

# Child Maltreatment

<http://cmx.sagepub.com/>

---

## A Reporting and Response Model for Culture and Child Maltreatment

Sherri Y. Terao, Joaquin Borrego, Jr. and Anthony J. Urquiza

*Child Maltreat* 2001 6: 158

DOI: 10.1177/1077559501006002008

The online version of this article can be found at:

<http://cmx.sagepub.com/content/6/2/158>

---

Published by:



<http://www.sagepublications.com>

On behalf of:



American Professional Society on the Abuse of Children

Additional services and information for *Child Maltreatment* can be found at:

**Email Alerts:** <http://cmx.sagepub.com/cgi/alerts>

**Subscriptions:** <http://cmx.sagepub.com/subscriptions>

**Reprints:** <http://www.sagepub.com/journalsReprints.nav>

**Permissions:** <http://www.sagepub.com/journalsPermissions.nav>

**Citations:** <http://cmx.sagepub.com/content/6/2/158.refs.html>

>> [Version of Record](#) - May 1, 2001

[What is This?](#)

---

# A Reporting and Response Model for Culture and Child Maltreatment

Sherri Y. Terao  
Joaquin Borrego, Jr.  
Anthony J. Urquiza  
University of California, Davis Medical Center

---

*As our society becomes increasingly culturally diverse, there is a growing concern in the mental health field as to whether clinicians are able to accurately distinguish different cultural parenting discipline practices from child maltreatment. Clinicians in various fields continue to differ on what is reportable. Although there is literature describing characteristics of various ethnic minority groups, there are limited data to support why clinicians do what they do and no decision-making model to guide a clinician's reporting behavior when working with clients from different cultures. This article focuses on cultural discipline practices rather than healing practices (e.g., coining) that may be challenging to assess. The authors propose a model to guide clinicians through the decision-making process and discuss interventions and clinical responses that may be most appropriate when presented with different scenarios involving cultural parenting discipline practices and child maltreatment. Finally, limitations of the presented model along with future clinical and research directions are discussed.*

---

**R**egardless of our field of study, the issue of cultural sensitivity and cultural competence has emerged in recent years (Abney, 1996; American Psychological Association, 1993; Betancourt & Lopez, 1993; Fontes, 1995, 1998). Due to this movement, conferences and courses have been designed to address this issue, with therapists, physicians, social workers, and law enforcement workers alike encouraged, or at times required, to participate in these activities. The themes of most conferences emphasize that professionals should be culturally sensitive, culturally competent, and gain

some knowledge and understanding of how to better serve ethnically diverse clients. Clinically, mental health professionals are asked to be empathetic, develop rapport, and demonstrate sensitivity to those issues that may be culture related (Fontes, 1995).

Writings pertaining to cultural sensitivity and cultural competence have proliferated over the past 20 years. A number of models and suggestions have been proposed to address the issues of sensitivity and competence among mental health professionals (Abney, 1996; Ben-David, 1996; Derezotes & Snowden, 1990; Dubanoski, 1981; Fontes, 1995; Leung, Cheung, & Stevenson, 1994; McPhatter, 1997; Montalvo, Lasater, & Valdez, 1982; Pedersen, 1990, 1997; Pedersen, Draguns, Lonner, & Trimble, 1996; Pedersen & Hernandez, 1993; Pedersen & Ivey, 1993; Sue, Ivey, & Pedersen, 1996; Sue & Sue, 1999). In evaluating these models, there are a number of steps one can take to become culturally competent. It is recommended that mental health professionals should be aware of their own cultural values and biases, have an awareness of their clients' worldviews, and use culturally responsive intervention strategies when working with ethnically diverse clients (Sue & Sue, 1999).

Although the concept of a model for multicultural competence is interesting, it is also problematic because though these models offer steps a clinician can take to become more sensitive to a particular cultural group, they do not address *how* this is accom-

---

Authors' Note: The authors wish to thank Eric C. Vargas for his assistance with this article. Correspondence regarding this article should be addressed to Sherri Y. Terao, Ed.D., CAARE Center, Department of Pediatrics, University of California, Davis Medical Center, 3300 Stockton Blvd., Sacramento, CA 95820; e-mail: sherri.terao@ucdmc.ucdavis.edu.

CHILD MALTREATMENT, Vol. 6, No. 2, May 2001 158-168  
© 2001 Sage Publications, Inc.

plished. How does a clinician know that he or she is culturally competent or that the issue they are addressing in therapy is related to culture? If the issue is related to culture, how does one proceed in therapy to address the issue? Furthermore, are cultural competence models unique to culture, or can they be models for clinical competence in general? At times, it seems our focus lies solely on achieving cultural competence in lieu of other important clinical issues such as accurate assessments, using validated instruments with specific populations, and utilizing effective treatment modalities.

In the field of child maltreatment, the issue of cultural competence becomes even more complicated by the legal statutes involved in reporting and responding to child abuse. Professionals working in the child maltreatment field are often faced with ethical issues when working with different child care and cultural parenting practices that might be mistaken for abuse or neglect (Dubowitz, 1997). It is often challenging to accurately assess and determine the appropriate course of treatment when a client has committed what one may consider a crime in the United States (e.g., child physical abuse) and an acceptable parenting practice in another country (e.g., striking a child on the back with a bamboo stick for bad behavior among Vietnamese families and leaving physical marks). Within the legal system, controversy still remains as to how cultural evidence enters into child welfare cases. According to Levesque (2000),

A close look at child welfare law does reveal, however, that the system allows for the use of cultural evidence. Yet it actually remains unknown how those who implement laws respect cultural differences. Likewise considerable evidence suggests a failure to recognize and consider cultural evidence in a formal and systematic fashion. (p. 154)

Not only are professionals challenged with differentiating cultural parenting practices from child maltreatment, they are also confronted with definitions of child abuse that vary from state to state. Though federal legislation has identified a minimum set of behaviors that might be characteristic of child physical abuse, each state is left to define what constitutes abuse (National Clearinghouse on Child Abuse and Neglect Information [NCCAN], 1999). Most states have identified exceptions for practices that exempt them from being defined as child maltreatment, with religious beliefs in the context of seeking medical help, cultural practices, corporal punishment, and poverty being the most popular cited (NCCAN, 1999). For purposes of this article, we are only interested in cultural parenting discipline practices and

thus will not be addressing healing practices (e.g., coining).

