Ethnic Disparities and the Psychological Trauma of Maltreated Children: Evidence from Three Multi-ethnic Counties in China

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Abstract

This study aims to discuss the effect of ethnicity on child maltreatment trauma in China and to contribute to international knowledge on the quality of life of children. The data come from a survey of 1763 rural children ($M_{age} = 12.34$, 50.0% boys) in three multi-ethnic counties in western China that was conducted from November 2019 to January 2020 with the modified versions of the “Juvenile Victimization Questionnaire” Scale. There are three important findings of this study. First, child maltreatment is significantly related to child depression in China. The depression score and rate of severe depression symptoms (SDS) are 2.09 times and 3.82 times higher, respectively, for maltreated children than children without maltreatment. Second, the effects of maltreatment on child depression differ significantly among the ethnic groups. The negative effect of maltreatment is most influential among the *Han* population and least influential among the *Zhuang* population. Third, ethnic disparities are also found in the effects of the influencing factors on child depression. The effect of intergenerational relationships on child depression is significant only in the *Han* and *Tibetan* populations, while the negative effect of peer support is found only among *Han*, *Tibetan*, and *Miao* children. Based on the confirmation of ethnic disparities in trauma due to maltreatment, this study suggests that it is necessary to establish a high-quality psychological intervention system in China’s multi-ethnic counties.

Keywords Ethnicity · Child maltreatment · Depression · Psychological trauma · Multi-ethnic counties

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Introduction

Child maltreatment (CM), which is recognized as a risk factor that seriously threatens the quality of life of children worldwide, can be defined as “all forms of physical and/or emotional ill-treatment, sexual abuse, neglect, or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power” (Butchart et al., 2006, p. 9). Many studies have confirmed that CM not only induces psychological problems such as anxiety, depression, or post-traumatic stress disorder (PTSD) symptoms (Messman-Moore & Bhuptani, 2017; Thoresen et al., 2015) but also is related to obesity, alcoholism, drug abuse, suicide attempts, and intimate partner violence (IPV) (Felitti et al., 2019; Kaplan et al., 2016). Although many countries have enacted specific laws to reduce the risk of CM, in the past decade, the rates of physical abuse (PA), emotional abuse (EA), sexual abuse (SA), and neglect (Ng) have still reached 22.6%, 36.3%, 12.7%, and 18.4%, respectively (Stoltenborgh et al., 2015).

The issue of ethnic disparities in CM is widely discussed. Ethnic minorities with relatively lagging economic development, such as the Māori in New Zealand (Rouland et al., 2019) and Native Americans in the United States (Wildeman et al., 2014), have been shown to have higher rates of CM, and ethnic groups who live in more developed modern societies have also shown striking differences in maltreatment rates. For example, Hispanic children tend to have a lower rate of abuse reports than White children (Drake & Jonson-Reid, 2011). In Israel, wealthier Jews have significantly higher reported rates of physical and sexual abuse than poorer Arabs (Ben-Arieh & Haj-Yahia, 2006). Although some scholars argue that the influence of ethnicity can be easily amplified in the name of prejudice or sympathy (Maydell, 2018), an increasing number of studies have shown that ethnic disparities in CM exist and are not simply subjective assumptions.

According to the most recent national census in China, the populations of *Han* (i.e., China’s largest ethnic group) and 55 other ethnic minorities have reached 1226 million and 114 million, respectively (National Bureau of Statistics, PRC, 2010). Among these ethnic minorities, the *Zhuang*, *Hui*, *Manchu*, *Uyghur*, *Miao*, *Yi*, *Tujia*, and *Tibetan* have the largest populations of over 6 million. These ethnic minorities mostly live mixed with *Han* in remote multi-ethnic areas. Due to difficulties in obtaining data, few studies have discussed the effect of ethnicity on CM trauma in multi-ethnic regions.

