Advanced Practice Nurse Barriers to Reporting Child Maltreatment

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The abuse and neglect of children is not a new phenomenon. History is replete with accounts of heinous acts perpetrated against the innocent. Healthcare providers have also taken note of child maltreatment (CM) in writings appearing as early as AD 900. In his text *Practica Puerorum,* the Arabic physician Rhazes stated that intentional injury might be a cause of some hernias in children (Labbé, 2005). In 1860, the French physician and child welfare advocate Ambroise Tardieu published details of 32 cases of CM in an attempt to raise social awareness about the "singular insanity" of child abuse and neglect (Labbé, 2005; Roche, Fortin, Labbé, Brown, & Chadwick, 2005). Tardieu's efforts to raise social awareness were met with resistance (Al-Holou, O'Hara, Cohen-Gadol, & Maher, 2009; Jenny, 2008), and it would take more than 100 years for healthcare professionals to rediscover CM. Similarly to Tardieu, Kempe also encountered resistance and disbelief (Jenny, 2008; Kempe, Silverman, Steele, Droegemueller, & Silver, 1962; Leventhal, 2003). Kempe and associates' publication of *The Battered-Child Syndrome* in 1962 transformed CM from a social phenomenon to a recognized detriment to childhood health and well-being.

For nearly a half-century, CM has been researched extensively; entire journals are dedicated to the subject. The fight against CM has made great strides with much more needing to be accomplished. Nevertheless, the consequences and costs of CM make it imperative that providers protect of healthcare and advocate for the most vulnerable populations.

The importance of identifying and reporting cases of suspected maltreatment is due in part to the prevalence of CM. National data indicate that 1.2% of the U.S. child population, nearly 1 million children, were either abused or neglected (Centers for Disease Control and Prevention, 2008; 2012). This number has remained stable over the past decade (Sedlak et al., 2010). The U.S. Department of Health and Human Services (HHS) estimates that only one third of abused and neglected children come to the attention of Child Protective Services (CPS). It further concluded in the National Incidence Survey-4 (Sedlak et al., 2010) that CPS does not investigate all reported cases meeting the criteria established by HHS. In a national survey of children and youth, Finkelhor, Turner, Ormrod, and Hamby (2009) found the incidence of CM to be 10 times greater than the number of CM cases substantiated by CPS, and a study conducted in North and South Carolina reported an incidence of CM greater than 40 times the official number of reported cases (Theodore et al., 2005).

The consequences of CM are pervasive and long-lasting, potentially affecting survivors of CM for their entire life. These outcomes have been linked with increased incidence of mental health issues such as depression, anxiety, posttraumatic stress disorder, and suicide (Dube et al., 2003). Abused and neglected persons also suffer poorer physical wellness and score lower on both subjective and objective measures of health. Sachs-Ericsson, Blazer, Plant, and Arnow (2005) found that persons who had been physically abused as children were more than 2 times as likely to suffer from a major physical illness as their nonabused counterparts. Individuals of advanced age with a history of CM were 1.5 times more likely to have three or more serious medical diagnoses (Draper et al., 2008). Heart disease, liver disease, and obesity occur at higher rates in people who were abused or neglected in childhood (Aaron & Hughes, 2007; Dong, Dube, Felitti, Giles, & Anda, 2003; Draper et al., 2008; Sachs-Ericsson, Blazer, Plant, & Arnow, 2005). Exposure to CM predisposes victims to engaging in high-risk health behaviors such as drug, alcohol, or tobacco use; early sexual debut; prostitution; a higher number of lifetime sexual partners; and lack of condom use. There is also a link between CM and behavioral issues with victims experiencing increased rates of juvenile delinquency, violent behavior, and adult criminality. The estimated annual cost of CM ranges from $80 billion to $124 billion (Fang, Brown, Florence, & Mercy, 2012; Gelles & Perlman, 2012). Although these estimates incorporate direct and indirect costs of the maltreated individual, they do not include some of the secondary costs incurred across the lifetime of the victim.