We speculate that for the most part, clinicians do not know what it means to be culturally competent or how to take culture into account with regard to child maltreatment. Given this difficulty, it can be assumed that there is great variability in what clinicians do and do not report in regard to cases of child maltreatment involving cultural issues. In an effort to address this problematic area, a decision-making model was developed to help guide a clinician's behavior when confronted with the challenging issue of reporting and responding to child abuse cases involving different cultural groups. This article is meant to serve as a starting point from which to develop a heuristic model for the consideration of culture in the context of child physical abuse reporting and appropriate clinical response. Before examining the proposed model, definitional issues will be presented to assist the reader with understanding how culture and child abuse intersect.

#### CHILD MALTREATMENT: PROBLEMS WITH DEFINITIONS

A number of articles have discussed the problem of defining child maltreatment (e.g., Glachan, 1991; Kolko, 1996; Korbin, 1991, 1994; Maitra, 1996; Portwood, 1999; Rubin, 1992). Problems with definitions of child abuse affect many areas of the field such as determining whether an incident falls within the realm of the definition of child abuse and the decision to report an incident (Garbarino & Ebata, 1983; Van Voorhis & Gilbert, 1998). Other issues that may arise include the rights of the child, rights and autonomy of the parent, and the right of authorities to intervene into the private lives of citizens. This problem is further complicated when the issue of culture is introduced. According to Korbin (1994), "Definitional ambiguity is a major impediment to multicultural work in child maltreatment. Imprecision and variability in definitions have hampered research and precluded valid and reliable comparisons" (p. 183). Korbin (1994) also mentions that cultural conflict in defining child maltreatment occurs when there is a greater divergence in child care practices and beliefs.

Korbin (1991) suggests consideration of three levels when developing culturally appropriate definitions of child maltreatment. First, one must consider specific parenting practices that may be acceptable in one culture but may not be acceptable in another. This should not be surprising given the fact that there are inconsistencies as to what may be deemed an "acceptable" parenting practice in the United States.

For example, there is widespread disagreement among professionals as well as the general population on whether practices such as spanking, using a belt, and making a child stand in the corner for an hour are considered to be abusive. Second, within each culture there is a limit suggesting that the practice has exceeded acceptable limits and may constitute abuse. This is what Korbin terms *idiosyncratic* abuse, suggesting that a practice falls out of the range of acceptability and may be considered abuse (e.g., disciplining a child with a switch and leaving physical marks). At the third level, Korbin suggests that societal harm to the child be considered. These are factors such as poverty, poor health care, and lack of proper housing. At this level, Korbin explains that the entire family is subjected to these conditions, and the circumstances are beyond the family's control.

Although there are clear instances of child maltreatment that are reportable (e.g., a child is physically beaten for bringing home bad grades and is left with bruises), many cases fall in those gray areas with questionable parenting practices, which leave no physical evidence of harm to the child. Rubin (1992) states a number of factors that might affect one's decision to report an incident that falls in those gray areas: societal standards of acceptable child-rearing practices, legal definitions of abuse and neglect, and an individual's own value system. Given these factors, it is understandable that clinicians would be challenged when deciding whether to report an instance of suspected child maltreatment.

#### RESEARCH ON REPORTING OF SUSPECTED CHILD MALTREATMENT

Though many professionals are identified as "mandated" reporters (e.g., medical doctors, teachers, psychologists, social workers, law enforcement), there appears to be great variability among professionals on what may or may not be reportable. What may be serious enough for one professional to report might not be serious enough for another professional (Fox & Dingwall, 1985). Besides legal statutes that vary from state to state, an important issue to address is what steps a clinician takes when making the decision of whether to report a specific incident. There are many variables that may affect a professional's decision-making process.

##### *Professionals' Variables Influencing Reporting Practices*

A number of studies have examined professionals' characteristics that may influence reporting behavior. Variables such as the reporter's professional back-

ground (Zellman, 1990b), attitudes toward the case (King, Reece, Bendel, & Patel, 1998), amount of training (King et al., 1998), knowledge of child abuse (Tilden et al., 1994), and institutional setting in which the case is seen (Gardner, Schadler, & Kemper, 1984; King et al., 1998) have been identified as strong predictors of reporting behavior. Another interesting finding is the fact that reporting behavior seems to be influenced more by discipline background than actual knowledge about child physical abuse (Tilden et al., 1994). More specifically, a professionals' training background (e.g., social work vs. medicine) was found to be more influential on reporting behavior than actual knowledge of child abuse. When examining professionals' demographic variables (e.g., age, gender, marital status, and parenthood), data have not supported the hypothesis that these variables influenced whether a report was made to Child Protective Services (CPS) (Ashton, 1999). Reporter behavior is also affected by the degree of certainty in reporting a case (Escobar, 1995; Tilden et al., 1994), a belief that some positive effect would come of reporting a case to CPS (Escobar, 1995), and the belief that reporting may negatively affect therapy (Rubin, 1992; Tilden et al., 1994).

##### *Perpetrator Characteristics Affecting Reports of Child Abuse*

Some studies have focused on perpetrator characteristics and their influence on professionals' reporting behaviors. According to Zellman (1992), perpetrator socioeconomic status seemed to influence a professional's decision to report an incident to CPS with perpetrators of low socioeconomic backgrounds more likely to be reported. Other strong predictors of making a report to CPS included the reporter's perception of the perpetrator as being lazy and angry, or a previous report of abuse (Zellman, 1992). Results also suggest that there is a relationship between attractiveness of the parent and subsequent reporting. In a study by Osborne, Hinz, Rappaport, Williams, and Tuma (1988), cases were more likely to be reported to CPS when the reporter found the parent socially unattractive (e.g., physical characteristics, hygiene). Caution should be raised in interpreting Osborne et al.'s results due to the fact that the participants in the study were undergraduate college students. It is not known whether undergraduate students respond differently than trained professionals when making decisions.

