SINGAPORE CHILDREN'S SOCIETY

Research Monograph No. 3

PROFESSIONAL AND PUBLIC PERCEPTIONS OF PHYSICAL CHILD ABUSE AND NEGLECT IN SINGAPORE

Jasmine S. Chan
Yvonne Chow
John M. Elliott

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We welcome your comments, feedback and suggestions.

Contact : Research Officer
Address : Singapore Children's Society
Yishun Family Service Centre
Blk 107 Yishun Ring Road
#01 -233
Singapore 760107
Telephone : (65) 6753-7331
Facsimile : (65) 6753-2697
Email : info@childrensociety.org.sg

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CONTENTS

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LIST OF TABLES

CHAPTER 1: WHAT IS PHYSICAL CHILD ABUSE AND NEGLECT?

1.1 Introduction: Objectives of the present study

This monograph is the third in our series on perceptions of child abuse and neglect in Singapore. The first monograph entitled *Public perceptions of child abuse and neglect in Singapore* by Tong, Elliott and Tan (1996) focused on the attitudes of members of the general public living in Housing Development Board flats. The second, entitled *Professional and public perceptions of child abuse and neglect in Singapore: An overview*, by Elliott, Thomas, Chan and Chow (2000) focused on providing an overview and comparison of professional and public attitudes. The present monograph and two other forthcoming ones will focus on separate aspects of the professional and public study reviewed in Monograph 2. This study will focus specifically on the attitudes of professionals and the public towards physical child abuse and neglect in Singapore, whilst the next two will discuss results on sexual abuse and emotional maltreatment separately.

The objectives of this study are threefold.

- Firstly, it aims to provide a comprehensive comparison of the professional and public attitudes towards physical child abuse and neglect in Singapore. As such, it aims to discover any similarities and differences in views towards physical child abuse and neglect among the professions and the public studied.

- Secondly, this study seeks an understanding of the professional's views on what constitutes physical child abuse and neglect and what does not. In particular, it highlights any differences that exist among the various professions themselves on these issues. Such knowledge is important as it has implications for recognising, reporting and treating physical child abuse and neglect cases.

- Thirdly, it is also the aim of the present study to help understand why the professionals and the public in Singapore have those particular views and attitudes towards physical child abuse and neglect.

1.2 Why physical child abuse and neglect?

This monograph will focus on physical child abuse and neglect for the following reasons. First, Tong *et al.* (1996) reported data from the Ministry of Community Development and Sports (MCDS, formerly the Ministry of Community Development) and Ministry of Home Affairs (MHA) showing that physical abuse is one of the two most common forms of child abuse and neglect in Singapore, the other being sexual abuse. This finding is further upheld by more recent statistics on child abuse and neglect provided by these Ministries (Table 1.1), which in fact indicate no confirmed cases of emotional abuse or neglect. Table 1.1 provides only statistics on the types of child abuse and neglect cases in Singapore. More detailed statistics on child abuse and neglect cases in Singapore can be referred to in Elliott *et al.*'s (2000). Given this predominance, a better understanding of the views and attitudes of both the public and the professionals towards physical child abuse and neglect is needed to inform

strategies for dealing with the problem. Second, these professionals come into contact with children and are at the frontline in identifying and responding to physical child abuse and neglect. As such, they play a vital role in the reporting, treatment, intervention and prevention efforts for the problem of child abuse and neglect. Understanding their views on the issue is therefore critical.

Table 1.1

Incidence of child abuse and neglect cases in Singapore (from Elliott *et al.*, 2000).

Incidence of child abuse and neglect cases in Singapore	**1994**	**1995**	**1996**	**1997**	**1998**	**%**
DATA FROM MCDS:						
Data on all cases reported						
Number of cases						
Evidence of abuse	29	37	18	28	28	20.2
Lack of evidence but needs assistance	55	50	73	134	100	59.5
False complaint	28	15	27	35	36	20.3
TOTAL	112	102	118	197	164	100.0
Data only on cases with evidence of abuse						
Type of maltreatment						
Physical abuse	28	37	18	24	26	95.0
Physical neglect	1	0	0	4	2	5.0
Emotional neglect*	0	0	0	0	0	0
TOTAL	29	37	18	28	28	100.0
DATA FROM MHA:						
Type of maltreatment						
All perpetrators included						
Sexual offences against children**	113	126	162	188	196	93.2
Hurt offences	15	10	14	14	4	6.8
TOTAL	128	136	176	202	200	100.0

** Includes any form of emotional or psychological maltreatment.*

*** MHA maintains figures for child sexual abuse, although cases are also handled by MCDS.*

Third, part of the significance of this study is its focus on physical neglect. We find that there is a general tendency to overlook the issue of neglect for a number of reasons. The consequences of neglect are often less noticeable than those of abuse, and its victims seem less in immediate danger than those of abuse. Yet the consequences of neglect can be as dire as that of abuse. Issues of neglect such as abandonment have to be addressed. For example, a news article last year (The Straits Times,

25/10/99) reported that more than 70 children were being looked after in welfare homes because their parents abandoned them. One-third of these children were physically or mentally handicapped, whilst the parents of the other children had no desire, time or financial means to take care of them. In addition, we can expect the number to increase as the Singapore family faces a number of challenges at the present time. For example, work structures have changed, and working parents are frequently required to travel in their jobs. In some cases, one parent may be posted overseas and be separated from other family members for a period that may last from a few days to a few months or years. Moreover, the traditional family is no longer appropriate when both parents work outside the home. Dual-earner families in Singapore are on the increase, with the number rising from 190,500 in 1989 to 343,200 in 1999 (The Straits Times, 19/2/2000). As such, many parents are seeking alternative care for their children. In some cases where alternative care is neither available nor affordable, children may be living in families where there is no adult caregiver to offer care and supervision to them. Under such circumstances, the child is more vulnerable to not only physical neglect but also to other forms of neglect such as emotional neglect.

This current study is timely, given that local research on child abuse and neglect is seriously lacking. Moreover, as the following discussion indicates, physical child abuse and neglect is a complex issue. As such, an in-depth study of attitudes towards physical child abuse and neglect in Singapore will help us understand physical child abuse and neglect in the local context. Through such insights, we highlight the need for a culturally sensitive understanding of the issue.

1.3 What is physical child abuse and neglect?

When the term 'child abuse and neglect' is mentioned, it is common for one to think of a child covered with bruises from a severe beating or one who is thin, scrawny and dirty through having been neglected by his parent or caregiver. However, physical child abuse is but one of four main types of child abuse: physical abuse, sexual abuse, emotional abuse and neglect.

Physical child abuse is the most visible and the most frequently reported type of child abuse. In contrast, other types of abuse tend to be under-reported, especially those entailing neglect. Indeed, neglect has been estimated to be five times more prevalent than physical abuse (Moore, 1992). However, much less is known about child neglect, sometimes referred to as the 'most forgotten' form of maltreatment, than physical or sexual abuse (Barnett, Miller-Perrin & Perrin, 1997).

Research has focused more on sexual and physical child abuse and emphasised less on child neglect and psychological maltreatment. This may be due to the fact that physical abuse and, to a lesser degree sexual abuse, result in immediate and usually observable harm. In contrast, psychological maltreatment and child neglect are more elusive with regard to their identification and consequences. A single act of child neglect or of psychological maltreatment is not likely to lead to immediate and significant harm. Indeed, neglect especially is usually not the result of a single act, but rather a cumulative state of affairs that may follow many relatively minor actions. The cumulative effects of these forms of

abuse/neglect are insidious and usually need repeated occurrences before harmful effects become evident (Barnett *et al.*, 1997).

Like other forms of child maltreatment, child neglect is not new. However, it was only in the early 20th century that the neglect of children's basic needs became acknowledged as a social problem. Historically, child neglect has been considered to be less significant than the other more tangible types of child maltreatment. Reasons for the lack of attention to child neglect include the belief that it does not lead to serious consequences, the view that other types of child maltreatment are more compelling, especially if life-threatening, and the notion that the vagueness and ambiguity about what constitutes child neglect will cause confusion (Barnett *et al.*, 1997).

Moreover, cross-cultural variability in beliefs about child rearing and behaviours means that there is no universal standard for what good childcare consists of, and therefore no uniform standard by which to measure child abuse and neglect (Korbin, 1987). Different cultures permit a wide range of actions and behaviours towards children, which can range from total indulgence to very harsh physical discipline including severe beating. Behaviours may or may not be interpreted as abusive, depending on the cultural context (Agathonos-Georgopoulou, 1992). Actions viewed as physical abuse in one country may be regarded as merely disciplining a child in another. For instance, a Swedish law that prohibits spanking children came into force in 1979, and subsequent surveys found that the majority of Swedish people were against all forms of physical punishment of children (Sanden & Lundgren, 1997). We can contrast this to Singapore, where, according to a recent survey, two in three parents have caned their children and half of those who used the cane to discipline said that it was the best way to keep their children in line (The Sunday Times, 11/4/99; The Straits Times, 12/4/99). Similarly, the notion of physical neglect may also be interpreted differently in different cultures. In other words, however plain a definition may be, such as that embodied in Singapore Law (see Section 1.4 below), difficulties arise over which actions should be deemed to fall under the definition.

However, ethical difficulties associated with cultural relativism in the acceptability of possibly abusive actions can be resolved if more attention is paid to outcome. Practices considered acceptable within a specific cultural context may actually be found to be harmful and damaging to a child's physical, emotional or psychological well being upon evaluation (Tong *et al.*, 1996). While we understand that those in the position to evaluate the effects of child abuse and neglect may themselves be affected by cultural beliefs such as class or ethnic differences in child-rearing techniques, we argue that professional training and experience would enable the professionals to assess child-rearing practices according to their impact on a child's overall growth and development regardless of culture. The emphasis on the overall growth and development of the child is crucial. This is because the issue of child abuse and neglect is usually raised only when a particular practice in question has negative or harmful effects on the child in the long run, or when certain actions are carried out with the intention to harm or damage the physical, emotional or psychological health of the child. This position would enable researchers and other professionals to have a systematic approach to the conceptualisation of actions or practices as abuse or neglect.

Even with the above suggestion, obtaining agreement on defining abuse or neglect is not easy. This is because even within a given culture, perceptions of what constitutes 'child abuse and neglect' are influenced by circumstances. For instance, the study by Tong *et al* (1996) highlighted the important role of mitigating circumstances on the public's perception of whether an action constituted child abuse and neglect or not. Moreover, while the respondents' ideas of child abuse and neglect included physical neglect, physical abuse, emotional maltreatment and sexual abuse, they viewed sexual abuse most seriously. In addition, respondents observed a distinction between 'abuse' and 'unacceptable' actions. Further details are discussed in the literature review in Chapter 2.

1.4 Singapore legislation against child abuse and neglect

Even where countries have different cultural norms with regards to childcare and discipline, all have some form of legislation in place to protect children. In the case of Singapore, the Children and Young Persons Act Chapter 38 provides the legal basis for the protection and intervention by the relevant authorities if a child (aged below 14 years) or young person (aged from 14 years to below 16 years) is found to be abused or neglected (Ministry of Community Development, 1999). Under the Children and Young Persons Act, it is an offence if:

- *Any person above the age of 14 years who has the custody, charge or care of any child, or any person above the age of 18 years who has the custody, charge or care of any young person, wilfully assaults, ill-treats, neglects, abandons or exposes the child or young person or causes or procures or knowingly permits the child or young person to be assaulted, ill-treated, neglected, abandoned or exposed, in a manner likely to cause that child unnecessary suffering or injury to his health (including injury to or loss of sight, or hearing, or limb, or organ of the body and, any mental derangement).*

- *A parent or other person legally liable to maintain a child or young person shall be deemed to have neglected him in a manner likely to cause injury to his health, if the parent or such other person wilfully neglects to provide adequate food, clothing, medical aid or lodging for the child or young person.*

According to the MCDS, which is the lead agency against child abuse and neglect, 'child abuse' is defined as any act of omission or commission by a parent or guardian which endangers or impairs the child's emotional or physical well-being, or which is judged by a combination of professionals and community values to be inappropriate (Ministry of Community Development, 1999).

Despite such legislation, enforcement may differ depending on how the public and professionals interpret and define child abuse and neglect. Hence, by examining the perceptions and attitudes of the public and the professionals in Singapore with regards to physical child abuse and neglect, the current study contributes to an understanding of the incidence and prevalence of physical child abuse

and neglect in Singapore. Such an understanding would also help to inform the prevention and intervention strategies that are required to address the problem of physical child abuse and neglect.

Chapter 2 discusses the current state of research on physical child abuse and neglect, while Chapters 3 and 4 provide an in-depth discussion on the findings with respect to the objectives mentioned earlier in Section 1.1.

CHAPTER 2: LITERATURE REVIEW ON CHILD ABUSE AND NEGLECT

2.1 Review of overseas studies on physical child abuse and neglect

As discussed in Chapter 1, there can be uncertainty as to what 'physical child abuse' and 'physical neglect' comprise. Disagreements occur when behaviours are for some reason unacceptable, but do not result in any physical signs of injury or when they lay in the grey area between acceptable corporal punishment and that which is seen as excessive. Even where legislation helps protect the general welfare of children, nevertheless, the effective enforcement of legislation would depend on objective definitions, balancing parental rights with children's rights, and implementation of workable solutions for such a complex human problem (Barnett *et al.*, 1997).

Although this monograph is focusing solely on physical abuse and neglect, it should be kept in mind that physical child abuse and neglect often occurs with one or more other types of child abuse. Rossman, Hughes and Hanson (1998) noted that there is a discrepancy between research that tended to study single types of abuse and clinical experience that suggests the co-occurrence of different types of maltreatment in numerous children. Claussen and Crittenden (1991), for example, found psychological maltreatment present in almost all cases of physical maltreatment studied. According to Rossman *et al.* (1998), physical abuse also involves psychological maltreatment by definition. On this view, it would be difficult to neglect or hit a child without also giving the child a message of rejection at the same time. It may be noted, though, that other authors (e.g., Chao, 1994; Rohner & Pettengill, 1985) have presented evidence that in families relying on Confucian traditions, corporal punishment is not necessarily intended or perceived as entailing rejection, but rather concern. In such cases a greater level of severity may be needed before the child perceives rejection. However, the focus in this monograph is not to identify the effects and consequences of child abuse and neglect behaviour, but rather, to examine the attitudes of the professionals and the public towards physical child abuse and neglect in Singapore.

Several studies have been carried out that examined the perceptions of the professionals and the public on child abuse and neglect, and these two groups do not always share the same opinions. For instance, in Giovannoni and Becerra's (1979) study in the United States, the public and four different groups of professionals that included lawyers, paediatricians, social workers and the police were asked to rate vignettes (scenarios) that described potentially abusive situations. Differences were found in what the public rated as most serious (sexual abuse or engaging a child in crime) as opposed to what the professionals rated as most serious (physical harm sustained through either physical abuse or physical neglect).

