**Title:** Navigating and negotiating meanings of child abuse and neglect: sociocultural contexts shaping Australian nurses' perceptions

**Abstract**

Nurses who work with children have the opportunity to make a difference by identifying and responding to child abuse and neglect. Little is known about the ways that nurses define, assess and respond to child abuse and neglect and how this subsequently affects children. This paper reports one of four themes identified through inductive analysis of a qualitative study exploring nurses' perceptions and experiences of keeping children safe from abuse and neglect. The aim of this paper is to report on how nurses understand and interpret child abuse, is found to be shaped by their own sociocultural contexts. A qualitative research design underpinned by social constructionism framed the study. Data was collected in 2016 and 2017 through 21 in-depth, semi-structured interviews with nurses who work with children in Australia. Key findings showed that nurses working with children had difficulty defining child abuse and drew upon multiple sources to construct a working definition. In addition to drawing from official legislation and

guidelines, nurses compared and contrasted the level of abuse with their own personal and professional experiences of parenting. Nurses described the challenges of making assessments when faced with cultural practices different from their own. Nurses' descriptions of how they defined abuse showed that their assessments of child abuse and neglect were inextricably linked to their personal values and beliefs. As such, nurses were often working from their own value systems rather than consistently taking a child-focussed approach. There was an absence of consistent and explicit critical reflection on ways that values and beliefs might shape practice at individual and system levels. We propose this is a missing aspect of child safe practice. Reflection on how personal and professional values and beliefs interact with the implementation of evidence-informed approaches will increase nurses' capacity to maintain a child-focus.

**What is known about this topic**

- Child abuse and neglect is a global public health concern causing significant harm to children.
- Nurses working with children have a role to play in identifying and responding to abuse and neglect.

- There is limited evidence around what influences nurses' assessment and subsequent responses to abuse.

**What this paper adds**

- Nurses' understandings of child abuse and neglect were linked to their sociocultural contexts, including professional experience and personal views.
- There was inconsistent evidence that nurses explicitly reflected on how their backgrounds might shape their interpretations of abuse.
- Nurses need to incorporate critical reflection into practice to effectively respond to children experiencing abuse or neglect.

**Keywords**:

Child abuse, violence, nurses, parenting, qualitative research, culture, child.

## INTRODUCTION

Child abuse and neglect impacts large numbers of children globally, but the precise number of affected children remains unknown (World Health Organisation, 2016). Child abuse can include physical, sexual, emotional abuse and neglect, with many children experiencing multiple forms of abuse (van Scoyoc, Wilen, Daderko, & Miyamoto,

2015). Nurses, especially those working with children, have numerous roles in keeping children safe; including prevention, early intervention and addressing the physical and psychosocial needs of children who have been abused (Lines, Grant, & Hutton, 2018). In paediatric and child health settings, nurses address abuse and neglect directly through their practice with children and families, as well as indirectly through referrals to child protection services.

In paediatric and child health settings, nurses have daily contact with children and thus need knowledge and skills to identify and respond to child abuse. In some settings such as emergency departments, nurses use formalised assessment tools including screening guidelines to assess suspicious physical injuries (Escobar et al., 2016). However, in paediatric and community child health settings, nurses are reliant on clinical judgements to form a suspicion whether child abuse may be occurring and decide whether they should refer to child protection authorities (Dahlbo, Jakobsson, & Lundqvist, 2017; Saltmarsh & Wilson, 2016). There is limited existing research that explicitly explores nurses' decision-making processes in relation to child abuse and neglect, but it is known that in neonatal, school and public health settings

nurses believe their initial suspicion is based upon a 'gut feeling' or 'intuition' (Kraft & Eriksson, 2015; Saltmarsh & Wilson, 2016; Schols, de Ruiter, & Ory, 2013). These feelings could be because signs of abuse are often insidious and inconclusive, and when nurses feel unsure they are less likely to report abuse (Svard, 2016). Nurses consider multiple information sources when assessing for abuse, but not all factors are considered equally. For example, Appleton, Harris, Oates, and Kelly (2013) found health visitors in the United Kingdom focussed more on maternal factors than the baby's behaviour and concluded that health visitors' assessments needed to place a more explicit focus on the child. It is important to understand what factors influence nurses' assessments of child abuse and neglect to recognise how this subsequently affects children experiencing abuse.