##### *Case Characteristics Influencing Reporting Behavior*

Studies have also examined specific case characteristics that might influence a professional's judgment



on whether to report. Case variables that might influence judgment include the perceived seriousness of the incident (Ashton, 1999; Zellman, 1990c, 1992) as well as whether sufficient evidence was available when making the decision to report (Zellman, 1990a). More specifically, studies have found that the seriousness of the incident and whether sufficient evidence was available were identified as the two factors likely to be of significant influence on the decision to report (Ashton, 1999; Escobar, 1995; Gardner et al., 1984; Saulsbury & Campbell, 1985; Zellman, 1990c, 1990c).

Other studies have looked at case characteristics such as history of previous abuse, severity of the abuse, and recantation (Zellman, 1992; Zellman & Faller, 1999) and found these to be strong predictors of reporting behavior. Studies have also consistently found that professionals are more likely to report cases involving younger children (Ards & Harrell, 1993; Hegar, Zuravin, & Orme, 1994; Tang, 1998). In a study by Ashton (1999), cases that involved some form of physical violence, imminent harm, or young children were more likely to be reported.

In considering the factors that affect one's decision to report an incident of suspected child maltreatment, it is evident that a number of variables come into play. One can assume that great complexity is involved in how clinicians respond to each individual case. Variables such as the reporter's own history or background, including level of experience, training, cultural and ethnic background, beliefs, and values in combination with other variables (e.g., severity of the case, details surrounding the incident, family history, prior history of abuse, etc.), interact in a way that affects one's decision whether to report an incident. This leads to the following section that addresses the consideration of culture.

#### SHOULD WE OR DO WE TAKE CULTURE INTO ACCOUNT?

As discussed in previous sections, a multitude of factors influences how a professional responds to a given scenario involving suspected child abuse. Currently, there are biases in clinical judgment related to client variables such as age, gender, and ethnicity status (Lopez, 1989). Clinically, this suggests that professionals might respond differently or make different decisions when presented with other demographic variables such as ethnicity. Though there are limited data to report in the child maltreatment field, there are data in clinical psychology that help support this argument.

In a series of studies conducted by Lopez and Hernandez (1986, 1987), they found that although clini-

cians report attending to cultural factors in clinical practice, it is not exactly known how it is accomplished. Lopez and Hernandez (1986) found that clinicians report that culture is taken into account when working with people from culturally diverse backgrounds (i.e., ethnic minority groups). They also found that clinical evaluations of clients change as a result of taking culture into account. Lopez and Hernandez (1986) reported that clinicians were more likely to consider problems *less severe* when it was thought that the problem or clinical issue was cultural in nature. As it relates to child maltreatment, there would seem to be a risk of minimizing actual abuse when clinicians assume that the practice is culturally normative (Mtezuka, 1996).

Another question that needs to be answered is, What does it mean to take culture into account? As Lopez and Hernandez (1987) found, although clinicians report that they take cultural factors into account in the assessment and treatment of individuals from culturally diverse backgrounds, it is not known how certain clinical problems are culturally based. What this means is that clinicians, along with other professionals, really do not know what it means to take culture into account. Though it is reinforcing to report that one is taking cultural factors into account and that one is trying to provide culturally sensitive and competent services to culturally diverse clients, the question still remains as to how this is actually being achieved.

#### LACK OF GUIDING PRINCIPLES OR DECISION-MAKING MODEL

There are many pitfalls involved in making sound clinical decisions. When clinicians are faced with a complex problem, they are responsible for making many decisions and recommendations. How clinicians arrive at these decisions is not exactly known. The literature suggests that clinicians do a poor job of integrating information that helps them make sound decisions (Garb, 1998). There is further evidence to suggest that racial biases occur with regard to predicting violent behavior (Garb, 1997). Another disturbing fact is that rather than testing alternative hypotheses, clinicians tend to collect information that will confirm their biases (Garb, 1998). Given this, it is safe to assume that clinicians would do a poorer job when working with people from cultures that are unfamiliar to them (Gray & Cosgrove, 1985). It is our opinion that although a clinician may be familiar with a particular cultural group and have some knowledge of what may be collectively deemed an appropriate parenting

practice, this should not affect reporting practices but may affect the way in which the clinician responds.

#### REPORTING VERSUS RESPONSE

Before examining the issue of culturally based discipline practices, it is important to distinguish between *reporting* child maltreatment and providing a clinical *response*. In the first instance, all children, regardless of sex, race, ethnicity, or religious beliefs, should have the opportunity to be raised in an environment free from physical, sexual, and emotional abuse and neglect (Terao, Borrego, & Urquiza, 2000). Furthermore, although state statutes governing child abuse reporting vary, it is the ethical and legal responsibility of clinicians to report all instances of suspected child maltreatment (NCCAN, 1999). We know of no parenting practice that would supersede a clinician's legal and ethical obligation to ensure the safety of a child. Therefore, it is essential that all clinicians provide a prompt response by reporting instances of suspected child endangerment, regardless of the ethnic or cultural background of the family.

However, issues of culturally diverse parenting practices may play a very important role in how clinicians respond to families of different cultural backgrounds. Although the clinician's obligation is clear (typically, this is to report *suspected* child maltreatment), parents have broad discretion in the manner they interact and discipline (i.e., parent) their children. Irrespective of culturally based parenting practices, it is important to assess whether the child is at risk for current or future physical harm (Terao et al., 2000). Although a parenting practice may be considered normative, if there is a clear risk of harm to the child, it must be reported to the appropriate authorities. What becomes more difficult is when clinicians are faced with cases that fall in the gray area. This gray area involves issues such as questionable parenting practices that leave no physical evidence of harm to the child. Due to what is considered acceptable in discipline techniques in the United States (e.g., spanking, time out), it might be the case that clinicians may react with skepticism or a degree of uncertainty to parenting practices that are unfamiliar.

