Child Maltreatment – The Important Interface Between Healthcare and Child Protection Services

Oliver Berthold [a,b], Ulrike Hoffmann [a], Jörg M. Fegert [a], Anna Eberhardt [a]

[a] Ulm University Medical Center, Department for Child and Adolescent Psychiatry, Psychotherapy and Psychosomatic Medicine, Ulm, Germany

[b] DRK Kliniken Berlin, Child Abuse Outpatient Clinic, Berlin, Germany

o.berthold@drk-kliniken-berlin.de

Keywords

Child abuse ; delivery of health care ; referral and consultation.

Abstract

Introduction

Healthcare professionals play a central role in preventing child maltreatment. However, major uncertainties remain regarding appropriate interventions and legal frameworks. In Germany, a 24/7 telephone helpline provides counselling to medical professionals. This article examines the topics raised by callers to the helpline and characteristics of cases.

Methods

The telephone counselling service is available to healthcare professionals, child and youth welfare workers and family court professionals. The counsellors are trained physicians who offer expert guidance on medical aspects related to cases of child maltreatment. A descriptive statistical analysis of calls from 2017 onward was conducted and free text case descriptions were assessed. Where possible, the characteristics of consultations were compared to the nationwide data of child protection service assessments of a risk to a child's wellbeing.

Results

Of 9,315 calls recorded, 78.0% (6,805) were from healthcare professionals, 10.0% (999) from child and youth welfare professionals and 0.6% (54) from professionals involved in court cases. Affected children were predominantly either of pre-school age or young adolescents, a majority was female (55.9%). The most prevalent form of child maltreatment was physical abuse and all forms of neglect.

Discussion

Most consultations originated from healthcare professionals, often regarding uncertainties with the threshold for reporting to the authorities. Although physical abuse was the most commonly reported form, sexual abuse was over-represented compared to data from child protection service. This suggests that this form causes particular concern in healthcare professionals. Uncertainty about child protection service involvement highlights the need for training.

Introduction

Child maltreatment and Adverse Childhood Experiences (ACEs) in general have enormous costs for individuals and society. While child maltreatment as an umbrella term includes physical and emotional neglect as well as physical, sexual and emotional abuse of children, the concept of adverse childhood experiences is broader and includes growing up in a household with a mentally ill or substance abusing parent, intimate partner violence, an incarcerated parent or instability due to divorce (1). While some affected children prove resilient and go on to lead normal lives, for others the burden means lifelong mental and physical health problems such as depression and anxiety, as well as a higher risk for common diseases such as hypertension, type 2 diabetes, cancer and others (2). A societal cost estimate by Klika et al. reported a total lifetime cost of $ 2.94 trillion for all U.S. child maltreatment cases assessed in 2018, including lost work, medical and welfare costs (3).

In many European countries, the responsibility for providing support to families and protecting vulnerable children from maltreatment lies with child protection services (CPS) (4, 5). Healthcare providers, on the other hand, have unique opportunities for primary, secondary and tertiary prevention: these include programs for primary prevention of abusive head trauma, screenings for early detection of cases of maltreatment in emergency departments and trauma focused treatments (6-9). However, the World Health Organization estimates that 90 per cent of child maltreatment goes undetected by healthcare professionals (10). Furthermore, collaboration and communication at this pivotal interface between the healthcare system and CPS have only recently been incorporated into nationwide medical training regulations, and they remain significantly deficient (11). In 2018, the German Medical Association has issued updated recommendations for specialist training, including basic knowledge on child abuse prevention and treatment for pediatricians, child and adolescent psychiatrists and pediatric surgeons.

Health care professionals are a highly relevant target group for prevention efforts. Reasons for missed opportunities for prevention are more likely on the individual level than in legislation (12). Common reasons for not pursuing a suspicion of child abuse

or neglect cited by healthcare professionals include that it was perceived as an "uncomfortable" topic, superiors were not willing to deal with the topic, a lack of training, particularly in dealing with the legal ramifications of medical confidentiality, involvement of CPS, or law enforcement (13-16).

