SINGAPORE CHILDREN'S SOCIETY

Research Monograph No. 2

Professional and Public Perceptions of Child Abuse and Neglect in Singapore: An Overview

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FOREWORD

Child maltreatment occurs in every society where it has been investigated, and has become an increasing focus of international concern. In 1996 and 1998 the Singapore Children's Society presented the results of its research in posters at biennial conferences of the International Society for the Prevention of Child Abuse & Neglect (ISPCAN), in Ireland and New Zealand respectively. These posters were based on the research being reported in our monograph series, including the present volume, which is the second published by the Singapore Children's Society.

Following our study on public perceptions (Tong, Elliott and Tan, 1996), we embarked on a similar survey on professionals in Singapore. The large sample and range of data allowed us to obtain a general understanding of the attitudes of the relevant professions and the public towards issues of child abuse and neglect locally.

This monograph gives an overview of the results of an investigation into the perceptions and experiences of no less than 1252 various professional respondents regarding child abuse and neglect. It targets the professions most likely to encounter child abuse or neglect, namely Doctors, Nurses, Teachers, Social Workers, Lawyers and Police Officers. It highlights the essential role that these professionals play in detecting and preventing child maltreatment of any kind, and in treatment for its effects. Where relevant, results were also compared with the 401 respondents from Tong *et al* 's (1996) data of the public.

Three subsequent monographs will follow in this series, each with in-depth analyses and discussions on the various aspects of child abuse and neglect recognised in Singapore, namely: physical child abuse and neglect, sexual abuse and emotional maltreatment. Of these, a volume entitled Professional and Public Perceptions of Physical Child Abuse and Neglect is being published concurrently (Chan, Chow and Elliott, 2000).

The findings suggest some need for further efforts to educate both the public and the professions in the pursuit of better services in this field. I hope that this monograph, as well as this whole series on perceptions of child abuse and neglect, will contribute to a better understanding and awareness of child maltreatment issues. Such understanding can only help improve efforts to combat abuse and neglect.

I would like to take this opportunity to thank and congratulate the Research Sub-Committee under the chairmanship of Associate Professor John Elliott who has, together with Dr Jasmine Chan, provided keen input and guidance to the research officers.

I look forward to more such good efforts from the research team.

Dr Ho Lai Yun
Chairman
Child Abuse and Neglect Prevention Standing Committee

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CHAPTER 1 : INTRODUCTION

1.1 Aims

This monograph is the second in a series published by the Singapore Children's Society dealing with aspects of child maltreatment in Singapore. It is directed primarily at professionals dealing with children and has three aims: -

- Firstly, the authors aim to outline the nature of child abuse and neglect (CAN). They also consider its definition and possible causes, and the nature of the responsibilities that lie with the various professions and the public with regard to recognition, reporting, prevention and treatment.

- Secondly, the monograph summarises the results of a study into the attitudes of various professionals towards actions that could amount to abuse or neglect. Subsequent monographs will give fuller details, but the present one makes available to readers a summary of findings.

- Thirdly, we report details of professional opinion on the experience and reporting of CAN, and on reasons for and against mandatory reporting of CAN.

All experts agree that the defence against CAN requires public awareness. It is important to be clear about the boundary between what is and is not acceptable treatment of children. It is also important to understand the attitudes of relevant professionals in comparison to the lay public, since the former provides services to the latter (Giovannoni & Becerra, 1979). It is especially important to determine if the need to intervene in certain situations will be so perceived by both groups. Approaches to CAN will be effective only if there is general agreement in perceptions and attitudes by both the general population and the professionals involved.

The first monograph sampled 401 members of the public living in Housing and Development Board (HDB) flats (Tong, Elliott & Tan, 1996) and found great variation in the acceptability of many actions, especially those that were less serious or which might have implied emotional or psychological maltreatment. This suggested a need for public education, especially where less severe instances were concerned.

Many professionals such as teachers, childcare personnel, social workers, doctors and nurses come in contact with children who have suffered abuse or neglect. However, a study by the Child Abuse Research and Action Team (1995) and a subsequent study by Fung and Chow (1998) both found a lack of consensus even amongst professionals. In many instances, cases of CAN are left unreported because the members of the public and the professionals who may otherwise have suspected CAN either do not regard certain instances as abuse or do not think it is their business to report. A reluctance to interfere in family matters is a common attitude. Such opinions and judgements can hinder the early discovery of CAN cases and could even lead to the deaths of the children concerned.

From time to time severe cases make the headlines. Over the past decade a range of cases have been publicised locally:

Girl 14, charged with sexual abuse of another girl (The Straits Times, 18 Jan. 2000)

Woman 'hit stepson till he bled' (The Straits Times, 21 Dec. 1999)

She stood by as boyfriend burned son's private parts (The Straits Times, 19 Nov. 1999)

Wife exposed man who raped underaged girls (The Straits Times, 17 Aug. 1999)

Baby dies an hour after being found (The Straits Times, 29 Sept.1998)

Young victims (The Straits Times, 28 Sept. 1992)

The hand that rocks the cradle (The Straits Times, 18 Jul. 1992)

Caned, burned, starved 3-year-old is only 7 kg (The Straits Times, 15 Apr. 1992)

My neighbour beats her child every day (The Straits Times, 10 Jan. 1992)

One reason why unwed mothers dump their babies- Beatings and rejection by parents (The Straits Times, 16 Jun. 1990)

Such headlines may reflect increasing awareness in CAN issues locally, while the publicity may also increase willingness to report CAN when observed or suspected. But not all cases are publicised, while the following news reports have also appeared concurrently:

Difficult for adults here to believe in child sexual abuse (The Straits Times, 7 Aug. 1995)

Starving a child: Such cases rare in S'pore (The Straits Times, 15 Apr. 1992)

Parents overdose kids on fever pills (The Straits Times, 1 Mar. 1993)

More stressed children seeking psychiatric help (The Straits Times, 21 Mar. 1991)

This may imply that low awareness of CAN and its detection still exists in 'modern' Singapore. Nevertheless it certainly indicates that not all CAN cases are clear-cut. Occasionally views of the public and professionals are reviewed:

Caning: What parents say (The Straits Times, 19 May 1994)

When some walloping is good for the child (The Straits Times, 21 Feb. 1993)

Dose of love and tough discipline needed (The Straits Times, 23 Feb. 1993)

Parents lock kids in cars but 'only for a few minutes' (The Straits Times, 30 Apr. 1993)

Parent-child relationship can be weakened, warn social workers (The Straits Times, 7 Jul. 1991)

Weekend parents say: We have no choice (The Straits Times, 7 Jul. 1991)

From time to time solutions and preventative strategies are sought locally:

Child abuse study meant to delve into people's attitudes (The Straits Times, 25 Jun. 1997)

Child abuse cases to get higher priority (The Straits Times, 22 Feb. 1997)

The Winny Ho case (The Straits Times, 6 Mar. 1997)

Sexually abused children to get help (The Straits Times, 21 Jan. 1996)

Child sex abuse: protection teams may be the way (The Straits Times, 18 Jan. 1996)

Society sets up container in school (The Straits Times, 17 Feb. 1994)

How to prevent your child from being molested (The Straits Times, 28 Sept. 1992)

Law takes serious view of child abuse (The Straits Times, 16 Jan. 1992)

There are certainly numerous considerations that complicate our understanding of the issues, not least of which is the definition of child abuse/neglect.

1.2 What is child abuse and neglect?

The term "Child Abuse" refers to non-accidental injury or maltreatment perpetrated by someone with a legal responsibility for the child. It is usual to include sexual and emotional or psychological maltreatment under the term "abuse". Emotional or psychological abuse is non-physical and refers to non-accidental actions that impair the child emotionally or psychologically, such as severely frightening or demeaning the child. Child sexual abuse refers to the use of a child for the sexual gratification of an adult with or without actual physical sexual contact. "Neglect" occurs when a caretaker fails to protect a child or to cater appropriately for his/her needs, such as to endanger the child's mental or physical well being. This includes ignoring signs of illness in a child e.g., high fever.

Child abuse is defined differently in different countries, which in turn vary in the range and severity of actions they are prepared to regard as abusive. In general, definitions include sexual offences and any non-accidental injury or neglect, whether physical or mental, under the heading of abuse or maltreatment.

To foster a common understanding of CAN, there have been attempts to develop a global definition. One such definition is provided by the World Health Organisation (WHO) in their recent *Report of the consultation on child abuse prevention*:

> *Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (WHO, 1999:15).*

In Singapore, the Children and Young Person's Act defines child abuse as the wilful assault, neglect, abandonment or exposure of a child or young person (under 16 years of age) in a manner likely to cause them unnecessary suffering or injury to health, which includes injury to or loss of sight or hearing or limb or organ of the body, or any mental derangement (Republic of Singapore, 1993). Neglect is defined as wilful failure to provide adequate food, clothing, medical aid or lodging for the child or young person. The guidelines from the Ministry of Community Development and Sports (MCDS, formerly the Ministry of Community Development) for the identification of CAN follow the Children and Young Persons' Act. Four types of child maltreatment are recognised, namely sexual abuse, physical abuse, physical neglect and emotional neglect.

The term "abuse" implies a failure of responsibility. An assault on a child by a stranger, for example, is not categorised as abuse in the same way as it would be if perpetrated by a parent or caretaker. It is recognised that care of a child entails certain responsibilities, which include protecting the child from danger and physical harm. Consequently, failure of responsibility is generally entailed in abuse. Sexual abuse of children, however, is deemed abuse and an offence, regardless of who the perpetrator is.

Professionals and non-professionals alike have generally perceived sexual abuse of any kind as serious (Corby, 1993; Segal, 1992). However the same cannot be said for physical abuse. Whether a case is perceived as physical abuse depends on the circumstances and include the seriousness of the resultant injuries, intention of the caregiver, age of the child, the views of the courts and also factors such as the character of the parents (Corby, 1993). As for physical neglect, it is not easy to formulate what exactly proper parental care and behaviour towards the needs of the child is. Emotional abuse of children is also a difficult matter for health, education and welfare workers alike. Apart from being a concept that is hard to define, it is also one whose legal recognition is virtually impossible due to the obvious difficulty of establishing the connection between the parents' behaviour and the consequences to the child (Goddard, 1996).

An additional difficulty is that acceptable standards of childcare differ between cultures and societies. What is unacceptable in one society is not necessarily seen as such in another. How hurt do children have to be before they are considered abused? Where is the line drawn between discipline and abuse? Are all physical punishments abusive? Such questions reflect the need to distinguish acceptable punishment from child abuse (Giovannoni & Becerra, 1979; Straus & Gelles, 1986; Clapp, 1988). How seriously the members of the public or the professionals perceive a particular scenario depends on several circumstances, such as the frequency or severity of incidents, the age and gender of child, and, of course, the nature of the actual abuse. Problems defining abuse are discussed in Tong *et al.* (1996). They note that the intention of the abuser complicates the issue, since harmful actions can be undertaken with good intentions. They recommend distinguishing between maltreatment, where the outcome for the child is harmful, and abuse, where the harmful act was malicious or intentional. Only abuse entails determining the intentions of the perpetrator, which can be difficult in practice. Whether what is done to a child is in fact likely to be harmful is an empirical question that may need to be settled by research.

1.3 How severe must unacceptable actions be to amount to abuse?

In the extreme, few could doubt that deliberate fatal or serious injury to a child or sex with a child constitutes abuse. Likewise, neglecting to feed a child or give needed medical attention or to provide any education for an intellectually normal child is patently neglect. It is with less extreme cases of maltreatment or neglect that difficulties arise. Many countries (e.g., Austria, Denmark, Finland, Norway & Sweden) outlaw corporal punishment of children and classify it as abuse, for example, but in others, including Singapore, a very different view prevails.

Similarly, it can be hard to know at what point legitimate scolding or reprimanding, for example, becomes excessive through excessive repetition and/or expressed anger, rage or contempt amounting to emotional maltreatment. Other forms of psychological maltreatment, in which the psychological needs of the child are affected, also exist, but may be insidious and chronic, having their effect cumulatively over a long period of time. This makes them hard to identify because there may be no defining incident or critical moment that in itself produces obvious harm. The idea of emotional or psychological maltreatment, though real enough to those who have suffered it, is hard to define and prevent.

Following Tong *et al.* (1996), Fung and Chow (1998) conducted a study to assess lawyers' and doctors' perceptions of CAN. A total of 368 family physicians, hospital doctors and lawyers completed a questionnaire. In addition to the 18 behaviours in Tong *et al.* 's (1996) survey, Fung and Chow included 3 more behaviours (i.e., total 21) in their study. It was revealed that more than 80% in all 3 groups agreed that Having sex with the child, Burning child with cigarettes, hot water and other hot things, Tying child up, and Not protecting the child from sexual advances by other adults were both unacceptable and abusive. The respondents also seemed more likely to act in cases of physical abuse and sexual abuse rather than cases of emotional abuse and neglect. They highlighted the need for the involvement of other professionals to understand how CAN is defined in Singapore.

Fung and Chow (1998) did not, however, make any explicit comparison between professionals and the public. Moreover, a wider range of professions other than Law and Medicine are entailed in responding to CAN. Evidently, there is still a need to examine the situation in Singapore, since if the public and the professionals do not agree, it would be a further indication of the need for education of both.

1.4 What is the incidence of child abuse and neglect?

The acceptability of actions affects the reported incidence of CAN. The higher the tolerance, the lower the reported rate is likely to be. In addition, the willingness of people to report, and the perceived effectiveness of intervention and remedial resources affect the statistics.

The Ministry of Community Development and Sports maintains figures of reported cases of child abuse and neglect. The Ministry of Home Affairs, though the cases are also handled by MCDS, maintains figures for child sexual abuse as they are classified as sexual offences against children. MHA also maintains figures for hurt offences against children. Tables 1.1 and 1.2 give the available statistics on CAN of all kinds for Singapore, supplied by courtesy of the respective Ministries. Cases handled by other organisations or individuals are not reflected in them.

These figures suggest a low incidence, compared with non-Asian countries (Children's Defense Fund, 1997; see also Tong *et al.*, 1996), especially the lack of cases of emotional abuse or neglect and the low rate for cases of physical neglect in Table 1.1 (see Chan, Chow & Elliott, 2000, for a more detailed discussion of physical abuse and neglect). To what extent this reflects differences in public or professional awareness of the problem and readiness to report it, and to what extent it reflects true differences in incidence rates are uncertain. However, it is clearly relevant to know the attitude and experiences of professionals in Singapore, and what they would regard as sufficient severity for a case to be considered abuse or neglect.

1.5 Why does child abuse and neglect occur?

There is no easy or simple answer to this question. Some may explain child abuse in terms of personality failures on the part of the caretaker (for example, Steele & Pollock, 1974) while others emphasise emotional or social stresses (for example, Straus & Gelles, 1986). In many cases abusers were themselves abused, frequently in similar ways, with the result that to some extent abuse may reflect inappropriate learning, or a failure to learn, when confronted with difficulties. In a few cases, abuse may just represent an inappropriate norm. Some parents, for example, may believe in disciplinary practices so severe that they fall within what the law or the rest of society might regard as unacceptable, though these parents may perceive nothing wrong in their actions.

Table 1.1

Number of cases of child abuse and neglect in Singapore (Source: Ministry of Community Development and Sports).

Item	1994	1995	1996	1997	1998	Mean	%
Data on all cases reported							
Evidence of abuse	29	37	18	28	28	28	20.2
Lack of evidence but needs assistance	55	50	73	134	100	82	59.5
False complaint	28	15	27	35	36	28	20.3
TOTAL	112	102	118	197	164	139	100.0
Data only on cases with evidence of abuse							
Type of maltreatment							
Physical abuse	28	37	18	24	26	27	95.0
Physical neglect	1	0	0	4	2	1	5.0
Emotional neglect*	0	0	0	0	0	0	0.0
TOTAL	29	37	18	28	28	28	100.0
Sex of victim							
Male	15	21	7	16	14	15	52.1
Female	14	16	11	12	14	13	47.9
TOTAL	29	37	18	28	28	28	100.0
Age of victim							
Below 2 years	2	3	5	2	3	3	10.7
3 - 5 years	7	12	2	5	3	6	20.7
6 - 11 years	16	16	11	18	13	15	52.9
Above 12 years	4	6	0	3	9	4	15.7
TOTAL	29	37	18	28	28	28	100.0
Relationship of perpetrator/s to victim							
Natural Parents	21	29	14	21	20	21	75.0
Adoptive/step/foster/defacto parent	5	3	1	4	2	3	10.7
Natural/step/foster sibling	0	2	0	0	0	0	1.4
Parent's lover	1	1	1	1	0	1	2.9
Relative	0	1	0	0	2	0	2.1
Friend	1	1	0	0	3	1	3.6
Others	1	0	2	2	1	1	4.3
TOTAL	29	37	18	28	28	28	100.0

*Includes any form of emotional or psychological maltreatment.

Table 1.2

Number of cases of child abuse and neglect in Singapore (Source: Ministry of Home Affairs).

Item	1994	1995	1996	1997	1998	Mean	%
Type of maltreatment							
All perpetrators included							
Sexual offences against children	113	126	162	188	196	157	93.2
Hurt offences	15	10	14	14	4	11	6.8
TOTAL	128	136	176	202	200	168	100.0
Only perpetrators who are caregivers included							
Sexual offences against child	47	47	56	53	44	49	88.8
Hurt offences	10	6	7	7	1	6	11.1
TOTAL	57	53	63	60	45	56	100.0
Sex of victim(all perpetrators included)							
Sexual offences against children							
Male	14	7	30	23	28	20	11.8
Female	103	128	162	178	186	151	88.1
TOTAL	117	135	192	201	214	152	100.0
Hurt offences							
Male	7	4	7	7	2	5	47.4
Female	8	6	7	7	2	6	52.6
TOTAL	15	10	14	14	4	11	100.0
Relationship of perpetrator/s to victim							
Sexual offences against children							
Father	18	11	23	16	16	17	10.7
Step-father/Adopted father	10	8	5	13	5	8	5.2
Grandparent	1	1	2	2	1	1	0.9
Sibling/Sworn brother	0	2	3	3	2	2	1.3
Relatives	8	13	17	11	9	12	7.4
Mother/grandmother's boyfriends/lovers	2	5	5	5	7	5	3.1
Babysitter/babysitter's family	7	5	0	0	3	3	1.9
Maid	1	1	0	3	1	1	0.8
Guardian	0	1	1	0	0	0	0.3
Others	66	79	106	135	152	108	68.5
TOTAL	113	126	162	188	196	157	100.0
Hurt offences							
Parents	5	5	5	5	0	4	36.2
Step-father	2	0	0	0	0	0	3.4
Sibling	0	0	1	0	0	0	1.7
Relatives	1	0	0	0	0	0	1.7
Mother's boyfriends/lovers	0	1	0	0	0	0	1.7
Babysitter/babysitter's family	1	0	1	0	0	1	3.4
Maid	1	0	0	2	0	1	5.2
Others	5	4	7	7	4	6	46.6
TOTAL	15	11	14	14	4	12	100.0

Summarised below are the main theories as to why CAN occurs. The theories should not be taken as necessarily incompatible. Each tends to focus on particular aspects of parenting, and none provides on its own an adequate account.

Attachment theory (Bowlby, 1969; Rutter, 1982)
There is much evidence that the nature and quality of the attachments between child and parents or other caretakers has considerable impact on the ability to form affectionate relationships in adulthood. In extreme cases where a relationship has never been allowed to develop, as can happen with institutionalised or very rejected children, the child may develop what amounts to an affectionless personality. In cases where the relationship is distorted by rejection, hostility, manipulation or excessive dominance by the parents, the child may remain immature in relationships and may then have problems in parenting in turn. Emotionally inadequate parents tend to resent the child and have difficulties in perceiving the child's own emotional and other needs, and this opens the way for abusive behaviour.

Therefore, poor quality of attachment in infancy or early childhood is a bad foundation for later effective parenting. However, there is another implication. Bowlby argued that a biological function of attachment is to protect the child from aggression or neglect. A failure of attachment may therefore not only be a consequence of abuse, it may contribute to it. Poor infant-caretaker attachment must be considered a risk factor for CAN.

Attachment theory in its original form put emphasis on the exclusive role of the mother (monotropy). To this day there remains a belief in some quarters that "mother is best", meaning the natural mother. In fact, the quality of a relationship is more important than the particular family member on which it rests; moreover multiple attachments to adults of both sexes are common and may serve an important 'buffering' function in cases where particular caretakers are absent or unable to cope.

The theory puts emphasis on the personal dynamics of attachment at the expense of stress factors such as unemployment, marital discord or financial difficulties. It is a theory about personal relationships, not about social circumstances.

Psychodynamic (Psychoanalytic) theory (Steele & Pollock, 1974)
This theory supposes that abusing parents, when children, were not allowed or able to progress through all the necessary psychosexual stages for maturity. Consequently good parenting breaks down through the parents' inability to cope appropriately and in a mature way with the demands of parenting. This inability or inadequacy is held to reflect unfulfilled needs remaining from the adult's own childhood experiences. Steele and Pollock hypothesised that parents physically abuse children as a result of their own inward frustration. The frustration arises from a lack of sufficient response from the caretaker, and the parent, when a child, develops an unconscious guilt and thus feels undeserving of the parents' love and affection. The same child as an adult then misidentifies his or her own child as an embodiment of the self and eventually directs frustration upon the child through aggression. The focus is often on the mother-child dyad, and women are regarded as the key caregivers without consideration of the situation they are in. Social or environmental factors are not taken into account. An additional limitation of psychoanalytic theories is the difficulty of testing them.

Whilst the psychodynamic theory seeks to explain physical abuse, as a discharge of aggressive energy focused on the child, the occurrence of sexual abuse is not so easily explained. Finkelhor & Baron (1986) suggested two main trends amongst child sexual abusers: either they have an arrested psychosexual development and choose to relate to the child's emotional development; or they have a generally low self-esteem and thus gain a sense of power and control by victimising children.

Learning theory (Skinner, 1953; Bandura, 1965)
According to learning theories, CAN is a problem not derived from personality traits or the lack of attachment, but through inappropriate reinforcement (Skinner, 1953) or modelling (Bandura, 1965). The behaviour of the abuser is explained as the result of learning dysfunctional child-care practices and not learning proper child-care practices. The idea of unsuitable role models, in the form of abusive parents, follows this perspective. Abused children who later abuse their own children often do so in a similar manner, lending support to the role of learning through modelling or imitation. Moreover, if an adult discovers that gratification (for example, sexual gratification) can be obtained or relief experienced (for example, a sense of control) through abuse, this experience will reinforce any abusive tendencies.

The emphasis in learning theories is on the contingencies that have lead to inappropriate learned patterns of behaviour. Consequently interventions tend to be directed at reinforcing desired patterns of behaviour and extinguishing undesirable ones. Although increasingly behavioural approaches are taking into account how the abuser perceives the situation, the primary emphasis is on behavioural change rather than on the beliefs or perceptions underlying the behaviour.

Cognitive approach (Newberger & White, 1989)
Cognitive psychology deals with how we mentally represent reality to ourselves. Thus how a parent views the child and the child's behaviour i.e., the thought processes within the individual regarding the child, can lead to the abusive actions. For example, if a parent believes a child intends to be aggravating or deliberately troublesome, this belief or 'representation' of the child will colour the parent's behaviour towards the child. In fact abusing adults do often have distorted or inappropriate beliefs or expectations about their children. The way they see the child need not depend on what they have learned or experienced as a child themselves, though it may. Therefore treating the problem would require understanding of how the child is perceived (or misperceived) by the abuser. The focus of treatment tends to be on changing these cognitive representations. Child abuse, on this theory, occurs when the abusive party has a sufficiently distorted or misplaced perception of the child, of what is possible, or of their own role and motivations.

Individual interactionist approaches (Kadushin & Martin, 1981)
According to this perspective, CAN is explained as the result of interpersonal relations rather than processes occurring within the individual. The dynamics of the current relationships are held to be more important than parental background experience or personality. Thus CAN is considered with respect to the child's and spouse's/partner's contribution to the situation(s) of abuse or neglect. This

approach does a useful service in focusing on the importance of social norms and expectations, together with the day-to-day context, in failures of good parenting. However, it ignores the contribution of individual differences in parents' reaction to events, which must depend on other things than the circumstances they are in.

Family dysfunction theory (Minuchin, 1974)
This theory explores the impact of family dynamics on the behaviour of its members. Proponents of this theory support family therapy as treatment. Whilst the earlier proponents explored the impact of family life on the psychological development of the individual, more recent supporters have taken on a systems perspective. According to this perspective, there are two systems within the family: the child and the parents. The emphasis is on the need for boundaries between the two systems (with some permeability) to ensure a healthy climate for all family members. In this case therapy is focused on examining the current boundaries and improving communication between family members.

Biological perspectives
There is ample evidence of aggression towards infants or juvenile in other species of animals, including primates. Such behaviour seems counterproductive until it is realised that the targets of aggression are often not related to the aggressing adult. Males among certain primates, and other mammals such as lions, kill the infants of females by other males. This action, while bad for the species as a whole, ensures paternity for future offspring of the males concerned. In the human case this has been used to explain the greater risk of child abuse of all kinds from unrelated adults such as step-parents towards stepchildren (Gelles & Lancaster, 1987).

In the case of sexual abuse, there is a natural brake on incest. Even without legislation, incestuous tendencies tend to be rare and unacceptable in most societies. The experience of children reared collectively in Israeli Kibbutz was that they tended not to seek marriage with others from the same collective, as if the familiarity of being reared together diminished rather than enhanced subsequent sexual and romantic attraction. This finding is hard for social theories to explain, since the intention behind the Kibbutz included promoting marriages within themselves as self-sustaining units. So while incestuous sexual abuse of children can occur within families, incest taboos do operate and there is a considerable risk of sexually maturing children being exploited by more remote relatives or strangers. It is probably for this reason that sexual abuse is not defined merely in relation to caretakers.

1.6 Risk factors in child abuse and neglect

From the point of view of practitioners, it is probably not so helpful to ask what causes child abuse and neglect, as to ask, what prevents it? In general, CAN represents a breakdown of the normal restraints on neglect, exploitation, desire, resentment or aggression on the part of parents and other caretakers. Therefore, anything that tends to undermine the normal operation of these restraints represents a risk to the child. Hence, rather than look for one among many competing theories as a

general explanation, it is more useful to keep in mind that there are many ways in which good care-taking can fail, and less desirable behaviours occur. This amounts to noting risk factors. Understanding the risk factors will help explain particular cases. The role of theory is just to help that understanding.

It must be strongly emphasised that a risk is not a certainty. For example, a major predictor of child abuse is parents who have themselves been abused, but most abused children do not subsequently abuse their own children.

