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Diagnostic and Treatment Guidelines

on

Child
Sexual
Abuse

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These guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. These guidelines reflect the views of scientific experts and reports in the scientific literature as of March 1992.

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Introduction

Intrafamilial child sexual abuse is a manifestation of a dysfunctional family. The physician should focus on assessment of the immediate safety and long-term best interests of the child. Sexually abused children will be seen in all practice settings, and to protect these children from further harm, the physician should:

- Identify the signs and symptoms of child sexual abuse
- Provide medical evaluation and treatment of injuries or conditions resulting from sexual abuse
- Take emergency measures needed to protect the child from further injury. The physician's responsibility extends to, as far as possible, assuring the safety of the child. Where permissible by law, a physician should arrange for the custodial care of an abused child when there is risk of further injury. Children at risk can be hospitalized or placed in emergency foster care.
- Provide an accurate and thorough medical evaluation and record
- Remain objective and professional toward child and caretakers
- When appropriate, attempt to establish or maintain a therapeutic alliance with the family. Often the physician is the only professional who maintains contact with the family after other care is terminated.
- Attempt to secure medical evaluation of other children present in the household
- Report all cases of suspected child sexual abuse in accordance with state and local legal requirements
- Be willing and available to give evidence in court

Child sexual abuse has been endemic for generations, but recognition of the prevalence and the potential devastating psychological effects have only recently received attention. In any clinical setting where children are cared for, a plan for the identification and management of such cases must exist; protocols are required for facilities accredited by the Joint Commission for the Accreditation of Healthcare Organizations. Guidelines for the evaluation of sexual abuse in children as well as rape in the adolescent have been published by the American Academy of Pediatrics.

The physician may feel inadequately prepared to perform an examination in a sexually abused child. The special needs of these sexually abused children generally require training well beyond that provided in a general residency curriculum. The physician's attention should focus early on potential pediatric referral or consultation and training needs in determining how best to assure skillful intervention without obstructing the collection of essential evidence.

The utilization of a multidisciplinary approach is essential in child sexual abuse cases. The mandatory involvement of social service and law enforcement agencies, the frequent need for consultation with experts in the field of sex abuse, and the absolute need for therapeutic mental health intervention with the child and family, all speak to this issue.

Thus, disciplines other than medicine must contribute to the diagnosis and development of case management plans for affected families. A multidisciplinary team should include representatives from the medical, mental health, social services and legal professions who can provide consultation and case review to primary care providers. Child protection teams are active in many communities and are mandated by law in some states. If a multidisciplinary team is not available, the physician can be a powerful advocate for team development.

Facts about Child Sexual Abuse

Child sexual abuse can be defined as the engagement of a child in sexual activities for which the child is developmentally unprepared and cannot give informed consent. Sexual abuse need not involve sexual intercourse. Often physical force is not used. Rather, the perpetrator uses gradual seduction techniques. The sexual activities may include genital or anal contact by or to the child or nontouching abuses, such as exhibitionism, voyeurism, or using the child in the production of pornography. Sexual abuse may result in ano-genital injury or be accompanied by other signs of physical abuse, such as bruises, or by neglect, such as poor hygiene. Survivors of child sexual abuse often experience long-term adverse effects on their psychological and social well-being and may be more likely to be victimized in later life as well.

Recent studies suggest that approximately 20% of children will be sexually abused in some way before they reach adulthood, with this figure cumulating at a rate of about 1% each year. Boys as well as girls may be victimized, and the abuse may take place in intrafamilial or extrafamilial settings. Although abusers are more often male than female, women also may be perpetrators; adolescents are perpetrators in at least 20% of reported cases. Sexual abuse generally is perpetrated by someone known to the child and frequently continues over a prolonged period of time. Children living in a home where other abuse is ongoing (e.g., spouse abuse) are at particular risk.

Evidence also suggests that the sexual and physical abuse of children often occurs in successive generations of families. This “cycle of abuse” as it is commonly called, rarely ends unless intervention takes place. The problem of sexual molestation by a stranger, although foremost in the minds of many people, actually represents only a small percentage of total cases.

Finally, perpetrators commonly deny any injury is caused by their sexual contact with the child as well as deny any victimization. They may also attack anyone who condemns the sexual activity and often try to raise civil rights issues.

Ethical Considerations

When a physician who has a prior professional relationship with a family suspects that a child is being abused by the parent(s), a conflict will likely arise between the physician's duty to report the abuse and the parents' desire to keep that concern between the physician and family. Physicians resolve this problem by calling parents' attention to the reporting mandate and by being neutral in their attitudes. Nonetheless, many parents may decide to terminate their relationship with the reporting physician. If the physician not only identifies the suspected abuse but also carries out the "definitive" medical assessment for abuse, she/he must be prepared to testify against the parent in an adversarial proceeding, making a continued physician-patient relationship involving the parent or other caretaker extremely difficult.