The adverse effects of CM are cumulative (Dube et al., 2003; Flaherty, Thompson, et al., 2006; Flaherty et al., 2009). Each episode of abuse or neglect a child experiences increases the probability of suffering serious or lasting harm. It is imperative to identify and intervene at the earliest opportunity to minimize the negative effects of maltreatment. Yet there is no point in the timeline of maltreatment that intervention is fruitless. To that end, all

fifty states have established mandatory reporting laws that require CPS to be notified when a reasonable suspicion of abuse or neglect exists. Research indicates, however, that clinicians do not report all suspicious cases for CM even when the probability of maltreatment suspected by the clinician is high (Flaherty, Sege, Binns, Mattson, & Christoffel, 2000; Flaherty, Sege, et al., 2006; Flaherty et al., 2008; Flaherty & Sege, 2005; Gunn, Hickson, & Cooper, 2005; Jones et al., 2008; Lazenbatt & Freeman, 2006; Schweitzer, Buckley, Harnett, & Loxton, 2006).

Several studies have examined the decision-making processes and factors that inform and influence a clinician's reporting behavior. The research has focused primarily on physicians without any inclusion of nurse practitioners or certified nurse midwives (hereafter identified as advanced practice nurses or APRNs). Certified nurse midwives provide healthcare to women of childbearing age, including girls as young as 12 years of age, and are also mandated to report suspected child abuse. As mandated reporters, APRNs have the opportunity and responsibility to identify and refer potential victims of CM. Advanced practice nurses play an increasingly large role in the delivery of healthcare (Allen & Viens, 2006; Brown, Hart, & Burman, 2009), and it is important to understand their reporting behaviors and experiences. The purpose of this study is to determine what barriers APRNs perceive in fulfilling their mandate to report suspected CM.

We reviewed the literature using MEDLINE, CINAHL, and PsychInfo databases with the search terms *child*, *abuse*, *neglect*, *maltreatment*, *reporting*, *mandatory reporting*, and *barriers*. Initially, we searched literature from 2000 to the present, which returned only 30 articles. The search was then expanded to include the years 1960 through the present to discover any insights into barriers that may have existed at the creation of mandatory reporting statues. Additionally, expanding the timeline provided an opportunity to gain an understanding of any changes in the identified barriers to reporting that have occurred across time.

Barriers to Reporting Child Maltreatment

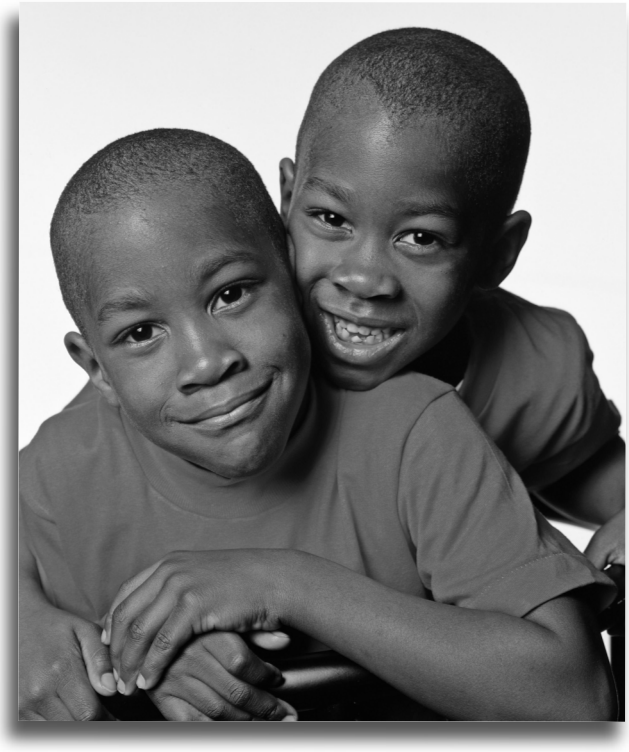
The decision not to report suspected CM appears to involve a complex decision-making process, and previous research has identified many barriers that inhibit reporting. Literature from the past several decades revealed that barriers to reporting CM as perceived by providers are consistent over time. These barriers can be divided into two categories: failure to recognize CM and anticipated consequences of reporting CM (Sege & Flaherty, 2008).

