# Child Abuse in Ethnic Minority and Immigrant Communities

## HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

### *Faculty*

**Alice Yick Flanagan, PhD, MSW**, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

### *Faculty Disclosure*

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

### *Audience*

This course is designed for physicians, nurses, social workers, therapists, mental health counselors, and other allied health professionals who may intervene in suspected cases of child abuse.

### *Accreditations & Approvals*

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*A complete Works Cited list begins on page 45.*

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NetCE designates this continuing education activity for 10 ANCC contact hours.


This activity was planned by and for the healthcare team, and learners will receive 10 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 12 hours for Alabama nurses.

AACN Synergy CERP Category B.

Social workers completing this intermediate-to-advanced course receive 10 Clinical continuing education credits.

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The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

***Disclosure Statement***
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***Course Objective***
The purpose of this course is to facilitate appropriate and culturally sensitive responses on the part of allied healthcare professionals to cases of child abuse and neglect.

***Learning Objectives***
*Upon completion of this course, you should be able to:*

1. Describe the historical emergence of child abuse and neglect.
2. Identify federal policies in the United States to address child abuse and neglect.
3. Define child abuse and neglect.
4. Outline the international prevalence of child abuse and neglect and variations in defining child maltreatment.
5. Discuss the impact of child abuse and neglect in the United States and Canada, particularly among ethnic minority groups.
6. Analyze how race, ethnicity, and culture impacts ethnic minority families' parenting styles and disciplining.
7. Identify the role of ecologic factors on the risk for child abuse and neglect.
8. Describe cultural theoretical frameworks to guide practice.
9. Discuss child abuse assessment, intervention, and training that consist of culturally sensitive best practice values.
10. Identify self-care issues and practices for practitioners working with child abuse cases.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

## INTRODUCTION

The United States' demographic landscape is diverse and multicultural, and minority and immigrant children are projected to constitute a significant population of the school systems in the United States in the near future. The non-White population of children younger than 15 years of age represented half of this population in 2018 [1]. In 2020, non-Hispanic White children younger than 18 years of age constituted 71.6% of minor-age population [3]. Hispanic children constituted 25.5% in 2020, and it is projected they will grow to 31.9% by 2060 [3]. In 2018, the District of Columbia, Hawaii, Washington, New Mexico, and California are the states/territories that had the largest number of non-White children younger than 15 years of age [1].

As of 2019, an estimated 26% of children younger than 18 years of age in the United States (18 million) reside with at least one immigrant parent [195]. This group tends toward lower socioeconomic statuses, and as of 2019, 31% of children of immigrants live with families with incomes less than 200% of the federal poverty line [195]. Almost 75% of racial and ethnic minority children live in poverty, and African American and Hispanic children are twice as likely as White children to experience food insecurity [12].

The process of immigration involves uprooting from the familiar—leaving one's homeland, family, friends, work, lifestyle, and in some cases, even value systems behind [4]. The adaptation process for immigrants often entails social, psychologic, and economic stressors. Many require new skills to navigate a new social and cultural system. Furthermore, immigrant families may be isolated, and isolation, along with the stressors, increases these families' vulnerability to child maltreatment and other problems [2]. Many immigrant families are reluctant to seek or accept formal assistance from medical and social service institutions given past experiences with oppression, fear of being deported, and general distrust of authority figures [2].

Despite these trends, the literature examining child abuse in immigrant and ethnic minority families is quite minimal when compared to the larger picture of child abuse/maltreatment research. In a meta-analysis of articles published between 1999 and 2002 on child abuse in America, researchers found that only 12% of the studies focused on ethnicity [5]. Of the 489 articles that did examine ethnicity, 52.3% found ethnicity to have a statistically significant effect on child abuse and help seeking, which emphasizes the importance of considering the role of ethnicity in child abuse and neglect.

Racial minority children are also over-represented in the child welfare system [48]. For example, in 2019, African American children constituted 14% of the child population in the United States, but they represented 23% of the foster care population [23]. In 2016, the rates of verified child abuse/neglect cases involving African American and Native American children were 1.51 and 1.59 times higher, respectively, compared with the general population [278].

Finally, when addressing child abuse with racial and ethnic minority families, practitioners should be knowledgeable about various cultures, values, and belief systems in order to formulate interventions that are culturally sensitive and competent [2].

## HISTORICAL OVERVIEW OF CHILD WELFARE AND PROTECTIVE SERVICES

### HISTORICAL VIEWS OF CHILDREN

The notion of childhood in Europe during the Middle Ages was very different from contemporary Western views. Childhood was not necessarily viewed as a distinct stage of the life cycle; rather, children were viewed as miniature adults [6]. It was not until the 15th and 16th centuries, with the rise of the middle class, that childhood began to be considered a separate developmental stage [6]. Many Renaissance scholars argued that children had their own unique needs, which were distinct from adults; however, this perspective was primarily held by the upper middle class [7].

A dualistic perspective about children emerged during the Reformation in the 16th century. Children were viewed as God's creatures, to be loved and protected, but also as sinful humans [8]. As a result, parents, teachers, preachers, and adults who were responsible for the moral upbringing and socialization of children were encouraged to use strict discipline to correct the evilness that was part of their human nature [8].

By the mid-19th century, a romantic perspective emerged and children began to be seen as the "torchbearers" of the future [7]. There was much emphasis on education, training, and the overall nurturance of children. The increase in industrialization and urbanization of the early 20th century resulted in heightened crime, poverty, and social disorganization, all of which affected children. As a consequence, social reforms targeted to children, such as child labor restrictions and compulsory education laws, began to emerge [93]. During the middle of the 20th century, there was increased emphasis on the rights of children, in part because of the grassroots movements advocating for the rights of disenfranchised populations [93].

### HISTORY OF CHILD ABUSE AND NEGLECT

The terms "child abuse," "child neglect," and "child maltreatment" are relatively new terms despite the fact that this social problem has existed through the ages. Records have documented cruelty to children by adults throughout the ages and across societies. Physical abuse has historically been justified because it was believed that severe physical punishment was necessary to discipline, to rid the child of his or her evil nature, and to educate children [9].

Sexual abuse of children, particularly incest (i.e., sex between family members), is very much a taboo. As early as the 16th century in England there have been concerted efforts to protect children from sexual abuse. For example, boys were protected from forced sodomy, and girls younger than 10 years of age were protected from forcible rape [9]. In the late 1890s, Sigmund Freud began seeing patients, many of whom were women and described memories of sexual abuse during their childhoods. Freud dismissed these as fantasies rooted in female psychopathology [192]. Freud's speculations contributed to later concerns about the reliability of sexual abuse reports [192]. As late as the 1920s, sexual abuse of children was described as an assault committed by "strangers" and the victim was perceived as a "temptress" rather than an innocent child [9].

The Massachusetts Adoption of Children Act of 1851 was the precursor of the modern U.S. foster care system [29]. In accordance with this Act, judges are required to determine if adoptive parents are fit to raise a child [29]. Between 1850 and 1919, the foster care movement was prominent in the United States, and it was within this landscape that the first child abuse case arose [29].

The first public case of child abuse in the United States that garnered widespread interest took place in 1866 in New York City. The child, Mary Ellen Wilson, was 10 years of age and lived with foster parents [10]. Neighbors became concerned that she was being mistreated; however, her foster parents refused to change their behaviors and said they could treat the child as they wished [9]. Because there were no agencies established to protect children specifically, Henry Berge, founder of the Society for the Prevention of Cruelty to Animals, intervened on her behalf [10]. He argued that she was a member of the animal kingdom and deserved protection. The case received much publicity, and as a result, the New York Society for the Prevention of Cruelty to Children was formed in 1874 [10]. By 1919, all but three states had juvenile courts. However, many of these nongovernmental agencies could not sustain themselves during the Depression [193]. Today, every state has a child protective services (CPS) system in place.

In 1946, a pediatric radiologist by the name of John Caffey published an article that talked about six young children he had seen with unexplained subdural hematoma and leg and arm fractures [193]. Although Caffey never used the word "abuse," it was implied, and this article generated some interest among physicians.

In 1962, Kempe and Heller published a study titled *The Battered-Child Syndrome*, in which they argued that battered-child syndrome consisted of traumatic injuries to the head and long bones, most commonly in children younger than 3 years of age and perpetrated by parents [11]. This is considered a seminal article in the child abuse field as it alerted both the general public and the academic community to the problem of child abuse [9].

Child abuse and neglect are now considered significant social problems with deleterious consequences. As noted, a system has been implemented in all 50 states to ensure the safety of children, with laws defining what constitutes abuse and neglect and mandated reporters of abuse.

## LEGISLATIVE RESPONSES IN THE UNITED STATES

There is some evidence of legal protection for children dating back to colonial America. For example, in 1642 in Massachusetts, there was a law that gave local magistrates the power to remove children from homes where parents were not "training up" their children [193]. In Georgia in 1735, an orphan girl was removed from a home where she was being abused sexually [193].

For the most part, in the 19th and early part of the 20th century, child protection responses were led by nongovernmental agencies [193]. Beginning in 1912, the federal government began to be involved. For example, the Children's Bureau was created, and the Sheppard-Towner Act was implemented to provide federal funds to health services for mothers and children [193].

The first major federal response can be traced to President Roosevelt's New Deal. A federal program for child welfare services was approved under the Social Security Act in 1935 [13]. The Federal Government provided grants-in-aid to states to assist in the development of state child welfare agencies and programs to deliver services to protect children. Over the years, the federal government has continued the funding, with the expectation that states will match the funds [13].

In the 1950s, there was an emphasis on maintaining children in their own families, referred to as child permanency, as studies demonstrated the negative effects of separating children from families for extended periods of time. The notion of child permanency is based on the belief that the family is paramount, the parent and child dyad is crucial for child development, and family stability has long-term positive impacts on children [14]. Ultimately, CPS must remove children from homes in some cases, and before this time, many children were in the custody of the state, without having any sense of permanency [14]. The emphasis on child permanency resulted in a move away from foster care placement and toward working with families to provide services to strengthen the family system.

In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was authorized under the Title XX Social Services Program. This federal legislation was targeted at states' responses to child maltreatment and focused on prevention, investigation, prosecution, and the delivery of a range of social services targeted to child abuse and neglect. It also encouraged demonstration research projects to examine how best to prevent child maltreatment and to evaluate various child abuse and neglect services [15; 16; 17]. This act was most recently re-amended in 2003 by the Keeping Children and Families Safe Act [17].

In 1978, the Indian Child Welfare Act (ICWA) was added to CAPTA to protect Native American children in the child welfare system [15]. Congress observed that Native American children removed from their homes were often placed in non-Native American homes. Furthermore, the mainstream judicial and social work systems were not familiar with traditional Native American value systems regarding childrearing and socialization, which resulted in labeling these homes dysfunctional [18]. The ICWA allows the tribe, instead of the state courts, to address issues of child custody and welfare for Native American children [19]. Ultimately, this act was intended to help maintain the integrity of the Native American nations, cultures, and families [18]. The ICWA has been criticized for being inadequately funded, for the lack of tribal involvement, and for reverse discrimination [194].

In 1980, the Adoption Assistance and Child Welfare Act was enacted. This act emphasized that foster care was not a permanent service; rather, it was crucial to reunite families by providing services to strengthen the family system [14]. This was a federal response to three main problems in child welfare at that time: an anti-family bias, causing children to be removed from their families without exploring other options; lack of individualized case planning based on each child; and a bias in federal funding incentives toward placing children in foster care versus returning children to homes or adoption [15]. This was further expanded by the Adoption and Safe Families Act (ASFA) of 1997 [16]. This act stressed time limits for foster care, reunification of the child with the family, and better linkage between child welfare services and other supportive services [14; 16].

The United States has continued to pass legislation to protect children. In 2007 and 2008, several states enhanced the review process for child fatalities [234]. During this period, Maryland, Missouri, Washington, California, Delaware, Maine, and Maryland passed legislation requiring a specific and systematic child fatality review process [234]. On a national level, CAPTA was reauthorized in 2010, which assists states to continue to provide services to identify and prevent child abuse and neglect [280].

In 2014, the Preventing Sex Trafficking and Strengthening Families Act was signed into law [240]. This law ensures that states implement mechanisms for reporting and collecting data on sex trafficking and identifying children who may be at risk of becoming victims of sex trafficking [240]. It also strengthens existing laws related to adoption incentives and the provision of services to foster parents [240].

In 2015, the Justice for Victims of Trafficking Act was enacted with the goal of providing grants to organizations and programs that deliver services for victims of child pornography and domestic child human trafficking and training for law enforcement officers, child welfare, and healthcare providers in order to better identify child human trafficking victims [279]. In addition, CAPTA modified the Comprehensive Addiction and Recovery Act of 2016 to include a provision for states to develop safety plans for the follow-up care of infants affected by substance abuse, withdrawal symptoms, or fetal alcohol syndrome [280]. In 2018, the Family First Prevention Services Act allowed federal funding for services for families whose children were at risk of being removed, including the provision of mental health, substance abuse, and parenting enhancement skills services [45]. Beginning in 2020, human resource employees working in a business with five or more employees are considered mandated reporters under the Child Abuse and Neglect Reporting Act [51].

## DEFINITIONS AND TYPES OF CHILD ABUSE AND NEGLECT

The federal definition of child abuse is formally established by CAPTA, which states that child abuse is any recent act or failure to act on the part of a parent or caretaker 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 [20]. A child (in this case defined as an individual younger than 18 years of age) victim of trafficking is also considered a victim of child abuse/neglect [20].

### FORMS OF CHILD ABUSE AND NEGLECT

There are several acts that may be considered abusive, and knowledge of what constitutes abuse is necessary for all healthcare providers and mandated reporters. In this section, specific behaviors that may be considered abuse and/or neglect will be reviewed.

#### Physical Abuse

Physical abuse injuries can range from minor bruises and lacerations to more severe neurologic trauma and even death. Physical abuse is one of the most easily identifiable forms of abuse and the type most commonly seen by healthcare professionals. Physical injuries that may be indicative of abuse include bruises, welts, burns, fractures, abdominal injuries, lacerations/abrasions, and central nervous system trauma [187].

Bruises and welts are of concern, particularly those appearing on:

- The face, lips, mouth, ears, eyes, neck, or head
- The trunk, back, buttocks, thighs, or extremities
- Multiple body surfaces

Patterns such as shapes of the article (a cord, belt buckle, teeth, or hand) used to inflict the bruise or welt should be noted. Cigar or cigarette burns are common, and they will often appear on the child's soles, palms, back, or buttocks. Patterned burns that resemble shapes of appliances, such as irons, burners, or grills, are of particular concern.

