

Child Abuse: Approach and Management

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Child maltreatment is a devastating type of adverse childhood experience that encompasses neglect and emotional, physical, and sexual abuse (including sex trafficking). Adverse childhood experiences are exposures to maltreatment or household dysfunction during crucial developmental periods that disrupt neurodevelopment and can result in lifelong physical and psychological harm, altering the child's behavior and disease risk into adulthood. Maltreatment can affect patients of any gender identity and from all racial and ethnic backgrounds, socioeconomic statuses, and community settings. Use of the validated five-item Pediatric Hurt-Insult-Threaten-Scream-Sex screening tool to identify victims of child abuse is recommended. All suspected cases of child abuse must be reported to Child Protective Services. A trauma-informed approach to care requires that team members be mindful of the potential for traumatic stress, recognize and appropriately respond to the symptoms and signs of trauma, and prevent retraumatization. Prevention through education and anticipatory guidance provided during routine well-child visits and community partnerships can foster awareness and resiliency in children. Although caring for victims of child maltreatment may be among the most challenging professional situations encountered by physicians, advocating for these endangered patients can save lives and help prevent revictimization and chronic sequelae associated with adverse childhood experiences. (*Am Fam Physician*. 2022;105(5):521-528. Copyright © 2022 American Academy of Family Physicians.)

The U.S. Department of Health and Human Services defines child maltreatment as “any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm.”¹ Child maltreatment is a type of adverse childhood experience. These involve exposures to maltreatment or household dysfunction during crucial developmental periods that can have profound impacts on physical, neurologic, and intellectual development (*Table 1*).²⁻⁴ These impacts may then result in negative and enduring effects on health and behavior in a compounding manner.⁵ Risk factors and protective elements for victimization and perpetration of child maltreatment can be framed in terms of the child, the caregiver or abuser, and the environment (*Table 2*).^{1,6}

Maltreatment can affect patients of any gender identity and from all racial and ethnic backgrounds, socioeconomic statuses, and community settings. The actual number of

maltreated children is challenging to track because of a lack of consistent reporting and difficulty confirming suspicions. The prevalence of maltreatment varies by type, gender, and geographic location.⁷ Approximately 4.4 million children are reported to Child Protective Services (CPS) each year, and about nine out of 1,000 children in the United States have evidence of maltreatment after investigation.⁸

TABLE 1

Potential Sequelae of Adverse Childhood Experiences Due to Child Maltreatment

Effects	Examples*
Health-risk behaviors	High-risk sexual behaviors, revictimization, sexually transmitted infections, substance abuse, suicidal ideations or attempts, unplanned pregnancies
Medical conditions	Fibromyalgia, irritable bowel syndrome, obesity
Psychological conditions	Anxiety, depression, posttraumatic stress disorder

*—The compilation of these conditions may result in early death.

Information from references 2-4.

Additional content at <https://www.aafp.org/afp/2022/0500/p521.html>.

CME This clinical content conforms to AAFP criteria for CME. See CME Quiz on page 458.

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TABLE 2

Risk Factors for Child Maltreatment and Protective Factors for Recovery

Source	Risk factors	Protective factors
Child	Chronic illness	Above average cognitive ability
	Emotional or behavioral difficulties	Belief in one's ability to control own destiny
	Physical disabilities	External attribution of blame
	Preterm birth	High degree of impulse control and modulation
	Unplanned or unwanted pregnancy	High self-esteem or sense of self-worth
		Presence of spirituality
Caregiver(s)	Alcohol or other substance abuse	Caregiver resilience
	Criminal history	Caregiver social support network
	Depression or other mental illness	
	Development of unrealistic expectations for the child	
	History of abuse	
	Low educational attainment	
	Low self-esteem	
	Negative perception of normal childhood behavior	
	Poor impulse control	
	Poor knowledge of the child	
	Young parental age	
Home environment	Family or intimate partner violence	Presence of caring and supportive adult
	Non-biologically related adult living in the home	
	Single-parent home	
Community environment	Poverty	Access to good health, education, and social welfare services
	Social isolation or lack of social support	Caring adult in school or extra-curricular activities
		Involvement with extracurricular activities or hobbies
		Involvement with religious community
		Structured school environment

Information from references 1 and 6.

