. (2)(3) Delay between the onset of abuse and disclosure is common. Adults surveyed about past experiences of child sexual abuse often report that they did not tell anyone about their abuse during childhood. (4)(5) One study found that approximately one-quarter of sexual abuse victims retract their statements of abuse at some point, (6) and recantation does not rule out sexual abuse.

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Epidemiology

Measures of sexual abuse frequency vary, depending on factors such as data source, definition of sexual victimization, and study population. The 2005–2006 National Incidence Study found that the incidence of sexual abuse cases that came to the attention of investigators or other community professionals was 2.4/1,000 US children under the age of 18 years. (7) A 2005 telephone survey of children and caregivers by Finkelhor et al evaluated the frequency of sexual victimization in a nationally representative sample of children in the United States. Overall, 82/1,000 (1 in 12) children aged 2 to 17 years experienced sexual victimization such as sexual assault, sexual harassment, or flashing in the study year, including 67/1,000 boys, 96/1,000 girls, and 168/1,000 teenagers. (8)

Other studies have estimated the frequency of child sexual abuse by asking adults about their childhood experiences. A frequently cited Los Angeles Times survey found that 27% of women and 16% of men reported childhood sexual abuse. (4) Because it is not possible to account for undisclosed cases of sexual abuse, measures of frequency probably underestimate the true scope of child sexual abuse.

As reflected by these data, sexual victimization is more common among girls than among boys. Boys, however, might be less likely to disclose sexual abuse and might be victimized more often than the reported gender ratios suggest. Compared with other age groups, teenagers have the highest rates of sexual assault. (9) Physical disabilities, prior sexual victimization, and absence of a protective parent are other potential risk factors. (1)(2)(9)(10)

Clinical Presentation

Health professionals caring for children can encounter instances of child sexual abuse in different contexts. Patients sometimes present for evaluation soon after an episode of suspected abuse. In many cases, however, disclosures of sexual abuse are delayed, and therefore medical attention is sought outside of the acute period. Some patients are brought to medical attention by way of involvement with community agencies such as child protective services or law enforcement agencies. In other cases, victims and their families turn to health care providers first.

Disclosure of sexual abuse generally leads to a medical evaluation. Children present after they have made a statement of abuse to a professional, such as a social worker, teacher, or law enforcement agent, or to a nonprofessional such as a parent or a friend.

Concern for sexual abuse also can be raised in children who have not disclosed abuse. Sexual abuse enters the differential diagnosis when children exhibit worrisome sexual behaviors. Sexual behavior problems must be differentiated from developmentally normal behaviors. Examples of normal behaviors in preschool-aged children include undressing in front of others, touching one’s own genitals, and trying to look at others undressing. Research, including Friedrich et al’s study of >800 children, has shown that transient, developmentally appropriate behaviors are common among children who have not been sexually abused. (11)(12) The pediatrician can reassure parents in cases of developmentally appropriate, transient behaviors.

In contrast, behaviors such as coercing others to engage in sexual acts or explicitly imitating intercourse are uncommon and warrant comprehensive evaluation. (11)(12) Children who have sexualized behavior problems may engage siblings or peers in sexual acts; immediate intervention is required to ensure that all children involved are protected. No behavior is in and of itself diagnostic of sexual abuse. The differential diagnosis for sexual behavior problems also includes exposure to violence in the home, emotional abuse, neglect, conduct disorder, witnessing sexual acts, and exposure to sexual materials. Community resources, including mental health professionals and pediatric subspecialists in child abuse pediatrics, can assist pediatricians in evaluating sexual behaviors. A 2009 clinical report issued by the American Academy of Pediatrics (AAP) discusses childhood sexual behaviors in detail. (12)

A study of 112 children aged 3 to 7 years found that children with a sexual abuse history were more likely to include genitalia in their drawings in comparison with controls. (13) It is important to note that, although drawing of genitalia raises concern for sexual abuse, it is not diagnostic of sexual abuse in and of itself.

Sexually abused children also can present with nonspecific physical or emotional complaints, such as unexplained abdominal pain, genital pain, encopresis, school failure, or sleep disturbance. The vast differential diagnoses for these nonspecific presenting complaints include both organic pathology and a range of psychological stressors. When concern is raised for sexual abuse because of a non-specific presenting complaint, questioning about stressors, including abuse, should be conducted in an open-ended, nonleading, developmentally appropriate manner. Nonspecific symptoms in isolation are not diagnostic of sexual abuse.

In rare cases, specific medical findings will be the initial indication that sexual abuse has occurred. The presence
of sperm in a sample taken directly from a child’s body and pregnancy are examples of medical findings that are diagnostic of sexual contact. (14)

Overview of the Medical Management of Child Sexual Abuse

As with medical evaluations for other pediatric complaints, components of medical evaluations for sexual abuse include history taking, physical examination, laboratory testing, and treatment planning. In addition, forensic evidence collection is indicated in some cases; in all cases, physicians are mandated to report suspected child abuse to the proper authorities in their jurisdiction.

There are many variables to consider when patients present for evaluation of sexual abuse, such as patient age and timing since the last episode of suspected abuse. Medical evaluations are tailored to the given context to ensure comprehensive evaluation and intervention. For example, there will be significant differences between the evaluation of a teenage victim of acute sexual assault and that of a preschooler who disclosed sexual abuse occurring 1 month ago. Specialists with training and experience in the management of child sexual abuse can provide consultation.

Medical History Taking

The medical history is often the most important part of a sexual abuse evaluation. Objectives in obtaining the medical history include:

1. Gather information needed to guide the medical evaluation (eg, determine the need for forensic evidence collection or testing for STIs).
2. Gather information needed to establish a medical treatment plan (eg, determine if postexposure prophylaxis is indicated).
3. Detect physical health symptoms related to abuse that require further evaluation and treatment.
4. Detect psychological sequelae of abuse.
5. Identify familial psychosocial consequences of abuse (eg, parental emotional distress, financial concerns).
6. Detect medical problems that are not directly related to the alleged abuse.
7. Assess the immediate safety of the child.

Potential sources of information include other professionals, the child’s caretakers, and the child. Caretakers who accompany the child to the medical evaluation should be supportive, and suspected perpetrators of abuse should not be present. In the absence of extenuating circumstances (eg, child refuses to separate from the caregiver), information sources should be interviewed separately.

Taking a History From Caretakers

In cases in which the patient made a statement of abuse before the evaluation, caretakers can be asked about the child’s disclosure. Information about the timing and nature of the suspected abuse is important for making decisions about STI testing, prophylactic treatments, and forensic evidence collection. Information provided about the alleged perpetrator, such as known health problems, history of intravenous drug use, and history of incarceration, is useful in assessing the patient’s risk for STIs. Asking about ongoing contact between the alleged perpetrator and the patient or other children is important in assessing child safety.

On review of systems, a report of dysuria or anogenital pain, bleeding, discharge, or itching could be indicative of infection or injury. Any history of constipation, enuresis, and encopresis also should be reviewed. Age of menarche and date of last menstrual period are pertinent to the assessment of pubertal development, symptoms of pregnancy, and the possibility of menstrual bleeding during physical examination. It is important to conduct a review of psychological and behavioral symptoms. In some cases, patients have symptoms such as suicidal ideation that require immediate mental health intervention. Reports of school failure, sleep disorders, sexually reactive behaviors, nightmares, anxiety, or depression require appropriate referrals and intervention. A history of other abusive or consensual sexual activity should be obtained.

Child sexual abuse also has an impact on the patient’s family. (15) In obtaining a social history, it is important to identify household members. Child protective services can collaborate to determine if other children in the home have been witnesses or victims of abuse. Financial concerns might be raised in cases where the alleged perpetrator was previously a financially contributing household member. The caretakers’ response to a child’s disclosure of sexual abuse is important. Asking about caretakers’ emotional state and support systems can be helpful in optimizing services for the family. Significant concerns for child safety are raised when a caretaker is openly disbelieving of a child’s disclosure and when a caretaker allows further contact between a child and the suspected perpetrator of abuse.