By using the latest data from three multi-ethnic counties in western China, this study attempts to reveal the potential ethnic disparities in CM trauma in China and contributes to the discussion on the relationships among ethnicity, maltreatment, and depression. Three research questions are proposed. First, does CM pose a general threat to children’s psychological health in multi-ethnic areas? Second, can ethnic disparities be found in the psychological trauma caused by CM in multi-ethnic areas? Finally, are there significant ethnic disparities in the effects of the influencing factors for maltreatment trauma in multi-ethnic areas?

Literature Review

Child Maltreatment Trauma and Its Influencing Factors

CM is a worldwide risk factor for psychological health, especially depression. Evidence from the United States shows that the likelihood of depression is 37.1% higher for neglected children than for children who are not neglected (Bennett et al., 2010). In Canada, women who were abused in childhood were four times more likely to suffer from depression than women who were not abused (Ouellet-Morin et al., 2015). Evidence from Australia also shows that 15.7% of depression in men and 22.8% of depression in women are related to childhood maltreatment (Moore et al., 2015). Research has also found that the effect of CM on psychological health varies among different subtypes. Although most studies have found that emotional abuse and neglect are the most influential categories (Crow et al., 2014; Vugt et al., 2013), other studies still suggest that different subtypes have equivalent psychiatric and behavioral effects, which range from anxiety and depression to rule-breaking and aggression (Vachon et al., 2015).

Children's psychological trauma is not only worsened by the frequency of maltreatment but also significantly mitigated by some protective factors. Among these protective factors, family relationships, including spousal and intergenerational relationships, are recognized as the most important predictors (Leung & Fung, 2021). Weak family cohesion and IPV between parents were found to be predictive of greater depression and PTSD symptoms and low life satisfaction in children (Fung, 2021; Kaur & Kearney, 2013; Yucel & Yuan, 2016). Parent-child relationships, especially mother-child relationships, have also been shown to be highly correlated with maltreatment trauma. Children with depression generally receive less care and have an unsecure attachment with maternal caregivers (Lowell et al., 2014). Even for children who have been severely abused by their parents, good parent-child relationships can still help them eliminate their depressive mood, and they will even consider beating as "an act of love" (Katz et al., 2020). However, there are also studies that challenge the effect of family relationships. For example, based on a survey in Pennsylvania, Wang and Kenny (2013) found that the family relationship was insignificant in moderating the relationship between parents' harsh verbal discipline and adolescents' depressive symptoms.

Social support is another important protective factor. Researchers have proved that the promotion of individual and environmental (e.g., family, school, community) resources and the enhancement of positive interaction between individuals and the environment effectively protect children from depression and other negative psychological symptoms (Qi et al., 2020; Zhou et al., 2020a, 2020b, 2020c). The ecological perspective likewise suggests that social support factors are crucial in promoting adolescent positive development, enhancing child resilience and competencies, and increasing opportunities for child growth (Shek et al., 2019). Specifically, family support and peer support are generally considered to be the main protective variables, as they provide securement and attachment for children (Leung et al., 2021; Li et al., 2019; Papafratzeskakou et al., 2011; van Harmelen

et al., 2016). Evidence from Louisiana even suggests that the support from the parent abuser is necessary to repair child trauma, especially when the abuser is the mother (Fleckman et al., 2019). The influence of school/teacher support on maltreatment trauma is also inconclusive. Some studies have indicated that adolescents with school intervention are four times less likely to display internalizing problems compared to their counterparts (Gabalda et al., 2010), while other studies have argued that the influence of school/teacher support is limited due to a lack of intervention skills (Alisic, 2012). Furthermore, with the development of professional community-based intervention techniques, communities are playing an increasingly role in reducing children's mental disorders in developed countries (Swenson et al., 2010).

In addition to these two protective factors, maltreatment trauma is also related to some demographic factors, such as a child's gender and age. Differences in maltreatment trauma have been found between girls and boys (Evans et al., 2013), and maltreatment trauma seems to decrease along with a child's maturity (Dunn et al., 2017). Other studies also suggest that children's maltreatment trauma is highly correlated with their parents' mental health and socioeconomic status. Children whose parents have psychological problems or alcohol dependence are more likely to suffer from maltreatment trauma (Ingersoll & Hambrick, 2011; Jose & Cherayi, 2020). Similarly, children who were raised in a family with limited education experiences and inadequate household income are found to be more likely to have mental disorders (Chigogora et al., 2019; Zhou et al., 2020a, 2020b, 2020c).