A similar study was carried out in India (Segal, 1992). This study included the public and various professionals including social workers, doctors, nurses and teachers, and many of the questions used in Giovannoni and Becerra's (1979) study were used. Differences were again found in the opinions

held by the public and the professionals, except social workers, with regards to their ratings of the vignettes given. The public and the social workers also seemed to rate the vignettes less seriously than the other human service professionals. Another study of this kind was carried out by Ajduković, Petak and Mršić (1993) in Croatia. Professionals who came into contact with child abuse cases, such as psychologists, judges, public prosecutors, teachers and social workers were included in this study, together with non-professional members of the public. Results suggested more similarities between the professionals and the public in attitudes towards the causes and conditions of child abuse than in reactions to the problems. The above studies are discussed in greater detail in Elliott *et al.* (2000).

It may be noted that the emphases which guide the practice of various professional disciplines may vary. For instance, nurses and physicians may tend to focus on the medical aspects of the injury, law enforcement officers and lawyers on evidence that determines the innocence or guilt of the suspected perpetrator, and clinical social workers on the family and care-giving systems that contributed to the abuse (Giardino, Christian & Giardino, 1997). Similarly, Tower (1996) also noted the differences in how various professions view child abuse and neglect by pointing out that whilst the medical community tend to concentrate on the physical harm sustained from the abuse and define abuse in the light of the child's injuries presented in the medical setting, the legal community (which includes the police) in contrast would define child abuse more in terms of intent.

The following review of overseas literature on physical abuse and neglect is not exhaustive. The reader needing a more thorough summary may be referred to Barnett *et al.* (1997), Briere (1992) and Tower (1996) in particular.

2.2 Physical abuse

Survey data and official reports of child abuse have contributed much towards our understanding of the socio-demographic characteristics of both perpetrators and victims of physical child abuse, while empirical and clinical studies have probed the psychological characteristics of the perpetrators. While these sources of information are not without their limitations (e.g., rate of abuse reported depends on the definition of abuse used), they are nevertheless useful in shedding some light on the characteristics of the perpetrators and victims of physical child abuse (Barnett *et al.*, 1997).

2.2.1 Victims

Evidence from research suggests that while the risk of physical maltreatment decreases with age in general with young children being the most frequently reported victims of physical child abuse, experts have grown to recognise that adolescents are also frequent victims of violence. The highest rates of physical injury happen to those in the two extreme age groups; that is, infants and toddlers, and adolescents (Barnett *et al.*, 1997).

Although physical child abuse occurs in all socio-economic groups, official statistics consistently suggest that that it is more frequently reported as occurring among socially and economically disadvantaged families. There also seem to be a relationship between low income and severity of

abuse, with serious or fatal injuries being more likely among those families with annual income below the poverty level. In addition, studies on the representativeness of the data showed that such a finding does not seem to be a result of bias in reporting (Barnett *et al.*, 1997).

In addition, certain characteristics of children may place them at a higher risk of being abused. For instance, premature infants, congenitally malformed babies and children who are conceived out of wedlock, are intellectually disabled, or have other developmental disabilities, are all particularly vulnerable to being abused (Hullings-Catalano, 1996; Tower, 1996). Children with such characteristics may be an actual or perceived source of stress and burden to the family and are hence vulnerable to being abused (Tower, 1996). Indeed, although many parents with developmentally delayed children manage to cope well, a lack of social and environmental supports heightens the risk of maltreatment for these children. It may also be noted that physical abuse itself has been suspected to be a cause of neurological handicapping conditions, including mental retardation and cerebral palsy, due to head injuries sustained before the children are 1 to 3 years old (Hullings-Catalano, 1996).

2.2.2 Perpetrators

With regards to the perpetrators of physical child abuse, abusive parents frequently start their family at a younger age than do families in the general population, with many such parents still in their teens at the birth of their first child. The abused child's parents are usually the perpetrators, with strangers or outsiders involved only in a minority of cases. Physical abuse may also be perpetrated by siblings (Barnett *et al.*, 1997). While studies point to the mother as the one committing most acts of physical abuse, this does not imply that women are more violent than men. Rather, it indicates the disproportionate amount of child-rearing responsibilities assigned to women and hence the amount of time that the children spend with their mothers (Briggs & Hawkins, 1997).

Certain personality characteristics have been found to be associated with physical child abuse perpetrators. Factors more common in abusive than non-abusive parents include anger control problems, depression and physiological over-reactivity. However, not every individual with these characteristics is an abusive person (Barnett *et al.*, 1997). Indeed, in every case where perpetrator risk factors for physical child abuse are identified, it is essential to note that these are only risk factors. For example, step-parenting is a risk factor for child abuse, but the overwhelming majority of stepparents are not abusive parents nonetheless.

2.2.3 Consequences of physical child abuse

The negative effects of physical abuse on the child include behavioural problems (e.g., antisocial behaviour, poor school adjustment); physical injuries (ranging from minor physical injuries like bruises, to serious physical disabilities or even fatalities); cognitive difficulties (e.g., poor school achievement and lower intellectual functioning), and social and emotional problems (e.g., poor social interactions) (Briggs & Hawkins 1997; Rossman *et al.*, 1998). However, the impact of physical child abuse on different individuals is not consistent or predictable. Certain characteristics of the victim's family or the abuse experience of the victim can help mediate the impact of the abuse. For example, victims who have a supportive parent figure and high levels of intelligence appear to suffer

fewer psychological symptoms (Barnett *et al.*, 1997). In general, some children are more resilient than others and appear to be unaffected by severely traumatic events. Factors that have a protective effect for the abused child include the child's level of intelligence and personality, access to good health and educational facilities and the development of positive relationships with people outside the family (Corby, 1993).

2.2.4 Why does physical child abuse occur?

The search for an explanation of why physical abuse occurs has led to several models. Certain psychopathological theories, such as the mental illness, psychodynamic and character-trait models, focus on the characteristics of the abuser as the main cause of the abuse. These theories view the main cause of abuse as residing within the perpetrator. The abuser's personality characteristics are considered to predispose the child to being abused and what is needed is a stimulus to trigger that abusive potential in the abuser. For instance, the character-trait model attributes certain traits to the abusive parent, viewing them as immature, self-centred and impulse ridden (Tower, 1996). Similarly, the social learning model suggests that abusive parents have not learned effective methods of discipline that are not harmful to their children, and with little knowledge of child development, they do not know what to expect from their children. Frustration arising from their inappropriate parenting methods or their children's failure to meet their expectations would then lead to abuse (Tower, 1996).

On the other hand, interactional theories view abuse as resulting from a dysfunctional system. The family-structure model, for example, considers the family as an intricate system that must maintain a certain degree of balance in order to continue to exist. In this view, child abuse results from dysfunctional family patterns, such as the distancing or the lack of communication among family members (Tower, 1996). Yet another type of theory takes into account stresses from the immediate culture, society or environment as the principal contributing factors to abuse.

The intergenerational theory points out that children who were abused are more liable to become abusive parents themselves. However, it is essential to note that this cycle of abuse occurs only in a minority of cases. Research shows that parents who have been physically abused as children and who later become abusers, were those less likely to have received some form of childhood social support (Barnett *et al.*, 1997). A long-term follow-up study of individuals who were severely battered as children also showed that the experience of early abusive trauma does not have a simple relationship with adult functioning. Some participants developed stable marriages, while others showed limited autonomy. There was also little evidence of overt aggression among those studied, although suspiciousness and resentment scores were high (Martin & Elmer, 1992). Briere (1992) also offers a useful discussion of the long-term consequences of various types of child abuse and neglect.

Cultural values and beliefs may also provide a set of rationalisations, which enable abuse to occur more easily, or which may prevent others from helping abused children. For example, Wu (1981) and Tang (1998) argued that certain cultural values and some child-rearing practices that prevail in Chinese societies may be conducive to child abuse. In his study on child abuse in Taiwan, Wu (1981) argued that the emphasis on filial piety might be conducive to child abuse. According to the ethic of filial piety in traditional Chinese culture, children are regarded as the property of their

parents who can deal with them with little or no interference from others (Tang, 1998). The two socialisation mechanisms that support the tradition of filial devotion of children to parents are discipline, to ensure obedience of the child, and an emphasis on attachment (Wu, 1981). Conversely, the pervasiveness of violence in America has been considered as an aspect of American culture that may create a cultural context encouraging the physical abuse of children (Barnett *et al.*, 1997). This has led researchers to look at the disciplinary methods of parents.

To date, a debate on the relationship between corporal punishment and physical child abuse still rages. Murray Straus (1994), a long-time critic of the cultural acceptance of corporal punishment which is often associated with authoritarian parenting style, contends that corporal punishment is harmful to children and that it is an ineffective method of disciplining them. It is argued that a connection exists between corporal punishment and sibling violence and other acts of physical aggression. Straus' (1994) contention is that when a parent strikes a child, he or she is unknowingly communicating to the child that when one does something that is intolerable and cannot be reasoned with, then it is morally correct to attack the person physically. In addition, Straus, Sugarman and Giles-Sims (1997) found that the long-term effect tends to be an increased level of antisocial behaviour when parents use corporal punishment to reduce antisocial behaviour. However, Larzelere (1999) criticised the study, stating that all the study proved was that spanking 6 to 9 year old children at the rate of 156 times a year has a small, but harmful effect (accounting for 1.3% of subsequent variation in antisocial behaviour). It was noted that a blanket mandate against spanking could not be supported scientifically. Larzelere noted that an earlier review had found eight studies that, like Straus *et al.* (1997), distinguished parental effects on children from the opposite causal direction. All eight studies found generally beneficial outcomes from non-abusive spanking of 2- to 6-year old children, when used as a back-up for time out or reasoning. Moreover, as earlier mentioned, Chao (1994) has argued against overextending to Chinese families a Western model in which corporal punishment is seen as a sign of parental hostility in an authoritarian style. It might be premature to argue the merits and demerits of corporal punishment as if they were independent of cultural context and belief.

In a number of countries today, corporal punishment is outlawed in schools. These countries include Belgium, Denmark, Ecuador, Great Britain, Holland, Italy, Japan and Sweden. Sweden has also outlawed corporal punishment by parents (Giardino *et al.,* 1997). However, outlawing corporal punishment need not lead to a corresponding decrease in physical child abuse. Using Sweden as a case study, although spanking has been outlawed since 1979 (Sanden & Lundgren, 1997), child abuse has increased at least by four-folds and youth violence at least by six-folds (Larzelere, 1999). This shows that one cannot reduce child abuse simply by outlawing the use of corporal punishment by parents. Similarly, in America, although spanking has been decreasing, child abuse has not (Lemonick, 1997). Although parenting experts have stated for years that caning or spanking had irreparable bad effects on children, it is clear that there is no simple relationship between corporal punishment and child behaviour. It appears that it is harmful for the child under certain conditions, but may be beneficial if used under other circumstances and in conjunction with other types of parental disciplinary measures (see Larzelere, 1998; Trumbull & Ravenel, 1996). It might be rash, similarly, to attempt generalisations that extend across cultures on this issue.

2.2.5 Intervention and preventive strategies

The principal goal of treatment for the physically abusive family is for the abuse to stop, which usually takes place when the social service system intervenes (Tower, 1996). Sometimes the mere intervention of neighbours or relatives might have a deterring or protective effect, however, and it need not be assumed that help can come only from social service intervention. Indeed, an important reason for raising public and professional awareness is that it would result in a much higher level of both formal reporting and informal interventions, to the benefit of the victims.

Social service interventions include the protection of children (e.g., via legislation and out-of-home care), psychological treatment that focus on the adult perpetrator, the child, the family or parent-child interactions (e.g., through play sessions and anger control techniques), and community interventions that emphasise on situational factors (such as conducting childcare programs, giving economic assistance for needy abusive families). However, as physical child abuse is a complex problem, it is not adequate to use just one type of intervention strategy to treat the problem, especially for high-risk families. It is also to be noted that though evaluation studies for these types of interventions have shown them to be promising, more research is required to improve efforts aimed to solve the problem of physical child abuse (Barnett *et al.*, 1997).

2.3 Physical neglect

This study is also concerned with the issue of physical neglect. Physical neglect is distinguished from physical abuse as an act of omission (neglect), as opposed to being an act of commission (abuse). Yet such a distinction becomes blurred in cases of 'severe neglect' where the caretaker wilfully allows or causes the child to be placed in a situation where his or her health is compromised (Rossman *et al.*, 1998). Consequently, neglect has been redefined by Briggs and Hawkins (1997) as either omission or commission of any act that impairs the child's physical, psychological, intellectual or social development. This includes situations whereby a parent or guardian has failed in the provision of food, shelter, clothing or essential medical care, or has failed to take necessary precautions to ensure the child's safety. Moreover, emotional abuse is implicit in most cases of physical neglect (Briggs & Hawkins, 1997). It is difficult to differentiate definitions of physical neglect and psychological maltreatment at times as certain caregiver actions appear inclined to be both physically and psychologically harmful (Rossman *et al.*, 1998).

Studies in the United States and the United Kingdom suggest that the physical neglect of children is the most common form of child maltreatment, and yet it is often the most ignored and tolerated, resulting in the under-reporting of cases (Briggs & Hawkins, 1997). Indeed, the true incidence of child neglect is unknown because of numerous methodological problems inherent in the study of rates of child maltreatment. These include definition variability, the failure to differentiate among the subtypes of neglect, and reporting biases (Barnett *et al.*, 1997). It is also necessary to note that neglect is a type of maltreatment that is dependent on cultural child rearing values and variations in the neighbourhood and community, and as such, the economic, political and cultural values of the particular society itself (Tower, 1996). Physical neglect is as detrimental for children as physical abuse.

Some would in fact view neglect as more harmful than physical abuse, as neglect is a form of ill-treatment that is applied to a child consistently over a period of time, as opposed to physical abuse that can be more irregularly inflicted (Johnson, 1990). It is probably not helpful to even attempt this kind of relative comparison, however, since in the extreme either form of maltreatment can be fatal.

The literature on physical neglect is sparse. Most authors include physical abuse and neglect together (Rossman *et al.*, 1998). However, since physical abuse and neglect have different sets of risk factors (Chaffin, Kelleher & Hollenberg, 1996), it is pertinent to focus on physical neglect as a form of abuse in its own right. In the following, we review both studies where physical neglect has been specifically identified, and those that deal with neglect in general (which may include other types of neglect other than physical neglect, e.g., educational neglect).