Abused parents not only may have never experienced a good model of child rearing, they may be ill-prepared to withstand the stresses of adult life in general and child-rearing in particular. Sometimes such adults appear to have what are called unfulfilled dependency needs, that is, they themselves have never been sufficiently secure as to be able to provide the stability and maturity needed by a child; they then may resent the demands their own children put upon them. Abusive parents often seem to resent their children, and may irrationally blame them for actually trying to get attention or cause distress. Thus in any CAN case, understanding the abuser's personal history and family background are crucial towards the effective treatment of the perpetrator as well as the victim. Nevertheless, given that a parent's history may create a risk, it has to again be stressed that it is only a risk, not a certainty.

Similarly, noting the fact that children are at greater risk of abuse from stepparents than natural parents is not to say that all step-parents are poor parents. On the contrary, most are not. Abuse is the exception, not the rule.

Main risk factors might be summarised as the following (based on Moore, 1984):

- Previous abuse of the child, especially if it was sadistic in nature
- Ignorance of children's needs; emotional, intellectual, physical or medical
- Poor parenting skills - inability to cope with child crying, with emotional situations, excessive/ inadequate/inappropriate discipline, etc.
- Parents who were themselves abused
- Step-parent, extra marital partners
- Poor (irritable, violent) parent/child interactions
- Parents who cannot control their anger
- Family stress, especially if originating or focused on the child, e.g., stress arising through having to care for a difficult child; disagreements with in-laws over child care practices or discipline; being embarrassed by and unable to control child's behaviour; financial stresses aggravated by child's clothing/educational expenses; a difficult or unwanted pregnancy
- Parents who are socially isolated
- Excessively young and immature parents
- Lack of emotional attachments between parents or other caretakers and the child
- Caretakers in unhappy or exploitative marital or sexual relationships, especially if family violence is occurring, or if a child is blamed for marital problems (scapegoating).

- Mental disorder sufficient to impair effective functioning, especially if the child is a focus of stress, as for example in post-partum depression
- Unrealistic expectations of the child or the child's rate of development
- Low parent IQ
- General family dysfunction due to extreme poverty or for other reasons

Risk factors are not evidence. They are indicators that alert one to the possibility of abuse when other evidence is found or when social investigations have to be carried out for other reasons. Evidence suggesting CAN includes the following:

- Injuries that appear to be non-accidental
- Sexual injuries or evidence of sexual activities
- Flirtatious 'sexualised' or sexually precocious behaviour
- Physical symptoms of persistent failure to thrive, such as the child remaining underweight
- Excessively fearful behaviour by the child towards an adult
- Excessively aggressive behaviour towards other children
- Imitation of adult abusive behaviours (e.g., hitting, shouting) towards dolls or in play.

1.7 Consequences of child abuse and neglect

There is now ample evidence that abuse in childhood is associated with an increased incidence of later mental health problems, even when other causes of such problems are allowed for (Briere, 1992, 1998). There is considerable consensus among child psychiatrists and psychologists that early emotional security is important for later emotional maturity, and that even though resilient children may be found to have survived a great degree of emotional deprivation, the long term consequences of emotional neglect or abuse tend to prevail (Perry, 1998). It may also be noted that although it is hard to define or establish emotional or psychological abuse with respect to visible or physical damage, it can and does occur with other types of abuse such as physical abuse. Indeed, the lasting deleterious effects of childhood abuse arise probably more from the emotional than from any physical component, unless the latter is so severe as to inflict permanent damage.

Sometimes necessary information may be lacking or hard to determine. Cases can be less severe than those that are considered newsworthy. Sustained or repeated examples of maltreatment that in themselves are not very severe might add up to a considerable degree of abuse. CAN cases may involve several types of maltreatment, including sexual, emotional and physical abuse, as well as physical or emotional neglect or a lack of proper protection from others. CAN is complex as a personal problem as well as a public issue. It involves not only the victim and the perpetrators, but also the family and the relevant professionals. The effective restoration of a child into a normal life, in particular, would depend upon the professionals as well as the family. The study reported below is an attempt to understand how such professionals perceive CAN.

Several researchers have emphasised that professionals dealing with CAN cases must have a "social map" of the community and its services, and be able to co-ordinate them, while also being an advocate for both the child and the family (Gelles, 1982; Clapp, 1988). We are aware of the dearth of local research on CAN. It is also clear that child-rearing practices differ from those currently found elsewhere, and is likely that there is a local tendency to see child care matters as confined to the family. In this light there are ways and means unique to this culture, where victims reveal their plight to the environment. The onus lies on the professionals to identify the voice crying out for help or attention.

1.8 Methodology for the present study

The present study aimed to understand the perceptions and the attitudes of different professionals on CAN in Singapore and to compare their views with those of the members of the public obtained from Tong *et al.* (1996). The research extended the Tong *et al.* study to a large sample (1252) of these various professional groups, and was directed at five underlying questions.

Firstly, do members of the relevant professions agree among themselves? One might expect that the training received by any member of a profession dealing with children in Singapore would impose some common set of norms and standards with regards to child abuse and neglect, insofar as this comes within the scope of the profession concerned.

Secondly, do our different professional groups agree with each other? It is important to be aware if, for example, different professions do not share a common attitude to abusive or neglectful actions.

Thirdly, do our professionals agree with the public? We know a good deal about what the public believes. Whether professionals take the same or a different view, it is important to be aware of it.

Fourthly, what characteristics do the professionals attribute to cases in specific and in general? Such a question provides information about the kinds of cases that come to the attention of the front-line professionals, and also tells us the kinds of case that the respondents themselves put into the category of "abuse".

Fifthly, what are the professionals' attitudes towards the reporting of CAN? Professionals are often the first to realise that a possible case of abuse or neglect may exist. Their specialist knowledge and the fact that they often deal systematically with many people (as clients, patients, etc.) also means that they are well placed to realise when all is not well, and they then find themselves in the position of having to decide whether or not to take the matter up.

Materials

The method in the present study is based on Tong *et al.* (1996) and Elliott *et al.* (1997), and extends to a wider range of professionals than studied by Fung and Chow (1998). The interview questionnaire was adapted for the present study (Appendix A).

Sample

The questionnaire was developed and distributed to 2141 randomly sampled professionals who are more likely to come into contact with abused children. These professions include the police, lawyers, nurses, doctors, social workers, teachers, childcare professionals and psychologists.

The eventual sample comprised 1238 professionals (817 female, 401 male and 20 with gender unspecified). The professions in the survey included social workers, doctors, nurses, police, lawyers, teachers and childcare professionals (see Table 1.3).

General Procedure

The professional groups were approached consecutively. Contact letters were distributed to randomly selected agencies/institutions comprising the different professions via mail. Follow-up phone calls were made to identify those consenting to participate. Distribution and collection of questionnaires took place either via mailing procedure or personal visits. The participants were allowed to complete the questionnaires by themselves and in their own time and return them within a week. Typically, a maximum waiting time of two weeks was generally given to each group. As expected the return rates with the mailing procedure were poorer than those done personally. The overall participation rate was 58.5%.

Each questionnaire had a cover page in the form of a letter of explanation. In it, the participants were provided with an outline of the types of questions they would encounter and the rationale for the study. They were encouraged to give personal views instead of professional opinions. In addition they were assured of confidentiality and anonymity. Finally, they were encouraged to share their comments either within the questionnaire or with the research officer via telephone, facsimile or mail. All respondents were asked to complete all sections of the questionnaire, unless otherwise stated. For instance, the Police, and MCDS welfare officers were not required to respond to some of the questions in Section D, which pertained to issues on the 'Reporting of Child Abuse and Neglect'. They were exempted from questions on the likelihood of reporting, to whom they would report, importance of reasons for reporting/not reporting CAN cases encountered, and the open-ended question.

Table 1.3
Breakdown of professions explored and respondents.

Profession		No. of questionnaires sent out		Received/ Collected		Response rate (%)	
Police							
Investigators, patrol officers, counter officers from the various Divisions							
	Subtotal	200		190		95.0	
Social Work							
MCDS Welfare Officers			20		7		35.0
Medical Social Workers			40		33		82.5
Volunteer Welfare Organisations			89		42		47.2
	Subtotal	149		82		55.0	
Medicine							
General Practitioners			150		41		27.3
Doctors in hospitals			452		165		36.5
Nurses			508		414		81.5
	Subtotal	1110		620		55.9	
Law							
Lawyers from private law firms			197		39		19.8
Deputy Public Prosecutors			22		21		95.5
	Subtotal	219		60		27.4	
Educators							
Primary/ Secondary School			300		251		83.7
Child Care			163		35		21.5
	Subtotal	463		286		61.7	
Total		**2141**		**1238***		**58.5**	

* This total excludes 14 additional respondents. These comprised a small group of psychologists/counsellors and those who had indicated "other" in response to "profession".

CHAPTER 2 : CATEGORISATION OF ACTIONS

2.1 Introduction

One way to explore how people define CAN is to observe how they classify actions. Knowing whether an action is regarded as abuse or not would give us an understanding of the behaviours that people would classify as abuse. Presentations of mere actions in themselves do not speak for the circumstances in which they may occur and which might facilitate the acceptability of some. Nevertheless, an analysis of the range of responses would throw light on the specific actions that would be regarded as abuse or not. In addition, an examination of the acceptability of actions would allow us to identify if there were actions classified as 'not abuse' and yet not acceptable. While the classification of an action according to abuse status allows us to assess the level of awareness of abusive actions, noting the level of acceptability allows us to understand if the actions are condoned in this society. Any uniformity of response would display the influence of culture upon the respondents. This common culture is not defined by demographics, but rather by a certain level and type of opinion/understanding that the respondents share. Given our sample size, we may be able to suggest that Singaporeans (the professionals and the public, on the whole) condone certain actions but not others. Any differences would imply that other factors, such as one's profession, might play a role in influencing one's responses. We thus attempted to compare the responses of the different professions with our public sample from Tong *et al.* (1996) by replicating their questions.

2.2 Method

Section A looked into "Definitions of Child Abuse and Neglect". This aspect was assessed in two parts for both the surveys. In the first part, the respondents were required to indicate their reactions to 18 behaviours (please refer to Figures 2.1 and 2.2 for a complete list of the actions explored in this part). The behaviours were derived from a study of local child abuse case files, previous studies (for example, Giovannoni & Becerra, 1979) and a pilot study. All 18 behaviours had a known history of occurrence and involved four major categories of CAN (i.e., physical abuse, sexual abuse, physical neglect and emotional maltreatment). The behaviours were listed in random order. For each behaviour the respondent was asked to answer two questions: whether the behaviour is abuse/neglect; and whether the behaviour is acceptable. The options to answer the first question were: *is not* abuse/neglect; *can be* abuse/neglect; or *is* abuse/neglect, the options for the second question were: *always* acceptable; *sometimes* acceptable; and *never* acceptable.

2.3 Results

Results were obtained for the response rates on the categorisation of acceptability and abuse status for the 18 behaviours. Figures 2.1 and 2.2 plot the acceptability and abuse status respectively, for pooled professions against the corresponding result from the study of the public by Tong *et al.* (1996) and Elliott *et al.* (1997). The response rates, broken down by professions and compared against the public sample for the acceptability and abuse status of the 18 actions, are presented in Tables 2.1 and 2.2,

respectively. Since the information for the public sample was obtained by structured interview, the results for the professional and public samples may differ somewhat for reasons unconnected with actual differences in attitudes. In particular, greater frankness may be obtained when no face-to-face contact is made and respondents remain anonymous. Therefore, differences between the public and the professionals are not readily interpretable. However, the overall pattern of differences and similarities in the results are clear from inspection.

Because the difference between the two samples' sizes is large, even small changes may yield statistically significant results, and we have therefore treated the data descriptively. Observations were made within and between groups for levels of consensus. A 'high' level of consensus was referred to when more than 90% of the respondents chose one of the three options in rating a behaviour. A 'moderate' level of consensus was referred to when the modal response ranged between 60% and 90%. A 'low' level of consensus was referred to when the modal response was less than 60%.

Ratings of Acceptability

Regardless of the option selected, there was overall moderate to high levels of consensus across all professionals for 13 of the 18 behaviours. This can be observed from the column for 'Pooled professionals' in Table 2.1. The highlighted cells indicate the items where the pooled professionals' responses were of low consensus (the predominant response was selected by less than 60% of the professionals pooled).

Comparison between professionals and the public

For the majority of behaviours, both the professional and public samples displayed moderate/ high consensus in their opinions. Items that received low levels of consensus on rating acceptability were generally similar for the 'Pooled professionals' as well as the 'Public', except for 'Making child study for a long time' and 'Telling child other children are better', where pooled professionals seemed to have a moderate level of consensus and the public displayed low levels of consensus.

For each action, we used the proportion of respondents from Elliott *et al.* 's (1997) public sample saying that the action was always, sometimes or never acceptable, as the baseline. We then compared the proportions for each profession with the baseline, testing significance with chi-square (χ^2_{cv} is 5.99 for $p < .05$, $DF=2$). It appears from examination of Table 2.1 that the professions, in general, are similar to the public, either with regards to the reported degree of acceptability of the eighteen actions, or the range of opinions within the professional and public samples. However, there were some statistically significant differences. The proportions differed significantly across professional groups for the following behaviours: 'Caning a child', 'Ignoring signs of illness in a child', 'Leaving a child alone in the house', 'Calling a child "useless"', 'Making a child study for a long time', and 'Telling a child other children are better'. Nevertheless, it is more important and meaningful to consider the general patterns of results than to single out the particular items of statistical interest. For instance, there were also items with no significant differences across all professional groups for ratings on acceptability. These were for 'Having sex with a child', 'Parent not protecting a child from sexual advances of other family members', 'Burning a child with cigarettes, hot water or other hot things',

and 'Tying a child up'. These behaviours notably belong to the categories of sexual abuse and physical abuse, and both the professional and the public samples had high consensus opinions for these items.

Consensus within and between the professions

Each of the professional groups displayed a moderate to high level of consensus for most of the 18 behaviours explored. The Social Workers in particular seemed to have such consensus for the most number of behaviours, in comparison to the other groups. Within this group, only the behaviours of 'Locking a child in a room' and 'Never hugging child' displayed low levels of within-group consensus. On the other hand, Doctors and Lawyers seemed to display the lowest levels of within-group consensus. However, even in these groups, there were moderate to high levels of consensus for up to two-thirds of the actions, similar to the trend of pooled professionals. Interestingly, low levels of consensus were displayed for both groups for the following behaviours: 'Adult appearing naked in front of a child', 'Slapping a child on the face', 'Locking a child in a room', 'Never hugging a child', 'Calling a child "useless"', and 'Always criticising a child'.

Ratings on Abuse Status

Regardless of the option selected for ratings on abuse status, there were overall moderate to high levels of consensus across all professionals for only 7 of the 18 behaviours. The highlighted cells in the column for 'Pooled professionals' in Table 2.2 indicate those items with low levels of consensus.

Comparison between professionals and the public

Unlike the responses obtained for acceptability ratings where the levels of consensus for both the professional and the public samples were generally similar in trend, the responses for abuse status ratings displayed no clear trends. Here, for nine out of the 18 behaviours, both samples seemed to have low consensus. Interestingly, low consensus was only found in the public sample and not in the professional sample for the behaviour of 'Caning a child', while for the behaviour of 'Locking a child in a room', low consensus was only for the professional sample, but not amongst the public.

Chi-square tests between each professional group with the baseline revealed significant differences across groups for the following behaviours: 'Adult appearing naked in front of child', 'Slapping a child on the face', 'Caning a child', 'Ignoring illness', and 'Leaving a child alone in the house'. In addition, across all items, there was at least one professional group that displayed a significant difference when compared with the public. This was unlike the trend in the acceptability ratings in Table 2.2 where there were items with no significant differences.

Figure 2.1
Acceptability ratings for 18 behaviours by 1238 professional respondents compared with ratings from 401 members of the public (from Tong *et al.*, 1996). The ratings for professionals are in the lower bar of each pair; those for public are in the upper bar.

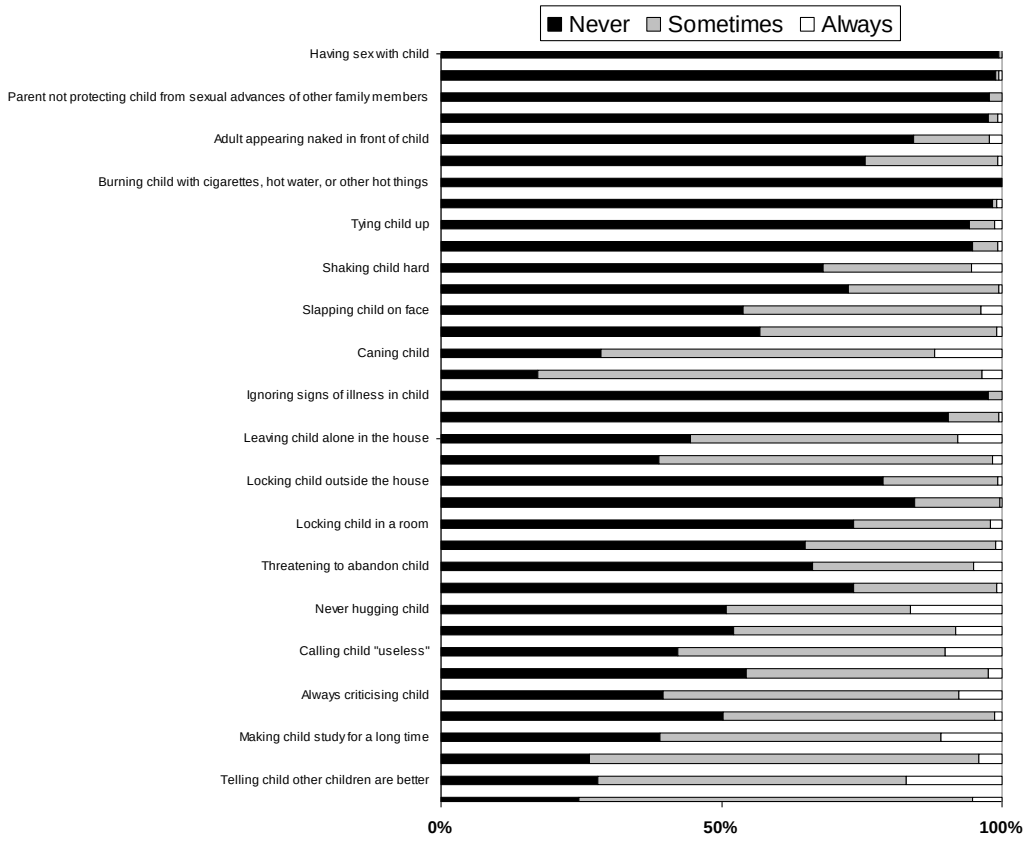

Figure 2.2
Abuse ratings for 18 behaviours by 1238 professional respondents compared with ratings from 401 members of the public (from Tong *et al.*, 1996). The ratings for professionals are in the lower bar of each pair; those for public are in the upper bar.

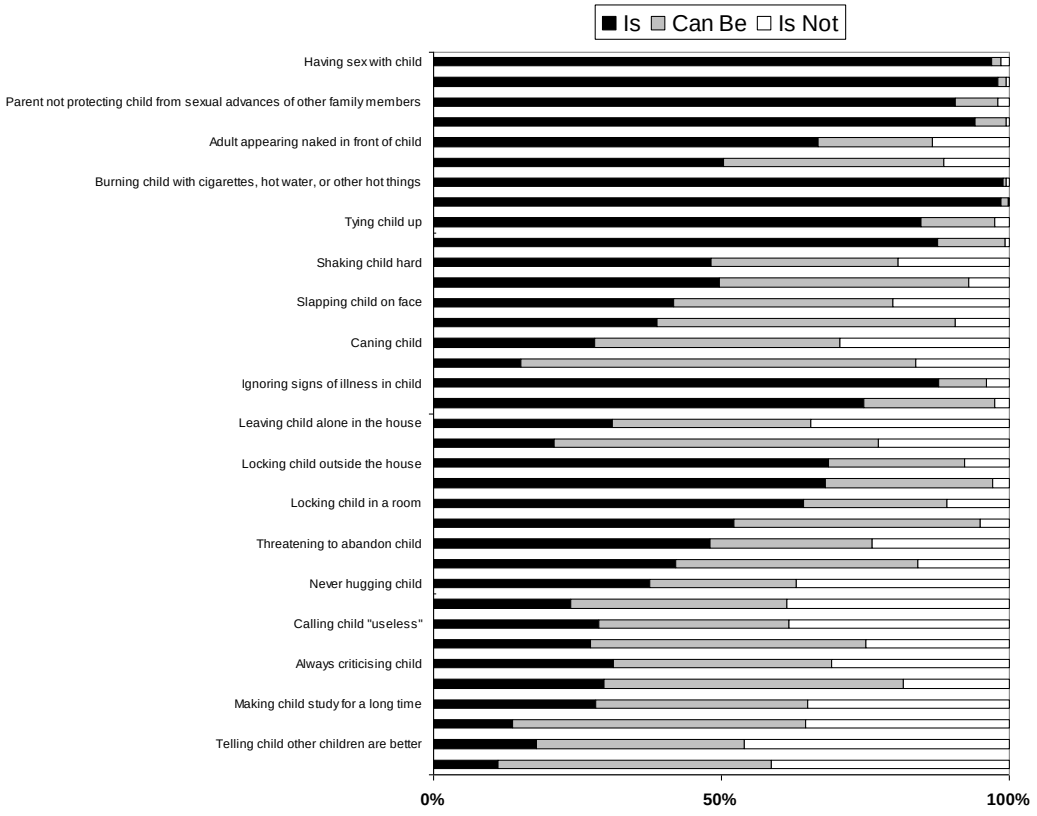

Table 2.1
Acceptability of 18 actions by professions and the public.

CATEGORY	ACTION EXPLORED WITH RATINGS ON ACCEPTABILITY		P	SW	D	N	L	ED	All Prof.	PUB
SEXUAL	Having sex with the child	*Always*	0	1.3	0	0.7	0	0.7	0.5	0
		Sometimes	1.6	0	0	1.0	0	0	0.6	0.5
		Never	98.4	98.8	100	98.3	100	99.3	98.9	99.5
		X^2	*4.63*	*0.40*	*1.03*	*1.92*	*0.3*	*1.43*		
ABUSE	*Parent not protecting child from sexual advances of other family members	*A*	0.5	0	0	1.7	0	0.7	0.8	0
		S	1.1	1.3	3.0	2.7	0	0.4	1.7	2.3
		N	98.4	98.8	97.0	95.5	100	98.9	97.5	97.7
		X^2	*1.21*	*0.38*	*0.41*	*0.54*	*1.40*	*4.53*		
	*Adult appearing naked in front of child	*A*	1.1	0	2.5	0.2	1.7	0.4	0.8	2.3
		S	14.8	31.7	47.3	17.3	43.3	15.2	23.5	13.4
		N	84.1	68.3	50.2	82.4	55.0	84.5	75.6	84.4
		X^2	*1.52*	*25.06*	*203.24*	*12.41*	*46.64*	*5.30*		
	Burning child with cigarettes, hot water, or other hot things	*A*	1.6	2.4	1.0	0.2	0	1.1	0.9	0
		S	1.1	0	0	1.0	0	1.1	0.7	0
		N	97.3	97.6	99.0	98.8	100	97.9	98.4	100
		X^2	*0.13*	*0.05*	*0.02*	*0.06*	*0*	*0.13*		
PHYSICAL	Tying child up	*A*	0.5	0	0.5	1.2	0	0.7	0.7	1.3
		S	4.8	8.9	5.5	2.2	1.7	5.6	4.5	4.5
		N	94.6	91.1	94.0	96.6	98.3	93.7	94.8	94.2
		X^2	*0.81*	*4.34*	*1.32*	*5.08*	*1.96*	*1.46*		
ABUSE	Shaking child hard	*A*	1.6	0	1.0	0.2	0	0.4	0.6	5.5
		S	29.8	22.8	25.6	22.1	28.3	32.6	26.9	26.4
		N	68.6	77.2	73.4	77.6	71.7	67.0	72.6	68.0
		X^2	*6.09*	*5.76*	*8.53*	*29.04*	*3.52*	*18.01*		
	*Slapping child on the face	*A*	1.1	0	2.0	1.0	1.7	0	**0.9**	3.8
		S	55.4	35.0	50.7	32.0	58.3	40.4	**42.3**	42.4
		N	43.5	65.0	47.3	67.03	40.0	59.6	**56.9**	53.8
		X^2	*14.60*	*5.94*	*6.67*	*31.94*	*6.41*	*12.91*		
	*Caning child	*A*	5.9	3.8	6.3	3.0	5.0	0.7	3.6	12.1
		S	73.4	88.8	81.1	74.8	85.0	83.4	79.0	59.4
		N	20.7	7.5	12.6	22.2	10.0	15.9	17.3	28.5
		X^2	*16.51*	*28.50*	*40.05*	*49.54*	*16.27*	*73.33*		
PHYSICAL	*Ignoring signs of illness in child (e.g., high fever)	*A*	1.1	0	0	0.5	0	1.1	0.6	0
		S	9.6	9.8	14.1	5.9	13.3	7.7	8.9	2.5
		N	89.3	90.2	85.9	93.6	86.7	91.2	90.5	97.5
		X^2	*38.78*	*17.43*	*112.99*	*18.84*	*28.61*	*31.73*		
NEGLECT	*Leaving child alone in the house	*A*	1.6	5.1	3.0	0.5	3.3	1.1	**1.6**	7.8
		S	65.3	80.8	65.2	51.2	75.0	54.6	**59.5**	47.7
		N	33.2	14.1	31.8	48.3	21.7	44.3	**38.9**	44.4
		X^2	*27.16*	*34.73*	*26.02*	*29.95*	*17.90*	*19.29*		
	Locking child outside the house	*A*	0	1.3	0	0.7	0	0	0.3	0.8
		S	19.8	19.5	20.2	11.9	23.3	11.2	15.3	20.4
		N	80.2	79.2	79.8	87.4	76.7	88.8	84.4	78.8
		X^2	*1.49*	*0.34*	*1.56*	*18.28*	*0.74*	*17.47*		
	Locking child in a room	*A*	1.1	3.7	1.5	0.7	0	0.7	1.1	2.0
		S	31.7	50.6	52.2	23.0	55.9	28.7	34.0	24.4
		N	67.2	45.7	46.3	76.3	44.1	70.6	65.0	73.6
		X^2	*5.88*	*32.44*	*85.60*	*4.04*	*32.11*	*4.89*		
EMOTIONAL	Threatening to abandon child	*A*	1.1	0	2.0	0.7	1.7	0.7	1.0	5.0
		S	27.5	20.3	35.5	26.0	26.7	18.3	25.5	28.7
		N	71.4	79.7	62.6	73.3	71.7	81.0	73.5	66.2
		X^2	*6.80*	*8.12*	*7.43*	*19.10*	*1.70*	*30.61*		
MALTREATMENT	Never hugging child	*A*	16	11.1	7.3	6.5	11.7	3.9	**8.2**	16.4
		S	49.5	37.0	43.2	32.3	35.0	43.3	**39.7**	32.7
		N	34.6	51.9	49.5	61.3	53.3	52.8	**52.1**	50.9
		X^2	*25.90*	*1.84*	*17.35*	*32.84*	*0.97*	*36.99*		
	Calling child "useless"	*A*	5.3	0	4.0	2.7	0	0.7	**2.5**	10.1
		S	44.4	32.5	52.5	38.7	55.0	42.1	**43.0**	47.6
		N	50.3	67.5	43.6	58.6	45.0	57.2	**54.5**	42.3
		X^2	*7.35*	*23.89*	*8.57*	*53.41*	*6.84*	*41.58*		
	Always criticising child	*A*	2.7	0	2.5	1.0	0	0.7	**1.3**	7.6
		S	62.2	31.3	49.0	42.7	53.3	50.4	**48.5**	52.9
		N	35.1	68.8	48.5	56.3	46.7	48.9	**50.2**	39.5
		X^2	*10.00*	*30.39*	*11.59*	*59.79*	*5.30*	*24.34*		
	*Making child study for a long time	*A*	3.2	2.5	9.4	4.2	8.3	0.7	4.2	10.9
		S	71.3	74.1	78.3	63.3	78.3	66.5	69.3	50.0
		N	25.5	23.5	12.3	32.5	13.3	32.7	26.4	39.1
		X^2	*37.27*	*19.73*	*70.32*	*35.57*	*20.19*	*44.97*		
	*Telling child other children are better	*A*	10.6	1.2	8.3	5.1	6.7	0.7	5.2	17.1
		S	67.7	65.9	72.8	69.2	75.0	72.5	70.2	54.9
		N	21.7	32.9	18.9	25.7	18.3	26.8	24.6	28.0
		X^2	*13.03*	*14.63*	*27.50*	*50.31*	*10.23*	*60.93*		

P = *Police*, ***SW*** = *Social Workers*, ***D*** = *Doctors*, ***N*** = *Nurses*, ***L*** = *Lawyers*, ***ED*** = *Educators*, ***ALL Prof.*** = *All/ Pooled professionals*, ***PUB*** = *Public*
* Refers to actions that were explored further with respect to circumstances

Table 2.2

Abuse status of 18 actions by professions and the public.