**Aim**

This paper reports on one of four themes from a larger qualitative study that explored the question: 'what are nurses' perceptions and experiences of keeping children safe from abuse and neglect?' It was intended the findings would provide an insight into nurses' understandings of child abuse and inform how the nursing workforce can be

mobilised and supported to respond to children experiencing abuse. This study identified four themes (numbered for clarity) through an inductive analysis and are 1) contextualising and defining child abuse, 2) nurse relational skills in addressing child abuse, 3) nurse experiences of communicating concerns of child abuse and 4) nurse perceptions of how systems and hierarchies shape their responses to abuse. The aim of this paper is to report on the first theme which outlines how nurses interpreted child abuse and neglect within their sociocultural contexts. The three key subthemes within this paper are: abuse is difficult to 'just define', navigating personal and professional views of parenting and negotiating a range of cultural values and practices. A summary of the four broad themes, the theme addressed in this manuscript and its subthemes are outlined in Figure 1.

## METHODS

### Framework

The research design was guided by a social constructionist approach which recognises knowledge and social practices as based within sociocultural contexts and often unquestioningly replicated and maintained (Burr, 2015).

This sociocultural context is particularly evident in child abuse and neglect because acceptable childrearing practices vary dramatically across social and historical contexts. For example, contemporary western views have changed from accepting corporal punishment as an 'important disciplinary tool' to the classification of these behaviours as assault (Montgomery, 2013). This approach means that the ways nurses keep children safe can be understood as culturally situated and reinforced through everyday practices. As researchers, we ourselves recognised the ways we 'know' about the world stem from our own backgrounds and cultural values that are produced by our social environment (Berger & Luckman, 1972). Consequently, the researchers acknowledge that their clinical backgrounds including paediatric nursing (all authors) and child health nursing (XX) will have influenced interpretation of the data.

**Design**

Data was collected through semi-structured, in-depth interviews with nurses who worked with children in Australia. Participants were recruited by purposive sampling through advertisements published by professional organisations relevant to nursing. Although

all nurses in Australia have an ethical and legal responsibility to respond to suspected child abuse, this study only included nurses who worked directly with children because they had frequent encounters with child abuse.

**Ethics**

This study was given ethical approval by redacted for peer review (no. XXXX). All participants were given information about their rights and provided written consent.

**Data collection**

The first author collected data through semi-structured, in-depth interviews (60 to 90 minutes long). Interviews were face-to-face (n=15), by telephone (n=5), or Skype (n=2) depending on participant location and preferences from August 2016 to August 2017. An interview guide (Table 1) was developed based on a review of the literature (redacted for peer review), but not pilot tested because it was intended as a general guide only. Preliminary analysis and reflections on the interview process meant the interviewer individualised questions to suit each partipant's context but the interview guide was not changed. Data saturation started at interview 17, but an additional five booked interviews were conducted

because the researchers became aware that nurses' experiences were context specific. These additional five interviews provided more nuanced data.

Interviews were audio recorded and transcribed by the primary researcher (n=13) or a professional transcriber (n=9). Participants could review and modify their de-identified transcripts; n=17 made no changes, n=4 made minor changes and n=1 chose to withdraw their transcript. The reason for withdrawal was the participant's concern they had not formally sought their employer's permission to participate.

**Data analysis**

Transcriptions were read and re-read by the first author before being coded inductively using NVivo software. Coding started with descriptive codes, but process and holistic codes (Saldana, 2016) were used later to better represent the data's complexity and nuances. Over time, the analysis produced a large number of codes (n=563) which were printed and displayed on poster paper to facilitate simultaneous visualisation (Gibbs, 2014). Similar codes were subsumed into single codes and arranged according to content until four clear themes were evident.