Fractures that result from abuse might be found on the child's skull, ribs, nose, or any facial structure. These may be multiple or spiral fractures at various stages of healing. When examining patients, note bruises on the abdominal wall; any intestinal perforation; ruptured liver or spleen; and blood vessel, kidney, bladder, or pancreatic injury, especially if accounts for cause do not make sense. Look for signs of abrasions on the child's wrists, ankles, neck, or torso. Lacerations might also appear on the child's

lips, ears, eyes, mouth, or genitalia. If violent shaking or trauma occurred, the child might experience a subdural hematoma [187].

### Sexual Abuse

Sexual abuse is defined by CAPTA as, "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children" [20]. Child sexual abuse can be committed by a stranger or an individual known to the child. Sexual abuse may be manifested in many different ways, including [21; 196]:

- Verbal: Obscene phone calls or talking about sexual acts for the purpose of sexually arousing the adult perpetrator
- Voyeurism: Watching a child get dressed or encouraging the child to masturbate while the perpetrator watches
- Commercial sexual exploitation and child prostitution: Involving the child in sexual acts for monetary profit
- Child pornography: Taking photos of a child in sexually explicit poses or acts
- Exhibitionism: Exposing an adult's genitals to a child or forcing a child to observe the adult or other children in sexual acts
- Molestation: Touching, fondling, or kissing the child in a provocative manner; for example, fondling the child's genital area or long, lingering kisses
- Sexual penetration: The penetration of part of the perpetrator's body (e.g., finger, penis, tongue) into the child's body (e.g., mouth, vagina, anus)
- Rape: May involve sexual intercourse, sodomy, or penetration with a foreign object without the victim's consent, and may include violence or the threat of violence. This definition is wide in scope and does not necessarily involve physical touching, contact, or physical force. Instead, it encompasses sexual intent against an individual's will. It also takes into consideration consent, as some cannot consent due to their age, disability, fear of harm, and/or state of consciousness or intoxication.

EVIDENCE-BASED PRACTICE RECOMMENDATION

According to the Centers for Disease Control and Prevention, management of children who have sexually transmitted infections requires close cooperation among clinicians, laboratorians, and child-protection authorities. Official investigations, when indicated, should be initiated promptly. Certain diseases (e.g., gonorrhea, syphilis, HIV, chlamydia, and trichomoniasis), if acquired after the neonatal period, strongly indicate sexual contact.

(https://www.cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf. Last accessed August 27, 2021.)

**Level of Evidence:** Expert Opinion/Consensus Statement

### Physical Neglect

Due to the ambiguity of definitions of neglect, the Study of National Incidence and Prevalence of Child Abuse and Neglect has attempted to standardize the definition [20; 22]. According to the study, neglect may include [20; 22]:

- Failure to provide adequate food, clothing, shelter, hygiene, supervision, education, and protection
- Refusal and/or delay in medical attention and care (i.e., failure to provide needed medical attention as recommended by a healthcare professional or failure to seek timely and appropriate medical care for a health problem)

- Abandonment, characterized by desertion of a child without arranging adequate care and supervision (e.g., children who are not claimed within two days or who are left alone with no supervision and without any information about their parents'/caretakers' whereabouts)
- Expulsion or blatant refusals of custody on the part of parent/caretaker, such as ordering a child to leave the home without adequate arrangement of care by others
- Inadequate supervision (i.e., child is left unsupervised or inadequately supervised for extended periods of time)

**Emotional Abuse/Neglect**

The following behaviors constitute emotional abuse and neglect [20; 22]:

- Verbal abuse: Belittling or making pejorative statements in front of the child, which results in a loss or negative impact on the child's self-esteem or self-worth
- Inadequate nurturance/affection: Inattention to the child's needs for affection and emotional support
- Witnessing domestic violence: Chronic spousal abuse in homes where the child witnesses the violence
- Substance and/or alcohol abuse: The parent/caretaker is aware of the child's substance misuse problem but chooses not to intervene or allows the behavior to continue
- Refusal or delay of psychologic care: Failure or delay in obtaining services for child's emotional, mental, or behavioral impairments
- Permitted chronic truancy: The child averages at least five days per month of school absence, and the parent/guardian does not intervene
- Failure to enroll: Failure to enroll or register a child of mandatory school age or causing the child to remain at home for nonlegitimate reasons
- Failure to access special education services: Refusal or failure to obtain recommended services or treatment for remedial or special education for a child's diagnosed learning disability

**Parental Substance Abuse**

Parental substance abuse falls into the category of child abuse and neglect in certain states [20]. This might include prenatal exposure due to the mother's use of an illegal substance, the manufacture of illegal substances in the presence of a child, or using substances that negatively affect caregiving abilities [20].

There has been some debate of whether exposing children to secondhand smoke is considered child abuse [241]. Some experts argue that if parents are informed by healthcare providers that the secondhand smoke is contributing to a child's illness (e.g., asthma, bronchitis) but do not make any attempts to protect the child from the smoke, it could be classified as child abuse [241].

**Abandonment**

In some states, abandonment is considered to be a type of child abuse or neglect [20]. CAPTA defines abandonment as, "when the parent's identity or whereabouts are unknown, the child has been left by the parent in circumstances in which the child suffers serious harm, or the parent has failed to maintain contact with the child or to provide reasonable support for a specified period of time" [20].

**Trafficking**

As noted, children who are the victim of trafficking are also considered child abuse victims [280]. Forms of child trafficking include forced labor, conscription, and sex trafficking. The 2015 Justice for Victims of Trafficking Act includes an amendment to CAPTA. In accordance with this amendment, states can track Sex trafficking victim data. This was again expanded in 2016 to collect and report data related to infants with prenatal substance exposure. In 2018, there was a total of 27,709 infants reported in the category.

## AN INTERNATIONAL PERSPECTIVE

When considering the implications of ethnicity and culture as they relate to child abuse, it is important to have an understanding of the global impact and experience of the problem. Particularly, there is controversy regarding whether various social problems are or should be considered child abuse and/or neglect.

### INTERNATIONAL PREVALENCE OF CHILD ABUSE AND NEGLECT

Worldwide, it is estimated that approximately 80% of children between 1 and 14 years of age have experienced physical punishment and/or psychological aggression by a caregiver in the past month [239]. This has been exacerbated during the coronavirus disease (COVID-19) pandemic. One in 10 girls younger than 18 years of age are believed to have experienced forced intercourse and other sexual acts [282]. In addition, estimates indicate that as many as 275 million (one in seven) children worldwide witness violence in the home. In a meta-analysis, 26.6% of children were found to have experienced physical abuse, 26% neglect, 19.6% emotional abuse, and 8.7% sexual abuse [283].

In some countries, child abuse and fatalities are the result of gender inequality and discrimination [24]. The United Nations Children's Fund (UNICEF) estimates there are 50 million unregistered births every year, and in some countries, particularly in some parts of South Asia, infants who are murdered within days of their birth are registered as stillbirths [25; 26]. Girls are often the victims of infanticide because they are viewed as an economic liability. In India, for example, high dowry payments can make girls a financial burden for parents [242]. In China, the ratio of male to female infants is 117 to 100, an imbalance that is attributed to female infanticide [27]. China also leads the world in reports of cleft-related infanticides [245]. In some countries, girls are targeted even before they are born. Gender-specific feticide (whereby a fetus is aborted based on a sex determination test indicating the child would be a girl) is relatively common in some countries, such as China and India. In India, it is estimated that 10 million female fetuses have been illegally aborted [243].

In addition, female genital mutilation/cutting (FGM/C) is a common practice in some areas of the world, predominantly in Africa. In a Ghanaian study, the overall prevalence was 11.7%, but FGM/C trends varied significantly by region [281]. It is estimated that between 100 and 140 million girls and women in the world have experienced FGM/C [244].

Ritual servitude is another potential form of child abuse or endangerment. In parts of Africa, mainly Ghana, Togo, and Benin, daughters younger than 10 years of age (due to their "virgin" status) are given to the priests in shrines in order to atone for sins and crimes of their dead ancestors [235]. These girls are generally expected to engage in sexual activity with the priest and elders.

Other independent studies support the UN's assertion that child abuse and neglect are common. In 2013–2014, there were 40,844 substantiated cases of child abuse and neglect in Australia [28]. A study of Iranian students 11 to 18 years of age found that more than one-third (38.5%) had experienced physical violence at home that resulted in mild-to-severe injury [30].

In a study of South African women between 15 and 49 years of age, approximately 21% disclosed having been forced to engage in sexual intercourse before the age of 15 years by a male relative [31]. One complication to obtaining data and an understanding of the extent of child sexual abuse is sanctioned forms, such as child marriages. Some countries and cultures are associated with high rates of child marriage [316].

## INTERNATIONAL DEFINITIONS OF CHILD MALTREATMENT

In Western industrialized countries, it is typical to subdivide abuse and neglect into different categories, such as physical abuse, neglect, sexual abuse, and emotional abuse. All of these acts are forms of psychologic trauma and may have lifelong consequences. However, the categorization of certain social issues, such as child labor, FGM/C, honor killing, and child prostitution and trafficking, has been debated as they are not easily placed into an established abuse category [32]. The difficulty in reaching a consensus in this debate stems from several factors, including acceptability of behaviors that occur in a complex, multifaceted cultural context; variations in beliefs about childrearing and socialization; and lack of a universal method to measure child abuse and neglect [32; 316]. All of these factors reflect the competing paradigms regarding universal rights and respect for cultural differences [236].

In some developing countries, the proliferation of poverty, gender inequality, political instability, and violence make it difficult to focus solely on child abuse and neglect, as these social problems are often intertwined with the issues of child welfare and protection [33]. Furthermore, social, cultural, and religious norms may hinder the ability of government or social organizations to fully implement protective policies. For example, androcentric cultural norms are deeply embedded in many countries, and to challenge the established patriarchal ideology would mean to challenge gender inequality and the structures that support this norm [33].

### Female Genital Mutilation/Cutting

It is beyond the scope of this course to resolve the complex questions of culture and child abuse or to uphold one position over the other. This becomes very clear in the case of FGM/C. FGM/C generally refers to the cultural practice of cutting away a part of or all of a girl's external genitalia for a variety of cultural and social reasons [25]. However, some groups participate in ritual cutting or piercing of female genitalia that does not result in the removal of tissue. The motivation or goal does not appear to be to intentionally harm the child (although the procedure often does); rather, this practice is reflective of a set of prescribed, deeply rooted cultural norms. In some cultures, FGM/C acts as a social mechanism to control female sexuality. In other cultures, FGM/C is a ritual to initiate girls into womanhood [25]. The World Health Organization categorizes the various practices of FGM/C into four major types [34]:

- Clitoridectomy: Partial or total removal of the clitoris and, rarely, the prepuce (the fold of skin surrounding the clitoris)
- Excision: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
- Infibulation: Narrowing of the vaginal opening (often to the width of a matchstick) through the creation of a covering seal formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris
- Other: All other harmful procedures to the female genitalia for non-medical purposes (e.g., pricking, piercing, incising, scraping, and cauterizing the genital area)

Prevalence rates of FGM/C are difficult to ascertain. One study found that rates ranged from 1% in Uganda to 98% of the female population in Somalia [284]. The highest rates of FGM/C are in Somalia [317]. It is estimated that, as of 2011, 500,000 immigrant women and girls in the European Union, Norway, and Switzerland in 2011 had experienced FGM/C [285]. There is some evidence that FGM/C rates are higher in rural areas (compared with urban areas) and in households with lower incomes [318]. Some countries (e.g., the United Kingdom) have laws in place making FGM/C illegal or traveling to another country for the purpose of performing FGM [284]. In some cases, physicians may be required to report FGM cases, regardless of the woman's/girl's age [284].

The question of whether FGM/C is child abuse remains. Some experts maintain that traditional cultural practices that may be unfamiliar should not necessarily be labeled as abusive [35]. In FGM/C cases, the adults do not explicitly intend to harm or punish the child; rather, the practice promotes cultural identity [35]. Similarly, male circumcision is a cultural ritual that marks a rite of passage for boys, and it is not considered abusive [36]. On the other hand, the literature demonstrates the host of negative short- and long-term repercussions associated with FGM/C, including severe scarring, infections, obstruction of urine and/or menstrual blood, infertility, postpartum hemorrhage, and death [246; 318]. Adverse psychologic effects, such as post-traumatic stress disorder, are also possible [246]. If a girl's parents are cognizant of the adverse consequences of the procedure, then is it considered abuse? Can and should culture be utilized to rationalize the use of practices that are shown to have adverse physical and psychologic consequences?

In some countries, such as Spain, FGM/C is a crime of injury [237]. Furthermore, instances in which healthcare professionals are aware of FGM/C or situations where a girl is at risk and do not intervene are considered crimes of omission, punishable by prison. The complex interaction of culture and values and the issue of rights is at the root of FGM/C. If countries implement strict control measures for FGM/C, this can have a strong impact on families. Surveillance and monitoring mechanisms, such as mandatory gynecologic exams for minors, can have negative effects on individuals' rights and dignity [237]. Clearly, the issue is complex and multiple questions arise.

### Childhood Conscription

It is estimated that approximately 300,000 children younger than 18 years of age are currently serving as child soldiers [37]. Child soldiers may be responsible for digging trenches, radio communication, performing guard duty, setting land mines, manufacturing bombs, and front-line fighting [247]. The majority of these child soldiers are 15 to 18 years of age, but some are as young as 7 years [238]. In one study with a sample of 330 former child soldiers of Uganda, the mean age was 10.8 years [238]. Of these children, 41.8% served as front-line soldiers and 99.7% were recruited by force. Isolation, witnessing violence, and forced killings are mechanisms used to control and indoctrinate child soldiers [286]. The atrocities these children witness and experience are beyond comprehension. Bayer, Klasen, and Adam conducted a study that included 169 former Ugandan and Congolese child soldiers who were on average 15.3 years of age at the time of the study [38]. Almost all (92.9%) reported witnessing a shooting, 89% witnessed someone being wounded, and 84% witnessed someone being seriously beaten. A total of 54% reported having killed someone, and 27.8% reported being forced to engage in sexual activity [38]. The experience of conscription among children produces emotional and psychologic trauma and a host of cognitive and behavioral problems [39]. In the Ugandan study, 33% of the children were diagnosed with current post-traumatic stress disorder, 36% were diagnosed with current major depressive disorder, and 19% had both [238]. In one study of 19 child soldiers, 18 had volunteered for service in the army and one had been abducted. Some of the children tried to run away or disobey, which resulted in beatings and imprisonment. In some cases, they were told to commit suicide. Although most of the children volunteered into the army, their participation became involuntary. Some also reported that they received educational and supportive services that they may not have otherwise obtained [39]. In one study of child soldiers in Colombia, the majority (83%) stated they joined an illegal armed group voluntarily, with 18% citing financial motivations [287]. If child soldiers escape and attempt to reintegrate back into their communities, they often face ostracism, ridicule, and a host of mental health issues [288].