CATEGORY	ACTION EXPLORED WITH RATINGS ON ACCEPTABILITY		P	SW	D	N	L	ED	All Prof.	PUB
SEXUAL	Having sex with the child	*Is Not*	1.1	0	0	0.7	0	0.4	0.5	1.5
		Can Be	2.2	0	0	2.0	0	1.8	1.4	1.5
		Is	96.8	100	100	97.3	100	97.9	98.1	97.0
		X^2	*0.74*	*2.49*	*6.25*	*2.17*	*1.84*	*2.64*		
ABUSE	Parent not protecting child from sexual advances of other family members	*IN*	0.5	1.3	1.0	0.5	0	0	0.5	2.0
		CB	4.8	6.3	5.0	7.3	1.7	4.3	5.4	7.3
		I	94.7	92.5	94.1	92.2	98.3	95.7	94.1	90.7
		X^2	*4.05*	*0.39*	*2.87*	*4.64*	*4.22*	*9.90*		
	Adult appearing naked in front of child	*IN*	15.0	7.3	19.4	11.7	6.7	5.0	11.3	13.4
		CB	34.8	48.8	51.2	31.4	66.7	32.6	38.4	19.9
		I	50.3	43.9	29.4	56.9	26.7	62.4	50.3	66.8
		X^2	*28.73*	*43.01*	*146.86*	*33.42*	*82.39*	*37.99*		
	Burning child with cigarettes, hot water, or other hot things	*IN*	0.5	0	0	0.2	0	0.4	0.2	0.5
		CB	0.5	0	1.5	2.0	0	1.4	1.3	0.5
		I	98.9	100	98.5	97.8	100	98.2	98.5	99.0
		X^2	*0.01*	*0.83*	*4.82*	*18.00*	*0.61*	*4.83*		
PHYSICAL	Tying child up	*IN*	1.1	0	0.5	1.0	0	0.4	0.7	2.5
		CB	10.2	25.0	10.9	10.9	10.0	10.9	11.7	12.8
		I	88.7	75.0	88.6	88.1	90.0	88.7	87.6	84.7
		X^2	*2.86*	*12.17*	*4.16*	*5.32*	*2.08*	*6.63*		
ABUSE	Shaking child hard	*IN*	9.1	6.3	5.0	6.8	11.7	7.4	**7.1**	19.3
		CB	50.3	45.6	40.6	38.0	41.7	46.8	**43.3**	32.4
		I	40.6	48.1	54.5	55.3	46.7	45.7	**49.6**	48.2
		X^2	*30.80*	*11.13*	*27.43*	*40.74*	*3.44*	*40.70*		
	Slapping child on the face	*IN*	15.5	2.6	11.4	8.8	11.7	6.3	**9.4**	20.2
		CB	52.9	71.1	62.4	41.3	60.0	51.1	**51.8**	38.1
		I	31.6	26.3	26.2	50.0	28.3	42.6	**38.8**	41.7
		X^2	*17.39*	*37.56*	*50.45*	*33.65*	*12.25*	*39.52*		
	Caning child	*IN*	15.0	8.8	17.6	16.4	15.0	18.6	16.3	29.4
		CB	66.3	87.5	74.0	62.0	78.3	68.2	68.7	42.7
		I	18.7	3.8	8.3	21.7	6.7	13.2	15.1	27.9
		X^2	*43.26*	*65.89*	*84.35*	*62.88*	*31.74*	*75.41*		
PHYSICAL	Ignoring signs of illness in child (e.g., high fever)	*IN*	3.2	2.4	3.4	2.7	0	1.8	2.5	4.0
		CB	21.8	24.4	31.4	19.7	28.8	19.4	22.8	8.3
		I	75.0	73.2	65.2	77.6	71.2	78.8	74.7	87.7
		X^2	*45.19*	*28.11*	*143.08*	*68.88*	*34.19*	*48.53*		
NEGLECT	Leaving child alone in the house	*IN*	30.2	17.7	18.1	25.6	15.0	20.4	**22.7**	34.5
		CB	51.3	78.5	67.8	50.8	70.0	50.7	**56.4**	34.5
		I	18.5	3.8	14.1	23.6	15.0	28.9	**20.9**	31.0
		X^2	*26.00*	*69.57*	*97.98*	*46.08*	*33.45*	*37.94*		
	Locking child outside the house	*IN*	3.7	1.3	4.0	3.2	5.0	1.4	2.9	7.8
		CB	34.8	41.0	28.9	27.1	36.7	24.1	29.1	23.6
		I	61.5	57.7	67.2	69.7	58.3	74.5	67.9	68.6
		X_2	*15.13*	*15.61*	*6.14*	*12.86*	*5.85*	*16.14*		
	Locking child in a room	*IN*	3.7	6.2	10.3	5.0	5.1	2.5	**5.1**	10.8
		CB	42.0	61.7	54.7	33.8	66.1	37.0	**42.8**	24.9
		I	54.3	32.1	35.0	61.2	28.8	60.6	**52.1**	64.3
		X^2	*33.91*	*58.90*	*99.74*	*26.22*	*53.64*	*35.61*		
EMOTIONAL	Threatening to abandon child	*IN*	20.1	13.9	22.6	14.8	15.0	11.0	**15.8**	23.9
		CB	36.5	50.6	49.2	36.9	43.3	44.5	**42.2**	28.1
		I	43.4	35.4	28.1	48.2	41.7	44.5	**42.0**	48.0
		X^2	*6.65*	*20.07*	*47.87*	*24.56*	*7.40*	*47.47*		
MALTREATMENT	Never hugging child	*IN*	53.2	46.9	41.0	32.0	54.2	30.2	**38.5**	37.0
		CB	32.4	34.6	40.5	37.5	23.7	42.3	**37.6**	25.4
		I	14.4	18.5	18.5	30.5	22.0	27.4	**23.8**	37.5
		X^2	*43.79*	*12.60*	*38.82*	*30.79*	*8.56*	*42.74*		
	Calling child "useless"	*IN*	38.5	13.8	29.2	24.4	33.3	16.2	**25.0**	38.3
		CB	36.9	67.5	54.0	41.1	43.3	53.9	**47.7**	33.0
		I	24.6	18.8	16.8	34.5	23.3	29.9	**27.3**	28.7
		X^2	*1.97*	*44.20*	*41.20*	*32.36*	*2.93*	*73.86*		
	Always criticising child	*IN*	27.1	6.3	22.0	17.3	25.0	14.5	**18.5**	30.9
		CB	50.5	60.8	55.0	45.5	46.7	56.7	**51.9**	37.9
		I	22.3	32.9	23.0	37.2	28.3	28.7	**29.6**	31.2
		X^2	*13.41*	*26.36*	*24.74*	*34.31*	*2.04*	*51.24*		
	Making child study for a long time	*IN*	37.8	35.8	45.5	33.8	45.0	26.5	**35.3**	35.0
		CB	47.9	59.3	50.5	48.1	48.3	54.5	**50.9**	36.8
		I	14.4	4.9	4.0	18.0	6.7	19.0	**13.8**	28.2
		X^2	*19.49*	*26.70*	*58.08*	*28.73*	*13.76*	*37.93*		
	Telling child other children are better	*IN*	52.4	43.8	45.9	40.9	45.0	31.2	**41.4**	46.0
		CB	35.4	48.8	49.3	44.6	45.0	57.1	**47.4**	36.2
		I	12.2	7.5	4.9	14.5	10.0	11.7	**11.2**	17.8
		X^2	*5.12*	*8.38*	*29.01*	*12.56*	*3.37*	*53.42*		

P *= Police,* ***SW*** *= Social Workers,* ***D*** *= Doctors,* ***N*** *= Nurses,* ***L*** *= Lawyers,* ***ED*** *= Educators,* ***ALL Prof.*** *= All/ Pooled professionals,* ***PUB*** *= Public*

Consensus within and between the professions

Unlike the observations for acceptability, here each of the professional groups displayed moderate to high levels of consensus for only some of the 18 behaviours explored. In particular, Social Workers and Lawyers seemed to have moderate to high consensus for most of the behaviours. Interestingly, most items with low consensus were from the emotional maltreatment category. However, for the behaviour of 'Shaking a child hard' (from the physical abuse category) in particular, all professional groups displayed low consensus when rating on its abuse status.

2.4 Summary and Conclusions

It was revealed that there were many (about 13) behaviours with moderate to high levels of consensus for *ratings of acceptability* among the professionals (pooled). Moreover, for items indicative of sexual abuse and physical abuse, there were high levels of consensus among the different professions and the public. These included items where there were no significant differences across all groups. However, for *ratings on abuse status*, there were less (only 7) behaviours with moderate to high levels of consensus. In addition there were no clear trends among professions when compared with the public. Comparisons across professions revealed that Social Workers had moderate to high levels of within-group consensus for the most number of items in both *acceptability* and *abuse status* ratings. Another interesting group comprised the Lawyers, who displayed the lowest within group consensus with regards to *acceptability ratings* but had the highest group consensus (similar to Social Workers) for *ratings on abuse status*.

Such results imply that the respondents within each of the professions and the public were more similar when considering the *acceptability levels* of the behaviours rather than their *abuse status*. This supports our earlier notion that acceptability and abuse status are independent factors in the categorisation of actions. Amongst the professions explored, it seems to be that the Social Workers in particular are the most homogenous group with regards to group consensus. This may not be related to the small group size as observed through the wider ranger of opinions amongst another small group, the Lawyers. This is certainly a strength of the Social Work profession, as this profession has a high probability of dealing with CAN directly including liaisons with professionals from other categories.

Chapter 3 : Mitigating Circumstances

3.1 Introduction

As mentioned in the previous chapter, the present assessment was also conducted to compare the views of professionals with those of the public obtained by Tong *et al.* (1996) and Elliott *et al.* (1997). The aim is to understand if circumstances might influence perceptions of actions that suggest CAN. Actions such as caning were regarded as 'sometimes' acceptable by a majority of both divisions. Perhaps it is more acceptable to cane a child who is older as opposed to a child who is younger? Perhaps caning is permissible if the adult has good intentions? Circumstances such as age of child and adult's intentions might play a role in the acceptability of actions. Moreover, do such circumstances play similar roles for all forms of CAN (i.e., the different CAN types)?

3.2 Method

In the second part of Section A of the questionnaire, 8 (that is, 2 representing each of the 4 types of maltreatment) of the 18 behaviours assessed in part one (see Chapter 2) were described with different circumstances (for example, frequency & age). The actions are listed below. The 8 behaviours were as follows:

- Caning a child;
- Slapping a child on the face;
- Appearing naked in front of a child;
- Parent not protecting a child from sexual advances of other family members;
- Making a child study for a long time;
- Telling a child that other children are better;
- Leaving a child alone in the house; and
- Ignoring signs of illness in a child (for example, high fever).

This part explored the influence of circumstances on the acceptability of these actions. Here, we were interested in identifying actions that were acceptable only under certain circumstances. The respondents were required to choose the option that best fitted their opinion of the circumstances as justifying the action. Each circumstance was provided with three or four situations. For example, for the action of Caning a Child, a circumstance such as the child's age, was presented with varying conditions, such as follows:

Conditions for the circumstance: child's age

A. Acceptable only if child is younger
B. Acceptable only of child is older
C. Acceptable regardless of age of child
D. Not acceptable regardless of age of child

3.3 Results

A detailed analysis of differences among professions is the subject of a paper in preparation. For this monograph, the professions have been pooled and considered as a single group for summary purposes. Tables 3.1-3.8 show, for 8 actions, the proportions of respondents choosing conditional acceptability in relation to the specified circumstances. For example, with respect to frequency of incidents, it is clear that if any action only happens once or twice, i.e., is a rare occurrence, it is much more likely to be viewed as acceptable, unless it is in any case a very unacceptable action (such as having sex with a child).

The findings highlight the fact that the circumstances of an action do have a bearing on whether it is regarded as acceptable or as abuse. This is seen most clearly by focusing on the range of variation in responses to the different potentially mitigating circumstances. We consider these briefly for each action.

Caning a child

Caning is a common disciplinary measure in Singapore, and child abuse cases involving it have been those where the caning has been grossly excessive (e.g., Wong, 1979). In general, overwhelmingly it is seen as sometimes or always acceptable, only 17.3% rated it never acceptable. However, this acceptability is highly conditional, as can be seen from Table 3.1. Over 80% of professionals rated caning acceptable provided that the intentions of the adult were good, the child had been disobedient, only the limbs or buttocks were affected, and provided there was no permanent mark or injury. Also, 77.4% were prepared to regard as acceptable occasional caning (if it only happens once or twice), and this figure was accompanied by a higher figure for acceptable regardless, suggesting that respondents approving of caning as a disciplinary measure were not inclined to limit their approval to such very occasional cases.

On the other hand, all other circumstances attracted very low level of acceptability. Poverty, stress, the busy work schedule of parents and the sex of the child were seen as grounds for acceptability by at most 2% of the respondents. Although handicapped children are at more risk of physical child abuse, handicap also was not seen as grounds for the acceptability. In the case of age, opinion was surprisingly divided as to whether acceptability was affected by age; 31.4% felt caning was acceptable only if the child was younger, probably reflecting the view that younger children could not understand reason, so needed to be controlled physically (Loh, 1990). However, 32.8% took the opposite view, that caning was acceptable only if the child was older, possibly reflecting an attitude that younger children can be indulged until they are of an age to understand right and wrong (a view is held to be traditional among Chinese parents generally, see Ho, 1986). A further 20.8% regarded age as irrelevant and indicated caning as acceptable regardless.

In general, the professional respondents were more inclined than the public to regard caning as acceptable, under appropriate conditions, and as unacceptable, under inappropriate ones. They were,

in other words, more discriminating, while expressing overall a similar pattern of acceptability. For example, the professionals were more likely to see caning as acceptable only if done with good intentions; whereas the public were more likely to see caning as simply unacceptable regardless (see Table 3.1).

Slapping a child on the face

This action is very much less acceptable than caning, more so among the professionals than among the public. A majority of professionals (57%; public 53.8%) thought it was never acceptable while the other 43% (public 42.4%) were prepared to allow that slapping on the face was sometimes acceptable. This contrasts with caning, where only 17.3% (public 28.5%) rated it never acceptable, and overwhelmingly the rest (78%; public 59.4%) thought it was sometimes acceptable (Table 3.2). In other words, caning is mostly viewed as an acceptable action (but sometimes may not be), while slapping on the face is mostly unacceptable (but sometimes may be). Adults may tend to see slapping of any kind as more dangerous to the child than caning, and not regard it as a common disciplinary practice (and therefore tolerable and acceptable) in comparison to caning.

As with caning, slapping on the face is most likely to attract an acceptable rating if the adult has good intentions, the child was disobedient, there is no permanent mark as a result, or it happens only once or twice. This pattern of increased acceptability is compatible with slapping being to some extent tolerated as a disciplinary action, even though it is generally not considered acceptable. This pattern is very similar for both samples of the public and the professionals.

Appearing naked in front of a child

No action connoting sexual abuse was ever acceptable to a majority of respondents. In the case of appearing naked, this majority comprised 74.9% of the professional sample. A significantly higher proportion of the public sample, 84.4%, responded similarly. This difference may have reflected the fact that this item was somewhat ambiguous – appearing naked is not necessarily an indication of sexual interest, a caretaker may be bathing or dressing, and in any case the nakedness may not be a deliberate exposure. In the interviews used in the HDB study, it was clear to respondents that innocent or accidental exposure was not the issue, but no such clarification could be offered to the professional respondent who simply relied on the questionnaire wording. However, the item was left the same in both studies for the sake of comparison. This interpretation is supported by the fact that the only circumstances which were given as grounds for appearing naked being acceptable were infrequency, good intentions, or if the child is younger, which, without a specified age, could be taken to include toddlers or infants (Table 3.3).

A parent not protecting a child from sexual advances of other family members

Not surprisingly, this action was overwhelmingly regarded as never acceptable (professionals 95.4%, public 97.7%). Respondents who found any circumstances in which this was acceptable could be counted in single figures, in both public and professional samples, whose patterns of responding were virtually identical (Table 3.4).

Table 3.1
Comparison between pooled professionals and public on ratings of circumstances for the action: Caning a child.

Circumstance		Professionals %	Public %
Frequency of incidents	Acceptable if it only happens once or twice	77.4	63.9
	Acceptable regardless of circumstance	9.8	13.0
	Not acceptable regardless of circumstance	12.9	23.1
Age of child	Acceptable only if child is younger	31.4	28.0
	Acceptable only if child is older	32.8	32.8
	Acceptable regardless of circumstance	20.8	15.5
	Not acceptable regardless of circumstance	15.1	23.8
Sex of child	Acceptable only if child is boy	2.9	6.8
	Acceptable only if child is girl	0.1	0.3
	Acceptable regardless of circumstance	78.0	66.4
	Not acceptable regardless of circumstance	16.0	26.6
Area of body affected	Acceptable if only limbs/buttocks affected	81.2	74.8
	Acceptable regardless of circumstance	2.0	2.0
	Not acceptable regardless of circumstance	16.8	23.3
Whether child is marked/injured or not	Acceptable only if child is NOT permanently marked or injured	81.5	67.7
	Acceptable regardless of circumstance	1.6	1.8
	Not acceptable regardless of circumstance	16.9	30.6
Whether child is disobedient or not	Acceptable only if child is disobedient	85.5	79.5
	Acceptable regardless of circumstance	1.4	1.8
	Not acceptable regardless of circumstance	13.2	18.8
Treatment of child compared to siblings	Acceptable only if child is treated differently from brothers/sisters	1.2	3.0
	Acceptable only if child is treated the same as brothers/sisters	69.0	45.7
	Acceptable regardless of circumstance	10.8	22.1
	Not acceptable regardless of circumstance	19.1	29.1
Physical or mental handicap of child	Acceptable only if the child is handicapped	1.2	1.3
	Acceptable only if the child is NOT handicapped	62.5	48.1
	Acceptable regardless of circumstance	15.6	14.9
	Not acceptable regardless of circumstance	20.6	35.8
Adult's intentions	Acceptable only if adult has good intentions	85.8	79.2
	Acceptable regardless of circumstance	1.5	1.8
	Not acceptable regardless of circumstance	12.7	19.0
Adult's stress level	Acceptable only if the adult is under stress	2.0	7.8
	Acceptable only if the adult is NOT under stress	60.4	34.3
	Acceptable regardless of circumstance	12.3	17.3
	Not acceptable regardless of circumstance	25.3	40.8
Family's financial status	Acceptable only if family is poor	0.4	1.3
	Acceptable only if family is NOT poor	0.6	3.0
	Acceptable regardless of circumstance	74.2	53.8
	Not acceptable regardless of circumstance	24.8	42.0
Parents' work schedule	Acceptable only if parents are busy working	0.5	1.8
	Acceptable only if parents are NOT busy working	6.5	7.0
	Acceptable regardless of circumstance	66.8	46.8
	Not acceptable regardless of circumstance	26.2	44.5

Table 3.2

Comparison between pooled professionals and public on ratings of circumstances for the action: Slapping a child on the face.

Circumstance		Professionals %	Public %
Frequency of incidents	Acceptable if it only happens once or twice	38.9	39.0
	Acceptable regardless of circumstance	3.5	7.5
	Not acceptable regardless of circumstance	57.7	53.5
Age of child	Acceptable only if child is younger (age not specified)	10.5	10.5
	Acceptable only if child is older (age not specified)	18.2	21.5
	Acceptable regardless of circumstance	11.6	12.3
	Not acceptable regardless of circumstance	59.8	55.8
Sex of child	Acceptable only if child is boy	2.4	4.3
	Acceptable only if child is girl	0.1	0.0
	Acceptable regardless of circumstance	37.3	37.3
	Not acceptable regardless of circumstance	60.1	58.5
Whether child is marked/injured or not	Acceptable only if child is NOT permanently marked or injured	39.6	37.8
	Acceptable regardless of circumstance	0.9	2.5
	Not acceptable regardless of circumstance	59.5	59.8
Whether child is disobedient or not	Acceptable only if child is disobedient	42.5	47.3
	Acceptable regardless of circumstance	1.4	1.5
	Not acceptable regardless of circumstance	56.1	51.3
Treatment of child compared to siblings	Acceptable only if child is treated differently from siblings	0.7	1.5
	Acceptable only if child is treated the same as siblings	32.5	27.5
	Acceptable regardless of circumstance	7.3	14.3
	Not acceptable regardless of circumstance	59.5	56.8
Physical or mental handicap of child	Acceptable only if the child is handicapped	0.6	1.0
	Acceptable only if the child is NOT handicapped	30.8	29.8
	Acceptable regardless of circumstance	8.1	9.3
	Not acceptable regardless of circumstance	60.5	59.9
Adult's intentions	Acceptable only if adult has good intentions	43.6	46.0
	Acceptable regardless of circumstance	0.8	2.3
	Not acceptable regardless of circumstance	55.6	51.8
Adult's stress level	Acceptable only if the adult is under stress	1.7	6.0
	Acceptable only if the adult is NOT under stress	27.3	19.5
	Acceptable regardless of circumstance	8.9	13.3
	Not acceptable regardless of circumstance	62.1	61.3
Family's financial status	Acceptable only if family is poor	0.2	2.0
	Acceptable only if family is NOT poor	0.7	1.3
	Acceptable regardless of circumstance	36.3	32.3
	Not acceptable regardless of circumstance	62.7	64.5
Parents' work schedule	Acceptable only if parents are busy working	0.5	1.5
	Acceptable only if parents are NOT busy working	3.4	5.5
	Acceptable regardless of circumstance	32.0	28.0
	Not acceptable regardless of circumstance	64.1	65.0

Table 3.3

Comparison between pooled professionals and public on ratings of circumstances for the action: Appearing naked in front of a child.

Circumstance		Professional %	Public %
Frequency of incidents	Acceptable if it only happens once or twice	16.2	10.0
	Acceptable regardless of circumstance	5.4	2.3
	Not acceptable regardless of circumstance	78.4	87.8
Age of child	Acceptable only if child is younger (age not specified)	24.5	11.8
	Acceptable only if child is older (age not specified)	0.3	0.8
	Acceptable regardless of circumstance	2.9	2.5
	Not acceptable regardless of circumstance	72.3	85.0
Sex of child	Acceptable only if child is boy	1.9	1.8
	Acceptable only if child is girl	0.7	0.5
	Acceptable regardless of circumstance	18.0	9.5
	Not acceptable regardless of circumstance	79.4	88.3
Treatment of child compared to siblings	Acceptable only if child is treated differently from siblings	0.5	0.5
	Acceptable only if child is treated the same as siblings	12.7	4.5
	Acceptable regardless of circumstance	5.8	6.5
	Not acceptable regardless of circumstance	81.1	88.5
Physical or mental handicap of child	Acceptable only if the child is handicapped	0.4	0.3
	Acceptable only if the child is NOT handicapped	4.1	1.8
	Acceptable regardless of circumstance	14.4	8.8
	Not acceptable regardless of circumstance	81.1	89.3
Adult's Intentions	Acceptable only if adult has good intentions	17.6	9.5
	Acceptable regardless of circumstance	2.0	2.0
	Not acceptable regardless of circumstance	80.4	88.5
Adult's stress level	Acceptable only if the adult is under stress	0.1	0.0
	Acceptable only if the adult is NOT under stress	7.5	5.3
	Acceptable regardless of circumstance	10.0	4.8
	Not acceptable regardless of circumstance	82.4	90.0
Family's financial status	Acceptable only if family is poor	0.2	0.5
	Acceptable only if family is NOT poor	0.4	0.3
	Acceptable regardless of circumstance	16.8	9.8
	Not acceptable regardless of circumstance	82.5	89.5

Table 3.4

Comparison between pooled professionals and public on ratings of circumstances for the action: A parent not protecting a child from sexual advances of other family members.

