Interculturality and research in the context of psychiatry – treatment of victims and perpetrators, migration, differences in cultural background

Prof. Dr. Jörg M. Fegert

19.06.2026

International Safeguarding Conference

Rome

Outline

- Introduction
- Forms of violence in healthcare settings
- (Child and Adolescent) psychiatry as a high-risk safeguarding field …. and the role of interculturality
- Transcultural psychiatry as a framework
- Conclusion

Introduction

Catholic Church as the world's largest non-governmental provider of healthcare services*

agenzia fides
at the service of the Church in mission

MISSIONARY OCTOBER

XCIX World Mission Sunday
October 19, 2025

CATHOLIC CHURCH
STATSTICS
2025

Hospital/clinics, charity work, welfare

	Hospitals	Dispensaries	Leprosy centers	Homes for the elderly/ chronically ill, disabled	Orphanages	Kindergartens	Marriage counsel centers	Catholic schools	Other institutes
Africa	1.634	4.973	189	652	1.151	2.369	1.478	240	1.186
America	1.391	3.520	38	3.405	2.127	2.743	3.027	1.412	15.245
Asia	1.166	2.449	257	2.620	2.906	2.747	1.032	475	2.900
Europe	960	2.397	20	8.515	2.284	2.839	5.092	914	15.460
Oceania	226	556	-	374	125	160	198	106	393
TOTAL	**5.377**	**13.895**	**504**	**15.566**	**8.593**	**10.858**	**10.827**	**3.147**	**35.184**

**Data «Church's Book of Statistics» (updated to December 31, 2023)*

Catholic charity and healthcare centers

Charity and healthcare centres run in the world by the Church are **103.951** and include: 5.377 hospitals and 13.895 dispensaries, mainly in Africa (1.634 hospitals and 4.973 dispensaries) and in America (1.391 hospitals e 3.520 dispensaries); 504 Care Homes for people with Leprosy, mainly in Asia (257) and Africa (189); 15.566 Homes for the elderly or the chronically ill or people with a disability, mainly in Europe (8.515); 8.593 orphanages, mainly in Asia (2.906) and Europe (2.284); 10.858 creches; 10.827 marriage counselling centres, mainly in Europe (5.092) and America (3.027); 3.147 social rehabilitation centers, mainly in America (1.412) and 35.184 other kinds of institutes, mainly in America (15.245) and in Europe (15.460).

Therefore, in addition to the education and child care sector, **healthcare settings** are also central for safeguarding!

*according to media news

Safeguarding in Healthcare is Grounded in International Ethical Standards

Across countries and healthcare systems, several key principles are widely shared:

- **Respect for human dignity**
- **Protection of vulnerable persons**
- **Non-maleficence ("do no harm")**
- **Professional responsibility and accountability**
- **Confidentiality and trust**
- **Prevention of abuse and exploitation**

➔ These principles form an important basis for safeguarding in medical and therapeutic contexts.

Oath of Hippocrates

- Named after Hippokrates of Kos (around 460-370 b.c.)

Key Principles:

- "Do no harm" (non-maleficence)
- Respect for vulnerable patients
- Maintaining professional boundaries
- Confidentiality and trust

👉 **Safeguarding relevance**

- Professional responsibility includes protecting patients from harm and exploitation

Oath of Hippocrates

„Into whatsoever houses I enter, I will do so to help the sick, keeping myself free from all intentional wrongdoing and harm, especially from fornication with woman or man, bond or free."

(https://pmc.ncbi.nlm.nih.gov/articles/PMC1114108/)

➔ Exclusive focus on patient welfare

➔ Prohibition of exploitation

➔ Early recognition of patient vulnerability

➔ Clear professional boundary ethic

Declaration of Geneva (World Medical Association)(1948)

https://www.wma.net/policies-post/wma-declaration-of-geneva/

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Key Principles:

- The health and well-being of the patient is the physician's first consideration.
- Physicians must respect patient dignity and autonomy.
- Care must be provided without discrimination.
- Confidentiality must be maintained.
- Medical knowledge must never be used to violate human rights.

👉 **Safeguarding relevance**

- Emphasis on dignity, non-harm, equality and protection from abuse

ICN Code of Ethics for Nurses (2021, revised version)

https://www.icn.ch/sites/default/files/2023-06/ICN_Code-of-Ethics_EN_Web.pdf

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Key Principles:

- Nursing is grounded in respect for human rights and dignity.
- Care must be provided without discrimination.
- Nurses are responsible for safe and ethical care.
- Nurses must protect patients from harm, abuse and neglect.
- Ethical responsibility applies in all roles and settings.

👉 **Safeguarding relevance**

- Strong emphasis on protection, responsibility and accountability.

Belmont Principles (1979): Ethical Principles and Guidelines for the Protection of Human Subjects of Research

Ethical Principles	
Non-maleficence (primum non nocere)	Obligation to prevent harm. Obligation to refrain from causing harm.
Beneficence	Obligation to do good.
Respect for Persons	Obligation to respect the person as an individual and the decisions they make autonomously.
Justice	Obligation to prevent discrimination and distribute resources fairly.

Charter for Healthcare Workers (1995)

https://www.vatican.va/roman_curia/pontifical_councils/hlthwork/documents/rc_pc_hlthwork_doc_19950101_charter_en.html

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Key Principles:

- Human dignity
- Holistic care (body–mind–spirit)
- Moral responsibility of professionals

👉 **Safeguarding relevance**

- Strong emphasis on the dignity of every human person
- Special concern for the vulnerable, weak and suffering
- Ethical responsibility to protect patients from harm and exploitation
- Importance of respectful, compassionate relationships in care
- Responsibility of institutions as well as individual professional

Safeguarding in Healthcare Reflects a Longstanding Ethical Commitment Across Cultures, Professions and Faith Traditions.