Again, the issue of child conscription being defined as a form of child abuse is debated. The definition of childhood and adulthood varies tremendously across different cultures in the international community [40]. Although child soldiers are clearly victims, they may be viewed and treated as perpetrators when they return home [319]. Consequently, it raises questions regarding the extent of protection that should be provided, to whom protection should be provided, and how the rights and autonomy of the individual can be achieved.

### Child Labor

Child labor is defined by the International Labour Organization (ILO) as economic labor performed by a child younger than the minimum age specified for the type of work as defined by the nation (generally 15 years in the United States) and that is thus likely to impede education and/or development [188]. It is important to note the difference between child labor and child work. Child work has been defined as activities supervised by an adult that promote the development and growth of the child. Child labor does not benefit the child [41]. Essentially, child work is not considered harmful while child labor is [42]. Child labor is deeply rooted in poverty, the infrastructure and political stability of the country, and market forces [41]. It is also entrenched in power structures reinforced by institutional norms that perpetuate a master-servant relationship (i.e., the child laborer is considered property of the owner). The owner/adult often uses corporal punishment or abusive behaviors to instill fear in child laborers [320]. A study of child labor in the Pakistani carpet industry found that 68% of cases were attributed to poverty [289]. Often, the families did not have an adult wage laborer to provide for the family. However, some have argued that this work/labor dichotomy is too simplistic. The delineation of harmful or nonharmful work activities and range of work, and by extension the categorization of certain labor as abuse, remains a debated issue [42]. In general, forced labor and the implication of children in illicit activities are recognized as harmful [188]. However, the health consequences of child labor tend to be ambiguous, particularly if one uses the categories of hazardous and non-hazardous work [321]. For example, eradicating forms of child labor on health-related grounds may cause significant economic hardship to families, especially if the child brings in necessary income. Child labor is not a homogenous phenomenon [322].

It is difficult to estimate the scope of child labor; however, the ILO reports there are 17.2 million children worldwide engaged in paid or unpaid domestic work [248]. It has been predicted that the COVID-19 pandemic will trigger an increase in child labor [323].

A qualitative study explored the lived realities of Ghanaian children trafficked for labor to a fishing village in Lake Volta [249]. This fishing village received international attention for the extensive amount of child torture and death. One rescued child reported [249]:

> When we went to the fishing village, we fished day and night, rain or shine. We were asked to dive when the net is trapped. Every day was a fishing day. There was no time set aside for sleeping. We could be called at midnight to go fishing.

### Child Trafficking

Child trafficking has also been examined as a possible type of child abuse. The United Nations has defined human trafficking as [43]:

> The recruitment, transportation, transfer, harbouring, or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation includes, at a minimum, the exploitation or the prostitution or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude, or the removal of organs.

Obtaining a true understanding of the scope of child trafficking is challenging. Trafficking is a secret activity. Further, there is no universal definition or central database to monitor reports and convictions. Existing institutional corruption can also contribute to its invisibility [324]. Children are sold or kidnapped for a multitude of reasons, including labor, sexual abuse, commercial exploitation, domestic servitude, and illicit adoption [44]. Trafficking of children may be intra-regional (e.g., children from rural areas trafficked to urban areas) or inter-regional (e.g., children trafficked from one country to another) [233]. With the widespread use of Internet technology and social networking sites, chatrooms, and Internet video and voiceover communication, young children and adolescents may be trafficked after having interacted with a perpetrator on the Internet [233]. Migrant children are also at risk of being trafficked. With the migration crisis in Europe and the amount of transience, it is estimated that there are 10,000 unaccounted-for migrant children [290].

According to UNICEF, girls as young as 13 years of age, mainly from Asia and Eastern Europe, are trafficked as "mail-order brides" into Western Europe and North America. Children are also trafficked in West and Central Africa, mainly for domestic work but also for sexual exploitation and commercial labor. Nearly 90% of these trafficked domestic workers are girls. Furthermore, thousands of infants and children from Central and South America are trafficked for adoption in North America and Europe every year [25]. There have also been reports of "baby factories" in West Africa, particularly Nigeria. Young women are trafficked to produce children, and the infants are then sold for adoption. Because of the stigma of infertility among African couples, many adopt illegally [291]. In other instances, the infants are raised to a certain age then trafficked [291]. The causes of child trafficking are rooted in the political, economic, and social instabilities in many countries. In many cases, the act also reflects the gender inequalities inherent in the countries' institutional and cultural norms [44].

Like child abuse, child trafficking results in consequences to the community and the individual, which ultimately undermine child development. For example, children who are trafficked for sexual exploitation experience physical and sexual abuse, resulting in long-term psychologic trauma [324]. Several factors make children particularly vulnerable to sexual trafficking, including the cultural myth that having sex with a virgin can cure human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and the increased popularity of Internet-based child pornography and child sex tourism [25]. If victims of child trafficking are rescued, reintegration back into the community is a challenge given the stigmatization [46]. Clearly there are adverse consequences to human trafficking, and the consequences may be compounded in childhood. However, questions remain regarding the categorization of this act as child abuse.

All of these social issues are complex and multifaceted. Professionals cannot simply take on a completely relativistic stance and justify all cultural practices as unharmful in the name of culture [46]. Simultaneously, it is important for professionals to avoid jumping to the conclusion that a cultural practice is deviant, bizarre, or abusive because it is outside of their own cultural experiences or beliefs.

## CHILD ABUSE IN THE UNITED STATES AND CANADA

A study of adults in the United States indicated that 14% recalled experiencing physical abuse during childhood [47]. In 2019, there were 4.4 million referrals to CPS agencies in the United States [250]. The majority (68.6%) of these reports were made by professionals. Girls tended to be victims at a slightly higher rate (51.4%) than boys (48.3%) [250]. The most common perpetrators were parents (91.4%); specifically, mothers were more often perpetrators compared with fathers (39% vs. 22.6%) [250].

As of 2019, 8.9% of children in the United States have been victims of abuse and/or neglect [250]. This is the unique rate, meaning it counts each child only once regardless of the number of reports of abuse/neglect. By far, the most common type of abuse reported in the United States is neglect, which accounts for 74.9% of reported cases. This is followed by physical abuse (17.5%), and sexual abuse (9.3%) [250].

There is some evidence that child abuse is on the decline in the United States. Between 2015 and 2019, the overall child maltreatment rate declined slightly from 9.2 to 8.9 per 1,000 children [250]. Approximately 1,840 children died of abuse and neglect in the United States in 2019 [250].

The accuracy of these statistical findings has been debated, with some attributing the change to a decrease in reporting, different standards for reporting, and changes in federal and state funding that have impacted child maltreatment services. One study hypothesized that the decrease in child sexual abuse cases was related to caseworkers' increased caseload size and inability to follow up adequately [50]. However, this hypothesis was not supported by analysis of data from the National Child Abuse and Neglect Data System. The researchers concluded that child sexual abuse may actually be declining. There has also been a decline in teenage suicide, juvenile delinquency, and teenage pregnancy, all of which are proxy indicators to child abuse [49]. However, it appears that cases of child neglect have increased. Compared to 1990, cases of substantiated neglect were up by 14% in 2003 [49]. The causes of the apparent decline in the prevalence of child physical abuse and the concurrent increase in child neglect have not been determined.

Research has shown that racial and ethnic minority children (particularly African American, Native American, and Hispanic children) have higher rates of reported child maltreatment compared to their White counterparts (***Table 1***) [250]. Studies examining prevalence of child sexual abuse in ethnic minority groups have yielded mixed results. These mixed results may be due to variations in definitions and methodologies used in the study of child abuse [52]. One study found that Latino and non-Latino children experienced rates of sexual abuse at 7.4% and 8.8%, respectively [52]. Another study found higher rates of child sexual abuse among African American children compared to Latinos [52]. However, there does appear to be one consistent trend: reported child sexual abuse tends to be lower in Asian countries as well as among Asian American families in the United States compared to the general population. It has been speculated that traditional norms about sexual activity or Asian cultural values such as filial piety, harmony, and collectivistic orientation impede Asian and Asian American children from reporting such abuse [52].

Overall, children of color are more likely than White children to be over-represented in child abuse and neglect reports in many Western countries, including the United States, and this has been identified as racial disproportionality [53; 251; 252; 325]. Aboriginal and First Nation children in Australia and Canada and African American children in the United States are over-represented in the child welfare system. For example, among African American children from birth to 18 years of age, the overall prevalence rate of child maltreatment is 21%; for White children, the rate is 11% [252; 292]. Some argue that the racial disproportionality exists at the reporting phase, while other data indicate it exists at the substantiation stage [251].

**CHILD MALTREATMENT RATES BY RACE[a]**

| Race | Maltreatment Rate (Per 1,000 Children) |
|---|---|
| African American | 13.8 |
| Native American | 14.8 |
| Hispanic | 8.1 |
| Non-Hispanic white | 7.8 |
| Asian American | 1.7 |

[a]The rates reported are for data from 2019.

*Source: [250]* *Table 1*

Not only are children of color over-represented, there is also indication they may move through the system differently in terms of length of placement, type of placement (e.g., greater use of kinship foster care), and services offered (e.g., less provision of mental health services) [197]. This trend has also been reported in Canada. In a large scale study of Aboriginal and non-Aboriginal families in Canada, Aboriginal children were over-represented at all phases of the child welfare system (first reports leading to investigations, substantiated reports, cases being kept open longer, and more frequent placement in out-of-home care) [54]. In another Canadian study, Aboriginal, Black, and Latino children were 1.77 times more likely to be involved in child abuse investigations compared to White children [55]. A 2019 study found that the rate of investigations for First Nations children was three times higher than that for White counterparts in Ontario, Canada [326]. In the United States, Native American Indian families had lower reunification rates compared with White families; however, Hispanic families have higher reunification rates [327].

Several factors might account for this disparity. It is possible that reporters, such as teachers, social workers, counselors, and other community workers, may be biased in the reporting of abuse [252; 328]. There is some empirical indication that although ethnic minority children are less likely to be viewed as being at risk for child abuse, case workers may be more likely to view a case that is under investigation as constituting abuse when an ethnic minority child is involved [53; 56]. Some experts argue that professionals have their own "professional ethnocentrism," whereby having been trained within the dominant culture's values, they see individuals from immigrant and cultural groups as being exotic, aberrant, or pathologic [46]. This perspective is also called the cultural deficit lens, which assumes that other cultures and their norms fall "short" and need correcting [198; 328]. In a series of focus groups conducted with community members, legal professionals, and caseworkers from communities in which there are a disproportionate amount of African American children being removed from their homes, caseworkers admitted they often used the benchmarks of appropriate parenting based upon their own experiences. Furthermore, some caseworkers admitted being fearful of going into unsafe neighborhoods; as a result, they tended to bypass some of the normal investigative procedures and simply remove the child [57]. Some choices may also be made based on stereotypes or behaviors outside of perceived norms [58]. For example, biases may lead professionals to believe rescuing a child from an "unhealthy" environment is better than placing the child with his or her large network of extended kin because of the misperception that such a network is "chaotic" [58; 328]. Related to biases, it is also possible that there is a disparity of services and resources allocated to racial and ethnic minority families, which then augments the risks for child maltreatment [252]. Practitioners' biases about kinship networks are not solely to blame; agency policies also tend to exclude willing caregivers from extended kinship networks from stepping in to care for children about to be removed [57].


According to the American Academy of Child and Adolescent Psychiatry, clinicians should be cognizant that cultural biases might interfere with their clinical judgment and work toward addressing these biases.

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**Level of Evidence**: Expert Opinion/Consensus Statement

Another bias may stem from practitioners' reductionistic perspectives about child safety and what factors are responsible for placing children at risk. In a study of the over-representation of Aboriginal children in Canada's child welfare system, researchers found it was not necessarily race or poverty of the case that influenced the decision making outcome of the case [199]. Rather, it was other factors, such as substandard housing, parental substance abuse,

and domestic violence, that predicted child protection decisions among practitioners. It is possible that child protective workers tend to identify individual causes (e.g., parental substance abuse, child's race, caregiver characteristics) more than structural causes (e.g., lack of access to resources). Whether biases exist on an individual level or on an agency level, it is important that the desire to help is tempered by a consideration of the role of cultural bias or racist attitudes in negatively affecting the helping process [58; 328].

On the other hand, some professionals, particularly those from the same ethnic group as the family they are working with, may deny or overlook instances of abuse because the family is very much like their own family and upbringing [46]. Professionals who adopt a cultural relativism perspective are hesitant to make judgments, believing that all cultures and their practices are equally valid [198]. It is also possible for practitioners to overlook abusive behaviors in an attempt to be culturally sensitive and avoid being called racist [59].

It is possible that there are more ethnic minority children in the child welfare system because the risk factors they are exposed to are greater. Immigrant and ethnic minority families, for example, are more likely to be poor, unemployed, and live in single-parent homes, all of which are risk factors for child abuse [251]. They may also reside in neighborhoods that are characterized as more socially disorganized. When neighborhoods have lower levels of cohesion and order, families cannot rely on neighbors for assistance, which increases stress [252]. In a study of Aboriginal children in Canada, researchers found that the over-representation of Aboriginal children in the child welfare system was related to poverty, parental use of alcoholism, and lack of housing [54]. In another study using an existing dataset from Texas' National Child Abuse and Neglect Data System, financial challenges, inadequate housing, and substance abuse among caregivers were the strongest predictors to foster care placement among African American children [293]. It has been argued that the experience of colonization and oppression exacerbate these environmental stressors. In Canada, the government attempted to assimilate many Aboriginal tribes by removing young children and placing them in Christian schools, causing devastating upheaval. These schools were in existence for more than 100 years, with the last school closing in 1996 [54]. A focus group study found that complex and interwoven factors of poverty, the breakdown of the traditional community and more supportive networks, and the disintegration of families all contribute to the disproportionate number of racial minority children, particularly African American children, being removed from their homes [57].

Some have argued that, because of this connection, there should be more social services available in these neighborhoods to serve as a buffer against child abuse. In one study, researchers found that African American families who reside in areas close to mental health services had lower rates of child neglect [294]. Closer proximity to substances abuse services or poverty services was not associated with improvements in child abuse or neglect rates.

It has also been suggested that practitioners make more "false positive" identifications of child maltreatment when working with immigrant and ethnic minority families [46]. False positives can result from a lack of familiarity with cultural beliefs, norms, and practices, or it can stem from professional ethnocentrism [46]. For example, some cultural groups have restrictions on hair cutting or bathing that could lead professionals to report child neglect if they are not familiar with the cultural practices [46]. In addition, differing beliefs about sleeping arrangements with young children could lead to allegations of sexual abuse. In a study with mothers from the United States and Guatemala, American mothers tended to move their infants out of their room by 3 to 6 months of age, while Guatemalan infants generally stayed in the parents' room much longer, up to their second year in life [60].