Circumstance		Professionals %	Public %
Frequency of incidents	Acceptable if it only happens once or twice	0.6	2.0
	Acceptable regardless of circumstance	0.4	0.8
	Not acceptable regardless of circumstance	99.0	97.2
Age of child	Acceptable only if child is younger (age not specified)	0.2	1.5
	Acceptable only if child is older (age not specified)	0.2	0.8
	Acceptable regardless of circumstance	0.7	0.3
	Not acceptable regardless of circumstance	98.9	97.5
Sex of child	Acceptable only if child is boy	0.2	1.0
	Acceptable only if child is girl	0.0	0.0
	Acceptable regardless of circumstance	0.8	0.8
	Not acceptable regardless of circumstance	99.0	98.2
Treatment of child compared to siblings	Acceptable only if child is treated differently from siblings	0.0	0.3
	Acceptable only if child is treated the same as siblings	0.4	0.8
	Acceptable regardless of circumstance	0.6	1.0
	Not acceptable regardless of circumstance	99.0	98.0
Physical or mental handicap of child	Acceptable only if the child is handicapped	0.0	0.0
	Acceptable only if the child is NOT handicapped	0.2	0.3
	Acceptable regardless of circumstance	0.8	1.3
	Not acceptable regardless of circumstance	99.0	98.5
Adult's Intentions	Acceptable only if adult has good intentions	0.8	3.3
	Acceptable regardless of circumstance	0.3	0.3
	Not acceptable regardless of circumstance	98.9	96.5
Adult's stress level	Acceptable only if the adult is under stress	0.4	0.5
	Acceptable only if the adult is NOT under stress	0.3	0.8
	Acceptable regardless of circumstance	0.6	0.5
	Not acceptable regardless of circumstance	98.7	98.2
Family's financial status	Acceptable only if family is poor	0.2	0.8
	Acceptable only if family is NOT poor	0.1	0.0
	Acceptable regardless of circumstance	0.7	1.0
	Not acceptable regardless of circumstance	99.0	98.2
Parents' work schedule	Acceptable only if parents are busy working	0.6	1.3
	Acceptable only if parents are NOT busy working	0.2	0.0
	Acceptable regardless of circumstance	0.6	0.8
	Not acceptable regardless of circumstance	98.6	98.0

Making child study for a long time

Good intentions of the parent and infrequency of occurrence were the only circumstances in which excessive compulsory study was acceptable (Table 3.5). Sex of child, financial status of family and parents' work schedule were evidently not considered relevant considerations, as hardly any respondents allowed acceptability contingent on these circumstances and were quite divided as to whether this was not acceptable regardless, or acceptable regardless. Evidently, a substantial proportion of respondents felt that there was a limit to the study one could require of a child, while others did not. In general, this is a tolerated action, with only 26.4% overall indicating it was never acceptable (Table 2.1). This figure is perhaps not surprising, given the emphasis on education, and the pressure on children prevalent in Singapore. It is also not surprising to discover that the figure is lower than the corresponding figure for the public (39.1%), since it is likely that members of professions will be educated and particularly inclined to stress the importance of studying, as compared to the public at large. This difference essentially accounts for the significant difference between professional and public responses across the various circumstances; their respective patterns of response are otherwise similar.

In view of the Singapore emphasis on educational attainment, it is worth noting that excessive pressure to study is treated as a potential ground for abuse in Hong Kong. An illustrative case was cited by Lam (1997), in which a child aged nine was made to study until midnight with breaks only for meals and baths. During the examination period, night-time study continued until daybreak.

Telling a child other children are better

This action was often acceptable, especially if the child was disobedient, the parent had good intentions, and it occurred infrequently, the same pattern as was found with physical actions that could be used to discipline a child. In reality, this action might be expected to be problematic if chronic, or severe. "Constantly telling a child other children are better" might, with hindsight, have been a better form of words for this item. Nonetheless, although qualified acceptance was given, a substantial minority of respondents provided the "not acceptable regardless" response on every item, as did the respondents from the public sample.

Differences between the professionals and the public sampled, were small in relation to the sample sizes, and reflected slight differences in emphasis. For example, the professionals were significantly more inclined to regard the action as only acceptable if occurring once or twice, but the difference is of the order of 7% of respondents (Table 3.6). In general the pattern as between the professions and the public is one of considerable similarity.

Leaving the child alone in the house

For many years the Singapore Children's Society has been concerned with provisions for latchkey children, and the need for alternative child-care arrangements for working or sick parents. Leaving a child alone in a house or flat deliberately is not a satisfactory solution, and 38.8% of respondents

Table 3.5

Comparison between pooled professionals and public on ratings of circumstances for the action: Making a child study for a long time.

Circumstance		Professionals %	Public %
Frequency of incidents	Acceptable if it only happens once or twice	61.9	45.3
	Acceptable regardless of circumstance	14.2	19.9
	Not acceptable regardless of circumstance	24.0	34.8
Age of child	Acceptable only if child is younger (age not specified)	3.8	7.0
	Acceptable only if child is older (age not specified)	43.9	31.4
	Acceptable regardless of circumstance	24.1	25.4
	Not acceptable regardless of circumstance	28.2	36.2
Sex of child	Acceptable only if child is boy	0.2	0.8
	Acceptable only if child is girl	0.2	0.5
	Acceptable regardless of circumstance	66.9	55.1
	Not acceptable regardless of circumstance	32.7	43.6
Treatment of child compared to siblings	Acceptable only if child is treated differently from siblings	0.2	1.0
	Acceptable only if child is treated the same as siblings	44.8	29.5
	Acceptable regardless of circumstance	21.8	29.0
	Not acceptable regardless of circumstance	33.2	40.6
Physical or mental handicap of child	Acceptable only if the child is handicapped	0.5	0.8
	Acceptable only if the child is NOT handicapped	53.3	37.9
	Acceptable regardless of circumstance	10.2	12.6
	Not acceptable regardless of circumstance	36.0	48.7
Adult's intentions	Acceptable only if adult has good intentions	71.2	62.8
	Acceptable regardless of circumstance	2.3	6.0
	Not acceptable regardless of circumstance	26.5	31.2
Adult's stress level	Acceptable only if the adult is under stress	1.2	1.3
	Acceptable only if the adult is NOT under stress	37.3	22.6
	Acceptable regardless of circumstance	24.3	25.9
	Not acceptable regardless of circumstance	37.2	50.3
Family's financial status	Acceptable only if family is poor	0.2	1.5
	Acceptable only if family is NOT poor	0.9	2.3
	Acceptable regardless of circumstance	61.2	47.0
	Not acceptable regardless of circumstance	37.7	49.2
Parents' work schedule	Acceptable only if parents are busy working	0.7	1.5
	Acceptable only if parents are NOT busy working	7.3	4.8
	Acceptable regardless of circumstance	53.2	45.0
	Not acceptable regardless of circumstance	38.7	48.7

Table 3.6

Comparison between pooled professionals and public on ratings of circumstances for the action: Telling a child that other children are better.

Circumstance		Professionals %	Public %
Frequency of incidents	Acceptable if it only happens once or twice	63.9	54.9
	Acceptable regardless of circumstance	7.4	14.8
	Not acceptable regardless of circumstance	28.7	30.3
Age of child	Acceptable only if child is younger (age not specified)	8.4	13.6
	Acceptable only if child is older (age not specified)	25.9	23.6
	Acceptable regardless of circumstance	29.1	28.6
	Not acceptable regardless of circumstance	36.6	34.2
Sex of child	Acceptable only if child is boy	0.2	1.3
	Acceptable only if child is girl	0.2	0.5
	Acceptable regardless of circumstance	61.1	60.1
	Not acceptable regardless of circumstance	38.5	38.2
Whether child is disobedient or not	Acceptable only if child is disobedient	41.5	48.9
	Acceptable regardless of circumstance	23.2	21.1
	Not acceptable regardless of circumstance	35.3	30.1
Treatment of child compared to siblings	Acceptable only if child is treated differently from siblings	0.7	0.5
	Acceptable only if child is treated the same as siblings	43.5	33.6
	Acceptable regardless of circumstance	16.9	27.1
	Not acceptable regardless of circumstance	39.0	38.8
Physical or mental handicap of child	Acceptable only if the child is handicapped	1.3	0.8
	Acceptable only if the child is NOT handicapped	48.3	39.7
	Acceptable regardless of circumstance	9.7	14.3
	Not acceptable regardless of circumstance	40.7	45.2
Adult's Intentions	Acceptable only if adult has good intentions	66.0	68.2
	Acceptable regardless of circumstance	2.8	4.8
	Not acceptable regardless of circumstance	31.2	27.1
Adult's stress level	Acceptable only if the adult is under stress	1.8	5.3
	Acceptable only if the adult is NOT under stress	36.6	24.3
	Acceptable regardless of circumstance	19.7	25.1
	Not acceptable regardless of circumstance	41.9	45.4
Family's financial status	Acceptable only if family is poor	0.2	2.3
	Acceptable only if family is NOT poor	1.5	2.8
	Acceptable regardless of circumstance	54.6	46.2
	Not acceptable regardless of circumstance	43.7	48.7
Parents' work schedule	Acceptable only if parents are busy working	0.8	1.5
	Acceptable only if parents are NOT busy working	6.2	6.8
	Acceptable regardless of circumstance	49.2	42.4
	Not acceptable regardless of circumstance	43.8	49.4

took the view that it was unacceptable. When mitigating circumstances are considered, however, this proportion rises to a nearly 50% (Table 3.7) and it is clear that respondents were quite discriminating in regard to the circumstances under which they considered leaving a child alone might be acceptable. Acceptable circumstances included infrequent occurrence, older children, absence of handicap, good adult intentions, and to some extent, the parent working. Sex of child and poverty of family made no difference. Respondents were quite divided as to whether obedience, the stress of the adult or the treatment of the child relative to siblings were relevant. Responses closely paralleled those of the public, and any differences reflected very small proportional changes.

Ignoring signs of illness in a child

This was regarded as never acceptable by over 95% of respondents, both professional and among the public, irrespective of the circumstances (Table 3.8). This suggests that high importance is attached to the health of children in Singapore, and that any failure to respond to signs of illness would be viewed as inexcusable.

3.4 Summary and Conclusions

As with the findings on acceptability and abuse status, there were few differences among the professions, or between the professions and the public. The overall pattern of results is very similar, reflecting small proportional changes in a large sample.

It was observed that the intentions of parents and the frequency of actions were major determinants of acceptability. Actions done with good intention, or only rarely, were often acceptable as compared to the same actions under other circumstances. However, if the actions are actually bad for children, they should be regarded as unacceptable nevertheless. As matters stand, given the range of opinion expressed, it seems unlikely that the different professions encountering cases of maltreatment in any form will respond in the same way even to equivalent cases.

These results highlight the need to consider maltreatment as distinct from abuse. Tong *et al.* (1996) and Elliott *et al.* (1997) highlighted a distinction between maltreatment and abuse. It should be generally agreed that if an action has harmful consequences, it is maltreatment and should be unacceptable regardless of circumstances; and that if it is intentionally harmful it amounts to abuse. This position, which should lead to more professional agreement on a course of action, is also consistent with Singapore law, which identifies both outcome and intention as elements in child abuse and neglect. However, the legal definition of abuse under the C & YP Act (Republic of Singapore, 1993) is applicable only to prosecutions under the Act. Child abuse in the broader sense includes actions under other statutes as well, for example in cases of hurt offences under the Criminal Procedure Code (Republic of Singapore, 1985).

Table 3.7

Comparison between pooled professionals and public on ratings of circumstances for the action: Leaving a child alone in the house

Circumstance		Professionals %	Public %
Frequency of incidents	Acceptable if it only happens once or twice	46.9	41.8
	Acceptable regardless of circumstance	6.4	11.3
	Not acceptable regardless of circumstance	46.7	47.0
Age of child	Acceptable only if child is younger (age not specified)	0.4	1.0
	Acceptable only if child is older (age not specified)	64.2	65.3
	Acceptable regardless of circumstance	1.6	3.3
	Not acceptable regardless of circumstance	33.8	30.5
Sex of child	Acceptable only if child is boy	3.6	8.8
	Acceptable only if child is girl	0.2	1.0
	Acceptable regardless of circumstance	48.0	43.8
	Not acceptable regardless of circumstance	48.2	46.5
Whether child is disobedient or not	Acceptable only if child is disobedient	2.5	5.0
	Acceptable only if child is obedient	27.1	16.0
	Acceptable regardless of circumstance	19.6	26.3
	Not acceptable regardless of circumstance	50.9	52.8
Treatment of child compared to siblings	Acceptable only if child is treated differently from siblings	0.4	0.5
	Acceptable only if child is treated the same as siblings	33.3	22.3
	Acceptable regardless of circumstance	15.9	24.5
	Not acceptable regardless of circumstance	50.4	52.8
Physical or mental handicap of child	Acceptable only if the child is handicapped	0.7	1.0
	Acceptable only if the child is NOT handicapped	46.2	38.3
	Acceptable regardless of circumstance	3.4	6.0
	Not acceptable regardless of circumstance	49.7	54.6
Adult's intentions	Acceptable only if adult has good intentions	45.6	44.8
	Acceptable regardless of circumstance	5.8	8.5
	Not acceptable regardless of circumstance	48.6	46.8
Adult's stress level	Acceptable only if the adult is under stress	1.8	2.3
	Acceptable only if the adult is NOT under stress	25.5	17.5
	Acceptable regardless of circumstance	19.7	22.3
	Not acceptable regardless of circumstance	53.0	58.0
Family's financial status	Acceptable only if family is poor	1.6	2.8
	Acceptable only if family is NOT poor	1.1	1.5
	Acceptable regardless of circumstance	44.7	39.5
	Not acceptable regardless of circumstance	52.6	56.3
Parents' work schedule	Acceptable only if parents are busy working	14.4	11.8
	Acceptable only if parents are NOT busy working	4.9	4.0
	Acceptable regardless of circumstance	28.8	29.3
	Not acceptable regardless of circumstance	51.8	55.0

Table 3.8

Comparison between pooled professionals and public on ratings of circumstances for the action: Ignoring signs of illness in a child (e.g., high fever).

Circumstance		Professionals %	Public %
Frequency of incidents	Acceptable if it only happens once or twice	3.8	3.5
	Acceptable regardless of circumstance	0.8	0.3
	Not acceptable regardless of circumstance	95.4	96.3
Age of child	Acceptable only if child is younger (age not specified)	0.2	0.5
	Acceptable only if child is older (age not specified)	3.6	3.0
	Acceptable regardless of circumstance	0.7	1.5
	Not acceptable regardless of circumstance	95.6	95.0
Sex of child	Acceptable only if child is boy	0.1	0.3
	Acceptable only if child is girl	0.1	0.0
	Acceptable regardless of circumstance	3.2	3.0
	Not acceptable regardless of circumstance	96.7	96.8
Treatment of child compared to siblings	Acceptable only if child is treated differently from siblings	0.2	0.5
	Acceptable only if child is treated the same as siblings	1.9	1.3
	Acceptable regardless of circumstance	1.2	2.3
	Not acceptable regardless of circumstance	96.8	96.0
Physical or mental handicap of child	Acceptable only if the child is handicapped	0.2	0.5
	Acceptable only if the child is NOT handicapped	1.9	1.5
	Acceptable regardless of circumstance	1.2	2.3
	Not acceptable regardless of circumstance	96.7	95.8
Adult's intentions	Acceptable only if adult has good intentions	3.0	4.3
	Acceptable regardless of circumstance	0.8	0.3
	Not acceptable regardless of circumstance	96.2	95.5
Adult's stress level	Acceptable only if the adult is under stress	1.2	2.0
	Acceptable only if the adult is NOT under stress	0.9	1.0
	Acceptable regardless of circumstance	1.5	1.8
	Not acceptable regardless of circumstance	96.4	95.3
Family's financial status	Acceptable only if family is poor	1.7	2.8
	Acceptable only if family is NOT poor	0.0	0.3
	Acceptable regardless of circumstance	2.4	2.0
	Not acceptable regardless of circumstance	95.9	95.0
Parents' work schedule	Acceptable only if parents are busy working	2.2	3.0
	Acceptable only if parents are NOT busy working	0.2	0.3
	Acceptable regardless of circumstance	1.3	1.3
	Not acceptable regardless of circumstance	96.4	95.5

CHAPTER 4 : SERIOUSNESS OF ACTIONS

4.1 Introduction

The professional respondents were also asked to respond to a series of vignettes, indicating how seriously they regarded the actions taken by the adults in each case. The purpose was to provide some additional information as to what professionals were prepared to regard as serious. Given the evident importance attached to circumstances by respondents in the study, it would be useful to note if specific scenarios (i.e., actions coupled with particular circumstances) would influence the perceptions of professionals. Rather than classifying the situation as abuse/acceptable (as explored in the previous sections) we were interested in understanding how seriously the different professions viewed each situation as it occurred. Scenarios are the closest possible replication of actual incidents as they are examples of possible situations.

The public and the professions do not always see eye to eye. Giovannoni and Becerra (1979), working in the US, developed vignettes (scenarios) briefly describing different potentially abusive situations. Sixty of these vignettes were assigned randomly to groups of police, social workers, paediatricians and lawyers, and to a sample of the Los Angeles public who were not members of these professions. The professionals rated as most serious, physical harm through either physical abuse or physical neglect. However the public rated as most serious, sexual abuse or engaging a child in crime. Furthermore their ratings for these aspects were higher than those of the professionals. The public's ratings for such aspects were also higher than those for physical injury.

Segal (1992) conducted a similar study in India that included many of the questions and vignettes used by Giovannoni and Becerra (1979). The study sample included social workers, other human service professionals who worked with children (such as doctors, nurses and teachers) and the public. The overall ratings in the study were generally high. Child prostitution was considered as most abusive whilst poor housing conditions, least abusive. Also, child prostitution and sexual abuse were perceived similarly across the groups. Furthermore, it appeared that social workers and the public shared similar perceptions and differed from the other human service professionals. The latter groups also seemed to rate the vignettes more seriously than the social workers and the public.

Sexual abuse was ranked as most serious, whilst housing was least serious by both the American and Indian samples. However, the remaining forms of abuse were ranked differently in the two countries. Segal (1992) regarded the general high ratings to reflect a relative lack of ability to distinguish short- and long-term impacts of the different forms of abuse. The high ratings for child beggary and child prostitution were attributed to the attention that had been given towards widespread societal abuse in the past decade in India. Whilst sexual abuse and selective neglect of the child were regarded unacceptable, the battering of children was considered much less detrimental to the welfare of the child. This reflects the notion of Finkelhor and Korbin (1988), that corporal punishment is relatively accepted as a suitable form of socialisation and discipline of the child. In addition Segal (1992) noted that in the Indian society, parental sexual mores on the child are considered as significant although sexuality is not openly displayed or discussed. This was compared to the American society where long

term effects of parental sexual abuse are not considered as harmful, though they may be, since expressed sexuality is apparently more acceptable.

Ajduković, Petak and Mršić (1993) carried out a similar study in Croatia. Questionnaires were distributed to 154 professionals (comprising social workers, psychologists, public prosecutors, judges and teachers) who had professional contact with child abuse cases and to 152 members of the public. The professionals and the public were similar in their attitudes towards the following: abusive parents, general social incompetence of abusive parents, agreeing about personal history of abuse as a cause of abuse, and about social factors in child abuse. In general, there were more similarities between the groups in issues concerning attitudes about causes and conditions of child abuse than the reactions to the problems. This implies that there may be a certain level of consensus between professionals and the public, in the awareness of child maltreatment. However, there is also cause for concern with the implication that the two groups may, in effect, have different responses upon discovering a case of child maltreatment. It may also be useful had Ajduković *et al.* explored the possibility of differences between professionals within and between the various fields involved with the management of child maltreatment cases in Croatia.

4.2 Method

Section B involved the 'Ratings of Incidents'. Here we were interested in exploring how seriously CAN situations (not just the actions in Section A) are viewed. Seventeen incidents with potential to be classified as maltreatment were rated by respondents according to an increasing scale of seriousness, which ranged from 'not serious' (1) to 'very serious' (9). Respondents were to give their opinions with respect to a 7-year-old child and regardless of the child's gender unless it was stated. The respondents were presented with the questions as seen in Table 4.1.

4.3 Results

One-way analyses of variance (ANOVA's) were conducted for levels of seriousness across all professions for each incident. For these tests, alpha is set at $p=.001$. This is because the large sample sizes will make small effects statistically significant. Nevertheless, throughout the reporting alpha levels of $<.05$ will be stated. However, caution has been exerted in the interpretation of such results in lieu of the possibility of Type I errors.

As can be seen in Table 4.1, most incidents were given high ratings indicating that the professional respondents viewed them seriously. It seems to be the case that the seriousness of incidents does not so much depend upon the type of abuse that is apparently occurring but if in fact the situation itself warrants attention/concern. In particular, incidents indicative of sexual abuse tended to be viewed very seriously, in line with the results of the previous section. In this section, the highest ratings were for the incidents, "The parent fondles the child's genital area" and "The parent repeatedly shows the child pornographic materials". Comparisons of the mean scores across professions revealed no significant differences across the professions. This implies that all professionals tend to view both incidents with similar and high levels of seriousness. While these results indicate that such incidents (and perhaps

sexual abuse itself) are viewed seriously, the high ratings may also have resulted from the use of suggestive words e.g., the use of "fondles" instead of 'touches/feels' and/or "repeatedly... pornographic" as opposed to 'occasional exposure ...naked'. The wordings adopted here were intended to imply a deliberate intent on the part of the adult.

In contrast, the lowest mean rating scores (i.e., below 5 for every profession) were for the incident where the parents with two children live in a flat with few furnishings (the fourth incident in Table 4.1). The low ratings for seriousness level here may be due to the absence of any obvious harm to the children in this scenario. Comparison of means revealed a significant difference of mean scores across the professions ($F_{5,1206}$ = 18.01, p<.0001). Post-hocs (Tukey's HSD) revealed 2 subsets. One subset comprised Lawyers (Mean = 2.3), Doctors (Mean = 2.5) and Social Workers (Mean = 2.6), whose means were amongst the lowest. The second subset comprised the Police (Mean = 3.9), Nurses (Mean = 3.9) and Educators (Mean = 4.0), whose mean scores were the highest. The professions from one subset were significantly different from those of the other subset while those within one subset did not differ from each other. Thus for this situation, it seems that the Lawyers, Doctors and Social Workers had similar perceptions of the level of seriousness, which differed somewhat from the perceptions of the Police, Nurses and the Educators. One might speculate that the former group had more direct experience of abuse cases and were therefore more aware that in contrast to serious or prosecutable offences, this scenario was, in actual fact, a less serious one.

There were also some incidents with intermediate levels of seriousness, where the mean rating scores were below 7 for each profession. These include "The parents cane the child because the child did not excel in an examination (Incident no. 5)", "The parents foster the child out to a relative and bring the child home every weekend (Incident no. 6)" and "The parents usually punish the child by spanking him (Incident no. 9)". There were significant differences across the professions for each of these incidents ($F_{5,1218}$ = 6.84, p<.0001; $F_{5,1217}$ = 12.00, p<.0001; and $F_{5,1222}$ = 15.8, p<.0001 respectively). For these scenarios, the actions reflect culturally sanctioned discipline or child management activities. Caning a child (Incident no. 5) who did not excel in an examination was regarded most serious by the educators (Mean = 7.0) who differed significantly in comparison to most other professions (except for Nurses), even though the mean rating scores were generally above 6. It should be noted that while this profession does focus on education, it does consider caning a child for the reason of not excelling (as opposed to doing badly) in one's exams as a cause for concern. None of the other professions differed with each other except for Nurses (Mean = 6.7) who differed from Doctors (Mean = 6.2).

Table 4.1

The mean rated seriousness of incidents by professions (minimum 1, maximum 9).

INCIDENT TO BE RATED	RATED BY						
	P	SW	D	N	L	ED	ALL
1. The parents know that their child often truants, but they don't do anything about it. Mean	7.89	7.68	7.78	8.06	7.65	8.56	8.06
(SD)	(1.58)	(1.53)	(1.54)	(1.49)	(1.70)	(0.94)	(1.45)
2. The parents ignore their child most of the time, seldom talking with him or listening to him.	7.80 (1.58)	7.99 (1.27)	7.81 (1.41)	8.27 (1.30)	7.22 (1.69)	8.28 (1.20)	8.05 (1.39)
3. The parent fondles the child's genital area.	8.81 (0.66)	8.84 (0.68)	8.87 (0.43)	8.74 (0.98)	8.93 (0.25)	8.90 (0.61)	8.83 (0.73)
4. The parents live in a flat with their two children. They have few furnishings, a bed where the parents sleep, and two mattresses, where each of the children sleeps.	3.87 (2.47)	2.62 (1.85)	2.51 (2.04)	3.87 (2.43)	2.28 (1.94)	4.00 (2.53)	3.52 (2.43)
5. The parents cane the child because the child did not excel in an examination.	6.29 (1.99)	6.06 (1.88)	6.15 (2.13)	6.70 (2.00)	6.18 (2.00)	6.97 (1.77)	6.54 (1.98)
6. The parents foster their child out to a relative and bring the child home every weekend.	5.78 (2.10)	4.69 (2.13)	4.36 (2.33)	5.28 (2.25)	4.55 (2.32)	5.57 (2.19)	5.20 (2.27)
7. The mother's boyfriend frequently bathes the girl.	8.10 (1.44)	7.84 (1.50)	7.92 (1.41)	8.16 (1.55)	7.70 (1.78)	8.66 (1.10)	8.18 (1.45)
8. The father is always at work and the mother is always playing mahjong. They do not bother whether the child eats or does his homework.	8.34 (1.27)	8.24 (1.03)	8.01 (1.34)	8.64 (0.93)	8.03 (1.25)	8.60 (0.90)	8.42 (1.11)
9. The parents usually punish the child by spanking him with the hand.	5.95 (2.48)	4.93 (2.30)	4.73 (2.23)	6.06 (2.34)	4.37 (2.59)	6.01 (2.36)	5.64 (2.43)
10. The parents foster the child out to a relative and never visit the child.	8.46 (1.18)	8.33 (1.00)	8.37 (1.13)	8.69 (0.84)	8.35 (1.09)	8.65 (1.12)	8.55 (1.01)
11. The parent repeatedly shows the child pornographic pictures.	8.84 (0.67)	8.88 (0.48)	8.93 (0.32)	8.87 (0.57)	8.82 (0.62)	8.93 (0.55)	8.89 (0.54)
12. The parents usually punish the child by making him kneel on the floor on uncooked rice grains.	8.01 (1.60)	7.70 (1.45)	7.91 (1.45)	8.13 (1.45)	7.76 (1.67)	8.20 (1.52)	8.04 (1.50)
13. The parents fail to prepare regular meals for their child. The child often has to prepare his own meals.	7.48 (1.70)	7.19 (1.70)	7.49 (1.56)	7.62 (1.66)	7.40 (1.60)	7.86 (1.53)	7.59 (1.63)
14. The parent strikes the child with a wooden stick.	8.39 (1.16)	8.00 (1.37)	7.89 (1.50)	8.18 (1.44)	8.07 (1.27)	8.35 (1.23)	8.18 (1.36)
15. The parents usually leave their child on a damp and dirty mattress.	8.27 (1.19)	7.86 (1.51)	8.08 (1.20)	8.45 (1.04)	7.10 (1.23)	8.44 (1.05)	8.30 (1.15)
16. The parents never see to it that their children do their homework. They let them watch TV all evening.	7.27 (1.92)	6.61 (1.43)	6.71 (1.80)	7.91 (1.40)	6.82 (1.87)	7.87 (1.37)	7.46 (1.66)
17. The parents do not see to it that their child has clean clothing.	7.57 (1.68)	6.93 (1.46)	7.19 (1.50)	7.94 (1.47)	7.27 (1.68)	7.89 (1.41)	7.65 (1.54)

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The scenario of weekend parenting for a child fostered out on weekdays (Incident no. 6) was considered to be of moderate seriousness, where the mean scores of the professions ranged from 4 to 6. Post-hocs again revealed groups Doctors (Mean = 4.4), Lawyers (Mean = 4.6) and Social workers (Mean = 4.7) differed significantly from the Police (Mean = 5.8) and Educators (Mean =5.6), but not with each other. Likewise the Police and Educators did not differ from each other. There were also no other significant pair-wise differences between the professions for this incident except for the Nurses (Mean = 5.3) who differed significantly from the Doctors. As for the incident of spanking a child (Incident no. 9), post-hocs revealed 2 subsets. One subset comprised Lawyers (Mean = 4.4), Doctors (Mean = 4.7) and Social Workers (Mean = 4.9), whose means were amongst the lowest. The second subset comprised the Police (Mean = 6.0), Educators (Mean = 6.0) and Nurses (Mean = 6.1) whose mean scores were amongst the highest. The professions from one subset were significantly different from those of the other subset. However, the professions within one subset did not differ from each other. Thus for this situation, it seems that the Lawyers, Doctors and Social Workers had similar perceptions of a lower level of seriousness, which differed from the perceptions of the Police, the Educators and the Nurses, who saw it as more serious.

