

## Original Article

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# Identifying signs of child neglect and abuse in general practice

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**ABSTRACT**

**INTRODUCTION:** Children who live with neglect and abuse are often identified late in the process. At the front line of Danish healthcare, where most children are seen regularly, general practice is well placed to raise concerns about child health and wellbeing. Little is known about the role general practitioners (GPs) play in suspecting and reporting child neglect and abuse. We explored challenges GPs are facing in identifying such children and illustrated some of the barriers preventing GPs from reporting on these cases.

**METHODS:** This was an explorative pilot study, preceding a larger multidisciplinary project. We conducted eight semi-structured interviews with selected Danish GPs. The interviews were transcribed verbatim and coded using thematic analysis.

**RESULTS:** GPs rarely experienced concrete signs of child neglect and abuse, and reporting to the social services was often a way of helping families to get the support they needed. When GPs suspected that “something was wrong”, this was based on a gut feeling, triggered by non-measurable and intangible signs such as changes in health-seeking behaviour or in the relationship between caregivers and children.

**CONCLUSIONS:** The intangibility of signs provoking suspicion of neglect and abuse made acting or reporting difficult and GPs felt that they lacked opportunities to take action. More knowledge is needed on how to approach matters of child protection and wellbeing across health professions and specialities.

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**TRIAL REGISTRATION:** not relevant.

Neglect and abuse have longstanding negative physical, psychological and social consequences for children [1]. In Denmark, however, there is no central registration or reporting of neglected or abused children. From 2016 to 2017, the number of children placed in child protection houses (CPH) in Denmark rose from 1,326 to 1,665, a 26% increase [2]. The CPH were established by law in 2013 and provide a physical framework for unravelling abuse among children and young people under 18 years of age. Cases within the CPH framework are the most complicated involving two authorities (e.g., social services, police or the healthcare system), and they may only represent the tip of the iceberg in terms of child neglect and abuse [3].

The majority of the children in CPH attend general practice, which is one of the few places within Danish healthcare where children are seen regularly throughout childhood. Every year until the age of six, all children are offered a preventive health examination, and general practice is often the first place families turn to for care when children are sick or injured. Consequently, general practice may possibly be seen as an important hub for detecting and reporting child neglect and abuse [4, 5]. Children in CPH often have long medical records and a

history of neglect and abuse that has been sustained for years. This prompts speculation as to whether signs are overlooked when children seek healthcare [6]. Thus, an enhanced focus and exploration are warranted of the signs potentially indicating poor wellbeing among children seen in general practice [7]. The aim of this article is to explore some of the complexities playing out in general practice in the space between suspecting that there may be problems relating to a child's wellbeing and acting on suspicions of child neglect and abuse. This study was inspired by a questionnaire study conducted among 92 Danish general practitioners (GPs) showing that 73.9% had been in contact at least once with a child who they suspected had been subjected to neglect or abuse. Among these, 22.7% had not reported their suspicion to the social services, and one of the significant factors influencing non-reporting was uncertainty about the suspicion [8].

## METHODS

This was a pilot study designed to inform a larger, ongoing multidisciplinary research project focused on the role of general practice in suspecting neglect and abuse in children and how these suspicions are managed. Participating GPs were invited from among 154 delegates at a training course on detecting signs of child neglect and abuse, and opportunities for action. After participating in the course, GPs had agreed that we could contact them for a follow-up evaluation or for research purposes. All participants received a questionnaire, which was completed by 92 GPs. Among those, we contacted eight GPs by e-mail asking if they would be interested in taking part in an interview. The eight GPs were selected to achieve variation in terms of gender, location and experience as a GP. They all agreed to participate. See **Table 1** for an overview of the participants.

