INTRODUCTION

Worldwide, many children suffer from abuse, often with numerous serious lifelong consequences. Unfortunately, child abuse remains undiscovered in 90% of cases. In the Netherlands, about 90,000–127,000 children aged 0–17 years (i.e. 3% of all children) are victims of child abuse, with at least 17 child fatalities a year. Prevention and early detection of child abuse have high priority in Dutch government policy.

An important tool is the national guideline on child abuse. It presents a five-step guide, from obtaining more information and documentation to consulting the Dutch Child Abuse Counselling and Reporting Centre (CACRC), discussing the matter with the parents or caregivers, consulting with a colleague and reporting it to authorities. The next step, discussing their suspicion with the parents, is a difficult one, and the CACRC might actually help to make this step easier.
the CACRC. Since 2008, the second step, consulting the CACRC, has been obligatory when a suspicion of child abuse arises. A CACRC report found that primary care workers who see many children, such as family physicians (FPs) and Child Health Care Physicians (CHCPs), submitted only a very low percentage of the reports received by the CACRC (1.6% and 3%, respectively). Other countries have similar low reporting rates by FPs, and the reasons for these low rates do not differ between countries; they include uncertainty about the diagnosis, a fear of harming the relationship with the parents, low confidence in organisations like the CACRC, lack of knowledge about risk factors and pressure of time.

There are many cues that indicate possible child abuse. Nevertheless, physicians generally underidentify it. As regards the CHCPs, a study showed that not all of them followed the five-steps of the national guideline. A substantial proportion of them (14%) was not even aware of the existence of the guideline. In addition to poor knowledge, other factors impeding adherence to the guideline were poor cooperation by parents, personal fears and lack of good communication skills for discussing signs of child abuse with parents. One participant said: ‘I think we are just not able to have a difficult conversation with parents’. A more recent study confirmed that many of the Preventive Child Health Care (PCHC) professionals experienced a fear of being wrong when confronted with suspicions of child maltreatment, and found it very difficult to express their concerns towards parents.

As regards the FPs, we found in a previous study that an early alert that can arouse suspicion of child abuse is the gut feeling that ‘there is something wrong here’. This uneasy feeling might induce an FP to observe the child and its parents more closely, to carefully examine the child. FPs found it difficult to decide whether a child was being abused, because parents, despite good intentions, may simply lack certain parenting skills or may have other values regarding good parenting. When there were clear signs of sexual abuse or physical violence, FPs did file a report to the CACRC, but in cases of emotional child abuse, they generally limited themselves to following up the child and the family. They also tried to build a supporting network of professionals around the family. FPs highly valued the patient–doctor relationship but recognised the risk of shifting boundaries at the expense of the child. We concluded that the low reporting rate to the CACRC by FPs did not imply a low detection rate. FPs used their patients’ trust to improve a child’s situation by involving other professionals.

1.1 Aim

Our aim was to examine how gut feelings of child health care physicians (CHCPs) contribute to the development of a suspicion of child abuse, how they act upon this suspicion, and what barriers they experience in their management. To gain insight into the youth health care chain we compared the diagnostic reasoning and management of the problem by CHCPs and family physicians (FPs).

Key Notes
- As with family physicians (FPs), gut feelings of child health care physicians (CHCPs) act as an early alert to look for the triggering cue(s).
- The difference between child abuse and a lack of parenting skills is difficult to establish.
- Involving the reporting centre (CACRC) is considered a measure of last resort only; the CACRC, CHCPs and FPs should therefore improve their collaboration.

2 METHODS

2.1 Study design

For this explorative study, we used a qualitative approach. We opted for focus group discussions as we wanted to know CHCPs’ views on the recognition and management of child abuse. In addition, the interactions between the participants in the group might enrich the data. Data collection took place in 2017.

2.2 Research context

In the Netherlands, Preventive Child Health Care (PCHC) for preschool children is provided at well-child care clinics, where professionals, including doctors and nurses, monitor children’s physical and mental development during routine medical assessments. During the first year of life, approximately eight well-child visits are scheduled for babies and in the subsequent years another five visits, until the child is 4 years old. There is some flexibility in this schedule, depending on the child’s health status. The goals of PCHC are monitoring growth and development, detecting health and social problems, screening metabolic conditions and hearing, delivering the vaccination programme and advising parents about raising their children. Over 95% of all children at preschool age attend this free public service, an average of fifteen times. CHCPs and nurses collaborate closely when seeing a child.