Not only are there disparities in the proportion of minority children entering the child welfare system, but there is evidence that suggests that their length of placement is longer than their White counterparts [197]. African American and Hispanic children are also more likely to be placed with kin compared to White children [197]. Although kin foster placement can be highly beneficial, there has been some evidence that there may be unfair treatment to kinship foster care parents, with these families receiving less financial support or services compared to other foster care parents [197].

In summary, families from racial and ethnic minority groups are often expected to conform to the norms and dominant culture in which they live; yet, many desire to raise their children to appreciate and continue to perpetuate their cultural traditions. Unfortunately, misunderstandings of certain cultural practices can lead to inaccurate reports of child maltreatment.

The questions that arise about the role of culture and child abuse and neglect are complex and multifaceted [59]:

- Can culture be a legitimate explanation for abuse?
- What is considered culturally acceptable and not acceptable as child discipline?
- What are reasonable cultural explanations for behaviors, and when do they override the rights of the child?

These questions do not have simple answers, and the goal of this course is not necessarily to provide quick, easy answers, but rather to raise practitioners' awareness of the range of issues. Furthermore, these explanations should not be viewed as mutually exclusive, but synergistically, contributing to an understanding of this very complicated issue [294].

## CULTURE, RACE, AND ETHNICITY

### CULTURE

Culture refers to the values and knowledge of groups in a society; it consists of approved behaviors, norms of conduct, and value systems [61; 62]. Culture involves attitudes and beliefs that are passed from generation to generation within a group. These patterns include language, religious beliefs, institutions, artistic expressions, ways of thinking, and patterns of social and interpersonal relations [63]. Culture can also represent worldviews, encompassing assumptions and perceptions about the world and how it works [64]. Culture helps to elucidate the reasons groups of people act as they do and respond to the environment as they do [65]. Culture is also shared among individuals in the same group across generations. It is the common ground that evokes certain feelings and ideas [200].

Kluckhohn and Strodtbeck proposed five different dimensions that comprise a worldview [66]:

- Human nature: How individuals view human nature
- Humans and nature: How individuals view themselves in relation to nature
- Time: How individuals view the past, present, and future
- Activity: How individuals view "doing" and "being"
- Relational: How individuals view social relations such as family and other social networks

Culture is not static; it is not merely inherited nor are groups of people passive recipients of culture. Rather, "culture and people negotiate and interact, thus transforming and developing each other. It is a process of continuous modification" [67].

Dividing cultural items into two categories, surface and deep structures, can assist in achieving cultural sensitivity [68]. Surface cultural dimensions include tangible and observable aspects, such as food, language, music, art, and clothing. Deep cultural dimensions, which are more difficult to identify and appreciate, include psychologic, historical, sociopolitical, and social forces [68].

### RACE

The term "race" is linked to biology and is partially defined by physical markers such as hair color, skin color, and facial features. Race may also be used to describe groups of people connected to a common origin or lineage [69]. The association of race with lineage is often used to explain why people are physically and culturally different [69]. Ultimately, value judgements are often associated with race and these differences [70]. Race has social, political, and economic ramifications, as it plays a role in stereotypes, discrimination, social arrangements of different groups, and access to various societal resources [70]. When skin color is used to identify culture, it may not be an accurate measure [71].

### ETHNICITY

In some ways, the term "ethnicity" refers to both culture and race [69]. Some have argued that the defining characteristic of an ethnic group is a subjective feeling of belonging. Ethnicity is closely related to culture, as ethnic groups often share common cultural traits that differentiate them from other groups [72]. However, ethnicity is now seen as more than just culture; rather, it is a category involving a group's socially constructed identity, at times based on class, politics, and sociopolitical factors [72].

## IMPACT OF CULTURE ON CHILDREARING

### PARENTING STYLES AND SOCIALIZATION

Just as there are multitudes of parents, there is a vast array of different parenting styles and socialization goals. Generally, the goal of many parents is to socialize their children to become self-reliant, productive, and responsible adults. How one accomplishes these goals is influenced by cultural norms. One example is the authoritarian parenting style, which is characterized by an emphasis on controlling the child's behaviors based on absolute standards, obedience, and respect for authority [73]. In Western societies, an authoritarian parenting style is regarded more negatively, and some believe it to be associated with negative outcomes such as poor self-esteem, poor academic achievement, and greater levels of aggressive behaviors [74]. In Western cultures, such as the United States, values focusing on individualism and autonomy often promote childrearing strategies that encourage children to explore their environment more independently.

The issue of immigration and acculturation will inevitably influence immigrants' parenting behaviors, as values in the host country may compete with established cultural belief systems. Part of the acculturation process involves adaptation and coping. In general, studies have shown that as immigrant parents reside longer in the United States, they become less authoritative and have more open communication with their children. There is more negotiation between parent and child, and fathers become more involved in parenting [201]. However, this does not necessarily mean that traditional cultural beliefs and values disappear.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The American Academy of Child and Adolescent Psychiatry recommends that clinicians should evaluate and address in treatment the acculturation level and presence of acculturation stress and intergenerational acculturation family conflict in diverse children and families.

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**Level of Evidence**: Expert Opinion/Consensus Statement

Asian parenting styles have also been described as authoritarian; yet, the authoritarian style is equated with parental concern, caring, and love in many Asian cultures [74; 75]. Asian cultures also emphasize relational socialization goals, such as obeying elders and parents, maintaining harmony, and caring for others [202; 329]. Many Asian parents emphasize the importance of moral training that aligns with Confucian principles, in some cases using authoritarian parenting styles (including physical punishment, guilt, and shame) [329]. As a result, Asian authoritarian parenting styles include harmony while focusing on achievement that will bring honor to the family. Some studies have found a positive relationship between authoritarian parenting and outcomes; for example, authoritarian parenting styles were correlated with higher academic achievement in a study of Chinese students [76; 253]. One study with 251 parents found that Chinese mothers tend to be more psychologically controlling of their children compared to both White and African American mothers [254]. The Chinese mothers' sense of worth was dependent on their children's performance, which may explain this tendency.

This concept may also be more fully understood if it is examined from the perspective of collectivistic cultures. Again, these are global themes and there is tremendous diversity within all cultural groups. In many collectivistic cultures, the goal is to promote harmony and relegate individual needs to that of the larger collective group (i.e., family and community) [77]. Chinese parents, for example, are charged with training their children to be cooperative, to respect their parents and elders, to learn self-control, and to value the needs of the group, all of which conform to Confucian principles [74; 78]. In Chinese culture, then, it is believed that parents who do not discipline their children effectively are abusive [74]. Affectionate and highly expressive behaviors among Asian parents are not the predominant parenting styles because a major lesson for children is the value of self-control; highly expressive and emotive behaviors are considered inappropriate [78]. However, the perception of Asian American authoritative parenting may be rooted in a comparison to White/European American parenting styles in the United States. In one study, the most common parenting style among Chinese parents was a supportive style [295].

The level of adherence to authoritative parenting styles may also depend on the level of acculturation. In a qualitative study with 20 highly educated Korean parents from middle to upper-middle socioeconomic brackets, the parents described trying to strive for Western norms of autonomy and individuality in their parenting, wanting to promote their children's sense of freedom in exploring the world around them [255]. However, they do limit freedom when it comes to academic achievement [296].

Just as there is heterogeneity within specific groups, there are obviously marked differences within collectivistic cultures. Studies that show that indulgent parenting styles (high degree of parental affection, acceptance, and emotional expressiveness) in some collectivistic countries, such as Spain and Italy, yield similar results in terms of children's level of self-esteem and adjustment compared to children socialized in Asia [79]. Similarly, in Hispanic/Latino groups, which are also characterized as collectivistic, childrearing practices have been described as very nurturing and permissive, with more emphasis on interdependence versus independence [80].

These seemingly contradictory findings about collectivistic cultures may be partially explained by the diversity within collectivistic cultures; some researchers subdivide these cultures into two categories: horizontal and vertical [81]. Horizontal collectivistic cultures emphasize egalitarian relationships, while vertical collectivistic cultures focus on relationships within a hierarchical structure.

However, it is also likely that divergent cultural values may contribute to differences in parenting styles in collectivistic cultures. It has been proposed that *machismo* influences parenting styles in Hispanic/Latino cultures. *Machismo* refers to a set of ideals placed upon Hispanic/Latino men, including physical strength, virility, and bravery [82]. Men are often considered to be dominant figures in the family structure [83]. This *machismo* attitude may promote rigid gender role expectations and misogyny [83]. It is also speculated that *machismo* adherence may influence more authoritarian parenting and punitive disciplining styles in Hispanic/Latino cultures. In one study of 150 Hispanic, African American, and White parents, *machismo* significantly predicted use of physical punishment by fathers regardless of ethnicity [84]. This supported an earlier study of Guyanese parents in which parents who were less nurturing and who tended to use more physical punishment were associated with *machismo* ideals [83].

More recently, the stereotypical portrayal of *machismo* and its effect on Mexican fathers' parenting has been questioned. For example, the positive dimensions of *machismo*, known as *caballerismo*, consist of dignity, honor, respect, and the role of men as providers. These values can lead to greater involvement of fathers with their children in Mexican families. In one study, Mexican children whose fathers who had higher levels of *caballerismo* reported greater positive father involvement [203]. However, other studies have conflicted with these findings [204]. It is important to remember that no simplistic cultural generalizations can be made when working with culturally diverse groups.

The concept of raising children to be *tranquilo*, *obediente*, *y respetuoso* (calm, obedient, and respectful toward adults) also underlies much of childrearing among Hispanic/Latino families [85]. In Mexican families, a well-educated child has been taught to treat others with courtesy and respect [80]. As a horizontal collectivistic culture, Hispanic/Latino families highly value respect because it accords worth to individuals regardless of their social hierarchy [82]. It has been said that Hispanic/Latino parents are more likely to make unilateral decisions on the behalf of their children and the children are expected to conform to their parents' decisions in part because of the emphasis on respect [86]. In focus groups with Dominican and Puerto Rican mothers and their adolescent children, Guilamo-Ramos and colleagues found that mothers expected their children to obey them, which was expressed through cultural values revolving around respect [86]. However, this does not mean their parenting practices were harsh; rather, the children knew they were loved, but the mothers acknowledged that "tough love" was used. These ideals may be retained, in part or entirely, in Hispanic American families.

The historical legacy and the pervasiveness of racism and discrimination in the United States has led many African American families to view parenting and childrearing as preparing their children to cope, manage, and succeed in an often oppressive and hostile environment [87; 88]. In a 2001 case study of two middle-class African American families, the theme of racial socialization was a key component in childrearing [89]. Racial socialization refers to the process of raising children to be healthy adults acting in a prosocial manner in a society that has a negative view of African Americans [89]. Some experts argue that this is a prominent dimension of childrearing for African American families regardless of socioeconomic class [89]. In a 2014 study with African American parents of adolescents (12 to 14 years of age), the parents reported desiring to verbally communicate with their children. For more serious situations, they tended to exhibit a firm use of disciplinary tactics [256]. It is speculated that African

American parents are attuned to racism displayed by the police toward African American adolescents, and consequently, they desire to eliminate negative and perceived antisocial behaviors [256]. In families concerned with racial socialization, demanding children's respect, obedience, and proper behavior in both the public and private arenas is essential [87]. Respect is highly valued because it involves exhibiting honor to elders and authority figures and acknowledging their wisdom and past experiences. This is consistent with literature that underscores the role of elders and other responsible adults in socializing children [88]. It has also been postulated that the emphasis of respect and the use of more authoritarian parenting styles among African Americans in part stems from their experiences with racial discrimination. Focus groups with low-income African American mothers found that the women tempered their "tough love" with demonstrative caring [205]. Teaching children early on to obey their parents and to change seemingly innocent behaviors rapidly is a means to protect their children from harm [206]. In a 2010 study, African American mothers expressed concerns about spoiling their children, even as infants. They also adhered to stronger beliefs about using punishment compared to the White mother participants [207].

Raising children so they are familiar with African American historical roots and kinship ties is also an important dimension in African American families [88]. The literature has consistently documented the importance of family in African American culture. This includes not only the immediate family unit but the extended family system [90]. The extended family plays a central role in childrearing [91]. During financially difficult times, Caribbean families adhere to a concept referred to as child fostering, whereby extended family members or fictive kin step in to rear children. This allows a family member to leave the area or country to look for employment without worrying about leaving children behind. The parent who leaves is not totally absent; he or she generally continues to maintain contact and provide financial support [92].

## DISCIPLINE AND CORPORAL PUNISHMENT

Discipline is a set of rules, norms, and consequences established in a family system to regulate children's behaviors with the overall objective of teaching children to act in a prosocial manner and to become responsible adults [94]. Discipline methods are much debated, particularly if physical or corporal punishment is used. Corporal punishment has been defined as punishment that inflicts physical pain [95]. Legally, it has been defined as comprising "reasonable force" [208].

It is estimated that 71% to 99% of parents in the United States use physical punishment during the course of a child's life [96]. In one survey study, almost 75% of Americans agreed or strongly agreed that a "good, hard spanking is necessary to discipline a child" [297]. However, a 2019 study found the past-year spanking rate was 37% for children younger than 18 years of age, supporting several studies reporting a decrease in spanking between 1988 and 2011 [330]. The researchers argued that this decline may be attributed to the increasing public education and awareness promotions in the United States about the negative effects of corporal punishment. Most commonly this involves spanking. Spanking is defined as using an open hand to hit a child on the buttocks or other parts without leaving a bruise or causing physical harm [97].

Professionals generally do not advocate the use of spanking. In a survey of psychologists, 86% felt that one should never recommend spanking to a parent, and more than 75% felt it was unethical for professionals to recommend spanking [298]. Despite practitioners, educators, and scholars advocating against the use of corporal punishment, 94% of parents of toddlers still spank [208]. In a study of 2,573 African American, Mexican American, and White low-income mothers with toddlers, 34% of the participants with children 1 year of age indicated that they or someone in the household had spanked their child within the last week [209]. This number increased to 49% for those with children 2 or 3 years of age. African American children were spanked

significantly more than the White and Mexican American children, and there were no differences in frequency of spanking between White and more acculturated Mexican American families.

The decision of whether or not to spank is controversial and is associated with moral and cultural undertones. Some argue for no spanking at all, maintaining that it constitutes physical violence; others argue that it is an effective means to discipline [97]. Three perspectives on spanking have been identified [97]. The first perspective is pro-corporal punishment and embraces the belief that spanking is a necessary part of childrearing in order to teach and train children about positive behaviors. For example, some studies have found that spanking has the positive effect of gaining immediate results in cases with significant detrimental outcomes [208]. The second perspective is anti-corporal punishment. Those who fall into this category believe that violence ultimately begets violence and that harmful results will occur from spanking; they equate corporal punishment with physical abuse [210]. Some countries, such as Sweden, Germany, and Cyprus, have outlawed the use of corporal punishment and consider it abusive [95; 98]. The third view is the conditional corporal punishment perspective, which advocates that it is too simplistic to make a blanketed statement about the use of spanking being positive or negative. Rather, the effects are contingent on a range of factors, such as frequency, context, intensity, and other parent-child variables, such as how the parent delivers the response and how the child understands the response [97; 210]. It is important to note that healthcare workers with higher scores in terms of approval of corporal punishment have been found to be less likely to perceive and report child abuse [99].