For the remaining incidents the mean rating scores were generally above 7 with statistically significant differences across the different professions:

The parents know that their child often truants, but they don't do anything about it (Incident no. 1).
For this incident ($F_{5,1217} = 11.31$, $p<.0001$), post-hocs revealed that the Educators (Mean = 8.6) were significantly higher than all other professions which did not differ from each other.

The parents ignore their child most of the time, seldom talking with him or listening to him (Incident no. 2).
For this incident ($F_{5,1222} = 10.9$, $p<.0001$), post-hocs revealed that the Nurses (Mean = 8.3) and the Educators (Mean = 8.3) comprised a separate subset where both differed from the Police (Mean = 7.8) and Doctors (Mean = 7.8). The professions within each subset did not differ with each other. Interestingly, for this incident the Lawyers (Mean = 7.2) were significantly different from all other professions, including the Social Workers (Mean = 8.0).

The mother's boyfriend frequently bathes the girl (Incident no. 7).
For this incident ($F_{5,1221} = 10.2$; $p<.0001$), post-hocs revealed that the Educators (Mean = 8.7) saw this as more serious than all other professions.

The father is always at work and the mother is always playing mahjong. They do not bother whether the child eats or does his homework (Incident no. 8).
For this incident ($F_{5,1224} = 12.82$; $p<.0001$), post-hocs revealed that the Nurses (Mean = 8.6) were significantly different from the Police (Mean = 8.3), Social Workers (Mean = 8.2), Doctors (Mean = 8.0) and Lawyers (Mean = 8.0). Also, the Police and Educators (Mean = 8.6) each differed significantly from the Doctors. In addition, the Educators also differed significantly from the Lawyers.

The parents foster the child out to a relative and never visit the child (Incident no. 10).
For this incident ($F_{5,1226}$ = 4.65; p<.0001), post-hocs revealed that Nurses (Mean = 8.7) and Educators (Mean = 8.7) each differed significantly from the Doctors (Mean =8.4).

The parents usually punish the child by making him kneel on the floor on uncooked rice grains (Incident no. 12).
For this incident ($F_{5,1224}$ = 2.46; p<.05), post-hocs did not reveal any statistically significant differences between the professions. This is not surprising given the higher alpha level for the significance of this result in comparison to the other incidents. This implies the similar level of seriousness with which this incident is viewed.

The parents fail to prepare regular meals for their child. The child often has to prepare his own meals (Incident no. 13).
For this incident ($F_{5,1222}$ = 3.07; p<.01), post-hocs revealed that the Social Workers (Mean = 7.2) were significantly different for the Educators (Mean = 7.9).

The parent strikes the child with a wooden stick (Incident no. 14).
For this incident ($F_{5,1221}$ = 4.09; p<.001), post-hocs revealed that the Police (Mean = 8.4) and the Educators (Mean = 8.4) each differed significantly from the Doctors (Mean = 8.0).

The parents usually leave their child on a damp and dirty mattress (Incident no. 15).
For this incident ($F_{5,1222}$ = 6.52; p<.0001), post-hocs revealed that the Nurses (Mean = 8.5) and the Educators (Mean = 8.4) comprised a separate subset where both differed from the Social Workers (Mean = 7.9) and Doctors (Mean = 8.1). The professions within each subset did not differ with each other.

The parents never see to it that their children do their homework. They let them watch TV all evening (Incident no. 16).
For this incident ($F_{5,1227}$ = 27.23; p<.0001), post-hocs revealed that the Police (Mean = 7.3) were significantly different from all other professions (Mean = 6.6 for Social Workers, Mean = 6.7 for Doctors, Mean = 7.9 for Educators, and Mean = 7.9 for Nurses) except for the Lawyers (Mean = 6.8). Also, nurses were significantly different from all other professions excluding the Educators. On the other hand, the Educators were significantly different from all other professions excluding the Nurses.

The parents do not see to it that their child has clean clothing (Incident no. 17).
For this incident ($F_{5,1226}$ = 13.08; p<.0001), post-hocs revealed that the Social Workers (Mean = 6.9) were significantly different form the Police (Mean = 7.6), Nurses (Mean = 7.9) and the Educators (Mean = 7.9). The Nurses and Educators were each different from both the Doctors (Mean = 7.2) and Lawyers (Mean = 7.3).

4.4 Summary and Conclusions

Most of the incidents were rated similarly by the professions and what differences were found tended to be small in absolute terms and statistically significant only because of the relatively large sample sizes. What is possibly of more concern is that the variation within each profession is often quite high. For example, Lawyers as a group regarded caning children for not excelling as moderately serious (Mean = 6.2). However the SD of 2 means that approximately 68% of the sample scored in the range =6.2 ±2, i.e., from 4 to 8, while the remainder scored below 4 or above 8. This shows quite a wide spread of opinion. There are many similar examples from various professions in Table 4.1.

However, given that there were differences noted between the professions in their perceptions of the incidents, Nurses and Educators seemed to provide the highest mean rating score in comparison to the other professions for the most number of incidents (i.e., 8 for each profession). The Police group had the highest mean rating scores amongst the professions for only 2 incidents: "The parents foster their child out to a relative and bring the child home every weekend" and "The parent strikes the child with a wooden stick". The Doctors and Educators similarly displayed the highest mean rating score for the incident, "The parent repeatedly shows the child pornographic pictures". The Lawyers group had the highest mean rating score only for the incident, "The parent fondles the child's genital area". The Social Work profession did not display the highest mean rating score for any of the incidents.

It seems that the nursing and the education professions take the most serious view of situations of probable abuse. On the other hand, the social work profession did not provide the most extreme response (i.e., either highest or lowest mean rating score) for any incident. This is probably in line with differences in professional culture. Though the respondents were requested to respond according to their personal opinion and not from their professional capacity, the possible influence of one's professional culture is to be expected. Nurses and teachers may not be able to assess the whole situation to analyse the child's predicament. Their nature of work does not involve investigation in to the causes and factors that may have led to the situation at hand. However, as professions who are involved and in contact with children, they are the best sources of referrals. On the other hand, social workers are required to assess the child and family, and thus need to know the whole situation before making decisions in their course of work.

CHAPTER 5 : PROFESSIONALS' RECOLLECTIONS OF CHILD ABUSE AND NEGLECT CASES

5.1 Introduction

It was a general presumption of this study that cases of abuse or neglect might have come to the attention of the respondents. The large sample provided an opportunity to ascertain directly from the respondents the nature of the cases (whether reported or not) that they had come across in the course of their work, if any. Also included were items inviting the respondents' opinions about trends and characteristics in CAN.

5.2 Method

In Section C of the questionnaire, respondents were asked about the characteristics of CAN cases encountered. The section was divided into two parts, one inquiring into the characteristics of the most recent case and the other, the general trends or characteristics of CAN in their experience.

In Part 1, amongst the cases encountered, respondents were required to indicate how they came to know the case, the demographic details of the case, when it took place, who the perpetrator(s) was/ were, the frequency and type of CAN as well as the action taken by the respondents following the encounter. With respect to how the professional came to know the case, each respondent indicated whether the case was discovered during the professional's course of work, reported to them or their organisation, or referred to them by the Police, MCDS or Hospital, or otherwise. Options were also provided for respondents to indicate the gender and race of the child victims (Chinese, Malay, Indian or other). Following that the respondents were asked to mention the age of the child and when the incident occurred. The next question inquired who the perpetrators were (both natural parents, mother only, father only, non-natural parent, relative, sibling, baby-sitter, or specify other possibilities). Finally, the respondents were invited to describe in their own words the ill-treatment the child experienced, the frequency of its occurrence, and the action they took.

In Part 2, with respect to the general trends of CAN, respondents were expected to indicate their opinions on whether CAN is on the rise, whether there is under-reporting, what the most common type of child maltreatment is, the typical gender of the victims, the 'at risk' age of the child victims, if there are any particular trends in CAN cases, and to give suggestions on how the handling of CAN cases could be.

Following these questions, the respondents were asked to indicate how experienced they regarded themselves on a 5-point Likert scale ranging from 'not experienced' (1) to 'very experienced' (5). Data for pooled professionals reported here include the 14 additional respondents in counselling related areas excluded from the other analyses. The total number of respondents here was therefore 1252.

5.3 Results

It may be noted at the outset that respondents did not usually regard themselves as experienced in CAN. On a scale of 1-5, a mere 73 respondents out of 1252 (6%) placed themselves above point 3 on the scale. The most common response was '1' selected by 419 respondents (33%). However, the details of the returns indicated that although respondents mostly declined to claim expertise, a substantial proportion were nevertheless able to provide detailed feedback based on their experience.

Characteristics of cases encountered by respondents

Section C of the questionnaire asked for information on the most recent case of CAN that the respondents had themselves encountered, and their opinion on trends in this area.

Table 5.1

Numbers and sources of respondents' most recent case.

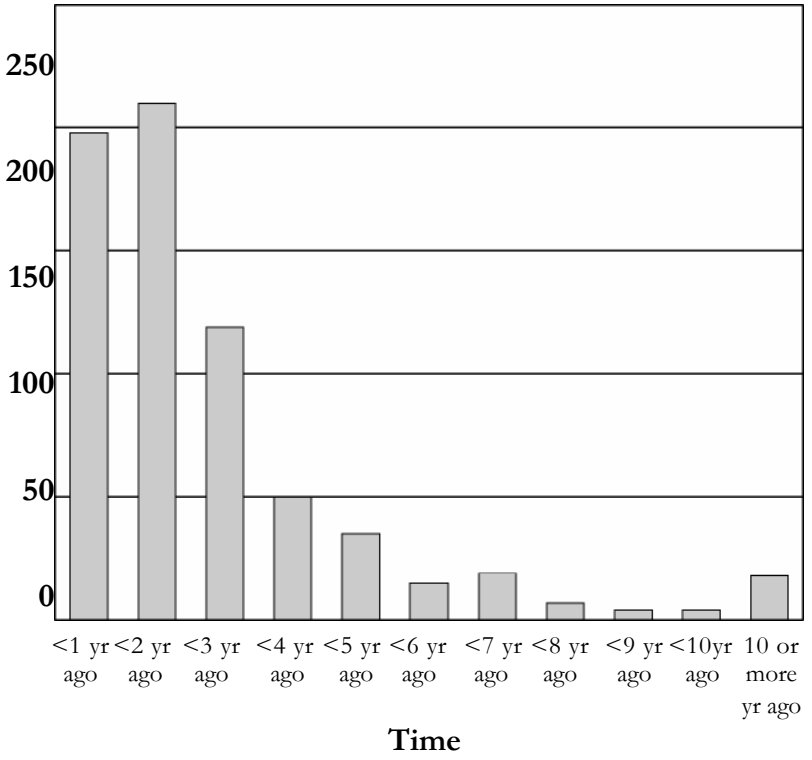
Source of case	No. of cases by source	Percentage	Percentage of overall respondents
Discovered in the course of work	400	56.4	31.9
Reported to respondents or their organisation	103	14.5	8.2
Referred to respondent's organisation by the Police[1]	61	8.6	4.9
Referred to respondent's organisation by the MCDS[2]	36	5.1	2.9
Referred to respondent's organisation by a hospital	27	3.8	2.2
Other sources	39	5.5	3.1
More than one source	43	6.1	3.4
Total	709	100.0	56.6
No case recalled	543		43.4
Total	**1252**		**100.0**

[1] Not applicable to police respondents
[2] Not applicable to MCDS respondents

Table 5.1 shows the number of cases under age 16 mentioned by respondents, broken down by source. It is possible that any given case was seen by several different respondents, each of whom might report it (if recent) as their most recent case. Moreover, there is no independent verification of the case details. It is therefore not possible to treat this data as an incidence estimate, and it complements the MCDS and MHA data reported in Tables 1.1 and 1.2 without any necessary contradiction. For this reason also it is not thought useful to break down the responses by professions, since the extent to which the cases are independent across professions is unknown.

It is clear that a considerable number of cases (709) which the respondents regarded as CAN cases had indeed occurred, and that these were most often encountered in the course of their work, rather than reported to them or their agency. Such a finding strongly reinforces the importance of ensuring that professionals in various fields do recognise CAN when they see it, and is also one reason for encouraging or requiring the public to report suspected CAN cases.

Figure 5.1
Number of respondents reporting cases as a function of period since most recent case.



These cases were spread over a number of years, and Figure 5.1 plots the number of years elapsed since the recalled cases. One hundred and ninety eight respondents indicated their most recent case was within the last year, and as with the data in Table 5.1, these recent cases may have overlapped. The median elapsed time, it may be noted, was between 1 and 1.5 years, for the 681 respondents with a case at all in Figure. 5.1. The picture emerging from Table 5.1 and Figure. 5.1 together is that some professionals, not surprisingly, see more cases than others. Consequently some of the variation in opinions on acceptability or seriousness reported in earlier chapters might reflect differential experience of CAN cases in the samples used in the study.

The cases in Table 5.1 comprised 51 % boys, 44.6% girls and 4.4% cases involving both. Figure 5.2 gives the ages of the victims (excluding 25 cases where more than one age was given, and 7 cases aged 16 or older). There were 9 cases under 1 year and 18 under 2 years of age. A breakdown by ethnic group yielded the following proportions: Chinese 57.2%, Malay 25.4%, Indian 12.9%, Other 2.4%, more than one 2.1 %. This is an under-representation of Chinese cases and an over representation of Malay and Indian cases. There are various possible reasons for this, including socio-economic differences and possible differences in willingness to bring cases to the attention of the authorities.

Figure 5.2
Age of respondents' cases at the time of occurrence

Table 5.2 indicates the perpetrator of the most recently recalled case. Except for child sexual abuse, the definition of CAN entails it be committed by someone with responsibility for the care of the child. It is thus not surprising that the CAN cases mentioned by the respondents are overwhelmingly perpetrated within the immediate family. Amongst a total of 84.3% of such responses, not only were 70.8% of cases perpetrated by one or both parents, a further 8.7% were perpetrated by a stepparent, and 4.8% by other relatives.

Respondents were also asked to indicate the action they took in respect of the most recent case they recalled. This information was only provided by a small number of respondents, except for Social Workers, who provided more than all other groups combined. The responses, broken down by professions are summarised in Table 5.3 below. Generally, the actions taken, including and referrals to other resources, lay within the professional domain of the respondent.

Table 5.2
Perpetrators for the most recently recalled case.

Perpetrator	No. of cases	Percentage
Mother	217	30.6
Father	181	25.5
Both natural parents	104	14.7
Step-parent	62	8.7
Relative (not a sibling)	28	3.9
Sibling	6	0.8
Baby-sitter	26	3.7
Other	44	6.2
More than 1	32	4.5
Not stated	9	1.3
Total	**709**	**100.0**

Respondents were asked to indicate the nature of the ill treatment encountered. Accordingly, Tables 5.4 - 5.7 summarise the ill-treatment reported by respondents in respect of their most recent experienced case of physical abuse, sexual abuse, physical neglect or emotional abuse respectively, broken down by profession. Despite the possibility of some cases being entered more than once, it was thought interesting to observe the nature of the cases encountered by each profession.

It is clear from Tables 5.4 - 5.7 that physical ill-treatment was overwhelmingly the most recalled type of CAN. The scarcity of recalled of sexual abuse cases is surprising given the preponderance of such cases in the official statistics (Table 1.2). Possibly respondents felt some inhibitions in reporting sexual details. The very low mention of neglect or emotional abuse tends to confirm the impression that these types of maltreatment are either unnoticed, regarded as unimportant, or genuinely infrequent.

Table 5.3

Actions reported taken by respondents in their professional capacity.

Profession	Action	Frequency
Doctors	Further medical action (Admit/report to hospital, refer to specialist ward or for examination, seek check-up)	7
	Refer/discharge case to MCDS/Social Services, Social Worker, Medical Social Worker, and request follow-up	10
	Advise parents	2
	Report/discharge to the Police	3
	Find place of safety, ensure child's safety	2
	Other (photo, phone calls)	2
	Subtotal	*28*
Lawyers	Further legal action (Prosecute)	13
	Refer/discharge case to MCDS/Social Services, request follow-up, inform senior	4
	Advise/warn parents, send for counselling	5
	Report to the Police	1
	Subtotal	*23*
Nurses	Further nursing action (admit to ward, reassure child)	8
	Refer/pass to MCDS/MSW	6
	Report to the Police	3
	Subtotal	*17*
Police	Further police action (arrest)	2
	Refer to MCDS or other agency	7
	Subtotal	*9*
Educators	Further education/pastoral action: advise or monitor child/caregiver	13
	Report to Principal	4
	Interview/warn care giver	4
	Refer/report/send case to hospital/MCDS/Social agency/doctor	8
	Other (photo, letter to newspaper, informed relative)	4
	Subtotal	*33*
Social workers	Counsel/advise child	15
	Counsel/advise caregiver/family	29
	Sought protection for child (apply guardian/place crisis centre/ recommend or arrange alternative care	19
	Report or refer to MCDS (25) or other social agency (e.g., FSC)	28
	Report or refer to medical/psychiatric/psychological services (including Child Guidance Clinic, hospitals)	13
	Report to police	8
	Case discussions with colleagues, other professionals	10
	Other interventions (educational placement, needs. Inform school/ retain in hospital/recommend parents support group/ bring child to court)	6
	Warn perpetrator/monitor child	10
	Subtotal	*138*
	Total	***248***

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Table 5.4
Details of physical abuse, where given, in respondents' most recently recalled case.

PHYSICAL ABUSE CASES	Police	Social Workers	Doctors	Nurses	Lawyers	Educators	All
1. Injuries, signs	24 *21.3%*	11 *23.9%*	31 *20.5%*	79 *28.8%*	1 *3.2%*	1 *5.9%*	147
2. Direct assaults	32 *28.3%*	13 *28.3%*	56 *37.1%*	62 *22.6%*	12 *38.7%*	3 *17.6%*	178
3. Excessive discipline	50 *44.3%*	15 *32.6%*	35 *23.2%*	85 *31.0%*	8 *25.8%*	9 *52.9%*	202
4. Burning or scalding	5 *4.4%*	4 *8.7%*	13 *8.6%*	41 *15.0%*	8 *25.8%*	4 *23.5%*	75
5. Maltreatment with objects	1 *0.9%*	1 *2.2%*	7 *4.6%*	4 *1.5%*	1 *3.2%*	0 *0.0%*	14
6. Infants	0 *0.0%*	0 *0.0%*	6 *4.0%*	0 *0.0%*	1 *3.2%*	0 *0.0%*	7
7. Other	1 *0.9%*	2 *4.3%*	3 *2.0%*	3 *1.1%*	0 *0.0%*	0 *0.0%*	9
Total	**113** ***100.0%***	**46** ***100.0%***	**151** ***100.0%***	**274** ***100.0%***	**31** ***100.0%***	**17** ***100.0%***	**632** ***100.0%***

1. *Injuries, signs, and symptoms*: mostly unspecified, but including vomiting blood, coma.
2. *Direct assaults* (no weapon): beating, hitting, punching, biting, strangling, and throwing on floor.
3. *Excessive or inappropriate discipline*: caning, belting, spanking, forced kneeling, pinching, excessive exercise, tying/chaining up.
4. *Burning or scalding*
5. *Maltreatment with objects or weapons* (other than 3); cutting, needles (including 'needle charming'), poking with chopsticks, rubber band tourniquet leading to gangrene in digit, wax in ears; also elaborate or contrived assaults e.g., hanging upside down.
6. *Infants* (specifically mentioned)
7. *Other* (no description/ambiguous/child labour/behavioural symptoms e.g., excessive anxiety).

Table 5.5

Details of sexual abuse, where given, in respondents' most recently recalled case (small numbers render percentages inappropriate).

SEXUAL ABUSE CASES	Police	Social Workers	Doctors	Nurses	Lawyers	Educators	All
1. Symptoms	0	2	3	0	0	1	6
2.Rape	0	0	1	1	10	0	12
3. Molest, outraging modesty	1	9	2	0	8	0	20
4. Failure to protect	0	2	0	0	0	2	4
5.Others	2	3	1	0	0	1	7
Total	**3**	**16**	**7**	**1**	**18**	**4**	**49**

1. *Symptoms, signs*: sexually transmitted disease, hypersexualised behaviour
2. *Rape* (including oral sex & sodomy).
3. *Molest and outraging modesty* (including oral foreplay, sexual assault, demanding sex)
4. *Failure to protect*
5. *Other* (unspecified/teaching masturbation/'threats'/witnessing sex)

Table 5.6

Details of physical neglect, where given, in respondents' most recently recalled case (small numbers render percentages inappropriate).

PHYSICAL NEGLECT CASES	Police	Social Workers	Doctors	Nurses	Lawyers	Educators	All
1.General	0	4	7	0	3	1	15
2. Specific	3	4	2	1	0	4	14
Total	**3**	**8**	**9**	**1**	**3**	**5**	**29**

1. *General* (unspecified - 'neglected', 'unattended', 'inadequate care')
2. *Specific* (No food, no school, ignore illness, intoxication, no pocket money, poor hygiene, physical signs)

Table 5.7

Details of emotional maltreatment, where given, in respondents' most recently recalled case (small numbers render percentages inappropriate).

EMOTIONAL MALTREATMENT CASES	Police	Social Workers	Doctors	Nurses	Lawyers	Educators	All
1.General	0	0	0	0	1	0	1
2.Active	1	13	3	0	2	0	19
3.Passive	0	3	1	0	1	0	5
Total	**1**	**16**	**4**	**0**	**4**	**0**	**25**

1. *General* (unspecified/general - 'neglected', 'divorced parents', 'symptoms')
2. *Active* (locking in or out, verbal abuse, threats, drinking urine, urinating on head)
3. *Passive* (being ignored, witnessing family violence, no privacy)

General Characteristics of cases – opinions of professionals

Based on their experience, the respondents were of the opinion that CAN was increasing rather than decreasing, in the proportions 54.3% to 21.2% with the remainder unsure (1.3%) or unwilling to offer a view (23.2%). Moreover, 48.4% answered 'Yes' to the question, "is it likely that CAN is significantly under-reported", as against 31.6% responding maybe and 3.7%, 'No', with 16.3% declining to respond. Asked for an opinion as to the commonest from of CAN, proportions were 45.4% physical abuse, 22.5% emotional abuse/neglect, 10.9% physical neglect and 4.7% sexual abuse, with 16.4% giving no opinion.

Respondents did not feel that local CAN cases were gender biased — 61 .5% maintained no particular trend on gender. Only 9.5% and 12.3% thought trends were to male or female victims respectively, with 16.7% offering no opinion.

Turning to qualitative details of the nature of trends, and pooling professions, it is possible to identify the following trends or causes of abuse/neglect in the details of open-ended responses. Respondents did not specifically distinguish descriptions (e.g., 'verbal abuse') from implicit causal attribution (e.g., parental overload). Attributions of trends and causes were categorised as follows:

1. Socio-economic: mentioned by 334 respondents. (E.g., Poverty, large family size, low educational level. A few respondents thought that CAN was increasing in better educated/ more affluent families.)

2. Family dysfunction: mentioned by 329 respondents. (E.g., poor parenting skills, broken families, single parents or young/unmarried mothers, fostered children.)

3. Parental load: mentioned by 151 respondents (E.g., unemployment, overwork, and unspecified parental stress.)

4. Parent dysfunction: mentioned by 88 respondents (E.g., Psychiatric problems, drug or gambling related problems, parents abused, bad habits, lack morals etc.)

5. Child dysfunction: mentioned by 25 respondents (E.g., Hyperactive or handicapped children.)

6. Other: mentioned by 92 (unclassifiable, or referring to the perpetrators or age of victims, etc., or commenting on increased publicity of cases, but with no clear trends)

7. Ethnic related: e.g., Indians/Malays/Chinese more. There was no consistent view, but more respondents mentioned Malay cases (67) than Indian (45) or Chinese (27)

Suggestions to improve effectiveness

A final aspect of this section of the questionnaire was the opinions of the respondents on suggestions to improve their effectiveness in providing services to CAN cases. This produced numerous suggestions, some specific, while others were more general. They provided an overview of professionals' knowledge and opinions in the areas that they felt needed improvement, or were lacking. However, they were not regarded to directly reflect areas of need in current practice as some of the areas mentioned may already have been implemented. The responses have been grouped under five headings— administrative, treatment and follow-up, detection and prevention, legal, other miscellaneous:

1. Administrative

- Clear guidelines and standards for recognising, reporting and managing cases, informing relevant parties, etc. Comprehensive system needed, which may include case conferences and multidisciplinary teams. Define clear roles. More and better resources and trained personnel.