Most primary care physicians resolve this problem by referring the child for the definitive forensic medical assessment and continuing to offer supportive and medical services to the child and family. If the primary physician is also the most qualified provider of definitive assessments, referral of the family to a new primary physician may be the most appropriate action. The problem cannot legally be resolved by failing to report the suspected abuse because this can endanger the child.

Presentation

Sexually abused children will be seen as patients under a variety of circumstances:

- They may be brought in for a routine physical examination, an unrelated medical illness, a behavioral condition, or a pertinent physical complaint
- They may be brought in by a caretaker who suspects the child has been sexually abused
- They may be brought in by social services or law enforcement personnel for a medical evaluation as part of an investigation

Because children who are sexually abused are commonly manipulated into secrecy, physicians must remain alert to the possibility of abuse, even when the child says nothing or says that she or he has never been hurt. When the child gives a history of sexual abuse, the information must be received in a sensitive manner and must be taken seriously. An evaluation is mandatory. If the physician feels emotionally or intellectually ill-equipped for this task, a referral must be made.

Retrospective surveys document the fact that the percentage of adult survivors of child sexual abuse is high enough, perhaps 20%, that every practitioner will encounter these patients in practice. Adults who have unresolved issues resulting from sexual abuse as children may present to a primary care physician in a variety of ways. These survivors of childhood trauma are among the patients with both perplexing and troubling complaints. They deserve sensitive, caring assessment of their complaints.

Behavioral Findings

Presenting behavioral symptoms are nonspecific, and caution must be exercised not to attribute all such complaints to sexual abuse. The symptoms also may be indicators of nonabuse-related stressors. Reactions to stressors depend on the age and emotional maturity of the child, the nature of the incident, the duration of the stress, the child's history, and the manner in which the child relates to the source of the stress.

The child, depending on age, may:

- Display extremes of activity (hyperactivity or withdrawal)
- Manifest poor self-esteem
- Evidence poor peer relationships
- Express general feelings of shame or guilt
- Display a distortion of body image (distorted drawings)
- Display regressive behavior
- Have enuresis and/or encopresis
- Appear frightened or phobic, especially of adults
- Show pseudomature behavior
- Exhibit a deterioration in academic performance
- Have an eating disorder
- Display sexually provocative behavior
- Engage in compulsive masturbation
- Sexually abuse a sibling, friend, or younger child
- Become sexually promiscuous
- Become pregnant
- Run away
- Attempt suicide

Among the more specific signs and symptoms of sexual abuse are:

- Rectal or genital pain
- Rectal or genital bleeding
- Sexually transmissible diseases in prepubertal children
- Sexually precocious behavior, particularly if persistent

Interviewing Process

The history is the keystone to making a diagnosis of child sexual abuse. Presenting signs or symptoms alone, however, can be adequate grounds for the physician to suspect sexual abuse. Children will sometimes disclose sexual abuse to a trusted adult such as their physician either during the history or physical examination. The physician must be willing to accept the fact that child sexual abuse does occur. She or he should listen to the disclosure in a nonjudgmental manner and should assess the physical and emotional status of the child. This information can then be used in a report to proper authorities.

When abuse is suspected, the physician must gather a detailed medical history from the child, if possible, and the caretakers. This history should follow the format of a thorough pediatric health assessment with special attention to the injuries and to factors that may help in determining continued risk to the child. In abuse cases, the explanation of an injury frequently is implausible or changes over time. The locally designated child protection agency and/or the police must be informed.

If possible, the child should be interviewed separately. The interviewer must be sensitive to the child's possible fears and apprehension when discussing the home situation and should tailor the interview to the child's developmental level. Although repetitive interviews can be problematic, the physician must gather the basic information necessary to help make decisions that are in the best interest of the child. When talking with younger children, it is best for the interviewer to sit at the child's eye level. Questions beginning with "How come . . ." are more productive than questions beginning with "Why . . ."

Local child protection service personnel or teams may be involved in the initial interview if requested. In cases of severe abuse, parents may flee with the child; thus it is advisable to contact the mandated reporting agency prior to informing the parents of the suspected diagnosis. *Above all else, the primary concern is to protect the child.*

Investigative aids, such as anatomically detailed dolls, may help the child communicate with the interviewer, but such aids are generally best left to those trained in their use. If anatomically detailed dolls are used, do not hand them to the child with the clothes removed. Drawings done by the child or diagrams to determine the child's name for body parts are most helpful.

