CME

Overcoming barriers to recognizing and reporting child abuse

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ABSTRACT

Infants and children under age 3 years have the highest risk of dying from child abuse and neglect. Clinicians treating children must recognize and report child abuse. Barriers to consistent recognition and reporting leave children in harm's way. Often, the signs of abuse in very young children are subtle, and clinicians may fail to recognize and report these signs. Clinicians also must understand the role of bias in the reporting of child abuse and ways to address abuse individually and as part of a larger system.

Keywords: child abuse, reporting, bias, sentinel injuries, TEN-4-FACESp, physical abuse

Learning objectives

- Identify the age at which children are most likely to die from child abuse and neglect.
- Define a sentinel injury.
- Describe how to use the TEN-4-FACESp clinical decision rule.
- Discuss how bias can affect a clinician's judgment in cases of suspected child abuse and neglect.

Child maltreatment encompasses neglect, physical abuse, sexual abuse, psychologic abuse, human trafficking, and medical abuse (formerly called Munchausen syndrome by proxy).[1] Per the Child Abuse Prevention and Treatment Act (CAPTA), child abuse is "any recent act or failure to act on the part of a parent or caregiver that results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm."[2] States must meet this minimum definition but may differ in how they define abuse according to their criminal and civil statutes. Additionally, local districts within any given state can differ in terms of how and when abuse is substantiated or prosecuted.[3] Child physical abuse is a pervasive and global problem and is just one form of violence children experience. The World Health Organization estimates that one out of every two children globally will experience some form of interpersonal violence.[4] The National Child Abuse and Neglect Data System (NCANDS) compiles statistics related to the prevalence of child maltreatment each year, with the latest statistics from 2 years earlier.[5] *Child Maltreatment 2021* reports on the latest available NCANDS data from fiscal year 2021 (FY 2021), discussing the characteristics of child maltreatment in the United States.[5] The authors of *Child Maltreatment 2021* estimated that 600,000 children experienced maltreatment in FY 2021, with more than 1,800 children dying from this maltreatment.[5] Of those 1,820 deaths, more than 60% of fatalities occurred in children under age 3 years, with almost half of the deaths occurring among infants under age 1 year.[5] Up to 40% of children who experience physical abuse will experience recurrent and/or escalating abuse.[6]

Because of the variation in how child abuse is defined across jurisdictions, and because much abuse goes unrecognized and unreported, estimates likely fall short of actual numbers. When surveyed as adults as part of the National Epidemiologic Survey on Alcohol and Related Conditions, more than 17.6% of respondents reported a history of physical abuse.[5]

The dramatic increase in risk for the youngest of children is multifactorial. Smaller, more fragile children depend completely upon their caregivers. They also are preverbal or have very early verbal skills, preventing them from telling others what has happened to them. Caregivers with unrealistic

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Key points

- Children under age 3 years are at the highest risk of dying from child physical abuse.
- Signs of physical abuse in young children can be subtle and easily mistaken for accidental injury.
- TEN-4-FACESp is a validated decision-making tool that can help clinicians treating young children to recognize when bruising should raise concern for child abuse.

expectations for the child, or who lack knowledge about normal developmental stages, can be more likely to harm children out of frustration and anger.[5,7] Persistent crying notoriously correlates with abusive head trauma.[8,9] Toilet training can be another particularly risky time, with toileting accidents often preceding immersion or other scald burns.[9] Because they are not yet school-aged, younger children may have little contact with other adults. In contrast, school personnel, one of the largest groups of reporters to child protective services (CPS), often recognize abuse in older children.[5]

Child abuse is among several adverse childhood experiences (ACEs) that can affect children's physical and psychologic well-being into and through adulthood.[10,11] In the short term, children who experience maltreatment are at an increased risk of behavioral issues, learning difficulties, and mental illness. Once these children reach adulthood, they are at an increased risk of chronic illness and early death independent of any genetic predisposition.[10] Clinicians caring for children are in a unique position to recognize and address these ACEs, and are key in recognizing and reporting suspected child abuse in the youngest of their patients.[6,12] As mentioned earlier, children under age 3 years, and especially those under age 1 year, are particularly vulnerable to maltreatment and death due to that maltreatment.[5] Although these young children may not attend school and come to the attention of others, they tend to have more frequent medical visits for well-child examinations and sick visits.[6] Therefore, clinicians treating young children should be prepared to recognize the often subtle findings of abuse in children under age 3 years.[6,12] Additionally, clinicians should be able to assess for risk for maltreatment and need for caregiver support. This can involve actively screening for ACEs in children and their caregivers, assessing for needs related to housing and food, and referring parents to resources such as quality parenting classes or home visitation programs.[11]