Taking Histories From Children

Children’s statements about abuse are a key component of most sexual abuse investigations. There is a breadth of information on obtaining accurate and comprehensive
histories from children suspected of being victims of abuse. Resources include practice guidelines from professional organizations such as the American Professional Society of the Abuse of Children, textbooks, and a growing body of research. (16)(17)(18)

General considerations in asking children questions about abuse include the types of questions asked, the patient’s developmental level, and the number of interviews. Open-ended questions and questions that invite narrative responses are preferred. Examples include, “Tell me why you came to see the doctor today,” and “Tell me everything that happened.” Questions that suggest an answer, such as, “Your uncle touched you, right?” are to be avoided. Compared with adults, children under the age of 10 to 12 years are more suggestible. Children as young as 3 or 4 can provide accurate accounts when questioned properly. Some interviewers may use human figure drawings or free drawings to help build rapport and collect information. Most professional interviewers usually do not interview children under the age of 3 years, depending on the child’s level of language development. Children should be interviewed separately from their caretakers in the absence of extenuating circumstances.

Avoid interviewing a child multiple times unnecessarily. In many communities, children’s advocacy centers coordinate community agencies and professionals to minimize the number of interviews. The first was established in Huntsville, Alabama, in 1985. There are now >700 children’s advocacy centers in the United States offering a multitude of services. Further information and center locations can be found at http://www.nationalchildrensalliance.org.

Professionals with specialized knowledge, such as child protective services investigators, trained forensic interviewers, or law enforcement officers, conduct investigative interviews. This action does not exclude health providers from obtaining medical history for the purposes of medical evaluation and treatment planning. Physical, behavioral, and psychological symptoms as outlined above can be reviewed with patients when developmentally appropriate. In some instances, children make spontaneous statements about abuse in the course of a medical visit. These statements should be documented carefully in the medical record.

In many jurisdictions, forensic interviews are video- or audio-taped. In many medical settings, however, audiovisual recording is not feasible nor is it common practice, and written documentation is used. Written documentation of children’s statements about abuse should contain the questions asked in addition to the child’s responses. The child’s exact words in quotations should be included where possible.

Professional interviewers sometimes use media such as anatomic drawings or anatomic dolls. (17)(19) Anatomic dolls have genitalia, anal and mouth openings, and developmentally appropriate secondary sex characteristics. The use of anatomic dolls has given rise to academic and legal debate. One of the main challenges to the use of anatomic dolls is concern for suggestibility. On the other hand, research studies demonstrate that anatomic dolls can be used nonsuggestively and may enhance children’s ability to describe an abusive event. The use of anatomic dolls should be reserved for professionals with specialized training in interviewing.

**Physical Examination**

**Objectives**

Objectives of the physical examination completed in the context of a sexual abuse evaluation include:

1. Recognize injuries that require immediate medical attention.
2. Identify anogenital abnormalities, including conditions that mimic injuries (eg, lichen sclerosis), and interpret physical findings appropriately (eg, normal variant, nonspecific, indeterminate, indicative of trauma).
3. Detect signs of STI.
4. Identify injuries outside of the anogenital region (eg, mouth, chest, extremities).
5. Recognize signs of self-injurious behaviors (eg, scars from cutting).
6. Address patient concerns about physical health that may arise subsequent to abuse.
7. Collect forensic evidence.

**Comprehensive Examination**

Physical examination in the context of a sexual abuse evaluation is not limited to the anogenital region. A comprehensive head to toe examination is indicated. Victims of sexual assault can sustain physical injuries outside of the anogenital region. Some injuries require immediate medical attention (eg, uncontrolled bleeding, injury to the airway or viscera). The oral cavity should be examined carefully for signs of injury to the teeth and soft tissues. Skin injuries such as bruises and bite marks should be identified and documented carefully. When possible, photographing findings is helpful. Psychological symptoms can manifest physically in the form of sequelae from self-mutilating behaviors, such as cutting. In addition, a 2006 study by Giradet et al demonstrated that health problems unrelated to sexual assault, such as dental caries, decreased visual acuity, pediculosis, tinea, heart murmurs,
A Normal Examination Does Not Rule Out Sexual Abuse

A normal physical examination does not exclude the possibility of sexual abuse or prior penetration. The majority of sexual abuse victims have normal anogenital examinations. Multiple research studies demonstrate a low prevalence of definitive physical findings among victims of sexual abuse. (21)(22)(23)(24) In a case control study of close to 400 prepubertal children, Berenson et al found that, in the majority of cases, genital examinations did not differ between sexually abused children and controls. Physical findings specific to previous genital trauma were found in only 2.5% of abused children. (23) Kellogg et al studied a cohort of 36 pregnant adolescents who underwent sexual abuse evaluations. Only 5.5% of the pregnant teenagers had definitive findings of penetration on genital examination. (24)

Reasons for the absence of definitive physical findings subsequent to sexual abuse include:

1. With some forms of abuse, sexual victimization would not be expected to result in injury. Some forms of sexual victimization, such as exhibitionism and voyeurism, do not involve physical contact between the perpetrator and the victim. It follows that there is no resultant physical injury. In some cases, children are solicited to touch the perpetrator’s genitals, another example of sexual abuse occurring without anogenital injury to the victim. Genital fondling or oral contact to body parts can occur without tissue damage. Furthermore, penetration of the genitalia includes not only penetration of the vagina but also penetration between the labia. Penetration of the labia without penetration of the hymen will not result in hymenal tearing.

2. Penetrated tissues are sometimes stretched without injury. Hymenal and anal tissues have the ability to stretch. Although it is a common misconception that the hymen is always damaged at coitarche, in actuality, the hymen can remain undamaged after penetration. The anus also has the ability to stretch and remain uninjured subsequent to penetration.

3. Injuries can heal by the time of the medical evaluation. Mucosal and epithelial tissues can heal rapidly between sexual victimization and disclosure of abuse. (25)(26) McCann et al studied the healing of hymenal injuries and found that hymenal petechiae resolved within 48 to 72 hours. (26)

In some instances, caregivers believe that a physical examination will determine if their child has been sexually abused. Patients, jurors, and nonmedical professionals may share this misconception as well. It is important to communicate that a normal examination does not rule out sexual abuse, and that the majority of sexually abused children do not have specific anogenital examination findings proving they were abused.

Anogenital Examination

Physical examination should not cause added trauma. Explanations to parents and the child before, during, and after the examination can ease stress. Supportive, nonoffending caretakers also can be comforting to the child. Older patients can indicate if they prefer to undergo the examination with or without their caretaker in the examination room. The AAP Committee on Practice and Ambulatory Medicine has published guidelines on the use of chaperones during the examination of pediatric patients. (27) Suspected perpetrators should never be present. Patients who refuse should not be forced to undergo an examination. The use of sedation is not routine practice but can be considered in rare cases where the examination is vital (example, active vaginal bleeding) and where the patient cannot tolerate the examination without it.

The physical examination can have a positive psychological impact on patients. Victims of sexual abuse often fear their bodies have been damaged by abuse and are relieved to learn that they are in good health. Mears et al studied adolescents’ responses to sexual abuse evaluations and found that, whereas some found the examination embarrassing or painful, the majority (78.9%) agreed that the examination helped them to feel better. (28)

When examining girls, it is important to know the appropriate terminology for the genital structures. Figure 1 shows names of common structures of the prepubertal introitus.

Gender, age, and pubertal stage influence examination procedures. In girls, estrogen influences hymenal morphology. In the newborn period, the hymen appears thick and redundant under the influence of maternal estrogen. The hymen changes in morphology during the first years of life. (29) The unestrogenized prepubertal hymen appears thin, more translucent, and redder in color, and vasculature can be visible (Fig 2). After pubertal estrogenization, the hymen appears thicker, paler, and redundant (Fig 3). It is important to recognize physiologic differences in hymenal morphology during childhood and adolescence.
Some examination techniques involve contact with the hymen. For example, moistened swabs can be used to unfold the hymen to visualize the hymenal rim. Prepubertal patients are unable to tolerate such techniques because the hymen is very sensitive to touch during this period of development. Likewise, prepubertal patients would not tolerate speculum examinations. In the rare cases in which an internal examination is required in a prepubertal child (eg, uncontrolled vaginal bleeding, foreign body), examination with a speculum or vaginoscopy should be performed under anesthesia.