Ethnic Disparities in Maltreatment Trauma

Currently, it is well documented in academia that maltreatment trauma is influenced by ethnicity. Many studies have shown that some ethnic groups have more severe trauma symptoms than other ethnicities in the United State. For example, with similar traumatic experiences, African Americans and Latinos often report lower depression compared to Whites (Roxburgh & MacArthur, 2014), and European Americans report greater anxious arousal symptoms compared to Latinos (Newcomb et al., 2009). Such ethnic disparities in maltreatment trauma have also been found in other parts of the world. The suicidal ideation of Asians with a history of childhood maltreatment is higher than the suicidal ideation of Whites, Hispanics and Blacks (Bertistianos et al., 2016), and Chinese *Han* girls have more serious mental problems than their ethnic minority peers with a similar severity of abuse (Wan et al., 2019). However, some studies have argued that there is no substantial ethnic difference in psychological trauma after maltreatment (Pérez Benítez et al., 2010). Other studies have offered a more neutral statement and suggest that the impact of ethnicity on the consequences of maltreatment involves tendency rather than severity. Neglected White children showed extensive mental health disorders, Black children showed more anxiety and dysthymia, and Hispanic children showed an increased risk of alcohol problems (Wildom et al., 2012).

There are mainly two theoretical approaches to explain the ethnic disparity in CM trauma. The first approach involves the prevalent attitudes toward discipline/physical

punishment among different ethnicities. Religion and cultural beliefs shape peoples' childrearing norms and their definition of CM (Ben-Arieh & Haj-Yahia, 2006; Coulton, et al., 2018). For example, it is suggested that the Spanish show a strong tolerance of CM due to the influence of patriarchy (Drake & Jonson-Reid, 2011). It is also explained that some physical punishment behaviors can be tolerated and not be regarded as abuse as they are frequently used as traditional ways to discipline children in Asian families (Kesner et al., 2016; Zhai & Gao, 2009). The internalized rationalization of violent behaviors reduces the possibility of maltreatment trauma (Duru et al., 2019), as the child is likely to attribute the abuse to his or her own mistakes rather than to error on the part of the abuser (Plus et al., 2019).

The other approach explains the ethnic disparity of CM trauma as the result of unequal child service resources among different ethnicities. Existing studies indicate that the benign interaction between the individual and the environment is important to restrain CM trauma (Qi et al., 2020), and the unavailability of sufficient child service resources will hinder the development of child resilience (Zhu & Shek, 2020). Evidence from the United States shows that compared to Latinos, Asians, and Anglos, it is more difficult for African-American children to access child service resources in terms of cases open to service, out-of-home placement, and family reunification (Lu et al., 2004). It is also reported that in Israel, it is more difficult for Arab children than for Jewish children to receive continuous child welfare services (Ben-Arieh & Haj-Yahia, 2006). Psychological trauma caused by maltreatment can be suppressed by the improvement of social communication skills. However, children raised in an ethnic community with insufficient professional child services and resources are likely to adopt internalized emotion-oriented coping or experiential avoidance strategies when encountering adversity (Flett et al., 2012; Shenk et al., 2014).

Despite its rapid development, China is still deeply influenced by Confucianism and patriarchal culture, under which the child is the personal property of the parent rather than an independent individual, and child obedience to parents is regarded as important to the maintenance of family order (Peng et al., 2015). Chinese people generally regard physical punishment as a necessary parenting technique (Zhao et al., 2017). A multi-country comparison found that Chinese people have the highest threshold for labeling behaviors as maltreatment (Mesman et al., 2020). Such high tolerance for childhood violence may reduce child post-traumatic depression, as children might rationalize such violent behaviors. In addition, the current child welfare system in China is still underdeveloped, and professional child and family services are very limited (Wan et al., 2020). This might make it difficult to conduct interventions for at-risk children, increasing the possibility of post-traumatic symptoms.