FPs and CHCPs are important partners in the primary care for children and adolescents. Both have tasks in the field of preventive and curative care for youth. There are, however, clear differences in emphasis. The FPs mainly see sick children or children with complaints, so curative care occupies a larger place in their consultations than preventive care. FPs and CHCPs both have knowledge of children’s families, FPs from their position as family doctors, CHCPs through their longitudinal counselling of the children. Together, FPs and CHCPs may therefore be able to identify health problems such as child abuse and domestic violence. Moreover, within the so-called youth care chain, they are the only primary care doctors who have the right to physically examine children.
2.3 | Participants

For our focus groups, we invited physicians who work in PCHC with children aged from 0 to 4 years, in the southernmost province in the Netherlands, Limburg. Twenty physicians (19 female) participated, divided over 3 groups (4–10 persons per group). Their experience as CHCPs varied from 1 to 36 years (mean 16.3; SD 12.2).

2.4 | Procedure

We asked the participants to focus on early suspicions of child abuse or maltreatment. Two trained moderators chaired the sessions using an interview guide addressing the research questions. Each group discussion took about 1 ½ hrs. All sessions were audio-recorded and transcribed. A member check was performed.

2.5 | Data analysis

A thematic content analysis of the verbatim text was made separately by the two first authors, using the data management tool NVivo. The last author supervised the analysis. We used a coding book that had been composed in our comparable study among FPs with almost the same research questions and methods. This procedure enabled us to compare the outcomes of the two studies. During the analysis, the coding book was adapted to account for domain-specific aspects, but the three major themes could be retained. Almost all codes came up in each focus group. As we did not find major differences between the results of the three groups, we concluded that we had reached data saturation with this sample.

3 | RESULTS

3.1 | Major themes

The three major themes in the data were developing a suspicion, acting upon this suspicion and reflection. Below, we provide summaries of themes and subthemes for each of the themes, illustrated by quotes (Table 1).

3.2 | Developing a suspicion

3.2.1 | Triggers

CHCPs considered prevention and detection of child abuse an important task. They mentioned many known triggers such as bruises, lack of cleanliness, a single parent situation, financial problems, retarded development, an unusually quiet child and an authoritarian parenting style. Usually, it was a combination of signs (from both parents and child) that alerted a CHCP (quotes a and b in Table 1).

3.2.2 | The role of gut feelings

All CHCPs perceived gut feelings and described them as a sense of 'there is something wrong here', a vague sense of alarm, though they did not (or not yet) know what caused it. These feelings often induced CHCPs to observe more closely, to ask specific questions, and to look for triggering cue(s). CHCPs trusted their gut feelings. Sometimes a CHCP only became aware of this uneasy feeling in their debriefing with the nurse. A gut feeling might disappear over time. (quotes c, d, e).

3.2.3 | Child abuse or a lack of parenting skills threatening the child's well-being?

In all groups, CHCPs said they struggled with the question whether to label their findings as child abuse or as a lack of parenting skills. They were aware that poor parenting might create an unsafe environment for a child, that is, a situation of possible future child abuse, and considered it their task to prevent this. CHCPs often understood the difficulties parents faced (quotes f, g).

3.2.4 | Frame of reference

CHCPs were aware of the role of their own values when considering a situation to be possibly abnormal (quote h).

3.2.5 | Contextual information

CHCPs took all relevant information about children and their family situation into account. Even before seeing a child for the very first time, a CHCP has already received contextual information from other professionals. CHCPs closely cooperate in teams with nurses who visit all new-borns at home and examine children and their parents as they visit the well-child health care clinics. These teams are part of a network of external professionals such as nursery school and playgroup staff, child psychiatrists, speech therapists and FPs. Early data and recent information, received from various sources, played an important role in considering the possibility of child abuse (quotes i, j, k).

