Journal of Applied Sciences

ISSN 1812-5654

science alert

ANSInet
an open access publisher
http://ansinet.com

Journal of Applied Sciences 14 (21): 2793-2803, 2014
ISSN 1812-5654 / DOI: 10.3923/jas.2014.2793.2803

Barriers to Child Abuse Identification and Reporting

[1]Intima Alrimawi, [2]Ahmad Rajeh Saifan and [3]Mohannad AbuRuz
[1]College of Nursing, Birzeit University, Palestine
[2]College of Nursing, Applied Science Private University, Amman,
Post Code 11931, P.O. Box 166, Jordan
[3]Applied Science Private University, Amman, Jordan

Abstract: Child abuse is an increasing phenomenon globally and is divided into four dimensions: physical, sexual, emotional and negligence. As in all countries in the world, child abuse is underreported in Arab countries, including Palestine. Therefore, the purpose of this study was to determine the potential barriers to child abuse identification and reporting by the Palestinian nurses. A total of 84 nurses from a major hospital in Ramallah city in Palestine constituted the sample of this study and returned the distributed questionnaire. The majority of the sample were young junior nurses holding BSc degrees. Interestingly, none of the nurses had received any training about child abuse. Almost 70% of nurses think that child abuse is a problem in the society, but that it is underreported due to different factors such as being concerned about child abuse identification, training about abuse identification, lack of time for identification of the abuse and child abuse not being considered a medical problem; these were the barriers most identified by the nurses. In conclusion, the presence of a well-organized system to deal with this phenomenon seems crucial. Protecting children from being abused is not the responsibility of a single agency or a governmental institution. Clear, concise and structured child protection policy is necessary to enable nurses to report and deal with abuse cases and to improve the effectiveness of reporting and caring for such cases.

Key words: Child abuse, quantitative, identification and reporting, palestine

INTRODUCTION

Child abuse is now recognised as a global phenomenon and a public health concern. The World Health Organization announced that more than 40 million children over the world are considered victims of child abuse yearly (Piltz and Wachtel, 2009). In the US for example, more than one in every hundred children is identified as an abuse case and more than 1,500 children die as a result of maltreatment per year (Paxson and Haskins, 2009). There are four commonly recognised dimensions of child abuse:

- Physical abuse, which means harming the child using physical force, including hitting, shaking and biting
- Sexual abuse, which includes the involvement of the child in any sexual activity against cultural norms
- Emotional abuse, which is defined as the failure to support a child's emotional, developmental and social needs (e. g. threatening and discrimination against girls)
- Negligence, which can be interpreted as the failure of the care-giver to provide the child with their basic needs of education, health and shelter (Jena, 2013)

The presence of a well-organized system to deal with this phenomenon is crucial. Protecting children from being abused is not the responsibility of a single agency or a governmental institution. Therefore, all governmental and private institutions in addition to the whole community should collaborate to protect children from being abused. Despite the importance of this collaboration, it is important to restrict this phenomenon by producing clear laws and regulations to assign accountability and responsibility in child abuse cases. Subsequently, governments should prepare clear policies that define theoretical and practical meanings of child abuse and the chain of responsibility in these incidences. The presence of clear, concise and structured child protection policy helps nurses to report and deal with abuse cases and improves the effectiveness of reporting as well as caring for such cases (Chihak, 2009).

Corresponding Author: Ahmad Rajeh Saifan, College of Nursing, Applied Science Private University, Amman, Post Code 11931, P.O. Box 166, Jordan Tel: +962790142942

The child abuse phenomenon seems to be a widespread issue in Palestinian society, but it is underestimated (i.e., systematically ignored) in official reports from the major healthcare institutions in Palestine, such as the Ministry of Health (Halileh *et al*., 2007). This is related to the general aversion of Palestinian society to discuss/engage with sensitive subjects deemed to be private matters, which also contributes to the deficiency of research about this topic. In Arabic society, parents' child-rearing practices are considered to be a private issue that others (especially non-family members) have no right to interfere with. Additionally, it is considered socially acceptable for parents to practice physical punishments and yelling to their children as a normal part of child-rearing (Chavis *et al*., 2013; Elbedour *et al*., 2006; Khamis, 2000). It is also common to hide child abuse cases in Palestine, particularly sexual abuse cases, due to the social stigma accrued by families identified with such abuse (Elbedour *et al*., 2006; Khamis, 2000). Given the prevailing cultural milieu, it seems incumbent upon health professionals, especially nurses (who spend more time with patients and are considered their advocates), to identify and report child abuse incidents.

Despite the limited research on child abuse in Palestine, a number of private institutions assessed this phenomenon and reported important findings in this field. For example, the Palestinian Central Bureau of Statistics' (the main statistical centre in Palestine, which follows international standards in its research) examined the violence against children in Palestine and reported that half of the mothers stated that their children were subject to either physical or emotional abuse from various people, such as household members, other children on the street, teachers at schools and the occupation forces (PCBoS, 2005). This percentage is high in comparison with results from similar studies conducted in the Western countries. For instance, May-Chahal and Cawson (2005) surveyed 2,869 adults in the UK to provide reliable abuse prevalence measurements. They found that 16% of the sample had experienced maltreatment. Serious forms of it were divided into sexual (11%), physical (7%), psychological (6%) and neglect (5-6%). Another important Palestinian study showed that 88.7% of physicians had faced child abuse cases during their work at least once (Halileh *et al*., 2007). These numbers show the importance of studying the phenomenon in more detail. The barriers to identifying and reporting these incidents should be explored, with the ultimate aim of protecting children and their families from more abuse in future.