Failure to Recognize Child Maltreatment

A child who has been abused or neglected is not a common clinical presentation (Lane & Dubowitz, 2009; Lazenbatt & Freeman, 2006). Some providers reported having never treated a child who had been abused (Flaherty, Sege, et al., 2006). Based on the vast undersubstantiation of CM, it is more likely that CM goes unrecognized in the clinical setting. Lack of training is a commonly reported barrier that causes clinicians to lack a sense of competence in recognizing CM (Flaherty, Sege, et al., 2006; Flaherty, Jones, & Sege, 2004; Lane & Dubowitz, 2009; Lazenbatt & Freeman, 2006; Leder, Emans, Hafler, & Rappaport, 1999). Studies indicate clinicians who have received education regarding CM are more likely to report their suspicions (Flaherty et al., 2000; Fraser, Mathews, Walsh, Chen, & Dunne, 2010), yet education remains sparse. Most emergency medicine residents and family practice residents receive fewer than 7 hours of didactic education on CM (Starling, Heisler, Paulson, & Youmans, 2009). McCarthy (2008) reported the median time spent educating about CM in medical schools is 2 hours. Furthermore, the CM education that providers receive varies greatly between specialties leading to differing levels of competence and comfort among providers (Lawrence & Brannen, 2000; Starling et al., 2009). Participants in one focus group described their training regarding CM as "haphazard and infrequent" (Flaherty et al., 2004), which may be due to a lack of CM training requirements in APRN education. No state medical board requires specific CM education for licensure or license renewal (American Medical Association, 2010), and Iowa is the only state that requires APRNs who routinely treat children to receive regular training on CM identification and reporting (Medscape, 2009; State of Iowa, 2007).

Anticipated Consequences of Reporting Child Maltreatment

Some have indicated that the reality of CM is too psychologically challenging for the provider to accept (Jones et al., 2008; Lazenbatt & Freeman, 2006; Leder et al., 1999). Denial that an



injury or behavior is the result of CM is not an unusual occurrence. Reports of sexual abuse have in the past been explained away as child fantasies or some other psychological dysfunction (Labbé, 2005). As participants of one study stated, "Do we really want to know this information and then [have to] deal with it?" (Leder et al., 1999).

A recurring barrier theme is the impact the CPS system has on clinicians' decision to report. Negative interactions with CPS staff and perceptions that CPS interventions are either inadequate or may potentially harm the family or child, discourage reporting (Flaherty et al., 2000; Flaherty et al., 2004; Gunn et al., 2005; Jones et al., 2008; Lazenbatt & Freeman, 2006; Leder et al., 1999; Vulliamy & Sullivan, 2000). In some instances, clinicians have felt their management of CM would be adequate or superior to CPS involvement (Flaherty, Sege, et al., 2006; Jones et al., 2008).

The legal environment in which clinicians practice appears to create a barrier to reporting CM. State laws always require mandatory reporting when a reasonable suspicion of abuse or neglect is evident (Child Welfare Information Gateway, 2008). This mandate is problematic in that there is no uniform definition of what constitutes *reasonable suspicion*. Levi and Loeben (2004) have extensively explored the concept of reasonable suspicion from both legal and cognitive perspectives and concluded that the term creates ambiguity. This lack of a clearly established threshold for suspicion leads to inconsistent reporting even among child abuse experts (Flaherty, Sege, et al., 2006; Levi & Brown, 2005; Levi & Loeben, 2004; Levi, Brown, & Erb, 2006; Lindberg, Lindsell, & Shapiro, 2008).

Many healthcare providers choose not to report in order to avoid the legal system (Flaherty, Sege, et al., 2006; Vulliamy & Sullivan, 2000). Those who have provided depositions or testified are less likely to report their suspicions again (Gunn et al., 2005); furthermore, fear of litigation or having been previously sued decreases the likelihood of reporting CM (Flaherty, Sege, et al., 2006; Gunn et al., 2005; Lazenbatt & Freeman, 2006).