In general, studies have found several patterns regarding attitudes toward corporal punishment. Within the United States, regional differences play a role. Individuals from the South tend to approve of the use of physical punishment, while persons in the Northeast are least likely to approve of spanking [100; 330].

Age and education are also predictors. Older adults and those with lower education levels tend to endorse the use of physical punishment compared to their younger and more educated counterparts [101; 102]. Religion also impacts attitudes toward corporal punishment. Christian individuals who take a literal interpretation of the Bible, particularly evangelical and fundamentalist Protestants, are more likely to support corporal punishment [103]. In general, persons who identify as members of a conservative religious organization are more likely to approve of corporal punishment [100]. In a national study, researchers found that more than one-third of conservative Protestants strongly agreed that spanking is an appropriate form of discipline. Younger age and higher educational attainment were correlated with decreased likelihood to endorse corporal punishment [299].

There is also variation across countries. Strong support for corporal punishment has been documented in Russia, Jamaica, and Barbados [98]. In one cross-cultural study, university students in Asian countries tended to approve of corporal punishment at greater levels than students from European universities [98]. In China, many believe that corporal punishment is acceptable and that beating a child is not antithetical to a display of love [300]. Countries with higher levels of economic insecurity and inequality have been associated with more frequent use of violent discipline strategies [331].

### Effects on Children

Regardless of intent, corporal punishment has effects on the children who experience it, some of which have long-term consequences. Although a clear causal relationship between corporal punishment and the emergence of antisocial or problem behavior in children and adolescents has not been clearly established, there is some evidence of correlation. In a large meta-analysis of corporal punishment and outcomes, use of physical discipline techniques was associated with one desirable outcome (immediate compliance), six undesirable outcomes in childhood (moral internalization, aggression, delinquent and

antisocial behavior, quality of parent-child relationship, mental health issues, and victim of physical abuse), and four adverse outcomes in adulthood (aggression, criminal or antisocial behavior, mental health issues, and perpetrator of family abuse) [104]. Research has linked spanking and physical abuse victimization, with spanking tied to adverse outcomes [301]. In a quantitative study, researchers found that women who justified husbands hitting their wives were more likely to approve of corporal punishment for children and their children were more likely to have experienced psychologic and physical violence [257]. An analysis concluded that corporal punishment has a relationship with children's initial antisocial behavior and with changes in antisocial behavior [105]. Some speculate that when parents use more aggressive discipline, children are less likely to learn empathy, which can lead to future antisocial and aggressive behaviors [302].

No evidence was found for differences in the effect of corporal punishment across racial groups. In a related study, parental use of corporal punishment was associated with an increase in children's externalizing behavior problems [106]. It is important to note that in all of these studies there was not proof of cause in the relationships. A study of university students from 19 different countries found that settings in which the rate of corporal punishment experienced by university students is high tend to be settings in which the rate of students assaulting and injuring a dating partner is also high [107].

**African American/Caribbean Families**

Some studies have found that African American parents use spanking, harsh disciplining methods, and physical punishment more frequently than White Americans, although more research is necessary to compare discipline techniques among ethnic minority populations [91; 104; 108]. In many African American families, discipline is viewed as a teaching method and is believed to be a part of the group's cultural norms [91]. In one survey of African American parenting approaches, participants continually reiterated the necessity and essentialness of discipline in childrearing [91]. They maintained that disciplining constitutes proper childrearing; however, many acknowledged that physical punishment as disciplining is not aligned with the dominant (White) values of childrearing. Endorsement of physical punishment was not believed to be child abuse among this group of participants [91]. This is consistent with Deater-Deckard, Dodge, Bates, and Pettit's argument that African Americans' use of corporal punishment is a cultural norm and is implemented with control used to socialize children versus corporal punishment used in an emotional and impulsive manner [211]. The key is that corporal punishment is not utilized impulsively, stemming from anger and frustration. However, this was not supported by a 2011 study with 453 White, Latino, and African American couples with children 3 to 7 years of age, which did not find that African American parents used corporal punishment with less emotionality or impulsivity compared to Latino and White parents [212].

In a qualitative study of 18 African American women 18 to 49 years of age, researchers explored the use of corporal punishment and its perceived effectiveness [213]. These women indicated that corporal punishment was an expression of love, with the aim of teaching respect and promoting the child's safety, and was also considered crucial for teaching life lessons necessary for survival. It was generally used as a last resort when other disciplining tactics were not effective. In addition, within the context of African Americans' experiences with oppression and racism, corporal punishment is seen as a way of teaching children to survive in a racist environment [332].

Studies of African American families and disciplining patterns do not all make linear, definitive conclusions that harsh physical punishment is the sole disciplinary tactic used. In a survey study of 176 low-income African American, Latino American, and White mothers, researchers found that preferred parenting strategies were more similar than different among the three groups [109]. Mothers from all three ethnic groups preferred praising their children as their first disciplinary strategy, followed by ignoring a behavior and spanking. Overall, the mothers

did not favor using harsh and punitive childrearing methods. Other studies examining the disciplinary patterns and practices of African American parents found that African American parents preferred to use rational means, such as discussions or lecturing, to physical discipline [87; 110].

Metaparenting involves a systematic type of parental thinking (involving evaluation, reflection, and anticipation) to help guide children back to positive behaviors. In one study, African Americans reported more metaparenting compared with White/European American parents [303]. In addition, African Americans and Mexican Americans tended to use reflection more.

Some experts propose that families who experience high levels of stress will use more punitive and harsh disciplinary strategies, in part because childrearing and caregiving are perceived to be arduous [111]. Due to multiple stressors that commonly occur in African American families, including single parenthood, racism/oppression, and socioeconomic factors, it is possible that this group is more prone to using harsh discipline. In a longitudinal study of 139 African American mothers, researchers found that perceived discrimination predicted health and depressive symptoms, which then decreased parenting practices characterized by high levels of involvement, vigilance, warmth, and nurturance [112].

Harsh disciplining has been documented in Caribbean cultures as well. Flogging is a common disciplinary strategy used for misbehaving Jamaican children [113]. Caribbean immigrant families in the United States are over-represented in child abuse cases, and many of these parents do not understand why their parental authority is being undermined when the cases are brought forth [113]. Some have speculated that the use of harsh discipline stems from the oppressive legacy of slavery, during which time cruelties and violence were rampant [113].

It has been speculated that African cultural beliefs about respect for elders and the role of education in training children into responsible adults facilitate the acceptability of corporal punishment [114]. In some African countries, such as Botswana and Kenya, caning is a common disciplinary practice even within the school setting [114; 214]. In Kenya, caning was banned in 2001, but many teachers still used it in the school setting in order to gain immediate compliance. In one study, teachers reported they felt that students misbehaved more since the ban [214].

Certain disciplining tactics are intertwined with cultural beliefs about childrearing and the symbolism attached to certain disciplining methods. In West African families, for example, suppositories of ginger root and/or pepper have also been used as forms of punishment, particularly to reduce sexually promiscuous behaviors [35]. For example, a girl who is perceived to be sexually promiscuous may be punished by inserting suppositories in her vagina, which then can result in pain and various infections [35].

**Hispanic Families**

Some studies have shown that Hispanic families use less corporal disciplining tactics. *Familismo*, the cultural value of the emphasis of the family and sacrificing for the family, is believed to influence this tendency [209]. Because of the collective values of family support and collectivism, there is less need for the use of physical punishments like spanking [258]. Caregivers' attitudes of *machismo* correlated with experiences of moderate-to-severe forms of physical punishment in a quantitative study with 736 racially/ethnically diverse undergraduate students [333].

Hispanic cultures are unique, and there are tremendous variations within the general Hispanic group. Acculturation also plays a role in these variations. In a large-scale survey study comparing foreign-born and native-born Hispanic parents, foreign-born parents were less likely to employ corporal punishment compared to their native-born Hispanic counterparts [258]. Using language as a variable to measure acculturation, Hispanic participants who answered written questions in English were less likely to respond favorably to physical punishment compared with those who responded in Spanish [332].

### Native American Families

Children are considered gifts from the Creator, and Native Americans believe that parents are the guardians of this gift and must teach their children respect and to honor their elders and tribal community [215]. In Native American cultures, the extended family unit is very involved in childrearing and disciplining. As oral historians and torchbearers of cultural traditions and wisdom, grandparents and other elders in Native American families often help with the socialization of children [216]. Furthermore, elders are viewed as the oral historians, who can help pass on traditions and wisdom through storytelling [216]. In one study, Native American parents who received more support from each other and others were less likely to use corporal punishment than those with little or no support [259].

In many Native American cultures, parents and extended family adhere to a belief in noninterference when disciplining and childrearing. This is based on a deep belief in fate and maintenance of harmony and peace within the family. Young children, such as infants and toddlers, are rarely disciplined because it is believed they are unable to discern right and wrong; older siblings often use scare tactics to divert younger children's attention from engaging in misbehavior [115]. Children's misbehaviors are not ignored; rather, the goal of discipline is to teach the lessons of life, using stories, and modeling [215]. As children get older, particularly during adolescence, same-sex siblings and cousins employ physical disciplining or directed verbal sarcasm. However, adult caretakers then "fend off" these "hurtful" words or behaviors. By "fending off" the discipline, caretakers demonstrate that the offending child is still loved [115]. This influential role of extended family members is supported by one study that indicated family, rather than peer group, was most influential in deterring the use of illicit substances in Native American adolescents [116]. It appears the boundaries between peers and family members are more nebulous in Native American families.

### Asian/Asian American Families

There is a common Vietnamese proverb that roughly translates to: "When we love our children, we give them a beating; when we hate our children, we give them sweet words" [117]. This idea that corporal punishment is a reflection of a parent's love is shared by many Asian cultures. Asian children are viewed as extensions of their parents, with the goal of bringing honor and pride to their families. As such, Asian children are expected to be obedient to their parents [117]. This unquestioning obedience is the foundation of parenting in many Asian cultures. Disciplinary practices commonly used among White Americans include time-outs and lecturing; however, this is not commonly practiced in Asian families. Asian parents frequently use physical disciplining, such as spanking with a hand or object [217]. In Singapore, caning is a prevalent and highly acceptable form of discipline [119]. Caning is often inflicted on a child's arm, palm, or buttocks. When used on these parts of the body, the wounds are often innocuous, but on other parts of the body or face, it may be extremely dangerous [119]. In a quantitative Chinese study, approximately half of parents reported having used corporal punishment in the past six months [334]. Mothers were more likely to use corporal punishment than fathers. Parents who had experienced corporal punishment as children were more likely to employ corporal punishment as parents. Verbal disciplining strategies may also be used, usually focusing on how the child shamed the family [217]. A survey of 89 mothers from Taiwan and Hong Kong found that the majority (91.4%) would use "power assertion," characterized as demanding immediate compliance.

Maintaining harmony within interpersonal relationships and respecting one's elders are paramount in Asian hierarchal family structures [77]. The Korean proverb *mae ga yak ida* (translated as "spare the rod and spoil the child") is commonly adhered to by many Korean families [126]. Another common Korean term is *sarangeei mae*, which translates to "whip of love," implying that parents whip their children out of love [118]. In general, Asian immigrants tend to believe only very severe physical punishment resulting in obvious injuries (e.g., fractures) constitutes child abuse [126].

Acculturation level can affect beliefs about disciplining. In a study with first-generation Korean Americans, parents viewed disciplinary tactics such as spanking and withholding affection as consistent with the Korean culture, and using time-outs, giving and removing privileges, and the use of sticker charts as American styles of discipline [218]. However, the longer the parents lived in the United States, the more likely they were to incorporate American disciplining techniques [218].

## CULTURE AND PERCEPTION OF CHILD ABUSE

Defining child abuse and child maltreatment is a complex matter. Hutchinson notes [120]:

> Both the sociocultural and social labeling perspectives challenge the sovereign role of professionals in providing the definition of child maltreatment. The sociocultural approach points to the varying expectations of caregivers across cultures and over time and cautions that the definitions of child maltreatment need to reflect cultural norms.

In most countries, sexual abuse is considered the most severe form of abuse. Most cultural groups limit or avoid talk about sex and sexuality; for children to discuss sexual acts is considered immoral. For example, African American girls live in a culture that stresses persevering and overcoming challenges and may feel that their sexual abuse is not a legitimate cause of complaint [219]. Other cultures may consider girls who are no longer virgins to be "ruined" or "spoiled," with the blame for this change falling to the girl regardless of circumstances [219]. Sexual abuse destroys children's innocence. Some experts and laypersons have expressed the belief that sexual abuse can facilitate hypersexualization, particularly among girl victims [304]. In a 2019 study with Vietnamese American students, the majority of participants did not believe that sexual abuse perpetrators could be relatives and felt that schools and homes were safe places. They also tended to believe that boys could not be victims of sexual abuse [335].

Abuse that involves physical aggression is also frequently viewed as abuse. In a study involving participants from the United States, Ghana, and Nigeria, the vast majority (95% to 100%) agreed that behaviors that involved a physical component and resulted in physical injury and pain (e.g., punching, kicking, burning a child with a hot object) were child abuse [260]. However, there is less agreement regarding the categorization of emotional and psychologic abuse and neglect. It becomes clear that definitions of child abuse are influenced by culture, race, and ethnicity. In one study of perceptions of child abuse among White, Chinese, and Filipino Americans, findings showed there were racial and ethnic differences in definitions [121]. In this study, White participants were more likely to rate behaviors as forms of abuse, particularly physical and emotional maltreatment, and to identify severe abuse, while the Chinese American and Filipino American participants were more concerned about parental sexual values and parental drug abuse and were more likely to view these behaviors as abusive. These differences may be attributed in part to the importance of parents' socialization of children in Asian cultures.

In a 2017 study in Beijing, participants tended to feel that the criteria for child abuse should focus on intent to harm and the severity of the harm being inflicted. They did not believe that biologic parents could abuse a child, only strangers [300]. In another survey study of 401 residents in public housing in Singapore, while more severe forms of physical punishment and physical neglect were considered to be child abuse, minor forms of physical punishment and emotional abuse were more likely to be viewed as acceptable [122]. Similarly, in a telephone survey of 1,001 Chinese participants residing in Hong Kong, the majority (80%) identified physical abuse as child abuse but often did not categorize psychologic abuse and neglect as child abuse [123]. By far, younger and more educated participants were more likely to view a behavior as abusive [123].