- Closer co-operation between medical and social services. Medical staff should have the power to retain patients (suspected abuse cases) under observation. Consider indemnity law to protect medical staff from perpetrators' counter claims. Centralising reporting and investigation in hospitals.

2. Treatment and follow-up

- Provision of fostering arrangements for abused children. To not be in a hurry to return a child to a family where abuse has occurred, and to be willing to separate children from suspected abusers pending investigation. Temporary places of safety other than hospitals. Compulsory therapy for perpetrators.

- Better support for at risk families, better follow-up on cases, including long-term follow-up and better programs in children's homes. More accessible programmes, including 24-hour support, helplines.

- Victim support groups.

3. Detection and prevention

- Early detection and intervention, faster responses from relevant bodies. Encourage civic-minded reporting and intervention "even in family problems".

- Improved public education, including de-emphasising scolding and corporal punishment and encouraging positive motivation of children (no less than 58 police officers stated the need for public education). Clear guidelines on drawing the line between discipline and maltreatment. Teach positive parenting skills.

- More proactive family life efforts by school based staff, such as teachers, social workers and psychologists. Relevant staff to be able to come to school or stationed there, as needed. Teachers could visit homes of children with suspicious behaviour.

- Better counselling provision, also premarital counselling for parents, and discouraging early marriage. Trained counsellors in Community Centres.

- Reduce education system stress on children. Smaller classes will help teachers know children better individually. Longer school hours. Better control or registration of kindergarten and pre-school staff.

- Provision of improved community services such as drop-in centres, mentors for children, parent support groups. Financial assistance to needy families. Involve religious organisations more.

4. Legal

- Stricter laws and more willingness to prosecute. Increased power of intervention or investigation for relevant authorities (police, medical staff, and welfare officers). Legal protection for people reporting CAN (extend section 8 of C&YP Act). Supervision orders for perpetrators. Probation for parents. More home visits by Welfare officers.

- Mandatory reporting.

5. Other miscellaneous

- Persuade employers to be more flexible towards the needs of employees with children.

- Waive hospital admission charges so they can be true places of safety (NB, opinion was divided as to whether hospitals should be true places of safety, or not places of safety at all with complete separation of medical and social issues).

It may be noted that a number of respondents mentioned problems or difficulties experienced when attempting to report CAN cases. Some problems simply arose from the nature of the case, for example uncooperative mothers, but other problems reflected administrative or procedural issues that would need resolution. Notable were issues relating to the speed with which action was taken, the accessibility of the relevant authorities, and the degree of protection afforded the victim. For example, it was suggested that there should be more effort to go to victims rather than requiring them

to go down and report. Comments were made on limits to interagency co-operation. In general, the difficulties encountered are closely reflected in the suggestions made above.

5.4 Summary and Conclusions

These findings suggest that professional perceptions are not necessarily in line with actual statistics for reported cases. For example, sexual abuse cases are vastly underrated. However, the figures also suggest that professions are aware of what they see as a significant number of emotional abuse or neglect cases even though they apparently do not report them. There is little doubt that while a substantial minority of respondents did not claim any experience of CAN cases, the majority were able to recall a case that they regarded as abuse or neglect from their own experience. Such cases may not have been reported and cannot be automatically assumed to be genuine abuse or neglect cases. However, the cases described were often quite detailed, while some indicated definite or even severe maltreatment. It should be a cause for some concern that if more encouragement were given to professionals to report cases, more might in fact be uncovered.

The cases mentioned by the respondents were almost always in the context of the family, and the attributed causes as likely factors behind maltreatment, most frequently referred to poverty, education, family disharmony or parental stress. Factors relating to dysfunctional parents, such as those who might be drug addicts or victims of psychopathology are a clear minority. Support is much stronger for explanations of CAN that highlight attachment failure and family dysfunction. Such opinions are of value, as they represent responses from a substantial total of 1252 professional respondents, and they clearly indicate a need both to educate the professionals on the details of child maltreatment cases, and to address the social problems that beset poorer or more stressed families. The deleterious effects of stress within families were clearly indicated in the respondents' comments.

A considerable number of suggestions were put forward as to how the situation could be improved. In particular, emphasis was put on the need for coordinating services, faster and better services, the need to have better follow-up of cases, the need for prevention as well as remediation, and the need for public education. There appeared to be a perceived conflict of interest in that hospitals are in effect places of safety, but are primarily medical establishments and not custodial institutions. On one hand, medical staff must have access to suspected cases, but on the other, they have only limited power and may not wish to have more. It would appear that there needs to be improvements to ensure the safety of the potential CAN case while necessary medical attention is provided.

The results also suggest a need to examine the adequacy of available remedial resources for cases that professionals encounter, since any encouragement to report will need to be complemented by adequate resources to handle cases. The next chapter turns to the issue of professional attitudes towards reporting CAN cases.

CHAPTER 6 : ATTITUDES OF THE PROFESSIONS TOWARDS REPORTING CHILD ABUSE AND NEGLECT

6.1 Introduction

A common issue faced by professionals dealing with CAN cases is whether to report child abuse. In a study by Kalichman, Craig and Folingstad (1990), 24% of their professionals indicated that they would tend not to report cases of suspected child abuse. There are several likely reasons for such reluctance. If unsure whether maltreatment has occurred, professionals may be understandably unsure whether more good or harm would be served by reporting suspicions. That judgement, in turn, would be affected by considerations such as the professional's confidence in his or her judgment and experience, and the likely effectiveness of any investigation, intervention or subsequent support for the child and the family (where appropriate). Moreover, a false accusation of abuse would be a serious matter, and there may be some reluctance to get involved with the law.

We thus decided to explore attitudes to reporting child abuse. When would one decide to report a case? Are there differences in relation to the type of abuse or to whom the report is made? In Singapore, reports of child abuse encounters or suspicions can be made through the MCDS' Child Abuse Hotline, or by contacting the nearest Neighbourhood Police Post. However, not everyone may be willing to report, for reasons just mentioned. While mandatory reporting may combat such reluctance, it carries dangers of abuse by well meaning but misguided or misinformed individuals, and the risk also arises of malicious false reporting.

According to a recent survey by Hiatt, Miyoshi, Fryer Jr., Miyoshi and Krugman (1998), only 22 (46.5%) of the 47 countries explored indicated having mandatory reporting. In addition, only 13 (22.7%) of the remaining countries practise voluntary reporting. Singapore is one of the latter countries, while reporting is mandatory in Malaysia. Thus we also attempted to explore reasons for and against mandatory reporting, as well as reporting in general.

6.2 Method

The final section of the questionnaire, Section D, focused on professionals' views towards reporting issues. These include: the likelihood of reporting CAN incidents, to whom the professional would most likely report to in such instances, the reasons for and against reporting, groups for whom reporting should be mandatory, reason for and against mandatory reporting, as well as procedures and problems encountered when the professional reported to a higher authority. Each of these issues was explored with several questions, which will be described along with the responses in the results section which follows.

6.3 Results

When inquiring on the likelihood of reporting CAN incidents, 4 incidents were presented, each representing a type of CAN recognised in Singapore. The respondents were required to rate their likelihood to report on a 5-point Likert scale ranging from 'not likely' (1) to 'very likely' (5). The incidents described are presented in Table 6.1.

As noted in previous sections, the professions were more keen to note/act upon encountering cases of physical abuse and sexual abuse but less so in cases when harm to the child is not clearly established (especially in cases of physical neglect and emotional maltreatment). As observed in Table 6.1, the respondents from the various professions explored (with the exception of the Police and welfare officers from MCDS) indicated that they were very likely to report the various types of CAN when encountered (as noted by the modal response of each profession in each case). However, there were differences in the proportions when observing the professionals' responses for each of the four CAN cases described. The professionals in general were highly likely (i.e., more than 7 5% of every profession selected 'very likely') to report upon encountering a child who is either "badly hurt physically" or is "sexually exploited or not protected from sexual advances". However, the modal responses per profession were below 75% for a child whose "basic necessities in life are not provided" or one who is "badly hurt emotionally or psychologically". In addition, the proportion of professionals selecting the modal response also differed between the professions. For example, the highest proportion of respondents within a profession who selected the modal response under physical abuse and neglect, and sexual abuse was the Doctors group. In the case of emotional maltreatment, the profession with the highest proportion selecting the modal response was the Nurses group. As observed in previous sections, it seem that this profession is keener to note emotional maltreatment in comparison to the other professions.

Following that, the respondents (excluding those from the Police force and MCDS officers) were required to indicate, on similar scales, their likelihood of reporting to certain professions. These included the Police, Ministry of Community Development and Sports, and a superior in the individual's organisation. In addition, they were also able to mention any other suitable profession or person to whom they might report, and rate the likelihood of reporting. The results for this question are presented in Table 6.2.

The modal response of each profession for each of the organisations/individuals listed was essentially similar. However, there were some differences in the actual proportion of each profession that selected the modal response itself. In comparison with the other professions, Lawyers were most likely (as the profession with the highest proportion selecting the response 'very likely') to report to the Police when they encountered a specific case of CAN. On the other hand, Social Workers seemed more likely to report their CAN encounters to MCDS or the Superior in their organisation.

Thirdly, the respondents were presented with options as reasons for reporting CAN. As with the former question, they were also allowed to specify other useful options. Each of these reasons

were required to be rated for its level of importance, using another 5-point Likert scale ranging from 'not important' (1) to 'very important' (5). The options and results are displayed in Table 6.3.

Table 6.1

Likelihood of reporting cases broken down by professions.

LIKELIHOOD OF REPORTING CASES	RANGE	P	SW	D	N	L	ED
The child is badly hurt physically	(not likely) 1	0	0	0.5	0.5	0	0.4
	2	0	0	0	0.5	0	0.7
	3	0	2.5	1.5	4.0	3.4	4.3
	4	0	6.3	7.0	15.1	10.2	16.8
	(very likely) 5	0	82.3	91.0	79.9	84.7	77.9
	NA(MHA/MCDS) or blank	100.0	8.9	0	0	1.7	0
Basic necessities in life are not provided to the child		0	1.3	3.0	2.0	1.7	2.9
		0	3.8	3.0	5.8	6.8	3.9
		0	19.0	15.6	23.5	13.6	22.6
		0	29.1	26.6	25.0	37.3	30.8
		0	38.0	51.8	43.7	39.0	39.8
		100.0	8.9	0	0	1.7	0
The child is sexually exploited or not protected from sexual advances		0	0	0.5	0.5	0	0.7
		0	0	0.5	0	0	0.7
		0	2.5	0.5	1.8	0	1.1
		0	2.5	1.5	4.1	3.4	3.9
		0	86.1	97.0	93.7	94.9	93.6
		100.0	8.9	0	0	1.7	0
The child is badly hurt emotionally or psychologically		0	0	1.0	0.5	0	2.5
		0	1.3	0.5	1.5	3.4	0.7
		0	7.6	8.1	6.9	15.3	10.0
		0	38.0	25.8	18.3	33.9	26.4
		0	44.3	64.6	72.8	45.8	60.4
		100.0	8.9	0	0	1.7	0

Table 6.2

Organisations/individuals to whom cases would be reported (if at all), broken down by professions.

LIKELIHOOD OF REPORTING TO PERSONS/ORGANISATIONS	RANGE	P	SW	D	N	L	ED
Police	(not likely) 1	0	4.0	5.6	2.4	5.2	10.1
	2	0	10.5	5.6	2.4	1.7	7.4
	3	0	10.5	12.8	11.6	12.1	21.0
	4	0	17.1	13.3	16.6	10.3	21.4
	(very likely) 5	0	48.7	62.8	67.1	69.0	40.1
	NA(MHA/MCDS) or blank	100.0	9.2	0	0	1.7	0
Ministry of Community Development and Sports		0	0	6.3	6.2	10.7	7.5
		0	0	4.2	4.0	5.4	4.3
		0	1.3	9.9	15.2	12.5	19.6
		0	15.4	16.7	20.6	16.1	28.6
		0	74.4	63.0	54.0	53.6	40.0
		100.0	9.0	0	0	1.8	0
Superior in Organisation		0	6.7	19.8	16.2	61.7	5.3
		0	2.7	7.8	6.4	10.6	2.6
		0	1.3	7.8	15.4	10.6	9.0
		0	5.3	10.8	16.2	2.1	13.2
		0	74.7	53.9	45.8	12.8	69.9
		100.0	9.3	0	0	2.1	0
Others		0	3.8	11.6	9.4	15.3	7.7
		0	1.3	0	1.3	0	0.4
		0	0	2.5	4.3	1.7	2.1
		0	5.1	3.0	3.0	1.7	2.8
		0	10.1	16.6	15.2	11.9	9.5
		100.0	79.8	66.3	66.8	69.5	77.5

The general patterns of response rates on the importance levels of the reasons for reporting CAN are displayed in Table 6.3. This part was not applicable to respondents from the Police force and MCDS officers. The professions indicated that the given reasons were, in general, very important to the individual respondent's decision to report CAN. Observation of the trends of responses by each profession revealed that Social Work profession and the Doctors (who are in the frontline of the decision making process when dealing with CAN cases) did not display any extreme/strong response to any of the reasons given. They were not amongst the professions with the highest proportion selecting the response 'very important' for any of the reasons provided. On the other hand, as noted by their highest modal responses, Lawyers chose child protection and treatment of child's injuries as very important reasons for deciding to report CAN cases. The Nurses regarded the remaining reasons as very important.

Table 6.3
Reasons for reporting, broken down by professions.

IMPORTANCE OF REASONS FOR REPORTING CASES	RANGE	P	SW	D	N	L	ED
To protect the child	(not important) 1	0	0	0	0	0	0
	2	0	0	0	0.3	0	0
	3	0	0	0.5	0.8	0	1.8
	4	0	3.8	3.5	7.3	1.7	5.3
	(very important) 5	0	87.3	96.0	91.7	96.6	92.9
	NA(MHA/MCDS) or blank	100.0	8.9	0	0	1.7	0
So that the child's physical injuries can be treated		0	1.3	1.0	0	0	0
		0	0	2.5	0.5	0	0.4
		0	1.3	3.0	2.8	1.7	2.8
		0	15.4	19.7	14.1	6.8	13.5
		0	73.1	73.7	82.6	89.8	83.3
		100.0	9.0	0	0	1.7	0
So that the child can be given therapy		0	0	1.5	0	0	0
		0	3.8	1.5	0.3	1.7	0.4
		0	6.3	3.5	3.8	5.1	2.1
		0	21.5	22.2	17.9	22.0	17.1
		0	59.5	71.2	77.9	69.5	80.4
		100.0	8.9	0	0	1.7	0
So that the perpetrator/s will be caught		0	2.5	1.0	1.0	0	0
		0	5.1	3.6	1.8	1.7	2.5
		0	19.0	12.2	7.9	13.6	11.4
		0	26.6	28.9	14.1	16.9	17.8
		0	38.0	54.3	75.2	66.1	68.3
		100.0	8.9	0	0	1.7	0
So that the perpetrator/s can be given therapy		0	0	2.5	1.3	20.3	1.4
		0	2.5	3.5	2.8	5.1	1.8
		0	17.7	11.6	6.2	23.7	11.4
		0	24.1	23.7	19.3	16.9	26.1
		0	46.8	58.6	70.4	32.2	59.3
		100.0	8.9	0	0	1.7	0
Because it is a duty or responsibility to report		0	3.8	4.1	1.8	11.9	1.1
		0	2.5	3.6	1.8	8.5	1.1
		0	8.9	11.7	10.8	17.0	11.7
		0	21.5	24.9	17.5	22.0	22.4
		0	54.4	55.8	68.1	39.0	63.7
		100.0	8.9	0	0	1.7	0
Other reasons		0	1.3	2.5	3.3	3.4	1.1
		0	0	0	0.5	0	0.4
		0	0	1.5	1.8	1.7	1.1
		0	0	1.0	1.5	0	1.4
		0	5.1	6.5	10.1	0	6.3
		100.0	93.7	88.4	82.8	94.9	89.8

Next, the respondents were presented with another set of options as reasons for not reporting CAN. Rating scales similar to the former question were used for the respondents. The options and results are listed in Table 6.4 below.

Table 6.4

Reasons for not reporting, broken down by professions.

IMPORTANCE OF REASONS FOR NOT REPORTING CASES	RANGE	P	SW	D	N	L	ED
The situation may be misunderstood	(not important) 1	0	7.8	13.2	6.1	12.7	6.7
	2	0	7.8	8.4	5.0	7.3	5.6
	3	0	28.6	26.3	36.9	9.1	28.9
	4	0	27.3	29.5	25.5	34.6	30.0
	(very important) 5	0	19.5	22.6	26.5	34.6	28.9
	NA(MHA/MCDS) or blank	100.0	9.1	0	0	1.8	0
There is not enough evidence to establish a case		0	3.8	5.2	6.3	7.3	3.6
		0	12.7	8.9	6.1	12.7	5.4
		0	24.1	16.2	32.3	18.2	21.0
		0	31.6	26.2	26.2	27.3	35.9
		0	19.0	43.5	29.1	32.7	34.1
		100.0	8.9	0	0	1.8	0
It is a family problem, others should not interfere		0	49.4	37.2	17.4	41.1	18.5
		0	22.8	25.1	13.6	17.9	18.1
		0	15.2	22.0	38.0	21.4	35.1
		0	1.3	13.1	18.4	12.5	18.5
		0	2.5	2.6	12.6	5.4	9.8
		100.0	8.9	0	0	1.8	0
The situation is not a serious one		0	11.5	16.1	11.5	9.1	8.4
		0	18.0	16.1	13.4	10.9	13.5
		0	33.3	37.0	38.8	25.5	34.9
		0	16.7	18.8	18.2	18.2	20.0
		0	11.5	12.0	18.2	34.5	23.3
		100.0	9.0	0	0	1.8	0
The one who reports may get into trouble		0	49.4	57.1	27.0	64.3	31.6
		0	24.1	21.5	16.9	17.9	27.3
		0	15.2	16.8	32.8	10.7	24.0
		0	2.5	3.1	12.2	0	10.6
		0	0	1.6	11.1	5.4	6.6
		100.0	8.9	0	0	1.8	0
The family will be more willing to receive help if they are not reported		0	15.2	22.6	10.8	33.9	7.3
		0	10.1	13.2	9.3	5.4	9.5
		0	32.9	35.8	35.2	19.6	33.9
		0	22.8	16.8	24.9	17.9	24.8
		0	10.1	11.6	19.8	21.4	24.5
		100.0	8.9	0	0	1.8	0
Other reasons		0	1.3	3.5	3.6	0	0
		0	0	0	0.5	0	0
		0	0	1.5	2.8	1.7	2.1
		0	1.3	1.0	2.6	0	0.4
		0	0	0.5	4.4	3.4	1.8
		100.0	97.5	93.5	86.2	94.9	95.7

The general patterns of response rates on the importance levels of the reasons for not reporting CAN cases are displayed in Table 6.4. This part was also not applicable to respondents from the Police force and MCDS officers. The responses in this part were not as homogenous as observed in the results previously. For the reasons, "The situation may be misunderstood" and "There is not enough evidence to establish a case", the modal responses of the professions ranged from neutral (i.e., a score of '3') to 'very important' (i.e., a score of '5'). These results seem to suggest that the possibility of misunderstanding a case, or that there may be insufficient evidence to confirm a case as CAN may hinder a professional from reporting the encounter. However, the professions in general did not seem

to accept that CAN is an issue that is confined solely to the family unit. This can be observed from the modal responses by the professions in rating the importance of the reason "It is a family problem, others should not interfere" which ranged from 'not important' (i.e., a score of '1') to neutral. The professions in general did not regard getting "into trouble" for reporting as an important reason, except the Nurses, whose modal response was neutral. The professionals' ratings (with the exception of the Lawyers group) were also generally neutral in their modal response to the rating on the family's willingness "to receive help if they are not reported". Such neutral responses highlight the low importance placed on such reasons and may require more/other factors to be included before the professions can take a more definite stance.

Following that, they were required to indicate how supportive they were of mandatory reporting by different professional and non-professional groups in Singapore. The required responses also involved a 5-point rating scale, where the lower extreme corresponded to 'not supportive' and the higher extreme, 'very supportive'. The results are presented in Table 6.5.

Table 6.5

Professions for whom reporting should be made mandatory or compulsory, broken down by professions.

FOR WHOM THE REPORTING OF CASES SHOULD BE MADE MANDATORY OR COMPULSORY	RANGE	P	SW	D	N	L	ED
Doctors and nurses	(not supportive)1	2.5	0	2.0	0.5	3.5	0
	2	0.6	0	2.6	0.5	0	1.1
	3	6.9	2.6	11.2	3.3	1.7	4.4
	4	16.9	11.7	19.4	18.6	8.6	20.4
	(very supportive)5	73.1	85.7	64.8	77.1	86.2	74.2
Teachers and principals		0.6	1.3	1.6	0.3	1.7	0.4
		0.6	0	2.1	0.5	0	1.1
		8.2	9.1	12.6	4.0	1.7	4.7
		15.8	14.3	22.6	19.0	17.2	22.7
		74.7	75.3	61.1	76.3	79.3	71.1
Child care providers		0.6	0	1.6	0.3	1.7	0.4
		0.6	1.3	2.6	0.3	0	1.1
		8.2	3.9	11.6	4.5	5.2	5.5
		14.6	18.2	25.3	20.8	15.5	21.5
		76.0	76.6	58.9	74.1	77.6	71.6
Social Workers		0.6	1.3	1.6	0.3	1.7	0.4
		0.6	1.3	1.1	0	0	0.4
		7.0	9.1	9.5	2.9	1.7	5.1
		12.0	10.4	24.7	13.5	12.1	17.8
		79.8	77.9	63.2	83.3	84.5	76.4
Lawyers		4.5	3.9	10.5	1.3	13.6	1.8
		4.5	1.3	6.3	2.7	13.6	1.1
		17.4	10.4	18.4	11.9	13.6	14.3
		14.2	19.5	18.4	15.6	15.3	19.9
		59.4	64.9	46.3	68.4	44.1	62.9
All residents of Singapore		3.6	9.1	10.0	1.6	24.1	3.0
		2.4	9.1	9.5	2.9	8.6	3.3
		16.4	15.6	26.3	15.0	17.2	21.2
		14.6	20.8	19.5	16.9	15.5	23.4
		63.0	45.5	34.7	63.6	34.5	49.1

The general patterns of response rates for the professions for whom reporting should be made mandatory or compulsory are displayed in Table 6.5. In general, all professions were in favour of mandatory reporting for all professionals and residents of Singapore. This can be observed by the maximum rating of '5' overall indicating 'very supportive' for all the groups included. In particular, Lawyers were most supportive (i.e., the highest proportion from a profession indicating that they were 'very supportive' by choosing the rating '5') for reporting by Doctors and Nurses, Teachers and principals, Child care providers, and Social Workers. But Nurses were the most supportive of reporting by Lawyers and All residents of Singapore. Interestingly, the modal responses by Doctors and Lawyers yielded the lowest importance when ratings were for their own profession.

Subsequently, the respondents were required to rate the importance level on reasons for supporting mandatory reporting of CAN. Each reason was to be rated on 5-point scales of importance, similar to the ones used before. The reasons presented are displayed in Table 6.6 below. The general patterns of response rates on importance levels for the reasons in support of mandatory reporting are displayed in Table 6.6. All professions seemed to regard almost all the reasons given as 'very important' (i.e., a modal rating of '5' given in response to rating the importance of a stated reason) except for the reason, "To increase the rate of reporting".

Table 6.6
Important reasons for mandatory reporting, broken down by professions.

IMPORTANCE OF REASONS FOR SUPPORTING MANDATORY REPORTING OF CASES	RANGE	P	SW	D	N	L	ED
To prevent the increase of child abuse and neglect	(not important)1	0	0	0	0	0	0
	2	0.6	1.3	2.1	0.3	1.7	0
	3	4.2	5.2	7.2	1.8	5.2	2.5
	4	13.2	13.0	19.0	8.7	8.6	15.0
	(very important)5	82.0	80.5	71.8	89.2	84.5	82.5
As a warning to perpetrator/s		0	0	2.6	0	1.7	0.4
		1.2	6.4	2.6	1.3	1.7	0.7
		6.6	9.0	13.3	4.9	15.5	4.3
		13.3	20.5	24.6	19.1	24.1	22.6
		78.9	64.1	56.9	74.7	56.9	72.0
It should be our legal duty		0	5.3	5.1	1.3	17.2	1.8
		1.8	5.3	6.6	1.3	5.2	1.8
		12.7	18.4	21.9	10.5	22.4	13.6
		17.6	28.9	26.5	19.0	13.8	27.2
		67.9	42.1	39.8	67.9	41.4	55.6
To increase the rate of reporting		15.3	24.4	17.6	11.2	29.3	21.2
		5.5	12.8	9.8	7.8	8.6	10.8
		20.9	21.8	25.4	15.1	19.0	24.1
		11.7	20.5	19.7	16.4	19.0	15.1
		46.6	20.5	27.5	49.5	24.1	28.8
To indicate to Singaporeans that child abuse and neglect is something that will not be tolerated		0.6	1.3	1.0	0.3	0	0.7
		1.8	0	3.1	0.8	3.4	0.4
		6.6	6.5	9.7	3.8	13.8	6.1
		13.3	20.8	27.0	15.1	19.0	18.2
		77.7	71.4	59.2	80.1	63.8	74.6
Other reasons		0.6	1.3	3.0	2.5	0	0
		1.2	0	0	0.3	0	0.4
		1.8	0	0.5	0.8	0	1.1
		1.2	3.8	1.5	2.8	1.7	0.7
		12.6	6.3	4.0	7.9	1.7	3.2
		82.6	88.6	91.0	85.8	96.6	94.7

Regarding "To increase the rate of reporting", ratings varied a good deal across different levels of importance and across the professions. Because of this variation, the modal response differed widely from group to group. Social Workers and Lawyers had a modal response of 1, not important; other professions' modal responses indicated that they regarded the reason as very important. The important finding is that there were very substantial individual differences across all respondents. This diversity of opinions may be due to the fact that while mandatory reporting would increase reporting by individuals, it would only be one reason for any increase in the rate of reporting. Also, it may not achieve a higher level of official confirmed cases unless changes are also made to reporting procedures in line with suggestions in the preceding chapter. Perhaps more agreement would have been achieved had the item been rephrased as "To increase/encourage the reporting of cases with actual evidence of CAN". It may also be that professionals vary in their awareness of a possible difference between possible and actual reported cases in the first place.

Reasons for not supporting mandatory reporting were then explored. Each reason was to be rated using the same scale as used in the previous question and were presented in similar manner as well. The reasons presented are in Table 6.7 as follows.