Being vigilant for possible child maltreatment, knowing how to assess for and report it, and remaining adept at providing a trauma-informed approach to care^{9,10} (Table 3^{3,11-13}) within a multidisciplinary team can help optimize patient care. The principles of trauma-informed care require the health care team to realize the widespread impact of trauma, recognize and appropriately respond to signs and symptoms of trauma, and actively prevent retraumatization in their patients.¹⁴

Types of Abuse

All suspected cases of child abuse must be reported to CPS.^{1,9,10} Major categories of abuse include neglect, and emotional, physical, and sexual abuse.

NEGLECT

Neglect consists of parental omissions in care that result in actual or potential harm to a child.^{1,15} It is the most common form of child maltreatment, occurring as the only offense in 61% of all cases of confirmed maltreatment and in combination with abuse in 15% of cases.¹⁶ Additionally, it accounts for 73% of child fatalities caused by maltreatment.¹⁶

Neglect occurs when a child's basic physical, emotional, educational, or medical needs are not adequately met in a consistent pattern.^{1,15} Physical neglect involves exposure to environmental hazards that could lead to injuries or harmful ingestions, or a failure to provide adequate hygiene, nutrition, clothing, or shelter.^{1,15,17} Inadequate supervision is a subtype of physical neglect that includes abandonment and expulsion.^{1,15,17} Medical neglect results from refusing or delaying necessary health care.^{1,9,15,17} Emotional neglect involves inadequate nurturing or affection, an exposure to intimate partner violence, permitted drug or alcohol abuse, or refusing or delaying necessary psychological care.^{1,15,17}

TABLE 3

Elements of Trauma-Informed Care to Incorporate While Interviewing and Examining Patients for Suspected Child Abuse

General

Preview chart, if available, for documentation regarding trauma to prevent revictimization by asking the patient to completely repeat this history

Remain seated to prevent the perception of a patient-physician power differential

Discuss the importance of confidentiality, trust, safety, and holistic care and expectations for the encounter (i.e., history with detailed note taking, comprehensive physical examination, and procedures, laboratory testing, imaging, and referrals as clinically indicated)

Ask open-ended questions in a nonjudgmental manner and explain medical rationale for asking sensitive questions (e.g., sexual and substance use histories)

If using an interpreter, inquire about cultural and gender preferences

Key history components

Developmental, medical, surgical, social, and family histories (especially with relation to genetic, metabolic, hematologic, and bone disorders)

Familial disciplinary methods, the child's baseline temperament and demeanor, and biopsychosocial stressors affecting the family

History of child, sibling, and parental/caregiver trauma

History of parental/caregiver substance abuse, incarcerations, arrests, intimate partner violence, behavioral health conditions, and previous or current Child Protective Services or law enforcement involvement with the patient's family

Maternal pregnancy and behavioral health histories

Physical examination

Consider referral to a medical forensic professional or child abuse team before performing an examination

Ensure presence of a chaperone

Ask the child if they are anxious about any components of the examination, and if there is anything that you can do to improve their comfort

Discuss that they can dictate the pace of the examination

Provide children with gowns and drapes for the examination

Judiciously expose and cover bodily areas (ask the patient to do so, if able, to promote personal empowerment) during examination to maximize privacy

Use age-appropriate language and ask permission to proceed with increasingly sensitive portions of the examination

Offer suggestions about how to potentially improve patient comfort while the examination is being performed (e.g., it may be helpful to take a deep breath during this portion of the examination)

Verbalize what is intended to be visualized and why

Discuss any invasive procedures (e.g., speculum examinations) in detail, obtain consent, and describe to the patient what they might experience (e.g., hearing a click with speculum opening)

Avoid performing repetitive anogenital examinations as able to prevent retraumatization

Information from references 3 and 11-13.