3.3 | Acting upon a suspicion

3.3.1 | Team discussion

When a suspicion arose, CHCPs often consulted with their team to get their suspicion confirmed (or otherwise) and to reach agreement about a plan of action (quote l).
| Focus group, participant | Quotes |
|--------------------------|--------|
| **Developing a suspicion: triggers** | |
| a FG2,1 | Because preventing child abuse is our daily job, for all children, and that's nothing unusual. And then you weigh up the factors: are they risk factors that you need to monitor, or is this really a problem? |
| b FG3,2 | It's often an accumulation of signals, in a particular context |
| **Developing a suspicion: the role of gut feelings** | |
| c FG3,4 | This sense of there's something wrong here, but you can't put your finger on it, that's often difficult, I think |
| d FG1,4 | You continuously relate this gut feeling to things you can make concrete, once again this ... you do get back to the analytical skills. I kind of see it as an ongoing interplay between the two |
| e FG1,3 | In every contact, you have that specific feeling about a family or a child... but after three or six months it might fade away completely |
| **Developing a suspicion: child abuse or a lack of parenting skills?** | |
| f FG2,2 | In our profession as youth health physicians you might see that the parents are not meeting the standards for the quality of parenting that we would like to see. And that these children are not yet suffering under the situation, that the parents think they're doing the right things, while we think they're not... That's of course when you start to feel, like, is this really safe for these children? |
| g FG3,1 | What happens is this accumulation of problems, possibly combined with poor skills... I really believe that if I should lose my job, my husband being unfaithful, my mother developing cancer, whatever, I'm not sure how I would react |
| **Developing a suspicion: frame of reference** | |
| h FG3,2 | That's what I find very difficult in the consulting room. To distinguish between "This is not how I would do it as a mother or as a professional", and what is really damaging for this child |
| **Developing a suspicion: contextual information** | |
| i FG2,2 | You might see a new baby in your office for the first time, but in fact you already have some information about what was found at the postnatal home-visit ... then a consultation here ... and at the back of your mind you may have aspects that make you think, well, I need to know a bit more about this, as they could represent risk factors |
| j FG3,2 | But it also happens to me that my assistant comes in saying, like, hey, this or that just happened [in the waiting room]. They sometimes tell me even before the parents come in, if they were really struck by something |
| k FG2,1 | But in the end, a number of factors coming together increase the risk of a harmful incident happening... It's that longitudinal aspect again, and getting information from various sources, in various ways, and as soon as there is something... then you take action |
| **Acting on a suspicion: team discussion** | |
| l FG3,9 | As long as all you have is a sense of alarm, you're not going to discuss everything with everybody. You first discuss it within your team |
| **Acting on a suspicion: discussing with parents** | |
| m FG2,5 | And you'd really want to work on prevention, by just openly discussing things with the parents and educating them about what a child needs |
| n FG1,3 | You try to use the right words, without being judgmental. When you just look at the situation and leave some room for discussion, to come to some sort of agreement .... So you really want to encourage them to get the best out of themselves and their children |
| o FG1,6 | Starting a discussion with the parent: I first saw this, now I'm seeing that. Just like the way you talk about height and weight, like, well, last time we were at this point and now, hey, this has come along as well. And I do see that, erm, that's what I would like to talk about. To me, that's the skill you need |
| **Acting on a suspicion: shifting criteria** | |
| p FG1,1 | So, you move along with each small change... Your criteria are shifting, and that's like a pitfall when you've known a family for a long time |
| q FG1,2 | That's also the advantage of being a locum, which is also very difficult, that who looks ata a situation and says, well, what's all this, and still my colleagues haven't intervened |
| **Acting on a suspicion: building a network for further diagnostics and support** | |
| r FG3,9 | [To a nurse] Why don't you go and pay them a visit? And use nutrition as the reason for the visit. But in addition to talking about nutrition, have a good look at the whole situation, to look at the interactions |

(Continues)
3.3.2 | Discussing with parents

CHCPs found it important to discuss their worrying observations with parents, not only to clarify the situation, but also to address the issue and raise awareness about the negative impact their behaviour may have on their children. However, using the term child abuse was not easy for CHCPs. They avoided the term, as they preferred an open discussion about their observations, without accusing the parents (quotes m, n, o).

3.3.3 | Shifting criteria

CHCPs acknowledged the danger of shifting criteria and accepting deviant situations because they were familiar with the family or saw a slight improvement, or because they would not like to lose contact with them. They then parked their gut feeling and postponed action. Locum CHCPs might look afresh at the situation and take prompt action (quotes p, q).

3.3.4 | Building a network for further diagnostics and support

When CHCPs suspected child abuse, they used clinical findings with a minor relevance as an argument for moving the next follow-up appointment forward or for asking the nurse to do a home-visit. Some CHCPs encouraged parents to send their children to kindergarten, where staff can evaluate children's behaviour and interactions with their parents and offer advice to parents, or they involved other professionals working in the PCHC and primary care (see quotes r, s, t, u, v).
3.3.5 | Documentation

Since parents can read the patient files, CHCPs tried to avoid explicitly documenting their suspicion of child abuse, but described observations that made them concerned (quote w).