The general patterns of response rates on importance levels for the reasons for not supporting mandatory reporting are displayed in Table 6.7. The professionals' responses were generally neutral for the reasons, "It should be up to the individual" and "People who report may get into trouble". The Doctors and Lawyers groups regard both reasons as 'not important'. The Police force tended to regard reporters "getting into trouble" with equally low and neutral levels of importance. It can be concluded that these reasons did not seem to be of sufficient importance to warrant the lack of support for the mandatory reporting of CAN cases. Of higher importance were the reasons, "People may make false reports" and "People may not know how to detect cases". The professionals' responses ranged from neutral to 'very important' for these reasons. For the reason, "People should be educated, not forced to report" the professions generally rated 'very important' (i.e., the rating of '5'). However, the modal response by the Social Work profession was not '5' but '4'. Nevertheless, this reason seemed to play an important role in the decision against reporting.

The final question in the section required an open-ended response. Here the respondents were required to indicate the procedures and problems encountered when the professional reported to a higher authority. Here, a number of respondents did so. Some problems simply arose from the nature of the case, for example uncooperative mothers, but other problems reflected administrative or procedural issues that would need resolution. Notable were issues relating to the speed with which action was taken, the accessibility of the relevant authorities, and the degree of protection afforded the victim. For example, it was suggested that there should be more effort to go to victims rather than requiring them to go down and report. Comments were made on limits to interagency co-operation. In general, the difficulties encountered are closely reflected in the suggestions for improving efficiency made in Chapter 5.

Table 6.7

Important reasons for not making reporting mandatory, broken down by professions.

IMPORTANCE OF REASONS FOR NOT SUPPORTING MANDATORY REPORTING OF CASES	RANGE	P	SW	D	N	L	ED
It should be up to the individual	(not important)1	18.4	27.3	30.4	11.3	44.8	13.8
	2	8.9	20.8	15.7	7.9	10.3	11.6
	3	27.8	36.4	26.2	33.0	15.5	38.4
	4	19.0	6.5	17.8	25.4	13.8	19.8
	(very important)5	25.9	9.1	9.9	22.5	15.5	16.4
People who have to report may get into trouble		26.6	28.6	36.7	18.6	53.5	21.2
		13.9	33.8	20.9	11.6	19.0	19.4
		26.6	31.2	24.1	36.2	8.6	30.8
		16.5	2.6	11.0	17.9	10.3	18.7
		16.5	3.9	7.3	15.8	8.6	9.9
People may make false reports		5.7	7.8	12.9	5.8	12.1	3.6
		8.9	7.8	8.8	9.2	5.2	6.5
		24.8	31.2	17.0	33.1	20.7	30.2
		21.7	37.7	28.4	26.0	19.0	23.6
		38.9	15.6	33.0	26.0	43.1	36.0
People may not know how to detect cases		3.8	3.9	10.4	5.5	6.9	3.6
		5.1	7.9	6.8	4.2	6.9	5.1
		34.2	15.8	27.6	34.4	27.6	30.3
		25.9	38.2	24.5	28.1	27.6	33.2
		31.0	34.2	30.7	27.8	31.0	27.7
The problem is not big enough to warrant this law		12.8	35.5	37.7	9.3	43.1	14.1
		10.3	26.3	17.8	10.3	19.0	11.1
		41.0	29.0	30.9	34.7	25.9	40.4
		15.4	5.3	11.5	25.7	5.2	20.4
		20.5	4.0	2.1	20.1	6.9	14.1
People should be educated, not forced to report		1.3	5.2	13.1	4.7	20.7	5.1
		8.2	9.1	7.3	4.4	13.8	5.1
		23.3	26.0	29.3	19.6	20.7	29.2
		17.0	33.8	19.9	24.3	19.0	24.8
		50.3	26.0	30.4	47.0	25.9	35.8
Other reasons		1.3	0	3.1	2.0	0	0.4
		0.6	0	0	0.3	0	0
		1.9	0	3.1	3.3	0	1.8
		3.1	1.3	0	1.5	0	0.7
		5.6	2.6	1.5	3.6	5.2	0.7
		87.5	96.1	92.3	89.3	94.8	96.5

6.4 Summary and Conclusions

The modal responses for the professions were similar when we explored the likelihood of reporting CAN cases, organisations to whom CAN cases would be reported, reasons for reporting CAN, and importance of reasons for mandatory reporting of CAN. The options or reasons provided were regarded as 'very likely' or 'very important' by all professions. In addition, all respondents were very supportive of mandatory reporting for all professions and general residents as listed in the questionnaire. However, the modal responses differed when exploring the importance of reasons for not reporting CAN and importance of reasons for not supporting mandatory reporting. Making reporting mandatory so as to increase the rate of reporting was not regarded as a very important reason.

Amongst the professions explored, Nurses were most keen to report emotional maltreatment while Doctors were most keen for sexual abuse, physical abuse and physical neglect. Nurses and Lawyers would most likely report to the Police, while Doctors would report to either the Police or

MCDS. The Educators were most likely to report to their own superior, as would the Social Workers. However, the latter were equally likely to report to MCDS. Concerning the reasons for reporting, Lawyers were the profession most likely to report for reasons of child protection and so that the child's physical injuries can be treated. Nurses were the profession most likely to report for the remaining reasons provided.

This implies that the different professions place different priorities for decisions against reporting in general or mandatory reporting. This difference of opinion between professions seems to further support the notion of a certain professional culture within each profession.

CHAPTER 7 : CONCLUSION

7.1 Findings

The findings of the study may be summarised as follows:

In broad terms there was agreement across different professions about the acceptability or otherwise of actions that might indicate child abuse or neglect, and of the nature and extent to which circumstances might affect acceptability. In fact circumstances, such as the adult's intention and the frequency of actions, were major determinants of acceptability. Evidently behaviour differs in its acceptability according to the specific circumstances under which it occurs.

There were also differences across professions, but these were not substantial compared to the similarities. However, despite broad agreement across professions, members of any given profession were often far from unanimous in their opinions. The range of opinion within a profession was often quite large for actions that were not perceived as highly unacceptable. Therefore, while the agreement among different professions reflected the usual response to an action, this could often disguise a wide difference in the opinions of individual respondents.

When it came to considering the abuse status of actions, respondents were more willing to regard actions as unacceptable than as abuse. Moreover, respondents within any given profession tended to be more similar when rating on acceptability levels than for abuse status. In effect, there was some reluctance to describe even quite definitely unacceptable acts as abuse, and this reluctance reflected something other than the acceptability of the actions. Respondents agreed more on the unacceptability of actions, than on whether they were abuse. This might be due to uncertainty as to the definition of abuse, or a varied degree of reluctance to use the term.

In the above responses, the pattern for the professionals was like that for the public sample, as determined in previous Monograph (Tong *et al.,* 1996). It will be recalled that respondents were asked for their personal opinions. The findings produced little evidence to suggest that professionals, by virtue of their training, held substantially different or more uniform personal views from members of the public.

Some differences in professionals' perceptions were also evident when exploring the seriousness of incidents, but again, the more notable finding was the variation in responses by individuals in the same profession. This and other variation in responses may have reflected differences in respondents' experiences of child maltreatment, since 543 out of 1252 respondents (44%) indicated that they had never encountered a case, and 419 (33%) rated themselves as inexperienced in CAN. However, the seriousness with which a professional person regards a case should not have to depend upon prior experience, but should be a function of training and expertise.

When the respondents were asked to recall the most recent case of what they regarded as ill treatment of a child that they had encountered, they were able to recall details of 681 cases. The

majority had occurred within the 3 years up to 1997, when the data were collected. This figure will almost certainly have included a considerable degree of overlap, and will have reflected a smaller unknown number of separate cases over a span of years. Since the cases were mentioned on the basis of respondents opinion that they reflected ill-treatment, they may not all have met the criteria required to be officially recognised as CAN cases. Nonetheless, the details reported did include many examples of what clearly would be regarded as very severe maltreatment by any reasonable standard.

The respondents also included a considerable number of comments and suggestions relating to difficulties they had encountered dealing with cases, and ways of improving services. Since the data were collected there has been a move to better centralisation and co-ordination of information and action, but the suggestions made derive from the actual experience of involved professionals, and many may be worth noting.

The details of the recalled cases showed some departure from the pattern of official CAN statistics. Sexual abuse was under-represented, and both neglect and emotional abuse were over represented, as compared to official statistics. Some cases were mentioned under more than one head, which reflects the reality that distinct types of maltreatment are to some extent classifications of convenience, rather than mutually exclusive categories. The ratio of mention was 632:49:29:25 or approximately 25:2:1:1 for Physical Abuse, Sexual Abuse, Physical Neglect and Emotional Maltreatment respectively.

On the issue of reporting CAN, The professions tend to agree in favouring mandatory reporting of CAN. However, there was less agreement between the professions when reasons for not reporting or not supporting mandatory reporting were considered. It is also clear that professionals, not surprisingly, are hesitant to report or do not report all suspicions of CAN.

7.2 Implications of the findings

Some implications can be drawn from the findings. Firstly, there is a need for agreement among professionals as a prerequisite for public education. Next, there is a need for awareness among professionals in connection with early intervention. And finally, there is a need for co-ordination among parties and relevant organisations.

Need for greater agreement among professionals.

The need for agreement among professionals is a prerequisite for public education. The results of the first monograph (Tong *et al.,* 1996) suggested quite diverse views among the public, which in turn suggested a need for public education and increased public awareness of child maltreatment issues. To the extent that the professionals appear to show similar diversity, a similar implication may need to be drawn.

The results reported in the present monograph consistently point to a measure of difference in the opinions across the professions explored, and to a diversity of attitudes to the various actions and

circumstances within any given profession. The latter - the existence of differences even amongst professional groups - is potentially a cause for concern.

Why do these differences exist? Is it due to the possible differences in professional culture? The professions may have different emphases when dealing with CAN (e.g., the police need to ensure that there is sufficient evidence to establish a case as CAN, while the doctors need to see sufficient physical/ medical information to conclude that a case is indeed non-accidental injury). However, differences over what actions fall under the definition of CAN implies a need for better agreement (or at least understanding) between professionals.

There may be some methodological reasons for the differences observed. As noted above, respondents' experience varied, and we were not in a position to ensure a strictly representative sample from the total population of each of the professions explored. Moreover, as with all such studies, we had to rely on the honesty of our respondents and had no check on their veracity or the extent to which they may have provided socially desirable responses. However, the samples obtained are for the most part not small ones, anonymity was ensured, and an encouraging number of respondents took the trouble to provide details on open-ended questions. This suggests that they took the survey seriously, and provides some confidence that in the main the descriptive patterns of data are a genuine reflection of professional attitudes.

Need for greater awareness among professionals in connection with early intervention.

One reason for possible underreporting by professionals may lie in their perceptions of CAN situations. Where a case is encountered there may be insufficient evidence to warrant attention or action. Judging by the responses to the seriousness with which CAN incidents are perceived (see Chapter 4) and the descriptions of cases encountered (see Chapter 5), respondents took maltreatment seriously. Moreover, MCDS notes cases that need assistance, but where evidence of CAN is lacking (see Table 1.1), and the proportions of reports where evidence is lacking (or when there are false complaints) are indeed greater than the number of substantiated cases. The issue would perhaps lie in the way the information is classified. Nevertheless, what we are concerned about is whether a case is dealt with effectively. Perhaps some of the cases described by the professionals as ill treatment may have been classified in the national statistics as assistance cases, and not as CAN cases per se. But regardless of speculation, if we assume that every genuine call is a cry for help, the need for early help is obvious. Our data suggest that management of potential child abuse cases may need a greater emphasis on the early provision of help to families and children before and during investigations as well as after confirmation of abuse or neglect.

Need for co-ordination among parties and relevant organisations.

From the characteristics of cases encountered (see Chapter 5) and the attitudes towards reporting (see Chapter 6), it can be noted that most professionals' first step is to notify their colleagues or superiors within the organisation before informing or engaging the services of the other related professions. In line with the need for early intervention, there is also a need to improve collaboration between professions before the problem escalates.

The results highlight the importance of examining each case as a whole. A holistic view includes the emphases of the different professions. This is one reason why innovations such as case conferences are welcome. Procedures ensuring fast and effective co-ordination between those involved in a suspected case are essential.

7.3 Responsibilities of professionals in Singapore

There are a number of reasons why reporting CAN is important, whether or not it is done on a voluntary basis. They can be summarised as follows:

- To provide immediate protection for the child.
- To prevent further abuse, including the risk of untimely death or permanent disability.
- To initiate appropriate professional advice, support and counselling for the child and the child's family.
- Reporting is necessary for the above, or if any case is to be prosecuted.
- To prevent long term mental health problems.
- To minimise the likelihood of another generation of abused children.

There are arguments both for and against mandatory reporting, but the data from the respondents does suggest that it might increase the number of needy cases brought to the attention of the relevant authorities. However, increases in reporting may uncover needs for extension in the provision of services to treat and manage cases. Reporting maltreatment will only benefit children in ways listed above if reports lead to effective action. Reports need to be made not only depending on the nature of the case, but the context of the consequences that will follow. In addition, it would be beneficial if there was further consideration of the issue of mandated reporting in the context of service provision and policy on child maltreatment generally.

7.4 Recognising limits when detecting and dealing with CAN

While there is a clear need for professionals to be better informed and more involved in CAN issues, a note of caution may be sounded regarding the possibility of harm by well-meaning but misguided or overzealous professionals.

As regards detection, while professionals need to be well informed about the possible risk factors and evidential signs of CAN, actually determining the occurrence of a specific case is not always straightforward. There is the obvious incentive for perpetrators to conceal what has occurred, and in many cases family members may in effect conspire to cover up potentially embarrassing disclosures. In addition, research suggests that even quite young children's memories are accurate when first recalled, but that they are susceptible to suggestion with repeated interviewing (e.g., Hewitt, 1999) or after long delays. The child will experience many pressures operating towards concealment, including the child's own irrational sense of guilt, concern over the consequences of admitting to being abused, and threats from the perpetrator. The young child's security resides in the known and familiar situation,

rather than the unknown, even where the familiar includes an abusive situation. It is also possible to suggest or lead children. Determination of abuse from children's accounts is a skilled and tricky task.

If it is difficult to determine the facts of abuse from children themselves, it is even harder to ascertain it retrospectively from adults. Recently there has been considerable interest in the possibility of adults' recalled memories of childhood abuse. In fact, memories, even of normal events, are notably unreliable, and claims by therapists to have recovered otherwise repressed memories of childhood or other abuse have to be taken with great caution.

> *"This is a very touchy issue, particularly in legal settings, where such 'memories' have been used in evidence in cases of abuse and assault. Alas, there is absolutely no evidence that hypnosis or suggestion can function to recover lost memories; worse, they tend to encourage confabulation [invention] and elaboration. Recovered memories are rarely true memories; they tend rather to be constructed at the prompting of the hypnotist or therapist" (Reber, 1995, p.449 q.v. "memory, recovered").*

In a review, Jones (1991) summarised several possibilities whereby harm can result from inappropriate CAN interventions. Jones lists overzealous professional intervention, repeated interviewing or multiple interviewers, repeated physical examinations, decline in living standards or family break-up consequent on the investigation, defensive (i.e., overprotective or overcautious) decision making, attendance in court without precautions to minimise trauma, withholding of treatment and overtreatment. This suggests that whilst professional decisions may be intended to ensure the safety of the victim, they may not be beneficial for the long-term development of the child. Some of Jones' points bear elaboration:

In addition to a sense of alienation, an abused child commonly feels responsible for the consequences to the family upon disclosure of abuse. The effects on an accused parent as a result of disclosure intensify any such feelings. Similar guilt arises when there is a break-up of the family for example, separation or divorce of parents (not only consequent on abuse).

Repeated physical examinations, interviewing or multiple interviews add considerably to the discomfort or trauma of the victim. This can occur if different professionals handle the same case, without sufficient information-sharing taking place. Whilst a physical examination is essential to detect cases of physical or sexual or multiple abuse, repeated physical examinations may exert a negative psychological effect upon the child.

"Better safe than sorry" would apply to cases where professionals decide upon the temporary placement of the child and/or non-access of a suspected abuser, even when there is insufficient evidence to justify the case as abuse or neglect. In such instances, the child could experience more trauma than protection. Likewise, professionals might be reluctant to admit that treatment is not achieving results and continue with it (overtreatment) for want of any more positive line of action.

An interesting issue arises when foster care is considered. Foster care in the context of CAN is essentially planned for the separation of the child from the abuser and further abuse, to provide a safe and more normal environment for the child. Problems can arise with repeated foster care, the lack of professional support for foster parents, the child's anxiety or adjustment problems with new environment(s), situations of foster care 'drift' where children remain in foster care placements without long-term plans for their future, and inadequate visiting arrangements by natural parents whilst the child is in foster care (see also Clapp, 1988). In Singapore, fostering arrangements are common among the population generally, in the form of placing infants or children with other families whether on a daily basis (which is not really "fostering") or on a weekly basis (visits by or to parents at weekends), or monthly, or even for several years at a time with or without regular parental contact. These practices appear quite widespread, and may have repercussions for even normal families in terms of the levels of feeling between children and parents under these arrangements. Evidently there is a relaxation locally of the expectation of continuity in parental care that attachment theory usually demands, and this may mean that the stress of separations of abused children taken into care may be underestimated.

7.5 Recommendations

On the basis of the results reported here, it is possible to offer some recommendations for consideration by Government or private agencies with responsibilities in the prevention or management of child abuse and neglect cases. It would not be appropriate to make highly specific and detailed recommendations on the basis of our research to date, but several areas of need and lines of attack can be identified. Consequently our recommendations are to highlight these areas with suggestions as to suitable lines of action that could be taken. Details of implementation would require discussions among the relevant agencies and parties. However, if these recommendations promote such discussions, or serve to elicit other better alternatives, then this will be an advance.

- ***Introducing and publicising the idea of Child Maltreatment as an important focus of concern.***

Although extreme forms of maltreatment will be rightly perceived as abuse, de-emphasising the "abuse" label may allow a wider range of unacceptable harmful actions to be brought to the attention of the public and the professions alike. As discussed in Tong *et al.* (1996) and Elliott *et al.* (1997) actions with harmful consequences are considered as maltreatment and should be deemed unacceptable regardless of the circumstances. It is evident that there is a reluctance to describe unacceptable actions as abuse, probably because the intentions of the perpetrators are considered important.

- ***Public and Professional education into all aspects of Child Maltreatment.***

There is a need for both public and private education. The range of responses to less severe forms of maltreatment suggests the need for a better consensus within professions as well as between them. A similar conclusion follows from the findings of the first monograph (Tong *et al.,* 1996) with respect to the public. Any such education is likely to be more readily accepted and effective if the emphasis is on maltreatment (as matter of unacceptable actions with damaging effects).

- ***That mandatory reporting of child maltreatment be considered for some professions, notably Social Workers, Teachers and Medical Doctors.***

More accurate and extensive information on the incidence of CAN in Singapore could be obtained if reporting was made mandatory for the relevant professions. While a benefit of voluntary reporting might be greater discretion for the management of cases in ways that maintain confidentiality, mandatory reporting might facilitate better support from related professions. However, the findings reported in this study, while suggesting a degree of underreporting, are not in themselves sufficient to support a call for immediate mandatory reporting. Since reporting is voluntary in Singapore, there is a possibility that cases can be dealt with within an agency or organisation e.g., if a case is treated as a child management problem and not a CAN case, where the professional does not regard it necessary to report to the relevant authorities. In the present study, many professionals supported mandatory reporting for All residents in Singapore (one of the options provided in the questionnaire). It is noted, however, that this may result in more false complaints as well as more genuine ones. It is thus suggested that reporting be made mandatory only for some professionals who possess accurate and informed knowledge of cases. This may facilitate a better estimate of the types and extent of CAN cases locally. This in turn may allow for more concerted efforts to be directed towards educating or treating the victims, perpetrators and the families involved, as well as to efforts in public education in general.

- ***An increased emphasis on the possibility of emotional maltreatment.***

It is noticeable that this is a category of maltreatment that is absent from official statistics but present in the recollections of the public. This is an example of the principle that labelling actions as abuse may have the effect of minimising their importance. It is very difficult to unequivocally recognise let alone prosecute cases of emotional or psychological abuse or neglect because the effects tend to be cumulative and insidious. Therefore, it would be good to include greater emphasis on good care practices that minimise such maltreatment and consequences, and provide help where needed, without necessarily emphasising that it is 'abuse' as such.

7.6 Suggestions for future studies

The present monograph provides an overview of the whole study, which involved a survey of professionals from various disciplines within Singapore. Other monographs in this series will focus on the physical (Chan *et al.,* 2000), sexual and emotional categories of maltreatment. However, there is a need for further research. Some possible research areas are as follows:

- ***A longitudinal cohort study on reported cases of CAN***

Studying a cohort of CAN cases reported to the relevant organisations for a single year would provide information on the nature of such cases. Cohort studies avoid all problems of sampling bias. A prospective study would allow systematic tracking of cases, and would enhance our understanding of the needs of the children and families in such cases. Relevant organisations would include the Ministries of Home Affairs, Health, and Community Development & Sports. If at all possible, an evaluation of outcome should be a part of such a study. Failing a full cohort study, studies that follow up cases selectively could be considered.

- ***A study on abuse and acceptability status of actual cases***

We noted that circumstances might affect the acceptability of actions in a scenario. While this implies that actions may be considered maltreatment depending upon circumstances, we cannot conclude that real actions will be perceived as either unacceptable or as abuse. Thus, it would be useful to examine how the classification of actual events is influenced by circumstances.

- ***A study of parenting and child care practices and beliefs***

It would be timely to conduct an enquiry into parenting and childcare practices in Singapore. As mentioned above, a range of fostering and substitute parenting practices occurs widely, but it is not known how widely. Also unknown are the beliefs that parents have as to the consequences of child care practices. This study could include a survey of disciplinary practices and beliefs.

7.7 Conclusion

The findings in this monograph have highlighted professional attitudes to child maltreatment, and throw some light on the nature of their experiences with it. It is to be hoped that the results will provide food for thought. Some recommendations are offered to improve detection, prevention and treatment, and readers will no doubt form their own conclusions, which may go beyond these.

Child maltreatment occurs in every society where it has been investigated. It is a humanitarian issue. It is unacceptable because children are a nation's resource, and especially so in Singapore where the importance of family life is officially recognised and promoted. It is to be hoped that the findings will contribute to a better understanding and awareness of child maltreatment issues here. Such understanding can only help improve efforts to combat abuse and neglect. This monograph is published in order to bring into the open the important role that professionals play in this endeavour. It is intended as a constructive contribution from the Singapore Children's Society to the ongoing concern that we should all have for the future of our children.

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APPENDIX A:

QUESTIONNAIRE FOR PROFESSIONALS

Dear Professional

Thank you for your participation in our study on "Singaporean Professionals' Perceptions of Child Abuse & Neglect".

Questions you will encounter

In this questionnaire, you will be asked about:

- what kinds of behaviours you would consider to be child abuse & neglect
- your experience with cases of child abuse & neglect
- your attitudes and experiences with reporting cases

Please answer all questions and do not ask others to answer for you.

Rationale for study

It is important to systematically study the similarities and differences in what is considered child abuse & neglect between professionals. Definitions affect you, the professional, at many levels. Definitional differences result in different criteria for categorization of cases, varying categories of cases, and differing methods of intervention. All these contribute to difficulties in co-operation between professionals. Multidisciplinary efforts are necessary in combating child abuse and neglect, and it is vital for professionals working in this field to understand each other's differences. Only then can we work more effectively. We would also like to ask a few questions regarding the cases that have come to your attention. Study of your attitudes towards reporting would help us understand your reasons for reporting or for refraining from doing so.

Your personal views

We are interested in your personal views, rather than your views as a professional, although we do understand that your profession may influence your personal views.

Confidentiality and anonymity guaranteed

We understand that we are asking about sensitive issues. That is why we are keeping your answers strictly confidential. In addition, your answers are given anonymously. Please do not put your name on the questionnaire.

Thank you for your comments

If you have any comments about our questionnaire, please feel free to write them on the questionnaire itself or contact our Research Officer, Singapore Children's Society, Yishun Family Service Centre, Blk 107 Yishun Ring Rd #01-233 Singapore 760107, tel: 753-7331, fax: 753-2697.

Yours sincerely

Dr Clarence Tan
Chairman
Child Abuse and Neglect Prevention Standing Committee

SINGAPOREAN PROFESSIONALS' PERCEPTIONS OF CHILD ABUSE AND NEGLECT

A Study Conducted by Singapore Children's Society
January 1997

We would like to know a little bit about your background. Please tick the appropriate answer.
NOTE: This information is **anonymous** and will be kept fully **confidential.**

1. Professional:

- Social Worker ____
- Doctor ____
- Nurse ____
- Police ____
- Lawyer ____
- Teacher ____
- Childcare professional ____
- Psychologist ____
- Others, specify ____

2. Number of years in profession:

- 4 years or less ____
- 5 - 9 years ____
- 10 - 14 years ____
- 15 - 19 years ____
- 20 years or more ____

3. Sex:

- Male ____
- Female ____

4. Age:

- 19 and below ____
- 20 - 24 ____
- 25- 29 ____
- 30 - 34 ____
- 35 - 39 ____
- 40 - 44 ____
- 45 - 49 ____
- 50 - 54 ____
- 55 - 59 ____
- 60 and above ____

Section A Definitions of Child Abuse and Neglect

Part 1

The following are a list of behaviours. For each of the behaviours, please indicate how acceptable you find it to be by circling the appropriate number on the three point scale on the left, where,

i = in your opinion, the behaviour is **always acceptable**
ii = in your opinion, the behaviour is **sometimes acceptable**
iii = in your opinion, the behaviour is **never acceptable**

Please also indicate whether or not you would classify it as child abuse or neglect by circling the appropriate number on the three point scale on the right, where,

1 = in your opinion, the behaviour **is not abuse or neglect**
2 = in your opinion, the behaviour **can be abuse or neglect**
3 = in your opinion, the behaviour **is abuse or neglect**

Note: A child or young person is defined as under 16 years of age, according to the Children and Young Persons Act 1993.