There are several barriers to child abuse identification and reporting suggested in the existent literature. Nurse-related barriers were considered as a major factor by several authors, including deficit in nurses' knowledge and skills about the identification and reporting of incidences of child abuse (Chihak, 2009; Fraser *et al*., 2010; Keane and Chapman, 2008; Pabis *et al*., 2011; Starling *et al*., 2009). Lee and Hoaken (2007) indicated the importance of considering the nurses' background about the meaning of child abuse and how they would respond to it. Some nurses considered addressing the phenomenon of child abuse to be an ethical obligation and they adopted the role of patient advocacy to support victims (Bannon and Carter, 2003; Peckover *et al*., 2013). On the other hand, some nurses considered this phenomenon to be a personal and family issue in which they had no role. To overcome this barrier, many nurses expressed their need for training about the signs and symptoms to be checked in the abuse situations (Reijneveld *et al*., 2008).

The experience of dealing with abuse cases and the communication skills are other nurse-related factors in the identification and reporting of child abuse (Piltz and Wachtel, 2009). The nurses should have the ability to ask the right questions in the right way (Nayda, 2004; Reid and Long, 2002). The nurses may also feel some discomfort and anxiety from dealing with these cases and they might have fears from the consequences of their actions (Lazenbatt and Freeman, 2006).

The second barrier to nurses' child abuse identification and reporting is work-related factors, including workload, community culture, colleagues and management support (Piltz and Wachtel, 2009; Yang, 2009; Yonaka *et al*., 2007). Feng and Levine (2005) reported that Taiwanese nurses avoid reporting child abuse incidences due to cultural issues. Similarly, Coope and Theobald (2006) aimed to identify the challenges that child protection practitioners face in identifying child neglect in Guatemala. They found that the contextual factors, such as societal and cultural norms, complicated the process of abuse identification.

The third category of barriers stems from the child protection system. This includes the follow-up strategies and the regulations that affect the identification and reporting the abuse cases (Flaherty *et al*., 2000; Yonaka *et al*., 2007). Sidebotham *et al*. (2007) admitted the role of the presence of clear protocols and practice guidelines in enhancing the effectiveness of child abuse detection and management by nurses. Additionally, the importance of collaboration between the different sectors and agencies in abuse detection is considered as a cornerstone to restrict this phenomenon in the community (Feng *et al*., 2010).

In general, many researchers' attempted to address the issue of child abuse from different perspectives (Adams, 2006). However, research about this phenomenon may face many difficulties because of its sensitivity. Furthermore, the researchers need to consider many practical and methodological problems when dealing with this subject, such as defining child abuse operationally and defining the children at risk (Kinard, 1994). Several researchers suggested more research to study how nurses apply their theoretical knowledge as well as personal perceptions about child abuse in identifying and reporting child abuse incidences, but there remains a lack of consideration of nurses' perceptions of child abuse despite numerous major studies on the phenomenon in general (Chanmugam, 2009; Paavilainen and Tarkka, 2003).

The purpose of this study was to determine the potential barriers to child abuse identification and reporting by Palestinian nurses. The key questions that this research addresses are: What are nurses' perceptions of child abuse (i.e. what practices do they consider to constitute child abuse)? What are nurses' main self-reported barriers to child abuse identification in Palestinian hospital nursing communities?

METHODOLOGY

Study design: A descriptive exploratory cross-sectional design was used in this study. This design was used as it mainly aims to describe nurses' self-reported barriers to child abuse identification, reporting and perception at one point of time.

For the purpose of this study, a 'child' is defined as a patient below the age of eighteen. 'Child abuse' is understood as any physical, sexual and/or psychological abuse committed by members of the family, school, neighbourhood communities, or anyone in the society at large. 'Neglect' was defined as intended or unintended failure to provide basic health, education, affection or material needs appropriate to the child's age and development (WHO, 2013).

Data collection method: The sensitivity of the study subject might make nurses uncomfortable discussing this subject face-to-face or by telephone interview. Therefore, the data was collected through the reapplication of a previously used structured questionnaire. With simple language usage to match the level of education of participants and careful design, the self-completion questionnaire method can be useful and informative (Polit and Beck, 2010).

Sample and setting: Data was collected using self-completed questionnaires via convenience sampling method due to the nature of the topic. This non-probability sampling method, although it can limit the ability to generalize results, is flexible and easy to conduct (LoBiondo-Wood and Haber, 2002). The inclusion criteria were nurses who: (1) Have contact with children during their work and (2) Are working on a full-time basis.

The research setting was a major governmental hospital in Ramallah city, Palestine. This setting was chosen because it is the main referral hospital located in a central city and serves most of the Palestinian population from different socioeconomic classes and has nurses from different districts (all over Palestine). Therefore, the sample is representative of the Palestinian nursing community, which supports the generalizability of the results.

About 170 nurses work in this hospital. Data collection was conducted in the departments where nurses deal with children, including the Paediatric Ward, Intensive Care Unit, Day Care Unit, Medical Ward, Surgical Ward and the Emergency Department. The number of nurses who work in these departments was 100; questionnaires were distributed to all of them. The response rate was 86%. Two respondents were excluded due to omitting major parts of the solicited data. Thus, the final sample was 84 nurses.