Responses to this problem vary from country to country. In many cases, however, specialized collegial consultation facilities for physicians have been established at the interface between child protection services and the healthcare sector. Examples include the Dutch Expertise Centre for Child Abuse and the child abuse evaluation clinics in the German Land of Berlin (17, 18). Furthermore, in 2017 the German federal Ministry for Families, Senior Citizens, Women and Youth established a nationwide child abuse helpline for professionals (CAHP).

The service functions as a low-threshold medical point of contact by telephone, offering guidance to healthcare professionals on potential cases of child maltreatment. The counselors' role is not to adopt the case, but rather to provide guidance to professionals seeking assistance, empowering them to initiate effective child protection interventions.

The present article aims to analyze the specialist disciplines and care settings of the professionals seeking advice, as well as the characteristics of the cases in terms of forms of maltreatment and the age distribution of the children affected. These data will be compared to the national statistics of child protection services in Germany (19). A particular focus is placed on pediatricians working in outpatient and inpatient settings, and the most common consultation topics are presented herein. The reader will be able to draw two conclusions: Firstly, what areas of child abuse and neglect are particularly important in training health care professionals? Secondly, what questions can be expected for similar counselling services in other countries?

Methods

Participants

The CAHP offers a telephone advisory service that is operational on a 24/7 basis for professionals working in healthcare, child and youth welfare and judges in "family courts". The latter, as opposed to criminal courts, refers to courts, which deal with the non-criminal issues of child abuse and neglect, such as out-of-home placement and custody issues. The telephone advisory service is available free of charge. Callers are directly connected with one of the consulting physicians who are either pediatricians, child and adolescent psychiatrists or forensic physicians. All have a certificate in child abuse medicine, which is not a board-certified pediatric subspecialty in Germany as it is for example in the U.S. A senior specialist from each of the three subspecialties is available to the consultants for advice at any time. The caller can give their own name and place of work but must describe the case anonymously regarding the child concerned. This ensures maintenance of medical confidentiality. Furthermore, the name of the caller is not recorded (figure 1).

In Germany, professionals bound by legal obligations to maintain professional confidentiality (e.g. physicians, psychotherapists, dentists, occupational and speech therapists, nurses and paramedics) are required to adhere to specific legal stipulations in instances of suspected child abuse and neglect. They are required to undertake measures to protect the child, including discussing their concern with the parents, give advice and recommend supplementary support services. If these measures prove insufficient to address the concerns of the professional, there is authority to inform CPS. However, the parents should be informed of this beforehand, unless this would jeopardize the protection of the child. Accordingly, there exists no obligation to report child abuse in Germany. Rather, each healthcare professional is bound by professional responsibility to take action to protect the patient. The duty to act provides a broader scope than the duty to report. In everyday practice, however, it is uncommon for professionals to be held responsible for failing to protect a child.

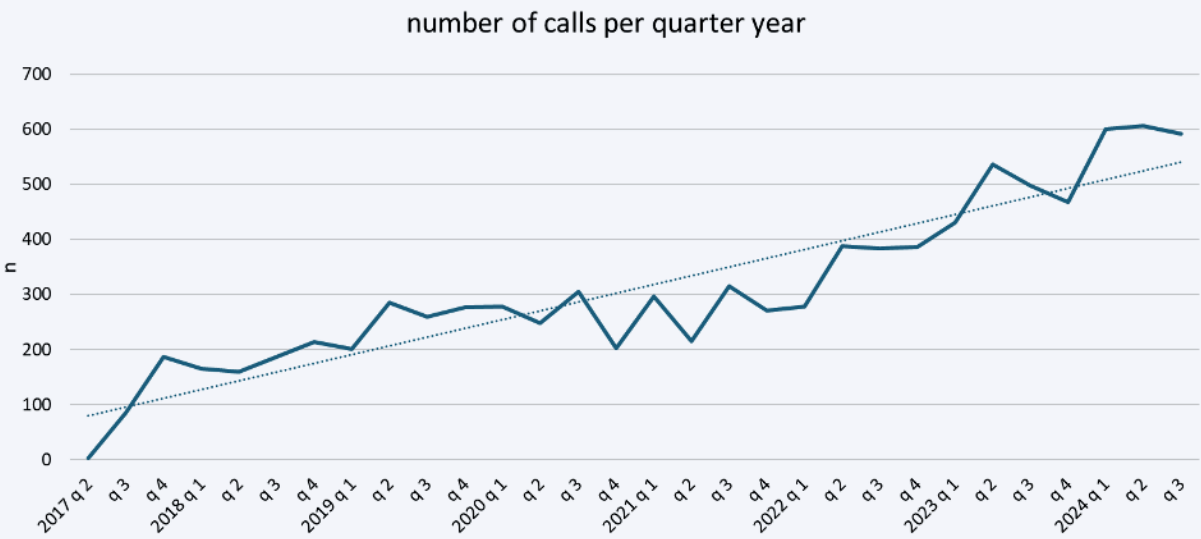
Professionals working in child protection services and judges who are involved in child abuse cases at family courts can seek advice on medical issues concerning a case of child maltreatment.