Different examination positions and techniques can be used to examine vestibular structures. The supine lithotomy position can be used for patients who are older and taller, whereas the supine frog leg position depicted in Fig 4 is used commonly in prepubertal patients. The frog leg position also can be attempted with the patient on the caregiver’s lap; this technique is useful when children are reluctant to get on the examination table. The external surface of the labia majora will be visible when patients are in the examination position. Separation and traction of the labia majora allow for visualization of the vestibular structures. In some instances, the hymenal opening is not readily visible. Adjusting labial traction may facilitate visualization of the hymenal rim. Also, dropping a small amount of normal saline in the vestibule while the patient is in the supine frog-leg position can lead to unfolding of the hymenal edges and improved visualization.

When an abnormality such as a hymenal transection is suspected, an alternate position or technique should be used to confirm the finding. In prepubertal patients, the prone knee-chest position can be used (Fig 4). In pubertal patients, moistened cotton swabs or Foley catheters can be used to unfold the hymen and visualize the posterior rim. Specialists with experience in using these techniques can provide consultation. Colposcopes provide magnification and lighting. In addition, colposcopy often allows for still or video recording of the examination. The colposcope does not come into contact with the patient, and this fact should be explained to children and parents.

Figure 1 depicts normal prepubertal female anatomy. Examination of the female external genitalia includes Tanner (sexual maturity) staging. The labia majora and minora should be evaluated for signs of trauma such as bruising or abrasions. Clitoromegaly should be addressed if it is noted. The urethral meatus should be assessed for discharge or prolapse. The hymen should be examined. When describing the hymen, it is useful to imagine...
a superimposed clock with the 12 o’clock position located anteriorly and the 6 o’clock position located posteriorly. Any irregularities can be described with respect to their position on the clock. The normal hymen can have a variety of configurations; crescentic (hymenal tissue not visible between the 11 and 1 o’clock positions) and annular (presence of circumferential hymenal tissue) configurations are common. Bleeding, discharge, or other abnormalities at the vaginal opening should be assessed. The fossa navicularis, posterior fourchette, and perineal body also should be evaluated.

Examination of the male external genitalia includes evaluation of Tanner stage, glans, and shaft of the penis, urethral meatus, scrotum, and perineum. Injuries such as bruises and bite marks should be noted. Discharge, inguinal adenopathy, and any other abnormality should be addressed as well.

Examination positions for the external anal examination include supine knee-chest and lateral decubitus. Any lesions, scars, or other abnormalities should be noted. Anal findings specific to sexual abuse (e.g., acute laceration not attributed to accidental injury, scar not attributed to medical condition or accidental injury) are not prevalent. Common findings that are not specific to sexual abuse include perianal redness, fissures, and venous congestion or pooling. The latter can be caused by being in the examination position for a prolonged period of time. Digital rectal examination is not indicated routinely.

**Interpretation of Examination Findings**

When present, medical findings indicative of sexual abuse are significant in criminal investigations, child protection investigations, and courtroom proceedings. In addition, anogenital findings affect medical decisions. For example, genital tract trauma is a risk factor for human immunodeficiency virus (HIV) transmission and can factor into the decision to initiate postexposure prophylaxis after acute sexual assault. Physical findings must be interpreted accurately. Health professionals with expertise in the evaluation of sexual abuse can provide consultation. Findings that are definitively indicative of previous trauma and those that are normal variants or nonspecific to sexual abuse must be differentiated. Research studies by authors such as Adams et al, Berenson et al, and McCann et al.

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provide an evidence base for interpreting physical findings. (14)(23)(30) The 2007 article by Adams et al includes a table classifying findings into categories such as:

1. Normal variants (eg, periurethral bands, hymenal tags, shallow hymenal notch, anal skin tag, perianal venous pooling).
2. Findings common to other medical conditions (eg, genital or perianal erythema, labial adhesions, infections such as group A Streptococcus, lichen sclerosis, eczema, anal fissures).
3. Indeterminate findings, in which there are insufficient data to determine definitively the significance of these findings in and of themselves (eg, deep notch or cleft in the posterior rim of the hymen, genital verrucous lesions).
4. Findings indicative of trauma (eg, laceration or bruising of the hymen, genital or perianal bruising, hymenal transections).
5. Findings diagnostic of sexual contact (eg, pregnancy, sperm on a specimen taken directly from patient’s body).

The diameter of the hymenal opening can be influenced by factors such as patient relaxation or labial traction and is not diagnostic of sexual abuse.

The AAP publishes an excellent resource for physicians that explains normal and abnormal genital findings in children, including medical conditions that can mimic trauma. (31)

### Forensic Evidence Collection

Another misconception about sexual abuse evaluations held by some families and jurors is that forensic evidence is always present. Given that victims often delay disclosing sexual abuse for days, weeks, or years, it is not possible even to attempt forensic evidence collection in many cases. Furthermore, forensic evidence collection does not always lead to positive results, even when victims present within 72 hours. In a retrospective review, Christian et al found that forensic evidence was identified in one-quarter of prepubertal patients who underwent evidence collection. (32) As with physical findings, forensic evidence is not required to make a diagnosis of child sexual abuse.

Timing and nature of the disclosed abuse are important considerations when determining whether forensic evidence collection is indicated. In most jurisdictions, forensic evidence collection is required if abuse involving the exchange of bodily fluids occurred within 72 hours. This time interval varies by state. It is noteworthy that forensic evidence rarely is found on swabs collected from the bodies of prepubertal children after 24 hours. In Christian et al's study of prepubertal patients, forensic evidence was more likely to be collected from clothes and household objects, such as sheets and towels, than from a child's body. (32) No swabs taken from prepuberal patients' bodies were positive for semen after 9 hours. (32) Blood, hair, semen or sperm, skin (which can be lodged under patients’ fingernails after scratching the alleged perpetrator), trace evidence such as fibers or debris, and saliva are examples of forensic findings. It is important to consider if the disclosed abuse could potentially result in forensic findings. For example, fondling over clothes does not involve contact with the alleged perpetrator’s semen, blood, or saliva.

Standardized forensic evidence collection kits typically include a container that will be identified with patient information, forms (eg, authorization forms, medical history forms), designated swabs and smears (vaginal or penile, anal, and oral), body swabs (for secretions, debris, or bite marks), test for DNA comparison (blood, saliva, or buccal sample), collection bags (for underwear, clothing, and debris), collection materials for pubic hair combings, and collection materials for fingernail scrapings. Instructions for collecting, drying, labeling, packaging, and sealing samples usually are included in the kit. Not all components of the kit will be applicable to every patient. For example, pubic hair combings are not applicable to patients who do not have pubic hair. Examiners should wear gloves. Local chain-of-evidence protocols, including transfer and storage of evidence kits, should be followed.

### Laboratory Testing

As with other medical conditions, decisions about laboratory testing for sexually abused children are based on clinical data. Testing for STIs, pregnancy, and drug-facilitated abuse sometimes are indicated.

