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### MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

#### How Should Clinicians and Students Cope With Secondary Trauma When Caring for Children Traumatized by Abuse or Neglect?

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##### Abstract

When health care professionals encounter child abuse and neglect, they can experience a range of emotions, such as anger, sadness, and frustration. Such feelings can cloud judgment, compromise care, or even undermine one's capacity to complete evaluation of a child. This article discusses key ethical values of honesty, objectivity, compassion, professionalism, respect for persons, and justice, which can be used to guide one's approaches to navigating secondary trauma during and after clinical interactions with children who have suffered abuse or neglect. Strategies for coping with intense feelings, especially during interactions with abused and neglected children's families, are also offered herein.

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##### Witnessing Abuse and Neglect

In fiscal year 2020, child protective services agencies received 3.9 million referrals alleging child abuse and neglect.<sup>1</sup> Approximately 618 000 children were identified as victims, with the highest rates for infants. Roughly 12% of reports to child protective services were made by medical personnel.<sup>1</sup> As mandatory reporters in all 50 states, health care professionals are often required to complete child abuse education training in mandated reporting.<sup>2,3</sup> However, there is no universal training program for teaching health care professionals—including students and trainees—how to manage and cope with their emotions in these cases, which can make it difficult to adhere to ethical standards, including honesty, objectivity, and respect and empathy for caregivers who might be **suspected perpetrators of child abuse** and neglect. Here, we offer recommendations for communication strategies health care professionals can employ in cases of suspected child abuse and neglect and discuss approaches to managing secondary trauma that such cases might evoke.

##### Honesty

When child abuse or neglect is being considered, it is best practice for health care professionals to communicate this concern to families in an open and honest way. For instance, the statement, "I am concerned someone may have harmed your child," is an

appropriate expression of concern, especially if a diagnosis of abuse is not certain. Alternatively, if the child is battered or has pathognomonic, multiorgan injury that can only be the result of abuse, it is appropriate to clearly state that the child is a victim of abuse. Sometimes staff do not know the appropriate language to use to convey concern, or they might worry about angering or offending parents or other caregivers or simply feel uncomfortable with confrontation. In consequence, staff might not communicate appropriately with families or might avoid communication with families, which can affect families' perceptions of how they are treated. In a study that examined parental perceptions of care during young children's hospitalization for traumatic injuries, parents who were evaluated for possible abuse by the hospital child protection team—even when the injury was determined to be nonabusive—reported feeling less informed by staff and were less likely to feel that they were treated honestly or respectfully than parents for whom abuse was not considered.<sup>4</sup> Additionally, parents of children who were abused were more likely to feel that the diagnosis of abuse changed the way they were treated by hospital staff. These perceptions may be due to parents thinking that they are being negatively judged by the hospital staff or to their recognizing the hesitancy of staff who are uncomfortable caring for families of children who might have, or who have, been abused. Potentially, both factors contribute to these perceptions, highlighting the need for repeated communication with families. It is often helpful for clinicians to begin the conversation with concerns about possible abuse and ask parents whether they have any concerns that someone might have hurt their child. This is a nonjudgmental way to begin an open dialogue.

It is also ethically important not to “hide” behind one's mandate to report child abuse when discussing concerns with families. That is, clinicians blaming a decision to report on the law (eg, “I don't think it's abuse, but I am mandated to report”) rather than taking full responsibility for acting on their discernment and concern obscure the best reasons they have for reporting. Transparency with families is too important for professionals to invite such obfuscation into an already complex and emotionally fraught discussion. In fact, families in most cases likely deserve to know the specific roles clinicians play on a team—whether consultant or admitting physician, trainee, or supervising clinician. Families should be introduced to the various members of the medical team, just as in any other patient-clinician interaction, and know that the team members take their responsibilities seriously. It is also important to educate trainee team members to be forthcoming about their role as a trainee.<sup>5</sup>