Procedure

All calls are directly connected to a physician working in the CAHP. The caller is asked to present the case anonymously regarding the child and family who are affected (index patient). Typically, a minimum set of information is requested, such as the caller's profession and the professional relation he or she has to the index

FIGURE 1: The child abuse helpline for professionals.

FIGURE 2: Number of calls to the CAHP from July 1st, 2017 until October 26th, 2024.



patient, along with age and gender of the index patient. The caller is then invited to describe the case and ask questions.

The counselling physicians document each consultation on a secure online platform, recording standard information in a structured manner (e.g. the caller's profession, specialist discipline, working environment, the professional role in relation to the index patient and data on the index patient). In addition, a case description is recorded in free text, which enables a qualitative evaluation of the consultations.

A descriptive analysis of the data regarding the callers and index patients for calls recorded between July 1st 2017 and October 26th, 2024 was performed, as well as a review of common topics of consultation.

Institutional review board approval

On the grounds of anonymous counseling, the institutional review board of Ulm University ruled in January 2017 that no formal approval is required to carry out the consultation and to publish the data.

Results

During the period of interest, a total of 9,315 calls were recorded at the CAHP. Of these, 6,805 (78.0%) were from healthcare professionals, 999 (10.0%) from child and welfare professionals (including CPS), and 798 (9.0%) from a heterogeneous group of teachers, police officers and non-professionals such as parents or relatives of children affected by abuse or neglect. Non-professionals (victims of abuse, relatives and other bystanders) have specialized counseling services available on their own, the latter mentioned professional groups are subject to such divergent legal frameworks that a counsel by physicians appears to be ineffective, such as police officers. However, there are currently discussions about whether the service should be opened up to teachers. In addition, 54 calls (0.6%) were from judges and other legal professionals. 216 calls (2.5%) were of an obviously non-serious nature (e.g. prank calls). Of note: CAHP service was opened to child and youth welfare professionals, judges and other legal professionals only since 2021, which can partly explain the comparatively low number of callers from these groups.

The number of calls has shown a consistent rise during the period of interest (see figure 2). It is important to note the unusual fluctuations in calls recorded in 2020, which appear to follow a sawtooth-like pattern. The most significant external influencing factor during this period was the course of the Covid 19 pandemic in Germany. The first documented case of the virus in Germany was on January 27, 2020, followed by a series of national lockdowns in March 2020, and then in December 2020 and January 2021.

Minor and maltreatment characteristics

All consultations concerned potential cases of child abuse and neglect, so at least indirectly one or more minors in focus (MIF) were the focus of the consultation. However, not all callers were able to provide detailed information on the MIFs. For instance, psychiatrists may become concerned that the children of a patient treated for substance abuse may be at risk. In these cases, they could often not provide detailed information on the MIF. Furthermore, the risk to children might be even more diffuse, when only a patient with pedophilia is known and the reason of the call is to decide whether there is a risk for children, but the children are not known to the caller.

However, the majority of calls (n=5,641, 60.6%), at least one MIF could be identified by the caller. If disclosed during the consultation, age and gender of the MIF were documented.