#### ASSESSMENT OF ACCULTURATION

When working with ethnic minority families, acculturation should always be taken into consideration when determining a probable course of action (Azar & Benjet, 1994). Adequately meeting the needs of ethnic minority populations and responding ethically has been of great concern to the mental health sys-

tem. One way of demonstrating competence as a clinician when working with culturally diverse populations is to assess for the influence of culture on the presenting problem through acculturation (Dana, 1993). This assessment should be conducted with ethnic minority groups whether they are indigenous, refugees, immigrants, or members of a group who have lived in the United States for an extended period of time. Acculturation status can serve as a moderator variable that may help account for cultural variance with regard to different practices (Dana, 1993).

Though the construct of acculturation has some limitations, we feel that measuring for acculturation can serve as a useful heuristic for clinicians in helping to determine an appropriate assessment and effective clinical response (i.e., intervention) when determining the influence of cultural practices in the context of child maltreatment. Measuring for acculturation might provide useful and valuable information pertaining to different parent discipline practices (i.e., discipline) and the different values, beliefs, and attitudes that are related to such practices. According to Tharp (1991), treatment of children and families should be offered to include aspects of their family and community structure taking into account language of the family, relationships, and meaning of different life events. For our purposes, we define acculturation as the practice whereby ethnic minority people come in contact with different environmental influences that have the potential of influencing different practices. We use the word *potential* because not everyone goes through an acculturation process across different domains to the same extent (e.g., language, beliefs). Given this definition, our focus becomes ethnic minorities who have either lived in the United States for generations (e.g., African Americans) or those who have recently immigrated from other countries (e.g., Mexicans, Vietnamese).

Historically, assessing acculturation suggested measuring preferences in language use (e.g., language spoken with family and friends). Besides assessing for language preference, clinicians are encouraged to also gather sociodemographic information such as educational level, generational status, and self-identified group membership status. More important though is the assessment of values, beliefs, and attitudes with regard to the presenting clinical issue (e.g., possible abuse).

There have been several acculturation scales developed for different ethnic minority groups. Though there are several acculturation scales available, they are rarely used by clinicians during the assessment process (Dana, 1996). Several acculturation scales specific for groups such as African Americans (e.g.,

Klonoff & Landrine, 2000; Snowden & Hines, 1999), Mexican Americans (e.g., Burman, Telles, Karno, Hough, & Escobar, 1987; Cuellar, Arnold, & Maldonado, 1995; Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987), Native Americans (e.g., Garrett & Pichette, 2000), Japanese Americans (e.g., Meredith, Wenger, Liu, Harada, & Kahn, 2000), Asian Americans (Suinn, Richard-Figueroa, Lew, & Vigil, 1987), and scales that are applicable to different ethnic minority groups (e.g., Stephenson, 2000) have been used by clinicians and researchers alike.

Though a detailed discussion of measuring for acculturation is beyond the scope of this article, we hope that clinicians will use sound judgment when selecting scales that have adequate psychometric properties (e.g., reliability, validity). We feel that it is not our position to promote specific acculturation scales. It is left to the discretion of individual clinicians to choose scales they feel comfortable using. There are, however, helpful reviews of specific scales (e.g., SL-ASIA; Ponterotto, Baluch, & Carielli, 1998) and ethnic minority groups (e.g., Dana, 1996) that might assist in the process of choosing an adequate acculturation scale.

As one can see, there are a number of factors in the assessment of acculturation. It is our opinion that if a clinician is unfamiliar with a cultural parenting practice or an ethnic minority group in general, they should consult the literature and/or an expert in the field. An expert should be someone who has extensive knowledge and experience working with the cultural or ethnic minority group. In the case of questionable parent discipline practices, an expert in culture and child maltreatment would be essential. Consultation with an expert would be particularly useful in cases where a parent reports, "It's part of my culture to raise my child this way," when in fact this may not be the case. We believe consultation with an expert will better inform the clinician to not simply base his or her assessment on the client's word or on a psychometric measure of overall acculturation but rather consider comprehensively all information concerning the case.

#### RESPONDING TO CULTURE IN THE CONTEXT OF CHILD MALTREATMENT

When determining the most appropriate response, it is suggested that parents with a low level of acculturation (practices embedded in their native culture) should initially be offered psychoeducational services (e.g., teaching/informing parents about acceptable parenting practices as well as alternative methods of discipline). Our assumption is that these parents

are adhering to cultural practices that are acceptable in their country of origin and this approach would provide low acculturated parents with alternative and effective methods of parenting (e.g., positive discipline techniques). People who are highly acculturated (who understand that it is against the law to harm their child) should be provided a therapeutic response (i.e., psychotherapy). For example, a parent-child treatment program that focuses on improving the quality of the relationship and assists the parent in learning positive and effective discipline strategies would be recommended. It is also hypothesized that these parents, given their level of acculturation, may have problems related to psychopathology or other problems (e.g., substance abuse). Though we suggest that services offered should initially have a psychoeducational focus for low acculturation parents and a psychotherapeutic approach for high acculturation parents, it is important to note that these services are not mutually exclusive. For example, it may be the case where a parent is practicing a culturally prescribed practice and may also be experiencing environmental stressors (i.e., marital discord, parent-child relationship issues, depression, or substance abuse). Treatment should educate the parent about appropriate methods of discipline as well as address other relevant clinical issues (e.g., appropriate referrals for other services such as individual therapy). The bidirectional relationship between a psychoeducational and psychotherapeutic response suggests that given the presenting problems, it may be that the parent will at some point in time require both types of services.

#### A MODEL FOR CHILD ABUSE REPORTING AND RESPONDING

To develop a model for child abuse reporting and responding that includes culture, one must consider the spectrum of parenting practices that may or may not be acceptable to a wide range of cultures. It is our opinion that there are a number of parenting practices viewed as acceptable by some and abusive by others. If one views parenting along a continuum, it is evident that there are practices that are clearly acceptable to most, those that fall in the gray area that are questionable, and those that are clearly inappropriate (i.e., may result in serious injury or fatality). Unfortunately, there is a lack of consistency within the gray area that suggests decisions may vary among professionals and lay people in consideration of different cultural groups. More specifically, a great amount of uncertainty lies in this area where some may consider an incident to be abusive and others might not.