When interviewing the child:

- Attempt to obtain pertinent information from others prior to the interview, including the specifics of the abuse—the date, exact time, place, sequence of events, people present, and time lag before seeking medical attention—and a complete social history, including where the child resides, length of residence, other household members, support systems available to the family, and child care arrangements
- Sit near the child, not across a desk or table, and at the child's eye level
- Attempt to establish an empathic, trusting relationship
- Conduct the interview in private and without the caretaker being present
- Have the child interviewed by the most experienced professional(s) available
- Find out who else has questioned the child
- Explain the purpose of the interview to the child in language appropriate to her/his developmental level
- Use the child's own words and terms in discussing the situation whenever feasible
- Always ask the child if she/he has any questions and answer them
- Carefully explain to the child the reason and nature of her/his removal from the home, if imminent

- Ask the child to explain words or terms that are unclear
- Acknowledge that the situation must have been a difficult one for the child and emphasize that the child was not at fault
- Ask about a history of ano-genital injury and, for adolescent girls, obtain a gynecologic and menstrual history

Do not:

- Suggest answers to the child
- Press the child for answers that she/he is unwilling to give
- Criticize the child's choice of language
- Suggest that the child feel blame or guilt for the situation
- Leave the child unattended or with unknown persons
- Display shock or horror concerning the child or the situation
- Offer rewards to the child

Physicians who suspect sexual abuse are urged to inform the parents or caretakers of their concerns in a neutral and calm manner. It is useful to remember that children spend time in the care of individuals other than their parents who may be responsible for sexual abuse. Maintaining a professional approach with the family, although not always easy, can facilitate the interviewing process. Explaining the reporting process and what the parents can expect to happen is often helpful. A nonaccusatory statement such as "I am required by law to make a report to the child protective service agency whenever I see a child with an injury (a condition) like this one" should be used.

When interviewing the caretakers:

- Reserve judgment until all facts are known
- Tell them the reason for the interview
- Advise them of the physician's legal obligation to report cases of suspected abuse
- Conduct the interview in private or, when indicated, with appropriate personnel (e.g., child protection service personnel)
- Attempt to be objective
- Reassure the caretakers of the physician's continued availability
- Explain further actions that will be required
- Answer questions honestly

Do not:

- Attempt to prove abuse
- Display anger, honor, or disapproval of the caretakers or situation
- Place blame or make judgments
- Give feedback on the caretakers' explanation of how the injury occurred since this will permit them to change an implausible explanation based on your feedback

It is not unusual for caretakers who were themselves abused as children to relive their victimization experiences during the investigation process. Female caretakers, for example, have been known to regain once-repressed memories of their own abuse after the traumatic discovery that their children have been victimized. It is also possible that a prior unresolved history of abuse may affect the caretaker's ability to recognize injurious behavior as abusive or to detect evidence of abuse, even when it occurs within the caretaker's household. Consequently, physicians must remain sensitive to the needs of all family members.

Physical Examination

If the physician decides to perform the examination, she or he should be prepared to collect all forensic evidence necessary or to stop the examination before any procedure would be likely to contaminate collection or observation of evidence by a more appropriate examiner. The goals of the examination should be to identify injuries or conditions requiring medical attention, to collect evidence of abuse, and to reassure the child or caretakers that the child will be all right. If the history or other circumstances suggest that collection of forensic evidence may be necessary, the examination should be performed immediately. In nonemergency situations, the examination should be scheduled for the near future.

The examination should be explained to the child and conducted with the child's consent in the presence of an adult not suspected to be a party to the abuse. It should be conducted in a gentle and sensitive manner, utilize no restraint or force, and should include all parameters of a usual pediatric health assessment. Genitalia should be examined in the context of a thorough physical exam. If the child exhibits an unusual level of disturbed behavior, consultation with a mental health professional may be warranted and should precede the examination.

In cases of recent sexual assault, clothing, blood samples, hair, urine, saliva, signs of bite marks, and other physical findings may be extremely persuasive evidence. In most cases of sexual abuse, rape kits and specimen collections are not needed. If such evidence is to be collected, however, the physician should observe the following procedures or adhere to the correct state protocol:

- Have the child stand over a clean sheet of paper while disrobing
- If possible, use a Wood's lamp to identify semen stains on skin and clothing

- Carefully preserve and identify samples of blood, semen, hair, and other evidence
- Place each item of clothing in a separate, clearly labeled paper bag
- Keep the bags in a locked place
- Sign over all samples or other evidentiary items to law enforcement personnel as soon as possible

The physician should be prepared to testify about the “chain of custody” of each specimen collected.

Physical Signs

Any of the following physical signs may be present in sexual abuse:

- Abrasions or bruises of the external genitalia (labia majora, penis or scrotum) and/or inner thighs
- Distortion or attenuation (marked reduction in amount) of the hymen
- Alterations in anorectal tone (severe anospasm or marked laxity)
- Sexually transmissible diseases, particularly in prepubescent children
- Pregnancy

It is important to realize that physical findings are frequently not seen in sexually abused children and that the absence of such findings does not preclude the diagnosis of sexual abuse.