Across secular and religious traditions, care for the sick is a shared ethical responsibility.

Both professional and spiritual sources recognize:

- the vulnerability of patients
- the responsibility of professionals and institutions
- the importance of dignity-centered care

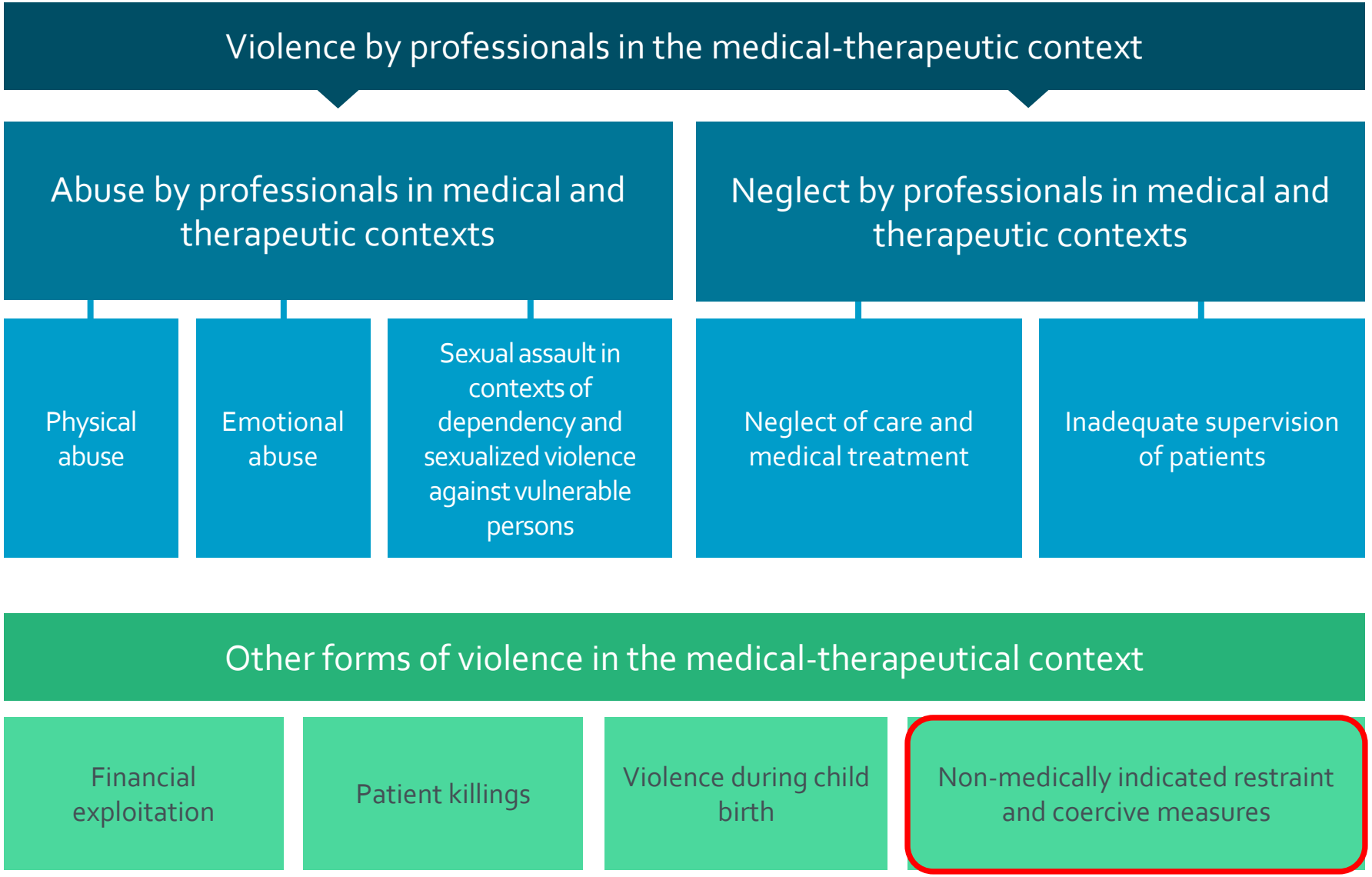
Core Shared Principles

- Respect for human dignity (Declaration of Geneva, ICN Code, Catholic teaching)
- Protection of vulnerable persons (Bible, Catholic pastoral care, Professional ethics)
- Commitment to non-maleficence (“do no harm”) (Hippocratic tradition, Medical ethics)
- Professional responsibility and accountability (ICN Code, Charter for Healthcare Workers)
- Relational and compassionate care (Pope Francis, Pope Leo XIV, Biblical tradition)

Forms of violence in healthcare settings

Forms of interpersonal violence

(Modified for the institutional medical context based on Leeb et al. 2008)



Survey on violence by nursing and care staff in Germany

- Population-representative survey conducted in 2018 with N = 2,516 (♀ 54.5%, ♂ 45.5%) in Germany
- The survey examined experiences of abuse by caregivers during childhood and adolescence, including in pediatric hospitals/adult hospitals and child and adolescent psychiatry settings

Child Abuse & Neglect 95 (2019) 104046

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Research article

Child maltreatment by nursing staff and caregivers in German institutions: A population-representative analysis

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ARTICLE INFO

Keywords:
Child maltreatment
Child abuse
Child neglect
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Institutions
Caregivers

ABSTRACT

Background: Child maltreatment by caregivers seem to make a significant contribution to general maltreatment rates. Interestingly, research assessing prevalence rates of maltreatment rarely focuses on individual components either in relation to different types of maltreatment or in relation to different types of institutions.