#### STIs

Approximately 5% of sexually abused children contract an STI from abuse. (12)(33) Thoughtful utilization of laboratory studies will maximize STI detection and minimize unnecessary testing. Clinicians must determine not only whether STI testing is indicated, but also which studies should be performed and how the tests should be timed. The following factors influence decision-making:

1. Characteristics of the disclosed abuse
   a. Type of sexual contact: Digital-genital contact would not increase the patient’s risk for STIs such as HIV, Chlamydia infection, or gonorrhea. Rectal swabs for Chlamydia and gonorrhea should be
considered when there has been a disclosure of receptive genital-anal contact.

b. Timing of the abuse: In addition to testing at the time of initial presentation, patients require repeat testing in cases in which the last episode of abuse was recent. For example, convalescent testing for syphilis and HIV are indicated at 6, 12, and 24 weeks’ postassault. Repeat *Chlamydia* and gonorrhea testing ~2 weeks after the last contact is indicated in cases in which prophylactic treatment was not given. (33)(34)

2. Perpetrator characteristics: Known history of STI, risk factors for STI such as multiple sexual partners.

3. Community prevalence of STI

4. Clinical findings
   a. Symptoms or signs of STI
   b. Physical findings indicative of penetrating trauma
   c. Family history of STI

5. Patients requesting testing or having a high level of concern for STI

Available tests include serologic studies for HIV, syphilis, and hepatitis B. Wet mounts and other studies of vaginal discharge can identify *Trichomonas vaginalis* and bacterial vaginosis. Polymerase chain reaction testing or culture of genital lesions can test for herpes simplex virus. Specimens from the rectum, male urethra, vagina, and urine can be tested for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*. Throat specimens also can be tested for gonorrhea. (33) Recent studies of *chlamydia* and gonorrhea infections in sexually abused children compared gold standard culture techniques to the newer nucleic acid amplification tests (NAATs). (35)(36) An important advantage of NAATs is that they can be performed on urine samples, thus providing a less invasive testing option. Positive NAAT results can be confirmed by tests that target a different nucleic acid sequence. It is important to ensure that tests used in the context of forensic evaluations are specific. Clinicians should review local testing procedures with child abuse and microbiology specialists.

Just as it is important to interpret physical findings accurately, providers must be aware of the forensic implications of STI. (14)(37) The following are facts to consider when a prepubertal child is diagnosed as having an STI. (33)(37)

1. Confirmed *trachomatis*, gonorrhea, and syphilis are diagnostic of sexual abuse when perinatal and rare nonsexual transmission are excluded.

2. HIV infection is diagnostic of abuse when perinatal transmission or transmission from transfusions or needle sticks are excluded.

3. *Vaginalis* infection is highly suspicious for sexual abuse.

4. Bacterial vaginosis can be unrelated to sexual abuse.

5. Anogenital warts (condyloma acuminata) and genital herpes simplex are suspicious findings. Anogenital warts can be transmitted sexually. There are other modes of transmission, however, including autoinoculation, nonsexual fomite transmission, and vertical transmission. Although anogenital warts raise suspicion for sexual abuse, they are not diagnostic of abuse.

**Pregnancy**

Pregnancy testing should be performed where indicated based on the patient’s pubertal stage and disclosure. A negative result should be ensured before administration of emergency contraception.

**Drug-Facilitated Abuse**

In some cases, perpetrators use drugs such as alcohol, flunitrazepam, γ-hydroxybutyrate, ketamine, benzodiazepines, and antihistamines to facilitate sexual assault. (9) Substances such as flunitrazepam can go undetected when added to a drink. Victims may be unaware that they are being drugged. Symptoms of drug ingestion include somnolence, amnesia, dizziness, and visual disturbances. These drugs are detectable in blood or urine for short periods of time (<12–72 hours). These drugs are not included in routine drug screens. Local resources can guide specimen collection and inform clinicians about available testing procedures.

**Psychosocial Outcomes**

Child sexual abuse is associated with a multitude of negative psychological and social outcomes. Negative outcomes are not limited to childhood and also have been demonstrated among adult survivors. Victims are at increased risk for sequelae such as depression, anxiety, posttraumatic stress disorder, sexualized behaviors, suicide attempts, substance abuse, eating disorders, sleep disturbances, personality disorders, somatization, early pregnancy, school failure, and repeat victimization. (1)(38)(39)

Early detection of psychological sequelae and prompt initiation of treatment are important. In some cases, psychological symptoms are not present initially, but develop over time. It is important to review psychological symptoms not only during the initial evaluation but also on follow-up visits.

Nonoffending caregivers also can experience negative psychosocial consequences. In the majority of cases, the family knows the perpetrator. Nonoffending caregivers
lose relationships in the course of protecting their children. Ending relationships can result in financial strain and housing concerns when the perpetrator was previously a financially contributing household member. Caregivers also may experience negative psychological outcomes such as depression, reliving of previous abuse experiences, and relapses of substance abuse.

Nonoffending caregivers’ responses to sexual abuse affect children’s well being. (40) Caregiver support has been associated with positive emotional and behavioral outcomes among abused children. The importance of the caregivers’ roles in supporting child victims should be reinforced. On the other hand, nonprotective caregivers who allow ongoing contact with the alleged perpetrator place children at risk for revictimization and significant psychological harm. Clinicians should report such concerns for child safety to child protective agencies.

Legal Considerations
In the United States, physicians are required by law to report child abuse. (37) Health providers are mandated to report not only confirmed cases, but also cases where there is reasonable cause to suspect abuse. A summary of state laws and procedures for reporting suspected child abuse can be found at http://www.childwelfare.gov/systemwide/laws%5Fpolicies/

In many states, a report to both the local child protection agency and law enforcement is required for cases of suspected sexual abuse. Failure to report a case of abuse places the patient and possibly other children at risk for harm. In addition, mandated reporters who fail to report child abuse can face legal ramifications and malpractice actions. As detailed in an AAP policy statement, Health Insurance Portability and Accountability Act (HIPPA) rules do not apply where state laws provide for reporting child abuse. (41) Professionals who make a report of child abuse in good faith are immune from liability by statutes in each state. In some cases, pediatricians question whether a report is indicated. Local child protection agencies and child abuse specialists can be contacted to discuss cases. Examples of scenarios that would not involve a mandated report include isolated nonspecific behavioral symptoms (eg, enuresis, aggression) or isolated nonspecific physical signs such as labial adhesions or vaginal irritation.

Another legal issue that might arise in evaluating patients for sexual abuse is involvement in criminal, juvenile, civil, or family court proceedings. There are different types of court proceedings and different types of witnesses. Some court proceedings involve criminal prosecution, whereas others concern custody of the child. Physicians are asked to testify as fact witnesses or as expert witnesses. Fact witnesses restrict their testimony to the facts of the case, but expert witnesses can provide interpretation and opinion. As discussed in the AAP statement on expert witness participation in civil and criminal proceedings, the new subspecialty of child abuse pediatrics sets high standards for professional conduct in expert witness testimony. Physicians who feel uncomfortable testifying as an expert in cases of child abuse and neglect should consider consultation with a specialist. (42)

Treatment
Treatment plans address physical health, mental health, child safety, and psychosocial concerns. Physicians can prescribe prophylactic medications in some clinical situations. (33) Baseline STI and pregnancy testing should be completed before prophylactic treatment. Prophylactic antibiotics can be used to prevent gonorrhea, Chlamydia infection, Trichomonas infection, and bacterial vaginosis among patients who present within 72 hours of an assault that could potentially result in STI transmission. These prophylactic antibiotics generally are not prescribed for prepubertal patients because, in this age group, the incidence of STI is low, patients are not at high risk for infection to spread to the upper genital tract, and it is generally possible to ensure follow-up testing. (33)

HIV postexposure prophylaxis involves a 28-day course of a two to three drug regimen initiated as soon as possible within 72 hours of potential exposure, and careful follow-up, as well. Risk factors for HIV transmission that might be identified on clinical evaluation include a perpetrator with known or suspected HIV infection, genital tract injury, receptive anal intercourse, absence of condom use, perpetrator with genital ulcer or other STI, and local infection at the exposure site. As detailed in an AAP clinical report, the decision to initiate HIV postexposure prophylaxis involves a careful risk benefit analysis. (43)(44) Table 1 lists options for prophylactic treatment of STIs among adolescents as recommended by the Centers for Disease Control and Prevention. (34)

Emergency contraception should be offered when female pubertal patients present within 72 hours of an assault that could potentially lead to pregnancy. (44) Pregnancy testing should be conducted before treatment. Because nausea is a common adverse effect of emergency contraception, prescription of an antiemetic should be considered. (33)(45) Formulation of hormonal medications, mechanism of action, timing, adverse effects, follow-up, and other considerations are discussed in detail in an AAP policy statement. (45)
Treatment planning also should address the potential mental health consequences of sexual abuse. In some cases, urgent psychiatric referral is indicated (eg, current suicidal ideation). In addition to mental health referrals for patients, counseling services for nonoffending parents often are indicated. Community resources can be activated to help families with social stressors such as housing and financial concerns that arise subsequent to a disclosure of abuse.