2.3.1 Victims

Neglect is a phenomenon that generally involves all the children in the family. When one child is neglected, usually the others in the family will be too. It has also been found that children were more likely to be neglected from birth to one year than at any other stage in their lives. After the first year, the incidence of neglect declines with age until only a small percentage of adolescents are reported as having been neglected (Tower, 1996).

2.3.2 Why physical neglect occurs and characteristics of perpetrators

Experts in the field have been applying theories meant to explain physical and sexual abuse of children to the area of psychological maltreatment and child neglect. However, there is limited available empirical information to support particular factors or causal models. Most research has focused on the characteristics of parents who neglect their children and of families who psychologically maltreat children. The research suggests that parents are the primary perpetrators of child neglect and that females are significantly more likely to be reported for neglect than males. This latter finding may reflect the fact that mothers rather than fathers are the ones responsible for tending to children (Barnett *et al.*, 1997).

The neglectful parent is typically an isolated person who faces difficulty in forming relationships or carrying out the routine tasks of daily life. Burdened with sadness and anger over their own unsatisfied childhood needs, the parent is unable to consistently recognise and meet the needs of his or her children (Tower, 1996). Briggs and Hawkins (1997) made a distinction between the characteristics of parents who are 'marginally negligent' and those who are 'seriously negligent'. 'Serious neglect' is referred to as negligent behaviour on the part of caregivers that can lead to life-threatening consequences. On the other hand, 'marginal neglect' refers to negligent actions that are less traumatic, and include actions like limiting the child to a restricted and unhealthy diet and a dirty home environment. Parents who are 'marginally negligent' tend to be poor and uneducated, rather than indifferent (Briggs & Hawkins, 1997). It is necessary to note that by no means all parents fitting the neglectful parent profile are in fact neglectful, and many cases of neglect involving parents who do not fit such a profile may also be encountered.

Compared to the 'marginally negligent' parents who have some degree of organisation in their lives, the 'seriously negligent' parents tend to lead a life that is disorganised in every aspect. The most common characteristic of families that are seriously negligent is that the parents lead chaotic lives. They live from day to day and do not plan ahead nor are they able to manage their own household (Briggs & Hawkins, 1997). Such parents may suffer from physical ill health, low self-esteem and depression, made worse by alcohol and drug problems, which further impede their ability to take care of their children and household effectively. Under such situations, it was thought that children may fail to learn responsible parenting and household management skills from their parents, and the cycle of disadvantage and deprivation continues (Briggs & Hawkins, 1997). However, those few studies that have examined this intergenerational transmission hypothesis with subjects who experienced child neglect alone showed conflicting results (Barnett *et al.*, 1997). It is important to note that until a study is done on the characteristics of physical neglect perpetrators in Singapore, it will not be known to what extent such findings apply in Singapore.

Besides the theory that neglect can be attributed to parental personality and character structure, there are two other theories that are also used to explain the cause of neglect. One is the economic theory, which emphasises the role of material deprivation and poverty in bringing about physical child neglect. Proponents of this theory contend that neglect is a response to stress and that poverty is an all-pervasive form of stress (Tower, 1996). On the other hand, the ecological theory proposes that a family's behaviour can be viewed as being a response to the larger social context in which it is imbedded. In other words, parents' ability to provide proper care for their children is influenced by the total social context in which they live and as such, feeling unsupported by their surroundings could result in neglectful parents. The neglectful family's issues are thus to be viewed in relation to the community's ability to provide relevant social supports and resources for them (Tower, 1996). However, it is clear that using any one of these theories by itself is inadequate to explain a phenomenon as complex as physical neglect. The family is a system with its own particular strengths and weaknesses, and it interacts with its surroundings. As such, a combination of the above three theories might give a better understanding of why physical neglect occurs.

2.3.3 Consequences of physical neglect

What then are the effects of neglect? Physically neglected children may suffer from cognitive deficits such as lower IQ scores and language comprehension, emotional problems such as suffering from lower self-esteem, and behavioural problems such as exhibiting greater non-compliance and avoidance of adults. Physically neglected children may also suffer from heightened anxiety, social deficits and anger and may have problems with functioning independently in school (Rossman *et al.*, 1998).

Another consequence of physical child neglect has been reported to be a disorder known as 'non-organic failure to thrive syndrome'. Malnutrition, chronic illness and chronic emotional neglect combine to cause weight and height gain that falls below the fifth percentile on standardised growth charts of expected development in a baby, with a delay in psychomotor skills, social and language development in infancy and beyond. Other characteristics of the condition include dull hair and poor skin clarity. Failure to thrive can be brought about by parental inexperience in not knowing how

to feed the child properly or provide adequate stimulation for the infant. It can also, of course, arise following extreme poverty, or with parents who deliberately reject and neglect the child (Tower, 1996; Rossman *et al.,* 1998).

2.3.4 Intervention and preventive strategies

Practitioners and researchers have suggested few interventions that deal specifically with child neglect and psychological maltreatment. Many of the interventions used currently are similar to those that deal with physical abuse, such as economic assistance, out-of-home placement, and the use of child protective services (Barnett *et al.*, 1997).

There is consensus among clinicians and researchers in the field that current interventions available for child neglect are not effective. However, behavioural techniques used to teach the parents particular skills have shown promise. Negligent parents can be taught problem-solving skills, nutrition skills, personal hygiene and skills in stimulating infants. Experts in the field have also suggested using multi-service intervention approaches for negligent families so that the multiple problems of such families could be addressed. Such programs have been evaluated with some positive results (Barnett *et al.*, 1997).

2.4 Identification and reporting of physical abuse and neglect

Building up knowledge of the characteristics of victims and perpetrators, and of the causes and effects of physical abuse and neglect, is necessary for the effective handling of the problems it creates. It is essential that professionals at the frontline who come into contact with cases of physical child abuse and neglect are able to accurately recognise such cases. However, the particular cultural, social and political context in which professionals and the public live and work affects how they perceive and define child abuse. For instance, Jones and Gupta (1998) examined decision-making in cases of child neglect among professionals within the context of child protection practice in Britain. They argued that the system fails to provide adequate protection for numerous children who suffer from chronic neglect, because professionals tend to focus on incidents of abuse irrespective of the context of the children's lives. Studies that focus on how the public and the professionals define and identify physical neglect and the factors that influence their decision to report a case are thus useful for gaining a deeper insight into how their perceptions affect the reporting rates of neglect.

2.5 Review of local findings on physical child abuse and neglect

In contrast with the vast literature on physical child abuse and neglect done overseas, research on the topic in Singapore is limited and scarce. This is reflected in the review of local studies in the 'Research Brief' (a bimonthly publication by the National Council of Social Service, Singapore) by Tan (1996) that compiled information from key local studies, especially in regard to the definition of child abuse. Tan's (1996) review provided information on the legal definition of child abuse and neglect in Singapore and a general overview of the characteristics of the victim, the perpetrator, sources of referrals and

reporting of all forms of child abuse and neglect, based on information gathered from several local studies. However, the present study is the first to provide a detailed summary and discussion of material specifically relevant to physical child abuse and neglect in Singapore.

As mentioned in Chapter 1 (Section 1.2), physical abuse is the second highest reported type of child abuse and neglect in Singapore, after sexual abuse. In contrast, from the MCDS statistics, physical neglect is now rarely reported in Singapore. From 1994 to 1998, the percentage of reported child abuse and neglect that comprised physical neglect ranged from 0% to only 14.3% at its highest. However, despite the low incidence of physical neglect reported, it should not be concluded that it is the least common form of child abuse and neglect in Singapore. Overseas studies on physical neglect are unanimous in their conclusions that child neglect is often overlooked. We would then expect it to be under-reported in the local context as well. It is to be noted that professionals, and not members of the public, constitute the main source of referrals for child abuse and neglect in Singapore (Tan, 1996). In addition, Tong *et al.*'s (1996) study found that respondents of their study (members of the public) tended to support the reporting of sexual and physical abuse more readily than neglect and emotional maltreatment (see also Elliott, Tong & Tan, 1997). Moreover, many parents in Singapore are working parents and thus spend only limited time with their children. In view of all these factors and bearing in mind that certain consequences of physical neglect (e.g., emotional and social problems) are not immediately noticeable and may be difficult to detect, physical neglect in Singapore may not be as rare as the figures suggest.

Fung and Chow (1998) have pointed out that there is a lack of working definitions of child abuse and neglect in the institutions in which lawyers and doctors work. They have also found interesting differences between the doctors' and lawyers' perceptions of child abuse and neglect. Likewise, in the first large-scale study on the professionals' perceptions of child abuse and neglect in Singapore (Monograph 2 in our series on child abuse and neglect), Elliott *et al.* (2000) found variations among the perceptions of child abuse and neglect by the different professionals studied. Variations have also been found among the public's perceptions of child abuse and neglect by Tong *et al.* (1996). This again raises the possibility that the actual incidence of physical neglect in Singapore may be higher than official statistics show.

With regards to the public's specific perceptions of physical child abuse and neglect, Tong *et al.* (1996) and Elliott *et al.* (1997) reported that caning is widely considered as a legitimate form of physical discipline, acceptable under certain circumstances. For instance, caning is viewed as acceptable if the child was disobedient; older; not physically or mentally handicapped; only caned on the limbs and buttocks; not treated differently from other siblings; the adult had good intentions and was not under stress; there were no permanent injuries or marks on the child; and the caning happened infrequently. However, slapping is not viewed as a legitimate form of discipline and is instead seen as a form of physical violence. Both 'ignoring illness' and 'slapping', actions that are potentially physical child abuse and neglect behaviour, were not acceptable regardless of any circumstances given. These authors also found that the public viewed 'Leaving child alone in the house' as acceptable if the child was older.

Likewise, professionals in Singapore surveyed on their perceptions of child abuse and neglect viewed caning as acceptable under certain circumstances (Elliott *et al.*, 2000). In general, the circumstances under which the professionals viewed caning as acceptable are similar to those that the public felt were acceptable in Tong *et al.* 's (1996) study. A wide range of different views within the various professions and the public has been found. Also, both the public and the professionals tended to view physical abuse, physical neglect and sexual abuse as more unacceptable than emotional maltreatment (Elliott *et al.*, 2000). It is also to be noted that the Child Abuse Research Action Team (1995) have found the programmes and services available in Singapore to deal with the problem of child abuse and neglect inadequate. It is important to ensure that there are adequate services to deal with child abuse and neglect, as a lack could lead to inadequate intervention, and repeated cases of child abuse and neglect could occur consequently.

It is clear from the above that literature on child abuse and neglect, let alone specific to physical child abuse and neglect, is very much lacking in Singapore. In addition, professionals in Singapore also face difficulties when dealing with child abuse and neglect cases, as there is no single working definition for each of the different sub-types of child abuse and neglect in Singapore. All these factors point to a need for further research and agency networking to contribute towards building up a knowledge base on child abuse and neglect locally so that cases could be dealt with effectively. This present study is a step towards achieving this goal.

2.6 Conclusion

From the review of overseas literature on physical child abuse and neglect, it is clear that physical child abuse and neglect is a social problem that results in serious and harmful consequences for both the abused children and their families. However, it cannot be concluded to what extent the results of research on physical child abuse and neglect done overseas are applicable to the physical child abuse and neglect cases in Singapore. Given that research on child abuse and neglect in general and the specific sub-types of child abuse and neglect in particular is still very much lacking in Singapore, further local research is needed before a conclusion can be reached on the nature of local abusers and victims of physical child abuse and neglect. Research is also particularly needed in the area of physical neglect, both overseas and locally. Indeed, building up a more comprehensive local knowledge base of physical child abuse and neglect would help to identify areas where more effective intervention efforts to deal with the problem of physical child abuse and neglect could be carried out.

CHAPTER 3: REACTION OF PROFESSIONALS AND THE PUBLIC TO ACTIONS SUGGESTING PHYSICAL CHILD ABUSE AND NEGLECT

3.1 Methodology

The analyses and discussions in this monograph are based on data documented in the first two monographs in our monograph series on child abuse and neglect. The first monograph was a study on the views of child abuse and neglect in Singapore by members of the public living in high-rise public housing in Singapore (Tong *et al.*, 1996). The second compared the views and attitudes of various professionals and members of the public towards child abuse and neglect in Singapore (Elliott *et al.*, 2000).

Data for these two studies were collected in two separate surveys. The data for Tong *et al.* (1996) was collected in an interview survey of 401 Singaporeans residing in public housing. These interviews were carried out from November 1994 to February 1995. There were 171 males and 230 females included in the survey and the respondents were randomly sampled from five Housing & Development Board (HDB) estates. The study was representative of the population who resides in HDB or public housing.

As for the questionnaire given to the professionals, it was adapted from the interview schedules used in Tong *et al.* (1996) and distributed to 1252 members of professions likely to come into contact with abused and/or neglected children. Data were collected in 1997. The professional respondents comprised 206 doctors, 414 nurses, 82 social workers, 190 police, 60 lawyers, and 286 teachers and childcare professionals from the education field, and 14 counsellors/psychologists. The last group of professionals was excluded from our analysis due to the small group size. Thus, our sample comprised a total of 401 males and 817 females amongst the respondents, with 20 unspecified.

The respondents had to state their reactions to eighteen different behaviours involving four main categories of child abuse and neglect (i.e., physical neglect, physical abuse, emotional maltreatment and sexual abuse). The respondents were asked to indicate how acceptable a particular behaviour is, and whether the behaviour is neglect or abuse. For the purpose of the present study, only answers to those questions pertaining to physical child abuse and neglect behaviours in the two surveys would be analysed. Specifically, there are 7 behaviours of interest for the present study. This list of questions pertaining to physical child abuse and neglect in the questionnaire is in Table 3.1.

Table 3.1
Questions pertaining to physical child abuse and neglect from Section A, Part 1 of the questionnaires given to the professional respondents (from Elliott *et al.*, 2000).

Questions ***(Numbered according to questionnaire)***		
	In your opinion, how acceptable is this?	In your opinion, is this abuse/ neglect?
	Always Sometimes Never	**Is not Can be Is**
1. Leaving child alone in the house	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
8. Slapping child on the face	i----------ii----------iii	1----------2---------3
13. Burning child with cigarettes, hot water, or other hot things	i----------ii----------iii	1----------2---------3
15. Caning child	i----------ii----------iii	1----------2----------3
17. Ignoring signs of illness in child (e.g., high fever)	i----------ii----------iii	1----------2----------3
	i----------ii----------iii	1----------2----------3

In Part 2 of the questionnaire sent to respondents, eight of the eighteen behaviours from Part 1 were described with various circumstances and the respondents were required to state whether the particular behaviour was acceptable under the circumstances given (see Elliott *et al.*, 2000 for the complete version of the questionnaire). For the purpose of the current study, only answers to those questions pertaining to physical child abuse and neglect actions were analysed. 4 specific actions are of interest for the purpose of the present study. They are: 'Slapping a child on the face', 'Caning a child', 'Ignoring signs of illness in a child (e.g., high fever)' and 'Leaving a child alone in the house'.