As with the previous issues, the relationship between the clinician and the family also affects the decision to report. Unlike the previously mentioned barriers, the clinician–family relationship may impede or support reporting behaviors. Lack of familiarity with the child or family appears to encourage reporting (Flaherty et al., 2008), but a closer relationship with the family deters reporting (Flaherty, Sege, et al., 2006; Flaherty et al., 2004; Jones et al., 2008). In some instances, however, a close relationship with the family supports reporting. Provider knowledge of previous or current CPS involvement or awareness of risk factors for abuse in the family positively affects reporting behavior (Flaherty et al., 2004; Jones et al., 2008).

Methodology of Our Reporting Barriers Study

Purpose

We examined the perceived barriers to CM reporting experienced by nurse practitioners and nurse midwives in an intermountain state to determine if these barriers are similar to the barriers perceived by physicians.

Sample

A search for APRNs in the state's Department of Professional Licensure's (DOPL) database provided a potential sample size of 1,223 nurse practitioners and nurse midwives. Using a random number table, we selected 400 names to participate in the study. Participants met inclusion criteria if they were actively licensed in the state as a Family Nurse Practitioner (FNP), Pediatric Nurse Practitioner (PNP), or Certified Nurse Midwife (CNM) who treated children under the age of 18 years and could read and speak English. Excluded from the study were nurses licensed as a nurse anesthetist or clinical nurse specialist, or who had not provided care to a child within the past 5 years, or had not been concerned about the possibility of abuse or neglect for any child in the past 5 years.

Procedures

Institutional Review Board approval was obtained. A cover letter explained the general purpose of the study. Participants were informed that returning the survey constituted their consent to participate in the study. The survey instrument was mailed to

individual addresses obtained through the DOPL search. A participation incentive of one dollar was included in the mailing. A self-addressed stamped envelope was also included to encourage the participants to return the survey. Anonymity was maintained through the following means: the survey was entirely anonymous; the mailing list and returned surveys were kept in a locked file. At the conclusion of the study, all identifiable documentation and the surveys were destroyed.

Instrument

A 25-question survey, entitled "Child Maltreatment Survey," was adapted specifically for this study, using a previous questionnaire for determining barriers to reporting CM developed by Gunn, Hickson, and Cooper (2005). Although validation data for the original study are not published, the purpose of our study was to compare APRN and MD barriers; therefore, use of the same survey was appropriate. The survey was divided into three sections and contained question formats such as yes/no, Likert scale, and free response. Section I posed questions to determine a respondent's familiarity with reporting laws and processes and also asked about any previous experience reporting abuse or neglect. Section II used a Likert scale to elicit the perceived barriers to reporting experienced by APRNs. Section III included three clinical vignettes in which a child presented for evaluation of an injury. After reading each case presentation, the participants were asked if they would report the situation as suspicious for abuse or neglect, and if so, to whom. Additionally, participants were asked to rate their level of suspicion using a visual analog scale to assess the level of suspicion that prompts the APRN to file a report of suspected CM. Demographic information was also obtained as part of the survey and included gender, race, age, number of years in practice, practice area, practice type, and degree type.

Data Analysis

The data collected were analyzed using SPSS® version 19 (SPSS Inc., Chicago IL). Descriptive statistics were used to define the sample characteristics. Likert items, which measure level of perceived barriers, were analyzed using descriptive statistics, including means and standard deviations. Additionally, correlational statistics were conducted to determine relationships between demographic data and perceived barriers. According to the levels of data collected, descriptive variables and T-tests were run. The vignettes, which assessed the provider's level of suspicion that would prompt reporting, were analyzed using the appropriate correlational statistics. Qualitative questions were analyzed according to themes and patterns (Lincoln & Guba, 1985), and the yes/no questions were analyzed using frequencies. Trustworthiness was established by having an experienced qualitative researcher review responses to the qualitative questions and confirm findings. The researchers discussed findings until they reached consensus according to Denzin and Lincoln (2000).