Physical and mental health symptoms as well as social stressors should be reevaluated on follow-up visits. In many cases, repeat testing for STI is indicated.

**Table 1. Recommended Prophylactic Medications for Adolescent Victims of Sexual Assault**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea</td>
<td>Ceftriaxone 250 mg intramuscularly, 1 dose</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>Cefixime 400 mg orally, 1 dose</td>
</tr>
<tr>
<td>Chlamydia trachomatis</td>
<td>Azithromycin 1 g orally, 1 dose</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td>Trichomoniasis and bacterial vaginosis</td>
<td>Doxycycline 100 mg orally, twice daily for 7 d</td>
</tr>
<tr>
<td>Hepatitis B virus</td>
<td>Metronidazole 2 g orally, 1 dose</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Begin or complete hepatitis B immunization if not fully immunized</td>
</tr>
<tr>
<td>HIV</td>
<td>Emergency contraception</td>
</tr>
<tr>
<td></td>
<td>Consider characteristics of the assailant, type of exposure, as well as</td>
</tr>
<tr>
<td></td>
<td>the risks and benefits of prophylaxis (see text)</td>
</tr>
</tbody>
</table>

Source: ref 34.

Timing of the Evaluation
When families contact pediatricians about situations of abuse, the need for urgent medical care versus a nonurgent appointment must be assessed. In some instances, urgent medical attention is indicated to treat or prevent health problems, address injuries, ensure safety, or perform forensic evidence collection. In cases in which urgent care is not required, however, scheduling an appointment will allow for nonrepetitive, comprehensive evaluation in a child-friendly setting. Physicians should be aware of local resources for medical evaluation of sexual abuse. Indications for urgent evaluation include, but are not limited to, situations in which:

1. The patient may benefit from prophylactic medical treatment as detailed above.
2. Clinical information is suggestive of anogenital injury (eg, report of injury, anogenital bleeding, or pain).
3. There is a possibility that forensic evidence may be collected (alleged abuse occurred within 72 hours and may involve transfer of biologic material).
4. An urgent child protection response is required (eg, child is not protected from alleged perpetrator or does not have a protective nonoffending caregiver).
5. There is report of an injury or symptom that may require urgent medical treatment.
6. There is report of a symptom that may require urgent mental health evaluation (eg, suicidal ideation).

**Prevention**
Many sexual abuse prevention programs focus on educating children about safety, appropriate and inappropriate touches, and telling an adult about abusive experiences. Parent education programs are being researched. (46) Technological developments have created a need for campaigns targeting Internet safety. The AAP clinical report on the impact of social media on children addresses healthy Internet use. (47)

**Summary**
- Child sexual abuse is a common pediatric problem that concerns all pediatric health care providers.
- Management of child sexual abuse is multifaceted and multidisciplinary.
- Specialized health providers can provide consultation, but this availability does not minimize the role of the referring physician who often has ongoing contact with the family.
- Physicians are mandated to report cases of suspected or confirmed sexual abuse.
- In the majority of cases, a child’s statement about sexual abuse is the strongest evidence that abuse has occurred.
Psychosocial issues

sexual abuse

- Physical examination is normal in the majority of sexual abuse victims.
- Accurate, evidence-based interpretation of physical and laboratory findings is essential. Normal examinations, normal variants, and findings indicative of sexual contact must be differentiated.
- Forensic evidence collection and prophylactic treatments may be indicated when patients present within 72 hours of an abusive episode, and patients should be triaged accordingly.
- Potentially negative psychosocial outcomes should be addressed for patients and their families on initial evaluation and follow-up.

References

PIR Quiz

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6. Among the following reported behaviors, the one most suspicious for sexual abuse of a 4-year-old child is:
   A. Humping classmates at preschool.
   B. Running around the home nude at bath time.
   C. Periodic touching of his or her own genitalia while at home.
   D. Taking off underwear in preschool.
   E. Trying to observe a parent undressing.
7. You suspect that a 5-year-old girl has been sexually abused. Confirmation of the diagnosis is most likely to come from:
   A. Appropriate interview of the child.
   B. Forensic evidence.
   C. Parental reports.
   D. Physical examination of the genitalia.
   E. Vaginal culture.

8. The most reliable way to conduct an interview with a 5-year-old child who claims her stepfather has sexually abused her is to:
   A. Assure that several interviewers obtain consistent results.
   B. Insist that the interview be videotaped.
   C. Interview the girl with her mother present.
   D. Simply invite the child to tell her story without specific prompting.
   E. Use anatomically correct dolls routinely.

9. Although the majority of sexually abused girls have normal findings on examination of the genitalia, in some cases, there are findings indicative of trauma. The examination finding that is most strongly indicative of sexual abuse in a 6-year-old girl is:
   A. A periurethral band.
   B. Anal skin tag.
   C. Bruising of the labia minora.
   D. Labial adhesions.
   E. Perianal warts.

10. An 8-year-old girl reports chronic sexual abuse by her mother’s boyfriend. Which of the following results of the physical examination and laboratory tests is most specific for the diagnosis of sexual abuse?
   A. Herpetic lesion on her lower lip.
   B. Two perianal warts.
   C. Urine nucleic acid amplification test positive for *Chlamydia trachomatis*.
   D. Wet mount positive for *Gardnerella vaginalis*.
   E. Wet mount positive for *Trichomonas vaginalis*. 
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Practical strategies

Mandatory reporting of child abuse and neglect: Crafting a positive process for health professionals and caregivers

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\textbf{ABSTRACT}

Health professionals working with children and their families are often required by law to report to governmental authorities any reasonable suspicion of child abuse and/or neglect. Extant research has pointed toward various barriers to reporting, with scant attention to positive processes to support the reporting process. This paper focuses on the context for mandatory reporting and evidence-informed practice for supporting a more structured and purposeful process of mandatory reporting. These practical strategies discusses: (1) the factors that positively influence the relationship between a child's caregivers and the mandated health professional reporter; (2) a framework and specific skills for discussing concerns about maltreatment and reporting to child protective services with the caregiver(s); and (3) the need for further training and education of health professionals.

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\textbf{Introduction}

Child maltreatment is a global health and social problem that impacts both (a) a significant number of children and their families and (b) the psychological and physical health and well-being of victims (Gilbert et al., 2009; Hibbard, Barlow, MacMillan & the Committee on Child Abuse and Neglect and American Academy of Child and Adolescent Psychiatry, Child Maltreatment and Violence Committee, 2012). The financial burden associated with child maltreatment includes costs associated with health care for the child and the indirect costs associated with the responses of the criminal justice system, child protection services (CPS), education, (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Waters et al., 2004). Using country-specific national methods, it was estimated that in 2006, children in the US experienced maltreatment at a rate of 17.1 per 1,000 children in the general population, while Canadian rates of substantiated child maltreatment in 2008 were estimated at 14.1 per 1,000, and Australian rates of substantiated cases in 2010–2011 were estimated at 6.1 per 1,000 (AIHW, 2012; PHAC, 2010; Sedlak et al., 2010). However, estimates of child maltreatment should be interpreted cautiously, as the true extent of child maltreatment is uncertain and widely regarded to be more prevalent than official reporting or community surveys can determine (Fallon et al., 2010; GAO, 2011; MacMillan, Jamieson, & Walsh, 2003; Sedlak et al., 2010).

Given their role with children and families, health professionals are in a unique position to intervene on behalf of children and to advocate for their welfare and protection. However, health professionals experience challenges and barriers to addressing suspected or confirmed child abuse and neglect (CAN) with families. Some of these include a lack of standardized training in identification and management of CAN cases and lack of knowledge in understanding the process of
initiating a report to CPS where mandated by law. Additional contributory factors in the failure to report CAN include the health professionals’ discomfort related to addressing maltreatment concerns directly with the child’s parents or caregivers (hereafter referred to as “caregivers”) because of concerns about the impact on the caregivers and/or themselves. This article is intended to discuss the issue of duty to report and to provide practical strategies for assisting the health professional with discussing concerns about CAN and his/her role as a mandated reported with the caregiver.