It is at this point that the clinician is confronted with the challenging task of deciding whether to report and how to appropriately respond. If the clinician is unsure of whether to report, a reasonable step would be to consult other professionals, or contact CPS and ask for assistance in making the determination of whether the incident is reportable. The clinician should be aware that no cultural parenting practice should outweigh their obligation to report harm to a child to the appropriate agency (Terao et al., 2000). When in doubt as to whether a practice is abuse or a cultural parenting practice, clinicians should take a more conservative route because it is imperative to keep a child free from present or future harm of abuse.

When the issue of culture is added to the continuum (see Figure 1), it is often challenging to determine the appropriate response. It is our opinion that one should respond differently given a parent's level of acculturation and the severity of the incident. Quadrant I is representative of those parents that are highly acculturated and use acceptable parenting practices. Quadrant II takes into consideration those parents that may be highly acculturated; however, they participate in parenting practices that may be harmful to their child. These are parents that may have a working knowledge of what are acceptable parenting practices and it is assumed that they know the laws concerning these practices. Quadrant III represents those parents that may have a low level of acculturation; however, they do not engage in parenting practices that are harmful to their child. Quadrant IV encompasses parents that have a low level of acculturation and are engaging in dangerous or harmful parenting practices. This raises the question of whether these parents are engaging in behaviors that are normative to their culture. This model of examining parent behavior and level of acculturation is universal across many ethnic minority groups. This model can potentially assist professionals with determining an appropriate clinical response to incidents of questionable cultural parenting practices.

Therefore, it is our position that one must go through a number of steps when determining an appropriate course of action that pertains to both the reporting of the incident and appropriate clinical response (see Figure 2). First, a legally mandated reporter must make a report if there is reasonable suspicion of child physical abuse. Reasonable suspicion consists of "knowledge of or observes a child in his or her professional capacity, or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse" (Office of Child Abuse Prevention, 1991, p. 4). Therefore, if the

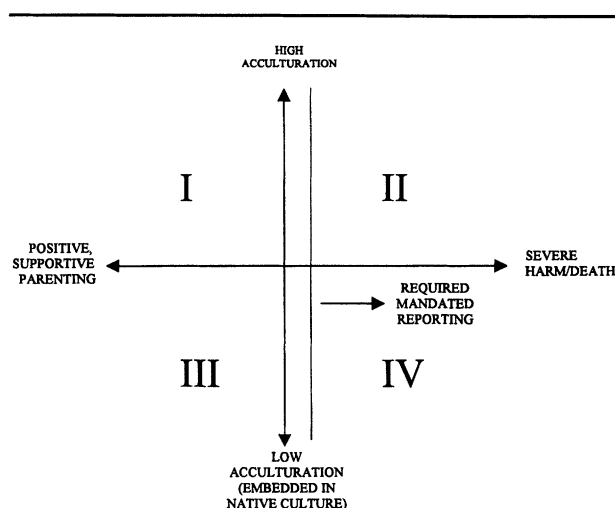


FIGURE 1: Culture and Child Maltreatment Response Quadrant

answer in Step 1 is "yes," then it is the professionals' legal (given the state statute governing child abuse reporting) and ethical responsibility to report suspected child maltreatment/harm. If the answer is "no," then a report would not be made.

The cultural background of the family should be considered when determining the appropriate course of treatment or clinical response. The family's level of acculturation (e.g., views on parenting, language use, duration of time in the United States, ethnicity of friends, involvement in religious/cultural traditions) should be assessed using a normed and valid acculturation scale. The purpose of this assessment would be to determine whether the parent would benefit most from a psychoeducational response or therapeutic response. If clients have a minimal knowledge of acceptable laws in the United States and acceptable child-rearing practices, then a psychoeducational response is recommended. This program would be offered in the client's language and would include an emphasis on acceptable methods of discipline and parenting. Resources would be made available to the parent as well.

If a client has the basic knowledge of laws in the United States and an understanding of acceptable parenting practices, a therapeutic intervention may be warranted. This assumes that the parent may benefit from a treatment modality that focuses on actual skills training in parenting and effective methods of discipline. This recommendation is based on the knowledge that the practices they are engaging in may be harmful to their child or are against the law. As stated previously, it should be noted that



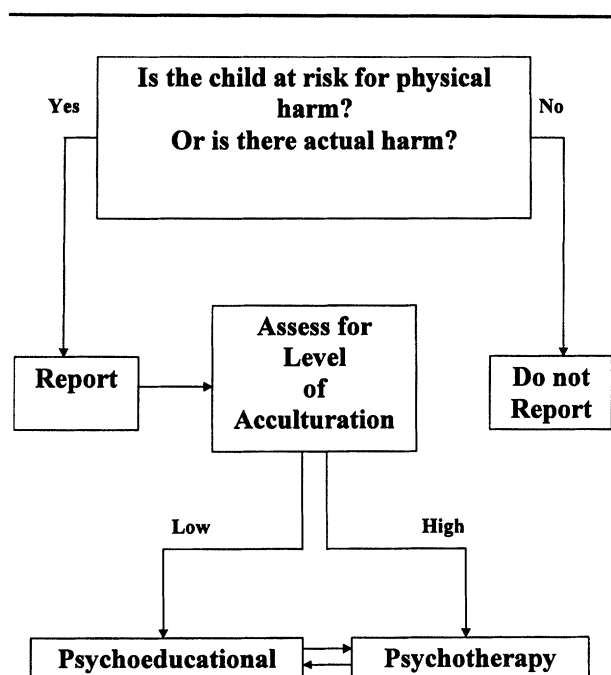


FIGURE 2: Culture and Child Maltreatment Decision-Making Model

psychoeducational and psychotherapeutic interventions are not mutually exclusive. Rather, both types of interventions may be warranted for certain families, depending on the hierarchy of presenting problems.