There are very few studies on Chinese ethnic disparities in maltreatment trauma, but evidence has suggested that different ethnicities in China may respond to stressful events or adversities differently. For example, *Tibetan* survivors were reported to have less PTSD symptoms than *Han* survivors after the 2008 *Wenchuan* Earthquake because of the support and comfort gained from Tibetan Buddhism rituals (Mao et al., 2009; Yuan et al., 2009). Religion influences its followers in how they perceive stressful events and how they address problems, which could further lead

to varied outcomes of adversity (Pargament et al., 1998). Moreover, most ethnic minorities in China live in economically underdeveloped areas where the high quality of social services are insufficient and inaccessible (Wan et al., 2019). This makes it difficult for the ethnicities located in less developed regions to receive professional counseling services when they encounter adversities.

Hypotheses

Based on the evidence from the literature, we proposed the following three research hypotheses.

H₁: Child maltreatment poses a general threat with respect to child depression in multi-ethnic areas. A child with maltreatment experiences is more likely to suffer from depression.

H₂: Ethnic disparities exist in the psychological trauma caused by child maltreatment in multi-ethnic areas. There are differences in the strength of the association between child maltreatment and depression in different ethnic groups.

H₃: The protective effect of family relationship and social support factors on child maltreatment trauma differs among ethnicities.

Methods

Procedure

The data of this study come from an empirical survey conducted in three multi-ethnic counties in western China from November 2019 to January 2020. All three of these counties are on the list of the 52 poorest counties in China. County *R* is a *Miao*-populated county in which the *Miao* accounts for 43.5% of the total population. Other ethnic minorities, including the *Dong*, *Yao* and *Zhuang*, together account for 32.4% of the population. County *T* is a *Tibetan* community in northwestern China. The proportion of *Tibetans* in the territory is approximately 38.4%, and other ethnic minorities account for another 8.8% of the population. County *H* is mainly constituted by the *Hui* minority group. The *Hui* and *Dongxiang*, along with other ethnic minorities, account for 57.0% of the total population in this area.

The survey in this study adopted a multistep cluster sampling strategy. First, in each county, one economically developed town, one medium-economically developed town, and one less-developed town were randomly selected. In each town, one elementary school and one junior high school were randomly selected. Considering children's ability to answer questions, we selected for investigation only students from the fifth to the ninth grade. In each grade, we randomly selected one class of students to participate in the survey. A total of 1885 questionnaires were sent out, and 1809 questionnaires were returned. Among them, 1763 questionnaires were valid, which was a valid response rate of 93.5%. The ethnic minority rates of the respondents in *R*, *T*, and *H* counties were 81.0%, 57.0%, and

66.1%, respectively, which were close to the overall ethnic ratios in each county. The ages of the children in our sample ranged from 9 to 16 years, and the average age was 12.34 years.

Ethical standards were strictly reviewed by Nankai University before the investigation. First, we entered each school with a letter of introduction from the local education department. Moreover, we obtained written consent before each investigation with a child. Second, trained investigators presented the entire process of investigation, answered inquiries and maintained order on the spot without any intentionally misleading language for the questions. All the investigators were trained, and they carefully read the written investigation manuals before the survey. Third, considering the potential interference of the teachers, the teachers were asked to be absent from the investigation site. Fourth, the children were required to sit at a distance to avoid mutual interference among classmates. Finally, the time for the investigation was sufficient so that all students could successfully complete the questions.