For further details of the methodology used for the present study, please refer to Monograph 2, the second monograph in our series on child abuse and neglect, by Elliott *et al.* (2000). The four questions pertaining to physical child abuse and neglect (in Part 2 of the questionnaire) that are used in this study may be referred to in Appendix A.

3.2 Data analysis

Sample sizes of each profession and the public differ from each other, due to the varying return rates for each group of respondents for the questionnaires. Type 1 error levels were therefore not guaranteed. Moreover, the distributions were quite skewed for particularly unacceptable actions. As such, though statistical tests may be useful in helping determine significant differences among groups, the presence of differences should not be allowed to obscure the general patterns of results observed from the data.

In particular, the variance accounted for in differences between the various sample groups is minute compared to the total variance. In other words, the effect size is very small and statistically significant differences are found only because the samples (even the small ones) are relatively large. Univariate analysis of variance with each sample group as the fixed factor and the response to each question pertaining to physical child abuse and neglect as the dependent variable showed that none of the eta squared values were above 0.055. In other words, not more than 5.5% of the variance among the different groups is explained by group differences. Consequently, even where the results show significant differences between particular sample groups, the significant differences would only be accounting for a small percentage of the variation in the scores.

3.3 Results

3.3.1 Opinions on the acceptability of actions suggesting physical child abuse and neglect

The acceptability statuses of the seven actions suggesting physical child abuse and neglect are in Table 3.2. The modal choice of each respondent group is highlighted in the table. The following paragraphs give a detailed account of acceptability with regards to the similarities and differences among the professionals and the public sample.

For every item, the modal choices of all groups of respondents are noted and compared. In addition, for each item, an Analysis of Variance (ANOVA) was carried out across the 7 groups of respondents (6 professions and the Public), and a post hoc test (Tukey's honestly significant difference (HSD) test) used to examine patterns of significant difference. Because of the large size of the samples, even very small effects will give statistically significant results. Therefore, a stringent alpha level was adopted ($p=0.001$). However, it is to be noted that sometimes, the modal choice of two respondent groups may differ but post hoc test results may not show any significant differences between them, whilst two respondent groups that have a similar modal choice may have significant differences found between them. This also applies for results reviewed in the other sections.

Table 3.2

Acceptability of actions suggesting physical child abuse and neglect. Responses for the professions (N=1238) and the public sample (N=401), from Elliott *et al.* (2000).

CATEGORY	BEHAVIOUR		P %	SW %	D %	N %	L %	ED %	PUB %
PHYSICAL ABUSE:	Burning child with cigarettes, hot water, or other hot things	*Always acceptable*	1.6	2.4	1.0	0.2	0	1.1	0
		Sometimes acceptable	1.1	0	0	1.0	0	1.1	0
		Never acceptable	**97.3**	**97.6**	**99.0**	**98.8**	**100**	**97.9**	**100**
	Tying child up	*A*	0.5	0	0.5	1.2	0	0.7	1.3
		S	4.8	8.9	5.5	2.2	1.7	5.6	4.5
		N	**94.6**	**91.1**	**94.0**	**96.6**	**98.3**	**93.7**	**94.2**
	Shaking child hard	*A*	1.6	0	1.0	0.2	0	0.4	5.5
		S	29.8	22.8	25.6	22.1	28.3	32.6	26.4
		N	**68.6**	**77.2**	**73.4**	**77.6**	**71.7**	**67.0**	**68.0**
	*Slapping child on the face	*A*	1.1	0	2.0	1.0	1.7	0	3.8
		S	**55.4**	35.0	**50.7**	32.0	**58.3**	40.4	42.4
		N	43.5	**65.0**	47.3	**67.0**	40.0	**59.6**	**53.8**
	*Caning child	*A*	5.9	3.8	6.3	3.0	5.0	0.7	12.1
		S	**73.4**	**88.8**	**81.1**	**74.8**	**85.0**	**83.4**	**59.4**
		N	20.7	7.5	12.6	22.2	10.0	15.9	28.5
PHYSICAL NEGLECT:	*Ignoring signs of illness in child (e.g., high fever)	*A*	1.1	0	0	0.5	0	1.1	0
		S	9.6	9.8	14.1	5.9	13.3	7.7	2.5
		N	**89.3**	**90.2**	**85.9**	**93.6**	**86.7**	**91.2**	**97.5**
	*Leaving child alone in the house	*A*	1.6	5.1	3.0	0.5	3.3	1.1	7.8
		S	**65.3**	**80.8**	**65.2**	**51.2**	**75.0**	**54.6**	**47.7**
		N	33.2	14.1	31.8	48.3	21.7	44.3	44.4

P = Police, SW = Social Workers, D = Doctors, N = Nurses, L = Lawyers, ED = Educators, PUB = Public

** Indicates behaviours that were further explored with mitigating circumstances.*

Burning child with cigarettes, hot water, or other hot things

The majority (at least 97.3%) of each of the 7 groups (namely, the 6 professions which include the Police, Social Workers, Doctors, Nurses, Lawyers and Education professionals, and the public sample) chose 'Never acceptable' for this behaviour. No significant differences were found among the respondents ($F_{6,1618} = 2.059$, $p>0.05$).

Tying child up

The majority (at least 91.1%) of each of the 7 groups chose 'Never acceptable' for this behaviour. No significant differences were found among the respondents ($F_{6,1607} = 0.724$, $p>0.05$).

Shaking child hard

The majority (at least 67%) of each of the 7 groups chose 'Never acceptable' for this action. Significant differences were found among the respondents ($F_{6,1612} = 3.753$, $p=0.001$). However, post hoc test results showed that significant differences were found only between Nurses and the Public. A higher percentage of the Nurses than the public sample viewed the action as 'Never acceptable'.

Slapping child on the face

The majority (at least 50.7%) of Police, Doctors and Lawyers chose 'Sometimes acceptable' for this action. On the other hand, the majority (at least 53.8%) of Social Workers, Nurses, Educators and the Public chose 'Never acceptable'. Significant differences between the groups were found ($F_{6,1609} = 8.425$, $p<0.001$). However, post hoc test results showed that significant differences were found only for the following contrast: the Nurses with Police, Doctors and the Public.

Caning child

The majority (at least 59.4%) of each of the 7 groups chose 'Sometimes acceptable' for the action. No significant differences were found among the respondents ($F_{6,1612} = 2.774$, $p>0.01$).

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

The majority (at least 85.9%) of each of the 7 groups chose 'Never acceptable' for this behaviour. Significant differences were found among the respondents ($F_{6,1618} = 5.194$, $p<0.001$). However, post hoc test results showed that significant differences were only found between Doctors and the Public. A lower percentage of the Doctors viewed the action as 'Never acceptable' compared to the Public. A reason for Doctors considering this action to be less serious than how the Public regarded it might be due to the professional training that doctors received on illnesses, as compared to members of the public who would not have such knowledge.

Leaving child alone in the house

For this action, 'Sometimes acceptable' was the modal choice of all 7 groups of respondents. At least 47.7% of each of the 7 respondent groups viewed this action as 'Sometimes acceptable'. There were small but technically significant differences among these groups ($F_{6,1602} = 9.193$, $p<0.001$). Post hoc test results showed that significant differences were found for these groups: between Doctors and Nurses; and for the Social Workers with Nurses, Educators and the Public.

Observations

As mentioned in Elliott *et al.* (2000), the professions broadly did not differ greatly from the public sample with regards to their views on the acceptability of the 18 actions suggesting child abuse and neglect. It was also noted that there was no obvious difference in the proportions for the acceptability of the 18 actions when the pooled professionals (combined response for the 6 different professions included in the study) and the public sample were compared.

From the above results for the present study, the following observations could be made:

- The majority of each of the professions and the public sample only considered those actions that appear to lead to obvious and severe physical harm as 'Never acceptable'. Specifically, the four actions were: 'Burning child with cigarettes, hot water, or other hot things', 'Tying child up', 'Shaking child hard' and 'Ignoring signs of illness in child (e.g., high fever)'. At least 67% of each of the 7 groups gave this response for the action of 'Shaking child hard', whilst at least 85.9% of each of the 7 groups (the 6 groups of professionals, and the public sample group) chose this response for the other 3 actions. For these 4 actions, there is thus a generally similar opinion obtained for the various professions and the public sample.

- On the other hand, for those actions that did not appear to lead to obvious injury to the physical well being of the child, many from the various professions and the public sample viewed them as 'Sometimes acceptable'. Such a response was obtained for the following actions: 'Caning child' and 'Leaving child alone in the house'.

- However, for the behaviour 'Slapping child on the face', the majority of certain groups of professionals (Social Workers, Nurses and Educators), together with the public sample, differed from the other groups of respondents (Police, Doctors and Lawyers) in their opinions of this action. For this action, there is thus a more obvious lack of consensus among the professions with regards to their views on the acceptability of the action.

- For results obtained for ANOVA and the post hoc test, although significant differences have been found among the various groups of respondents, no obvious trend in the results could be observed, other than that the Nurses sample appeared to have significant differences with various groups of respondents more frequently than any other group of respondents in their opinion of the 7 actions suggesting physical child abuse and neglect. It is to be noted that the Nurses sample consisted of the largest group of respondents when compared to the other 6 groups of respondents and significant differences may have occurred due to the unequal sizes of the various groups.

- Interestingly, there were 3 actions that had no significant differences (for both ANOVA and Tukey's HSD test) found among the respondents in their opinions for them. These actions were: 'Burning child with cigarettes, hot water, or other hot things', 'Tying child up' and 'Caning'. The first two actions were also the ones with the highest percentage of respondents in all 7 groups (more than 90% within each group) who viewed the behaviour as 'Never acceptable'.

- It is also interesting to note that for the action 'Slapping child on the face', the majority of Doctors (50.7%) regarded it as 'Sometimes acceptable', whilst the majority of Nurses (67%) viewed it as 'Never acceptable'. The Tukey's HSD test also found significant differences for these 2 groups. However, the majority of both groups held similar views with regards to the other 6 behaviours suggesting physical child abuse and neglect. It thus appears that professionals from a particular field, in this case the medical field, may not always hold similar views for **all** types of behaviours.

3.3.2 Opinions on the abusiveness of actions suggesting physical child abuse and neglect

The following 7 actions suggesting physical child abuse and neglect were also obtained from the 18 actions suggesting child abuse and neglect that were found in Part 1 of Section A in the questionnaire that focused on 'Definitions of Child Abuse and Neglect'. The abuse status of each of these actions is displayed in Table 3.3. The modal choice of each respondent group is highlighted in the table. A detailed account of opinions on the abuse status of these actions with regards to similarities and differences among the professionals and the public sample is found in the following.

Likewise, for every item, the modal choices of all groups of respondents are noted and compared. In addition, an Analysis of Variance (ANOVA) was carried out for each item across the 7 groups of

respondents, and a post hoc test (Tukey's HSD) used to examine patterns of significant difference. Because of the large size of the samples, even very small effects will give statistically significant results. A stringent alpha level was hence adopted (p=0.001) for this reason.

Table 3.3

Abuse status of actions suggesting physical child abuse and neglect (Elliott *et al.*, 2000).

CATEGORY	BEHAVIOUR		P %	SW %	D %	N %	L %	ED %	PUB %
PHYSICAL ABUSE	Burning child with cigarettes, hot water, or other hot things	*Is Not abuse*	0.5	0	0	0.2	0	0.4	0.5
		Can Be abuse	0.5	0	1.5	2.0	0	1.4	0.5
		Is abuse	**98.9**	**100**	**98.5**	**97.8**	**100**	**98.2**	**99.0**
	Tying child up	*Is Not*	1.1	0	0.5	1.0	0	0.4	2.5
		Can Be	10.2	25.0	10.9	10.9	10.0	10.9	12.8
		Is	**88.7**	**75.0**	**88.6**	**88.1**	**90.0**	**88.7**	**84.7**
	Shaking child hard	*Is Not*	9.1	6.3	5.0	6.8	11.7	7.4	19.3
		Can Be	**50.3**	45.6	40.6	38.0	41.7	**46.8**	32.4
		Is	40.6	**48.1**	**54.5**	**55.3**	**46.7**	45.7	**48.2**
	*Slapping child on the face	*Is Not*	15.5	2.6	11.4	8.8	11.7	6.3	20.2
		Can Be	**52.9**	**71.1**	**62.4**	41.3	**60.0**	**51.1**	38.1
		Is	31.6	26.3	26.2	**50.0**	28.3	42.6	**41.7**
	*Caning child	*Is Not*	15.0	8.8	17.6	16.4	15.0	18.6	29.4
		Can Be	**66.3**	**87.5**	**74.0**	**62.0**	**78.3**	**68.2**	**42.7**
		Is	18.7	3.8	8.3	21.7	6.7	13.2	27.9
PHYSICAL NEGLECT	*Ignoring signs of illness in child (e.g., high fever)	*Is Not*	3.2	2.4	3.4	2.7	0	1.8	4.0
		Can Be	21.8	24.4	31.4	19.7	28.8	19.4	8.3
		Is	**75.0**	**73.2**	**65.2**	**77.6**	**71.2**	**78.8**	**87.7**
	*Leaving child alone in the house	*Is Not*	30.2	17.7	18.1	25.6	15.0	20.4	**34.5**
		Can Be	**51.3**	**78.5**	**67.8**	**50.8**	**70.0**	**50.7**	**34.5**
		Is	18.5	3.8	14.1	23.6	15.0	28.9	31.0

P = Police, SW = Social Workers, D = Doctors, N = Nurses, L = Lawyers, ED = Educators, PUB = Public

** Indicates behaviours that were further explored with mitigating circumstances.*

Burning child with cigarettes, hot water, or other hot things

The majority (at least 97. 8%) of each of the 7 groups chose 'Is abuse' for this behaviour. There were no significant differences found among the respondents ($F_{6,1612} = 0.520$, $p>0.05$).

Tying child up

The majority (at least 75%) of each of the 7 groups chose 'Is abuse'. No significant differences were found among the respondents ($F_{6,1604} = 2.302$, $p>0.01$).

Shaking child hard

The modal choice for both the Police and Educators (at least 46.8%) was 'Can be abuse'. In contrast, the modal choice (at least 46.7%) for the Social Workers, Doctors, Nurses, Lawyers and the Public was 'Is abuse'. Significant differences were found among the respondents ($F_{6,1601} = 4.233$, $p<0.001$). However, post hoc test results showed the only significant difference found was that between Nurses and the Public.