## CONCLUSION

This article appears to raise more issues and questions than it attempts to answer. One of our goals in writing this article was to promote future discussion and dialogue on how to respond when faced with the task of differentiating cultural parenting practices from child maltreatment. If the article has provoked more questions on the part of the reader, then we have accomplished one of our goals. Multidisciplinary professionals (e.g., school, law, medical, and mental health personnel) need to be cognizant of the multitude of factors affecting their decision-making process when confronted with the issue of reporting and responding to suspected incidents of child maltreatment that may include cultural aspects. Our premise remains, however, that irrespective of parenting practices that may be viewed as normative to a particular cultural group, it is imperative to assess for current or future risk of harm to the child. If this exists, then it is the clinician's legal and ethical obligation to make a report to the appropriate agency.

Although the concepts of cultural sensitivity and cultural competence are good premises to work from, we also believe that further exploration is warranted. Presently, we believe that these terms are often nebulous. To date, there are limited guidelines determining what clinicians should do beyond promoting the basic therapeutic skills of building rapport and empathy. Though it is impossible to gain expansive knowledge about every cultural group one comes in contact with, we suspect there are ways of detecting cultural practices that might be harmful to the child.

The main limitation of the proposed model is that it has not been tested with professionals. For now, it should be used cautiously as a heuristic model that serves as a guide for clinician's behavior when determining the most appropriate treatment response. An important component of this model is the assessment of the level of acculturation. Once the appropriate level of acculturation has been determined, this information should assist the clinician in helping to formulate an appropriate treatment plan. For example, if a clinician determines that a family is of low acculturation, a psychoeducational approach might be implemented. The focus of the intervention would be teaching the parent about child maltreatment laws of the state (including the consequences) and appropriate as well as inappropriate parenting and discipline practices. This would be followed with a treatment that is educational in nature. On the other hand, if a parent is highly acculturated (e.g., third generation with a high school degree and speaks fluent English), a psychotherapeutic intervention should be carried out. The clinician should understand that these interventions are not mutually exclusive and both may be applicable for certain families. It is left to the clinician to determine whether a family may first benefit from a psychoeducational approach followed by a psychotherapeutic approach or vice versa.

It is important to note that we are not advocating that the United States is without a child abuse problem but rather that there are laws that deem certain practices as abusive. If parents regardless of their ethnicity or culture engage in these practices in the United States, there are potential consequences (i.e., removal of the child from the parent's home and custody). It is the clinician's decision to determine the most appropriate clinical response.

We close with future clinical and research recommendations focusing on child maltreatment and different cultural practices. Clinically, standards of care should be developed to help clinicians work effectively with members from different ethnic groups. As our society becomes increasingly diverse, it is important that clinicians respond ethically and responsibly

without being pejorative to their clients when responding to different forms of child maltreatment that may be unfamiliar. It is also suggested that the use of acculturation scales or consultation with an expert be part of the assessment when working with ethnic minority or cultural groups.

Future areas of research should focus on different professionals' (e.g., social workers, psychologists, police, and physicians) responses to a variety of scenarios that depict cultural parenting practices (that would include both discipline and healing practices) that could be mistaken for child maltreatment. It may also be the case where someone is practicing a specific behavior that is prescribed in his or her culture that may be unrelated to whether someone is acculturated to "American" culture. An interesting research question might be to examine therapists' decision-making patterns when presented with scenarios involving practiced behaviors where cultural information is left out of the vignette. For example, one group could be presented with a scenario depicting an African American parent using a switch to discipline their child versus another group with a vignette where the ethnicity of the parent is left out. This would investigate the effects of presentation or absence of cultural information on a professional's decision-making process with regard to reporting and responding. It would also be beneficial to investigate how one's own ethnic identity influences judgment in working with people of the same and different ethnic background. Though there are vignette studies depicting different discipline scenarios (e.g., Ashton, 1999), no study to date has specifically examined cultural practices that might be normative to one group but viewed as abusive in the United States. Data gathered on clinician's responses to these gray area scenarios could possibly lead to better definitions of child maltreatment that would subsequently result in more uniform reporting procedures and reporting behaviors. It would be important that these definitions be multidisciplinary, suggesting that despite one's discipline (e.g. mental health, law enforcement, medical, etc.), a uniform response should occur.