MINOR INJURIES WITH MAJOR SIGNIFICANCE

Infants and young children can have significant occult injuries while continuing to be well appearing, eating well, and growing. Sugar and colleagues determined that infants "who don't cruise rarely bruise."[13] They found bruising in only 2.2% of premobile infants who had not yet begun pulling to stand and cruise, compared with bruising in 17.8% of cruisers and 51.9% of walkers.[13] Therefore, bruising anywhere on a premobile child should prompt an evaluation for further injuries and a safety assessment.[13]

Sheets and colleagues named these contusions in premobile infants *sentinel injuries*.[14] Like a sentry tasked with sounding the alarm when danger is present, a sentinel injury should alert clinicians to the possibility that an infant has been physically abused. Sheets and colleagues retrospectively reviewed the histories of infants who were admitted to the hospital after sustaining significant injuries. A panel of experts in the field of child abuse determined whether the children were *definitely abused* or *not abused* or whether there was an *intermediate* cause for concern. A significant portion (27.5%) of the children in the *definitely abused* cohort had a history of a sentinel injury before their admission. Per medical record reviews and accounts from caregivers, a clinician knew about almost half of these previous injuries. Among the children whose injuries were determined to be nonabusive, none had evidence of one of these previous injuries.

Sheets and colleagues illuminated the fact that injuries in premobile infants are minor but not insignificant.[14] Bruises accounted for the vast majority (80%) of previous injuries, with intraoral injury (such as a tear to the frenulum) as the next most significant category of injury (11%). A faint bruise on the cheek or a frenulum tear in a 2-month-old infant will heal without treatment. However, these seemingly minor injuries in such a young infant may be the only indication that the child could have more serious underlying injuries. Importantly, even if that child is found to have no occult injuries upon further evaluation, the child remains at risk for having been abused and for experiencing escalating abuse.

Shanahan and colleagues demonstrated the significance of previous injury, and even previous suspicion of child abuse, in young children.[6] Their retrospective study reviewed the medical records of children who were diagnosed with child abuse before their first birthday. The records revealed that one-third of the children diagnosed as abused were seen for an injury, such as a bruise or abrasion, or underwent a skeletal survey.[6] In fact, the use of diagnosis codes likely underestimates the true incidence of these minor injuries, because clinicians may not have coded a minor injury if they deemed it insignificant.[6] The addition of skeletal surveys as a marker for injury is particularly interesting because skeletal surveys are performed when concern exists that an infant has been maltreated. Therefore, the children who previously underwent skeletal surveys were those who had a workup for abuse but who were not diagnosed as such at that time.

Shanahan and colleagues reported that the average age of the child at the time of their initial injury was 4.4 months old, and the average span of time between the injury and the diagnosis of abuse was about 6 weeks.[6] Many reasons exist for why a child undergoing a workup for abuse would not receive a definitive diagnosis of abuse. In any case of

suspected abuse, much may remain unknown. Especially with a preverbal infant unable to provide a history, the investigators may lack enough evidence to prove abuse definitively. A negative workup only indicates that clinicians did not identify further injuries. It does not rule out abuse as a cause of the injury.[6] Therefore, clinicians who see children with a previous injury or concern for abuse, even if unsubstantiated, should consider this a risk factor for future maltreatment.