Objective: The current study assesses prevalence rates for child maltreatment by caregivers in hospitals, rehabilitation centers, facilities for the disabled, schools, Kindergartens, and after-school care or residential care.

Participants and setting: In a cross-sectional survey, a representative sample of the German population above the age of 14 (N = 2,516) was selected in a random route approach. Participants were questioned retrospectively for the experience of physical, emotional and sexual abuse and neglect by caregivers in institutions.

Results: The results demonstrate a relatively high rate of child maltreatment in German institutions. In detail, during inpatient stays in medical institutions, 19.0% of the participants reported to have experienced at least one type of maltreatment by nursing staff. Furthermore, 30.3% reported to have experienced at least one type of maltreatment by teachers during school life and 11.6% reported maltreatment by caregivers in care facilities. A significant number of participants reported multiple forms of maltreatment in all assessed institutions. Younger age of the respondents was associated with lower prevalence rates, which could be attributed to higher awareness for maltreatment in institutions nowadays.

Conclusions: Our results demonstrate that child maltreatment by caregivers in institutions is a prevalent problem. A higher awareness for caregivers as potential perpetrators of maltreatment in institutions, including schools, medical institutions and care facilities, is needed in order to improve this alarming situation.

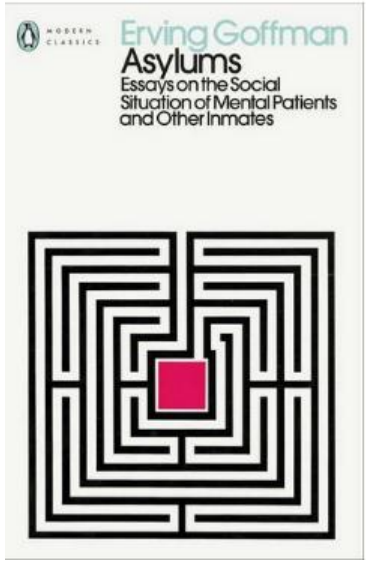
Survey on violence by nursing and care staff

Form of maltreatment	Child and adolescent psychiatry (N =39-41)	Pediatric hospital/adult hospital (N =459-465)
	Total in %	
Physical abuse	31.7	8.6
Emotional abuse	23.1	9.5
Sexual abuse	7.3	0.7
Neglect	22.0	11.2

Hoffmann et al., 2020

(Child and Adolescent) psychiatry as a high-risk safeguarding field …. and the role of interculturality

Goffman „Asylums“



- **“Total institutions” as structurally violent environments**: all areas of life are controlled and isolated from the outside world → **power imbalance**
- **Everyday transgressions by staff**: violence often does not appear as overt physical aggression, but rather as coercion, humiliation, threats, deprivation of liberty, or chemical sedation
- **Depersonalization and loss of protective mechanisms**: patients lose identity, autonomy, and credibility → complaints about violence are thereby systematically devalued
- **Violence between patients as a consequence of institutional conditions**
- **Structural impunity and invisibility of violence** due to isolation from external oversight and the absence of effective control mechanisms

Specific risk factors in the medical cotext

- Dependency relationship between children/adolescents and professionals
- Children and adolescents are required to tolerate physical contact
- Lack of knowledge and understanding
- Uncertainties for patients:
  - ***Is the intervention medically necessary?***
  - ***Is the procedure being carried out according to professional standards?***
  - ***What are the procedures and responsibilities within the medical context?***
  - ***Unfamiliar environment***
  - ***Specialized medical terminology / technical language***

And what about environmental and societal risk factors?

Violence, interculturality, culture, and migration

- Child abuse and neglect as a global phenomenon
  - BUT:
    - Different perceptions
    - Different responses across cultures
    - Different thresholds for intervention

Risk factors differ across cultural settings, but also across protective systems (extended family, community-based care, institutions likes psychiatries etc.)

a. Child abuse and neglect, childhood and „normal development": universal but differently defined

- International discrepancies in:
  - **Parenting practices**
  - **Norms around child discipline/punishment**
  - **Family hierarchies**
  - **Gender norms**
  - **Social acceptance of violence**
  - **Fewer rights for certain groups of people**

Sr. Josée Ngalula: Abuse and Violence against children are bad in every culture…. listen to the Language of the heart

→ Example: In India, physical discipline is traditionally viewed quite differently from Western standards; the direct transfer of purely Western intervention programmes is therefore highly questionable (Segal, 1992)

b. Hierarchy and the possibility of critique despite it

More on this in my next presentation at noon

And what about environmental and societal risk factors?

Violence, interculturality, culture, and migration

c. Cultural issues in disclosures of child sexual abuse

- Cultural norms affect the likelihood that child sexual abuse will be discovered by an adult or disclosed by a child
- Cultural norms also affect whether abused children's families will report child sexual abuse to authorities → Underreporting and invisibility

Fontes & Plummer (2010)

d. Migration and vulnerability

- **Increased risks due to:**
  - **Language barriers**
  - **Mistrust of institutions**
  - **Legal insecurity**

  → attitudes of apprehension and cultural mistrust may interfere with help-seeking behaviors due to common knowledge about past abuses

Guinart (2019)

Victim and Perpetrator Perspective

The Victims Perspective

Cultural Meaning of Trauma: Cultural backgrounds heavily shape how the consequences of trauma are expressed and interpreted.

The Burden of Shame: In many cultures, victims respond with deep internalized shame, which severely hinders disclosure and help-seeking.