Educational neglect includes a failure to enroll a child in school, truancy, or inattention to special education needs.^{15,17}

Manifestations of the subtypes of neglect overlap and can include malnourishment or failure to thrive, advanced medical or dental disease, developmental delays, attention-deficit/hyperactivity disorder, and alcohol or drug abuse, all of which can cause long-term intellectual, social, and psychological deficits.^{15,17,18} Assessment of suspected neglect involves taking a detailed medical and psychosocial history (i.e., growth, immunization status, previous hospitalizations, family stressors, and past contact with CPS) and performing a thorough physical examination.¹⁵ Additional guidance is provided in *Tables 3*^{3,11-13} and *4*.^{11,19} Evaluations should also include screening for contributing factors (e.g., poverty, food insecurity, lack of transportation, lack of health care access, language barriers, low health literacy). Screening tools are listed in *eTable A*. Referral to appropriate community resources is warranted when concerns are identified.^{9,15,18} Home visitation programs have been shown to reduce the incidence of maltreatment in high-risk families.²⁰⁻²² CPS referrals are indicated when assistance has been offered and refused, and the child's needs have been left unmet.¹⁵

EMOTIONAL ABUSE

The Child Abuse Prevention and Treatment Act defines psychological maltreatment as repeated patterns of caregiver behavior or extreme incidents that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs.^{4,23} Also known as emotional abuse, this subtype may be widely prevalent but is difficult to detect because of a lack of physical findings and difficulty discerning when suboptimal parenting becomes maltreatment.²⁴ Even though emotional abuse is generally present when other forms of abuse are identified, only 8% of victims substantiated by CPS are confirmed to have experienced emotional abuse in isolation.¹ Harmful parental behaviors are varied and include spurning, terrorizing, rejecting, isolating, exploiting, corrupting, denying emotional responsiveness, demonstrating unreliability or inconsistency, verbally assaulting, overpressuring, and neglecting emotional needs.^{4,23,24}

TABLE 4

Differential Diagnoses of Physical Abuse

Injury	Differential diagnoses
Bite marks	
Abrasions, lacerations, or ecchymoses in an ovoid or elliptical pattern May require co-evaluation by dentist or forensic odontologist	Accidental or nonaccidental bite mark from animal or another human
Bruises*	
Age cannot be accurately determined forensically External sign of potentially severe internal injury Inflicted bruises may occur in atypical locations (e.g., behind ears, inside lips, along hard palate of mouth) Noninflicted bruises are usually notable on shins, knees, and forehead	Accidental or nonaccidental trauma, dermatologic disorders, congenital dermal melanocytosis, Henoch-Schönlein purpura, genetic disorders (e.g., Ehlers-Danlos syndrome), vascular or hematologic disorders
Burns	
Object contact burns Scalding immersion burns	Accidental or nonaccidental burn, dermatitis, skin infection, Stevens-Johnson syndrome, toxic epidermal necrolysis
Fractures	
Commonly identified on skeletal radiographs Improved detection with repeated imaging	Accidental or nonaccidental fracture, birth trauma, congenital syphilis, leukemia, osteogenesis imperfecta, osteomyelitis, physiologic changes, vitamin deficiencies
Head trauma	
Associated with abuse-related fatalities Recommend co-assessment by ophthalmologist	Accidental or nonaccidental trauma, birth trauma, hemorrhagic disease, infection, intracranial vascular anomalies, metabolic disease

*—TEN-4 mnemonic (Torso, Ears, Neck; and any infant younger than four months or child younger than four years) helps identify bruises likely associated with abuse.

Information from references 11 and 19.