## REFERENCES

- Abney, V. D. (1996). Cultural competency in the field of child maltreatment. In J. Briere, L. Berliner, J. A. Bulkley, C. Jenny, & T. Reid. (Eds.), *The APSAC handbook on child maltreatment* (pp. 409-419). Thousand Oaks, CA: Sage.
- American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist*, 48, 45-48.
- Ards, S., & Harrell, A. (1993). Reporting of child maltreatment: A secondary analysis of the national incidence surveys. *Child Abuse & Neglect*, 17(3), 337-344.
- Ashton, V. (1999). Worker judgments of seriousness about and reporting of suspected child maltreatment. *Child Abuse & Neglect*, 23(6), 539-548.
- Azar, S. T., & Benjet, C. L. (1994). A cognitive perspective on ethnicity, race, and termination of parental rights. *Law and Human Behavior*, 18(3), 249-263.
- Ben-David, A. (1996). Therapists' perceptions of multicultural assessment and therapy with immigrant families. *Journal of Family Therapy*, 18, 23-41.
- Betancourt, H., & Lopez, S. R. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist*, 48(6), 629-637.
- Burman, M. A., Telles, C. A., Karno, M., Hough, R. L., & Escobar, J. I. (1987). Measurement of acculturation in a community sample of Mexican Americans. *Hispanic Journal of Behavioral Sciences*, 9, 105-130.
- Cuellar, I., Arnold, B., & Maldonado, R. (1995). Acculturation rating scale for Mexican-Americans-II: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences*, 17(3), 275-304.
- Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology*. Boston: Bacon & Ally.
- Dana, R. H. (1996). Assessment of acculturation in Hispanic populations. *Hispanic Journal of Behavioral Sciences*, 18(3), 317-328.
- Derezotes, D. S., & Snowden, L. R. (1990). Cultural factors in the intervention of child maltreatment. *Child and Adolescent Social Work*, 7(2), 161-175.
- Dubanoski, R. A. (1981). Child maltreatment in European and Hawaiian-Americans. *Child Abuse & Neglect*, 5(4), 457-465.
- Dubowitz, H. (1997). Ethical issues in professionals' response to child maltreatment. *Child Maltreatment*, 2(4), 348-355.
- Escobar, S. F. (1995). A study of factors influencing child abuse reporting by mental-health professionals. *Science & Engineering*, 56(5-B), 2586.
- Fontes, L. A. (1995). Culturally informed interventions for sexual child abuse. In L. A. Fontes (Ed.), *Sexual abuse in nine North American cultures: Treatment and prevention* (pp. 259-266). Thousand Oaks, CA: Sage.
- Fontes, L. A. (1998). Ethics in family violence research: Cross-cultural issues. *Family Relations*, 47(1), 53-61.
- Fox, S., & Dingwall, R. (1985). An exploratory study of variations in social workers' and health visitors' definitions of child mistreatment. *British Journal of Social Work*, 15, 467-477.
- Garb, H. N. (1997). Race bias, social class bias, and gender bias in clinical judgment. *Clinical Psychology: Science and Practice*, 4(2), 99-120.
- Garb, H. N. (1998). *Studying the clinician: Judgment research and psychological assessment*. Washington, DC: American Psychological Association.
- Garbarino, J., & Ebata, A. (1983). The significance of ethnic and cultural differences in child maltreatment. *Journal of Marriage and the Family*, 45, 773-783.
- Gardner, G. M., Schadler, M., & Kemper, S. (1984). Classification strategies used by mandated reporters in judging incidents of child abuse. *Journal of Clinical Child Psychology*, 13(3), 280-287.
- Garrett, M. T., & Pichette, E. F. (2000). Red as an apple: Native American acculturation and counseling with or without reservation. *Journal of Counseling and Development*, 78(1), 3-13.
- Glachan, M. (1991). Child abuse: A social and cultural phenomenon. *Early Child Development and Care*, 74, 95-102.
- Gray, E., & Cosgrove, J. (1985). Ethnocentric perception of childrearing practices in protective services. *Child Abuse & Neglect*, 9(3), 389-396.
- Hegar, R. L., Zuravin, S. J., & Orme, J. G. (1994). Factors predicting the severity of physical child abuse injury: A review of the literature. *Journal of Interpersonal Violence*, 9(2), 170-183.