Slapping child on the face

The modal choice for both the Nurses and the Public (at least 41.7%) for this action was 'Is abuse'. The majority (at least 51.1%) of the Police, Social Workers, Doctors, Lawyers and Educators chose 'Can be abuse'. Significant differences were found among the respondents ($F_{6,1598} = 6.826$, $p<0.001$). Post hoc test results showed that significant differences were found among the following groups: for Nurses with the Police, Doctors and the Public.

Caning a child

The modal choice (at least 42.7%) for all 7 groups was 'Can be abuse'. No significant differences were found among the respondents ($F_{6,1599} = 1.937$, $p>0.05$).

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

The majority (at least 65.2%) of each of the 7 groups chose 'Is abuse'. Significant differences were found among the respondents ($F_{6,1609} = 4.895$, $p<0.001$). Post hoc test results showed that the only significant difference found was that between Doctors and the Public.

Leaving child alone in the house

For all 6 professions, the majority (at least 50.7%) of each group chose 'Can be abuse' for this action. For the Public, 34.5% chose 'Is not abuse', 34.5% chose 'Can be abuse' and 31% chose 'Is abuse'. Significant differences were found among the respondents ($F_{6,1591} = 2.111$, $p>0.01$). However, the post hoc test results showed no significant differences for the groups.

Observations

It has also been mentioned in Elliott *et al.* (2000) that the professions broadly did not differ greatly from the public sample with regards to the opinions of the abuse status of the 18 actions suggesting child abuse and neglect. There was also no obvious difference in the proportions for the abuse status of the 18 actions when the responses of both pooled professionals (combined response for the 6 different professions included in the study) and the public sample were compared.

From the above results for the present study, the following observations could be made:

- Like the responses obtained for the acceptability of the 7 actions suggesting physical child abuse and neglect in the earlier section, the majority of each of the various professions and the public sample only viewed those actions that appear to lead to obvious and severe physical harm as 'Is abuse'. Specifically, the three actions were: 'Burning child with cigarettes, hot water, or other hot things', 'Tying child up' and 'Ignoring signs of illness in child (e.g., high fever)'. At least 65.2% of each of the 7 groups gave this response for the action of 'Ignoring signs of illness in child (e.g., high fever)', whereas at least 75% of each of the 7 groups (the 6 groups of professionals, and the public sample group) chose this response for the other 2 actions. For these 3 actions, there is thus a generally similar opinion obtained for the various professions and the public sample. However, when compared to the earlier results on the acceptability of the same 7 actions, it appeared that the respondents were more reluctant to term the same actions

which they had viewed as 'Never acceptable' to constitute as 'abuse'. As mentioned in Tong *et al.* (1996) and Elliott *et al.* (1997), this may be because people viewed the term 'abuse' to carry a more negative connotation.

- Similar to responses obtained for the earlier section on the acceptability of actions, for those behaviours that did not appear to lead to obvious injury to the physical well-being of the child, the majority of the various professions and the public sample viewed them as either 'Can be abuse' or 'Is abuse'. However, for a number of actions, many from certain groups of professionals differed from the other groups of respondents in their opinions of the actions. From the results above, it is clear that the actions that did not have strong consensus among the respondents with regards to their abuse status were: 'Shaking child hard' and 'Slapping child on face'. There is thus a more obvious lack of consensus among the professions with regards to their views on the abuse status of these actions.

- Generally, there is consensus among the various professions and the public sample with regards to the abuse status of 'Caning child' as many from each of the 7 groups (at least 42.7%) rated the action as 'Can be abuse'. However, the level of consensus is considered much lower when compared to results on the abuse status of extreme actions like 'Tying child up', for instance.

- The only action which had general consensus among the professions (although the level of consensus is not high, at only at least 50.7% for each of the 6 professions) but which the Public had varied views on is 'Leaving child alone in the house'. For this behaviour, the majority of each of the 6 professions regarded it as 'Can be abuse', whilst for the Public, 34.5% regarded it as 'Can be abuse', another 34.5% viewed it as 'Is not abuse' and 31% considered it as constituting abuse.

- For results obtained for ANOVA and the post hoc test, although significant differences have been found among the various groups of respondents in their opinions, no obvious trend in the results could be observed. However, what is of interest is that there were 4 actions that had no significant differences (for both ANOVA and Tukey's HSD test) found among the respondents in their opinions for them. These actions were: 'Burning child with cigarettes, hot water, or other hot things', 'Tying child up', 'Caning child' and 'Leaving child alone'.

- For the action 'Shaking child hard', there appeared to be differences between the two professions that come from the law and order field. The majority of Police (50.3%) considered it as 'Can be abuse', whilst many Lawyers (46.7%) viewed it as 'Is abuse'. However, post hoc test results showed that no significant differences were found for these two groups.

- For the behaviour 'Slapping child on the face', the majority of Doctors (62.4%) viewed it as 'Can be abuse', whilst 50% of the Nurses viewed it as 'Is abuse'. Significant differences were found between these two groups.

3.3.3 Opinions on the influence of mitigating circumstances on perceptions of actions suggesting physical child abuse and neglect

For every item of the following four actions suggesting physical child abuse and neglect, the modal choices of all groups of respondents are noted and compared. An Analysis of Variance (ANOVA) was also carried out across the 7 groups of respondents, and a post hoc test (Tukey's HSD) used to examine patterns of significant difference. It is to be noted that because of the large size of the samples, even very small effects will give statistically significant results. Hence, a stringent alpha level was adopted ($p=0.001$).

Slapping a Child on the Face

Detailed results for the influence of mitigating circumstances on the acceptability of the behaviour of 'Slapping a child on the face' are examined in the following. General responses of the respondents for this behaviour can be found in Table 3.4. The modal choice of each respondent group is highlighted in the table.

Acceptability of slapping a child with respect to frequency of incident

The modal choice of Doctors (49.5%) was 'Acceptable if it only happens once or twice' and the majority of Lawyers (53.4%) chose the same response. However, the modal choice of Police, Social Workers, Nurses, Educators and the Public (at least 46%) for this action was 'Not acceptable regardless of frequency of incidents'. Significant differences were found among the respondents ($F_{6,1615} = 7.089$, $p<0.001$). Post hoc test results showed that significant differences were found for Nurses with Police and Doctors.

Acceptability of slapping a child with respect to age of child

The modal choice (at least 44.8%) for all 7 groups for this action was 'Not acceptable regardless of age of child'. Significant differences were found among the respondents ($F_{6,1613} = 7.812$, $p<0.001$). Post hoc test results showed that significant differences were found for Nurses with Police and the Public.

Acceptability of slapping child with respect to sex of child

The modal choice of the Police (48.9%) and the Lawyers (48.3%) was 'Acceptable regardless of whether child is a boy or girl'. The majority (at least 52.3%) of Social Workers, Doctors, Nurses, Educators and the Public chose 'Not acceptable regardless of whether child is a boy or girl'. Significant differences were found among the various groups of respondents ($F_{6,1612} = 7.813$, $p<0.001$). Post hoc test results showed that significant differences were found for Nurses with Police, Lawyers, Educators and the Public.

Table 3.4

Influence of mitigating circumstances on acceptability of slapping child on face

CATEGORY AND BEHAVIOUR	MITIGATING CIRCUMSTANCE		P %	SW %	D %	N %	L %	ED %	PUB %
PHYSICAL ABUSE	*Acceptability of slapping with respect to (wrt) **frequency**	*Acceptable if once/ twice*	45.5	30.9	**49.5**	29.6	**53.4**	39.6	39.0
		Acceptable regardless	8.5	1.2	2.5	2.4	3.4	3.2	7.5
SLAPPING		*Not acceptable regardless*	**46.0**	**67.9**	48.0	**68.0**	43.1	**57.2**	**53.5**
	*Acceptability of slapping wrt **age**	*Acceptable if child is younger*	13.8	8.6	9.5	5.9	12.1	15.9	10.5
		Acceptable if child is older	24.5	8.6	24.4	15.2	29.3	14.1	21.5
		Acceptable regardless	14.9	8.6	15.9	8.3	13.8	12.0	12.3
		Not acceptable regardless	**46.8**	**74.1**	**50.2**	**70.7**	**44.8**	**58.0**	**55.8**
	*Acceptability of slapping wrt **sex**	*Acceptable if child is a boy*	2.7	0	1.5	0.7	6.9	4.9	4.3
		Acceptable if child is a girl	0	0	0	0.2	0	0	0
		Acceptable regardless	**48.9**	27.2	46.2	28.5	**48.3**	37.1	37.3
		Not acceptable regardless	48.4	**72.8**	**52.3**	**70.5**	44.8	**58.0**	**58.5**
	*Acceptability of slapping wrt **marks/ injuries**	*Acceptable if child is not permanently marked or injured*	**52.4**	30.9	49.5	26.8	**55.2**	41.2	37.8
		Acceptable regardless	1.1	0	0	1.5	0	1.1	2.5
		Not acceptable regardless	46.6	**69.1**	**50.5**	**71.7**	44.8	**57.7**	**59.8**
	*Acceptability of slapping wrt **disobedience**	*Acceptable if child is disobedient*	53.4	30.9	50.7	33.0	55.9	43.3	47.3
		Acceptable regardless	2.1	0	0.5	1.0	1.7	2.5	1.5
		Not acceptable regardless	44.4	69.1	48.8	66.0	42.4	54.2	51.3
	*Acceptability of slapping wrt treatment **compared to siblings**	*Acceptable if child is treated differently*	1.1	1.2	0.5	0.7	0	0.7	1.5
		Acceptable if child is treated the same	36.2	22.2	41.3	22.2	**50.9**	37.7	27.5
		Acceptable regardless	14.4	6.2	7.0	6.7	3.5	5.0	14.3
		Not acceptable regardless	**48.4**	**70.4**	**51.2**	**70.4**	45.6	**56.6**	**56.8**
	*Acceptability of slapping wrt **physical or mental handicap of child**	*Acceptable if child is handicapped*	1.6	0	0	0.2	0	1.1	1.0
		*Acceptable if child is **not** handicapped*	43.0	12.3	36.8	23.0	41.4	33.8	29.8
		Acceptable regardless	7.0	14.8	12.4	4.6	13.8	7.1	9.3
		Not acceptable regardless	**48.4**	**72.8**	**50.7**	**72.1**	**44.8**	**58.0**	**59.9**
	*Acceptability of slapping wrt **adult's intentions**	*Acceptable if have good intentions*	**56.5**	32.1	**51.5**	34.2	**56.9**	43.7	46.0
		Acceptable regardless	0.5	0	0.5	1.2	0	1.1	2.3
		Not acceptable regardless	43.0	**67.9**	48.0	**64.5**	43.1	**55.3**	**51.8**
	*Acceptability of slapping wrt **adult's stress levels**	*Acceptable if adult is under stress*	2.2	0	3.0	1.2	0	1.8	6.0
		*Acceptable if adult **not** under stress*	30.6	20.0	35.0	17.2	34.5	34.6	19.5
		Acceptable regardless	13.4	6.3	11.0	6.9	20.7	6.0	13.3
		Not acceptable regardless	**53.8**	**73.8**	**51.0**	**74.8**	**44.8**	**57.6**	**61.3**
	*Acceptability of slapping wrt **family's financial status**	*Acceptable if family is poor*	0.5	0	0	0.2	0	0.4	2.0
		*Acceptable if family is **not** poor*	0	0	1.0	0.2	0	2.1	1.3
		Acceptable regardless	45.9	25.0	46.5	24.4	**55.2**	39.1	32.3
		Not acceptable regardless	**53.5**	**75.0**	**53.5**	**75.1**	44.8	**58.5**	**64.5**
	*Acceptability of slapping wrt **parents' working schedule**	*Acceptable if parents are busy*	1.1	0	0	0.5	0	0.7	1.5
		*Acceptable if parents are **not** busy*	1.6	0	3.5	3.4	3.4	5.3	5.5
		Acceptable regardless	41.1	25.0	43.3	18.9	**50.8**	35.3	28.0
		Not acceptable regardless	**56.2**	**75.0**	**53.2**	**77.1**	45.8	**58.7**	**65.0**

P = Police, SW = Social Workers, D = Doctors, N = Nurses, L = Lawyers, ED = Educators, PUB = Public

Acceptability of slapping a child with respect to whether child is permanently marked/ injured

The majority of Police (52.4%) and Lawyers (55.2%) chose 'Acceptable only if child is not permanently marked or injured'. The majority (at least 50.5%) of Social Workers, Doctors, Nurses, Educators and the Public chose 'Not acceptable regardless of whether child is injured or not'. Significant differences were found among the respondents ($F_{6,1617} = 9.787$, $p<0.001$). Post hoc test results showed that significant differences were found for Nurses with Police, Doctors and Lawyers.

Acceptability of slapping a child with respect to whether child is disobedient or not

The majority of Police (53.4%), Doctors (50.7%) and Lawyers (55.9%) chose 'Acceptable only if child is disobedient'. The majority (at least 51.3%) of Social Workers, Nurses, Educators and the Public chose 'Acceptable regardless of whether child is disobedient or not'. Significant differences were obtained among the respondents ($F_{6,1616} = 7.410$, $p<0.001$). Post hoc test results showed that significant differences were found for Nurses with Police, Doctors, and the Public.

Acceptability of slapping a child with respect to treatment of child compared to siblings

The majority of Lawyers (50.9%) chose 'Acceptable only if child is treated the same as brothers/ sisters'. The modal choice (at least 48.4%) of the Police, Social Workers, Doctors, Nurses, Educators and the Public was 'Not acceptable regardless of how child is treated'. Significant differences were found among the respondents ($F_{6,1606} = 7.565$, $p<0.001$). Post hoc test results showed that significant differences were found for Nurses with Police, Doctors and Educators.

Acceptability of slapping a child with respect to whether child is physically/mentally handicapped

The modal choice (at least 44.8%) for all 7 groups was 'Not acceptable regardless whether child is physically/mentally handicapped or not'. Significant differences were found among the respondents ($F_{6,1608} = 9.389$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: between Social Workers and Police, and for the Nurses with Police and Doctors.

Acceptability of slapping a child with respect to adult's intentions

The majority of Police (56.5%), Doctors (51.5%) and Lawyers (56.9%) chose 'Acceptable only if the adult has good intentions'. The majority (at least 51.8%) of Social Workers, Nurses, Educators and the Public chose 'Not acceptable regardless of adult's intentions'. Significant differences were found among the respondents ($F_{6,1611} = 7.003$, $p<0.001$). However, post hoc test results showed that the only significant difference was that between Nurses and Police.