Indicators that may warrant an evaluation include attention problems, violent or oppositional behaviors, difficulty with attachment or impaired social skills, developmental or educational delays, depression, anxiety, or physical manifestations (e.g., psychosocial short stature or failure to thrive).^{1,4,24,25} During the assessment, it is important to include specific quotes from both parent and child to document observations and substantiate claims.^{4,24} Reports from a child's school, childcare workers, or other professionals involved with the family can help guide management.⁴

The response to emotional abuse depends on both intent and harm, and options include parental education, counseling, CPS referral, and potentially removing the child from their home.²³ Trauma-specific psychotherapy with an emphasis on cognitive behavior therapy or other behavioral therapies can provide benefit; psychopharmacologic intervention as a temporary adjunct may be useful to modulate specific symptoms such as difficulty sleeping, nightmares, and anxiety.^{1,25,26} Although the U.S. Preventive Services Task Force found insufficient evidence to balance the benefits and harms of primary care interventions, the American Academy of Family Physicians still endorses the provision of developmentally appropriate anticipatory guidance and preventive education, and instructions on healthy parenting approaches during well-child visits.^{27,28} Participation in parenting training programs (e.g., Triple-P: Positive Parenting Program) and educational home visitation programs (e.g., Nurse-Family Partnership) may be indicated when risk factors are present (Table 2).^{1,6}

PHYSICAL ABUSE

Physical abuse encompasses any nonaccidental physical injury (e.g., biting, striking, burning, kicking) or action that results in the physical impairment of a minor.¹ The most common types of injuries include bruises, burns, bite marks, fractures, and head trauma¹; further details are available in Table 4^{1,19} and eTable A. When a child

presents with an injury, the potential for nonaccidental trauma should always remain in the differential diagnosis, because earlier detection of nonaccidental trauma can reduce morbidity and mortality.¹² Using the validated five-item Pediatric Hurt-Insult-Threaten-Scream-Sex screening tool to identify victims of child abuse and taking a trauma-informed approach to care are recommended.^{3,29,30} The Pediatric Hurt-Insult-Threaten-Scream-Sex questionnaire assesses on a scale from 0 to 5 how often an immediate family member was estimated to have physically hurt,

insulted, threatened, screamed or cursed at, or forced sexual acts on a child 12 years or younger within the past year; higher scores indicate an increased exposure to abuse.²⁹

After ensuring that the child is hemodynamically stable, the clinician should obtain a comprehensive history from the patient (if able, based on language capabilities) and caregivers, preferably separately, using a nonaccusatory and sensitive manner with a focus on open-ended questions to create a safe environment and develop a trusting rapport. It is important to note details about the timing and mechanism of injury, symptom onset and progression, the child's behavior at baseline, any changes in behavior during and after the injury, and the child's demeanor both with and without the caregiver present. Vague and inconsistent explanations, denials of injury, and excessive delays in obtaining medical care may indicate abuse.^{11,12} Additional useful information to obtain during this trauma-informed assessment is included in *Table 3*.^{3,11-13}

In all children presenting with injuries, physical examination findings should be evaluated carefully in the context of their developmental levels, mechanisms of injury, histories, and laboratory and imaging findings. Isolated injuries are rarely pathognomonic for child abuse. Resources that can help clinicians identify suspicious injuries are included in *eTable A*. Injuries should be distinguished as either noninflicted/unintentional or inflicted/intentional. Inflicted injuries can be further classified as sentinel injuries (i.e., minor injuries that are detected before the recognition of child abuse) and defensive injuries (i.e., those sustained in self-defense, such as on the forearms). Signs of potential abuse include injuries that are unexplained, patterned, involving more than one organ system, in various stages of healing, in an atypical location (e.g., on the ears, neck, and face), or involving a preambulatory infant.^{11,12}

Imaging and laboratory studies are typically indicated to further investigate physical examination findings (*Table 5*^{11,12,31}). Per guidelines from the American Academy of Pediatrics and American College of Radiology, a skeletal survey should be performed in all children with suspected physical

abuse, especially those two years or younger.^{11,12,31,32} Comprehensive and detailed documentation is essential, and the inclusion of body diagrams and confidential forensic photographs may be useful to supplement the medical record, especially if requested to provide a court testimony or if records undergo a peer review¹³ (*eTable A*). Additionally, it is important to maintain a chain of custody with law enforcement or CPS that chronologically records the movement of medical documentation and other evidence from the assessment. Elements that have potential evidentiary value include sterile swabs and items of clothing containing biologic materials (e.g., saliva, blood, semen).