Results

Out of the 400 surveys sent to APRNs in the original sample, 26 were returned as undeliverable. Of the remaining 374 possible participants, 182 (48.6%) returned surveys. Ninety-three indicated they had, in the past 5 years, either not treated a child under the age of 18 years or not treated a child under 18 whom they suspected had been abused or neglected. Of the 89 eligible respondents, 88 completed the survey. One returned the survey refusing to answer. Respondent demographics, practice setting, specialty certification, and prior CM reporting experience are listed in Table 2. The study sample is similar to the demographic trends for APRNs within the United States (Allen & Viens, 2006). The mean age of all respondents was 45.5 years (range: 26–65 years) with standard deviation of 10.3 years (range: less than 12 months–36 years) of practice experience in the nurse practitioner role. Family nurse practitioners made up nearly two thirds (64.6% n=51) of the sample while 12.7% (n=10) and 8.9% (n=7) identified themselves as pediatric nurse practitioners or certified nurse midwives, respectively. The majority of respondents identified themselves as female (88.6%) and Caucasian (98.9%).

Nearly all of those responding to the survey (85.2%) reported at least one case of possible CM, with a mean of 5.3 reports. However, most of the respondents (76.1%) filed a total of five or fewer reports, with the median number of CM reports filed being two. In response to the question "Have you ever considered

Table 1. Respondent Demographics and Reporting Experiences

Demographics	% Who Suspected Maltreatment but Did Not Report	Significance
Gender		NS
Male (10)	40	
Female (78)	29.48	
Specialty		NS
FNP (51)	19.6	
PNP (10)	30	
CNM (7)	57	
Other (11)	40	
Practice Setting		NS
Primary care (36)	25	
Hospital (26)	42	
Emergency dept (6)	16.7	
Other (20)	30	

Based on descriptive variables and T-tests.

reporting suspected child abuse or neglect, but chose not to do so?" 31% (n=27) of participants indicated that at some time they suspected a child to be a victim of CM but had declined to report their suspicions.

When comparing those providers who had not reported cases suspicious for CM with those who had always reported their suspicions, no statistically significant differences were discovered. While no differences were found between the groups of APRNs included in this study, the survey did identify some beliefs that may negatively affect reporting. At least half of all respondents expressed frustration with CPS during the reporting process and that CPS provided no follow-up with the reporter. Although a significant number of respondents expressed negativity toward CPS, most agreed that CPS involvement is necessary to provide adequate assistance to resolve the CM issue. Other potential barriers were the beliefs that reporting suspected CM may harm the child and may negatively impact the family. Interestingly, while nearly half (45.3%) of respondents agreed or strongly agreed that reporting may result in harming the child victim, three fourths (75.6%) disagreed with the statement "Reporting suspicions of child abuse or neglect does not improve the outcome for the child victim."

The APRNs who declined to report suspected CM were asked to list the factors that influenced their decision. The most common reason for not reporting was lack of evidence that CM had occurred. From the remaining responses, lack of certainty that CM had occurred and lack of physical evidence were overwhelmingly cited as the reason for not reporting. Out of the total responses provided, only two stated that additional patient history or the physical exam lead the APRN to exclude CM as a reasonable diagnosis. Table 3 lists themes of the responses for declining to report.

All survey participants were asked to list reasons why a healthcare provider might decide not to report possible CM. Ten distinct themes emerged during the analysis of these perceived barriers: (1) Fear of being wrong about the diagnosis of CM; (2) Fear reporting may harm the provider personally, professionally, or legally; (3) Lack of time; (4) Provider lack of confidence in CPS; (5) Not wanting to become involved in reporting; (6) Lack of knowledge about CM or the reporting process; (7) Fear report would harm the victim; (8) Fear report would harm the family; (9) Relationship with the family; and (10) Assumed someone else would report.