The researchers met regularly during data analysis to ensure codes and themes were confirmable and representative. Supplementary file 1 outlines some examples of initial coding and how they formed the final codes. Following a framework of social constructionism, we acknowledge that codes, themes and subsequent findings arise from our interpretations of the data which are linked to our own sociocultural contexts. This understanding of researchers' backgrounds as intrinsically linked to the findings is based on the premise that objectivity is impossible because researchers explore phenomena using particular perspectives, and it is not possible to 'step outside' of social backgrounds when conducting research (Burr, 2015).

## FINDINGS

### Demographics

Twenty-one interviews were included in this study. Participants were all female and typically very experienced clinicians (from 10 and 40 years). All worked with children at the time of recruitment. Most participants practiced in metropolitan areas (n=18 metro, n=3 rural/remote), predominantly in the state of South Australia (n=19), but also in Queensland (n=1) and Victoria (n=1). Overall, 10

nurses worked in child and family health (CH), seven in paediatrics (P), two in both paediatrics and child health (P&CH) and the remaining two in community roles (C). In Australia, the role of a child and family health nurse is equivalent to that of a health visitor in the United Kingdom, whereas a paediatric nurse generally practices in acute care settings. Community nurses do not have a consistent nation-wide role, but community nurse participants worked for community-based, non-government organisations.

**Key finding 1: Abuse is difficult to '*just define*'**

In Australia, there is no national definition of abuse and neglect as these are specific to each jurisdiction. Even nurses from the same legislative jurisdictions had different ways of defining abuse which varied from personal views, through to definitions that made links to guidelines and policies. For example, when asked to define abuse and neglect, Participant 1 (C) responded: '*that's quite a difficult question to just define…'* and explained *'[child protection service] do have some guidelines… which I don't just happen to be able to reel off the top of my head*' while also acknowledging: '*it would depend on the situation…'* Other participants (n=2) referred to Children's Rights, with

Participant 3 (CH) outlining how children's human rights could be applied to abuse and neglect: '*you have a right to live in an environment that is free from violence and… supports your health and wellbeing.*' Similarly, some participants referred to research evidence, such as Participant 5 (P&CH) who discussed harms of domestic violence on children: *'they [parents] say they only argue… or fight when the child's not there. Well, we know from research… that there's still a huge impact on children.'* In this way, nurses drew upon a variety of sources including law, clinical guidelines, Children's Rights and research findings to try to explain abuse, but no participant clearly and succinctly defined abuse and neglect.

In other situations, participant definitions did not have a clear evidence base. For example, when asked to define child abuse, Participant 18 (P) initially explained that physical abuse was the only type of abuse that '*you could put in a neat box*.' On further exploration, Participant 18 (P) elaborated that physical abuse could be contentious: '*it does come down to your beliefs*… *some people think a smack is abuse and that's okay for them to believe that.*' Similarly, Participant 2 (P) acknowledged the diversity of parenting practices, but explained she had clear

boundaries between acceptable and abusive parenting behaviours: '*outright screaming at your child… that's not appropriate in any parenting style'*. The examples illustrate that these nurses had difficultly concisely defining abuse and neglect, and instead attempted to do so using existing ideas, beliefs and preconceptions.

Defining abuse and neglect was reported to be a balancing act because there is no perfect environment for a child. Instead, defining abuse was explained as making a professional judgement around whether parenting was '*good enough'* (P 5, 15 & 20). For example, Participant 19 (CH) recalled a home that was '*pretty messy,'* but explained she did not consider the situation to be neglect because the children were well cared for and '*there's risks in every household.'* Similarly, Participant 22 (CH) explained that nursing assessments need to recognise that it is not possible for parents to respond to *all* of their child's needs: '*it's being responsive to that child and it doesn't have to be 100 per cent of the time because that's actually not realistic.'* In the emergency setting, Participant 21 (P) described how she encountered children following accidental injury and that was difficult to determine to what extent parents were culpable, because:

'*any accident with a child is in hindsight preventable…'* but acknowledged that families' decisions may not have the same priorities as health professionals. In this way, determinations of neglect were always '*subjective'* (P 21, P) because they depended upon professionals' interpretations.