Data collection procedure: The data collection process was carried out between May and July 2010. Full explanation of the study purposes was given to the nurses in each department. The questionnaire was then distributed to nurses when they were on duty, to be filled in by them either during their break or when they returned to their homes. Three nurses who work in the hospital volunteered to support this research and they assisted in getting nurses involved in the study and in the questionnaire completion. Participants were asked to return the completed questionnaire either to the researcher or to one of these volunteers within two weeks.

The study questionnaire was derived from two previous studies (Smith *et al*., 2008; Yonaka *et al*., 2007). The authors of these studies were contacted and their permission to apply their questionnaires in the current study was obtained. Yonaka *et al*. (2007) used a questionnaire to study the barriers to child abuse identification, while Smith *et al*. (2008) focused on studying the barriers to reporting child abuse incidences. In addition to the demographic characteristics, the current study questionnaire examines nurses' barriers to child abuse identification and reporting.

The final constructed questionnaire contained the following sections: demographic data and the potential barriers to child abuse identification and reporting and their perceptions of child abuse and potential barriers to its identification. Statements were assessed using a four-point Likert scale (always agree, mostly agree, sometimes agree and do not agree), with a space for participants' additional comments.

The questions regarding whether nurses' had ever seen suspected cases of child abuse and what they considered potential barriers to child abuse reporting were answered with either yes or no. In addition, open questions were used in most of the demographic and personal characteristic questions, such as place of residence, level of education and years of nursing experience. Open questions were also used to provide a space for further exploration and comments after each section and at the end of the questionnaire there are questions about the existence of a protocol and reference system usage that could be answered either with yes or no.

A few questions were added to this questionnaire, for instance the question about nurses' training needs was added for the purpose of gaining more holistic information about the possible obstacles to child abuse identification and reporting. On the other hand, other questions were deleted totally; for example, in the potential barriers to child abuse identification the statement "Language barriers make it difficult to talk about abuse" was deleted because it is not applicable to the Palestinian context, as all of the population speaks the same language (Arabic) and the statement "I have a history of abuse in myself or in my close family" statement were deleted after the pilot study, as participants saw it as intrusive (Yonaka *et al*., 2007).

Validity and reliability: To ensure the rigor of the research, the authors need to consider the validity and reliability of the questionnaire. Validity refers to the degree to which questionnaires measure what they are structured to measure (Coughlan *et al*., 2007). Reliability means the repeatability of the instrument; in other words, reliability means that if the measurements are repeated using the same instrument under the same conditions, they will yield approximately the same results (Coughlan *et al*., 2007). Reliability is usually checked by measuring the internal consistency of the instrument. In this research, the authors examined the internal consistency by measuring the Cronbach's alpha to assess the correlation between questionnaire items and it was found to be (0.55). Although, this does not reflect high reliability, it is an acceptable value for reliability (Peat, 2001).

There are two factors that reflect face and content validity: Firstly, the questionnaire had been used before in published research papers and the content of the this questionnaire was covered thoroughly in the literature reviews (Smith *et al*., 2008; Yonaka *et al*., 2007) secondly, a pilot study had been conducted among a sample of ten nurses to ensure that respondents understand the questions. This aimed to identify any practical problems in the questionnaire and to test their reaction to certain questions, which contributes to ensuring the quality of the data obtained (Peat, 2001).

Ethical considerations: Ethical approval was obtained from the Ministry of Health in Palestine and research setting hospital managers. The participants autonomously decided whether to voluntarily participate in the study. Informed consent was signed by each participant before filling in the questionnaire. The study purposes were explained for each participant. The participants' responses were identified by the questionnaire number in the computer, so their privacy and confidentiality was protected and nobody outside the research team was informed of their involvement.

Data analysis: All data was analysed using SPSS software version 20 (SPSS Inc, Chicago, Illinois). Most of the data were analyzed using descriptive statistics with the aims of filling the gap in the numerical data in this area. Nurses' perceptions of child abuse were analysed using means and standard deviation, while the barriers to child abuse reporting and identification and the open question were analysed using frequencies and percentages (Kirkpatrick and Feeney, 2008).

Mann-Whitney (non-parametric) testing was used to assess nurses' perceived barriers to child abuse identification based on certain characteristics such as level of education, experience in nursing practice and seniority in the department. This was done as a result of the available sample size and the presence of two categories in some occasions, such as junior and senior or head nurses. This may make the normal distribution of the sample questionable. In all of these analyses, a p value of less than 0.05 was considered to be statistically significant. Those characteristics were chosen as many studies reflected their importance with regard to nurses' perceptions of child abuse and perceived barriers to its identification (Lee and Hoaken, 2007; Nayda, 2004; Piltz and Wachtel, 2009).

RESULTS

Participants' characteristics and demographic data: At the end of the data collection stage, 84 nurses from the sample of 100 who met the inclusion criteria completed and returned the questionnaires. The received 84 questionnaires were drawn from nurses working in: Intensive care unit (15 out of 15), Emergency department (22 out of 30), Medical ward (12 out of 15), Surgical ward (14 out of 15), Paediatric ward (13 out of 15) and Day care unit (8 out of 10).

Almost 57% of participants were male and the mean age of the sample was 28±6.4 years, which reflects that the majority of them are young. As the research setting was a governmental hospital in Ramallah, almost half of them were permanently resident in the city (48%), while the other resided elsewhere in the West Bank. Approximately two-thirds of the sample held bachelor's degrees or more. The majority of them (82%) held junior nursing positions in their departments (Table 1).