	In your opinion, how acceptable is this?			In your opinion, is this abuse/neglect?		
	Always	**Some-times**	**Never**	**Is not**	**Can be**	**Is**
1. Leaving child alone in the house	i	ii	iii	1	2	3
2. Threatening to abandon child	i	ii	iii	1	2	3
3. Shaking child hard	i	ii	iii	1	2	3
4. Tying child up	i	ii	iii	1	2	3
5. Locking child outside the house	i	ii	iii	1	2	3
6. Having sex with child	i	ii	iii	1	2	3
7. Always criticizing child	i	ii	iii	1	2	3
8. Slapping child on the face	i	ii	iii	1	2	3
9. Calling child "useless"	i	ii	iii	1	2	3
10. Parent not protecting child from sexual advances of other family members	i	ii	iii	1	2	3

	In your opinion, how acceptable is this?			In your opinion, is this abuse/neglect?		
	Always	**Some-times**	**Never**	**Is not**	**Can be**	**Is**
11. Adult appearing naked in front of a child	i	ii	iii	1	2	3
12. Making child study for a long time	i	ii	iii	1	2	3
13. Burning child with cigarettes, hot water, or other hot things	i	ii	iii	1	2	3
14. Telling child other children are better	i	ii	iii	1	2	3
15. Caning child	i	ii	iii	1	2	3
16. Never hugging child	i	ii	iii	1	2	3
17. Ignoring signs of illness in child (e.g., high fever)	i	ii	iii	1	2	3
18. Locking child in the room	i	ii	iii	1	2	3

Part 2

Circumstances are important in deciding whether certain actions are acceptable or not. The same action might be acceptable in some circumstances and unacceptable in others. We are interested in how different circumstances affect what you think about actions adults might do to children. Please answer by circling appropriately.

Caning a child is

- A. Acceptable if it only happens once or twice.
  B. Acceptable regardless of frequency of incidents.
  C. Not acceptable regardless of frequency of incidents.

- A. Acceptable only if child is younger.
  B. Acceptable only if child is older.
  C. Acceptable regardless of age of child.
  D. Not acceptable regardless of age of child.

- A. Acceptable only if child is a boy.
  B. Acceptable only if child is a girl.
  C. Acceptable regardless of whether child is a boy or girl.
  D. Not acceptable regardless of whether child is a boy or girl.

Caning a child is

- A. Acceptable if only limbs/buttocks affected.
  B. Acceptable regardless of area of body affected.
  C. Not acceptable regardless of area of body affected.

- A. Acceptable only if child is not permanently marked or injured.
  B. Acceptable regardless of whether child injured or not.
  C. Not acceptable regardless of whether child injured or not.

- A. Acceptable only if child is disobedient.
  B. Acceptable regardless of whether child is disobedient or not.
  C. Not acceptable regardless of whether child is disobedient or not.

- A. Acceptable only if child is treated differently from brothers/sisters.
  B. Acceptable only if child is treated the same as brothers/sisters.
  C. Acceptable regardless of how child is treated.
  D. Not acceptable regardless of how child is treated.

- A. Acceptable only if the child is physically/mentally handicapped.
  B. Acceptable only if the child is NOT physically/mentally handicapped.
  C. Acceptable regardless of whether child is physically/mentally handicapped or not.
  D. Not acceptable regardless whether child is physically/mentally handicapped or not.

- A. Acceptable only if the adult has good intentions.
  B. Acceptable regardless of adult's intentions.
  C. Not acceptable regardless of adult's intentions.

- A. Acceptable only if adult is under stress.
  B. Acceptable only if adult is NOT under stress.
  C. Acceptable regardless of whether adult is under stress or not.
  D. Not acceptable regardless whether adult is under stress or not.

- A. Acceptable only if family is poor.
  B. Acceptable only if family is NOT poor.
  C. Acceptable regardless of whether family is poor or not.
  D. Not acceptable regardless whether family is poor or not.

- A. Acceptable only if parents are busy working.
  B. Acceptable only if parents are NOT busy working.
  C. Acceptable regardless of parents' working schedule.
  D. Not acceptable regardless parents' working schedule.

Slapping a child on the face is

- A. Acceptable if it only happens once or twice.
  B. Acceptable regardless of frequency of incidents.
  C. Not acceptable regardless of frequency of incidents.

- A. Acceptable only if child is younger.
  B. Acceptable only if child is older.
  C. Acceptable regardless of age of child.
  D. Not acceptable regardless of age of child.

- A. Acceptable only if child is a boy.
  B. Acceptable only if child is a girl.
  C. Acceptable regardless of whether child is a boy or girl.
  D. Not acceptable regardless of whether child is a boy or girl.

- A. Acceptable only if child is not permanently marked or injured.
  B. Acceptable regardless of whether child injured or not.
  C. Not acceptable regardless of whether child injured or not.

- A. Acceptable only if child is disobedient.
  B. Acceptable regardless of whether child is disobedient or not.
  C. Not acceptable regardless of whether child is disobedient or not.

- A. Acceptable only if child is treated differently from brothers/sisters.
  B. Acceptable only if child is treated the same as brothers/sisters.
  C. Acceptable regardless of how child is treated.
  D. Not acceptable regardless of how child is treated.

- A. Acceptable only if the child is physically/mentally handicapped.
  B. Acceptable only if the child is NOT physically/mentally handicapped.
  C. Acceptable regardless of whether child is physically/mentally handicapped or not.
  D. Not acceptable regardless whether child is physically/mentally handicapped or not.

- A. Acceptable only if the adult has good intentions.
  B. Acceptable regardless of adult's intentions.
  C. Not acceptable regardless of adult's intentions.

- A. Acceptable only if adult is under stress.
  B. Acceptable only if adult is NOT under stress.
  C. Acceptable regardless of whether adult is under stress or not.
  D. Not acceptable regardless whether adult is under stress or not.

- A. Acceptable only if family is poor.
  B. Acceptable only if family is NOT poor.
  C. Acceptable regardless of whether family is poor or not.
  D. Not acceptable regardless whether family is poor or not.

Slapping a child on the face is

- A. Acceptable only if parents are busy working.
  B. Acceptable only if parents are NOT busy working.
  C. Acceptable regardless of parents' working schedule.
  D. Not acceptable regardless parents' working schedule.

Appearing naked in front of a child is

- A. Acceptable if it only happens once or twice.
  B. Acceptable regardless of frequency of incidents.
  C. Not acceptable regardless of frequency of incidents.

- A. Acceptable only if child is younger.
  B. Acceptable only if child is older.
  C. Acceptable regardless of age of child.
  D. Not acceptable regardless of age of child.

- A. Acceptable only if child is a boy.
  B. Acceptable only if child is a girl.
  C. Acceptable regardless of whether child is a boy or girl.
  D. Not acceptable regardless of whether child is a boy or girl.

- A. Acceptable only if child is treated differently from brothers/sisters.
  B. Acceptable only if child is treated the same as brothers/sisters.
  C. Acceptable regardless of how child is treated.
  D. Not acceptable regardless of how child is treated.

- A. Acceptable only if the child is physically/mentally handicapped.
  B. Acceptable only if the child is NOT physically/mentally handicapped.
  C. Acceptable regardless of whether child is physically/mentally handicapped or not.
  D. Not acceptable regardless whether child is physically/mentally handicapped or not.

- A. Acceptable only if the adult has good intentions.
  B. Acceptable regardless of adult's intentions.
  C. Not acceptable regardless of adult's intentions.

- A. Acceptable only if adult is under stress.
  B. Acceptable only if adult is NOT under stress.
  C. Acceptable regardless of whether adult is under stress or not.
  D. Not acceptable regardless whether adult is under stress or not.

- A. Acceptable only if family is poor.
  B. Acceptable only if family is NOT poor.
  C. Acceptable regardless of whether family is poor or not.
  D. Not acceptable regardless whether family is poor or not.

A parent not protecting a child from sexual advances of other family members is

- A. Acceptable if it only happens once or twice.
  B. Acceptable regardless of frequency of incidents.
  C. Not acceptable regardless of frequency of incidents.

- A. Acceptable only if child is younger.
  B. Acceptable only if child is older.
  C. Acceptable regardless of age of child.
  D. Not acceptable regardless of age of child.

- A. Acceptable only if child is a boy.
  B. Acceptable only if child is a girl.
  C. Acceptable regardless of whether child is a boy or girl.
  D. Not acceptable regardless of whether child is a boy or girl.

- A. Acceptable only if child is treated differently from brothers/sisters.
  B. Acceptable only if child is treated the same as brothers/sisters.
  C. Acceptable regardless of how child is treated.
  D. Not acceptable regardless of how child is treated.

- A. Acceptable only if the child is physically/mentally handicapped.
  B. Acceptable only if the child is NOT physically/mentally handicapped.
  C. Acceptable regardless of whether child is physically/mentally handicapped or not.
  D. Not acceptable regardless whether child is physically/mentally handicapped or not.

- A. Acceptable only if the adult has good intentions.
  B. Acceptable regardless of adult's intentions.
  C. Not acceptable regardless of adult's intentions.

- A. Acceptable only if adult is under stress.
  B. Acceptable only if adult is NOT under stress.
  C. Acceptable regardless of whether adult is under stress or not.
  D. Not acceptable regardless whether adult is under stress or not.

- A. Acceptable only if family is poor.
  B. Acceptable only if family is NOT poor.
  C. Acceptable regardless of whether family is poor or not.
  D. Not acceptable regardless whether family is poor or not.

- A. Acceptable only if parents are busy working.
  B. Acceptable only if parents are NOT busy working.
  C. Acceptable regardless of parents' working schedule.
  D. Not acceptable regardless parents' working schedule.

Making a child study for a long time is

- A. Acceptable if it only happens once or twice.
  B. Acceptable regardless of frequency of incidents.
  C. Not acceptable regardless of frequency of incidents.

- A. Acceptable only if child is younger.
  B. Acceptable only if child is older.
  C. Acceptable regardless of age of child.
  D. Not acceptable regardless of age of child.

- A. Acceptable only if child is a boy.
  B. Acceptable only if child is a girl.
  C. Acceptable regardless of whether child is a boy or girl.
  D. Not acceptable regardless of whether child is a boy or girl.

- A. Acceptable only if child is treated differently from brothers/sisters.
  B. Acceptable only if child is treated the same as brothers/sisters.
  C. Acceptable regardless of how child is treated.
  D. Not acceptable regardless of how child is treated.

- A. Acceptable only if the child is physically/mentally handicapped.
  B. Acceptable only if the child is NOT physically/mentally handicapped.
  C. Acceptable regardless of whether child is physically/mentally handicapped or not.
  D. Not acceptable regardless whether child is physically/mentally handicapped or not.

- A. Acceptable only if the adult has good intentions.
  B. Acceptable regardless of adult's intentions.
  C. Not acceptable regardless of adult's intentions.

- A. Acceptable only if adult is under stress.
  B. Acceptable only if adult is NOT under stress.
  C. Acceptable regardless of whether adult is under stress or not.
  D. Not acceptable regardless whether adult is under stress or not.

- A. Acceptable only if family is poor.
  B. Acceptable only if family is NOT poor.
  C. Acceptable regardless of whether family is poor or not.
  D. Not acceptable regardless whether family is poor or not.

- A. Acceptable only if parents are busy working.
  B. Acceptable only if parents are NOT busy working.
  C. Acceptable regardless of parents' working schedule.
  D. Not acceptable regardless parents' working schedule.

Telling a child that other children are better is

- A. Acceptable if it only happens once or twice.
  B. Acceptable regardless of frequency of incidents.
  C. Not acceptable regardless of frequency of incidents.

- A. Acceptable only if child is younger.
  B. Acceptable only if child is older.
  C. Acceptable regardless of age of child.
  D. Not acceptable regardless of age of child.

- A. Acceptable only if child is a boy.
  B. Acceptable only if child is a girl.
  C. Acceptable regardless of whether child is a boy or girl.
  D. Not acceptable regardless of whether child is a boy or girl.

- A. Acceptable only if child is disobedient.
  B. Acceptable regardless of whether child is disobedient or not.
  C. Not acceptable regardless of whether child is disobedient or not.

- A. Acceptable only if child is treated differently from brothers/sisters.
  B. Acceptable only if child is treated the same as brothers/sisters.
  C. Acceptable regardless of how child is treated.
  D. Not acceptable regardless of how child is treated.

- A. Acceptable only if the child is physically/mentally handicapped.
  B. Acceptable only if the child is NOT physically/mentally handicapped.
  C. Acceptable regardless of whether child is physically/mentally handicapped or not.
  D. Not acceptable regardless whether child is physically/mentally handicapped or not.

- A. Acceptable only if the adult has good intentions.
  B. Acceptable regardless of adult's intentions.
  C. Not acceptable regardless of adult's intentions.

- A. Acceptable only if adult is under stress.
  B. Acceptable only if adult is NOT under stress.
  C. Acceptable regardless of whether adult is under stress or not.
  D. Not acceptable regardless whether adult is under stress or not.

- A. Acceptable only if family is poor.
  B. Acceptable only if family is NOT poor.
  C. Acceptable regardless of whether family is poor or not.
  D. Not acceptable regardless whether family is poor or not.

- A. Acceptable only if parents are busy working.
  B. Acceptable only if parents are NOT busy working.
  C. Acceptable regardless of parents' working schedule.
  D. Not acceptable regardless parents' working schedule.

Leaving a child alone in the house is

- A. Acceptable if it only happens once or twice.
  B. Acceptable regardless of frequency of incidents.
  C. Not acceptable regardless of frequency of incidents.

- A. Acceptable only if child is younger.
  B. Acceptable only if child is older.
  C. Acceptable regardless of age of child.
  D. Not acceptable regardless of age of child.

- A. Acceptable only if child is a boy.
  B. Acceptable only if child is a girl.
  C. Acceptable regardless of whether child is a boy or girl.
  D. Not acceptable regardless of whether child is a boy or girl.

- A. Acceptable only if child is disobedient.
  B. Acceptable only if child is obedient.
  C. Acceptable regardless of whether child is disobedient or not.
  D. Not acceptable regardless of whether child is disobedient or not.

- A. Acceptable only if child is treated differently from brothers/sisters.
  B. Acceptable only if child is treated the same as brothers/sisters.
  C. Acceptable regardless of how child is treated.
  D. Not acceptable regardless of how child is treated.

- A. Acceptable only if the child is physically/mentally handicapped.
  B. Acceptable only if the child is NOT physically/mentally handicapped.
  C. Acceptable regardless of whether child is physically/mentally handicapped or not.
  D. Not acceptable regardless whether child is physically/mentally handicapped or not.

- A. Acceptable only if the adult has good intentions.
  B. Acceptable regardless of adult's intentions.
  C. Not acceptable regardless of adult's intentions.

- A. Acceptable only if adult is under stress.
  B. Acceptable only if adult is NOT under stress.
  C. Acceptable regardless of whether adult is under stress or not.
  D. Not acceptable regardless whether adult is under stress or not.

- A. Acceptable only if family is poor.
  B. Acceptable only if family is NOT poor.
  C. Acceptable regardless of whether family is poor or not.
  D. Not acceptable regardless whether family is poor or not.

- A. Acceptable only if parents are busy working.
  B. Acceptable only if parents are NOT busy working.
  C. Acceptable regardless of parents' working schedule.
  D. Not acceptable regardless parents' working schedule.

Ignoring signs of illness in a child (e.g., high fever) is

- A. Acceptable if it only happens once or twice.
  B. Acceptable regardless of frequency of incidents.
  C. Not acceptable regardless of frequency of incidents.

- A. Acceptable only if child is younger.
  B. Acceptable only if child is older.
  C. Acceptable regardless of age of child.
  D. Not acceptable regardless of age of child.

- A. Acceptable only if child is a boy.
  B. Acceptable only if child is a girl.
  C. Acceptable regardless of whether child is a boy or girl.
  D. Not acceptable regardless of whether child is a boy or girl.

- A. Acceptable only if child is treated differently from brothers/sisters.
  B. Acceptable only if child is treated the same as brothers/sisters.
  C. Acceptable regardless of how child is treated.
  D. Not acceptable regardless of how child is treated.

- A. Acceptable only if the child is physically/mentally handicapped.
  B. Acceptable only if the child is NOT physically/mentally handicapped.
  C. Acceptable regardless of whether child is physically/mentally handicapped or not.
  D. Not acceptable regardless whether child is physically/mentally handicapped or not.

- A. Acceptable only if the adult has good intentions.
  B. Acceptable regardless of adult's intentions.
  C. Not acceptable regardless of adult's intentions.

- A. Acceptable only if adult is under stress.
  B. Acceptable only if adult is NOT under stress.
  C. Acceptable regardless of whether adult is under stress or not.
  D. Not acceptable regardless whether adult is under stress or not.

- A. Acceptable only if family is poor.
  B. Acceptable only if family is NOT poor.
  C. Acceptable regardless of whether family is poor or not.
  D. Not acceptable regardless whether family is poor or not.

- A. Acceptable only if parents are busy working.
  B. Acceptable only if parents are NOT busy working.
  C. Acceptable regardless of parents' working schedule.
  D. Not acceptable regardless parents' working schedule.

Section B Ratings of Incidents

Many incidents have the potential to be classified as child abuse or neglect. Some are considered very serious acts, while others are not considered serious. The following are descriptions of potential incidents of child abuse and/or neglect. Please rate each incident on a scale of increasing seriousness from 1 to 9, circling a high number if you believe the incident is very serious and a low number if you believe the incident is not so serious. Base your decision on your professional experience with children and assume that the statements refer to a seven-year-old child. The pronoun "he" and "him" will be used for the sake of convenience. However, please assume that the child could be of either sex unless the context indicates otherwise.

1. The parents know that their child often truants, but they don't do anything about it.
   not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

2. The parents ignore their child most of the time, seldom talking with him or listening to him.
   not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

3. The parent fondles the child's genital area.
   not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

4. The parents live in a flat with their two children. They have few furnishings, a bed where the parents sleep, and two mattresses where each of the children sleeps.
   not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

5. The parents cane the child because the child did not excel in an examination.
   not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

6. The parents foster their child out to a relative and bring the child home every weekend.
   not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

7. The mother's boyfriend frequently bathes the girl.
   not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

8. The father is always at work and the mother is always playing mahjong. They do not bother whether the child eats or does his homework.
   not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

9. The parents usually punish the child by spanking him with the hand.
   not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

10. The parents foster the child out to a relative and never visit the child.
    not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

11. The parent repeatedly shows the child pornographic pictures.
    not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

12. The parents usually punish their child by making him kneel on the floor on uncooked rice grains.
    not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

13. The parents fail to prepare regular meals for their child. The child often has to prepare his own meals.
    not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

14. The parent strikes the child with a wooden stick.
    not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

15. The parents usually leave their child on a damp and dirty mattress.
    not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

16. The parents never see to it that their children do their homework. They let them watch TV all evening.
    not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

17. The parents do not see to it that their child has clean clothing.
    not serious 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 very serious

Section C Characteristics of Cases

In your field of work, you are likely to have come across or dealt with cases which you would consider child abuse and/or neglect. The following are some questions regarding your experience of such cases. Please be reminded that the information is given anonymously and is fully confidential.

<u>Part 1</u> Characteristics of most recent case

Please indicate below the characteristics of the most recent case of child abuse and neglect that you came across. Please note that the case should be of an individual who is under 16 years of age, as those 16 years and above are not considered children or young persons, according to the Children and Young Persons Act 1993, and their case will be taken care of under other laws.

1. How did you come to work with this case?

I discovered it in the course of my work _____
It was reported to myself or my organization _____
It was referred to my organization by the Police _____
It was referred to my organization by the Ministry of Community Development _____
It was referred to my organization by a hospital _____
Other, specify: _____

2. Was the child a boy or a girl?

Boy _____
Girl _____

3. What race was the child?

Chinese _____
Malay _____
Indian _____
Other _____

4. What age was the child? _____ years old

5. When did this happen? _____ years old

6. Who was/were the perpetrator/s?

Both natural parents _____

Mother only _____

Father only_____

Non-natural parent _____

Relative _____

Sibling _____

Babysitter _____

Other, specify _____

7. Please describe the ill-treatment the child experienced, including the frequency with which it happened.

_____

_____

_____

_____

_____

_____

_____

_____

8. Please describe any actions that you took, if any.

_____

_____

_____

_____

_____

_____

_____

_____

<u>Part 2</u> Characteristics of all cases

1. In your experience, has the number of cases of child abuse and neglect increased over the last ten years?

Yes _____

No _____

2. In your opinion, is it likely that there is any significant underreporting of child abuse and neglect?

Yes _____

No _____

Maybe _____

3. In your opinion, what is the most common type of child abuse and/or neglect?

Physical abuse _____

Physical neglect _____

Sexual abuse _____

Emotional abuse and neglect _____

4. In your opinion, do the children tend to be girls or boys?

Boys _____

Girls _____

There is no particular trend _____

5. In your opinion, at what age are children most at risk for abuse and/or neglect?

_____ years old

6. Have you observed any particular trends in cases of child abuse and neglect (e.g., with respect to the types of families/relatives in respect of which child abuse and neglect occurs, ethnic differences, etc.)?

7. Do you have any suggestions about how the handling of cases of child abuse and neglect may be improved? Please include suggestions that would help you to be more effective in your provision of services to such cases.

8. How experienced are you in dealing with cases of child abuse and neglect?

not experienced very experienced

1 — 2 — 3 — 4 — 5

Section D Reporting of Child Abuse and Neglect

1. What is the likelihood that you would report the following cases? (not applicable to police and MCD welfare officers)

		not likely	very likely
a.	The child is badly hurt physically	1 — 2 — 3 — 4 — 5	
b.	Basic necessities of life are not provided to the child	1 — 2 — 3 — 4 — 5	
c.	The child is sexually exploited or not protected from sexual advances	1 — 2 — 3 — 4 — 5	
d.	The child is badly hurt emotionally or psychologically	1 — 2 — 3 — 4 — 5	

2. What is the likelihood that you would report cases of child abuse and neglect to the following persons/organizations? (not applicable to police and MCD welfare officers)

		not likely	very likely
a.	Police	1 — 2 — 3 — 4 — 5	
b.	Ministry of Community Development	1 — 2 — 3 — 4 — 5	
c.	Superior in your organization, specify:_____	1 — 2 — 3 — 4 — 5	
d.	Others, specify: _____	1 — 2 — 3 — 4 — 5	

3. Imagine that you have decided to report a case of child abuse and neglect. How important are the following reasons in your decision-making? (not applicable to police and MCD welfare officers)

		not important	very important
a.	To protect the child	1 — 2 — 3 — 4 — 5	
b.	So that the child's physical injuries can be treated	1 — 2 — 3 — 4 — 5	
c.	So that the child can be given therapy	1 — 2 — 3 — 4 — 5	
d.	So that perpetrator/s will be caught	1 — 2 — 3 — 4 — 5	
e.	So that the perpetrator/s can be given therapy	1 — 2 — 3 — 4 — 5	
f.	Because it is a duty or responsibility to report	1 — 2 — 3 — 4 — 5	
g.	Other reasons, specify: _____	1 — 2 — 3 — 4 — 5	

4. Suppose that you decide not to report a case of child abuse and neglect. How important are the following reasons in your decision-making? (not applicable to police and MCD welfare officers)

		not important very important
a.	The situation may be misunderstood	1 — 2 — 3 — 4 — 5
b.	There is not enough evidence to establish a case	1 — 2 — 3 — 4 — 5
c.	It is a family problem; others should not interfere	1 — 2 — 3 — 4 — 5
d.	The situation is not a serious one	1 — 2 — 3 — 4 — 5
e.	The one who reports may get into trouble	1 — 2 — 3 — 4 — 5
f.	The family will be more willing to receive help if they are not reported	1 — 2 — 3 — 4 — 5
g..	Other reasons, specify: _____	1 — 2 — 3 — 4 — 5

5. In some countries, reporting of child abuse and neglect is made compulsory or mandatory for some professionals or even for all citizens. How supportive would you be of such a new law in Singapore for the following persons?

		not supportive very supportive
a.	Doctors and nurses	1 — 2 — 3 — 4 — 5
b.	Teachers and principals	1 — 2 — 3 — 4 — 5
c.	Child care providers	1 — 2 — 3 — 4 — 5
d.	Social workers	1 — 2 — 3 — 4 — 5
e.	Lawyers	1 — 2 — 3 — 4 — 5
f.	All residents of Singapore	1 — 2 — 3 — 4 — 5

6. How important are the following reasons for your support of a law on mandatory reporting?

		not important very important
a.	To prevent the increase of child abuse and neglect	1 — 2 — 3 — 4 — 5
b.	As a warning to perpetrator/s	1 — 2 — 3 — 4 — 5
c.	It should be our legal duty	1 — 2 — 3 — 4 — 5
d.	To increase the rate of reporting	1 — 2 — 3 — 4 — 5
e.	To indicate to Singaporeans that child abuse and neglect is something that will not be tolerated	1 — 2 — 3 — 4 — 5
f.	Other reasons, specify: _____	1— 2 — 3 — 4 — 5

7 . You may also have some reservations about a law on mandatory reporting. How important are the following reasons for your lack of support of a law on mandatory reporting?

		not important	very important
a.	The situation may be misunderstood	1 — 2 — 3 — 4 — 5	
b.	There is not enough evidence to establish a case	1 — 2 — 3 — 4 — 5	
c.	It is a family problem; others should not interfere	1 — 2 — 3 — 4 — 5	
d.	The situation is not a serious one	1 — 2 — 3 — 4 — 5	
e.	The one who reports may get into trouble	1 — 2 — 3 — 4 — 5	
f.	The family will be more willing to receive help if they are not reported	1 — 2 — 3 — 4 — 5	
g..	Other reasons, specify: _____	1 — 2 — 3 — 4 — 5	

8. Have you, in your professional capacity, reported cases of child abuse and neglect to any higher authority before? If yes, what was the procedure you used? Did you encounter any problems in reporting (not applicable to those who have never reported a case before, police and MCD welfare officers)?

We would like to know a bit more about you. Please tick the appropriate answer.
NOTE: This information is **anonymous** and will be kept fully **confidential**.

1. Number of children:

None _____
One _____
Two _____
Three _____
Four and more _____
Other child rearing experience,
Specify? _____

2. Race:

Chinese _____
Malay _____
Indian _____
Other, specify _____

3. Religion:

Buddhist _____
Taoist _____
Christian _____
Muslim _____
Hindu _____
Free thinker _____
Others, specify _____

4. Language most often spoken at home:

English _____
Mandarin _____
Chinese dialect _____
Malay _____
Tamil _____
Other, specify _____

5. Family Monthly Income:

$999 and less _____
$1,000 - $1,999 _____
$2,000 -$2,999 _____
$3,000 - $3,999 _____
$4,000 - $4,999 _____
$5,000 - $7,499 _____
$7,500 - $9,999 _____
$10,000 - $14,999 _____
$15,000 and more _____

If you have any comments about our questionnaire, please feel free to write them on the questionnaire itself or contact our Research Officer, Singapore Children's Society, Yishun Family Service Centre, Blk 107 Yishun Ring Rd #01-233 Singapore 760107, tel: 753-7331, fax: 753-2697.

The End
Thank You For Your Participation