The age distribution of MIFs exhibited a double peak pattern for pre-school children and young adolescents (4 to 6 years and 13 to 15 years, respectively), as illustrated in figure 3. The age distribution of children who were subject to child protection assessments in Germany in 2023 is illustrated in 4 (19).

In 688 cases (11.8%), gender information was not recorded. Of the 4,973 cases for which gender information was available, 2,781 (55.9%) were recorded as female, 1,999 (40.2%) as male and 193 (3.9%) as other. "Other" refers to instances where the child's gender is not specified or where there is more than one child.

The gender distribution of children subjected to CPS assessments in Germany in 2023 was as follows: female in n=101,886 (48.1%) and male in n=109,809 (51.9%) cases (19).

In 5,987 CAHP cases, at least one form of child maltreatment could be identified. The most prevalent forms of maltreatment that were addressed in counseling sessions were physical abuse

FIGURE 3: Age distribution of minors in focus (MIFs) of calls to the CAHP, n=5,641.

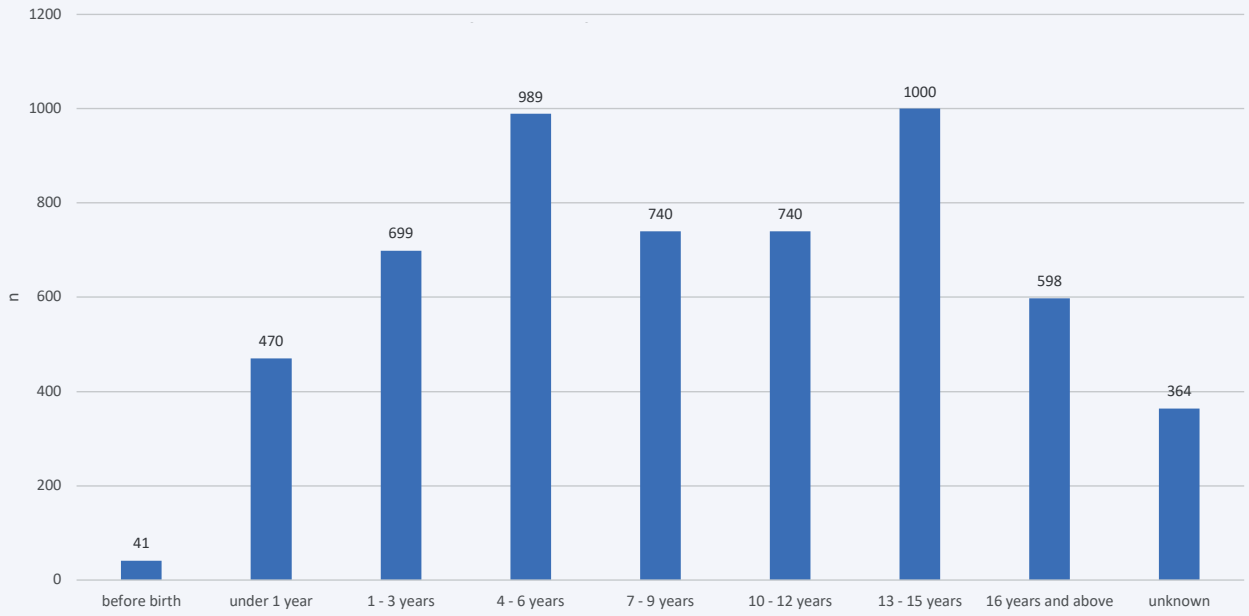
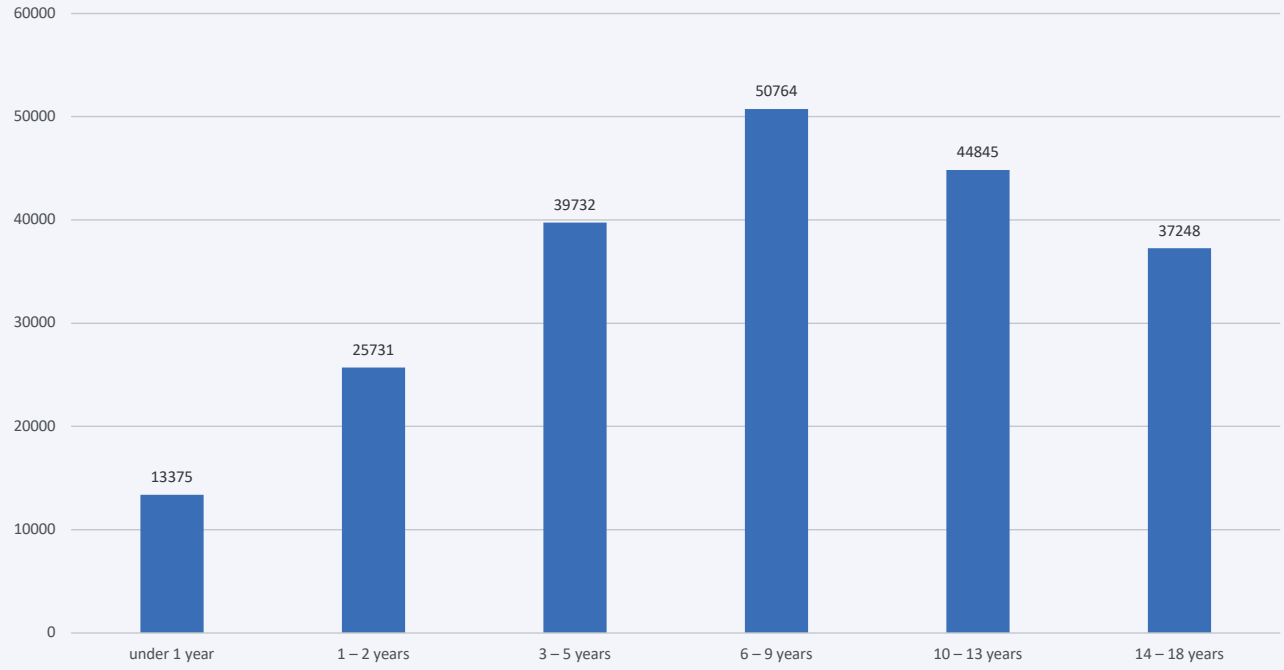