In a study of Korean mothers, participants generally felt that child abuse was a result of a parent's love toward a child [124]. As in other studies, education played a role. Mothers with higher levels of education tended to have more negative attitudes toward child abuse. Korean immigrant mothers who felt they had experienced discrimination as immigrants were more likely to approve of the use of corporal punishment [124].

A study with urban Native Americans found that the participants had very strong views regarding the classification of child neglect [220]. Overall, Native American parents rated the majority of the vignettes as violating standards of appropriate child care. In this study, the most serious style of neglect was identified as "unwholesome circumstances," such as parental substance abuse or parents' sexual behaviors and value systems.

It is also important to examine cultural differences in professionals' perceptions and attitudes toward child abuse, as these differences can affect reporting patterns. In a study of 80 Korean American pastors, participants stated that they were familiar with the child abuse reporting laws and felt that these laws were important to protect children [125]. However, when presented with various vignettes describing different types of maltreatment, the majority reported that they would recommend the family for pastoral counseling rather than reporting the incidents to child protective agencies. The majority (83%) also felt that the child abuse laws were at odds with child-drearing practices in Korean culture.

In a survey of health visitors in England, participants were asked to rank various behaviors according to the extent of which they could be considered child neglect [127]. The top signs of child abuse included violence against the child, the family deliberately excluding the child, the child left unsupervised or a young child attending to other young children, a home environment marked by criticism, signs of human or animal excrement, an unsafe environment, a child who was not well nourished, and unmet medical needs.

## ECOLOGIC FACTORS

Some experts have advocated for the consideration of the range of social and psychologic dimensions that contribute to social problems, including child abuse and neglect. Ecologic theory is a conceptual framework used to examine a social problem within a multi-level context: the individual, family, neighborhood, and community contexts, and sociopolitical and sociocultural structures [128]. Garbarino, who has applied the ecologic model to child abuse, argues [129]:

The overarching hypothesis generated by an ecologic analysis of child abuse is that destructive organism-environment adaptions are "permitted" by ideologic support for the use of physical force and by naturally occurring and socially engineered support systems that inadequately monitor deviance and fail to encourage effective parenting.

Ecologic theory organizes the various factors that may affect child maltreatment into four levels: macrosystem, exosystem, microsystem, and ontologic levels. It emphasizes that there is no single pathway that precipitates child abuse and neglect.

The strength of ecologic theory is that it has the ability to examine many variables, exploring both their direct and indirect influences on child abuse and neglect [221].

## MACROSYSTEM

The macrosystem level of ecologic theory includes the broad social and cultural values that affect the individual. Cultural norms about the justification of force or violence used to support conditions that lead to child abuse fall into this category. The lack of a consensus among professionals regarding a definitive definition of child abuse, neglect, and maltreatment can also play a role in confusing the identification, reporting, and criminal prosecution of child abuse cases [130]. Stereotypical cultural depictions can confuse definitions and perceptions of child abuse. For example, children may be simultaneously infantilized and hypersexualized. In racialized perceptions, African American girls may be viewed as "bad," overly sexual, or immoral, which can negatively affect reports of and responses to sexual abuse [337]. Overall societal attitudes about children and appropriate behavior can also affect parenting and discipline [131]. For example, if parents adhere to the cultural belief that children are the property of parents, this can breed child maltreatment [129]. Using the ecologic model to examine child maltreatment in Korea, the following macro factors were identified [222]:

- Alcohol drinking culture, particularly the mother's consumption of alcohol
- Views about corporal punishment, particularly a technique known as the "cane of love" (*sarangui mae*)
- Family adherence to Confucianism regarding parent-child relationships

Of course, the ecologic model is not meant to be deterministic or reductionistic. Cultural attitudes alone are not necessarily sufficient to lead to child maltreatment. However, coupled with a variety of other parental factors, such as lack of social support and inability to cope with the social stress, macrosystem issues can contribute to child maltreatment [129].

## EXOSYSTEM

The influence of formal and informal social structures, such as work, peer groups, support groups, friendships, school settings, community, and neighborhoods, on larger social problems and individual behaviors is referred to as the exosystem level. As an example, some argue that a neighborhood's social organization (or lack thereof) contributes to child abuse. When neighborhoods have high rates of poverty, there are often co-occurring effects, such as high residential turnover, crime, and violence, which result in higher levels of disorganization and general decline [252]. The amount of drug use in a community or city, for example, can also impact child abuse [305]. Greater availability of drugs in a neighborhood is associated with higher reported incidences of physical child abuse and neglect.

Individuals in these communities may have more difficulty trusting and collaborating with each other, which may correspond with higher rates of victimization and violence [132]. Neighborhoods with few resources to support parents and children may experience higher incidences of child maltreatment [132]. Some experts argue that parents experience more stressors and challenges, a risk factor for child maltreatment, when raising children in impoverished neighborhood communities due to the disorder and instability impinging upon the family system.

The COVID-19 pandemic exacerbated family stressors, which contributed to the rise of child maltreatment during this period. Research indicates that 20% of parents employed more discipline on their children during the pandemic; nearly 25% reported yelling at their children more, and 26.7% disclosed that they emotionally neglected their children. Parents experiencing more financial stress also reported an increase in parent-child physical and verbal conflicts [338].

As a second example, school systems are also considered part of the exosystem. Studies have shown that the school environment can serve as a protective buffer against the negative repercussions of child abuse. When children believe the adults in school are caring, they have positive self-esteem and self-concept, which may have been damaged by the abuse [133]. Teachers are also on the frontlines to witness children's behavior on a day-to-day basis, and when they witness behaviors or symptoms that are consistent with child abuse, how do they react?

### MICROSYSTEM

The microsystem level refers to the family unit or the immediate context of the child. This level includes the physical characteristics of the immediate family, interactions within the family system, and the child's perception of the familial environment [131]. Families characterized by greater relational stress, marital discord, poor communication, and conflict are more vulnerable to child neglect [261; 339]. A review of empirical studies that examined ecologic factors and child abuse/maltreatment concluded that there is no provable relationship between family structure and child abuse, but there are other studies that show a correlation between shorter intervals between births and child neglect [134; 261]. Inconsistencies in data collection and small sample sizes may have contributed to conflicting results.

Parental unemployment has also been linked to child abuse, likely a result of financial strain on a family. However, unemployment can also allow parents to spend more time with their children and enhance their quality time [306]. In the future, more studies are needed to examine these variables.

Other studies have shown a correlation between a family's socioeconomic status and child abuse; specifically, families from lower socioeconomic brackets are more likely to use force when parenting [135; 307]. It is believed economic conditions affect the quality of parent-child relationships due to the increased number of external and extenuating life stressors. Coupled with families' lack of knowledge of child development and parenting skills, this could contribute to child abuse [130]. It is possible that not having sufficient parenting skills can result in parenting stress and resultant child abuse [307].

### ONTOLOGIC LEVEL

The ontologic level refers to the factors inherent to the individual (developmental history, skill level, behavior patterns, and personality structure). Risk factors in this level that contribute to child abuse include parental substance abuse, depression, low educational levels, and experiences of interpersonal violence [130; 261]. In addition, parents' own childhood and early adult development can play a role in the perpetration of child abuse, causing the abuse to appear intergenerational [131]. Other ontologic risk factors include the child's age, coping skills, temperament, and personality. In one study, the greatest predictors of child neglect were related to parental factors, such as a history of antisocial behaviors, criminal offense, mental illnesses, and childhood abuse [308]. A study of children 11 to 17 years of age in Pakistan found that child maltreatment was correlated with the child's age, birth order, parental education, and maternal age [339].

Utilizing an ecologic model to discuss child abuse shifts the problem from being solely a parent-child issue to the true etiology and consequences of child abuse. It is important to note that the ecologic model is transactional; each level influences the others [129]. When examined in this manner, it is clear to see that child abuse is a multifaceted social problem, with ripple effects on multiple layers.

## CULTURALLY RELEVANT THEORETICAL FRAMEWORKS

Cultural relevance or sensitivity is defined as behaviors, attitudes, and policies that are aligned or harmonious with a group's belief and value systems and that ultimately enable agencies, communities, practitioners, policymakers, and researchers to work effectively in a cross-cultural situation [136]. Cultural sensitivity entails the "ethic or moral imperative to value and respect the beliefs, norms, and practices of

the people to be served" [137]. Culturally competent practice theories take into account how the social environment intersects at all levels [138]. Overall, cultural competence, awareness, and sensitivity are fluid processes. Each time a new patient enters a relationship with a provider, it is important to set a respectful tone and use the encounter as an opportunity to learn about his or her culture [262]. In this section, several theories will be highlighted and very briefly reviewed. It is not meant to be an exhaustive listing of all culturally relevant theories for practitioners when dealing with child abuse in ethnic minority and immigrant families. The application of these theories for child abuse assessments and interventions will be discussed in depth later in this course.

It can be argued that ecologic theory may be utilized to guide interventions when working with child abuse in immigrant families because cultural competency involves a multisystemic approach [139].

## LEININGER'S CULTURE CARE THEORY

Madeline Leininger, a nursing scholar, developed a theory for transcultural nursing in the 1950s as nurses' patient populations became more diverse [140]. Leininger argues that care is the essence of nursing, and care is inevitably linked to culture [141]. Because patients are cultural beings, the goal, according to Leininger, is to provide culturally sensitive and relevant care to individuals and families that is acceptable and consistent with the individual's/group's cultural beliefs and value systems [141; 263]. This theory emphasizes holism, or the idea that the whole is greater than the sum of the parts. According to the culture care theory, effective caring involves taking a range of factors into account, including the patient's religious and spiritual beliefs, language, cultural health beliefs, sociocultural milieu, and social, political, and economic environment [140; 142]. Cultural care promotes the use of culturally derived acts to support an individual or group. Health is then culturally defined by the individual or group [140].

## AIRHIHENBUWA'S PEN-3 MODEL

The PEN-3 model was originally developed by Airhihenbuwa for use to guide HIV prevention programs in Africa. Since then, the model has been used to understand cancer, diabetes, smoking, nutrition, domestic violence, and other social problems [264]. The PEN-3 model is a theoretical framework that places a social problem within a cultural context; culturally relevant health education and interventions can then be formulated [143].

The PEN-3 model has three interrelated dimensions, each with three components. The three primary dimensions are cultural identity, relationships, and cultural empowerment [143; 144].

### Cultural Identity

The cultural identity dimension is based on three components: persons, extended family, and neighborhoods and their roles in health education and interventions. As part of this category, healthcare professionals are asked to evaluate how individuals, extended family networks, and the community may be supportive or resistant toward the health education and intervention activities.

### Relationships and Expectations

The concept of relationships and expectations explores the perceptions of the targeted audience for the health education and intervention programs. Identifying factors that enable and nurture health behaviors is the main task in this dimension.

### Cultural Empowerment

Cultural empowerment entails examining the positive, existential, and negative components of the culture combined to empower individuals to adopt healthy behaviors. Positive behaviors involve beliefs or activities that assist in lessening the problem. Existential (neutral) behaviors are practices with no adverse health consequence. Finally, negative behaviors are beliefs and practices that are harmful and should be altered [143].

## KLEINMAN'S CULTURAL EXPLANATORY MODEL

Kleinman, a cross-cultural psychiatrist and researcher, argues that health behaviors are enmeshed in a cultural context [145]. How individuals make decisions about health, how they experience particular social problems and associated symptoms, and how and where they ultimately seek help are influenced by three sectors: lay/popular, folk, and professional [145].

### Lay/Popular Sector

In many cultures, the lay/popular sector is typically the first avenue to seek help when individuals experience a problem. This sector is comprised of friends, family members, and the community. The information available in this section is typically founded on general knowledge and wisdom. Self-treatment and family care generally fall under this heading [146].

### Folk Sector

An individual's cultural and social beliefs and value systems about health, illness, and healing are referred to as the folk sector. Religious practitioners and indigenous healers also fall into this category [145; 146].

### Professional Sector

The professional sector is closely aligned with Western approaches to health and illness. This sector involves professionals and healthcare providers who are considered "legitimate" in Western society [146].

## STRENGTHS-BASED PERSPECTIVE

The strengths-based perspective focuses on moving away from a client's deficits and emphasizing untapped strengths, competencies, and capabilities [147]. This perspective is based on the belief that all people have the capability for positive growth and change. Empowering individuals may assist them in accessing internal and external resources.

The central premises of the strengths-based perspective are [148]:

- The individual is viewed as the expert.
- The individual is the facilitator of change.
- The hierarchal power relationship between the individual and the practitioner should be minimized.
- Individuals should be provided the opportunity to reach self-identified goals and obtain new skills.
- Healthcare professionals should work with community stakeholders to change existing resource allocations.

The strengths-based perspective emerged as a result of the tendency in many disciplines to pathologize and blame the victim [148]. The concept of "blaming the victim" was first identified in 1976 [149]. This concept recognized that social problems in America are often blamed on victims' characteristics and value systems. In taking such an approach, practitioners working with families and children with trauma and abuse histories can help their clients to realize that they are survivors and they have "survival stories" [223]. Furthermore, acknowledging clients' strengths can build rapport [340]. Resiliency, hope, and survival are emphasized.

A common theme in these theoretical frameworks is the view that an individual's culture should be at the forefront when conducting assessments and formulating interventions. For example, some experts assert that the strengths perspective is suitable in working with Muslim patients in fostering hope and delivering services that incorporate social and multicultural dimensions aligned with religious value systems [265]. Instead of making Western interventions fit into the individual's cultural context, these frameworks emphasize a biculturalization approach for assessments and interventions. The biculturalization of assessments and interventions involves [150]:

- Identifying cultural values and beliefs to be incorporated into assessment and interventions

- Ensuring that interventions are congruent with the individual's and family's cultural norms
- Identifying indigenous interventions that can be incorporated into Western interventions
- Formulating a plan that promotes an individual's values and belief systems
- Explaining to the individual (and family) that the Western-based intervention will not negate the client's value systems but can work in harmony with indigenous interventions

## CHILD ABUSE ASSESSMENT AND INTERVENTIONS

### ASSESSMENT

Assessment for child abuse and neglect involves the systematic collection of data and being able to assess accurately and competently with professional judgment [266]. Information should be obtained regarding the primary reason for the visit, the family health history, the child's health history, the history of illnesses, the parents' attitudes toward discipline, and the child's pattern of nutrition, sleep, and diet [189].

It is important for professionals to ask questions in a nonjudgmental manner. A nonconfrontational manner is important to ensure the parent or caregiver does not feel accused [267]. The practitioner can inform the parent/caregiver of his or her duty to explore the concerns [267]. An environment where support and concern facilitate an open, trusting relationship between the parent and the practitioner must be created. Practitioners should reinforce the idea that parents are the experts on their culture and child [341]. By providing such an environment, the parent has the opportunity to voice concerns and ask for help [189]. Questions that convey concern and can provide valuable information to the professional include, "Who helps you care for your children?" or "How do you discipline your children?" [189]. Healthcare professionals should discuss how disciplining strategies might be influenced by cultural beliefs and norms and avoid using stigmatizing language [341]. It may be necessary to interview the child and parent separately; however, by spending some time with the child and parent together, practitioners can observe interactions and communication. Finally, it is vital to remember that risk and safety are on a continuum and not necessarily dichotomous entities (e.g., safe vs. not safe) [266].