**TABLE 1** Overview of the participants.

	GP 1	GP 2	GP 3	GP 4	GP 5	GP 6	GP 7	GP 8
Age, yrs	48	48	46	47	67	41	73	60
Gender	Male	Male	Female	Female	Male	Female	Male	Female
Time as GP, yrs	10	8	9	10	26	< 1	26	23

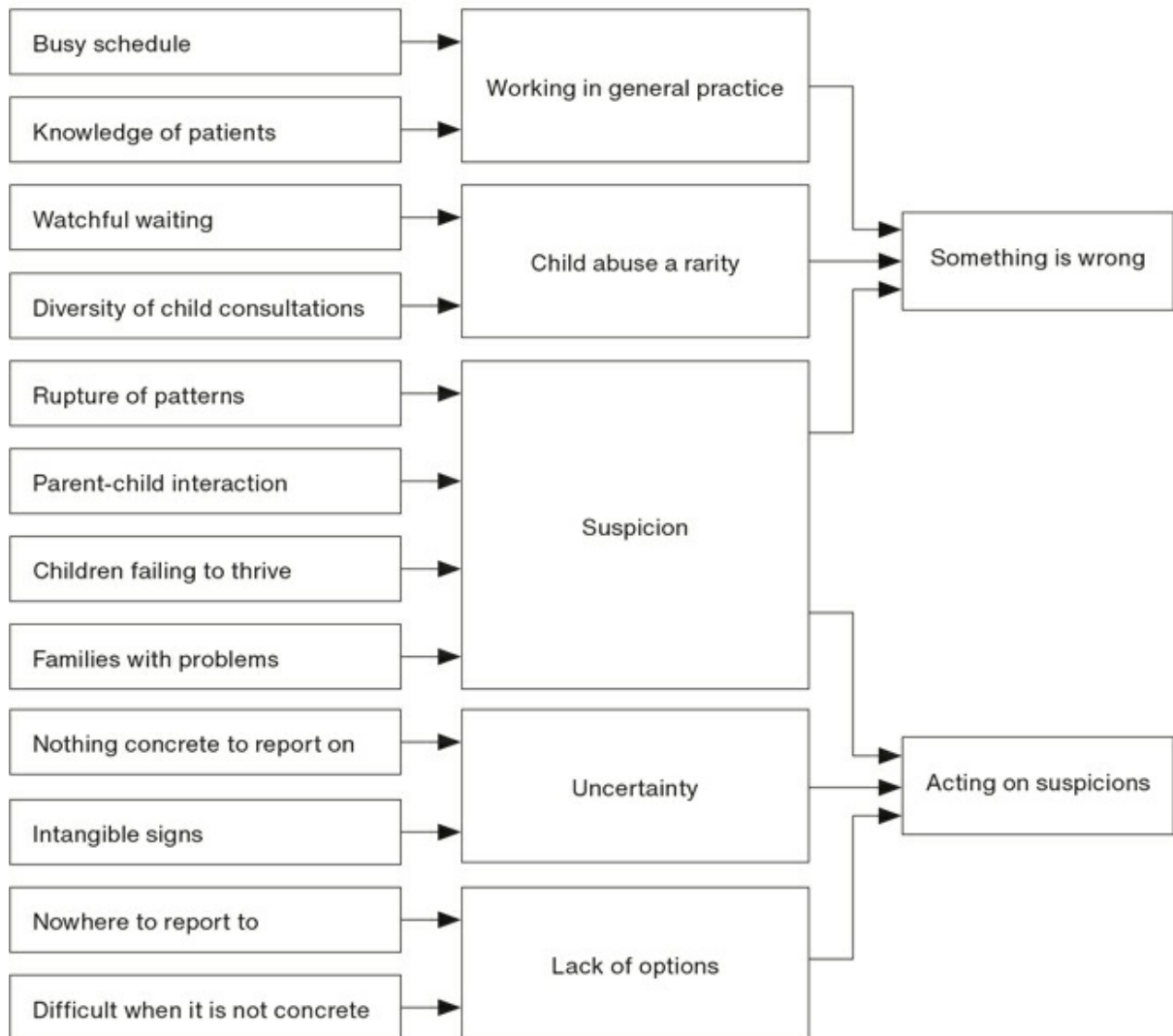
GP = general practitioner.