Measurement

Child Maltreatment

This study used a modified version of the “Juvenile Victimization Questionnaire” (JVQ) Scale to measure CM (Radford et al., 2011, pp. 125–130). Three subtypes of CM, including physical abuse, emotional abuse and neglect, were investigated in the survey. The sexual abuse category was excluded because children in East Asia usually conceal their experiences to avoid family stigma (Zhai & Gao, 2009). Physical abuse was measured by the following items: (1) physical punishment such as standing, kneeling and palming; (2) slapping the face or kicking; (3) beating or kicking important body parts such as the head and chest; (4) beating with a belt, stick or blunt object; (5) striking with hard objects; and (6) burning or scalding. Emotional abuse was measured by the following six items: (1) deliberate insulting; (2) verbally insulting the child’s dignity; (3) refusing to speak to the child; (4) mocking or a lack of respect toward the child; (5) witnessing or hearing violence; and (6) being threatened with violence. Neglect was measured by (1) inadequate daily care, (2) a delay or absence of medical care, (3) ignoring the child’s feelings or emotions, (4) the indulgence of bad behavior, (5) showing a reluctance/unwillingness to assist in the child’s education, and (6) a lack of concern about the child’s safety.

The items were measured by asking the question, “Have you suffered the following experiences in your family in the past year?”. The response options ranged from 0 to 4 (0 = never, 1 = occasionally, 2 = sometimes, 3 = often and 4 = always) on a Likert scale. The Cronbach’s alpha coefficients of physical abuse, emotional abuse, and neglect were 0.74, 0.83, and 0.76, respectively. The KMO coefficients for these three subtypes of maltreatment were 0.80, 0.87, and 0.83, respectively. Bartlett’s significance was 0.00, which showed good reliability. The scores for all three maltreatment subtypes ranged from 0 to 4. When the score was higher, the children were maltreated more frequently.

Depression

This study mainly focuses on child depression because it is most frequently discussed in academia. The DSM-5 Depression Scale (11–17 years old) was used in our survey to measure the children's depression (American Psychiatric Association, 2013). The DSM-5 scale has been used worldwide. Related studies have applied and validated this scale in the Chinese context (Zhang et al., 2018). For all 9 items that measure depression (see Table 2), the respondents were asked to reply to the statement, "Did you experience the following symptoms in the past two weeks?". There were four possible categories of responses to this question (0=none, 1=several days, 2=more than once a week, 3=almost every day). The Cronbach's alpha and KMO coefficients of the 9 items were 0.84 and 0.91, respectively, and Bartlett's significance was 0.00. The depression score ranged from 0 to 27; when the score was higher, the child's depression was more severe. According to McLeod et al. (2016), the measurement of severe depression symptoms (SDS) includes the following two dimensions: (1) *subthreshold depression symptoms* (in which the child reports having at least one of the core symptoms of major depression but has not been diagnosed with a major depressive episode), and (2) *major depressive disorder* (in which the child meets the diagnostic criteria for a major depressive episode).

Influencing Factors

The influencing factors consisted of CM as the risk factor and the parent–child relationship and social support as the protective factors. Specifically, the parent–child relationship was measured through the three variables of the "IPV of parents" (0=neither parent suffers, 1=one parent suffers, 2=both parents suffer IPV), "parent–child trust" (0=neither parent is trusted, 1=one parent is trusted, 2=both parents are trusted), and "parent–child interaction" (interaction that includes playing with, talking to, and educating children; 0=neither parent actively interacts with the child, 1=one parent actively interacts with the child, 2=both parents actively interact with the child). The social support factors included family support (support from parents and relatives), peer support (support from classmates and friends), community support (support from neighbors and community social workers), and school/teacher support (support from teachers and school counselors). These support factors were measured by asking whether the respondents had received psychological counselling services from the above people (0=no, 1=yes).

As suggested by the literature, six other factors were also included as control variables in this study. The child's gender (0=male, 1=female) and age (continuous variable) were first included as these two factors are often reported to be predictive of CM trauma. The socioeconomic status of the family might be also influential. Considering that children might be unable to accurately report the household income of their family, we instead used the father/mother's education experiences (0=no schooling, 1=primary school, 2=junior high school, 3=high school, 4=undergraduate, 5=graduate student) and father/mother's occupation (0=jobless, 1=non-public servant, 2=public servant) to examine the possible influence of parents' socioeconomic status. Non-public servant mainly includes farmers and migrant workers, while public servant mainly includes civil servants, teachers, doctors and village officials. Parents' mental health condition,

namely, whether they have mood disorders or substance-abuse disorders, might also be influential (Huang et al., 2019). Therefore, we also included the factors of father/mother's depressive mood (whether father/mother shows depressive symptoms, 0=yes, 1=no) and father/mother's alcohol dependence (whether father/mother drinks more than 3 times or was drunk once a week, 0=yes, no=1) as control variables in this study.