It is also important to remember that many immigrant families and their children may not be proficient in speaking English. The assessment interview is too important for individuals to struggle to convey information in a language with which they are not proficient [224]. Families and children appear more competent and less depressed and anxious and are able to provide more details when they are speaking their native language. So, it is vital that the practitioner can speak the same language as the parent and child whenever possible. If that is not possible, a well-trained professional interpreter is necessary. However, the use of an interpreter should always be discussed with the family [341].

Accuracy in record taking is also important as it ensures continuity of care and serves to enhance risk management [268]. Be sure to record the date and time of the visit, sources of any information, and the date, time, and location of the alleged abuse or assault [190]. When talking to the child, the practitioner should use developmentally appropriate language that will be easily understood. Leading questions should be avoided [190]. Asking the following questions may be helpful when interacting with children [190]:

- Do you know why you are here today?
- Can you tell me what happened?
- How did it begin?
- What happened next?
- Where did this happen?
- Have you been hurt lately?

Because studies have demonstrated a correlation between child abuse and domestic violence, there is a need for dual screening for both types of family violence [191].

Assessment guided by a strengths-based perspective focuses on an individual's or family's strengths, coping strategies, and resiliencies. This is particularly crucial when assessing racial and ethnic minorities, as they are often depicted in a negative light in society [151]. As part of the assessment process, practitioners may ask individuals involved in family violence the following questions [152]:

- What do you believe is working well for you now?
- What difficulties are you experiencing now?
- What in your life gives you strength or a sense of meaning?
- What role does your family play in your life?
- How have you dealt with this experience in the past?

The goal is to give individuals the opportunity to tell their stories and frame their experiences from their own point of view. Patient-centered communication is crucial. The stories patients tell are personal and intimate, and they should have the opportunity to invite the practitioner into their lives instead of having entry demanded [309]. It is also key for the practitioner to avoid the use of jargon, which reinforces distance between the two parties.

Assessment guided by ecologic theory will address all four levels. At the exosystem level, it is important to explore how migration or immigration experience has affected the family system, childrearing, and coping ability. Immigration and migration, depending upon the circumstances, can infuse hope and new dreams with the vision of building a better life for oneself and family members. Or, it can be an experience fraught with loss, as existing social networks and supports are left behind [153].

When assessing immigrants, healthcare professionals should consider incorporating the following assessment questions of the individual and/or family [153]:

- Why did you immigrate?
- What is your documentation status?
- Who was left behind? Who plans to emigrate?
- What regrets or disappointments resulted from the immigration?
- How are you coping and adjusting to your new environment? Are some having more difficulties than others? If so, who?

Exploring immigration experience and status is crucial. In a research study involving immigrant parents in New York City who had a recent experience (within the previous five years) with child protective services, participants consistently indicated there was a lack of caseworker knowledge of the family's immigration status [154]. This lack of knowledge had serious implications, because it affected the families' ability to access services and to meet the mandated service plans, which then delayed reunification with their child [154]. For example, one family was mandated to attend a series of psychologic evaluations, parent education training, and other services [154]. However, the caseworker was not aware that the family had immigrated illegally and therefore was not eligible for free services. After several months of attendance, the family was told that they would have to pay for these services, which they could not afford. Similarly, participants in another focus group reported that interventions are often proposed without any sense of families' understanding of the requirements or ability to access the recommended services (i.e., ability to access transportation) [57]. "Cookie cutter" interventions are made without a comprehensive assessment of families' resources; these interventions are certainly not tailored to the unique needs of the families' social realities [57].

A technique referred to as "photovoice" has been studied, whereby research participants take photographs to express their thoughts and concerns about the child welfare system [225]. Using photovoice, a 2009 study found that the philosophies of the child welfare system were often dissonant with the belief systems of parents from minority cultural groups. Refugee parents stated that resettlement and adjustment to a new country was extremely challenging, with many living in high-crime and poverty-ridden areas. As a result of their dangerous living situations, they found themselves having stricter disciplinary practices to protect their children from harm. However, they felt that the social workers they encountered judged them harshly and undermined their parenting styles. They described how they needed support services and assistance rather than the social workers' negative evaluations of how they were raising their children [225].

Assessments guided by Leininger's, Airhihenbuwa's, or Kleinman's theoretical frameworks infuse the notion of culture into all aspects of planning. For example, the folk sector of Kleinman's cultural explanatory model focuses on the cultural group's social value systems about health and healing. When ethnic minority and/or immigrant families come to practitioners for child abuse, it is necessary to momentarily put aside any established conceptualization of abuse. It is important to hear from the individual or family what circumstances brought the family to the child protective system. Questions about parenting, childrearing, and disciplining must be asked. Many immigrant families come from countries where state involvement in family affairs is minimal and may have traditional cultural beliefs about parental disciplining [154].

### Identifying Harmful Practices in an Ethnically Diverse Population

It is simply not feasible to ask practitioners to be informed and familiar with every cultural practice and nuance. However, it is also unethical for practitioners to explain away certain practices in the name of culture. So, how then do practitioners determine the best course of action? A model has been created to assist practitioners in conceptualizing cultural practices along a continuum [35]. On one end of the continuum there are beneficial practices, of which the practitioner should promote the continuation. On the opposite end of the continuum lie harmful practices that must cease and should be prevented by the practitioner [35]. At the center of the continuum, there are neutral practices. These are behaviors that practitioners should learn more about in order to strengthen their cultural competency. There are also potentially harmful behaviors, which are not fully understood or recognized as abusive. In these cases, practitioners should engage in a dialogue with the family to evaluate the potential negative outcomes. It may then be necessary for the practitioner to educate the family. This framework is aligned with the PEN-3 model.

## INTERVENTIONS AND BEST PRACTICES

It is not surprising that greater cultural competence is correlated with patient retention and satisfaction. Using a sample of 1,305 participants from a statewide family preservation program, patients who perceived higher cultural competence among their providers had higher goal attainment and satisfaction with services [269]. Developing and delivering interventions that are culturally competent is a process and "should never be treated as a one-time initiative or as an after-thought" [139]. Building rapport with families and children is important. It is vital to keep in mind that immigrant families and children are often anxious and fearful, particularly with mainstream Western social and health services. A few strategies can help put the family at ease [224]:

- Snacks: When children are hungry, thirsty, or tired, they are less likely to talk or remember details. However, snacks should not be used as rewards for responses provided.
- Familiar ethnic objects: Familiar pictures, books, magazines, and/or toys will reassure immigrant parents and children and make them feel more welcomed.
- Non-uniformed officials: If the police must be involved in the interviews or sessions, they should be dressed in plain clothes to avoid scaring the family/child.

Building alliances and collaborative relationships with the community and other agencies and organizations is also key. Four tasks have been identified as beneficial for organizations and practitioners in order to build strong working relationships with stakeholders in ethnic communities. It is recommended that healthcare professionals should [155; 156; 157]:

- Develop a knowledge base about the demographics, values, norms, and cultural practices of ethnic minority groups. Case discussions about real life cases involving immigrant families can facilitate practitioners learning about new cultures. As part of practitioners' professional development, cultural experts may be invited to discuss real life cases of immigrant families. Of course, families should always be contacted to ask for permission, ensuring that confidentiality will be protected.
- Build relationships with stakeholders in ethnic minority communities. For example, practitioners can represent an organization or agency by attending events where immigrants and community leaders are present to begin developing relationships and alliances.
- Facilitate opportunities for practitioners and organizations to discuss stereotypes and generalizations regarding ethnic and cultural groups. For example, discussion during training workshops may reveal that practitioners hold preconceived notions that African American men are absent or marginally present in their families' lives. It is important to consider the possibility of stereotypes becoming self-fulfilling prophecy. In this example, if child welfare agencies ignore African American men as decision-makers, the men may feel as if they do not contribute in a positive manner to society. Such stereotypes should be identified and challenged.
- Form alliances with diverse communities. Many ethnic minority communities have "hidden" resources, in the sense that organizations are not familiar with the informal support networks. For example, in the African American community, churches, kinship groups, self-help groups, and voluntary associations are rich resources.

Cultural brokers are mediators or intermediaries serving as bridges between practitioners and clients/patients. They can facilitate understanding of the individual's cultural heritage as well as typically Western paradigms of health and mental health to those who find the concepts foreign [158; 341]. Cultural brokers are not usually trained in the area of health and mental health issues. In the context of this course, cultural brokers may be members of ethnic minority communities who could serve as "cultural consultants" [156]. As such, cultural brokers may be utilized in a variety of ways when dealing with individuals of a specific cultural group. Elders in ethnic minority communities could be solicited to help plan community education events sponsored by organizations or agencies. Because in many cultures, elders' experiences and wisdom are valued, the community may more readily accept events promoted by this group [155]. Cultural brokers can also assist

as interpreters or translators. English language proficiency is a major barrier to accessing services for many ethnic minority patients. Because of the complexities of child abuse, it is recommended that professional interpreters be used to assist in translating communications. Cultural brokers may also be ideal for helping to translate written information and contributing to the graphic design of brochures to ensure they are culturally meaningful. Finally, cultural brokers can help in laying a foundation for practitioners from agencies to enter into the ethnic community. This may be a needed link to the "hidden" informal support networks.

## INTERPROFESSIONAL COLLABORATION

Interprofessional collaboration is defined as a partnership or network of providers who work in a concerted and coordinated effort for the common goal of improving patients' health, mental health, and social and/or family outcomes [342]. Positive outcomes have been demonstrated on the individual and organizational levels with interprofessional collaboration [343; 344; 345]. However, implementing and promoting this approach can be challenging. For example, child welfare workers rarely engage with physicians or nurses; instead, these service providers focus primarily on investigations and the home environment. But understanding the patient's health context can assist in understanding family adversities [346]. Not understanding each other's roles is another barrier.

## PROFESSIONAL DEVELOPMENT

One way to support practitioners is to provide professional training and development so they have sufficient resources to handle the unique questions and issues that arise when working with diverse patients and the sensitive topic of child abuse. In reality, most individuals learn best when they have the opportunity to engage in the content and apply the information to real-life situations. Consequently, one-day training sessions may not be the most effective [270]. Coaching is one way to facilitate learning that results in sustainable change. Coaches can encourage the practitioner to question, evaluate, and reflect on specific information and can challenge the practitioner to apply new skills and reflect on their practice [270]. While organizations may not be able to offer coaching, training sessions can allocate time to ask questions that facilitate critical thinking and reflection.

### Cultural Knowledge

Some behaviors and practices are universally unacceptable (e.g., teaching a child to steal), but other behaviors may be culturally idiosyncratic or existential behaviors (from the third dimension of the PEN-3 model). These culturally rooted behaviors are neutral, with no negative health ramifications, but may be unfamiliar to practitioners. Examples are the use of coining, cupping, and *cao gio*, all of which are practiced by many Southeast Asians. Very briefly, coining, cupping, and *cao gio* are all traditional dermabrasion therapies intended to reduce the *phong* or "wind" in the body. Coining consists of a coin or metal piece being rubbed against the client's/patient's skin in order to remove the *phong* [159; 160]. Cupping is an intervention whereby one applies warm cups to the ailing individual's skin to draw the *phong* out [161]. *Cao gio* involves rubbing an ointment comprised of various oils including camphor, menthol, and wintergreen oil onto the body [162]. A spoon edge or a coin is then used to firmly rub the ointment on the body area for about 15 to 20 minutes, until a red mark is produced [162]. Based on yin-yang principles, moxibustion involves putting a piece of material (e.g., yarn, string) on the painful area of a patient's body and lighting the material on fire [347]. Healthcare professionals have at times misinterpreted marks from these therapies as being abusive. Teachers who notice red marks on their students' arms or back have attributed them to child abuse and have reported it as such [162; 347].

In Hispanic culture, there is a cultural practice (*hincar*) whereby children are disciplined by kneeling on uncooked rice [347]. There is some controversy regarding whether this should be considered abusive. In Namibia, there is a common cultural practice called child fosterage, whereby a child is raised by an extended family member, but the child may also have to perform household duties [348].

Three questions may help practitioners determine whether a behavior is abusive or culturally specific [351]:

- Are the children and family members/caregivers from an ethnic group?
- Does the group have such a tradition?
- Was the family member/caregiver motivated by the tradition when he or she acted?

Healthcare providers and other professionals are increasingly becoming educated about these practices in order to understand the health beliefs that surround these practices; therefore, they may be less likely to construe the marks as evidence of abuse.

**Immigration Knowledge**

Practitioners working with racial and ethnic minority families require some understanding of the stages of migration for different immigrant groups and the complex issues related to immigration status. It is important to understand that not all immigrant groups are the same. The variables that influence the pre-migration stage (prior to leaving their homeland), the transit or intermediate stage (the time before settling in their new homeland, which may include detention centers or refugee camps), and the resettlement stage will vary tremendously among immigrant groups [156]. Continuing education or independent study focusing on various nations and immigrant groups may be useful. Reviewing the migration journey for these groups can provide practitioners with a basis on which to build cultural knowledge [156].

It is also important for practitioners to understand how immigration status affects the lives of their patients or clients. For example, immigration status may affect individuals' ability to access services and benefits [154; 163]. When providing care for undocumented immigrants, practitioners may need to think "outside the box" to help families access informal community networks versus the traditional public benefits [154]. Immigrant groups may also be concerned regarding potential ramifications of interacting with government agencies [163]. Therefore, a basic, high-level knowledge of local and federal laws related to immigration and language access is necessary [163]. In reality, practitioners cannot know all aspects of immigration and how it affects service delivery within the context of child welfare and protection. Therefore, cross-collaboration with service delivery experts such as advocacy groups and immigration specialists is vital [226].

**Law and Ethics**

Practitioners should be familiar with appropriate child welfare legislative policies and their historical foundations, particularly the laws pertaining to racial and ethnic minority groups. For example, practitioners who work with Native American families should be familiar with the ICWA. A basic understanding of this act is needed to understand the services for which Native American families are eligible [164]. It is also crucial for practitioners to understand the historical backdrop that led to the legislation, as it may help practitioners understand the reluctance to accept government assistance [164].

**Training Methods**

The PEN-3 model can frame training for practitioners. Using the three dimensions of the model, practitioners may be encouraged to identify specific cultural values and norms and how they support or enable health education and interventions for child abuse, parent education, and childrearing. When practitioners project their own cultural values onto the patient or client, labeling "foreign" cultures as "bad" or "good," this can cause misunderstandings [165].