FIGURE 4: Age distribution of minor assessed by German CPS in 2023, n=211,695, taken from (19).



and all forms of neglect, followed by sexual abuse (see figure 5 for a comparison of CAHP cases, CPS assessments in 2023 and population-representative data from 2017 (19, 20)).

Caller characteristics

In 4,492 calls from health care professionals, the subspeciality of the caller was most commonly either child and adolescent psychiatric or pediatric. Adult psychiatry or psychotherapy was the third most common specialty. For details, see figure 6.

Contents of counseling

The majority of consultations pertained to matters of collaboration with CPS (n=2,643, 53.8%), encompassing inquiries into the degree of concern that would necessitate the involvement of such services. One typical question was, for example: "Do my findings constitute reasonable suspicion that would be requisite to breach medical confidentiality?" Additionally, inquiries addressed more structural concerns, such as how to contact CPS, particularly in circumstances where immediate intervention during nocturnal hours or on weekends appeared imperative. Finally, there were instances where respondents expressed stereotypes regarding

FIGURE 5: Comparison of maltreatment forms in calls to the CAHP, confirmed cases of "acute risk" in assessments of the German CPS in 2023 (n=34,286) (19) and in the population based study by (20).

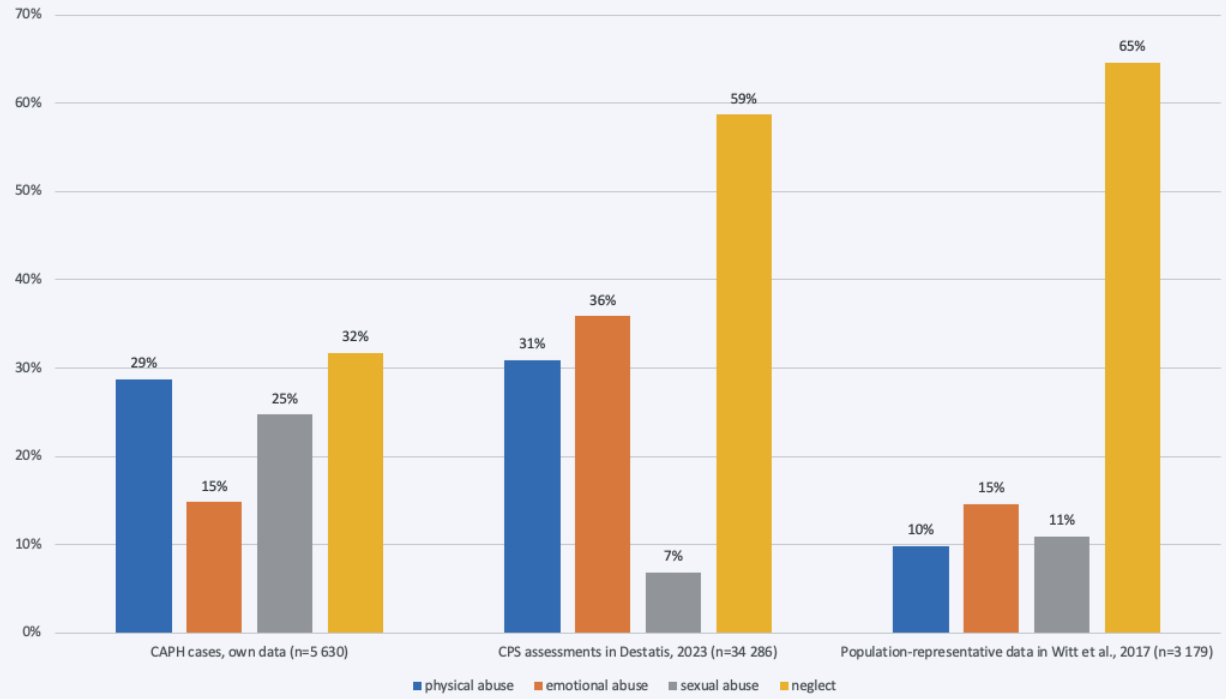
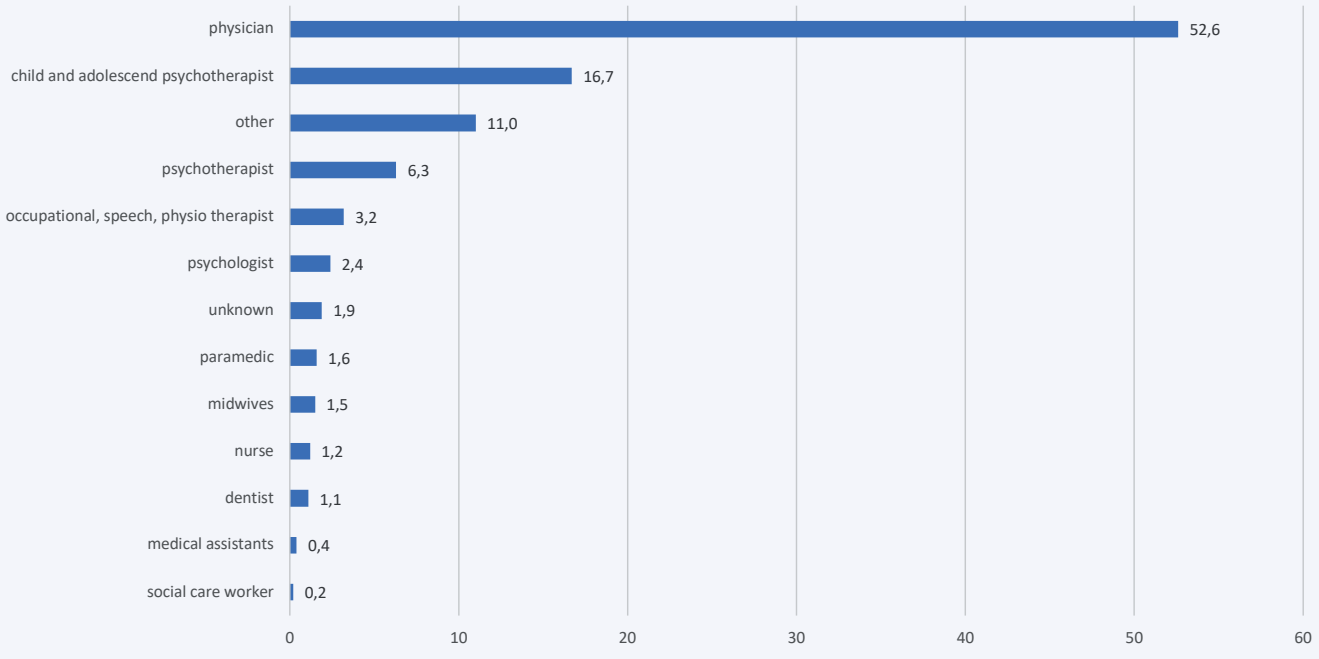