- King, G., Reece, R., Bendel, R., & Patel, V. (1998). The effects of sociodemographic variables, training, and attitudes on the lifetime reporting practices of mandated reporters. *Child Maltreatment*, 3(3), 276-283.
- Klonoff, E. A., & Landrine, H. (2000). Revising and improving the African American acculturation scales. *Journal of Black Psychology*, 26(2), 235-261.
- Kolko, D. J. (1996). Child physical abuse. In J. Briere, L. Berliner, J. A. Bulkley, C. Jenny, & T. Reid. (Eds.), *The APSAC handbook on child maltreatment* (pp. 21-50). Thousand Oaks, CA: Sage.
- Korbin, J. E. (1991). Cross cultural perspectives and research directions for the 21st century. *Child Abuse & Neglect*, 15(1), 67-77.
- Korbin, J. E. (1994). Sociocultural factors in child maltreatment. In G. B. Melton & F. D. Barry (Eds.), *Protecting children from abuse and neglect: Foundations for a new strategy* (pp. 182-223). New York: Guilford.
- Leung, P., Cheung, K. M., & Stevenson, K. M. (1994). A strengths approach to ethnically sensitive practice for child protective service workers. *Child Welfare*, 73(6), 707-721.
- Levesque, R. J. R. (2000). Cultural evidence, child maltreatment, and the law. *Child Maltreatment*, 5(2), 146-160.
- Lopez, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. *Psychological Bulletin*, 106(2), 184-203.
- Lopez, S. R., & Hernandez, P. (1986). How culture is considered in evaluations of psychopathology. *Journal of Nervous & Mental Disease*, 174(10), 598-606.
- Lopez, S. R., & Hernandez, P. (1987). When culture is considered in the evaluation and treatment of Hispanic patients. *Psychotherapy*, 24(1), 120-126.
- Maitra, B. (1996). Child abuse: A universal 'diagnostic' category? The implication of culture and definition and assessment. *International Journal of Social Psychology*, 42(4), 287-304.
- Marin, G., Sabogal, F., Marin, B. V., Otero-Sabogal, R., & Perez-Stable, E. J. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences*, 9, 183-205.
- McPhatter, A. R. (1997). Cultural competence in child welfare: What is it? How do we achieve it? What happens without it? *Child Welfare*, 76(1), 255-278.
- Meredith, L. S., Wenger, N., Liu, H., Harada, N., & Kahn, N. (2000). Development of a brief scale to measure acculturation among Japanese Americans. *Journal of Community Psychology*, 28(1), 103-113.
- Montalvo, F. F., Lasater, T. T., & Valdez, N. G. (1982). Training child welfare workers for cultural awareness: The cultural simulator technique. *Child Welfare*, 61(6), 341-352.
- Mtezuka, M. (1996). Issues of race and culture in child abuse. In B. Fawcett & B. Featherstone (Eds.), *Violence and gender relations: Theories and interventions* (pp. 171-177). London, England: Sage.
- National Clearinghouse on Child Abuse and Neglect Information. (1999). *Child abuse and neglect statutes at a glance*. Washington, DC: Department of Health and Human Services.
- Office of Child Abuse Prevention. (1991). *The California child abuse and neglect reporting law: Issues and answers for health practitioners*. Sacramento, CA: State Department of Social Services.
- Osborne, Y. H., Hinz, L. D., Rappaport, N. B., Williams, H. S., & Tuma, J. M. (1988). Parent social attractiveness, parent sex, child temperament, and socioeconomic status as predictors of tendency to report child abuse. *Journal of Social & Clinical Psychology*, 6(1), 69-76.
- Pedersen, P., & Hernandez, D. A. (1993). *A student workbook for counseling across cultures*. Honolulu: University of Hawaii Press.
- Pedersen, P. B. (1990). The multicultural perspective as a fourth force in counseling. *Journal of Mental Health Counseling*, 12(1), 93-95.
- Pedersen, P. B. (1997). *Culture-centered counseling interventions: Striving for accuracy*. Thousand Oaks, CA: Sage.
- Pedersen, P. B., Draguns, J. G., Lonner, W. J., & Trimble, J. E. (Eds.). (1996). *Counseling across cultures* (4th ed.). Thousand Oaks, CA: Sage.
- Pedersen, P. B., & Ivey, A. E. (1993). *Culture-centered counseling and interviewing skills: A practical guide*. Westport, CT: Greenwood.
- Ponterotto, J. G., Baluch, S., & Carielli, D. (1998). The Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA): Critique and research recommendations. *Measurement & Evaluation in Counseling and Development*, 31(2), 109-124.
- Portwood, S. G. (1999). Coming to terms with a consensual definition of child maltreatment. *Child Maltreatment*, 4(1), 56-68.
- Rubin, G. B. (1992). Multicultural considerations in the application of child protection laws. *Journal of Social Distress and the Homeless*, 1(3/4), 249-271.
- Saulsbury, F. T., & Campbell, R. E. (1985). Evaluation of child abuse reporting by physicians. *American Journal of Diseases of Children*, 139, 393-395.
- Snowden, L. R., & Hines, A. M. (1999). A scale to assess African American acculturation. *Journal of Black Psychology*, 25(1), 36-47.
- Stephenson, M. (2000). Development and validation of the Stephenson multigroup acculturation scale (SMAS). *Psychological Assessment*, 12(1), 77-88.
- Sue, D. W., Ivey, A. E., & Pederson, P. B. (1996). *A theory of multicultural counseling and therapy*. Pacific Grove, CA: Brooks/Cole.
- Sue, D. W., & Sue, D. (1999). *Counseling the culturally different* (3rd ed.). New York: John Wiley & Sons.
- Suinn, R. M., Richard-Figueroa, K., Lew, S., & Vigil, S. (1987). The Suinn-Lew Asian self-identity acculturation scale: An initial report. *Educational and Psychological Measurement*, 47, 401-407.
- Tang, C. S. K. (1998). The rate of physical child abuse in Chinese families: A community survey in Hong Kong. *Child Abuse & Neglect*, 22(5), 381-391.
- Terao, S. Y., Borrego, J., Jr., & Urquiza, A. J. (2000). How do I differentiate culturally based parenting practice from child maltreatment? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 97-100). Thousand Oaks, CA: Sage.
- Tharp, R. G. (1991). Cultural diversity and treatment of children. *Journal of Consulting and Clinical Psychology*, 59(6), 799-812.
- Tilden, V. P., Schmidt, T. A., Limandri, B. J., Chiodo, G. T., Garland, M. J., & Loveless, P. A. (1994). Factors that influence clinicians' assessment and management of family violence. *American Journal of Public Health*, 84(4), 628-633.
- Van Voorhis, R. A., & Gilbert, N. (1998). The structure and performance of child abuse reporting systems. *Children and Youth Services Review*, 20(3), 207-221.
- Zellman, G. L. (1990a). Child abuse reporting and failure to report among mandated reporters: Prevalence, incidence, and reasons. *Journal of Interpersonal Violence*, 5(1), 3-22.
- Zellman, G. L. (1990b). Linking schools and social services: The case of child abuse reporting. *Educational Evaluation & Policy Analysis*, 12(1), 41-55.
- Zellman, G. L. (1990c). Report decision-making patterns among mandated child abuse reporters. *Child Abuse & Neglect*, 14(3), 325-336.
- Zellman, G. L. (1992). The impact of case characteristics on child abuse reporting decisions. *Child Abuse & Neglect*, 16(1), 57-74.
- Zellman, G. L., & Faller, K. C. (1996). Reporting of child maltreatment. In J. Briere, L. Berliner, J. A. Bulkley, C. Jenny, & T. Reid. (Eds.), *The APSAC handbook on child maltreatment* (pp. 359-381). Thousand Oaks, CA: Sage.

*Sherri Y. Terao, Ed.D., is a psychologist with the CAARE Diagnostic and Treatment Center at the University of California, Davis Medical Center. Dr. Terao's research interests include cross-cultural issues in mental health, parent-child relationships in abusive situations, the use of Parent-Child Interaction Therapy (PCIT) with different populations, and group psychotherapy with abused children. Dr. Terao is a member of the American Professional Society on the Abuse of Children and a participant on the cultural diversity and colloquium planning committees.*

*Joaquin Borrego, Jr., M.A., is a graduate student in the Ph.D. program in clinical psychology at the University of Nevada, Reno. His research focus is on physically abusive parent-child relationships and ethnic minority issues in clinical psychology. He is*

*especially interested in examining the influence of culture on different parenting practices and potential physically abusive behaviors among ethnic minority groups. He is also interested in the generalizability and applicability of empirical treatments with Spanish-speaking populations.*

*Anthony J. Urquiza, Ph.D., is a child clinical psychologist and director of Mental Health Services, CAARE Diagnostic and Treatment Center, Department of Pediatrics, University of California,*

*Davis Medical Center. Dr. Urquiza has extensive clinical experience with children, adolescents, and adults in a variety of inpatient and outpatient settings. His primary clinical and research interests and publications focus on family violence and ethnic minorities, the treatment of children and adult survivors of childhood sexual abuse/physical abuse, and mental health psychodiagnostic issues as they apply to child maltreatment. Dr. Urquiza is a member of the advisory board for the American Professional Society on the Abuse of Children.*