Colposcopic Examination

The colposcope has been established as a useful but not essential instrument for examination of children’s genital and anal areas. The magnification provided helps to define small structures and lesions. Colposcope mounted cameras can obtain photographs or videotapes that preserve findings visually, thereby allowing for second opinions without additional examinations.

Photographs

Conventional photographs are particularly valuable as evidence. State laws vary with respect to the taking of photographs by physicians or other designated parties; some authorize photographs being taken without the parent’s consent and many states provide authorized persons with statutory immunity from liability in the taking of photographs. In any case, photographs do not replace a careful, written description of the injury.

- When possible, take photographs before medical treatment is given
- Use color film, but photograph bite marks in black and white as well as in color, if possible
- Photograph from different angles, full body, and close-up
- Hold up a coin, ruler, or other object to illustrate the size of an injury
- Include the child’s face in at least one picture

- Take at least two pictures of every major trauma area
- Precisely mark photographs with the child's name, the date, location of injury, name of photographer, and others present
- Use a color standard

Laboratory Data

Immediate examination of appropriate body fluids by a laboratory is often advisable to document the presence of organisms (such as trichomonas) or sperm. Decisions regarding testing for gonorrhea, syphilis, human immunodeficiency virus, or other sexually transmissible diseases should be based on symptoms manifested by the child, the epidemiology of sexually transmissible diseases in the area, the history obtained and mandated state protocols. In general, routine cultures and screening of all sexually abused children are not recommended. Specific assistance in drawing conclusions about sexually transmissible diseases is summarized in Table 1.

TABLE 1

Implications of Commonly Encountered Sexually Transmitted Diseases (STDs) for the Diagnosis and Reporting of Sexual Abuse of Prepubertal Infants and Children

<u>STD Confirmed</u>	<u>Sexual Abuse</u>	<u>Suggested Action</u>
Gonorrhea ¹	Certain	Report ²
Syphilis ¹	Certain	Report
Chlamydia ¹	Probable ³	Report
Condylomata acuminatum ¹	Probable	Report
Trichomonas vaginalis	Probable	Report
Herpes 1 (genital)	Possible	Report ⁴
Herpes 2	Probable	Report
Bacterial vaginosis	Uncertain	Medical follow-up
Candida albicans	Unlikely	Medical follow-up

¹If not perinatally acquired.

²To agency mandated in community to receive reports of suspected sexual abuse.

³Culture only reliable diagnostic method.

⁴Unless there is clear history of autoinoculation.

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Although not listed in the table, HIV infection in children is probably a sign of abuse if it is not acquired perinatally or through transfusion. The sexual abuse of children will likely become the second most common mechanism of HIV infection in prepubescent children in the near future.

Treatment Issues

All children who are sexually abused deserve evaluation by a qualified mental health professional. The need for treatment will vary with the type of sexual molestation, the length of time the molestation has gone on, the age of the child, and the symptoms manifested.

Prophylaxis against STDs and pregnancy counseling, when appropriate, should be offered. Treatment for STDs should only be given following cultures and other diagnostic procedures.

Documentation

Medical records provide the most concrete and sometimes only evidence of abuse of a child, and if court evidence becomes necessary, well-documented medical records may eliminate or reduce the time a physician may be required to spend in judicial proceedings.

The significance of a statement or piece of evidence is not always clear at the time it is revealed, so it is crucial to keep an organized record of everything that may be needed as proof in a case involving a child. Some states mandate the use of special forms for documenting assessments of abuse in children. The records should be kept in a precise, professional manner and should include the following:

- A standard, thorough pediatric health assessment, including a medical history and a relevant social history that includes information on the physical and sexual abuse history of the child, siblings and other family members
- Statements made by the child and caretaker, including any taped interviews
- Observed behavior
- The location of the alleged abusive event(s)
- A detailed description of the injuries, including type, number, size, degree of healing, possible causes, explanations given, and location recorded on a body chart or drawing
- An opinion on whether the injuries were adequately explained
- Results of all pertinent laboratory and other diagnostic procedures
- Photographs and imaging studies, if applicable
- Any other significant facts or materials that address the who, what, where, when, and why of the injuries

In order to be admissible in court, the physician should be prepared to testify:

- That the records were made during the “regular course of business” at the time of the examination or interview
- That the records were made in accordance with routinely followed procedures
- About the care, custody of, and access to the records

The physician's record is often a key determinant of outcome in a case and, therefore, of the protection of the child.

Reporting Requirements

All states have mandatory reporting laws for physical abuse of children. Most of these laws specifically require reporting of child sexual abuse as well, but even those that do not are broad enough to encompass sexual abuse implicitly. If a person required by statute to report such cases even merely suspects that a child has been sexually abused, the proper authorities must be notified. Reporting laws apply to all physicians, not only to those treating children. Physicians may be obligated to report suspected abuse even if they have never seen the child (e.g., when an adult patient makes a revelation involving abuse of a child).