The distribution of participants according to their previous work in paediatric wards shows that 50% of them were either currently working in or had worked in the paediatric ward before. The mean participant experience in paediatric wards was 1.6 years (S/D: 3.6, Range: 0-23), while their mean experience in general nursing was 5.7 years (S/D: 5.4, Range: 1-24), which means that 51% of them had more than four years' of experience in general nursing.

Table 2 shows that none of the nurses received any training about child abuse phenomena or child protection and 88% of them think that there is no clear protocol for dealing with child abuse cases in the hospital. However, the remaining 12% think that they had such a protocol in the hospital. Finally, one-third (33%) of nurses intend to use the referral system in co-operation with the Ministry of Social Affairs, child protection organizations, or the police in Palestine to deal with child abuse cases.

The vast majority of participants (from the 37 who answered this question) think that the main reasons for not referring these cases are that: there is no clear protocol for referring (N: 19), they do not know how to refer (N: 13) and the child protection system in Palestine is ineffective (N: 7). The least important reasons for not referring the cases were: to maintain patient privacy (N: 3) and because nurses think that this is not part of their job (N: 2).

Barriers to child abuse identification and reporting: To assess nurses' perceived barriers to child abuse identification, the questionnaire from the study of Yonaka *et al*. (2007) was adopted. Participants' responses were coded to "Not agree or sometimes agree' and 'mostly agree or always agree". Table 3 reflects the percentage of nurses' perceived barriers to child abuse identification statements. Among these responses, the higher percentage of mostly agree or always agree were: "I am concerned about child abuse identification" statement (P: 73%), then "I would like some training about how to identify child abuse cases" (P: 71%) and "Child abuse is a problem in the Palestinian society" (P: 70%). In other words, almost 70% of nurses think that child abuse is a problem in the society, they are interested in it and they want some training about it. However, it can be inferred that 30% do not take the issue seriously, which is perceived as a major barrier to addressing the issue.

Some other barriers appears in the statements: "I am not trained to deal with the problem of child abuse" (P: 57%) and "I do not have time to detect abuse cases" (P: 54%). Few participants answered the question about their training needs, but some stated that they needed training about how to deal with abuse cases (N: 10) as well as how to identify them (N: 8). In contrast, "it is not a medical problem, so it is not part of my job" (P: 14%) and "some children bring this to themselves, I cannot change it" (P: 13%) had the lowest percentages as barriers to child abuse identification (Table 3).

Table 1: Main participants' characteristics

Parameters	Frequency (total: 84)	Percentage (%)
Gender		
Male	48	57.1
Female	36	42.9
Permanent residency		
Rammalha city	40	47.6
Other West Bank cities	44	52.4
Highest academic degree		
Diploma	32	38.1
Bachelor's degree or more	52	61.9
Seniority in the department		
Junior nurse	69	82.1
Senior nurse or head nurse	15	17.9
Previous work in paediatric ward		
Yes	42	50.0
No	42	50.0
Years of experience in nursing (categorical)		
Up to 4 years	41	48.8
More than 4 years	43	51.2

Table 2: Participants' received training, thoughts about clear protocol existence and intention to use referral system

Item	Frequency	Percentage
Received training about child abuse phenomena (child protection)		
Yes	0	0.0
No	84	100.0
Think that there is a clear protocol for child protection		
Yes	10	11.9
No	74	88.1
Intend to use referral system for child protection		
Yes	28	33.3
No	56	66.7

Table 3: Nurses self reported barriers to child abuse identification

Barriers to child abuse identification	Participant responses	Percentage
Child abuse is a problem in the Palestinian society	Do not agree or some time agree	29.8
	Mostly agree or always agree	70.2
I am not trained to deal with the problem of child abuse	Do not agree or some time agree	42.9
	Mostly agree or always agree	57.1
I would like some training about how to identify child abuse cases	Do not agree or some time agree	28.6
	Mostly agree or always agree	71.4
I am concerned about child abuse identification	Do not agree or some time agree	27.4
	Mostly agree or always agree	72.6
I intend to detect child abuse, but have not done so yet	Do not agree or some time agree	46.4
	Mostly agree or always agree	53.6
I do not have time to detect abuse cases	Do not agree or some time agree	46.4
	Mostly agree or always agree	53.6
It is none of my business, it is a private issue	Do not agree or some time agree	75.0
	Mostly agree or always agree	25.0
I believe I may offend my patient or his family if I asked about abuse	Do not agree or some time agree	79.8
	Mostly agree or always agree	20.2
I expect child abuse more in lower socioeconomic family	Do not agree or some time agree	61.9
	Mostly agree or always agree	38.1
Some abuse may be expected in families, I see no reason to interfere	Do not agree or some time agree	69.0
	Mostly agree or always agree	31.0
Even if a patient tells me she/he is abused there is no way to verify it is true	Do not agree or some time agree	70.2
	Mostly agree or always agree	29.8
I feel more qualified to deal with concrete physical problems than psychological issues	Do not agree or some time agree	53.6
	Mostly agree or always agree	46.4
Middle and upper class patients are unlikely to be victims of abuse	Do not agree or some time agree	81.0
	Mostly agree or always agree	19.0
Some children bring this on themselves. I cannot change it	Do not agree or some time agree	86.9
	Mostly agree or always agree	13.1
It is not a medical problem, so it is part of my job	Do not agree or some time agree	85.7
	Mostly agree or always agree	14.3
There are too many other important problems to deal with	Do not agree or some time agree	75.0
	Mostly agree or always agree	25.0