As children gain mobility and begin to explore their environment, they sustain accidental bruising.[13] However, toddlers remain at a high risk for physical abuse. These two facts pose an issue for alert clinicians who may suspect abuse but are faced with a vigorous and active toddler. Pierce and colleagues initially developed the TEN-4 clinical decision rule that indicated that bruising on the torso, ears, or neck of a child under age 4 years, or anywhere on a child under age 4 months, should prompt an evaluation for child abuse.[15] TEN-4 has a sensitivity of 80.7% and a specificity of 91.1%, and the study was limited by including only a small number of children in a pediatric ICU.[15,16]

Pierce and colleagues set out to validate the TEN-4 tool and expanded it to the more comprehensive TEN-4-FACESp.[16] Use of the TEN-4-FACESp mnemonic helps clinicians to remember that suspicion for child abuse should be raised if a child has any bruising to the torso, ear, or neck (TEN); injury or bruising to the frenulum, angle of jaw, cheeks, eyelids, or subconjunctivae (FACES); or any patterned (p) bruising. The "4" represents the notion that any bruising anywhere to an infant 4.99 months or younger should raise concern for abuse. The expanded version of the rule is more sensitive (95.6%) and almost as specific (87.1%) as the earlier TEN-4 rule. In their recent article, Pierce and colleagues studied a larger group of children evaluated in several pediatric EDs over a span of several years. The children enrolled in the study underwent full skin examinations. Examiners noted the location and number of bruises, photodocumented their findings, and mapped the bruises to a body diagram. An expert panel reviewed the photographs, laboratory and radiology reports, and presentation histories. This panel divided the cases into *abused*, *nonabused*, and *indeterminate* cohorts. The most potent predictor of abuse in these children under age 4 years was the location of the bruising. **Table 1** describes the TEN-4-FACESp rule more fully.

A clinical decision rule such as TEN-4-FACESp helps clinicians recognize child maltreatment. It organizes clinical variables into an acronym that a clinician can easily remember or reference when faced with suspicious injury. Clinicians also can reference these rules and feel more confident that a child abuse workup is necessary, even if a young child seems well appearing and is presenting with a seemingly appropriate caregiver. Having established rules and guidelines to follow on a consistent basis also bolsters the argument for a workup if caregivers or even other colleagues question a clinician's judgment.

TABLE 1. TEN-4-FACESp clinical decision rule

Consider physical abuse under the following conditions.

Under age 4.99 months	Under age 4 years
4 Any bruising anywhere on the body, or intraoral injury, is concerning for abuse	**TEN** Bruising to the: • Torso—includes abdomen, back, buttocks, and genitals • Ears—may be hidden on the posterior aspect of the auricle • Neck—can appear as patterned or nonpatterned
	FACES Injury or bruising to the: • Frenulum—bruising or lacerations from injuries caused by forced feeding or sexual abuse • Angle of jaw—bony prominence but typically due to forceful grabbing or hitting rather than accidental • Cheeks—fleshy portion, not including the zygomatic arch • Eyelids—may appear as petechiae • Subconjunctival hemorrhage—rare in infants and young children other than immediately after birth
	p Patterned injuries: • Slap marks • Grab marks (in the shape of fingers or fingertips) • Strap/belt marks • Loop marks (charging cables, extension cords) • Ligature marks on neck, wrists, ankles A pattern is concerning for a nonaccidental injury even if the clinician cannot immediately identify the object that caused the patterned injury. Scene investigators (social workers or law enforcement) may ultimately be able to find the object that matches the injury.

Reproduced with permission from Pierce MC, Kaczor K, Lorenz DJ, et al. Validation of a clinical decision rule to predict abuse in young children based on bruising characteristics. *JAMA Netw Open*. 2021;4(4):e215832-e215832.

BARRIERS

Many clinicians lack a solid foundation of knowledge for recognizing child abuse. While in training, a healthcare professional student may receive a lecture or two about child maltreatment, but few have in-depth training on this topic. A clinician will not perform the proper workup if child abuse is absent from the differential diagnosis. For example, Mandadi and colleagues noted that, as of 2009, only a third of pediatric emergency medicine fellowships required a child abuse rotation, and no general emergency medicine residencies at that time required such a rotation.[17] Accreditation standards for physician associate/assistant (PA) programs require that violence identification and prevention are part of the curriculum but do not specify education on child maltreatment.[18] Failure to ensure these exposures results in a significant lack of training among clinicians highly likely to encounter these injuries. The medical community continues to miss far too many cases of abuse, and fatalities from child abuse continue to increase.[17]