Acceptability of slapping a child with respect to adult's stress level

The modal choice for (at least 44.8%) all 7 groups was 'Not acceptable regardless of whether adult is under stress or not'. Significant differences were found among the respondents ($F_{6,1608} = 8.884$, $p<0.001$). Post hoc test results showed that significant differences found were that for the Nurses with Police, Doctors and Educators.

Acceptability of slapping a child with respect to financial status of family

The majority of Lawyers (55.2%) chose 'Acceptable regardless of whether family is poor or not'. The majority (at least 52.5%) of Police, Social Workers, Doctors, Nurses, Educators and the Public chose 'Not acceptable regardless of whether family is poor or not'. Significant differences were found among the various groups of respondents ($F_{6,1609} = 8.350$, $p<0.001$). Post hoc test results showed that significant differences found were for Nurses with Police, Doctors and Educators.

Acceptability of slapping a child with respect to parents' working schedule

The majority of Lawyers (50.8%) chose 'Acceptable regardless of parents' working schedule'. The majority (at least 53.2%) of Police, Social Workers, Doctors, Nurses, Educators and the Public chose 'Not acceptable regardless of parents' working schedule'. Significant differences were found among the respondents ($F_{6,1608} = 7.254$, $p<0.001$). Post hoc test results showed that significant differences were found for Nurses with Doctors and Educators.

Observations

From the above results for the present study, the following observations could be made:

- Many respondents from both the professional and the public samples agreed that the behaviour 'Slapping a child on the face' was not acceptable regardless of the following conditions: age of the child, whether the child is physically/mentally handicapped or not and adult's stress level.

- Many respondents from each of the various groups, except for Lawyers, viewed the behaviour as not acceptable regardless of the three conditions of treatment of child compared to siblings, family's financial status and parents' working schedule. Lawyers tended to view the action as either acceptable given a particular circumstance or acceptable regardless of any conditions given.

- Overall, it appeared that more respondents were more disapproving of this behaviour than that of 'Caning a child', seen in the next section. There were also more varied responses or weaker consensus found among the various professions for this action than for the behaviour 'Caning a child'. Such a finding is similar to the observation made in Elliott *et al.* (2000), where it was stated that caning was mostly considered to be an acceptable behaviour (though it may not be sometimes), whilst slapping a child on the face was mostly viewed to be unacceptable (though it may be acceptable sometimes).

- From the post hoc test results, it appears that Nurses was the group that has significant differences with other groups most often.

- Differences between professions belonging to similar fields of work have also been observed. For instance, a large number of Police and Lawyers did not share similar views on the acceptability of slapping a child under the following conditions: frequency of the incident, treatment of child compared to siblings, family's financial status and parents' working schedule. The Police appeared to be more disapproving of slapping a child than the Lawyers were. In addition, many

Doctors and Nurses had varied views on whether slapping a child was acceptable under the following circumstances: frequency of the incident, whether the child is disobedient or not, and adult's intentions. It appeared that the Nurses were more disapproving of the action than the Doctors.

Caning a Child

Detailed results for the influence of mitigating circumstances on the acceptability of the behaviour of 'Caning a child' are examined in the following. Tabulation of the general responses of the respondents for this action can be found in Table 3.5. The modal choice of each respondent group is highlighted in the table.

Acceptability of caning a child with respect to frequency of incident

The majority (at least 63.9%) of each of the 7 groups chose 'Acceptable if it only happens once or twice' for this action. Significant differences were found among the respondents ($F_{6,1609} = 6.737$, $p<0.001$). Post hoc test results showed that significant differences found were for the Public with Social Workers, Doctors and Educators.

Acceptability of caning a child with respect to age of child

For Social Workers (43%) and Educators (41.8%), the modal choice was 'Acceptable only if child is younger'. For Police (33.9%), Doctors (34.5%), Nurses (35.3%) and Lawyers (47.5%), the modal choice was 'Acceptable only if child is older' for the behaviour. Significant differences were found among the respondents ($F_{6,1608} = 5.479$, $p<0.001$). Post hoc test results showed that significant differences were found for Educators with Nurses and the Public.

Acceptability of caning a child with respect to sex of child

The majority (at least 66.4%) of each of the 7 groups chose 'Acceptable regardless of whether child is a boy or girl' for the behaviour. Significant differences were found among the respondents ($F_{6,1606} = 13.276$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Police and Educators, and for Educators with Doctors and the Public.

Acceptability of caning a child with respect to area of body affected

The majority (at least 73.8%) of each of the 7 groups chose 'Acceptable if only limbs/buttocks affected'. Significant differences were found among the respondents ($F_{6,1607} = 7.035$, $p<0.001$). Post hoc test results showed that significant differences were found for Educators with Nurses and the Public.

Acceptability of caning a child with respect to whether child is permanently marked or injured

The majority (at least 67.7%) of each of the 7 groups chose 'Acceptable only if child is not permanently marked or injured'. Significant differences were found among the respondents ($F_{6,1602} = 11.885$, $p<0.001$). Post hoc test results showed that significant differences were found for these groups: Nurses with Educators, and for the Public with Social Workers, Doctors and Educators.

Table 3.5
Influence of mitigating circumstances on acceptability of caning a child.

CATEGORY AND BEHAVIOUR	MITIGATING CIRCUMSTANCE		P %	SW %	D %	N %	L %	ED %	PUB %
PHYSICAL ABUSE	*Acceptability of caning with respect to (wrt) **frequency**	*Acceptable if once/twice*	**72.1**	**83.8**	**79.2**	**76.6**	**76.3**	**79.3**	**63.9**
		Acceptable regardless	13.7	11.3	8.9	5.7	13.6	12.1	13.0
		Not acceptable regardless	14.2	5.0	11.9	17.7	10.2	8.6	23.1
CANING	*Acceptability of caning wrt **age**	*Acceptable if child is younger*	31.2	**43.0**	24.6	25.4	28.8	**41.8**	28.0
		Acceptable if child is older	**33.9**	24.1	**34.5**	**35.3**	**47.5**	26.1	**32.8**
		Acceptable regardless	20.1	26.6	29.1	16.3	13.6	22.5	15.5
		Not acceptable regardless	14.8	6.3	11.8	23.0	10.2	9.6	23.8
	*Acceptability of caning wrt **sex**	*Acceptable if child is a boy*	8.5	0	3.0	1.0	10.2	14.6	6.8
		Acceptable if child is a girl	0	0	0	0	0	0.4	0.3
		Acceptable regardless	**76.1**	**93.7**	**83.1**	**75.2**	**78.0**	**75.0**	**66.4**
		Not acceptable regardless	15.4	6.3	13.9	23.8	11.9	10.0	26.6
	*Acceptability of caning wrt **area of body**	*Acceptable if only limbs/buttocks affected*	**78.8**	**90.0**	**81.7**	**73.8**	**89.7**	**88.4**	**74.8**
		Acceptable regardless	1.6	2.5	5.4	1.3	0	1.4	2.0
		Not acceptable regardless	19.6	7.5	12.9	25.0	10.3	10.2	23.3
	*Acceptability of caning wrt **marks/injuries**	*Acceptable if child not permanently marked or injured*	**78.8**	**92.5**	**87.1**	**72.7**	**89.7**	**86.6**	**67.7**
		Acceptable regardless	2.6	0	0.5	1.8	0	2.1	1.8
		Not acceptable regardless	18.5	7.5	12.4	25.6	10.3	11.3	30.6
	*Acceptability of caning wrt **disobedience**	*Acceptable if child is disobedient*	**84.7**	**93.8**	**87.6**	**80.5**	**88.1**	**88.7**	**79.5**
		Acceptable regardless	2.6	0	0	1.0	1.7	2.5	1.8
		Not acceptable regardless	12.7	6.3	12.4	18.5	10.2	8.9	18.8
	*Acceptability of caning wrt **treatment compared to siblings**	*Acceptable if child is treated differently*	2.6	1.3	0.5	1.5	0	0.4	3.0
		Acceptable if child is treated the same	**61.4**	**76.3**	**79.0**	**56.3**	**84.2**	**79.5**	**45.7**
		Acceptable regardless	15.9	15.0	8.0	12.9	5.3	6.8	22.1
		Not acceptable regardless	20.1	7.5	12.5	29.2	10.5	13.3	29.1
	*Acceptability of caning wrt **physical or mental handicap of child**	*Acceptable if child handicapped*	2.6	0	1.0	1.2	3.4	0.4	1.3
		*Acceptable if child **not** handicapped*	**66.7**	**46.8**	**62.8**	**55.9**	**62.1**	**73.9**	**48.1**
		Acceptable regardless	10.1	42.9	22.1	11.7	24.1	11.0	14.9
		Not acceptable regardless	20.6	10.4	14.1	31.2	10.3	14.8	35.8
	*Acceptability of caning wrt **adult's intentions**	*Acceptable if have good intentions*	**87.8**	**91.3**	**89.1**	**78.6**	**89.7**	**89.8**	**79.2**
		Acceptable regardless	3.2	0	0.5	2.2	0	1.1	1.8
		Not acceptable regardless	9.0	8.8	10.4	19.2	10.3	9.1	19.0
	*Acceptability of caning wrt to **adult's stress level**	*Acceptable if adult is under stress*	2.1	1.3	1.5	2.5	0	2.1	7.8
		*Acceptable if adult is **not** under stress*	**52.9**	**70.9**	**67.2**	**47.9**	**70.7**	**72.8**	34.3
		Acceptable regardless	14.8	11.4	15.4	11.2	17.2	9.5	17.3
		Not acceptable regardless	30.2	16.5	15.9	38.4	12.1	15.5	**40.8**
	*Acceptability of caning wrt **family's financial status**	*Acceptable if family is poor*	1.1	0	0	0.3	0	0.7	1.3
		*Acceptable if family is **not** poor*	0.5	0	0.5	0	0	1.8	3.0
		Acceptable regardless	**71.0**	**80.8**	**81.8**	**63.8**	**89.7**	**80.5**	**53.8**
		Not acceptable regardless	27.4	19.2	17.7	36.0	10.3	17.0	42.0
	*Acceptability of caning wrt **parents' working schedule**	*Acceptable if parents are busy*	1.1	1.3	0	0.8	0	0	1.8
		*Acceptable if parents are **not** busy*	3.2	5.1	5.6	7.0	3.4	8.9	7.0
		Acceptable regardless	**67.4**	**73.1**	**77.8**	**53.1**	**84.5**	**73.7**	**46.8**
		Not acceptable regardless	28.3	20.5	16.7	39.1	12.1	17.4	44.0

P= Police, SW = Social Workers, D = Doctors, N = Nurses, L = Lawyers, ED = Educators, PUB = Public

Acceptability of caning a child with respect to whether child is disobedient or not

The majority (at least 79.5%) of each of the 7 groups chose 'Acceptable only if child is disobedient'. Significant differences were found among the respondents ($F_{6,1604} = 4.042$, $p=0.001$). However, post hoc test results showed no significant differences for the various groups.

Acceptability of caning a child with respect to treatment of child compared to siblings

The modal choice (at least 45.7%) for all 7 groups was 'Acceptable only if child is treated the same as brothers/sisters'. Significant differences were found among the respondents ($F_{6,1589} = 15.408$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: Nurses with Social Workers, Doctors, and Educators; and for the Public with Social Workers, Doctors, Lawyers and Educators.

Acceptability of caning a child with respect to whether the child is physically/mentally handicapped or not

The modal choice (at least 46.8%) for all 7 groups was 'Acceptable only if the child is not physically/ mentally handicapped'. Significant differences were found among the respondents ($F_{6,1597} = 11.207$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Educators, and for the Public with Police, Doctors and Educators.

Acceptability of caning a child with respect to adult's intentions

The majority (at least 78.6%) of each of the 7 groups chose 'Acceptable only if the adult has good intentions'. Significant differences were found among the respondents ($F_{6,1608} = 5.599$, $p<0.001$). However, post hoc test results showed no significant differences for the various groups.

Acceptability of caning a child with respect to adult's stress level

The modal choice (at least 47.9%) of all 6 groups of professionals was 'Acceptable only if adult is not under stress'. The modal choice of the Public (40.8%) was 'Not acceptable regardless of whether adult is under stress or not'. Significant differences were found among the respondents ($F_{6,1604} = 15.694$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Doctors and Educators; and for the Public with Social Workers, Doctors and Educators.

Acceptability of caning a child with respect to financial status of family

The majority (at least 53.8%) of each of the 7 groups chose 'Acceptable regardless of whether family is poor or not'. Significant differences were found among the respondents ($F_{6,1595} = 10.378$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Doctors and Educators; and for the Public with Doctors and Educators.

Acceptability of caning a child with respect to parents' working schedule

The modal choice (at least 46.8%) for all 7 groups was 'Acceptable regardless of parents' working schedule'. Significant differences were found among the respondents ($F_{6,1594} = 8.617$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Educators; and for the Public with Doctors and Educators.

Observations

From the above results for the present study, the following observations could be made:

- The behaviour of 'Caning a child' was generally acceptable among the various professions and the Public under particular circumstances. The majority of each of the 7 groups of respondents found the action acceptable provided it did not happen frequently; that only the limbs/buttocks were affected; if the child was not permanently marked/injured; if the child was disobedient; if the child was treated in the same manner as his/her siblings; if the child was not handicapped; and if the adult had good intentions. It is thus clear that overall most of the respondents viewed caning a child as acceptable when there were reasons to carry out the action and so long as the child was not physically harmed. This is probably reflective of the parental disciplinary practices in Singapore where caning is an acceptable form of disciplinary measure for children whether in schools or at home (see The Sunday Times, 1 1/4/99, and The Straits Times, 12/4/99, pp.32-33).

- Some circumstances however had little influence on the views of the respondents with regards to the acceptability of the behaviour. For instance, most respondents in all the different professional groups and the Public viewed the behaviour as acceptable regardless of the following conditions: sex of the child, family's financial status and parents' working schedule.

- However, there was a lack of general consensus on whether other circumstances affected the acceptability status of the behaviour 'Caning a child'. For example, many Police, Doctors, Nurses, Lawyers and the Public viewed caning as acceptable if the child is older, but many Social Workers and Education professionals considered it acceptable only if the child is younger. In addition, many from the 6 professions viewed caning as acceptable if the adult is not under stress, whilst many respondents from the public sample considered it as not acceptable regardless of the adult's stress level.

- From the post hoc test results, it was observed that Nurses and the Public were the two groups with which other groups tended to have significant differences with more frequently. However, this may be due to the fact that they are the two groups with the largest size samples, when compared to other respondent groups.

Ignoring Signs of Illness in a Child (E.g., High Fever)

Detailed results for the influence of mitigating circumstances on the acceptability of this behaviour are examined in the following. General responses of the respondents for this behaviour can be found in Table 3.6. The modal choice of each respondent group is highlighted in the table.