Cultural Betrayal Trauma (Gómez, 2022):

- Intracultural violence (abuse within the same minority group) violates foundational trust and solidarity.
- This specific violation is proven to lead to significantly more severe, clinically elevated PTSD symptoms.

The Perpetrator Perspective

Attribution of Guilt: Culture influences who is held responsible and how different communities define what constitutes violence

Accountability vs. Reintegration: Tensions between Western focus on punishment/accountability and community-based models of reintegration

Social & Structural Drivers (Rousseau, 2021 / Alcalá, 2017): Violent extremism and harm are fueled by systemic social dynamics and deep structural inequalities
Discrimination and systemic exclusion (e.g., anti-Muslim sentiment) isolate individuals and foster perpetrator environments.

Prevention Focus: Interventions must address structural inequities and strengthen broad social solidarity.

Psychiatry as a high-risk safeguarding field

The Reality of Psychiatric Safeguarding

- **Care vs. Control:** Psychiatric care uniquely combines support with involuntary, coercive measures as a form of discipline or as a means of exercising power and control
- **High Vulnerability:** Migration and refugee histories introduce severe stressors like trauma, discrimination, and systemic isolation.
- **Cumulation of risk factors**
- **Working both with victims and perpetrators**
- **Long inpatient stays including overnight stays**
- **Trust-based relationships in psychotherapy and in everyday interactions with professionals**
- **In some cases, limited external monitoring and support from parents or other caregivers**

The Dual Risk of Misassessment

Pseudo-Culturalization (Downplaying): Danger of minimizing or normalizing actual violence as a "cultural trait" or custom.

The Sensitivity Trap (Over-interpreting): Danger of rashly misinterpreting precarious living conditions or minor cultural differences as immediate child abuse.

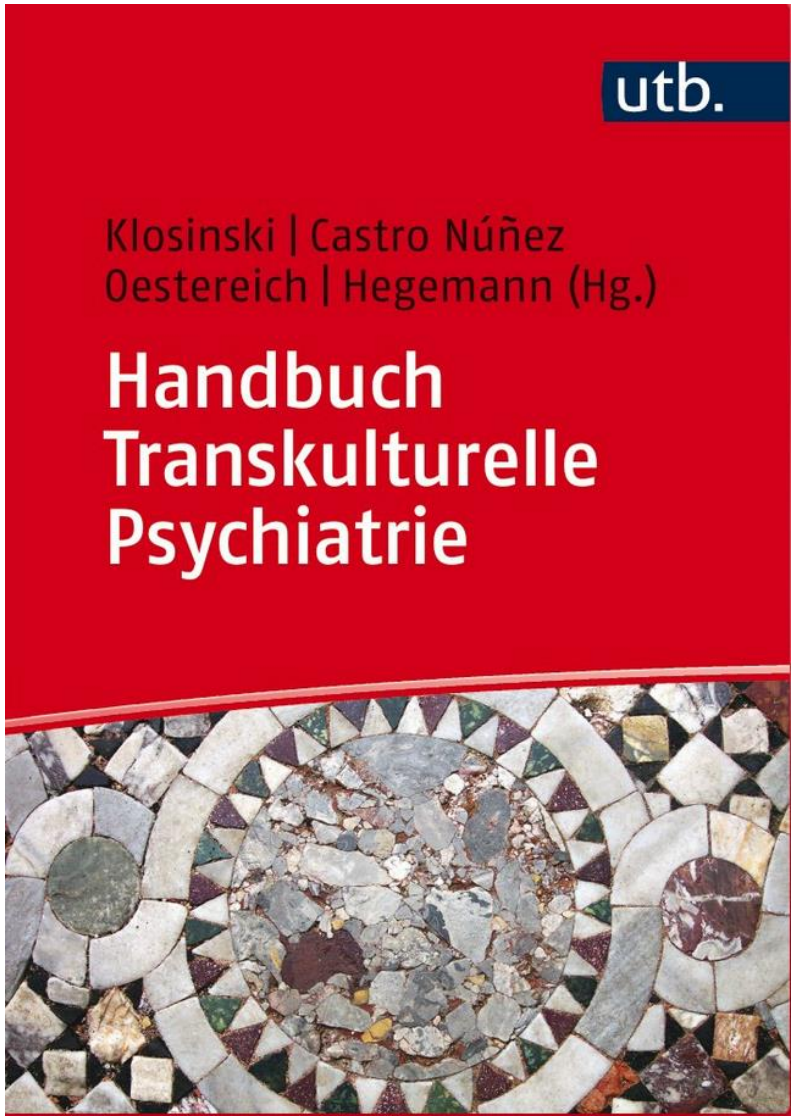
(KKG NRW, 2023)

Core Requirement: Ethical reflection and cultural humility are non-negotiable to prevent the institutional misuse of power.