Nurses indicated they often encountered ambiguous signs and it was difficult to build upon their suspicions. When this occurred, 14 of the 21 nurses explained they brought their focus back to the child. These nurses explicitly articulated a child-centred approach to defining abuse and neglect, *'It's about having the child at the centre… when we talk about incidents [of abuse], what's that like for the child*? *How have they experienced that?'* (P 1, C). Similarly, Participant 20 (CH) outlined how she would contextualise different parenting practices by looking at the bigger picture of a child's experience and consider: *'Is that baby being loved and… nurtured?'* However, this practice of defining abuse by whether the child is loved could be used to discount children's experiences of abuse within loving families. Thus, nurses found that even when putting the child first, there was still the need to use professional judgement to contextualise their observations. For

example, Participant 5 (CH&P) explained that in some families, a child might be loved but could still be in a situation of abuse: *'I have seen families where the parents do love the child but they are still abusive or neglectful'* (P 5, CH&P).

When contextualising ambiguous signs of abuse, nurses believed it required ongoing observation to piece together the details. Suspicions of abuse were considered to start with an intuition, with Participant 15 (CH) explaining: '*you can't actually put your finger on it, something just doesn't add up*.' Often, this came down to nurses' previous experiences which taught them: *'sometimes everything can look fine… but there's just something that you know isn't quite right'* (P 4, P). For example, in hospital settings, paediatric nurses drew upon their clinical knowledge and experience of 'normal' to detect things out of the ordinary: '*something wasn't quite right with her [the baby]. She was really, really sick for a [baby with] pertussis… she was having brachycardias and apnoeas even without coughs, so we got a bit concerned.*' (P 13, P). This example shows how Participant 13 used her clinical knowledge of pertussis to identify this baby was showing unusual signs, which were later attributed to illicit drug

exposure. Even though nurses might have suspicions based on previous experiences, they equally outlined the importance of avoiding: '*jump[ing] to conclusions'* (P 5, CH&P) before conducting a full assessment. For example, nurses believed children's behaviours might be indicators of abuse, but observations on a single occasion may not reflect usual behaviour: '*a one-off day… that baby doesn't want to be held by its mother at all, is not necessarily saying something's terribly wrong, they [baby] might be sick…*' (P 11, CH).

In summary, the first key finding showed that in the absence of a single set of unifying guidelines, nurses drew upon a variety of sources to construct working definitions of child abuse and neglect. Because nurses constructed their definitions from multiple places, interpretations of child abuse and neglect differed according to individual nurses and their social contexts.

**Key finding 2: Navigating personal and professional views of parenting**

In addition to drawing upon local policies, legislation and research, nurses' constructions of abuse were influenced by their own experiences, values and beliefs as they

compared and contrasted situations with past experiences. Just over half of participants were cognisant of how their personal characteristics influenced their practice and openly reflected on this during the interviews. For example, Participant 4 (P) was aware her views on children's body piercings were not mainstream: '*piercing a child's ears… I hate to see that because… that child's not made that decision. You've inflicted that pain on them and it's cosmetic and it's for your benefit, not the child's.*' Although Participant 4 (P) personally disagreed with children's body piercings, other nurses' personal experiences meant they had different things they were uncomfortable with, such as the presence of pets around young children (P 19 & 22), standards of household hygiene (P 20) and physical discipline (P 2 & 11). For example, Participant 19 (CH) was '*a bit cautious of dogs'* and thus saw it essential to keep children separate from one family's outdoor dog.