Overview of mandatory reporting

The UN Convention on the Rights of the Child established that government is the main body responsible for preventing and responding to violence against children, considering children as rightful participants, with particular attention to ensuring that children are recipients of the safeguard mechanisms supporting human rights (Pinheiro, 2006). The Convention on the Rights of the Child requires all signatory nations to establish integrated child protection systems to ensure a coordinated response to child abuse and neglect (Svevo-Cianci, Hart, & Rubinson, 2010). These integrated systems are commonly divided into three main areas: (1) mandates (laws, regulations, and policies); (2) mechanisms/interventions (education, service programs, and data management); and (3) child outcomes (performance measures of the child’s health, development, and well-being) (Svevo-Cianci et al., 2010). An additional consideration is the resource provision to support recovery following exposure to violence, where mandatory reporting is conceptualized as a key element in the resilience-in-the-context-of-maltreatment process (Wekerle, 2013). Mandatory reporting of suspected or confirmed CAN represents one common, key strategy to address violence against children. Legally requiring certain individuals to report child abuse is justified with the assumption that early detection of abuse helps prevent serious injuries and relieves the victims of the responsibility to seek help for themselves, thus enhancing coordination between legal, medical, and service responses (Krug et al., 2002). The Convention emphasized that when countries have higher legal standards than the standards identified in the Convention to address violence against children, the higher legal standards prevail (Pinheiro, 2006).

Legislation mandating health professionals to report concerns for CAN is available in many countries across the world (US, Canada, Australia, Argentina, Israel, Poland, Sri Lanka, etc.). However, a number of countries (United Kingdom, New Zealand, etc.) do not mandate health professionals to report concerns for CAN (Krug et al., 2002). Additionally, mandatory reporting of CAN varies between jurisdictions. Differences exist regarding the type of maltreatment that is required to be reported and in some cases the source of the maltreatment. In Canada, US, and Australia all forms of CAN (physical, sexual, and psychological abuse and neglect) is generally reportable by law with some exceptions. For instance, in the US, the States of Idaho and Illinois do not require reports of psychological maltreatment and in Australia, Victoria and the Australian Capital Territory do not require reports of neglect and psychological abuse (Matthews & Kenny, 2008). In some Canadian provinces and US states, the legislation requires reports of abuse or suspected abuse by persons other than the parents. Additionally, the types of harms included in the definitions of CAN outlined in the mandatory reporting legislation varies. For instance, the exposure of children to intimate partner violence is expressly identified as reportable in some jurisdictions in Australia and Canada but few states in the US include this form of maltreatment in their mandatory reporting legislation (Matthews & Kenny, 2008). In almost every case across the US, Canada, and Australia, no proof of maltreatment must be present for the mandate to hold (Cheng, Munn, Jack, & MacMillan, 2006; Child Welfare Information Gateway, 2010; Matthews & Kenny, 2008). Nevertheless, significant variability exists between jurisdictions (both between countries and within countries) regarding the degree of harm to a child that is required to initiate a report to CPS (Matthews & Kenny, 2008). Therefore health professionals must be aware of the legislation that governs their locale. Country specific websites are available in many jurisdictions that can guide the health professional on where to find state legislation and other mandatory reporting resources. In the US, The Child Welfare Gateway website (www.childwelfare.gov/) provides information about statutes and child welfare services and related organizations by State. Similarly, in Canada this information can be found on the Canadian Child Welfare Research Portal website (www.cwrp.ca/) for individual provinces and territories and the Australian Government, Australian Institute of Health and Welfare website (http://www.aihw.gov.au/child-protection/) provides information for child protection services for each Australian state and territory. Additionally, most US states have anonymous toll-free numbers that serve as the first step in reporting suspected child maltreatment (Child Welfare Information Gateway, 2010). Furthermore, opportunities for consultation and collaboration with the local CPS can assist the health professional to evaluate the options and needs of a given situation, as well as set the stage for in-service education as laws are refined over time (AIHW, 2012; Cheng et al., 2006; Child Welfare Information Gateway, 2010; Portal, 2011).

Who is reporting maltreatment?

Health professionals are in a unique position to identify CAN and intervene on behalf of children and families. However, health professionals account for only a small number of reports to CPS. Reports from professionals (community health or social services, school, hospital, police etc.) represented almost 70% of the 235,842 investigations conducted in 2008 in Canada (PHAC, 2010). Community health and social services accounted for 12% and hospital personnel made up 5% of Canadian reports to CPS whereas school representatives accounted for the greatest number of reports to CPS at 24% (PHAC, 2010). In the US, three fifths of the reports to CPS made in 2010 came from professional personnel with the following breakdown: social service personnel accounted for 11.5%, education and law enforcement accounted for 16.4% and 16.7% respectively and medical workers accounted for 8.2% of the total reports by professionals (The Administration on Children,
There is some evidence to suggest that health professionals may fail to identify child maltreatment, or, may not report it even when they hold suspicion (Sege et al., 2011). The Child Abuse Recognition and Evaluation Study (CARES), a large US prospective study that examined decision-making by primary health care providers (PHCPs), found that 27% of PHCPs did not report injuries to CPS, despite believing that they were “likely” or “very likely” caused by child abuse (Flaherty et al., 2008). Post hoc evaluation of some CARES visits by child abuse experts and PHCPs, found that the experts agreed with the PHCP reporting decisions in 84% of cases, but also indicated that 21% of non-reported cases should have been reported (Sege et al., 2011). A US national study of the incidence of maltreatment reviewed the children identified as maltreated but not reported to CPS (Sedlak et al., 2010). It was estimated that according to CPS screening policies in the US, 80% of the non-reported cases would have been investigated had they been reported. The authors concluded that at least two-thirds of children suspected of having been the victims of maltreatment may not be reported to CPS by mandatory reporters (Sedlak et al., 2010). These data suggest that professionals are under-reporting.

The importance of mandatory reporting: Preventing revictimization and promoting early intervention

Poor recognition and reporting of suspected maltreatment may leave children vulnerable to continued victimization, and the potential resulting morbidity and mortality (Sege et al., 2011). In the US, longitudinal analysis of national survey data of children’s well-being found that between 7% and 38% of children reported to CPS for substantiated CAN, met with a re-report for substantiated CAN (Dakil, Sakai, Lin, & Flores, 2011; Fluke, Shusterman, Hollinshead, & Yuan, 2008). Data from substantiated maltreatment cases in Canada also illustrated the chronicity of victimization. In 2008, 58% of substantiated cases of child maltreatment involved multiple incidents of maltreatment (PHAC, 2010). Repeat victimization has the potential to lead to devastating consequences for the child (Widom, Czaja, & Dutton, 2008). A review of head injuries caused by abuse that was not recognized as maltreatment upon initial presentation to the hospital reported that 9% died, 28% suffered further abuse and injury, and 41% experienced medical complications related to the missed diagnosis (Jenny, Hymel, Ritzen, Reinhart, & Hay, 1999). Finally, the presenting child is not the only potential victim to suffer the consequences of delayed or failed reporting of maltreatment; all children in a family are at increased risk for abuse when one child is known to be physically abused (Asnes & Leventhal, 2010; Vitale, Squires, Zuckerbraun, & Berger, 2010).

Barriers to mandatory reporting

Investigators have identified a number of barriers to mandatory reporting encountered by health professionals. In their review of the literature, Sege and Flaherty (2008) broadly classified these barriers into two groups: (1) lack of knowledge and recognition of CAN and (2) decision not to report suspected CAN to CPS due to concern about the impact of reporting on the family and themselves (Alvarez, Kenny, Donohue, & Carpin, 2004; Flaherty, Sege, Binns, Mattson, & Christoffel, 2000; Flaherty et al., 2008; Jones et al., 2008; Loo, Bala, Clarke, & Hornick, 1998; Morris, Johnson, & Clasin, 1985; Vulliamy & Sullivan, 2000).