Acceptability of ignoring signs of illness in child with respect to frequency of incident

The majority (at least 90.2%) of each of the 7 groups chose 'Not acceptable regardless of frequency of incidents'. No significant differences were found among the respondents ($F_{6,1618} = 3.516$, $p>0.001$).

Acceptability of ignoring signs of illness in child with respect to age of child

The majority (at least 90.1 %) of each of the 7 groups chose 'Not acceptable regardless of age of child'. Significant differences were found among the respondents ($F_{6,1617} = 4.980$, $p<0.001$). However, post hoc test results showed the only significant difference found was that between the Doctors and Nurses.

Acceptability of ignoring signs of illness in child with respect to sex of child

The majority (at least 93.2%) of each of the 7 groups chose 'Not acceptable regardless of whether child is a boy or girl'. There were no significant differences among the respondents ($F_{6,1616} = 2.033$, $p>0.05$).

Acceptability of ignoring signs of illness in child with respect to treatment of child compared to siblings

The majority (at least 93.2%) of each of the 7 groups chose 'Not acceptable regardless of how child is treated'. No significant differences were found among the respondents ($F_{6,1619} = 2.357$, $p>0.01$).

Acceptability of ignoring signs of illness in child with respect to whether child is physically/ mentally handicapped or not

The majority (at least 93.2%) of each of the 7 groups chose 'Not acceptable regardless of whether child is physically/mentally handicapped or not. No significant differences were found among the respondents ($F_{6,1617} = 2.469$, $p>0.01$).

Acceptability of ignoring signs of illness in child with respect to adult's intentions

The majority (at least 89.8%) of each of the 7 groups chose 'Not acceptable regardless of adult's intentions'. Significant differences were found among the respondents ($F_{6,1614} = 3.638$, $p=0.001$). However, post hoc test results showed no significant differences between the various groups.

Acceptability of ignoring signs of illness in child with respect to adult's stress level

The majority (at least 91 .5%) of each of the 7 groups chose 'Not acceptable regardless of whether adult is under stress or not'. No significant differences were found among the respondents ($F_{6,1617} = 3.476$, $p>0.001$).

Acceptability of ignoring signs of illness in child with respect to financial status of family

The majority (at least 92.6%) of each of the 7 groups chose 'Not acceptable regardless of whether family is poor or not'. No significant differences were found among the respondents ($F_{6,1619} = 2.125$, $p>0.01$).

Acceptability of ignoring signs of illness in child with respect to parents' working schedule

The majority (at least 91.5%) of each of the 7 groups chose 'Not acceptable regardless of parents' working schedule'. No significant differences were found among the respondents ($F_{6,1618} = 2.141$, $p>0.01$).

Table 3.6
Influence of mitigating circumstances on acceptability of ignoring signs of illness in child (e.g., high fever).

CATEGORY AND BEHAVIOUR	MITIGATING CIRCUMSTANCE		P %	SW %	D %	N %	L %	ED %	PUB %
PHYSICAL NEGLECT	*Acceptability of ignoring illness with respect to (wrt) **frequency**	*Acceptable if once/twice*	2.1	8.5	7.4	2.5	5.0	2.5	3.5
		Acceptable regardless	1.1	1.2	2.0	0.2	0	0.7	0.3
		Not acceptable regardless	**96.8**	**90.2**	**90.6**	**97.3**	**95.0**	**96.8**	**96.3**
IGNORING SIGNS OF ILLNESS IN A CHILD (E.G., HIGH FEVER)	*Acceptability of ignoring illness wrt **age**	*Acceptable if child is younger*	0	0	0.5	0	0	0.4	0.5
		Acceptable if child is older	2.1	9.9	7.4	2.0	8.5	1.4	3.0
		Acceptable regardless	1.1	0	2.0	0.2	0	0.7	1.5
		Not acceptable regardless	**96.8**	**90.1**	**90.1**	**97.8**	**91.5**	**97.5**	**95.0**
	*Acceptability of ignoring illness wrt **sex**	*Acceptable if child is a boy*	0	0	0.5	0	0	0	0.3
		Acceptable if child is a girl	0.5	0	0	0	0	0	0
		Acceptable regardless	1.6	4.9	5.9	1.7	6.8	3.2	3.0
		Not acceptable regardless	**97.9**	**95.1**	**93.6**	**98.3**	**93.2**	**96.8**	**96.8**
	*Acceptability of ignoring illness wrt **treatment compared to siblings**	*Acceptable if child is treated differently*	0	0	0.5	0	0	0.4	0.5
		Acceptable if child is treated the same	1.6	3.7	2.9	1.0	6.8	1.1	1.3
		Acceptable regardless	1.1	2.4	2.9	0.7	0	0.7	2.3
		Not acceptable regardless	**97.4**	**93.9**	**93.6**	**98.3**	**93.2**	**97.9**	**96.0**
	*Acceptability of ignoring illness wrt **physical or mental handicap of child**	*Acceptable if child is handicapped*	0	0	0.5	0	0	0.4	0.5
		*Acceptable if child is **not** handicapped*	1.6	4.9	3.5	0.7	5.1	1.4	1.5
		Acceptable regardless	1.6	1.2	2.5	0.7	1.7	0.7	2.3
		Not acceptable regardless	**96.8**	**93.9**	**93.6**	**98.5**	**93.2**	**97.5**	**95.8**
	*Acceptability of ignoring illness wrt **adult's intentions**	*Acceptable if have good intentions*	1.6	7.5	5.4	1.5	10.2	1.8	4.3
		Acceptable regardless	2.1	0	1.0	0.7	0	0.4	0.3
		Not acceptable regardless	**96.3**	**92.5**	**93.6**	**97.8**	**89.8**	**97.9**	**95.5**
	*Acceptability of ignoring illness wrt **adult's stress levels**	*Acceptable if adult is under stress*	1.1	6.1	2.5	0.2	1.7	0.4	2.0
		*Acceptable if adult **not** under stress*	0	1.2	1.5	1.0	0	1.1	1.0
		Acceptable regardless	1.6	1.2	2.0	0.7	6.8	1.1	1.8
		Not acceptable regardless	**97.4**	**91.5**	**94.1**	**98.0**	**91.5**	**97.5**	**95.3**
	*Acceptability of ignoring illness wrt **family's financial status**	*Acceptable if family is poor*	2.6	3.7	3.4	0.5	0	1.4	2.8
		*Acceptable if family is **not** poor*	0	0	0	0	0	0	0.3
		Acceptable regardless	1.6	2.4	3.9	1.5	6.8	2.1	2.0
		Not acceptable regardless	**95.8**	**93.9**	**92.6**	**98.0**	**93.2**	**96.5**	**95.0**
	*Acceptability of ignoring illness wrt **parents' working schedule**	*Acceptable if parents are busy*	2.1	4.9	4.4	1.2	3.4	1.1	3.0
		*Acceptable if parents are **not** busy*	0	0	0.5	0	0	0.4	0.3
		Acceptable regardless	0.5	0	2.0	1.0	5.1	1.4	1.3
		Not acceptable regardless	**97.4**	**95.1**	**93.1**	**97.8**	**91.5**	**97.2**	**95.5**

P = Police, SW = Social Workers, D = Doctors, N = Nurses, L = Lawyers, ED = Educators, PUB = Public

Observations

From the above results for the present study, the following observations could be made:

- The majority of each of the professions and the Public, at least 89.8%, viewed the action as unacceptable regardless of all the 9 mitigating circumstances given. Among the four actions (i.e., 'Slapping child on the face', 'Caning a child', 'Ignoring signs of illness in a child' and 'Leaving child alone in the house') examined for the influence of mitigating circumstances on their acceptability status, this action is the only one where there is strong consensus found among all the professions and also among the various professions with the Public.

- Generally, few significant differences were found for ANOVA and the post hoc test among the respondents. There was also no obvious trend in the significant differences obtained. This was because the results were all heavily biased as 'Not acceptable' regardless of the mitigating circumstances.

- The above results were similar to that obtained for Elliott *et al*'s (2000) study, where a high proportion of both the professionals and the public sample were found to regard the action as unacceptable regardless of all the circumstances given. As noted, this may be due to great importance being attached to the health of children in Singapore.

- In addition, the results obtained for this section are in line with the earlier observation that respondents tended to be more disapproving of actions that may result in serious physical harm to the child.

Leaving Child Alone in the House

Detailed results for the influence of mitigating circumstances on the acceptability of the behaviour of 'Leaving child alone in the house' are examined as follows. General responses of the respondents for this behaviour can be found in Table 3.7. The modal choice of each respondent group is highlighted in the table.

Acceptability of leaving child alone in the house with respect to frequency of incident

The modal choice (at least 48.3%) of Police, Social Workers, Doctors, Lawyers and Educators was 'Acceptable if it only happens once or twice'. The majority of Nurses (59.3%) chose 'Not acceptable regardless of frequency of incidents' and the modal choice of the Public (47%) was the same. Significant differences were found among the respondents ($F_{6,1606} = 6.995$, $p<0.001$). Post hoc test results showed that significant differences were found for Nurses with Social Workers and Doctors.

Acceptability of leaving child alone in the house with respect to age of child

The majority (at least 55%) of each of the 7 groups chose 'Acceptable only if child is older'. Significant differences were found among the respondents ($F_{6,1614} = 8.635$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Social Workers and Doctors; and between the Educators and Social Workers.

Acceptability of leaving child alone in the house with respect to sex of child

The modal choice (at least 48.7%) of Police, Social Workers, Doctors and Lawyers was 'Acceptable regardless of whether child is a boy or girl'. For Educators, 47.1% chose 'Acceptable regardless of whether child is a boy or girl' and 47.1% chose 'Not acceptable regardless of whether child is a boy or girl'. The majority of Nurses (61.7%) chose 'Not acceptable regardless of whether child is a boy or girl' and the modal choice for the Public (46.5%) was the same. Significant differences were found among the respondents ($F_{6,1603} = 7.526$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Police, Doctors and the Public.

Acceptability of leaving child alone in the house with respect to whether child is disobedient or not

The modal choice for Lawyers (40.7%) was 'Acceptable regardless of whether child is disobedient or not'. The modal choice for (at least 39%) the Police, Social Workers, Doctors, Nurses, Educators and the Public was 'Not acceptable regardless of whether child is disobedient or not'. Significant differences were found among the respondents ($F_{6,1600} = 4.714$, $p<0.001$). Post hoc test results showed that the only significant difference found was that between Nurses and Doctors.

Acceptability of leaving child alone in the house with respect to treatment of child compared to siblings

The modal choice of Social Workers (39.2%), Doctors (41.8%) and Lawyers (40.4%) was 'Acceptable only if child is treated the same as brothers/sisters'. The modal choice (at least 47.7%) of Police, Nurses, Educators and the Public was 'Not acceptable regardless of how child is treated'. Significant differences were found among the respondents ($F_{6,1599} = 11.317$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Social Workers, Doctors, Lawyers and Educators; and for the Public with Doctors.

Acceptability of leaving child alone in the house with respect to whether child is physically/ mentally handicapped

The modal choice (at least 48.9%) of Police, Social Workers, Doctors, Lawyers and Educators was 'Acceptable only if child is not physically/mentally handicapped'. The majority of Nurses (64.6%) and the Public (54.6%) chose 'Not acceptable regardless of whether child is physically/mentally handicapped or not'. Significant differences were found among the respondents ($F_{6,1602} = 10.919$, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Police, Social Workers, Doctors, Lawyers and Educators; and for the Public with Doctors.

Acceptability of leaving child alone in the house with respect to adult's intentions

The modal choice (at least 48.9%) of Police, Social Workers, Doctors and Lawyers was 'Acceptable only if the adult has good intentions'. The majority of Nurses (62.8%) chose 'Not acceptable regardless of adult's intentions', and the modal choice of Educators (48.4%) and the Public (46.8%) was the same. Significant differences were found among the respondents ($F_{6,1596} = 9.897$, $p<0.001$). Post hoc test results showed that significant differences were found for Nurses with Police, Doctors and Lawyers.

Table 3.7
Influence of mitigating circumstances on acceptability of leaving child along in the house

CATEGORY AND BEHAVIOUR	MITIGATING CIRCUMSTANCE		P %	SW %	D %	N %	L %	ED %	PUB %
PHYSICAL NEGLECT	*Acceptability of	*Acceptable if once/twice*	**50.0**	**59.5**	**55.5**	37.3	**48.3**	**48.6**	41.8
	leaving child alone with	*Acceptable regardless*	8.0	11.4	7.5	3.4	20.7	5.0	11.3
	respect to (wrt) **frequency**	*Not acceptable regardless*	42.0	29.1	37.0	**59.3**	31.0	46.4	**47.0**
LEAVING CHILD ALONE IN THE HOUSE	*Acceptability of	*Acceptable if child is younger*	0	0	2.0	0.2	0	0	1.0
	leaving child alone	*Acceptable if child is older*	**64.0**	**87.8**	**72.9**	**55.0**	**75.9**	**62.4**	**65.3**
	wrt **age**	*Acceptable regardless*	3.7	0	1.0	1.2	1.7	1.8	3.3
		Not acceptable regardless	32.3	12.2	24.1	43.5	22.4	35.8	30.5
	*Acceptability of	*Acceptable if child is a boy*	6.3	0	4.0	2.0	1.8	5.4	8.8
	leaving child alone	*Acceptable if child is a girl*	1.1	0	0	0	0	0.4	1.0
	wrt **sex**	*Acceptable regardless*	**48.7**	**67.5**	**59.1**	36.4	**67.9**	**47.1**	43.8
		Not acceptable regardless	43.9	32.5	36.9	**61.7**	30.4	**47.1**	**46.5**
	*Acceptability of	*Acceptable if child is disobedient*	5.9	0	2.0	1.0	1.9	2.9	5.0
	leaving child alone wrt	*Acceptable if child is obedient*	23.4	34.2	30.5	24.9	24.1	28.9	16.0
	disobedience	*Acceptable regardless*	22.3	26.6	28.5	10.1	**40.7**	19.6	26.3
		Not acceptable regardless	**48.4**	**39.2**	**39.0**	**64.0**	33.3	**48.6**	**52.8**
	*Acceptability of	*Acceptable if child is treated differently*	0	1.3	0.5	0.2	0	0.7	0.5
	leaving child alone wrt	*Acceptable if child is treated the same*	31.4	**39.2**	**41.8**	22.8	**40.4**	40.4	22.3
	treatment compared to	*Acceptable regardless*	20.7	22.8	20.9	11.9	28.1	11.2	24.5
	siblings	*Not acceptable regardless*	**47.9**	36.7	36.8	**65.1**	31.6	**47.7**	**52.8**
	*Acceptability of	*Acceptable if child is handicapped*	0.5	1.3	1.0	0.7	0	0.7	1.0
	leaving child alone wrt	*Acceptable if child is **not** handicapped*	**48.9**	**54.4**	**57.5**	33.2	**64.9**	**49.5**	38.3
	physical or mental	*Acceptable regardless*	5.9	7.6	4.5	1.5	5.3	2.2	6.0
	handicap of child	*Not acceptable regardless*	44.7	36.7	37.0	**64.6**	29.8	47.7	**54.6**
	*Acceptability of	*Acceptable if well intended*	**48.9**	**52.6**	**58.7**	33.9	**62.5**	45.9	44.8
	leaving child alone wrt	*Acceptable regardless*	8.0	10.3	5.5	3.2	12.5	5.7	8.5
	adult's intentions	*Not acceptable regardless*	43.1	37.2	35.8	**62.8**	25.0	**48.4**	**46.8**
	*Acceptability of	*Acceptable if adult is under stress*	0	2.6	3.0	1.5	0	2.9	2.3
	leaving child alone wrt	*Acceptable if adult **not** under stress*	26.6	23.4	31.0	19.7	24.1	29.6	17.5
	adult's stress level	*Acceptable regardless*	23.4	33.8	25.5	12.1	**40.7**	17.1	22.3
		Not acceptable regardless	**50.0**	**40.3**	**40.5**	**66.7**	35.2	**50.4**	**58.0**
	*Acceptability of leaving	*Acceptable if family is poor*	0.5	6.5	2.5	0.5	1.8	1.4	2.8
	child alone wrt	*Acceptable if family is **not** poor*	1.6	0	0.5	1.0	0	1.8	1.5
	family's financial status	*Acceptable regardless*	48.1	**54.5**	**56.0**	31.3	**65.5**	47.5	39.5
		Not acceptable regardless49.7	**49.7**	39.0	41.0	**67.2**	32.7	**49.3**	**56.3**
	*Acceptability of	*Acceptable if parents are busy*	11.7	23.7	17.5	9.9	14.3	17.9	11.8
	leaving child alone wrt	*Acceptable if parents are **not** busy*	5.9	5.3	5.0	4.4	1.8	5.4	4.0
	parents' working	*Acceptable regardless*	33.0	31.6	**39.0**	19.2	**51.8**	27.9	29.3
	schedule	*Not acceptable regardless*	**49.5**	**39.5**	38.5	**66.5**	32.1	**48.9**	**55.0**