FIGURE 6: Professions of callers to the CAHP, n=4,492.



CPS, often holding the misconception as the agency which automatically takes children from their parents when involved.

Discussions of the specificity of medical findings regarding abuse and how to talk to MIF and their parents were approximately equally prevalent, with n=1,416 (28.8%) and n=1,255 (25.6%), respectively. Examples for the former topic include the specificity of certain genital infections like herpes, molluscum contagiosum, genital warts, lues etc. in prepubertal children for sexual abuse, the specificity of findings in abusive head trauma or the specificity of attachment disorders for emotional abuse or neglect. As stated above, German law requires that, where reasonable, the parents be spoken to before CPS is informed. Therefore, preparing those conversations is an important part in the consultations to the helpline. The question of whether and how to broach the subject of sexual abuse with affected children is also a frequent topic of counselling. In rare cases, CAHP consultants are asked to provide a second opinion on visible findings, such as bruises or x-ray or

MRI images. In these cases, CAHP refers to forensic medicine institutes that offer such a service. CAHP does not provide a second opinion on visible findings.

Next were questions regarding reporting laws in n=1,148 (23.4%) cases. Questions on networking partners in child protection, including child advocacy centers, advice and counselling centers, law enforcement and others, were asked in n=839 (17.1%) cases. The discussion encompassed specific counsel on medical procedures, predominantly concerning the treatment of minors after sexual assaults in n=552 (11.2%) cases. Finally, the implementation of legally secure documentation of the findings was discussed in n=415 (8.5%) cases.

Caller satisfaction was evaluated by the Deutsches Jugendinstitut at two points in time: 2018/19 and 2022. Callers rated the benefits as very positive. Of 107 respondents who completed an online questionnaire after a consultation, 80.8% stated that the consultation was very useful for understanding the child protection system. For the specific case and their next steps, 92.4% found the consultation very useful and 88.3% said they were able to better place their own findings in the context of child protection (21, 22).

Discussion

The data offers valuable insight into the experiences of medical professionals handling cases of suspected child abuse and neglect. The majority of these calls originated from the healthcare sector, which is not unexpected, given that the initiative commenced as a counseling service for healthcare professionals. Subsequently, professionals from CPS and family courts were included as target groups. Additionally, the healthcare professional population is considerably larger than those in child and youth welfare and family courts. This discrepancy is particularly pronounced in the context of family courts, where the number of calls remains comparatively low.

The fluctuation of calls in 2020 and 2021 correlates with the fact that there was a drastic decline in the number of patients in all areas of the healthcare system during the Covid 19 pandemic (23, 24). While patient numbers have only gradually returned to pre-pandemic levels, the CAHP has documented a period of overcompensation following the conclusion of lockdown measures, accompanied by a subsequent and accelerated increase in call volumes relative to prior levels. Extensive media coverage on whether domestic violence, child physical and sexual abuse became more prevalent during the pandemic, might have brought the topic more to the awareness of professionals.

Compared to the age distribution of assessments by CPS in Germany, callers to the CAHP tend to see a higher percentage of younger children (19). This observation Is in line with the fact that not all preschool children at risk are seen in daycare facilities, but almost all of them at least visit a pediatrician more or less regularly.