Mandated reporting laws dictate that medical professionals report suspected child abuse. Although states can differ on who qualifies as a mandated reporter, CAPTA dictates that states must require certain groups of people to report suspected child abuse.[2] Failing to report can result in legal consequences, yet clinicians who suspect child abuse often fail to report this to CPS.[19] Baker and colleagues evaluated state-sponsored mandated reporter training in the United States and revealed that significant deficits in this training contribute to a lack of knowledge among potential reporters and a reluctance to make a report.[20] Deficiencies included a lack of comprehensive education about what constitutes abuse in its various forms and a failure to address the many reasons why people fail to report when abuse is suspected.[20]

Azizi and Shahhosseini discussed how barriers to reporting among healthcare professionals can be categorized into individual, interpersonal, organizational, and situational barriers.[21] Individual barriers can include a lack of knowledge or confidence in making the diagnosis. Concerns about disrupting the relationship with the patient and family constitute an interpersonal barrier. Deficiencies in protocols or effective pathways to reporting create organizational barriers. Situational barriers can include a lack of physical or definitive evidence of abuse, or assumptions and biases about whether a particular caretaker is capable of child maltreatment.[21]

The responses from a survey of pediatric emergency medicine physicians echoed these concerns even among those confident in their ability to recognize child abuse.[17] The survey indicated that many physicians lacked confidence in knowing how and when to report abuse.[17] Respondents also reported roadblocks to reporting, including fear of upsetting the family, lack of confidence that CPS involvement would improve the child's situation, previous lack of feedback from CPS after reports were made, and concern that reporting would result in the family failing to seek care in the future.[17] Clinicians often struggle with reporting highly suspicious injuries because they are familiar with the family and do not consider the parents capable of abuse.[17] Not uncommonly, clinicians assume that they can employ measures themselves that can prevent future harm and incorrectly believe their actions absolve them of the duty to report.[19] Although surrounding a family with resources and support should be a goal of any clinician treating children, doing so does not negate the duty to report.

Statutes mandating the reporting of suspected child abuse vary by state, and medical professionals must be aware of the laws in their jurisdiction. In general, a clinician who suspects abuse would be expected to report that suspicion to CPS. Mandated reporting laws protect reporters from litigation if reports are made in good faith. Therefore, a clinician need not prove or know without doubt that abuse occurred.[20] That said, mandated reporting alone is not sufficient to protect children, and the child protection system in the United States is not without its flaws. Critics calling for a complete overhaul of the system may be asking to swing the pendulum too hard in the other direction, but their concerns about the influence of racism on the system are not unwarranted.[22]

BIAS IN REPORTING

A discussion about recognizing and reporting abuse is not complete without introducing a significant complicating factor: bias. Although cut-and-dried rules for decision-making and diagnoses would be welcome, most clinicians recognize that medicine is very much a practice and even an art. Rarely does a patient present classically with their signs and symptoms laid out like a tidy case study. Previous training, experience as a practicing clinician, and knowledge about previous outcomes all can influence a clinician's initial *gestalt* (or gut feeling) about a case. Unfortunately, implicit and explicit biases also inform this so-called gut feeling, and these biases can lead to harm.[23-25] Although clinicians cannot eliminate implicit biases completely, they must commit to interrogating these biases to ensure that they do not cloud their clinical judgment.

Historically, clinicians have been trained to rely heavily on their assessment of the child's social situation or family dynamics.[26] Although clinicians' experiences certainly inform their clinical judgments, a diagnosis of child abuse cannot be based on a subjective assessment alone. Rational analysis and evidence-based decision-making must play a significant role in making the diagnosis.[25-27] Allowing bias to enter the equation not only results in overreporting in certain populations but prevents the recognition of abuse in others.[24]

Questions that clinicians can ask of themselves when considering abuse as a diagnosis include: *What is the supporting evidence? Is it objective? If a subjective or gut feeling is driving the decision to report, what is behind that feeling? Does the feeling have to do with assumptions about race, socioeconomic status, or cultural values?*[24] Clinicians also can ask these questions of one another, whether in an

informal curbside consultation in the clinic, or as part of a more formal peer review or multidisciplinary review.

A subjective or gut feeling can stem from a clinician's clinical experiences and accumulation of knowledge, and can alert a clinician that something else may need to be investigated. At that point, the clinician should provide an analytical and objective assessment. When explicit and implicit biases not only inform that subjective feeling but also overshadow objective facts, however, the clinician has entered treacherous waters.[24,25] Consistent use of decision rules or institutional protocols ensures that clinicians treat each finding similarly regardless of their feelings about the family.