SEXUAL ABUSE

Sexual abuse represents a significantly underreported public health crisis that is associated with an array of potentially lifelong biopsychosocial manifestations. According to the Centers for Disease Control and Prevention, an estimated one in four girls and one in 13 boys are sexually abused

TABLE 5

Imaging and Laboratory Studies for Child Physical Abuse Evaluations

Study	Indications
Funduscopy examination	Retinal hemorrhages (in children younger than two years)
Imaging studies	
Abdominal CT scan with contrast media	Intra-abdominal injuries
Bone scan	Occult fractures (up to two weeks after injury)
Chest CT scan with contrast media	Intrathoracic injuries
Head CT scan without contrast media	Subarachnoid, subdural, or intraparenchymal injury
Skeletal survey radiography	Old or new fractures in all children, particularly those two years or younger, with suspected physical abuse
Laboratory testing	
Amylase and lipase, coagulation panel (international normalized ratio, prothrombin time, and partial thromboplastin time), complete blood count, complete metabolic panel, fecal occult blood test, urinalysis, urine drug screen	Genitourinary or intra-abdominal trauma, bleeding and coagulation disorders, metabolic dyscrasias

CT = computed tomography.

Information from references 11, 12, and 31.

during childhood, and the perpetrators are known by the child or the child's family in about 90% of cases.³³ Additionally, sex trafficking of minors is an underestimated form of child sexual abuse that can involve the recruitment, provision, transportation, harboring, and solicitation of persons younger than 18 years in exchange for commercial sex acts. Victims may be children of all ages, races and ethnicities, gender identities, and socioeconomic backgrounds within rural, suburban, and urban communities in the United States and abroad.³⁴ *Table 6* lists psychosocial warning signs and physical features to look for in victims or their traffickers during an office visit.^{35,36}

Once the potential for child sexual abuse or sex trafficking is suspected, a physician's priorities comprise the following: (1) a safety assessment of the child's home environment (i.e., inquiring if the child is safe to return home, at risk of sustaining additional maltreatment in response to disclosing abuse, or at risk of being reexposed to a suspect at home), (2) the physician's professional duty to report suspected cases of abuse to appropriate government agencies, (3) a comprehensive evaluation of the child's mental and physical health, and (4) the possible need for a medical forensic examination (especially if patients present within 72 hours of an act of sexual abuse to obtain biologic specimens that could potentially have evidentiary value via rape/sexual assault kits) by referral to trained medical forensic professionals or transfer to a higher level of care (e.g., an emergency department, a child advocacy center, an abuse assessment clinic).^{11,13}

When assessing children who may have been sexually abused, it is important to differentiate between normal and abnormal sexual behaviors. *eTable A* provides examples of ways to distinguish these behaviors in children up to 12 years of age. Many sexual behaviors that are considered normal increase in frequency and variety up until five years of age and wane afterwards.³⁷ Notably, children with developmental delays may have different expectations of normal and abnormal sexual behaviors.