Table 2. Themes for Nonreporting Behavior

Reasons for declining to report (actual) – 24 responses

Reason	n=	%
Not enough evidence or unsure abuse occurred	17	70.8
Lack of knowledge about abuse or reporting	2	8.3
Assumed someone else would report	2	8.3
Influenced not to report by others	1	4.2
Concerned report would harm the victim	1	4.2
Lack of confidence in the child protection system	1	4.2

Why would others be reluctant to report (hypothetical) – 170 responses

Reason	n=	%
Afraid of being wrong about CM diagnosis	51	30
Fear report may harm the provider personally, professionally or legally	40	23.5
Lack of time	25	14.7
Lack of confidence in the child protection system	13	7.6
Do not want to become involved in the reporting–legal process	10	5.9
Lack of knowledge about abuse or reporting	9	5.3
Fear report would harm the victim	7	4.1
Fear report would harm the family	6	3.5
Relationship with the family	5	2.9
Assumed someone else will report	4	2.4

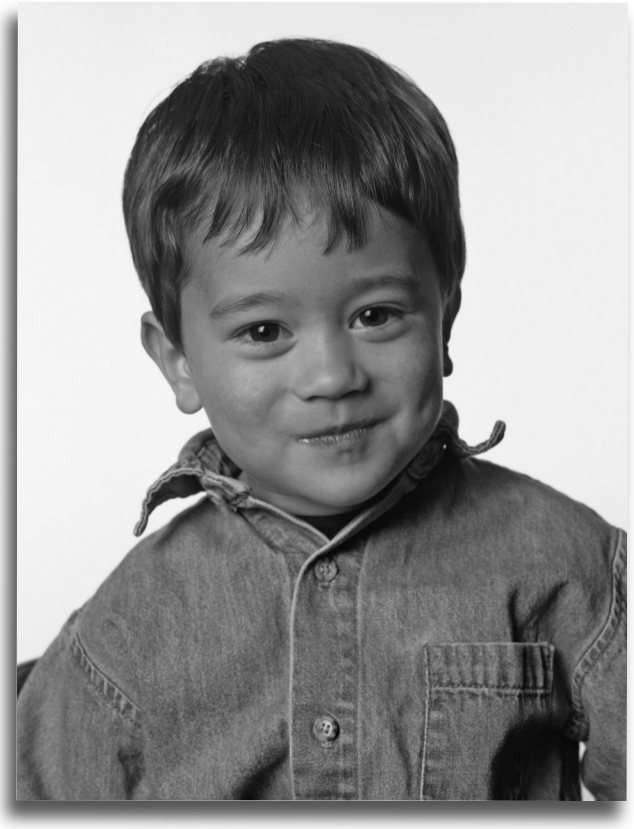
Discussion

This study demonstrates that the perceived barriers reported by APRNs are similar to those previously reported by physicians, with 31% of APRNs and 28% of MDs not reporting a case of suspected child maltreatment (Gunn et al., 2005). The primary obstacle to reporting identified by the participants was uncertainty that CM had occurred. This manifested as clinicians citing a lack of evidence or expressing fear of CM being an incorrect diagnosis. These misgivings and resultant inaction may be the result of inadequate CM training or little exposure to CM in the clinical setting (Flaherty et al., 2004; McCarthy, 2008; Starling, et al., 2009). Lack of training about CM or feelings of being unqualified to render a definitive opinion about whether or not CM occurred is a barrier that is recurrent in the literature about reporting behavior (Flaherty et al., 2004; Gunn et al., 2005; Lane & Dubowitz, 2009; Lazenblatt & Freeman, 2006; Leder et al., 1999). Participants of this study indicated that clinicians infrequently see CM. These results are congruent with other studies that indicate CM is an uncommon presentation or CM is dramatically underrecognized in the clinical setting (Flaherty, Sege, et al., 2006; Lane & Dubowitz, 2009; Lazenbatt & Freeman, 2006). This paucity of experience reinforces the feelings of inadequacy by professionals in the identification of CM.