In attempting to manage their personal views, nurses outlined the importance of putting their values: '*to one side'* (P 22, CH) when working with families, recognising there are many different ways to parent. Participant 18 (P) expressed the tension inherent in attempting to

compartmentalise one's values and beliefs: '*we're taught not to put our values… on people… but we have to use our own values in order to decipher what's happening*.' Although nurses had their own standards of ideal parenting, they saw how inequity might prevent all parents from achieving this perceived optimal standard. Participant 17 (CH&P) explained: *'it's about thinking… this is what I have to support me in my parenting quest but what does this family have to support them?'* In this way, Participant 17 recognised that expecting the same standard of parenting from all families with vastly different access to support and resources was unrealistic. Nurses conceded that although a child's situation may not be optimal, it might not be reasonable to expect more given parents' personal, social and environmental circumstances. Although all nurses wanted to improve children's situations, they frequently felt limited in what they could do due to lack of resources and/or perceived inaction from child protection services. Instead, nurses recognised that their standards around what is best for children would shift due to continued exposure: '*it's almost like your tolerance for what you felt was okay actually had to go up…'* (P 22, CH). Through this desensitisation process, nurses reconstructed their

definitions of abuse and needs of children were perceived less acutely over time.

In many instances, participants expressed awareness that their personal views influenced practice, but then did not appear aware of how these views intersected with their assessments of abuse. This was illustrated in two nurses' explanations of what constitutes neglect, in which their views reflected values and beliefs about children's needs that were specific to their time and cultural context. For example, Participant 22 (CH) discussed the importance of childhood immunisation in the context of a family's transient accommodation and inadequate health records: '*we don't know whether the baby is even immunised, so this basic… needs of a baby.*' This quote demonstrates Participant 22's professional view of immunisations as essential for maintaining a child's health. Similarly, Participant 14 (CH) had expectations about appropriate supervision for children as she described her experiences in a remote Aboriginal community: *'you'll see a two-year-old running around and think 'who's actually minding her' and then [community members] say 'well, no, no we are' or 'no, no nana's over there or someone's over there' so kind of broadly being watched but not enough.'* These

examples show that an awareness of personal values and beliefs may not translate to understanding how values and beliefs shape practice.

**Key finding 3: Negotiating a range of cultural values and practices**

Recognising abuse and neglect was particularly challenging when nurses worked with families who were culturally different from themselves. Families who were culturally different often had parenting practices which did not necessarily conform to nurses' own beliefs about parenting. For example, some families had different views and practices relating to physical discipline and infant bed-sharing.

The challenge of defining child abuse within varying cultural contexts was apparent in nurses' attempts to explain what might be considered 'culturally acceptable' parenting practices in Australia. For example some nurses (n=5) discussed actions they deemed culturally acceptable by contrasting them with 'Australian' cultural values. When discussing their experiences working with families from different cultural backgrounds, P3 (CH) said: '*It doesn't matter whether it's culturally acceptable to smack*

*a child in another country, it's not culturally acceptable to do it here*.' There was significant variation in participants' views on the appropriateness of physical discipline, ranging from those who were completely against physical discipline (P 2, 3, 11), to those who felt that mild physical discipline might be warranted in certain situations (P 9, 18). Only one participant (P 22, CH) explicitly referred to research evidence when discussing their view on the acceptability of physical discipline. Subsequently, basing assessments of abuse and neglect on what each nurse deems 'culturally acceptable' is likely to be highly variable, and may not be based on research evidence around the impacts of physical discipline.

Co-sleeping was another contentious area for participants because of nurses' awareness of the role of co-sleeping in Sudden Infant Death Syndrome. Participants used the term 'co-sleeping' as synonymous with 'bed-sharing' in line with the language of local guidelines (for example South Australia Health, 2016). Several nurses (n=6) discussed their concerns around co-sleeping, often explicitly referring to their local infant safe sleep guidelines. As with physical discipline, nurses had different views on co-sleeping, and whether it was an acceptable