Expressing concerns about child abuse and neglect to a family can be unsettling for any health care professional, but it is especially unsettling for trainees. Trainees may never have encountered child abuse and neglect before and may have minimal experience with challenging patient interactions. Just as mentors would not send trainees independently to deliver bad news without modeling how to do so, so they should not send trainees independently to discuss child abuse and neglect concerns without adequate preparation. To better prepare trainees for these patient encounters, we recommend **modeling communication** with families prior to having trainees lead the discussion. We also recommend emphasizing the importance of explaining medical terminology using language that is easily understood by patients and families. In addition, trainees should be taught to inform families that a report of suspected abuse is needed to further investigate the cause of the child's injury or condition. We often tell families that we will evaluate for underlying medical explanations while asking child protective services to investigate the possibility of abuse or neglect. In general, health care professionals are **expected to report** those cases in which there is reasonable

suspicion that a child was a victim of abuse or neglect by an individual whose care they were under.<sup>2,6</sup>

### **Objectivity**

Medical professionals cannot allow their disgust or horror at a patient's clinical presentation to affect how they treat the patient or the patient's caregivers. Regardless of their degree of concern about child abuse and neglect, trainees and medical professionals must take an objective approach to evaluating children for child abuse and neglect and making decisions regarding mandated reporting. Trainees should be educated on mandated reporting laws and clinical guidelines that inform appropriate medical evaluations in child abuse and neglect cases.<sup>3</sup> It is important to note that while there is a minimum federal definition of child abuse and neglect for purposes of reporting, each state has its own definition.<sup>6</sup> Nonetheless, health care professionals are mandated reporters in all 50 states.<sup>7</sup> Although medical school curricula exist to teach students about child abuse and neglect, it is critical to continue educating clinicians along the training continuum beyond medical school.<sup>3</sup>

The threshold for reporting requires only a reasonable suspicion of child abuse and neglect. However, there are no clear-cut, universal guidelines on what constitutes a reasonable suspicion. Each individual likely has their own threshold to report based on clinical experience, culture, religious background, personal upbringing, and knowledge. How do you teach trainees where and how to draw the line? Health care professionals can educate trainees and students to use a consistent framework to approach cases of child abuse and neglect, such as Leventhal's triangle, which acknowledges that there is a continuum between accident or medical condition and child abuse or neglect and that there is a threshold for a presentation to warrant reporting.<sup>2</sup> We know that racial bias—implicit or explicit—exists both in reporting practices and in investigative outcomes.<sup>8,9,10</sup> As health care professionals, we have an obligation to recognize our individual potential for bias, work diligently to address our biases, and educate trainees to be careful, thorough, and objective in their approach to child abuse and neglect.<sup>2</sup>

A number of resources are available to assist in making evaluations. The American Academy of Pediatrics provides recommendations for evaluations in cases of suspected child abuse.<sup>11,12</sup> Some institutions have created clinical pathways for providing an objective, evidence-based evaluation to reduce bias in medical evaluations.<sup>13</sup> Such pathways can also serve as tools to bolster clinician confidence in reporting when a concern for child abuse and neglect is identified, as health care professionals miss cases of abuse and do not always report cases when they have suspicion.<sup>14,15,16</sup> Several reasons for not reporting have been identified, including familiarity with the family, perceptions of what would be the outcomes of child protective services reports, and consistency of the injury with elements of the patient's history.<sup>15,17</sup> Moreover, some clinicians elect not to report suspected child abuse and neglect because of their concern that it might harm families. However, we do not recommend this approach, as there is significant potential for children who remain with their family to return to the health care facility with signs of additional, more severe abuse or neglect. Cases of child abuse and neglect are challenging for a myriad of reasons. When cases are ambiguous or complicated, clinicians can seek consultation and recommendations from pediatricians who specialize in child abuse and neglect or others who have expertise in this area, such as social workers.

### **Compassion and Respect**

One responsibility of health care professionals is to treat each patient with compassion and respect. This ethical standard holds for caregivers who may be perpetrators of child abuse and neglect. While it might be easy for health care professionals to feel sympathy for victims of abuse and neglect and to provide compassionate care to such children, it is more challenging to show compassion for potential perpetrators of or accomplices in child abuse and neglect. It is essential to teach trainees and students to refrain from apportioning blame to parents or caregivers, as there may be extenuating factors in a given case. Various stressors can lead to a child's victimization, such as lack of support, isolation, fractured family structure, or poverty. We know that poverty, for example, is a potent risk factor for child abuse and neglect; however, most impoverished caregivers do not neglect their child's needs.<sup>18</sup>

We also must recognize that perpetrators often still love their child, despite their abusive acts. Additionally, we often do not know the identity of the perpetrator when talking with families, and we must recognize that the person at the bedside may be a nonoffending parent who was unaware of the abuse. Abuse can also be perpetrated by other adults, such as daycare workers, teachers, clergy, or relatives. It is not our role to be investigators in cases of child abuse and neglect. Rather, our role is to render a medical opinion and communicate the medical information to investigators. We should educate caregivers on what to expect through the child protection and criminal processes and support families through the initial investigation and hospitalization.