In Germany, the legal definition of a child commences at birth. Consequently, assessments of the danger to a child's best interest are only possible from birth. In contrast, concerns regarding the current and future well-being of a fetus may arise for healthcare professionals, either due to substance abuse by the pregnant woman or due to the situation of older siblings. This is why "before birth" is an age category in the consultations of the medical helpline, but not in assessments by CPS.

With respect to the various forms of maltreatment, the sample from the child abuse helpline consultations varies significantly both from the assessments of child protection services and population-based research (19, 20). While neglect is the most prevalent form of maltreatment in CAHP data, CPS assessments and population-based research, physical and sexual abuse are almost as prevalent in the consultations of the CAHP. Conversely, emotional abuse is more prevalent in CPS assessments, while sexual abuse is comparatively uncommon. The order of the forms of abuse are the same in the population-representative study; however, a comparatively higher prevalence of sexual abuse is observed. Overt manifestations of child maltreatment are more prevalent in calls to the CAHP. This could indicate that medical professional often overlook emotional forms of abuse. The alternative explanation that healthcare professionals feel confident in dealing with cases of emotional abuse and therefore do not need guidance in these cases seems unlikely. Sexual abuse in particular has been found to be particularly distressing and disconcerting for professionals, so that professionals feel they need advice on how to deal with cases of sexual abuse disproportionately often.

The sample of MIFs in consultations at the CAHP was female to a higher percentage compared with the children under assessment by CPS in general. This can be partially attributed to the relatively high proportion of consultations regarding sexual abuse compared to the assessments of CPS. In child sexual abuse, female children and adolescents are more often affected than male children and adolescents (20, 25).

In terms of consultation topics, it is not surprising that the most common concern expressed by physicians was cooperation with CPS – as intersectoral collaboration and communication is only recently starting to be part of medical training, structured curricula are only recently being developed. In this context, numerous consultations refer to the determination of whether a particular finding or situation already constitutes reasonable suspicion (in German: "gewichtige Anhaltspunkte") for a child being at risk. This term is the legal expression for the precondition of being allowed to disclosure information to child abuse services. However, this term remains undefined in German law. Consequently, the evaluation of the data from the CAHP aligns with the findings of earlier studies, which identified a lack of understanding of legal terms as a significant impediment to cooperation between healthcare and child and youth welfare (26). CPS, as a state authority with sovereign tasks, are subject to completely different processes and logics than clinical medicine. One of the main problems at this interface is the different understandings of urgency and prognosis. The failure of physicians to communicate their findings to CPS and the inability of CPS professionals to pose the appropriate questions to physicians, can result in the child being subjected in further or even additional harm. Many providers in the healthcare sector offer their services on a 24/7 basis, while child protection services are de facto not available 24/7 in all administrative districts – although this is required by law.

CPS possesses a wide range of options for intervention in Germany, the permanent placement of children in foster care remains the last resort used in rare cases. However, this form of intervention is the one most frequently mentioned when healthcare hesitate to inform the CPS. This underscores the necessity for additional training in the future. In summary, it can be stated that the differentiated obligation to act as intended by the legislature nevertheless largely leads to the question of whether a particular case should or must be "reported" or not. It is only through the counseling provided by CAHP that these professionals become aware of their options for action and the legal conditions for passing on information.

Limitations

First, it is important to keep in mind the nature of the service, which is to provide guidance to professionals struggling with uncertainties concerning cases of suspected child maltreatment. The primary limitation in the generalizability of the data stems

from the fact that the sample does not constitute a representative sample of healthcare professionals. The observed fluctuation in calls, whether occurring over a short or long term, cannot be directly interpreted as indicative of a general trend in child maltreatment incidence. Additionally, the evaluation is derived from counselling dialogues rather than structured interviews developed for research purposes, resulting in a certain heterogeneity of the data.

Conclusions

The hesitancy of medical professionals in collaborating with CPS, as evidenced in previous studies, is also apparent in the counsel sought from the CAHP. This suggests that the service is commensurate with the existing demand. Moreover, there is a pronounced necessity for additional training in the domains of intersectoral collaboration, legal frameworks and communications skills.

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