Transcultural psychiatry as a framework

Transcultural psychiatry as a framework

Handbook of Transcultural Psychiatry



Transcultural psychiatry highlights:

- Mental illness and trauma are culturally shaped (forms and prevalences of psychiatric disorders)
- Symptoms are expressed differently across contexts
- Meaning ist attributed differently to suffering
- Responses to mental health needs of culturally diverse populations have to be adapted (models of service)
- Psychiatry itself is a product of specific cultural history

→ One universal model of psychiatry is **insufficient**

→ Clinical practice is **not culturally neutral**

Methodological challenges in research of interculturality in the context of (child) psychiatry

global mental health

POLICY AND SYSTEMS

REVIEW

Cross-cultural child and adolescent psychiatry research in developing countries

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Global Mental Health (2015), **2**, e5, page 1 of 12. doi:10.1017/gmh.2015.8

Mental disorders are currently a major source of morbidity among children and youth globally. The bulk of the epidemiological data about childhood mental health morbidity currently comes from the industrialized countries which paradoxically host a small (about 20%) proportion of global children and youth population. As the world seek to generate more data on the mental health of the teeming children and youth population in low- and middle-income countries (LMICs), cross-cultural issues need be considered. This consideration is imperative for reasons which include the high level of ethno-diversity in LMICs; the contextual issues in the conceptualization of normal (and abnormal) childhood across cultures, the cross-cultural nuances in risk and protective factors, and the plurality of nature and expression of childhood psychopathology. As much as it is imperative to do so, advancing cross-cultural child and adolescent research in LMICs will need to overcome challenges such as inclusive sampling and cultural validation of instruments developed in the industrialized countries of the West. Funding, technical resources, and publication bias are other potential challenges. These issues are appraised in this narrative review and some ways forward are proffered.

Received 29 January 2015; Revised 8 April 2015; Accepted 15 April 2015

Key words: Culture and mental health.

- Lack of funding in low- and middle-income countries (LMICs)
- Tools often developed in Western contexts -> **invalid assessment of child psychopathology or adverse childhood experiences across cultures**
- Standard instruments often not culturally validated
  - Challenges: translation issues, conceptual mismatch (e.g., underdiagnosis oder misdiagnosis)
- Global imbalance in knowledge production: **publication bias**

Even in one region of the world (European Region) there are huge differences in psychiatric care

European Child & Adolescent Psychiatry
https://doi.org/10.1007/s00787-025-02902-7

ESCAP COMMUNICATIONS

About differences in the availability of child and adolescent psychiatric hospital beds across Europe and possible implications for mental health care. Are more or less hospital beds the solution to the youth mental health crisis?

Based on a debate at the 21st International Congress of the European Society for Child and Adolescent Psychiatry, Strasbourg, June 30, 2025

Joerg M. Fegert[1,2,3] · Isabel Boege[1,4,5] · Dario Calderoni[6] · Diane Purper-Ouakil[7,8] · Emily Sitarski[1,2,3] · Benedetto Vitiello[9,10]

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Abstract
A number of indicators point to a decline in youth mental health globally over the past 15 years. Access to medical treatment and assistance is becoming increasingly difficult as the social divide is widening due to an imbalance between supply and demand. Hospitalization remains a critical yet costly component of child and adolescent mental health care, reserved for the most severe cases. While necessary in some situations, inpatient treatment carries substantial drawbacks, including family separation and social disruption. This paper discusses if increasing hospital beds across Europe can be the solution to the youth mental health crises by examining differences in the availability of child and adolescent psychiatric hospital beds across Europe. International comparisons reveal striking heterogeneity in hospital beds availability, which does not correlate with improved mental health and behavioral outcomes in young people at the population level. Furthermore, the data does not suggest that this heterogeneity reflects the need to address different levels of psychopathology. Besides the limitations of the currently available data, evidence suggest that effective outpatient and home-based interventions can reduce hospital dependence without compromising treatment efficacy. The COVID-19 pandemic highlighted both the vulnerability of traditional services and the growing role of digital mental health support, which adolescents increasingly access via online platforms. Emerging stepped-care and community-based models, including lay-provider interventions, demonstrate potential to expand reach while conserving specialized resources. Given scarce capacity, European-wide recommendations are needed to ensure equitable access to acute care, while integrating innovative, digitally supported, low-threshold services into youth mental health systems.

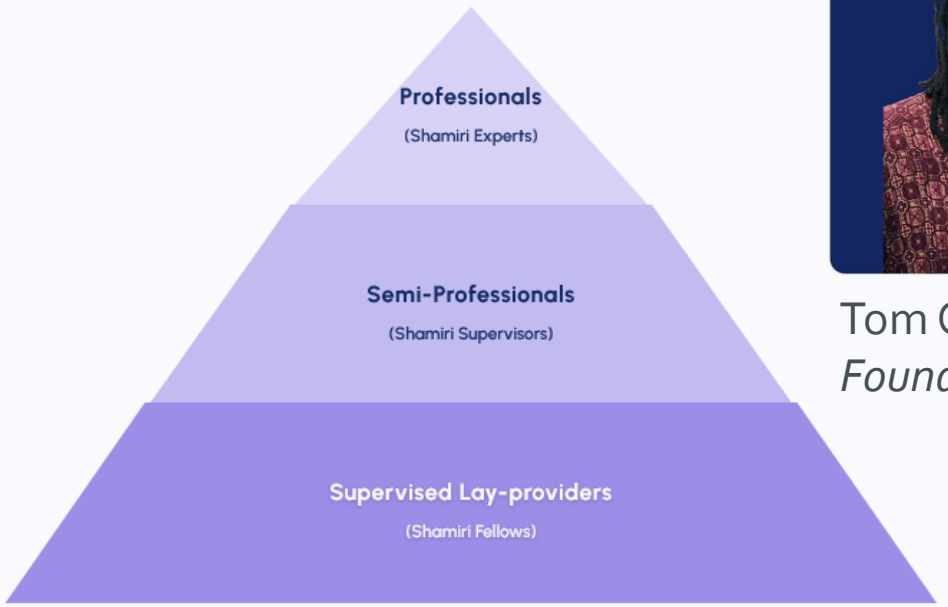
Keywords Youth mental health crisis · Child and adolescent psychiatric hospital beds · Europe · Mental health · Hospitalization · Child and adolescent mental health care · Behavioral outcomes · Psychopathology · Innovative youth mental health services

Across Europe, the number of beds in child and adolescent psychiatric care **does not** correlate with better mental health among young people at the population level

- It is also very expensive, offers no immediate solution, and has many drawbacks for those affected
- Shortage of skilled workers

What we can learn from other countries and continents: The Shamiri Model from Africa

- Evidence-based
- Cost-effective
- Scalable



Tom Osborn
Founder & CEO

→ **Tier 1: Shamiri Fellows**

Young lay-providers (ages 18-24) from local communities deliver group-based interventions after just 10 hours of training. They teach practical skills like growth-mindset, gratitude, and problem-solving that strengthen core beliefs about self and the world.