Table 4: Nurses' self reported barriers to child abuse reporting

Barriers to child abuse reporting	Nurses who said yes (%)
Patient family did not want to report	85.7
Afraid of repercussions	78.6
Afraid of disruption of family relationships	77.4
Unaware of laws regarding child protection	77.4
No enough evidences	73.8
Did not want to get involved	73.8
Keeping patient confidentiality	73.8
Person of authority did not want to report	63.1
Fear of intrusion of privacy	63.1
Uncomfortable with the situation	59.5
Someone else already reported	54.8
Did no how	52.4
Time constraints	47.6
Problem not serious enough	32.1

Table 4 shows that the most frequently reported barriers to abuse reporting by nurses were: Patient's family did not want the episode to be recorded (86%), afraid of repercussions or retaliation (79%), afraid of disruption of family relationships (77%), as well as unaware of laws regarding child protection (77%). On the other hand, the least-mentioned barriers were: Time constraints (48%) and problem not being serious enough (32%). For those eight participants who answered the question about other reasons for not reporting child abuse cases, the main reason was: Family does not like to report case (N: 6), followed by there is no effective child protection system in Palestine to follow-up such cases (N: 5) and finally that there are no laws to protect nurses if they report abuse (N: 3). For those answers, more than one nurse gave more than one option.

Nurses characteristic effects: To assess whether there is a difference in nurses' perceptions of child abuse based on certain characteristics among them (including level of education, experience in nursing practice and seniority in the department), Mann-Whitney's non-parametric statistical analysis was used (LoBiondo-Wood and Haber, 2002). Differences in nurses' perceived barriers to child abuse identification based on certain characteristics were also assessed using the Mann-Whitney test. The results indicated that the educational level of nurses significantly affected their responses to two statements: "I expect child abuse more in lower socioeconomic status families" (Sig: 0.46), with which 22% of diploma nurses always agreed but only 12% of those with bachelor's degrees or higher; and "I feel more qualified to deal with concrete physical problems than psychological issues" (Sig: 0.3), with which 31% of diploma nurses always agreed, compared to only 14% of nurses with bachelor's degrees or higher (Table 5).

Experience and seniority in the department's effects on nursing characteristics reflect the same picture, as for

Table 5: Certain participants' characteristics (level of education, experience, seniority in the department) and their self reported barriers to child abuse identification

		Level of education					Nursing experiences					Seniority in the department				
		Diploma		BA or more			Up to 4 years		More than 4 years			Junior nurse		Senior nurse or head nurse		
Barriers to child abuse identification	Participant response	No.	%	No.	%	p-value Mann-whitney	No.	%	No.	%	p-value Mann-whitney	No.	%	No.	%	p-value Mann-whitney
I would like some training about how to identify child abuse cases	Do not agree	5	15.6	7	13.5	0.35	8	19.5	4	9.3	0.02	12	17.4	0	0.0	0.02
	Sometimes agree	4	12.5	8	15.4		7	17.1	5	11.6		10	14.5	2	13.3	
	Mostly agree	3	9.4	13	25.0		10	24.4	6	14.0		15	21.7	1	6.7	
	Always agree	20	62.5	24	46.2		16	39.0	28	65.1		32	46.4	12	80.0	
I am concerned about child abuse identification	Do not agree	2	6.2	3	5.8	0.40	4	9.8	1	2.3	0.03	5	7.2	0	0.0	0.03
	Sometimes agree	7	21.9	11	21.2		10	24.4	8	18.6		16	23.2	2	13.3	
	Mostly agree	3	9.4	13	25.0		10	24.4	6	14.0		15	21.7	1	6.7	
	Always agree	20	62.5	25	48.1		17	41.5	28	65.1		33	47.8	12	80.0	
I expect child abuse more in lower socioeconomic status families	Do not agree	8	25.0	23	44.2	0.046	13	31.7	18	41.9	0.16	23	33.3	8	53.3	0.31
	Sometimes agree	8	25.0	13	25.0		9	22.0	12	27.9		19	27.5	2	13.3	
	Mostly agree	9	28.1	10	19.2		11	26.8	8	18.6		16	23.2	3	20.0	
	Always agree	7	21.9	6	11.5		8	19.5	5	11.6		11	15.9	2	13.3	
I feel more qualified to deal with concrete physical problems than psychological issues	Do not agree	5	15.6	16	30.8	0.03	14	34.1	7	16.3	0.04	18	26.1	3	20.0	0.63
	Sometimes agree	8	25.0	16	30.8		13	31.7	11	25.6		20	29.0	4	26.7	
	Mostly agree	9	28.1	13	25.0		7	17.1	15	34.9		17	24.6	5	33.3	
	Always agree	10	31.2	7	13.5		7	17.1	10	23.3		14	20.3	3	20.0	
	Sometimes agree	7	21.9	9	17.3		10	24.4	6	14.0		16	23.2	0	0.0	
	Mostly agree	3	9.4	6	11.5		4	9.8	5	11.6		8	11.6	1	6.7	
	Always agree	5	15.6	7	13.5		4	9.8	8	18.6		10	14.5	2	13.3	

the following statements: "I would like some training about how to identify child abuse cases" (Sig: 02) and "I am concerned about child abuse identification" (Sig: 03). Nurses with more than four years of experience and seniority in the department more frequently always agreed that they would like some training about child abuse identification (up to four years' experience with 39%, more than four years' experience with 65% and junior nurses' 46% against senior or head nurses' 80%) and more frequently always agreed that they are concerned about abuse identification (up to four years' experience 42%, against more than four years' experience 65% and junior nurses' 48% against senior or head nurses' 80%). In addition, there is a significant effect of nurses' experience on "I feel more qualified to deal with concrete physical problems than psychological issues" (Sig: 04), as 17% of nurses with up to four years' experience always agreed with this statement, compared to 23% of those with more than four years of experience (Table 5).