The aforementioned principles of assessing victims of physical abuse in a trauma-informed manner also

apply to victims of sexual abuse. For female victims of sexual assault, a speculum examination is recommended in pubertal and postpubertal girls, but it is usually contraindicated in prepubertal children. For male and female victims, digital rectal and anoscopic examinations usually are not indicated. Sexually abused children with abnormal physical examination results should be further evaluated by clinicians with specialized training and experience.^{13,38} Medical examinations and records from all victims of sexual trauma should, ideally, be further reviewed by an experienced physician with medical forensic-related training.^{13,19,38}

Of note, many victims of sexual abuse have anogenital examinations that appear normal, and a negative examination cannot disprove the occurrence of sexual trauma. These patients should be screened for sexually transmitted infections (i.e., HIV, syphilis, gonorrhea, chlamydia, and trichomoniasis). They can also be tested for bacterial vaginosis and vaginal candidiasis. Patients should receive treatment for any detected sexually transmitted infections

TABLE 6

Identifying Features of Child Sex Trafficking

Psychosocial warning signs	Physical warning signs
Claim that the patient is "just visiting the area"	Atypical behavior (e.g., caused by traumatic brain injury)
Display of emotional distress (e.g., depression, anxiety, low self-esteem)	Branding (e.g., tattoos with a name or initials)
Dominating or controlling adult in room with patient	Discrepancy between apparent and reported age (e.g., clues in behavior and appearance)
Family dysfunction, abuse in the home, neglect or absence of a caregiver	Inappropriate dress
Involvement with several sex partners	Injuries around the head or mouth
Lack of identification (e.g., driver's license)	Multiple visits for sexually transmitted infections
Multiple foster home or group home placements	Presence of unexplained scars, scar tissue, or bruises
Prior record of arrest for prostitution	Signs of drug use, substance abuse, or intoxication
Relationship with an older adult	Signs of having intercourse while masking menses (e.g., retained cotton balls, tampons, and makeup sponges in the vaginal canal)
Repeated attempts to run away from home	Signs of malnourishment
Restricted or controlled communication	Signs of self-inflicted injuries or suicide attempts
Sex industry association	Signs of sexual trauma
Use of slang relating to street work	Vaginal wall thinning or tearing
Victim in crisis, but downplaying health problems or risks	
Victim resisting help because of fear	

Information from references 35 and 36.

SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	Evidence rating	Comments
A trauma-informed approach to evaluating, diagnosing, and treating child abuse within a multidisciplinary team is recommended. ^{3,9,10}	C	Expert opinion
All suspected cases of child abuse should be reported to Child Protective Services. ^{1,9}	C	Legal mandate
Primary care physicians should incorporate preventive education into their practice. ^{27,28}	C	Expert opinion
Physicians should include abuse as part of the differential diagnosis for childhood injuries. ^{11,12}	C	Expert opinion; detection at first presentation reduces morbidity and mortality
The validated Pediatric Hurt-Insult-Threaten-Scream-Sex screening tool can be used effectively in clinical settings to identify victims of child abuse. ²⁹	B	Validation study
A skeletal survey should be done in all children with suspected physical abuse, especially those two years or younger. ^{11,12,31,32}	C	Organizational guidelines
Sexually abused children with abnormal physical examination results should be further evaluated by clinicians with specialized training and experience. ^{13,38}	C	Expert opinion

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to <https://www.aafp.org/afpsort>.

and be offered emergency contraception and HIV postexposure prophylaxis.^{13,38}

Once the occurrence of childhood sexual trauma is divulged, it can trigger distressing and emotionally charged responses throughout the child's support system. Physicians should remain vigilant for these responses and provide caregivers with anticipatory guidance, education, and resources for behavioral health services (especially those that specialize in childhood trauma) and child advocacy facilities. Parents are encouraged to support and believe their children, respond in a protective and calm manner, reassure their children that they are not at fault, and ensure close follow-up with their children's medical and behavioral health professionals.^{11,13}

Although the various types of child maltreatment may have nuances in their presentations, there are similarities in many aspects of diagnosis and treatment. Physicians should use a trauma-informed approach and employ their duty to report all suspected cases of maltreatment, and the patient's medical care team should stay actively involved by facilitating access to behavioral health services and community resources.^{1,9,39} Strategies for preventing and managing all types of abuse and neglect, as well as helpful resources, can be found in *eTable A* and *eTable B*.