Health care professionals should build rapport with patients and caregivers. Toward this end, health care professionals should teach students and trainees to use the "Ask-Tell-Ask" approach to deliver concerns about abuse.<sup>19,20</sup> Trainees and students can also be taught to respond to caregivers' strong emotions—including anger, frustration, sadness, or confusion—using open-ended, nonjudgmental language. One useful strategy is the NURSE mnemonic: naming, understanding, respecting, supporting, and exploring.<sup>19,20</sup> These basic communication skills are essential in all aspects of medicine but can be especially helpful in cases of child abuse and neglect.

### **Coping With Secondary Trauma**

Health care professionals are at risk for secondary trauma as a result of these interactions and the feelings that they evoke. Secondary trauma occurs from indirectly being exposed to another person's trauma, such as through caring for a patient who is a victim of child abuse or listening to a caregiver's own history of domestic violence or sexual abuse.<sup>21</sup> Secondary trauma is distinct from second victim syndrome, which describes the psychological harm that occurs to a clinician who makes a recognized mistake, such as when abuse goes unrecognized and the child sustains further injury.<sup>22</sup>

For a variety of reasons, child abuse and neglect may be challenging for students and trainees to address and may arouse a range of emotions—from sadness and disbelief to anger and abhorrence—in a given clinical situation. For many students and trainees, the clinic may be their first exposure to family violence and child abuse. Some students and trainees have been victims of sexual and physical abuse as children. Others may feel a sense of guilt when diagnosing abuse or filing a report to child protective services due to potential sequelae, such as criminal investigation or placement of the child in kinship or foster care. Some mandated reporters have had previous experiences with child protective services and believe that their report will fail to make a positive difference for the child and thus hesitate or fail to report suspected abuse and neglect.<sup>15,17</sup>

Secondary trauma can affect clinicians' well-being. One study of child abuse pediatric clinicians demonstrated a positive association between secondary trauma and burnout.<sup>23</sup> Another study found that pediatricians and trainees caring for patients with suspected abuse and neglect had high average scores of secondary traumatic stress and low average compassion satisfaction scores.<sup>24</sup> When educating trainees and students, mentors must acknowledge this challenging aspect of the work and offer strategies to cope with and mitigate secondary trauma.

One potential strategy to help trainees and students cope with secondary trauma is to debrief after difficult cases—for example, after caring for a child with severe polytrauma or fatal injury, as well as after interactions with families who express anger or frustration toward the medical team. Emotional debriefing may reduce burnout and promote resilience.<sup>25</sup> Debriefing tools used in other care environments, such as the emergency department or the critical care unit, could be employed to help teams process challenging clinical situations or family conversations.<sup>26,27</sup> Our institution's child protection team uses a debriefing tool for difficult interactions, as well as for severe cases or fatalities. It can be helpful to debrief in all cases of child abuse and neglect and to create trauma-informed health care environments for both patients and health care professionals.<sup>24</sup> Additionally, educating trainees on positive coping strategies, providing peer support, promoting self-care, and helping them find hope and meaning in their work may reduce secondary traumatic stress and risk of burnout.<sup>23,28</sup>

### Conclusion

Cases of child abuse and neglect can evoke a range of emotions in health care professionals, especially in inexperienced students and trainees. It is important to educate learners to maintain objectivity, to speak honestly, and to treat patients and their families with compassion and respect. Additionally, it is critical to support students and trainees in cases of child abuse and neglect and to provide strategies to mitigate the effects of secondary trauma through activities such as debriefing.

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#### Conflict of Interest Disclosure

Dr Bennett reports providing expert witness testimony in cases for which she is subpoenaed, and Dr Christian reports performing medical-legal expert work in child abuse cases.

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