Although child abuse laws vary among jurisdictions, all statutes include definitions of child abuse; descriptions of reporting procedures, including the designation of an agency to investigate reports (usually social services or law enforcement); and grants of immunity from liability for mandatory reporters who make reports in good faith. Initial reports usually can be made orally, but they must be made immediately or as soon as possible in order to protect the child quickly. Written reports prepared within a few days of the oral report also may be required. The required contents of reports vary, but normally include the names of the child and parents or caretakers and a description of the injuries. Physicians are advised to obtain copies of their jurisdiction's child abuse reporting laws from their medical society or local child protection service agency.

As with laws requiring reporting of certain infectious diseases, overriding interests of individual safety can limit some physician-patient rights of confidentiality. Protecting patient confidentiality does not legally justify a failure to report. Most state statutes allow physicians to share confidential information with people working on a case without violating the physician-patient privilege. Furthermore, virtually all states specify that the physician-patient privilege does not provide grounds for excluding testimony at trial.

To encourage reporting, all states provide mandatory reporters with immunity from liability. Such immunity may be either absolute or qualified. Absolute immunity protects reporters even when their reports are made negligently or with knowledge of their falsity. Qualified immunity is the more common type; it protects physicians who make reports in good faith, and prevents them from being held civilly or criminally liable even when no abuse is ultimately found to have occurred. Most states provide additional immunity for reporters who participate in judicial proceedings that arise from their reports. Unfortunately, however, the immunity that protects the reporting physician from liability does not mean that a lawsuit cannot be filed.

Most states also impose criminal penalties for failure to report such cases. Failure to report is usually classified as a misdemeanor, punishable by a fine and/or jail sentence. Physicians who fail to report also are at serious risk for civil action by the child or the

child's family if a court determines that a reasonable physician should have suspected abuse based on the symptoms, signs, or history.

More significant than the legal penalties, however, are the potential adverse effects on the child when someone fails to report a case of suspected child abuse. A number of states require mandated reporters to sign statements demonstrating their awareness of their duty to report and their intention to fulfill that duty, and some states require mandated reporters to take training courses.

Once a report has been filed, the child protection service agency will conduct an investigation. If the suspected incident of child abuse or neglect is substantiated, several outcomes are possible. Depending upon the circumstances, counseling or psychotherapy may be provided, and foster placement may be arranged. Criminal charges alleging a crime may be filed, although criminal indictments occur in only a small percentage of cases. Civil and juvenile courts are charged with assuring the protection of children, and their standards of proof are not as high as those of criminal courts. Participation by physicians at both levels is essential as part of advocacy for children. The physician should maintain contact with the protective services agency by telephone or written correspondence in order to coordinate follow-up care. Some agencies are required by statute to communicate their actions to the person who reported the abuse.

Table 2 presents guidelines for making the decision to report cases of suspected sexual abuse in children. Physicians who are in doubt about the appropriateness of a report may find informal peer consultation helpful as well.

Table 2
Guidelines for Making the Decision to Report Sexual Abuse of Children*

Data available			Response	
<i>History</i>	<i>Physical</i>	<i>Laboratory</i>	<i>Level of Concern about Sexual Abuse</i>	<i>Action</i>
None	Normal exam	None	None	None
Behavioral	Normal exam	None	Low (worry)	±Report ¹ ; follow closely (possible mental health referral)
None	Nonspecific findings	None	Low (worry)	±Report ¹ ; follow closely
Nonspecific history by child or history by parent only	Nonspecific findings	None	Possible (suspect)	±Report ¹ ; follow closely
None	Specific findings	None	Probable	Report
Clear statement	Normal exam	None	Probable	Report
Clear statement	Specific findings	None	Probable	Report
None	Normal exam, nonspecific or specific findings	Positive culture for gonorrhea; positive serologic test for syphilis; presence of semen, sperm, acid phosphatase	Definite	Report
Behavioral changes	Nonspecific changes	Other sexually transmitted diseases	Probable	Report

¹A report may or may not be indicated. The decision to report should be based on discussion with local or regional experts and/or child protective services agencies

*From American Academy of Pediatrics Committee on Child Abuse and Neglect (November 1990).
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Obtaining an Order of Temporary Custody

When a physician has reason to believe that a child will be in imminent danger if released to the caretaker, the appropriate authority as designated by law should be contacted immediately. Most states authorize certain parties, such as hospitals, physicians, child protection agencies, or the police to detain children in emergency situations. Physicians should check their local statutes or hospital protocol to determine the appropriate agency to call. The period of protective custody is usually no longer than 72 hours and the appropriate court must be notified of the action, sometimes before taking the child into custody.

Testimony

Some physicians are concerned about the time and inconvenience of a court appearance. In some cases, medical records may be admitted without requiring the physician's in-court testimony. However, if testimony is required, it may be possible to place the physician "on call" so that she or he need appear only when it is time to testify.