DISCUSSION

Due to the nature and sensitivity of child abuse, doing research on this topic is challenging. To our knowledge, this is one of the rare studies that were conducted in Palestine about barriers to child abuse identification and reporting. The findings of our research are consistent with the results of most previous studies, concluding that there is a problem not only in identifying but also reporting child abuse (Chihak, 2009; Fraser *et al*., 2010; Keane and Chapman, 2008; Lee and Hoaken, 2007; Starling *et al*., 2009). However, these problems seem relatively more significant in Palestine. It was clear that the process of identification and reporting the abuse cases was very weak.

Internationally, the impacts of both cultural and child protection systems on child abuse detection and reporting has been demonstrated (Elbedour *et al*., 2006; Jena, 2013; Yonaka *et al*., 2007). In Palestine, Halileh and Abdullah (2009) investigated the available services for abused children. They randomly interviewed 62 institutions from different health sectors that dealt with child abuse cases. It was found that the main challenges to effective child protection services were sociocultural issues, training and funding (Halileh and Abdullah, 2009).

Several studies indicated that nurses' willingness to identify and report child abuse is affected by cultural norms (Feng and Levine, 2005; Gilbert *et al*., 2009). This is in agreement with our findings. The nurses' perceptions seemed to be influenced by some cultural and religious issues. The Palestinian community is mainly composed of Muslims and Christians. Leininger and McFarland (2002) and Halligan (2006) were aware of the role of religion and culture in shaping the worldviews of Arab Muslim people. Respecting the wishes of elders and implementing their orders is considered sacrosanct in Arab culture, particularly with regard to parents. Similarly, students are requested to respect their teachers to the maximum extent; a common proverb reflecting this attitude in Palestine is "I will be a slave for whoever teaches me a letter". Moreover, with regard to harsh verbal or physical chastisement, parents and teachers often feel that they are implementing a necessary abuse for the long-term benefit of children in their care, which might explain why children and society generally often do not consider such behaviour to be or report it as abuse. In short, some kinds of abuse might be socially acceptable in Palestine and nurses may feel sympathy with family members or teachers when they are the source of abuse. This may explain the finding that 80% of the nurses feared disruption in family relationships if they reported abuse.

Corroborating the tendency to overlook abuse in Palestinian society, Khamis (2000) and Elbedour *et al*. (2006) also observed that it is particularly notable that sexual abuse cases in particular are hidden. Family members might see this abuse as a stigma with negative impacts on the family and wider group reputation. Family is the basic unit of Palestinian society; this explains why 86% of the nurses in the current study expected that patients' families did not want the episode to be recorded.

In times of crisis or challenging events such as health emergencies, families draw together for mutual support in Palestine and the importance of the family/group identity is a defining characteristic of Arab culture generally, in contrast with Western culture, in which individual identity has relatively more importance (Al-Hassan and Hweidi, 2004). In extended family units, elderly people are highly appreciated; a strong relationship between family members exists and providing support to ill members of the family is highly encouraged (Al-Hassan and Hweidi, 2004). This may add more pressure to nurses when they receive abuse cases. This may also explain the fear of more than two-thirds of the nurses feared repercussions or retaliation in case of reporting these incidences.

Halileh and Abdullah (2009) examined the services available for abused and neglected children in Palestine. The absence of clear regulations and accreditations to deal with child abuse cases formed the main barrier to adequate service delivery. This is in agreement with our findings, which concluded that that there was no policy to identify and report child abuse incidences. Several authors explained that there is a relationship between the political factors and the political environment in one arena and the welfare status of population in that arena

(Espelt *et al*., 2008; Parton, 2011). Parton (2011) explained that achieving the required level of child protection needs political will to prioritise family and child wellbeing and to frequently evaluate child protection programs and services. The absence of assertive law and regulations participated in reducing the identification and reporting of child abuse. There is a need for a specific law that protects children from being exposed to violence.

Economic factors play an essential role in the quality of healthcare systems (Bambra *et al*., 2005) and this factor was viewed as one of the main reasons for the inequality in health and welfare status between and within countries (Bambra *et al*., 2005; Smith *et al*., 2002). The economic status of people is a major determinant of health and illness, including housing, income and employment (Bambra *et al*., 2005). Halileh and Abdullah (2009) explained that health services in Palestine were funded by and dependent on foreign aid. Poor economic status resulted in lack of training and educational courses on child abuse identification and reporting. This may also be a significant reason behind the absence of a computerised system to organize dealing with these cases. The lack of computerisation and staff shortages makes the assessment of dates and reasons for children's previous attendances to the healthcare institution more difficult. This inhibits the ability of Palestinian healthcare systems to discover child abuse cases. Dependence on foreign aid also contributes to the presence of health programs that meet the objectives of donors and not necessarily the needs of the local community. Essentially, priority is given to physiological needs and emergency assistance related to the Israeli Occupation; this partly explains why more than half of the surveyed nurses indicated that they have no time to assess potential abuse cases.