cultural practice. For example, Participant 8 (C) disputed co-sleeping as a cultural practice: [people say] *''oh it's cultural to co-sleep' but it's not.'* Conversely, Participant 14 (CH) worked closely with Aboriginal families and empathised with their reasons for co-sleeping: '*I think they [mothers] do that [co-sleep] because they know where the kids are at night, they keep them safe.'* However, regardless of nurses' personal views around co-sleeping, Participant 1 (C) recognised that the guidelines are not law, so parents are free to disregard them: '*they're really a guideline… it's not the law that you can't co-sleep*' (P 1, C). When parents did choose to co-sleep, it came down to professional judgement around whether the nurse should notify child protection services: 'if *I've given [a] parent that advice and they still chose to co-sleep then that mixed with some other risks… may be enough to make a notification but… that's a really blurry line coz lots of parents co-sleep and they're never notified about*.' (P 1, C). In this way, cultural practices that are not consistent with local guidelines can lead to nurses' constructing certain cultural practices as child abuse and led to ambiguity around appropriate actions.

**DISCUSSION**

This paper reports on how nurses navigate definitions of child abuse and neglect which are constantly being constructed and reconstructed both culturally and temporally. This is core to nurses' experiences of addressing abuse and neglect. In the absence of guidelines that could apply to all possible scenarios and sociocultural contexts, nurses drew upon multiple factors including official guidelines, legislation, research evidence through to personal and professional experiences of parenting to help them understand child abuse and neglect. Although it is rare that child abuse fits simple or straightforward definitions (Einboden, 2017), the difficulty in naming abuse presents a dilemma for nurses given that in some countries (i.e. USA, Australia) nurses are legally required to report abuse and neglect, while in other jurisdictions they have an ethical duty to prevent harm to children (International Council of Nurses, 2012). If nurses use their own values and beliefs to define child abuse and neglect, there is likely to be significant variation amongst professionals who all have different specialised knowledge along with their own values and beliefs. To some extent, this may be inevitable in a field as complex as child protection, however, it is essential to consider to what effect nurses' experiences, and sociocultural positioning

could have on children who are experiencing abuse and neglect.

Values and beliefs influence the way people see the world; they originate from and are continuously shaped by an individual's sociocultural context (Gergen, 2015). Values refer to what people find personally meaningful, and inform how the world 'should' be, while beliefs refer to what individuals perceive to be true (Foresman, Fosl, & Watson, 2016). As such, beliefs nurses hold to be true about child abuse many not be universally applicable. Burr (2015) further argues that there can be no value-free or impartial knowledge because all knowledge is derived from looking at the world from a particular perspective, or by asking certain questions. In this way, it is unavoidable that nurses' values and beliefs will influence the ways they understand and interpret situations of potential child abuse and neglect. As a result, it's important that nurses actively manage their values and assumptions so they can mitigate any potential impacts on children.

Actively managing values and beliefs is important because research into other areas of healthcare shows that health professionals' personal views can influence the type and

quality of care they provide to clients. For example, a systematic review by Hendry et al (2017) found that mental health nurses' conservative attitudes about clients' sexual health meant nurses avoided conversations about sexuality. Similarly, another systematic review identified that primary care clinicians' personal beliefs about osteoarthritis meant they were less likely to recommended evidence-based treatments (Egerton, Diamond, Buchbinder, Bennell, & Slade, 2017).

In this study, participants' personal parenting beliefs appeared to shape their interpretation of potential child abuse and neglect. According to Gergen (2015), our beliefs, such as those about parenting, are developed through interactions with others and are not necessarily shared across other social contexts. For example, Participant 22's (CH) views of immunisation as a basic necessity, and Participant 14's (CH) beliefs around what constitutes adequate supervision reflect their socially constructed perceptions about inherent 'needs' of children. However, 'needs' of a child are subjective, and assume a uniform and uncontroversial view about what is good for children (Woodhead, 2015). Such statements about children's 'needs' typically leave the goal unsaid

and un-critiqued (Woodhead, 2015). It might therefore be more accurate to say that children *need to be immunised* to prevent infectious disease and promote herd immunity. Immunisation has only been constructed as a 'need' of children in relatively recent times, thus demonstrating that perceived needs of children are closely linked to the values and beliefs of a particular culture and time. Similarly, discussions about children's 'need' for adult supervision, make value judgements about adults' parenting roles and children's vulnerability by assuming children cannot survive without constant adult attention (Furedi, 2002). Although many children do die from injuries linked to 'lack of supervision' (Damashek, Drass, & Bonner, 2013), the precise level of required supervision remains unclear and debated. This means nurses need to be critical of their own values and beliefs which are linked to their culture rather than necessarily based on children's needs.