3.3.6 | Reporting to the CACRC

As long as parents accepted some kind of support, CHCPs did not contact the CACRC for advice or to file a report. The CACRC was the option of last resort in a CHCP's management. CHCPs emphasised their preventive approach, and often felt that filing a report was not yet justified or would not do any good (quotes x, y, z).

3.4 | Reflection

3.4.1 | Barriers for diagnosing and managing child abuse

Most participants said that the increasing use of guidelines and the pressure to record everything did not improve the quality of their work. CHCPs became stressed by having to tick so many boxes, or they adopted a defensive attitude to prevent that parents might complain to a disciplinary tribunal. Remarkably, participants mentioned that there was no space provided in the patient file to document a gut feeling. And the fact that parents could read the patient file was another serious problem, as it restrained CHCPs from ticking the child abuse box. (quotes aa, bb, cc) Parents visit CHCPs voluntarily, so they must remain motivated to come, and not have the impression that the CHCP only checks on the quality of their upbringing. And although accumulating problems such as debts, stress, poor housing or unemployment are known to be risk factors for child abuse, they were mostly regarded as unsolvable. Having a gut feeling but not being able to find any clear trigger gave at least one CHCP a rather helpless feeling (quotes dd, ee).

3.4.2 | Need for further training

A recurrent topic was the communication with parents: how to raise concerns, how to communicate without inducing resistance, how to make parents aware of shortcomings in their parenting while at the same time offering practical solutions. How could CHCPs encourage parents to do their best, as in most cases they actually love their child? CHCPs in all groups emphasised their need for more communication skills training to improve their impact.

4 | DISCUSSION

CHCPs considered prevention and early detection of child abuse, an important part of their job. Among other triggers, a gut feeling that ‘there is something wrong here’ acted as an early alert to look for the triggering cue(s), by observing more closely and asking relevant questions, and to discuss their suspicion with their team. In assessing a suspicious case, they struggled to decide whether it was a matter of child abuse or of a lack of parenting skills, and how their own values influenced their judgment. CHCPs took contextual information derived from various sources into account when considering child abuse. When faced with a suspicion, CHCPs often discussed it within their team, in order to reach agreement about a plan of action. CHCPs found it important but still difficult to discuss their worrying observations with parents, to explore the situation and seek opportunities for support. They avoided the term child abuse, instead aiming to motivate parents to improve the situation. They mentioned the danger of shifting boundaries and postponing action, as well as their efforts to build a supporting network, and the problems associated with documenting their suspicions. Involving the CACRC was considered a measure of last resort only. The increasing pressure to record data did not benefit the discussion with the parents as it took up so much of their time. CHCPs emphasised their needs to improve their communication skills.

In our view, the struggle Dutch CHCPs had after becoming aware of their gut feelings, was a key issue in our findings. CHCPs struggled to distinguish between child abuse or a lack of parenting skills, and how to communicate their concerns with parents. Their focus was on prevention of child abuse and they considered the guideline regarding actual child abuse not helpful. CHCPs struggled with explicitly documenting their suspicion. Finally, they felt resistance against involving CACRC.

This was the first study about the role of gut feelings in clinical reasoning and their follow-up in the domain of Preventive Child Health Care. The strength of this study was the qualitative approach of using focus groups, which yielded valuable insights into the CHCPs’ work. The vivid and open discussions showed that child abuse was a topical issue in their work. A member check ensured the validity of the results. Since the work situation of CHCPs in the south of the Netherlands, where we did our study, does not differ from that in other areas in the country, we may assume that our findings also apply to other Dutch CHCPs. The study design we chose was similar to that of a previous study among FPs on the same topic. 17 This approach enabled us to compare the results regarding both professions working in the youth health care chain.

A limitation of our research was that we did not examine the predictive value of gut feelings in relation with child abuse. We focused on how gut feelings function in the clinical reasoning process of CHCPs concerning child abuse. Based on previous studies, we are in principle of the opinion that gut feelings are not right or wrong, but might raise the suspicion of a potentially serious problem, in our case that of child abuse, and might induce further diagnostics and actions. There have been many studies, showing the positive predictive value of gut feelings that lead to working hypotheses such as cancer, lung embolism and serious childhood infections.26-28 Child abuse is often hidden, and a gut feeling might be an important signal to become suspicious, to observe more closely and to examine the child better.
Such an uneasy feeling may, for instance, arise from observing a lack of parenting skills and induce CHCPs to discuss their uneasiness with the parents. Non-analytical, intuitive reasoning is a vital part of diagnostic reasoning and stimulates physicians such as CHCPs and FPs to switch to analytical mode.\textsuperscript{19}