→ **Tier 2: Shamiri Supervisors**

Semi-professionals with bachelor's degrees or social work experience provide oversight and offer one-on-one support.

→ **Tier 3: Shamiri Experts**

The few psychologists and psychiatrists manage complex cases requiring specialized care, ensuring every youth receives the right level of support.

This approach is needs-based, with built-in quality control at every level and clear pathways for escalation when youth need more intensive support.

https://shamiri.co/

Transcultural psychiatry as a framwork

The Cultural Formulation Interview (CFI)

- Cultural Formulation Interview (CFI) published in *DSM-5*
- aims to improve culturally sensitive diagnosis and treatment by focusing clinical attention on the patient's perspective and social context
- improves clinical communication by enhancing clinician-patient rapport, allowing the clinician to obtain new, cultural data in a relatively short period, eliciting patients' perspectives on what caused their symptoms
- CFI takes approximately 20 min. to complete
- evaluated internationally in the US, Canada, Kenya, Peru, the Netherlands, India, and Mexico and has been found to be clinically acceptable and useful in these varied settings

→ CFI provides a simple way for the process of cultural assessment, and its systematic use can foster a reflective stance and promote systemic thinking in routine clinical practice about the patient's life and experience.

Jarvis et al. (2020)

Interculturality in clinical practice: case examples

1. **Language barriers**

- Communication challenges in sensitive cases
- Risk: loss of critical safeguarding information

→ Linguistic barriers: The use of lay interpreters jeopardises validity; qualified language mediators are mandatory in medical child protection (Schouler-Ocak, 2026; KKG-NRW)

2. **Cultural differences between staff/interviewer and patient**

- Different concepts of:
  - Authority
  - adult–child relationships
  - Trauma / suffering
  - Disclosure

→ Interaction effects during disclosure: Ethnic matching/interaction between the interviewer and the child significantly influences the level of detail provided in accounts of abuse (Springman et al., 2006)

Psychiatry as a safeguarding actor

Psychiatry as an interface between:

- Medicine
- Legal systems
- Social services

Key challenges:

- Recognition of abuse
  - Culturally different symptom expression
- Intervention
  - Balancing protection and coercion
- Work with perpetrators
  - Culturally shaped narratives of responsibility

→ Who defines:"risk" and "appropriate protection" in intercultural clinical settings?

Communication & Practical Assessment Frameworks

Social & Cultural Dimensions:

- *Individualism vs. Collectivism:* Be mindful that individualist approaches may be perceived as arrogant or isolating in collectivist contexts.
- *Concept of "Saving Face":* Public blunders can violate the core of personality e.g. in some Asian or Arabic contexts; constructive criticism should occur strictly in private.

Non-Verbal & Paralinguistic Markers:

- *Eye Contact:* Viewed as a sign of honesty in the West, but often signals a lack of respect in Asian cultures.
- *Communication Styles:* Adapt to variations in speech volume, pacing, and the cultural meaning of silence.

Systemic Adaptation (Greater Manchester SCP, 2024): Psychiatric services must flexibly adapt to diverse lived realities rather than forcing the patient into rigid institutional structures.

Interculturality in psychiatry: Key insights from practice

Safeguarding challenges are often:
- not about knowledge
- but about context, norms and culture

Institutional norms remain implicit. Risk of dominance of certain cultural perspectives and marginalization of others.

- Informal hierarchies shape safeguarding practice, decisions, interpretations of risk, intervention strategies
  - **Example: "When the boss speaks, it has an impact"**

- Informal power influences:
  - Decisions
  - Norms
  - what is considered "right"

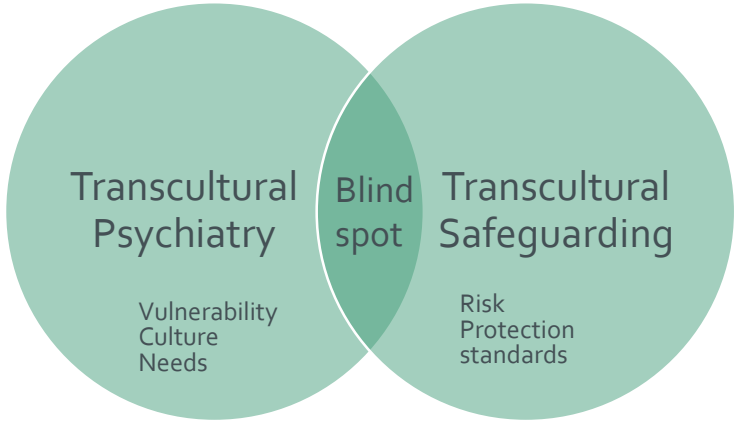
Transcultural psychiatry as a framwork: Relevance for safeguarding

Power dynamics and moral judgments complicate safeguarding in psychiatry and psychotherapeutic care, highlighting the need for culturally responsive approaches.