P = Police, SW = Social Workers, D = Doctors, N = Nurses, L = Lawyers, ED = Educators, PUB = Public

Acceptability of leaving child alone in the house with respect to adult's stress level

The modal choice of Lawyers (40.7%) was 'Acceptable regardless of whether adult is under stress or not'. The modal choice (at least 40.3%) of Police, Social Workers, Doctors, Nurses, Educators and the Public was 'Not acceptable regardless whether adult is under stress or not'. Significant differences were found among the respondents ($F_{6,1598}$ = 7.333, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Doctors and Educators; and for the Public with Doctors.

Acceptability of leaving child alone in the house with respect to financial status of family

The majority of Social Workers (54.5%), Doctors (56%) and Lawyers (65.5%) chose 'Acceptable regardless of whether family is poor or not'. The modal choice (at least 49.3%) of Police, Nurses, Educators and the Public was 'Not acceptable regardless of whether family is poor or not'. Significant differences were found among the respondents ($F_{6,1598}$ = 9.564, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Social Workers, Doctors, Lawyers and Educators.

Acceptability of leaving child alone in the house with respect to parents' working schedule

The majority of Lawyers (51.8%) chose 'Acceptable regardless of parents' working schedule', and the modal choice of Doctors (39%) was the same. The modal choice (at least 39.5%) of Police, Social Workers, Nurses, Educators and the Public was 'Not acceptable regardless of parents' working schedule'. Significant differences were found among the respondents ($F_{6,1599}$ = 7.286, $p<0.001$). Post hoc test results showed that significant differences were found for the following groups: for Nurses with Social Workers, Doctors and Educators.

Observations

From the above results for the present study, the following observations could be made:

- The majority of each of the professions and the Public viewed this action to be acceptable provided that the child was older. This is the only condition under which the majority of each of the 7 respondent groups held the same view.

- Many respondents from the public and the various professional groups, except for Lawyers, found the action unacceptable regardless of whether the child was disobedient or not and the adult's stress level. Many Lawyers viewed the action as acceptable regardless of these two circumstances.

- Many respondents from the different professional groups and the public sample held varied opinions on whether the following circumstances had any influence on the acceptability of the behaviour of leaving a child alone in the house: frequency of the incident, sex of the child, treatment of the child compared to siblings, whether the child was physically/mentally handicapped, adult's intentions, family's financial status and parents' working schedule. For the condition of the sex of child, 47.1% of the Education professionals regarded the action as acceptable regardless, whilst another 47.1 % regarded it as unacceptable regardless. This shows a lack of consensus within the group with regards to the opinion on the acceptability of the action.

- Nurses appeared to have significant differences with other groups of respondents most frequently. This may again be because of the Nurses sample being the largest sample group.

- Differences between professions belonging to similar fields of work have also been observed. For instance, many Police respondents differed from the Lawyers with regards to the influence of the following conditions on the acceptability of leaving a child alone in the house: whether the child was disobedient, treatment of the child compared to siblings, adult's stress level, family's financial status and parents' working schedule. However, no significant differences were found between these two groups. Many of the Police respondents appeared to be more disapproving than the Lawyers as they viewed the behaviour to be unacceptable regardless of those conditions just listed, as opposed to the Lawyers who viewed the action to be acceptable with particular conditions or regardless of the conditions.

- Another instance whereby differences could be found among professions within a similar field is that found between the Doctors and Nurses. They differed in their opinions on the acceptability of the action under the following circumstances: frequency of the incident, sex of the child, treatment of child compared to siblings, whether child is physically/mentally handicapped, adult's intentions, family's financial status and parents' working schedule. In this case, many respondents from the Nurses sample appeared to be more disapproving of the action than those of the Doctors sample.

- It appeared that there is even weaker consensus among the various professions and between certain professions and the Public for the action 'Leaving child alone in the house' than for the other two actions (i.e., 'Caning a child' and 'Slapping a child on the face') examined in the above sections.

CHAPTER 4: DISCUSSION AND CONCLUSION

4.1 Discussion of findings and implications

4.1.1 Acceptability and abuse status of actions

The majority of the professional and public respondents only considered those actions that appear to lead to obvious and severe physical harm as 'Never acceptable'. Specifically, the four actions were: 'Burning child with cigarettes, hot water, or other hot things', 'Tying child up', 'Shaking child hard' and 'Ignoring signs of illness in child (e.g., high fever)'. On the other hand, for those actions that did not appear to lead to obvious injury to the physical well being of the child, many from the various professions and the public sample viewed them as 'Sometimes acceptable'. Such a response was obtained for the following actions: 'Caning child' and 'Leaving child alone in the house'.

However, the acceptability of an action and its abuse status are different things. For every item of behaviour, there was a greater tendency to regard it as sometimes or never acceptable than to regard it as being, or possibly being, abuse. It appears that the respondents were generally more reluctant to regard actions suggesting physical child abuse and neglect as 'abuse'. This was also found by Tong *et al.* (1996) and Elliott *et al.* (2000).

In addition, although certain actions may belong to the same category of child abuse and neglect, their acceptability status may differ. This is not surprising as a general finding, because actions in any given category selected for inclusion in the study were not equated for severity, and there was no reason to assume they would all be equally acceptable. Interest lies rather in the extent to which acceptability varied within and between professions, and between professions and the Public.

For instance, there was some lack of consensus among the professions and between certain professions and the Public with regards to the acceptability of 'Slapping a child on the face' compared to 'Caning a child'. The latter is a generally acceptable form of punishment for a child, albeit with qualifications, but the former is not. To understand this finding, it is necessary to have an understanding of the forms of punishment that are acceptable in the local culture for disciplining children. The studies that have so far investigated disciplinary preferences in Singapore report a high use of beating and scolding (e.g., Kong, Kok, Tsoi, Wong, Tay & Yeoh, 1986), but the fact that beating is often acceptable should not imply that slapping on the face is included as appropriate discipline. In addition, Singapore families appear to attach great importance on the physical health of the child, judged by the strong consensus amongst both professional and the public respondents with regard to the unacceptability of ignoring signs of illness in the child. A slap in the face is probably more likely to be seen as a dangerous assault than as an acceptable rebuke.

In addition, Wu (1981) and Tang (1998) argued that the emphasis on the Chinese moral code of filial piety lays the ground for physical child abuse to take place. Following this argument, in so far

as Chinese parents are concerned, in those cases where excessive caning amounting to physical abuse occur, these cases may be grounded in, or at the very least rationalised as reflective of, the local cultural tradition where corporal punishment is an approved means of child discipline. However, most local research has focused on Chinese children (e.g., Kong, Wong, Goh, Lam, Chua & Kok, 1988) and it is unclear to what extent there might be ethnic differences in actual parenting practices or beliefs, or to what extent different religious beliefs might moderate practice, if at all.

These considerations do not imply that corporal punishment is necessarily harmful for the child, nor, as a cultural tradition, that it is necessarily good either. As mentioned in Chapter 2 (Section 2.2.4), corporal punishment remains a debated issue and there are arguments for and against it in moderation. Parents and caregivers need to be educated on how to control the way in which they administer corporal punishment, and on its potential ill effects. It would be beneficial to have systematic local research into the use of and consequences of this and other disciplinary actions.

4.1.2 Influence of mitigating circumstances

The general finding, that opinions varied, was found also when mitigating circumstances were examined. That is, defining a scenario did not result in a more uniform response from respondents. It seems that in general, variation of opinion was not simply a result of respondents imagining varied scenarios when envisaging the action under consideration. A more varied range of opinions among the various respondent groups were found for the actions 'Slapping a child on the face' and 'Leaving a child alone in the house', compared to 'Caning a child' and 'Ignoring signs of illness in a child', when the influence of mitigating circumstances was examined. As such, it is clear that different actions suggesting physical child abuse and neglect, except for those that appear to obviously lead to serious physical harm for the child, are to some extent acceptable to different professions and the public sample under different conditions. Highly unacceptable actions are always unacceptable, which is to be expected, but moderately unacceptable ones have qualified acceptance, to some respondents, under some scenarios. This lowered consensus for less extreme actions is a cause for concern.

4.1.3 Differences in opinions among professionals and implications

Different professions do not always see eye to eye even in a similar field of work. For instance, the results showed that differences in opinions on different actions suggesting physical child abuse and neglect existed between the Nurses and Doctors and also between the Police and Lawyers, although each pair belong to similar and complementary occupations. It is also notable that Nurses generally appeared to be less tolerant of the actions in which their opinions differed from the Doctors. Similarly, the Police appeared to be less tolerant of those actions where their opinions varied from the Lawyers. Such findings are interesting as common aspects were expected to guide the practice of professionals from similar disciplines (Giardino *et al.,* 1997). However, the findings here seemed to suggest otherwise.

It is also apparent that some professions can share similar views with the public sample whilst

other professions held other opinions, on the same action. As such, the findings are similar to the results of local studies by Fung and Chow (1998), Elliott *et al.* (1997) and Elliott *et al.* (2000), where professionals were found to hold different perceptions towards child abuse and neglect, even though they may all be working in positions that allow them to come into contact with child abuse and neglect cases. Such differences in opinions are likely to have a direct effect on the reporting rates of child abuse and neglect and how such cases are dealt with. A lack of strong consensus among the professions regarding the acceptability of actions may pose a problem for more effective efforts to combat physical child abuse and neglect in Singapore.

Findings from this study thus suggest the need to build greater consensus in opinions across different professions so as to facilitate more effective intervention efforts and preventive measures against physical child abuse and neglect. Given the serious and harmful consequences of physical child abuse and neglect, it is important that steps are taken to ensure that the various professions that come into contact with physical child abuse and neglect cases achieve greater consensus on these issues. This is especially crucial given the fact that physical abuse is a major form of child abuse and neglect in Singapore (Tong *et al.*, 1996). Moreover, physical neglect may also be under-reported in Singapore, if research findings elsewhere are any indication.

4.2 Conclusion

On a more general level, this study shows clearly that whether an action is regarded as physical abuse or neglect depends in some measure on the circumstances of the case. It is then important to know which mitigating circumstances affect people's perceptions of physical child abuse and neglect so that public education efforts for physical child abuse and neglect issues could be attuned to the needs of the public and professionals. However, whether an action should or should not be regarded as a case of physical child abuse and/or neglect is another matter. The criterion of abuse or neglect, we maintain, should reside in the consequences of the action for the child. This approach reflects the apparent intention of the law as expressed in the Children and Young Persons Act, where the intention and consequences of the action are both considered. However, what this study reveals is that in the general substance of their reaction to the actions and scenarios examined, the professionals are on the whole not much different from the public. There is little support in this study for the idea that the professions adopt any very different criteria from the public for recognising physical abuse or neglect, a result that we find worrying.

The differences among the professions themselves are not great compared to their similarities. However, it is clear that within any given profession, there is often a considerable range of opinion. There is often substantially less than unanimity in the choice of response by the members of any given profession. Agreement is greater with more severe and damaging actions such as burning or neglecting to take action in the face of signs of illness. However, because extreme, these actions are less controversial and attract consensus among the public too. When less obviously harmful actions are considered, consensus is reduced.

It is possible that some measure of disagreement among the professions may reflect different

degrees of experience. One cannot assume that all respondents have actually had experience of physical child abuse and neglect cases, and those who have, or whose experiences were of more serious cases, might well have a more professionally and personally informed view. Nonetheless, even with this allowance, there would seem to be a clear need for greater education of professionals on agreed criteria by which physical child abuse and neglect may be recognised, reported, and remedied. In addition, preventive measures would similarly require professional agreement.

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APPENDIX

Appendix A: Questions pertaining to physical child abuse and neglect from Section A, Part 2 of the questionnaires given to the professional respondents (from Elliott *et al.*, 2000).

Questions:
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.
• 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 child is physically/mentally handicapped. B. Acceptable only if 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.

Questions:

Caning a child 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 of 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 is injured or not.
  C. Not acceptable regardless of whether child is 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 child is physically/mentally handicapped.
  B. Acceptable only if 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 of 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 of whether family is poor or not.

Questions:

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

Questions:

Leaving a child alone in the house 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 of 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 child is physically/mentally handicapped.
  B. Acceptable only if child is NOT physically/mentally handicapped.
  C. Acceptable regardless of whether child is physically/mentally handicapped or not.
  D. Not acceptable regardless of 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 of 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 of 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 of parents' working schedule.