Analytical Method

This study mainly adopted four research methods. The descriptive statistics were mainly used to compare the data, especially to analyze the SDS rates among different ethnic groups with the Chi-square test. A mean analysis was used to examine the impact of maltreatment on the depression score (DS) with the *F test*. A factor analysis was mainly used for the measurement of CM and depression, which focused on the reliability of their sub-indicators. A linear regression analysis was used to measure the risk factors and protective factors for psychological trauma. Our main statistics were the *B*, standard error (*S.E.*) and *p*-value.

Sample Description

Seven ethnicities were included in our statistics. The data in Table 1 show that the *Dongxiang* (prevalence=82.8%, Mean=1.06) and *Hui* (prevalence=76.9%, Mean=1.01) populations had the highest maltreatment risk. Additionally, *Tibetan* (prevalence=64.3%, Mean=0.62) and *Han* (prevalence=66.7%, Mean=0.64) children had the lowest risk. For the family relationship, *Zhuang* family cohesion was limited; compared to the other ethnic groups, their IPV ratio (8.5%) was significantly higher, while their parent-child trust ratio (32.5%) and active interaction ratio (66.7%) were relatively lower. The parent-child relationship of *Han* and *Tibetan* families seems to be the best. Their parent-child trust ratio (*Han*: 37.1%; *Tibetan*: 38.4%) and parent-child interaction ratio (*Han*: 80.2%; *Tibetan*: 82.7%) were evidently higher than the other ethnic groups. Moreover, the *Han*, *Tibetan* and *Hui* populations showed a relatively higher rate of social support, and their average rates were 36.9%, 39.4% and 37.2%, respectively, compared to the average rates of the *Miao* (28.8%), *Zhuang* (28.8%) and *Dongxiang* (29.0%) populations. In terms of these control variables, the distributions of the gender and age factors in each ethnicity were similar. However, *Miao* and *Zhuang* children reported higher rates of their father's alcohol dependence. Moreover, the *Hui* and *Dongxiang* populations reported relatively higher rates of their parents' unemployment and mood disorders and lower levels of their parents' education.

Results

Child Maltreatment Trauma

Table 2 shows the effect of maltreatment on child depression. The total DS of children with maltreatment experience was 2.09 times the total DS of children