The physician may testify about general observations of behavior or statements made, a function that is distinct from the use of the doctor as an expert. A physician should never feel insulted if called to give only this type of "layperson" testimony or to testify about a nonmedical issue because this may be the only way to get such information before the court. When called as an expert witness, she or he may be requested to give an opinion on whether the explanation given is consistent with the findings.

With regard to testimony, the following guidelines should be followed:

- Insist on pre-trial preparation by the attorney presenting you as a witness
- Determine the legal and factual issues and how your testimony relates to these issues
- Determine what demonstrative evidence (eg, photographs) should be part of your testimony
- If testifying as an expert witness, propose questions for the attorney to ask
- Brief the attorney on questions to ask the opposing expert
- Answer only the question asked
- If a question is not understood, ask that it be repeated; explain when a one-word answer is not enough
- Do not volunteer information
- Calmly correct an attorney who misstates prior testimony

Risk Management

Most physicians will encounter cases of child sexual abuse in their practices. Physicians must be aware of their obligations in these cases, as well as their potential liability for failing to diagnose and report child abuse. In general, doing what is medically best or most appropriate is good risk management.

In every state, a potential cause of action exists for a physician's failure to diagnose and report child abuse. If an abused child is treated by a physician, returned to the parents' care, and subsequently sustains further injury or abuse, the physician may be held liable. In legal terms, the physician breached a duty owed to the child and her or his failure to take action was the proximate cause of the child's injuries.

Specialists must adhere to the standards of their specialty and not that of general practitioners. In diagnosing and treating victims of child abuse, every physician should:

- Have a thorough knowledge of the reporting laws in her/his state of practice
- Be aware of behavioral signs that suggest abuse
- Be aware of populations at high risk for abuse
- Arrange for physical examinations and interviews as appropriate
- If uncomfortable with a situation, request a specialist to examine or interview the child
- Get a second opinion in unclear situations
- Provide follow-up medical care for the child
- Be sensitive to the problems of abusive parents
- Be familiar with abuse-related problems
- Even after taking all possible measures to handle all cases correctly, a physician may become a defendant in a medical malpractice suit. The physician should:
 - Not panic
 - Immediately contact her/his attorney or insurance carrier
 - Not discuss the case with anyone else until speaking with her/his attorney
 - Record the circumstances involved in the serving of a summons
 - Have clear documentation

Trends in Treatment and Prevention

The physician's role in the treatment of child abuse and neglect historically has been one of detection, medical diagnosis, and treatment or referral. However, the role of the physician can be greatly expanded. Physicians may serve on hospital child protection teams, provide medical services to private service agencies, participate on community multidisciplinary review boards, and participate on advisory boards of voluntary agencies (e.g., Parents Anonymous). Physicians also may work with local child protection agencies to develop a follow-up mechanism for reported cases.

Physicians can participate in the primary prevention of child abuse and neglect as well. Comprehensive prevention strategies should be directed at increasing parents' (or future parents') knowledge of child development and the demands of parenting. Parent-child bonding, emotional ties, family communications, and home and child management issues should be addressed. These same strategies may be used to strengthen parents' skills in coping with the stresses of infant and child care and, in particular, caring for children with special needs. Approaches to prevention should attempt to reduce the burden of child care, family isolation, and long-term consequences of poor parenting. Increased access to health

and social services for all family members is another goal of any prevention effort, and physicians can actively participate in national, state, or community programs that are directed at achieving these goals.

Interaction with government agencies may be puzzling and frustrating unless personal relationships are developed that assure continued, open communications. The physician is encouraged to foster such relationships and to participate in community efforts and professional societies to coordinate activities that promote child abuse prevention, intervention, and treatment.

State Reporting Agencies

Alabama

Information:

Department of Human Resources
Bureau of Family & Children Services
South Gordan Persons Building
50 Ripley Street
Montgomery, AL 36130
205 242-9500

Reporting:

County office of Department of
Human Resources

Alaska

Information and reporting:

Local office of Family and Youth Services or call statewide 24-hour hot line: 800 478-4444

Arizona

Information and reporting:

Regional office of child protection services under the Arizona Department of Economic Security (32 regional offices; each has 24-hour hot line) Phoenix hot line: 800 541-5781

Arkansas

Information and reporting:

Department of Human Services
Central Registry
PO Box 1437, Slot 830
Little Rock, AR 72203
800 482-5964 (information, reporting, and parents under stress—24-hour)

California

Information:

Department of Social Services Office of Child Protective Services
916 657-2030

Reporting:

Abuse by family member:

County Child Protective Services (under Department of Social Services); each county has a 24-hour hot line. Abuse by non-family: Local police department

Colorado

Information and reporting:

County office of Department of
Social Services

Denver County: 24-hour hot line
303 727-3000

Other counties: After hours call
Sheriff's office (on-call social worker)

Connecticut

Information:

Department of Human Resources
Department of Children and Youth
Services

170 Sigourney Street
Hartford, CT 06105
203 566-3661

Reporting:

Regional office of Department of
Human Resources
800 842-2288, 24-hour hot line will
refer to regional offices

Delaware

Information:

Department of Services for Children,
Youth & Their Families
Child Protective Services

62 Rockford Road
Wilmington, DE 19806
302 577-2163

Reporting:

County office where child is resident
24-hour hot line: 800 292-9582

District of Columbia

Information and reporting:

DC Police Department

Youth Division

1700 Rhode Island Avenue, NE

Washington, DC 20018

To report child abuse: 202 576-6762

To report child neglect: 202 727-0995

Florida

Information and reporting:

Florida Abuse Registry

800 962-2873

(904 487-2625)

Georgia

Information:

Department of Human Resources

Child Protective & Placement

Services Unit

878 Peachtree Street

Atlanta, GA 30308

404 894-5672

Reporting:

County office of Department of Human

Resources

Hawaii

Information and reporting:

Department of Social Services

Family and Children Services

24-hour hot line: 808 832-5300 or report

to island police department

Idaho

Information:

Department of Health and Welfare

Reporting:

Regional offices (26 field offices!

7 regions). For information and referral

to regional office, call 208 334-5700

Illinois

Information:

Department of Children and Family
Services

Division of Child Protection

State Central Register

406 E. Monroe Street

Springfield, IL 62701

217 785-4010

Reporting:

24-hour hot line for reporting and
parents under stress

800 252-2873

Indiana

Information and reporting:

Indiana Family and Social Services

Administration

Division of Family and Children

402 West Washington Street, Rm W364

317 232-4431

Hot line for reporting institutional
abuse/neglect of children

800 562-2407

Iowa

Information and reporting:

Local office of Department of Human
Services (there are 8 district offices) or
call state hot line: 800 362-2178

Kansas

Information:

Department of Social and Rehabilitative Services

Child Protection and Family Services

Youth Services

913 296-4657

Reporting:

Regional office of Department of
Social and Rehabilitative Services

24-hour hot line: 800 922-5330

Kentucky

Information and reporting:

Local Department for Social Services
or statewide hot line: 800 752-6200
In Jefferson County call 502 581-6184
Parents Anonymous: 800 432-9251

Louisiana

Information and reporting:

Regional offices of Child Protection
Services or call 24-hour hot line:
504 925-4571

Maine

Information:

Department of Human Services
Children's Emergency Services
207 289-2983

Reporting:

Business hours: County office of
Department of Human Services
After hours: 800 452-1999 (24-hour)

Maryland

Information and reporting:

County office of Department of
Social Services
Each office has 24-hour hot line
Baltimore City hot line: 301 361-2235

Massachusetts

Information:

Information packet for mandated reporters available through Department of Social
Services
24 Farnsworth Street Boston, MA 02210 617 727-0900 (x573)

Reporting:

Make reports to area office of
Department of Social Services where
child is resident
24-hour state hot line: 800 792-5200

Michigan

Information and reporting:

Each county protective services (under Department of Social Services) has 24-hour hot line
Private hot line run by GATEWAYS can direct to county offices and provide information:
800 942-4357

Minnesota

Information and reporting:

County office of Department of
Human Services
Each office has 24-hour hot line

Mississippi

Information:

Department of Human Services
601 354-6659

Reporting:

County office of Department of
Human Services or to 24-hour hot line:
800 222-8000

Missouri

Information:

Department of Social Services
Child Abuse and Neglect
Broadway State Office Building
PO Box 88
Jefferson City, MO 65103
314 751-3448
Parental Stress Helpline: 800 367-2543

Reporting:

800 392-3738 (24-hour)

Montana

Information:

Department of Family Services
Child Abuse & Neglect Program
PO Box 8005
Helena, MT 59604
406 444-5900

Reporting:

Local Department of Family Services or
800 332-6100 (24-hour)

Nebraska

Information:

Department of Social Services
Child Protective Services
1001 O Street
Lincoln, NE 68508-3649
402 471-7000

Reporting:

800 652-1999 (24-hour)

Nevada

Information:

Department of Human Resources
Division of Child and Family Services
711 East 5th Street
Carson City, NV 89710
702 687-5982

Reporting:

Local child protection agency or
800 992-5757 (all areas except Clark
County)
702 399-0081 (Clark County)

New Hampshire

Information

Department of Health and Welfare
Division for Children and
Youth Services
Health & Welfare Building
6 Hazen Drive
Concord, NH 03301
603 271-4451

Reporting:

800 562-2340 (eastern area)
800 624-9701 (western area)
800 458-5542 (central and northern areas)
800 852-3388 (24-hour helpline)