Implications for Practice. Findings from this study indicate that a significant barrier to reporting CM is lack of competency in recognizing CM. Educating providers about CM has been shown to increase rates of reporting (Flaherty et al., 2000; Fraser et al., 2010). In light of this, states should consider implementing mandatory CM education as part of the licensure renewal process in order to increase awareness of CM and, consequently, reporting. However, it has been demonstrated that experience with CPS via the reporting process negatively impacts reporting behavior (Flaherty et al, 2000; Flaherty et al., 2004; Gunn et al., 2005). Merely educating the clinician may not be enough to sustain lasting and meaningful behavior change. What may be necessary is to change the reporting process altogether. One option could be for the clinician to refer the child to an abuse expert. Lane and Dubowitz (2009) in their study of pediatricians found strong support for the use of referrals to CM specialists. A referral allows for the child victim to be screened by a healthcare provider with CM expertise who can determine the need for CPS involvement, thus mitigating some of the perceived barriers by removing the APRN from the reporting process. Furthermore, such a process provides an opportunity for the expert to provide the referring clinician's validation or education regarding the appropriateness of one's suspicions, increasing the clinician's sense of competency. Another option is to increase the number of clinical sites that provide social services interventions via an onsite licensed clinical social worker (LCSW). This provides an opportunity to develop a collegial relationship with individuals who, by virtue of their education and training, may have had more positive and effective interactions with CPS staff.

Limitations. Although the return rate for the survey was good (48.6%), the low incidence of recognized CM in the clinical setting resulted in a usable sample size (23.5% of all possible participants) that may have not been large enough to adequately determine if any actual differences are present between APRNs who always report CM and those who have declined reporting. This means that the results are not representative of APRNs. Mailing a reminder card 2 to 3 weeks after the initial mailing of the survey was not done but may have helped to increase the return rate and, subsequently, the number of usable surveys.

Recommendations for Further Research. It is important to accurately determine the reporting barriers APRNs experience in order to implement effective interventions to overcome them. Research comparing reporting rates between states that have mandatory CM training and those that do not may be of value in determining the effectiveness of such training. Next, focus groups to determine why APRNs require such a high degree of certainty prior to intervening in cases of suspected CM have the potential to be of great benefit. Finally, research is needed to determine what processes must be changed or implemented to increase the collaboration between clinicians and CPS workers. Such research should focus on determining healthcare providers' knowledge of the CPS system and its mandate, as well as understanding the qualifications of CPS staff members, their case loads, and how they proceed with a report of suspected CM. Focus groups of



CPS staff members would facilitate understanding their perceived barriers about working with healthcare providers.

Conclusion

This study demonstrates that the nonreporting rates among APRNs are similar to physician rates of nonreporting and that the perceived barriers are similar (Gunn et al., 2005; Lane & Dubowitz, 2009; Schweitzer et al., 2006). Lack of evidence or certainty CM occurred was the most common reason given for failing to report. Also, CPS may exert an important influence regarding the clinician's decision to report.

Ironically, mandatory reporting laws are written to empower the clinician to refer suspected victims of CM to investigators, specifically CPS. Unfortunately, negative interactions between CPS and healthcare providers, lack of follow-up, and the perception that CPS interventions are inadequate or harmful may be directly responsible for a provider's need for a greater level of certainty prior to intervening than with other clinical presentations (Jones et al., 2008; Leder et al., 1999). Referring to CM experts within the healthcare field may be one option for overcoming this barrier, but unless current laws are changed, it would not remove the legal responsibility of reporting to CPS nor would it guarantee that the family would follow up with the referral.

Ultimately, APRNs must remain open to the possibility that any child they treat may be the victim of CM and should appropriately include CM in their differential diagnosis. Acknowledging the possibility of CM promotes caution and awareness when gathering history and performing the physical assessment and may help to overcome the failure to recognize CM in the clinical setting. The next critical step is reporting to the appropriate agency. Although the CPS system is far from perfect, it is what currently exists to intervene in cases of abuse and neglect, and merely avoiding its use will not improve it. In summary, increased interaction between clinicians and CPS workers has the potential to aid in the identification of and the improvement in the reporting–response process.

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