Interculturality in psychiatry: Challenges

- Culture creates a framework for the assessment of emotional, cognitive, and behavioral expressions and for the thresholds of disease and disorder
- **Translation Limits:** simple direct translation from one language to another may not guarantee full transfer of the content validity
- **Religion & Spirituality (Jarvis & Kirmayer, 2025):** Dual role as a key resource for resilience/recovery, but also a potential source of distress and identity conflicts

Risk of failing to reflect on transcultural safeguarding challenges in transcultural psychiatry:



Guinart et al. (2019)

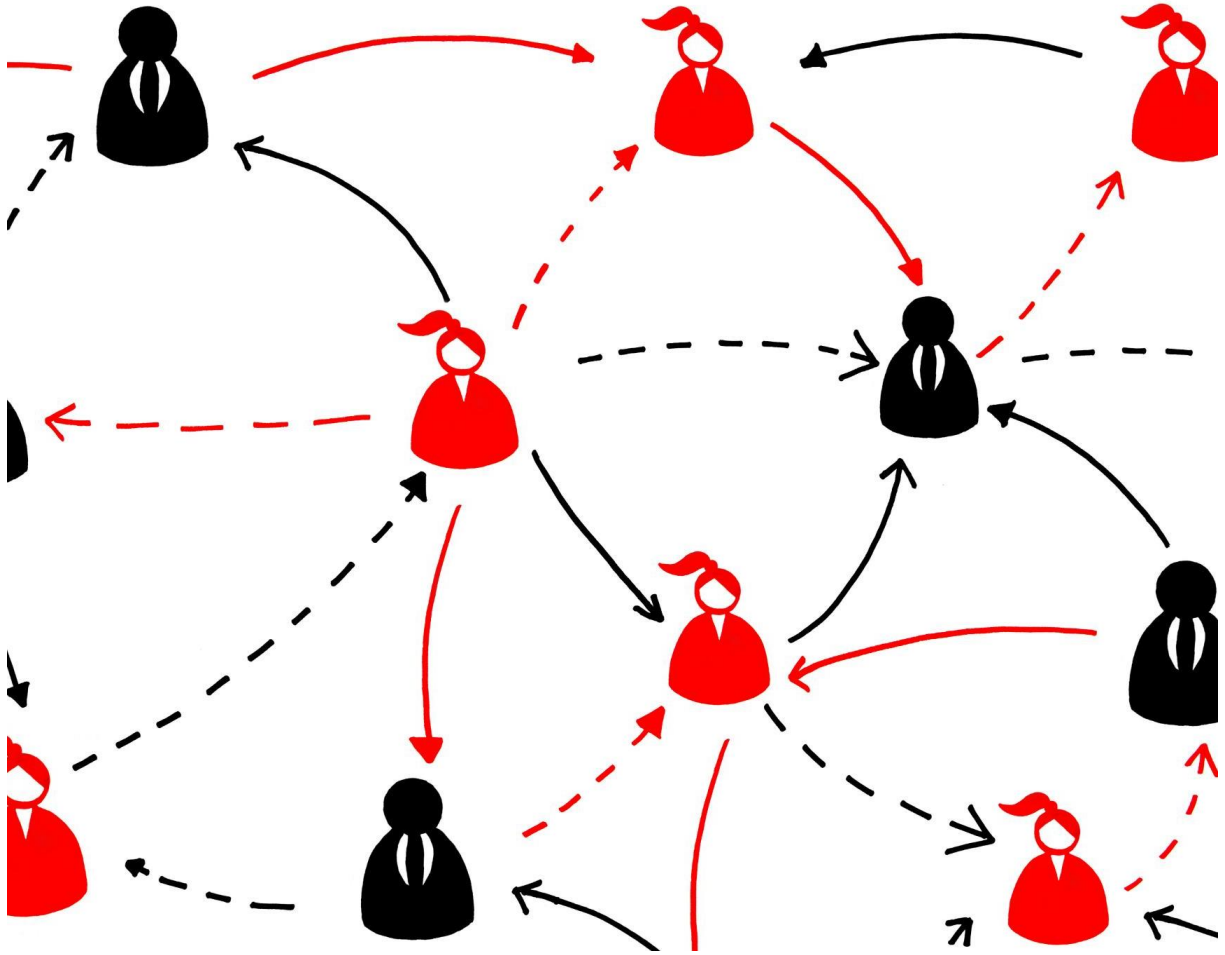
Power as a central safeguarding issue

Role of Formal and Informal Power
Formal hierarchies structure organizations, but informal authority often shapes daily norms and decisions beyond rules.

Ethical Challenges in Power Dynamics
Power concentration raises questions about whose values dominate, who can dissent, and whose voices are marginalized.

Cultural and Professional Intersections
Power dynamics intertwine with cultural dominance, professional status, and language, impacting safeguarding effectiveness.

Making Power Visible and Accountable
Addressing power means acknowledging it transparently to ensure safeguarding moves beyond symbolic compliance.



Conclusion

Universal rights vs. cultural practice

Children's Rights, Medical Ethics, and Ongoing Tensions

Universal Children's Rights
Children's rights are globally recognized but implemented differently across cultures and institutions.

Medical Ethics Foundations
The Hippocratic Oath represents universal principles of non-maleficence adapted over time and cultures.

Tensions in Practice
Psychiatric interventions often highlight conflicts between universal rights and cultural norms (lived realities).

Negotiated Safeguarding
Effective safeguarding balances shared ethical values with respect for cultural diversity through dialogue.

→ Safeguarding operates between **universal rights and culturally embedded practices.**

More on this in my next presentation at noon

Conclusions: Towards context-sensitive and reflexive safeguarding

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Context-Dependent Safeguarding
Safeguarding must consider local meanings and cannot rely on universal checklists to ensure real safety: culturally adapted assessment tools, context-sensitive interventions, cross-cultural research etc.