Lack of knowledge and recognition of CAN

Physicians and medical students alike have identified that they do not feel that they have received adequate training in the identification of child maltreatment (Flaherty et al., 2008; Jones et al., 2008), and many are unfamiliar with the precise guidelines for mandatory reporting (Ward et al., 2004). Additionally, ambiguity in the mandatory reporting statutes that references “suspicion” of maltreatment and “reasonable suspicion” of maltreatment may negatively contribute to physicians’ confidence in identifying CAN (Levi & Crowell, 2011). A qualitative study of home visiting nurses involved with high-risk families identified variability in knowledge, attitudes, and opinions about what constitutes maltreatment, as well as when to report children exposed to intimate partner violence (Davidov, Jack, Frost, & Coben, 2012). A Canadian study of pediatric residents arrived at similar conclusions, with 92% of residents reporting a desire for a more extensive educational program in child protection (Ward et al., 2004). These studies suggest that additional training for professionals may be valuable. Physicians who had received formal education in child maltreatment following their residency program, were 10 times more likely to report concerns to CPS than providers who had not received any formal training (Flaherty et al., 2008). Professionals who received training specific to reporting child maltreatment demonstrated improved knowledge of legislation and relevant clinical skills and were more likely to identify maltreatment (Alvarez et al., 2010). In addition to knowledge, professionals require opportunities for knowledge transfer and practice in order to develop their skills and comfort (Christian, 2008). A systematic review (Carter, Bannon, Limbert, & Barlow, 2006) of training programs suggested that training may improve self-reported knowledge and confidence of professionals working in child maltreatment, however, most of the studies lacked rigor. The review highlighted the need for a consistent and evidenced-based approach to child maltreatment training.

Factors that influence health professionals’ decision not to report to CPS

Health professionals who have had prior negative experiences in dealing with CPS may feel reluctant to report cases to CPS, believing that involvement with CPS caused more harm than good (Flaherty, Schwartz, Jones, & Sege, 2012; Jones et al., 2008; Steinberg, Levine, & Doueck, 1997; Zellman, 1990). Some physicians feel better equipped to address the concerns...
directly with the family rather than reporting concerns to CPS (Flaherty et al., 2000; Jones et al., 2008; Zellman, 1990). However, in a US survey of pediatricians, the majority of respondents identified positive benefits (protection from further abuse; interventions) as a result of CPS involvement (Flaherty et al., 2006).

Fear of physical or legal reprisal has been identified by health professionals as a barrier to mandatory reporting. A survey of pediatricians in the US (North Carolina) found that their experiences with the court system, whether positive or negative, predicted their likelihood of reporting to CPS in the future (Theodore & Runyon, 2006). In a survey of physicians across jurisdictions working in the area of child abuse, 50% reported that caregivers had made complaints to their supervisors and 13% identified formal complaints to their state licensing agency. Fifty two percent of these physicians also reported receiving verbal threats from caregivers, however physical threats were rare (Flaherty et al., 2012). Canada, Australia, and the US provide immunity to professionals who report cases of child maltreatment in good faith, requiring proof that a professional made the report with the intent to cause harm to the family to substantiate a case against the professional (Alvarez et al., 2004; Matthews & Kenny, 2008).

The potential loss of the relationship with the child and family subsequent to a report to CPS has also been identified by health professionals as a barrier to mandatory reporting. Although the majority of respondents in a national survey of pediatricians reported benefits associated with making CPS reports, the negative consequence most often cited was a loss of the family as patients (Flaherty et al., 2006; Asnes & Leventhal, 2010). Physician loyalty to parents as a barrier to reporting maltreatment was identified as a common theme in a survey of Canadian pediatricians (Vulliamy & Sullivan, 2000). Concerns included a worry about the loss of the relationship and impact on the family if the suspicions proved unwarranted.

**Practical strategies in mandatory reporting**

As stated above, health professionals can access resources to assist them in identifying legislation and mandatory reporting obligations based on jurisdiction. Additionally, maintaining a collaborative relationship with caregivers in the context of concerns for child maltreatment and mandated reports to CPS is important but perceived to be very challenging (Asnes & Leventhal, 2010). Various studies have examined the factors that positively or negatively influence the relationship between caregivers suspected of CAN and the CPS workers involved in their child(ren)'s case, and many of these principles may also be relevant to preserving the relationship between the family and the mandated health professional reporter. Caregivers who have been involved with CPS frequently report feelings of helplessness, akin to passive observers, excluded from participating in the CPS referral process (Corby, Millar, & Young, 1996; Dumbrill & Maiter, 2003), often perceiving the CPS authorities as a highly powerful force dictating the direction of their lives. The caregiver’s perception of the CPS worker’s power has significant implications for the caregiver’s response to the intervention, such that they may choose to “fight” or “play the game,” rather than “work with the system,” if they feel that the power is being used against them (Dumbrill, 2006). Similarly, the caregiver’s perception of the health professional’s power in the context of CAN concerns may negatively impact on the health professional’s ongoing relationship with the child and caregiver. However, if the health professional can engage the caregiver to work collaboratively with the common goal of ensuring the child’s best interests, there is a greater likelihood that appropriate interventions can be put in place for the child and potentially negative consequences for the health professional. Analysis of qualitative data collected from community stakeholders, clients and home-visiting nurses emphasizes the importance of working supportively and collaboratively with clients (Davidov et al., 2012).

A collaborative approach between the caregiver and the health professional in the context of CAN reporting obligations can be facilitated through the use of a framework and the development of specific skills and strategies for discussing concerns for maltreatment and the duty to report with the caregiver. However, there is little empirical research to support a specific approach or skills in this context. The “SPIKES” protocol for breaking bad news, originally developed for use in oncology cases (Baile et al., 2000) is a useful framework that can be adapted to addressing concerns for CAN with the caregiver. SPIKES is an acronym for the following strategies: setting, perception, invitation, knowledge, emotion, strategy, and summary. In a survey of oncologists about the utility of the protocol, 99% responded that the protocol was “practical and easy to understand” (Baile et al., 2000). Moreover, in an educational role, the SPIKES strategy has been found to afford confidence in breaking bad news to those that have been trained in its utility (Baile et al., 2000; Bowyer et al., 2010).

Addressing concerns for CAN and a subsequent referral to CPS can be likened to breaking bad news. Two of the authors of this article have utilized SPIKES in their academic role with the affiliated school of medicine. In the academic context, the SPIKES protocol is shared and reviewed with medical students who then have an opportunity to practice the skills with a standardized patient and receive feedback. The authors have further utilized the SPIKES framework in their clinical work with a multidisciplinary hospital-based child abuse program. In this context, the SPIKES framework has assisted learners (medical students, residents, social work interns, psychology interns, etc.) working in this clinical setting to develop skills and strategies to share concerns about CAN and mandatory reporting obligations with caregivers. Learners have the opportunity to practice, reflect, discuss, and receive feedback which enhances confidence and skill development (Dosanjh, Barnes, & Bhandari, 2001; Rosenbaum, Ferguson, & Lobas, 2004). The SPIKES framework provides the basic steps for the delivery of information that may be perceived by the caregiver as threatening and ‘bad.’ The practical manner in which the conversation with caregivers could take place, utilizing SPIKES is detailed below.
Setting

Before the conversation with caregiver takes place, it is important to establish a private setting, making an effort to ensure that there will be no interruptions to the conversation (Baile et al., 2000). If there is any fear of physical reprisal by the caregiver, additional support (additional staff, security, etc.) should be nearby. However, as mentioned above, the worry for retaliation is frequent, but realization of this fear is rarely the case (Alvarez et al., 2004). Conversations with the caregiver should occur away from the child(ren). Providing privacy and respecting the confidentiality of the caregiver, even if they are culpable, preserves the caregiver’s dignity. Addressing the limits of confidentiality at the start of a clinical relationship is an important consideration for health professionals and may mitigate the negative impact of reporting to CPS any concerns about the caregiver (Davidov et al., 2012).