Nurses' definitions of child abuse and neglect are not neutral, but stem from their values and beliefs of which they may not be aware. If nurses are unaware of the intersection between their values and beliefs and how they define child abuse and neglect, they could risk

expecting unfairly high or rigid standards of parenting, or alternatively may accept practices known to be harmful to children. There is also a risk that populations who do not fit mainstream childrearing practices could be unfairly targeted for different rather than harmful parenting practices. Given the possible impacts of nurses' personal values and beliefs on the way they interpret potential child abuse and neglect, it is imperative that nurses working with children critically examine their own cultural, personal or professional values to determine how their views influence their practice and to what extent their practice is consistent with research evidence. Existing literature supports the use of critically reflecting on practice to 'bring assumptions to the surface' and prevent professionals practicing on 'autopilot' (Bassot, 2016). The risk of practicing on 'autopilot' can include stagnation of practice, loss of creativity and working in discriminatory or oppressive ways (Bassot, 2016). In contrast, reflective practice can help practitioners become agents of social change, through individual practice development through to identifying oppressive organisational structures and practices (Garneau, 2016; Smith, 2016; Wood, 2017).

Reflective practice is the ability to enhance one's own practice through analysis of past events (Bassot, 2016) and is underpinned by self-awareness of how one's values, beliefs and feelings influence behaviour (Atkins & Schutz, 2013). Nurses in this study had varying levels of reflective practice and self-awareness, as indicated by some nurses appearing unaware of their own values and beliefs, to others who were active in reflection and critique. Given that defining abuse and neglect can be difficult and subjective, it's imperative that nurses critically reflect upon the factors that influence their decision-making. If nurses are unaware of influences on their decisions, there is a risk that decisions around abuse and neglect will not be targeted towards where they are most needed – which is children at greatest risk of harm. Nurses hold a position of authority in their roles of assessing child abuse and can be gatekeepers of information meaning what they say, or fail to say, can influence child protection services' decisions around children and families (Einboden, 2017; Peckover & Aston, 2018). Thus, it is essential that nurses critically reflect on what influences their decisions so they can explore and articulate the extent to which assessments are based on personal values and beliefs, professional experiences and/or evidence informed practice. This will

promote nurses' capacity to manage their values and assumptions and any subsequent impact upon children and families.

**Study limitations**

This study was limited to a small sample (n=21) of nurses from Australia, primarily in the state of South Australia. Thus, views may not reflect perspectives of nurses in other geographical areas. Similarly, participants all had at least 10 years of experience in nursing, and so their perspectives are unlikely to represent those of individuals new to the nursing profession.

**CONCLUSION**

Nurses have many opportunities to make a difference for children experiencing abuse and neglect. This study has shown the ways nurses understand child abuse are shaped by their values and beliefs which originate from their sociocultural contexts. It is possible that certain values and beliefs could adversely affect the ways that nurses respond to situations of potential abuse, such as influencing if or how nurses respond to situations that may be harmful to children. As such, nurses need to take a critical reflective approach towards their understandings

of child abuse to explore how personal views may influence their practices around promoting children's safety. There needs to be organisational and structural support to facilitate professional opportunities and capacity for nurses to incorporate critical reflection into their daily practices with children and families. If nurses are supported to explicitly reflect on how their personal values and beliefs shape their practice, they can consider the potential impacts on how they implement evidence-informed approaches and maintain a clear focus on children's wellbeing.

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