New Jersey

Information:

Division of Youth and Family Services

50 East State Street - CN717

Trenton, NJ 08625

Reporting:

800 792-8610 (24-hour)

New Mexico

Information:

Department of Human Services

Social Services Division

Pollon Plaza

Santa Fe, NM 87504

505 827-8400

Reporting:

Local Department of Human Services

or 800 432-6217 (24-hour, information
and referral)

New York

Information:

Department of Social Services

Division of Family and Child Services

40 N Pearl Street

Albany, NY 12243 518 474-9003 (public information)

Reporting:

800 342-3720 (24-hour)

North Carolina

Information:

Department of Human Resources

Division of Social Services

Child Protective Service Unit

325 North Salisbury Street

Raleigh, NC 27603

919 733-2580

Reporting:

County Department of Social Services

800 662-7030 (helpline)

North Dakota

Information:

Department of Human Services
Child Abuse and Neglect
State Capitol
Bismarck, ND 58505
701 224-2316

Reporting:

County Social Services

Ohio

Information:

Department of Human Services
Child Protective Services Unit
Bureau of Children Services
65 East State Street 5th floor
Columbus, OH 43215
614 466-9824

Reporting:

Local Department of Human Services

Oklahoma

Information:

Department of Human Services
Division of Child Welfare
PO Box 25352
Oklahoma City, OK 73125
405 521-2283

Reporting:

800 522-3511 (24-hour, all areas
except Oklahoma County)
800 841-0800 (24-hour, Oklahoma
County)

Oregon

Information:

Department of Human Resources
Childrens' Services Division
198 Commercial Street, SE
Salem, OR 97310
503 378-4722

Reporting:

County Child Protective Services or
503 378-4722

Pennsylvania

Information:

Department of Public Welfare
Child Abuse Central Registry
Lanco Lodge, 3rd floor
PO Box 2675
Harrisburg, PA 17120
717 783-8744 (administrative)

Reporting:

800 932-0313 (24-hour, reporting and information)

Puerto Rico

Information:

Department of Social Services
Family Services
PO Box 11398
Santurce, PR 00910
809 724-0303
809 723-2127

Reporting:

809 724-1333 (24-hour)

Rhode Island

Information:

Department of Children, Youth,
and Families
610 Mount Pleasant Avenue
Providence, RI 02908
401 457-4708

Reporting:

800 742-4453 (24-hour, reporting and information)

South Carolina

Information:

Department of Social Services
Division of Child Protective and
Preventive Services
1535 Confederate Avenue
PO Box 1520
Columbia, SC 29202
803 734-5670

Reporting:

County Department of Social Services

Tennessee

Information:

Department of Human Services
Child Protective Services
400 Deaderick
Nashville, TN 37248-9300
615 741-5927

Reporting:

County Department of Human Services. After business hours, contact local sheriffs department

Texas

Information:

Department of Human Services
Childrens' Protective Services
7901 Cameron Road
Building 3, 3rd floor
Austin, TX 78761
512 834-0034

Reporting:

800 252-5400 (24-hour)

Utah

Information:

Department of Human Services
Child Abuse
2835 South Main
Salt Lake City, UT 84101
801 538-4171

Reporting:

800 678-9399 (24-hour)
801 487-9811(24-hour investigation line)

Vermont

Information:

Department of Social and Rehabilitation Services
Division of Social Services 103 South Main Street Waterbury, VT 05671-240 1 802 241-2131

Reporting:

Regional Department of Social and Rehabilitative Services during business hours
Emergency/after hours: 800 356-6552

Virginia

Information:

Department of Social Services
Child Protective Services Unit
8007 Discovery Drive
Richmond, VA 23229
804 662-9081

Reporting:

800 552-7096 (24-hour, within
Virginia)
804 662-9084 (24-hour, from out
of state)

Washington

Information:

Social and Health Services
Division of Child and Family Services
Childrens' Protective Services
Mail Stop 5710
Olympia, WA 98504
206 753-7002

Reporting:

800 562-5624 (24-hour)

West Virginia

Information:

Department of Health and
Human Resources
Office of Social Services
State Capitol Complex
Building 6 Room 850
Charleston, WV 25305
304 348-7980

Reporting:

800 352-6513 (24-hour)

Wisconsin

Information:

Department of Health and
Social Services
Children, Youth, and Families Bureau
Office of Child Abuse and Neglect
1 West Wilson Street
Madison, WI 53703
608 266-3036

Reporting:

Local county Department of Health and Social Services

Wyoming

Information:

Department of Family Services
Youth Services Division
Hathaway Building
2300 Capitol Avenue
Cheyenne, WY 82002-0490
307 777-7150

Reporting:

Local county sheriff or police for on call social worker

National Child Abuse Hot Line (Child Help USA): 800 422-4453