It was clear that the nursing characteristics have a significant impact on the identification and reporting the child abuse cases. In the level of educational characteristic for example, 22% of diploma nurses always agreed with statement: "I expect child abuse more in lower socioeconomic status families" while only 12% of those with bachelor's or more always agreed with it (Sig: 0.46). Moreover, nurses with more than four years' of experience and seniority in the department are more frequently always agreed that they would like some training about child abuse identification. These factors were raised in some previous studies (Flaherty *et al*., 2006; Lagerberg, 2001). All these studies agreed with the importance of these characteristics in the process of child abuse identification and reporting.

CONCLUSION

This study was conducted in one of the major hospitals in Palestine, to which patients from all over Palestine are referred for treatment. More than half of the study participants were from different cities in the West Bank. This makes this study important in terms of uncovering the reasons behind current nursing practice and low rates of child abuse identification and reporting. This study provides important information about the factors that prevent nurses from reporting child abuse incidences. This information is important for nursing managers and policy makers who are interested in child abuse phenomena, as it enables them to understand the situation on the ground and hopefully work in future to overcome these barriers. Despite the need for more studies in this field, this study has implications on developing child abuse detection and reporting policies and might participate in improving nurses' practice (mainly in identification and reporting).

This study contributes to answering the question about barriers to child abuse identification and reporting. However, there is a need for more detailed investigation about this topic that includes (beside the governmental sector) the private and non-governmental sector. There is a need to conduct more research that involves nurses who work in the primary and tertiary health services. Moreover, it is important to further investigate the factors that impeded nursing practice toward child abuse detection, reporting and referral, including child protection systems (laws, protocols, resources, training), context (culture) and nurses' characteristics (decision making, experience, education).

ACKNOWLEDGMENT

We are very grateful to all those who took the time to participate in this study.

REFERENCES

Adams, C.M., 2006. The consequences of witnessing family violence on children and implications for family counselors. Family J., 14: 334-341.

Al-Hassan, M.A. and I.M. Hweidi, 2004. The perceived needs of Jordanian families of hospitalized, critically ill patients. Int. J. Nursing Pract., 10: 64-71.

Bambra, C., D. Fox and A. Scott-Samuel, 2005. Towards a politics of health. Health Promot. Int., 20: 187-193.

Bannon, M.J. and Y.H. Carter, 2003. Paediatricians and child protection: The need for effective education and training. Arch. Dis. Childhood, 88: 560-562.

Chanmugam, A., 2009. A qualitative study of school social workers' clinical and professional relationships when reporting child maltreatment. Children Schools, 31: 145-161.

Chavis, A., J. Hudnut-Beumler, M.W. Webb, J.A. Neely, L. Bickman, M.S. Dietrich and S.J. Scholer, 2013. A brief intervention affects parents' attitudes toward using less physical punishment. Child Abuse Neglect, 37: 1192-1201.

Chihak, A., 2009. The nurse's role in suspected child abuse. Paediatrics Child Health, 19: S211-S213.

Coope, C.M. and S. Theobald, 2006. Children at risk of neglect: Challenges faced by child protection practitioners in Guatemala City. Child Abuse Neglect, 30: 523-536.

Coughlan, M., P. Cronin and F. Ryan, 2007. Step-by-step guide to critiquing research. Part 1: Quantitative research. Br. J. Nurs., 16: 658-663.

Elbedour, S., S. Abu-Bader, A.J. Onwuegbuzie, A. Abu-Rabia and S. El-Aassam, 2006. The scope of sexual, physical and psychological abuse in a Bedouin-Arab community of female adolescents: The interplay of racism, urbanization, polygamy, family honor and the social marginalization of women. Child Abuse Neglect, 30: 215-229.

Espelt, A., C. Borrell, M. Rodriguez-Sanz, C. Muntaner and M.I. Pasarin *et al*., 2008. Inequalities in health by social class dimensions in European countries of different political traditions. Int. J. Epidemiol., 37: 1095-1105.

Feng, J.Y. and M. Levine, 2005. Factors associated with nurses' intention to report child abuse: A national survey of Taiwanese nurses. Child Abuse Neglect, 29: 783-795.

Feng, J.Y., S. Fetzer, Y.W. Chen, L. Yeh and M.C. Huang, 2010. Multidisciplinary collaboration reporting child abuse: A grounded theory study. Int. J. Nurs. Stud., 47: 1483-1490.

Flaherty, E.G., R. Sege, H.J. Binns, C.L. Mattson and K. Christoffel, 2000. Health care providers' experience reporting child abuse in the primary care setting. Arch. Pediatrics Adolescent Med., 154: 489-493.

Flaherty, E.G., R. Sege, L.L. Price, K.K. Christoffel, D.P. Norton and K.G. O'Connor, 2006. Pediatrician characteristics associated with child abuse identification and reporting: Results from a national survey of pediatricians. Child Maltreatment, 11: 361-369.

Fraser, J.A., B. Mathews, K. Walsh, L. Chen and M. Dunne, 2010. Factors influencing child abuse and neglect recognition and reporting by nurses: A multivariate analysis. Int. J. Nurs. Stud., 47: 146-153.

Gilbert, R., A. Kemp, J. Thoburn, P. Sidebotham, L. Radford, D. Glaser and H.L. MacMillan, 2009. Recognising and responding to child maltreatment. Lancet, 373: 167-180.

Halileh, S. and A. Abdullah, 2009. Child abuse and neglect services in the occupied Palestinian territory. Eastern Mediterr. Health J., 15: 1504-1512.

Halileh, S., A. Abdullah and S. Narrainen, 2007. Child abuse and neglect in the West Bank: Training, perception and management of cases among Palestinian physicians. Institute of Community and Public Health, Birzeit University.