This article updates a previous article on this topic by McDonald.¹²

Data Sources: A PubMed search was completed in Clinical Queries using the key terms "child abuse," "physical abuse," "physical trauma," "sexual abuse," "sexual trauma," and "sex trafficking." Search dates: February 20 and March 23, 2021. Essential Evidence Plus was also used with the search terms "child abuse" and "neglect." Search dates: March 22, 2021, and January 7, 2022.

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eTABLE A

Helpful Resources Regarding Child Maltreatment**Educational websites and screening tools**

Child Welfare Information Gateway: Child Abuse and Neglect
<https://www.childwelfare.gov/topics/can/>

National Child Traumatic Stress Network
<https://www.nctsn.org/resources>

Screening tools for adverse childhood experiences
<https://www.acesaware.org/screen/screening-for-adverse-childhood-experiences/>

Tools for assessing social determinants of health and patient resources

The EveryONE Project
<https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html>
<https://www.aafp.org/family-physician/patient-care/the-everyone-project/neighborhood-navigator.html>

Clinical resources

Evaluation of Suspected Child Physical Abuse
<https://pediatrics.aappublications.org/content/119/6/1232.full>

Trauma-informed care

<https://pediatrics.aappublications.org/content/pediatrics/148/2/e2021052580.full.pdf>
<https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf>

Suspicious injuries concerning for nonaccidental trauma or physical injury
https://www.domusmedica.be/sites/default/files/Kos_Ped_Derm_2006_23_4_311-320.pdf
<https://jamanetwork.com/journals/jamapediatrics/fullarticle/379539>

Sexual abuse and trafficking

National Human Trafficking Hotline
<https://humantraffickinghotline.org/resources>

Normal and abnormal sexual behaviors in children
https://www.protectchildren.ca/pdfs/C3P_SexualizedBehaviourInChildren_en.pdf

Evaluating the Child for Sexual Abuse
<https://www.aafp.org/afp/2001/0301/p883.html>

Common Health Issues Seen in Victims of Human Trafficking
https://www.acf.hhs.gov/sites/default/files/documents/orr/health_problems_seen_in_traffick_victims.pdf

Prevention

Child abuse prevention programs
<https://www.childwelfare.gov/topics/preventing/prevention-programs/>
 The Pediatrician's Role in Child Maltreatment Prevention
<https://pediatrics.aappublications.org/content/126/4/833>

Reporting and documentation

Hotlines and telephone numbers for reporting suspected abuse:

- (1) National Sexual Assault Hotline: 1-800-656-HOPE (4673)
- (2) Childhelp National Child Abuse Hotline: 1-800-4A-CHILD (422-4453)
- (3) National Human Trafficking Hotline: 1-888-373-7888
- (4) National Teen Dating Abuse Helpline: 1-866-331-9474
- (5) National Suicide Prevention Lifeline: 1-800-273-8255

Listing of state child abuse and neglect reporting numbers
https://www.childwelfare.gov/organizations/?CWIGFunction=rols:main.dspList&rolType=custom&rs_id=5

How to Report Child Abuse and Neglect
<https://www.childwelfare.gov/topics/responding/reporting/how/>

An Advocate's Guide to Mandatory Reporting
<https://tinyurl.com/5fdde4x5>

Forensic photography
<https://www.safeta.org/wp-content/uploads/2022/03/Photography.pdf>

Tips for clinicians preparing to testify in court
<https://journals.sagepub.com/doi/full/10.1177/2377960818757097>

eTABLE B

Management and Prevention Principles for All Subtypes of Child Abuse

Management/treatment	Prevention
Cognitive behavior therapy–based parenting programs or referral to mental resources	Developmentally appropriate anticipatory guidance
Counseling	Encouraging healthy parenting approaches, including appropriate disciplinary practices
Education	
Frequent follow-up	Nurse-Family Partnership and other home visitation or school and community programs
Legal notification	
Referral to resources if financial or other stressors identified	

Information from:

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