The interviews were conducted either in the GPs' homes or at their clinic and lasted between 30 and 60 minutes (40 minutes on average). The location of the interview may have influenced the comfortability of the interview situation as the interviews conducted in the GPs' homes tended to last longer than those conducted amid the bustle of clinics. All interviews were semi-structured [9] and the topics centred on child consultations, child wellbeing and signs and symptoms of neglect and abuse. All interviews were recorded and transcribed verbatim. The transcripts were read several times, and we conducted a thematic analysis [10] driven by our research question which focused on how suspicion of child neglect and abuse emerges in general practice.

After initial data coding, we developed sub-themes in the transcripts, which we grouped into two closely interlinked main themes that we chose as our analytical topics and according to which we have structured our results [10]. **Figure 1** provides an overview of the coding process. The interviews were conducted by both authors together, and coding and analysis were primarily carried out by the first author, and subsequently discussed with the second author until agreement was reached.

*Trial registration:* not relevant.

**FIGURE 1** The coding process.



## RESULTS

### Something is wrong

What came across in the interviews was the challenges of managing children not displaying physical signs of neglect or abuse, but who left the GP with a sense that something was wrong. As one GP said:

*“Sometimes it is a feeling, where you cannot say that it is one thing or the other. ... And that is what makes it difficult. Because sometimes it is hard to put that feeling into words. What exactly it is”. (GP 4)*

The GPs described how they dealt with a variety of different child health concerns in a typical day, and how they saw children with more or less trivial problems in short time intervals. Thus, concerns about child neglect and abuse were rarely based on physical signs but mixed with issues of wellbeing, mental health and general health problems. GPs spoke of patterns of behaviour in families or in children and their care-seeking, and they described how their attention or suspicions were raised when this pattern was disrupted. Also, when something changed, e.g., in the child’s behaviour or in the relationship with the parent, or when the family suddenly

sought care more often than they had used to, or stayed away, the GPs all agreed that these behaviours would alert their attention.

*“I have an alarm bell that goes off if the care-seeking pattern is strange. That is what I notice ... .. if children or parents are strange. ... Like if there are no proper parent observations”.* (GP 2)

These descriptions came in different shades from all the interviews and illustrate the ambiguity of GPs' concerns or raised attention. They were often in doubt as to whether their sense of something being wrong related to poor physical or mental wellbeing, or to neglect or abuse. Thus, one major challenge seemed to be to identify from where the feeling that “something is wrong” originated. The GPs applied a number of strategies to keep track of their concerns, such as making new appointments or making esoteric entries in the patient record. Occasionally, formal reporting became a strategy, a way of “doing something” when the suspicion was intangible and elusive. As one GP described it:

*“Sometimes we have to report, sometimes we have to admit somebody because something is wrong, I just don't know what it is. And in a report you have to have something concrete. ... You can't just file a report on having some sort of suspicion”.* (GP 3)

Hence, reporting suspicions or referring children to specialised departments as a form of safety netting was a difficult strategy to use because the feeling that something is wrong is not a legitimate reason for referral.

## Acting on suspicions

When asked about the process of reporting their suspicions to social services, the GPs all agreed that it was not difficult as it was typically presented to parents as a way of helping the family get the help they needed.

*“If you tell the caregiver, or the mother or father or whoever ... .. if we want to get him into this system, then this is the way I have to communicate with the municipality about my concern. I don't think I have ever experienced anyone who did not think that was OK”.* (GP 1)

However, the GPs described that there was a large and diverse group of children who, for one reason or another, did not thrive and needed support from specialised health or social services. Some had psychological problems, some lived in difficult social circumstances and occasionally they had parents or caregivers who were sick or lacked the ability to care for them. These children caused the GPs a great deal of concern as they had very few options available to help them.

*“The current law on those proper abuse cases, if you can call them that, is really great, but I think we need a box, and that is really by far the largest, where the GP is left ,holding the baby' ... As a GP, I play the piano and there are many keys to play, but when it comes to the most important in our lives, namely the children, we don't have that”.* (GP 5)

It seems that the GPs made a distinction between concrete cases of child neglect and abuse, supported by existing legislation, and more intangible cases in which the child's wellbeing was in question, or where “something was wrong” without having anything concrete to back up the suspicion. In these more ambiguous cases, they lacked options to act on their suspicion and were challenged by long waiting lists and uncertainty about how the social services and the specialised CPH could help these children and families. There was a feeling that they had nowhere to send the children who were not thriving, and that no one was capable of assisting them with further clarification when they felt that something was wrong.