Perception

The first step is to assess the caregiver’s perception of the concerns. Specifically, one could ask, “What have you been told of the situation with your child?” “What is your understanding of the child’s injuries, presentation?” “What are your worries, concerns?” “How do you think that your child was injured?” Caregivers, especially in the initial stages of investigations, can be under extraordinary levels of stress, which can impact their ability to understand and/or retain information presented to them (Ghaffar, Manby, & Race, 2012). A health professional who shows patience and a willingness to take the time to ensure that the caregiver has understood what was said, can aid in lessening the confusion. Using open-ended questions, and evaluating the caregiver’s understanding, one can address potential misconceptions (Baile et al., 2000). For example, the caregiver(s) may be fearful that a referral to CPS may result in their child’s removal from their care by CPS (Davidov et al., 2012). It is important for the health professional to clarify that although children are sometimes removed from the parent’s care, not all referrals to CPS result in out of home placement for the child and the goal of CPS is to support families, provide appropriate services to ensure the child’s safety, and ultimately reunification of the child and the caregiver if in fact the child is removed (Alvarez et al., 2004; Asnes & Leventhal, 2010). By engaging the caregiver in the discussion and soliciting their opinions suggests a non-judgmental and collaborative approach. More than just the ability to convey information, however, is the health professional’s ability to listen to the caregiver’s concerns and ensure they are addressed. This is an attribute consistently found to be of fundamental importance in the professional’s ability to foster a relationship with a family (Drake, 1996; Dumbrill & Maiter, 2003).

Invitation

This aspect of the traditional SPIKES protocol suggests that the health care professional asks the patient for permission to divulge information related to their health (Baile et al., 2000). As stated above, in the context of child maltreatment, permission of the caregiver and/or the child in making a report to CPS is not required. However, in an effort to maintain honesty and openness within the therapeutic relationship, it is recommended that health professionals directly inform the child’s caregiver about their concerns (Asnes & Leventhal, 2010). For instance, the health professional can say, “I’m worried that someone has hurt your child . . .”. Additionally, it is important that health professional outline their responsibility. “When I’m worried that a child has been hurt by someone, I have a duty to report to CPS.”

It may be helpful to negotiate with the family members the scope of the information that is shared with CPS. For instance, CPS requires information that is directly pertinent to the concerns for CAN; however, the caregiver’s history of a previous relationship, or the caregiver’s own health history may not be relevant. In some cases, it may be beneficial to have the non-offending caregiver be given the option to contact CPS with support from the health professional, which gives the caregiver some degree of agency within the situation. Alternatively, the health professional could invite the caregiver to be present for the call to CPS. For instance, in a situation where the child or the caregiver has disclosed information about an extended family member causing harm to the child and the caregiver seeks counsel from the health professional, it may be beneficial to review the concerns with the caregiver and support the caregiver to make the report to CPS given the caregiver’s primary knowledge of the concerns. If however the caregiver does not wish the report to be made to CPS, the health professional is still required to report concerns.

Although neither the caregiver’s consent nor cooperation is required to make a report to CPS, informing the caregiver of the decision to report can help preserve the relationship unless it is a situation where this would be contraindicated (Alvarez, Donohue, Kenny, Cavanaugh, & Romero, 2005; Davidov et al., 2012). Informing the caregiver prior to the report to CPS may not be warranted in situations where the child may be at imminent risk of harm, retaliation by the parent comment or blamed for disclosing. If the health professional is concerned that the caregiver is directly responsible for the CAN and the child is present, then less information should be shared with the caregiver about the health professional’s concerns at the time of referral to CPS. There are situations where the health professional is less clear about their duty to report and what is reportable. When unsure, health professionals are encouraged to contact their local CPS to consult and if CPS supports a referral, the health professional can subsequently inform the family. Alternately, health professionals can access child maltreatment experts such as child abuse pediatricians or child abuse specialty teams within their hospital or community.
when they are unclear or unsure whether their concerns are consistent with CAN or in circumstances where they are unclear as to their role as a mandated reporter.

Knowledge

The health professional can share the relevant medical information that led to a decision to report to CPS. In giving this information, it is important to: use simple language that the caregiver can understand, avoid medical jargon, avoid excessive bluntness, and give information in small pieces (facilitating comprehension) (Baile et al., 2000). Good communication skills have been identified as important for developing and maintaining a strong therapeutic relationship with caregivers (Drake, 1996; Spratt & Callan, 2004). Additionally, it may be helpful to discuss the possible outcomes associated with a report to CPS. In many circumstances, health professionals have only suspicions or concerns about potential maltreatment. It is important to acknowledge concerns in the face of limited medical evidence. Caregivers can be informed about the concerns “I have some concerns that need further assessment, investigation, understanding” “I’m worried that someone has hurt your child.”

Emotions

Responding to the caregiver(s) emotions, whatever they may be throughout the conversation, is essential. In responding, it is important to observe any emotion, identify the emotion and the reason for the emotion, and finally and most importantly, let the caregiver(s) know that the emotion has been understood (Baile et al., 2000). The health professional may need to sit with strong emotion (anger, fear, and sadness). These emotions may or may not be directed at the health professional, however, maintaining composure in the face of these emotions and responding with empathetic statements is helpful. Acknowledging the fear, anger, and/or sadness will often temper the caregiver’s responses. Although it may be difficult to withhold judgment, an empathic response toward the caregiver and withholding criticism strengthens the therapeutic relationship between the caregiver and the health professional and may make the caregiver more willing to participate in the care of their child by sharing further pertinent information (Forrester & Harwin, 2008). Facilitating ongoing disclosure is an important intervention given the vulnerabilities associated with exposure to maltreatment and the increased risk of ongoing victimization (Behl, Conyngham, & May, 2003; Wolfe, 1999).

Strategy and summary

Caregivers consistently indicated how appreciative they were when professionals involved with their families took a non-judgmental and respectful approach (Davidov et al., 2012; Drake, 1996; Spratt & Callan, 2004). Health professionals can achieve this with their patients by being empathic, acknowledging the high levels of stress the family is experiencing and, where evident, recognize the efforts of the family to modify their behavior (DeBoer & Coady, 2007; Ghaffar et al., 2012). Additionally, verbal recognition of any of the caregiver’s parenting strengths may reassure them that the health care provider has a balanced view of their parenting abilities (Davidov et al., 2012). By maintaining a respectful and non-judgmental demeanor, the caregiver may be more inclined to schedule follow-up appointments to discuss the pending investigation or other issues relating to the child’s health. The health professional is encouraged to schedule a follow up appointment with the child and caregiver if warranted and appropriate (Asnes & Leventhal, 2010). By being ‘on the side’ of the caregiver and child, the health professional can remain, as a primary function, an advocate for the health and well being of the child.

Conclusion

This paper focuses on the context for mandatory reporting and evidence-informed practice for supporting the reporting process. This article has specifically focussed on the strategies that might be useful for the health professional working with the caregiver of a child exposed to CAN. In addition to the above framework, health professionals are encouraged to access support, additional training, and peer review and work collaboratively with experts (child abuse pediatricians, CPS, etc.) in their community to develop their skills and clarify the gray areas in mandatory reporting (Asnes & Leventhal, 2010; Davidov et al., 2012).

Child maltreatment is a public health concern. Given the role of health professionals with children and families, they are in the unique position of identifying child maltreatment and providing referrals that can prevent further maltreatment and offer opportunities for resiliency (Wekerle, 2013). However, health professional require ongoing education regarding their duty to report as well as skills training to address and manage child maltreatment (Christian, 2008). The manner in which difficult or ‘bad’ news is conveyed to a caregiver directly influences the caregiver’s emotions, beliefs and ongoing relationship with the health professional and how they view their future (Fallowfield & Jenkins, 2004). The SPIKES framework provides structure and support for difficult conversations with caregivers. The informed health professional is better positioned to be supportive to the family, and the CAN report may be an opportunity for therapeutic change for the child, and for their family.
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