Halligan, P., 2006. Caring for patients of Islamic denomination: Critical care nurses' experiences in Saudi Arabia. J. Clin. Nurs., 15: 1565-1573.

Jena, P.P., 2013. Sniff of child abuse: Need for precautionary strategies of society and school. Asian J. Multidisciplin. Stud., 1: 55-66.

Keane, C. and R. Chapman, 2008. Evaluating nurses' knowledge and skills in the detection of child abuse in the Emergency Department Int. Emerg. Nursing, 16: 5-13.

Khamis, V., 2000. Child psychological maltreatment in Palestinian families. Child Abuse Neglect, 24: 1047-1059.

Kinard, E.M., 1994. Methodological issues and practical problems in conducting research on maltreated children. Child Abuse Neglect, 18: 645-656.

Kirkpatrick, L. and B. Feeney, 2008. A Simple Guide to SPSS: for Version 16. 9th Edn., Cengage Learning, Belmont, USA., ISBN: 9780495597667, Pages: 128.

Lagerberg, D., 2001. A descriptive survey of Swedish child health nurses' awareness of abuse and neglect. I. Characteristics of the nurses. Child Abuse Neglect, 25: 1583-1601.

Lazenbatt, A. and R. Freeman, 2006. Recognizing and reporting child physical abuse: A survey of primary healthcare professionals. J. Adv. Nurs., 56: 227-236.

Lee, V. and P.N.S. Hoaken, 2007. Cognition, emotion and neurobiological development: Mediating the relation between maltreatment and aggression. Child Maltreatment, 12: 281-298.

Leininger, M. and M. McFarland, 2002. Transcultural Nursing: Concepts, Theories, Research and Practice. 3rd Edn., McGraw-Hill Companies, Inc., New York, ISBN-13: 978-0071353977, Pages: 621.

LoBiondo-Wood, G. and J. Haber, 2002. Nursing Research: Methods, Critical Appraisal and Utilization. 5th Edn., Mosby, Philadelphia, ISBN: 9780323012874, Pages: 520.

May-Chahal, C. and P. Cawson, 2005. Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect. Child Abuse Neglect, 29: 969-984.

Nayda, R., 2004. Registered nurses' communication about abused children: Rules, responsibilities and resistance. Child Abuse Rev., 13: 188-199.

PCBoS, 2005. Child statistics series. Palestinian Central Bureau of Statistics.

Paavilainen, E. and M.T. Tarkka, 2003. Definition and identification of child abuse by Finnish public health nurses. Public Health Nurs., 20: 49-55.

Pabis, M., I. Wronska, B. Slusarska and T. Cuber, 2011. Paediatric nurses' identification of violence against children. J. Adv. Nurs., 67: 384-393.

Parton, N., 2011. Child protection and safeguarding in England: Changing and competing conceptions of risk and their implications for social work. Br. J. Soc. Work, 41: 854-875.

Paxson, C. and R. Haskins, 2009. Introducing the issue. Future Children, 19: 3-17.

Peat, J., 2001. Health Science Research: A Handbook of Quantitative Methods. Sage Publication, USA., ISBN: 9781446233917, Pages: 328.

Peckover, S., S. Smith and F. Wondergem, 2013. Doing serious case reviews: The views and experiences of NHS named and designated safeguarding children professionals. Child Abuse Rev. (In Press). 10.1002/car.2301

Piltz, A. and T. Wachtel, 2009. Barriers that inhibit nurses reporting suspected cases of child abuse and neglect. Aust. J. Adv. Nurs., 26: 93-100.

Polit, D. and C. Beck, 2010. Essentials of Nursing Research: Appraising Evidence for Nursing Practice. 7th Edn., Lippincott Williams and Wilkins, China, ISBN: 9781609130046, Pages: 610.

Reid, B. and A. Long, 2002. Suspected child abuse: Communicating with a child and her mother. J. Pediatric Nurs., 17: 229-235.

Reijneveld, S.A., G. de Meer, C.H. Wiefferink and M.R. Crone, 2008. Detection of child abuse by Dutch preventive child-healthcare doctors and nurses: Has it changed? Child Abuse Neglect, 32: 831-837.

Sidebotham, P., T. Biu and L. Goldsworthy, 2007. Child protection procedures in emergency departments. Emergency Med. J., 24: 831-835.

Smith, G.D., D. Dorling, R. Mitchell and M. Shaw, 2002. Health inequalities in Britain: Continuing increases up to the end of the 20th century. J. Epidemiol. Community Health, 56: 434-435.

Smith, J., S. Rainey, K. Smith, G. Alamares and D. Grogg, 2008. Barriers to the mandatory reporting of domestic violence encountered by nursing professionals. J. Trauma Nurs., 15: 9-11.

Starling, S.P., K.W. Heisler, J.F. Paulson and E. Youmans, 2009. Child abuse training and knowledge: A national survey of emergency medicine, family medicine and pediatric residents and program directors. Pediatrics, 123: e595-e602.

WHO, 2013. European Report on Preventing Child Maltreatment. World Health Organization, Regional Office for Europe, Copenhagen, Denmark, ISBN-13: 9789289000284, Pages: 124.

Yang, S., 2009. Cane of love: Parental attitudes towards corporal punishment in Korea. Br. J. Soc. Work, 39: 1540-1555.

Yonaka, L., M.K. Yoder, J.B. Darrow and J.P. Sherck, 2007. Barriers to screening for domestic violence in the emergency department. J. Continuing Educ. Nurs., 38: 37-45.