Thus, the GPs had few concerns about clear-cut cases of neglect and abuse, whereas concerns were greater for those ‘in between’ cases affecting the wellbeing of the child, and the ability or interest of the parents in caring for them. It seems that the main challenge for many GPs was how to help “*the 90% of the children who are not*

*red* [in acute danger], *but where you know that things are not going well*. (GP 5)

## DISCUSSION

Our results suggest that GPs experience uncertainty about how to separate issues of poor wellbeing from aspects of neglect or abuse in children under 18 years of age, which is in line with other studies [11]. Our findings suggest that subtle and intangible signs, such as changes in care-seeking patterns or in the interactions between parent and child, provoked a sense of alarm that something was wrong, even though the GPs found no specific indication of harm. This corresponds closely to Erik Stolper's description of the concept of gut feeling [12]. Within the biomedical sciences, gut feeling is often described as a skill or competence enabling doctors to recognise non-measurable and intangible signs, and it is often associated with situations of uncertainty. It resembles what is known as intuition within phenomenology and the social sciences [13]. The role of intuition in clinical judgement has been subject to debate, and the diagnostic use of gut feeling is controversial [12]. It has been deemed unscientific, but gut feeling has also been acknowledged as a form of tacit, yet rational and experience-based knowledge and an inevitable part of clinical reasoning. Gut feeling has been studied in relation to different diagnostic procedures [14, 15] and has been shown to provide useful information in the diagnostic process "based on the interaction between patient information and a GP's own knowledge and experience" [12, p. 197]. It has been argued that GPs need more training in how to discover signs of child neglect and abuse [5, 6, 16]. We suggest that knowledge about concrete, objective signs of child neglect and abuse produced in other medical specialities or disciplines may fall short in the complex reality of clinical general practice [17]. Here, gut feeling is central in those less clear-cut cases where GPs' suspicions are raised by disruptions in, for instance, behavioural and care-seeking patterns.

In general practice, children present with a variety of health and social problems. Thus, child wellbeing is often a multifactorial issue rather than a red flag screening process to identify neglect or abuse. Research suggests that approx. one in six children has significant somatic, psychological or social health problems, often in combination [18], which indicates that child wellbeing relates to a wide range of factors [19]. We found that GPs are challenged by cases in which children presenting more elusive signs of poor wellbeing are in what some GPs described as the "yellow" zone, where "something" seems wrong and does not fit the pattern. They had very few options to help these children and were left largely on their own with their concerns or suspicions. Such cases may go unnoticed for long periods of time, perhaps due to uncertainty and perhaps because they fall between chairs in the healthcare system. Other studies have pointed out that in some of these cases of concern, reporting or referral to paediatric departments or social services may be used as a safety net [11], which is in line with our findings. In addition, our study illustrates that referral is also used as a way to assist the family in getting help to improve a desperate situation and to get a child "into the system".

When considering the findings of this study, some methodological issues must be taken into account. The participants were all recruited from a training course which focused on child neglect and abuse, and therefore they may have a particular interest in the subject compared with other GPs. The aim of the study, however, was to explore challenges and having a group of interested; and engaged interviewees may, in fact, have enhanced the conversation. The number of interviews conducted was small, but as the focus of the study was narrow, we found that no new themes emerged during the last couple of interviews.

## CONCLUSIONS

In general practice, concrete cases of neglect and abuse constitute a minor part of the large group of children who are failing to thrive. GPs had few doubts about screening for concrete signs of child neglect and abuse, and

were much more troubled when they had a feeling that something was wrong with a child or in the family. One very important factor in raising a suspicion seems to be the GP's gut feeling. A major challenge for GPs was to figure out whether their gut feeling related to a child's poor wellbeing due to other reasons or neglect or abuse. In these cases, GPs lack opportunities to help children. This suggests a need to further examine how to approach matters of child protection and wellbeing across health professions and specialities.

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