Broaching the possibility that a child has been abused can be daunting for a clinician. Maintaining the focus on the safety of the child without attempting to assume or assign blame can help a clinician communicate clearly and effectively with the caregiver. The stigma felt by caregivers can be reduced when a clinician can sincerely inform the caregivers that the focus is on ensuring the child's safety and that the same workup would be pursued in any other child with a similar presentation.[26] The caregivers may still be upset or angered; however, they will likely feel less targeted or singled out. For example, if a 45-year-old woman with a breast lump presented without other risk factors, her clinician would still want to pursue an evaluation of that lump. Likewise, a child with an injury falling under TEN-4-FACESp requires additional evaluation to assess for nonaccidental injury.

> Abusive head trauma is more likely to be missed if the child is from a White, two-parent household.

Involvement with CPS does not always, or even typically, result in a child being removed from their home.[5] However, certain populations are overrepresented in reports to CPS and in turn are overrepresented in terms of case substantiation and use of foster care.[28] Black and Latinx children are significantly more likely than White and non-Latinx children to be involved with CPS at all levels.[28] A Black child is up to three times as likely as a White child to be placed into foster care.[28] The disparity does not end with foster care placement, because that same Black child is more likely to be placed with multiple foster homes and is less likely to be reunited with his or her family.[29] Likewise, ignoring a sign of abuse because a clinician is biased in favor of the family allows that abuse to remain hidden and potentially escalate.[27,30] Jenny and colleagues noted that abusive head trauma is more likely to be missed if the child is from a White, two-parent household.[31]

Multidisciplinary approaches to child maltreatment serve several purposes. Rather than remaining siloed, professionals working in various fields review cases and discuss (or debate) what measures can best support the children and families. A clinician making a report of child abuse to CPS is unlikely to receive much in the way of follow-up, leaving that clinician with the impression that no action was taken. Clinicians who are part of a multidisciplinary team, however, become versed in the parameters within which others must work. They can understand how social workers pursue their investigations and make their decisions. Likewise, they can come to understand why law enforcement may or may not be involved in certain types of cases. Multidisciplinary teams are standard of practice for child advocacy centers, and often are found in hospital systems with child protection teams.[32,33] Professionals from varied backgrounds hold each other accountable and challenge one another's thought patterns when necessary. More research is needed into whether including clinicians in ambulatory settings would influence their ability to recognize and report abuse.

CONCLUSION

Child abuse is a complex issue and can be a sensitive topic to discuss during clinical encounters. A host of barriers can impede a clinician's ability to recognize and report signs of physical abuse in young children. The following strategies can reduce the risk that abuse goes unrecognized.

Individual barriers Clinicians working with children must be aware of the signs of abuse and knowledgeable about the steps to take when abuse is recognized. Education for PA students and continuing education for practicing clinicians are crucial to ensure that a lack of knowledge does not impede the ability of clinicians to keep children safe. Core pediatric rotations can include some time at a child advocacy center or with a child safety team to provide exposure to child maltreatment work and connection with professionals in the field. Future research can focus on how best to deliver that education and should aim to recognize and address inequities in our healthcare and child welfare systems.

Interpersonal barriers Fear of damaging a relationship with a family or concern about violating confidentiality may influence a clinician's ability to respond to suspected child maltreatment. Exposure to others working in the field and understanding how they approach these delicate situations are key to providing less-experienced clinicians with the skills and confidence needed to navigate this hurdle.

Organizational barriers Clinical decision tools such as TEN-4-FACESp and institutional protocols are useful resources to encourage consistent and systematic evaluation of injuries. Likewise, the expanded use of multidisci-

plinary teams appears to be a key factor in promoting an exchange of knowledge, as well as a platform for accountability.

Situational barriers Clinicians who fail to report suspected abuse due to a lack of definitive evidence or assumptions about the characteristics of the child or the family face situational barriers to reporting. Mandated reporting laws dictate that suspicion or belief that abuse has occurred should trigger a report. Clinicians should understand that their role is to report the suspicion and not to determine guilt or innocence. **JAAPA**

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