## PRACTITIONER STRESS WHEN WORKING WITH CHILD ABUSE CASES

Practitioners who work on child maltreatment cases can experience a tremendous amount of stress caused by the complex problems associated with child abuse and neglect cases. The organizational characteristics of child welfare agencies can also contribute to the stress experienced by practitioners. Child welfare agencies often operate on limited resources in terms of staffing and funding, which can affect services rendered. Practitioners attempting to access services may feel frustrated by seemingly overwhelming bureaucracies, which can contribute to feelings of helplessness. Mandated reporters may feel torn between the notions of family privacy and child protection [166].

Practitioners who enter the helping professions often do so because they deeply subscribe to the notion of contributing to society. Some beliefs and expectations held when child protection professionals begin their careers include [167]:

- "Family problems can be solved."
- "I can help, and families will want my help."
- "I should always understand and be empathic."
- "I will always be safe because I am offering services to those in need."
- "My work will receive support by others (e.g., colleagues, family and friends, society in general)."

Obviously, these expectations are not always met. Child protection workers who enter the field are enthusiastic at first but can end up feeling discouraged when outcomes do not meet their expectations [168].

Ongoing and continual exposure to stressors related to child abuse cases can lead to practitioners experiencing burnout, secondary trauma, and other professional issues [167]. The following section will focus on the emotional reactions practitioners may experience when working with child abuse/maltreatment cases. There will also be a discussion of supervision issues related to child abuse cases and a review of the importance of engaging in self-care strategies.

### TRANSFERENCE AND COUNTERTRANSFERENCE ISSUES

Child abuse and neglect cases epitomize betrayal; adult caregivers have broken a child's trust, misused their power, and severely violated boundaries (particularly in child sexual abuse). This betrayal may induce clients or patients to unconsciously engage in dissociated re-enactments of the abusive relationships, in some cases with the practitioner [169]. Countertransference hostage syndrome refers to a situation in which the practitioner feels controlled by the patient and the events he or she is experiencing [170]. The practitioner ultimately feels silenced, with minimal options. Practitioners working with child abuse victims and families may take on various roles, being a rescuer, abuser, and victim [171]. In more serious cases such as working with child soldiers, Draijer and Van Zon observe that [271]:

> Clinicians are confronted with oppression and dissociation in and outside of psychotherapy. Relatively minor stressors can trigger classic fight, flight, or freeze reactions, manifested by severe aggression and/or regressed dissociative states...Clinicians are pulled into the reenactments of old trauma scenarios and become part of a wild therapeutic dance of approach and avoidance that can feel like war.

As a result, transference and countertransference issues may arise. Identification with child abuse victims is not uncommon. Practitioners may feel as if they are in a delicate situation, similar to victims who may feel they are always on the edge of danger [172]. Child abuse victims often feel helpless, powerless, and isolated. Because the perpetrator wields the power, the victim is frequently not in the position to defend him/herself. Being exposed to these situations and emotions, practitioners can also feel helpless and powerless. In a qualitative study exploring the lived experiences of clinicians who work with sexual abuse victims, one worker stated, "'I feel disempowered in cases where I can't do anything to help...incompetent" [272]. If these feelings are ignored and not dealt with, the practitioner can inadvertently end up abandoning the client/family on an emotional level [173]. It is not uncommon for practitioners to dissociate while listening to their clients [172]. This has negative effects on the client, and it can indicate to supervisors and employers that the practitioner is incompetent and/or negligent [173]. When a practitioner is also a survivor of child abuse, detachment may be an issue [310].

Practitioners have also reported feeling exploited and manipulated, again very much like the victims' experiences [172]. Furthermore, victims often view the world dualistically, as good and bad or victims and perpetrators [173]. If this is the case, the practitioner may be placed into the role of victim or perpetrator by the victim/family. If not careful, the practitioner can adopt roles in which boundaries are blurred and inappropriate promises are made, such as contacting the client or family after hours [173].

Despite the horror of child abuse cases, some clients' stories may be fascinating, arousing, or exhilarating to practitioners due to their forbidden nature [168]. Although these emotions are unconscious, they can be tremendously shocking to the practitioner if brought to consciousness, provoking feelings of shame and guilt [168].

In some instances, a practitioner may avoid talking about cases with the hope that the feelings of hopelessness or frustration will disappear. Along these same lines, they may discuss cases in supervision in a removed or theoretical manner, dissociating themselves from the feelings [173].

Boundary issues are particularly relevant in child abuse cases because trust, intimacy, and power have been violated. Boundaries are the spoken or unspoken separations of the client and the practitioner [171; 272]. The maintenance or dismissal of boundaries conveys messages regarding power, trust, and authority to clients [171]. For example, some practitioners use self-disclosure to promote rapport building. But, in child maltreatment cases, self-disclosure can be misinterpreted by victims and their families. If practitioners are not very clear regarding the overall intent of the self-disclosure or if they are unsure how it will affect the clinical process and the client, then there is possible risk of doing harm [171].

Similar transference and countertransference issues exist for practitioners working with abusers. In a qualitative study with nine professionals working with incest sexual abusers, the participants reported feelings of disgust and extreme anger and hostility [227]. For example, one therapist discussed having fantasies of punishing the abuser. Another therapist felt like physically stepping back from the client to avoid contact. Overidentification with an abuser can also occur. One practitioner talked about feeling sorry for the client, and another talked about having loving feelings toward the abuser [227].

Practitioners who are able to identify transference and countertransference issues specific to child abuse may use these dynamics both to help the client work through the trauma and to aid in their own professional development [173]. It is crucial that practitioners have the opportunity to self-reflect and identify various roles they may be adopting [171]. If countertransference issues are not recognized and addressed, the practitioner may begin acting out,

leading to negative repercussions for the client or family, or the practitioner may experience secondary traumatization [173].

## SECONDARY TRAUMATIZATION

The terms secondary traumatization, secondary traumatic stress, secondary victimization, vicarious traumatization, and compassion fatigue all refer to the psychologic trauma experienced by those in close contact with trauma victims. This includes, but is not limited to, families, friends, and helping practitioners, such as nurses, mental health counselors, therapists, and social workers [174]. Secondary traumatic stress is defined as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" [174]. Secondary trauma can affect practitioners' beliefs about the world, others, and self, including concepts of safety, trust, control, and intimacy [175]. It has been argued that trauma caused by another person (i.e., abuse) may be difficult for practitioners to deal with because it brings up the issue of human evilness. This may affect existing beliefs and ideals more than trauma caused by natural events (e.g., natural disasters) [175]. Seven psychologic areas may be negatively affected by trauma or secondary trauma [228]:

- Frame of reference: The need for a stable perspective to understand the world and one's experience
- Trust: The need to depend on others and their ability to care
- Esteem: The need to be validated by others
- Safety: The need to feel safe and secure
- Independence: The need to feel in control over one's own behaviors
- Power: The need to exert control over others
- Intimacy: The need to feel connected to others

In a systematic review of child protection and welfare workers, many workers reporting having lost trust in the world and in the goodness of other people [336]. In a survey study with 310 professionals who worked with clients who experienced various traumas, researchers found that 60% of the research participants indicated that their beliefs about the world changed as a result of their work, particularly to beliefs about the world being a dangerous and unjust place [229]. About 20% felt they lost a sense to the meaning of life and that they may not recover from what they heard from their clients.

Practitioners with large caseloads of clients with a history of trauma and those who have minimal clinical experience in working with traumatized clients are vulnerable to secondary or vicarious traumatization. In these situations, it is easy to suppress one's emotions and begin distancing oneself from clients [230].

## BURNOUT

Practitioners involved in child maltreatment cases are at risk for burnout. Burnout refers to the extreme stress experienced by practitioners that depletes emotional, mental, physical, and psychologic resources [176]. Signs of burnout include depression, physical and mental exhaustion, anger, cynicism, acting out, frustration, lack of productivity at work despite working longer hours, and difficulty controlling feelings [167]. A practitioner experiencing burnout often feels drained or tired and at times emotionally detached from clients [176]. Burnout can result from occupational characteristics, such as long work schedules, case overload, low staffing patterns, feelings of lacking power and control, lack of reward structures, poor management, and poor interpersonal relationships among colleagues [177; 311]. A survey study of 170 home visitors found that sense of empowerment and a positive organization climate positively affected workers' feelings of burnout [273]. A study of child welfare caseworkers showed that job stress and time pressure predicted burnout [312]. In a 2020 study, there was a positive relationship between secondary traumatic stress and burnout [349]. A sense of hope and finding meaning

in one's work are mitigating factors. Supervisor and peer support, the accessibility of client services, and the caseworker-client relationship can also be protective against burnout [312]. However, these factors alone, or in combination, do not necessarily predict burnout; some practitioners may experience one or more factors but not burn out.

## CONSIDERATIONS FOR CLINICAL SUPERVISION: BEST PRACTICES

Clinical supervision serves several functions, ensuring the delivery of high-quality, client-centered care [178; 179; 274]. Supervision can be delivered by self-facilitated peer groups, individual discussion with an experienced specialist who can assist with emotionally difficult cases, or individual discussion with a specialist [180].

Supervision of practitioners who work with child abuse cases has an inquisitorial nature [178]. This stems in part from the tremendous amount of follow-up necessary in child abuse cases; therefore, supervisors may assist in prioritizing cases [178; 181]. Supervision also involves monitoring practitioners' emotional well-being, especially given the distressing nature of the cases [178; 181].

There are several established best practice recommendations for clinical supervision of child abuse cases. Supervision should take place in an environment where practitioners feel safe to identify and label the feelings they are experiencing. Having a safe space to vent frustrations and to discuss and manage countertransference issues without feeling judged is important [350]. If supervision is delivered via a group format, the group should be small enough to allow each member the opportunity to adequately discuss his or her work and the issues that have emerged in specific cases [181]. Managers who facilitate supervision groups may feel conflicted, wanting to be a supporter while being held to the organization's mission and policies [182]. However, additional studies are needed to explore this further. It is important to ensure the members of the group are not further traumatized by hearing other members' stories. Practitioners may need to be reminded that empathic listening can exacerbate secondary traumatization [174]. Clinical supervisors help practitioners find the words to capture their experiences and feelings [168]. Furthermore, clinical supervisors should be mindful that a supervisory session can unconsciously mimic the trauma triangle of "victim/victimizer/bystander" [275]. Spiritual/religious consultants may help practitioners through grief reactions, if necessary [168]. Clinical supervisors should be aware of personal life circumstances that could negatively affect practitioners' work, for example, life crises, bereavement, and personal stressors [180]. Finally, clinical supervisors should operate from a resiliency model, with a caveat that seemingly resilient individuals should not be expected to take on all difficult cases [313].

Because of the power given to them by the state to make decisions about child abuse cases, practitioners have tremendous responsibilities. They must constantly navigate between power and compassion; therefore, in supervision, it is important to allow practitioners to explore how the issue of power emerges in their daily practice and how it affects their relationships [183].

Finally, supervisors must ensure they are engaging in self-care to avoid burnout, particularly because they model these positive behaviors to their supervisees [184]. Self-care is integral to the prevention of negative symptoms in practitioners, including burnout, secondary traumatization, and compassion fatigue. As discussed, practitioners experience the stressors associated with emotionally charged cases in addition to the normal stressors of daily life [185]. Yet practitioners may be more likely to overwork and neglect to adequately care for themselves [185; 314].

An effective self-care plan may include cognitive and stress management techniques, including relaxation techniques, meditation, biofeedback, and hypnosis [186]. Good nutrition and diet, regular physical exercise, and maintaining social and familial relationships are also important. Self-awareness and mindfulness are incorporated into many self-care

plans. Self-awareness refers to knowledge about one's self, and mindfulness has been defined as one's knowledge and awareness of one's experience at and in the present moment [231]. Mindfulness-based stress reduction interventions teach individuals to attend to emotions, thoughts, and feelings as they arise and to be aware of the present moment experience [232]. Mindfulness has been found to play a mediating role in the relationship between self-care and well-being among mental health professionals [231]. Instead of practicing self-care, child welfare workers tend to engage in unhealthy behaviors to manage their stress [315].

Some argue that trauma-informed self-care is particularly pertinent for practitioners who work with patients who have experienced trauma such as child abuse [276]. The focus of trauma-informed self-care is on helping practitioners to deal with patients who have been traumatized and are learning to use strategies to mitigate stress [276]. The National Child Traumatic Stress Network has developed self-care training, which is available online at https://rems.ed.gov/docs/NCTSN_ChildTraumaToolkitForEducators.pdf.

Self-care can be described as a continuum, with proactive planning and reactive intervention on either end [176]. Self-care activities include an array of behaviors involving physical (e.g., exercise, nutrition, sleep), recreational (e.g., play activities, vacation time, hobbies), social (e.g., interaction with friends and family members), and spiritual/religious (e.g., prayer, meditation) support [176]. The concept of self-compassion has also been proposed as an integral component in self-care practice. This approach emphasizes human imperfection and may be particularly pertinent for practitioners who feel inadequate and powerless in the face of witnessing patients' adversity and trauma [277]. Practitioners should not merely consider these activities in passing but should spend some time exploring the activities in which they are engaged and whether they are practicing effective self-care [176].

Monitoring ongoing self-care is as important as promoting and developing it. To achieve this, self-care check-ins, whereby a practitioner is assigned to one of his or her peers so they can hold each other accountable to a self-care plan, may be established [184; 350]. Collegial support can also help to minimize burnout. Colleagues can help by alleviating work task stress, providing insight and comfort, and offering humor to lighten the mood [230]. Another option is for the supervisor to incorporate this monitoring into regular supervision.

When providing education to practitioners regarding self-care and secondary traumatization, it is important to avoid conveying a message of blame or weakness [166]. Along the same lines, organizations should consider whether their culture and environment may hinder practitioners from engaging in self-care activities. For example, practitioners who take vacation time or who decline to work overtime should not feel they will be perceived as less motivated than their colleagues [182]. Things like a coffee maker, relaxing photos, comfortable furniture, and soft music can provide opportunities for practitioners to take breaks after emotionally difficult meetings with clients and their families [182].

## CONCLUSION

For child welfare practices to be culturally meaningful for racially and ethnically diverse families, helping professionals in all disciplines must have a clear understanding of the multifaceted nature of oppression, marginalization, and differential access to resources and how these factors affect child abuse and maltreatment [58]. The first step in this process is for diverse groups and stakeholders to identify and name the oppression and racism affecting child welfare [58]. Second, professionals must acknowledge that best practice guidelines are often influenced by Western, Eurocentric beliefs and may not be the best course of action for racial and ethnic minority families. The third step involves restoration,

"whereby dominant and culturally specific peoples take mutual responsibility for child welfare services and its outcomes" [58]. The last step is relating, which consists of all parties (e.g., families, communities, professionals, other stakeholders) recognizing reconciliation as a continual journey that can only work if everyone is committed to the process [58].

**Implicit Bias in Health Care**

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

## FACULTY BIOGRAPHY

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