Other studies among CHCPs have found that effective communication with parents about child abuse was difficult, and our results confirmed this finding.\textsuperscript{13,14} There is a large grey area between observing a lack of certain parenting skills and deciding it is a case of child abuse. We showed that CHCPs focussed on the prevention of abuse and therefore did not fully apply the Dutch child abuse guideline. Even in actual cases of child abuse, they hesitated to follow the guideline and report it as abuse, as long as they were able to improve the child’s situation. This finding might explain the low adherence to the guideline by CHCPs found in other studies.\textsuperscript{13,14}

The wording CHCPs used to describe their gut feelings was similar to how other physicians expressed it.\textsuperscript{29,30} Compared to FPs,\textsuperscript{17} the role of CHCPs is less self-evident: they have less authority, see parents only in connection with their small children, and seem to have to put in much greater effort to gain the parents’ trust. On the other hand, CHCPs might be better informed than FPs about the children’s situation because of their collaboration with nurses and other easily accessible professionals working closely with the family, such as district nurses, schoolteachers and the police. Observations made by nurses about parents and their children in the waiting room might also alert a CHCP. We may conclude that collaborating in a team of professionals enabled CHCPs to reflect upon consultations and to draw up action plans, based on joint responsibility. This might be an advantage they have over FPs.

CHCPs hesitated to use the term child abuse - as indeed did FPs - as it might hamper the communication with parents. Also, CHCPs mentioned that they sometimes doubted whether a situation was a case of child abuse or of a lack of parenting skills. CHCPs have to focus on the prevention of child abuse, much more so than FPs. In an early stage, they try to support parents to improve the situation of their child. The CHCPs considered these tasks to be crucial. CHCPs and FPs both had insufficient confidence in the CACRC. We found similar resistance in both groups against involving the CACRC or filing a report.

The accessibility of the patient file for the parents was a much bigger problem for CHCPs than it appeared to be for FPs. In the case of suspicions of child abuse, the parents’ right of access to their children’s electronic medical record is a key consideration, intended to protect children’s privacy and safety. However, electronic child records do have suitable privacy default settings and customizable controls to protect the privacy and confidentiality of children at risk of maltreatment. The participants in our study did not appear to be well informed about the possibility of blocking some notes for the parents. The electronic records mostly contain closed questions with only two response options (e.g. whether or not child abuse), but in practice it is often not so clear. Questions about gut feelings are lacking, so it remains unclear whether a sense of alarm has arisen and how the CHCP has acted upon it. In addition, a CHCP may have forgotten about their gut feeling at the next consultation, or a locum may be less aware of, or less attentive to, child abuse.

Although FPs and CHCPs are important partners in the primary care for children, in practice their collaboration did not appear to be self-evident and could be improved. Their knowledge about children and parents could be complementary. A strong point of CHCPs is their extensive network of professionals working closely with the families. Many parties are monitoring the situation, and a suspicion of child abuse may arise from the sum of their observations.

A key aspect of the work of PCHC is their focus on the prevention of child abuse. The lack of certain parenting skills is not the same as child abuse, but it could be the first step towards it. Parents might be fond of their children but still not act in their interest. In such situations, good communication skills of CHCPs and a relationship of mutual trust between parents and CHCPs are vital to intervene and prevent child abuse (or its continuation). The feeling among some parents that a CHCP is acting like a supervisory authority or an agent checking their parenting, could hamper the communication.

The CACRC stores a lot of knowledge about the prevention of child abuse, and it might be very useful for CHCPs to involve the CACRC at an earlier stage than is presently the case in abuse situations. However, the collaboration with the CACRC will only succeed in a situation of mutual confidence and shared responsibility. These conditions are not well developed, as can be seen from the low reporting rates to the CACRC.\textsuperscript{4} Mandatorily discussing even mere suspicions of child abuse does not seem a good solution for improving the collaboration between CHCPs and the CACRC.\textsuperscript{8}

Gut feelings support CHCPs in becoming attentive to child abuse or to situations which can lead to child abuse. The next step, discussing their suspicion with the parents, is a difficult one and the CACRC might actually be able to help make this step easier. Improving the collaboration between CHCPs, FPs and the CACRC could contribute to timely detection or prevention of child abuse in the youth health care chain.

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CONFLICT OF INTEREST
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DATA AVAILABILITY STATEMENT
The research data for this article are available to share.

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