Valuing Local Perspectives
Local ethical frameworks are vital knowledge sources (underrecognition of abuse, misinterpretation of behavior etc.), promoting dialogue over deficit-based evaluations.

Addressing Power Dynamics
Recognizing and challenging institutional power imbalances is key to preventing safeguarding failures.

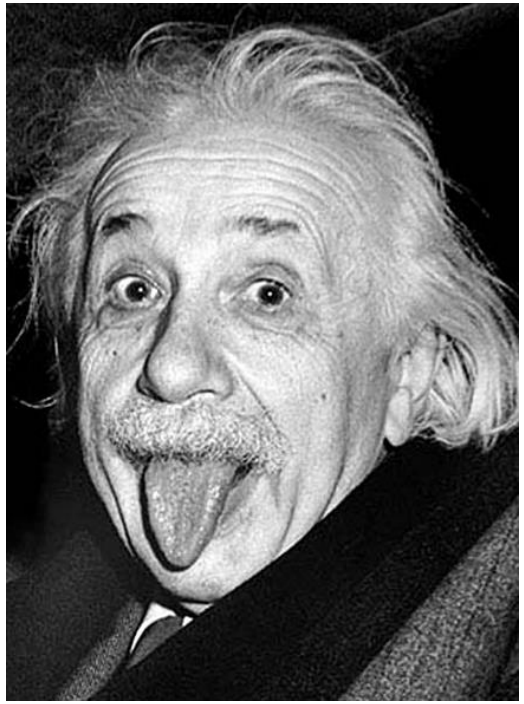
Reflective Ethical Practice
Safeguarding is an evolving ethical practice requiring interdisciplinary dialogue and culturally informed training.

- Safeguarding in child abuse is not only about protecting children –it is about understanding how harm, responsibility, and protection are defined across cultures.
- Without a transcultural perspective, safeguarding risks becoming either blind to harm or imposing inappropriate frameworks.

Thank you for your attention!

There are no great discoveries and progress as long as there is still an unhappy child on earth.

Albert Einstein (*1879 in Ulm)



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Literature

Alcalá, H. E., Sharif, M. Z., & Samari, G. (2017). Social determinants of health, violent radicalization, and terrorism: a public health perspective. *Health equity*, *1*(1), heq-2016. DOI: 10.1089/heq.2016.0016

Fontes, L. A., & Plummer, C. (2010). Cultural issues in disclosures of child sexual abuse. *Journal of child sexual abuse*, *19*(5), 491-518. DOI: 10.1080/10538712.2010.512520

Gómez, J. M. (2022). When solidarity hurts:(Intra) cultural trust, cultural betrayal sexual trauma, and PTSD in culturally diverse minoritized youth transitioning to adulthood. *Transcultural psychiatry*, *59*(3), 292-301. DOI: 10.1177/13634615211062970

Greater Manchester Safeguarding Children Partnership. (2025). *Female Genital Mutilation Multi-Agency Protocol*. Greater Manchester Safeguarding Children Procedures Manual. https://greatermanchesterscp.trixonline.co.uk/chapter/female-genital-mutilation-multi-agency-protocol

Guinart, D., Kane, J. M., & Correll, C. U. (2019). Is transcultural psychiatry possible?. *Jama*, *322*(22), 2167-2168. https://doi.org/10.1001/jama.2019.17331

Jarvis, G. E., & Kirmayer, L. J. (2025). Religion and spirituality in cultural psychiatry. *Transcultural Psychiatry*, *62*(4), 413-421. DOI: 10.1177/13634615251367860

Jarvis, G. E., Kirmayer, L. J., Gómez-Carrillo, A., Aggarwal, N. K., & Lewis-Fernández, R. (2020). Update on the Cultural Formulation Interview. *Focus*, *18*(1), 40–46. https://doi.org/10.1176/appi.focus.20190037

Klosinski, M., Núñez, S. C., Oestereich, C., & Hegemann, T. (Eds.). (2022). *Handbuch Transkulturelle Psychiatrie* (Vol. 5945). UTB.

Kompetenzzentrum Kinderschutz im Gesundheitswesen NRW. (2023, April). *Interkulturalität im Medizinischen Kinderschutz* (In Zusammenarbeit mit B. Çıtlak) [Informationsblatt]. https://www.kkg-nrw.de

Rousseau, C., Aggarwal, N. K., & Kirmayer, L. J. (2021). Radicalization to violence: A view from cultural psychiatry. *Transcultural psychiatry*, *58*(5), 603-615. DOI: 10.1177/13634615211048010

Schouler-Ocak, M. (2026). Interkulturelle Psychiatrie: Herausforderungen und Perspektiven. *Nervenheilkunde*, *45*(1/2), 16–17. https://doi.org/10.1055/a-2727-8225

Segal U. A. (1992). Child abuse in India: an empirical report on perceptions. *Child abuse & neglect*, *16*(6), 887–908. https://doi.org/10.1016/0145-2134(92)90090-e

Springman, R.E., Wherry, J.N., Notaro, P.C. (2006). The effects of interviewer race and child race on sexual abuse disclosures in forensic interviews. J Child Sex Abus.15(3):99-116. DOI: 10.1300/J070v15n03_06

Sturm, G., Bonnet, S., Coussot, Y., Journot, K., & Raynaud, J. P. (2017). Cultural sensitive care provision in a public child and adolescent mental health centre: A case study from the Toulouse university hospital intercultural consultation. *Culture, Medicine, and Psychiatry*, *41*(4), 630-655.