Table 1 Descriptive summary of the study sample

Variable	Overall (N = 1763)	Han (N = 564)	Tibetan (N = 255)	Hui (N = 221)	Miao (N = 231)	Zhuang (N = 117)	Dongxiang (N = 174)	Others (N = 204)
<i>Main independent variables</i>								
Child maltreatment (prevalence)	71.3	66.7	64.3	76.9	71.0	78.6	82.8	73.0
Child maltreatment (severity)	<i>0.76</i>	<i>0.64</i>	<i>0.62</i>	<i>1.01</i>	<i>0.66</i>	<i>0.80</i>	<i>1.06</i>	<i>0.84</i>
IPV of parents (both parents suffer IPV)	5.2	5.9	4.3	5.9	4.3	8.5	3.4	4.4
Parent-child trust (both parents are not trusted)	36.9	37.1	38.4	33.5	40.7	32.5	35.1	37.7
Parent-child interaction (both parents are interactive)	77.1	80.2	82.7	73.8	67.5	66.7	77.0	77.5
Family support (yes)	48.8	52.6	60.0	48.9	39.0	44.4	36.8	48.0
Peer support (yes)	24.8	27.1	25.9	33.0	19.0	17.9	19.5	23.0
Community support (yes)	22.7	25.8	22.4	21.7	16.5	17.1	21.8	26.5
School/teacher support (yes)	42.3	42.2	49.4	45.2	40.7	35.9	37.9	39.2
<i>Control variables</i>								
Child's gender (Male)	50.0	46.8	51.8	52.0	54.1	44.4	51.8	53.4
Child's age	<i>12.34</i>	<i>12.24</i>	<i>12.24</i>	<i>12.78</i>	<i>12.39</i>	<i>11.76</i>	<i>12.82</i>	<i>12.12</i>
Father's education experience	<i>2.69</i>	<i>2.99</i>	<i>2.83</i>	<i>2.23</i>	<i>2.57</i>	<i>2.80</i>	<i>2.34</i>	<i>2.58</i>
Mother's education experience	<i>2.30</i>	<i>2.69</i>	<i>2.32</i>	<i>1.78</i>	<i>2.06</i>	<i>2.71</i>	<i>1.78</i>	<i>2.23</i>
Father is jobless	5.3	4.1	5.5	6.8	4.3	2.6	8.6	6.9
Mother is jobless	13.0	12.5	15.7	13.1	10.0	6.0	14.4	17.2
Father's depressive mood	2.9	1.4	2.7	6.3	2.6	1.7	4.6	2.9
Mother's depressive mood	2.8	2.7	2.7	4.1	0.9	3.4	5.2	2.0
Father's alcohol dependence	7.4	7.3	6.3	2.7	13.3	12.0	5.2	6.9
Mother's alcohol dependence	1.9	2.7	1.2	2.7	1.3	0.9	2.3	0.5

Non-italic characters represent %, italics represent *Mean*

without maltreatment experience ($p=0.00$). The SDS rate of the children with maltreatment experiences also increased to 8.4% from 2.2% ($p=0.00$). Among the three subtypes of maltreatment, the effect of neglect on child depression was the most significant. The DS of children who suffered from neglect was 1.93 times the DS of children who did not suffer from neglect ($p=0.00$). The SDS rate of this group increased from 3.5% (without neglect experiences) to 10.4% ($p=0.00$). The effect of emotional abuse was also significant. The DS of victims of emotional abuse increased by 69.3% ($p=0.00$), and their SDS rate increased by 2.03 times ($p=0.00$). The effect of physical abuse was comparatively less influential; the DS of children who suffered from physical abuse increased by 63.2% ($p=0.00$), and their SDS rate increased by only 75.0% ($p=0.00$). Therefore, H_1 cannot be rejected.

Ethnic Disparities in Maltreatment Trauma

Table 3 shows the results of the effect of maltreatment on child depression in each ethnic group. The data show that among the ethnic groups, *Han* children seemed to be most likely to suffer from maltreatment trauma. The DS of *Han* children with maltreatment experience increased by 1.70 times ($p=0.00$), and their SDS rate increased by 6.55 times ($p=0.00$) compared to the rates in children without maltreatment experience. The effect of maltreatment on ethnic minority children, including the *Miao*, *Tibetan*, *Hui*, and *Dongxiang*, was also influential. The DS of these ethnic minority children who suffered from maltreatment generally increased by 1.81 to 2.03 times ($p\leq 0.01$) compared to the DS of their peers. Comparatively, the effect of maltreatment on children's depression was the lowest among *Zhuang* children. The DS of *Zhuang* children with maltreatment experience increased by only 23.6% ($p=0.32$) and their SDS rate increased by only 1.73 times ($p=0.30$) compared to the rates in *Zhuang* children without maltreatment experience.

Ethnic disparities were also found in the effects of the three subtypes of maltreatment on child depression. The effects of the three subtypes of maltreatment were significant for both *Han* children's DS ($p\leq 0.01$) and their SDS rate ($p\leq 0.05$). Significant effects of the three subtypes of maltreatment on these two dependent variables were also found in *Miao* children ($p\leq 0.05$). For *Tibetan*, *Hui*, and *Dongxiang* children, the effects of the three subtypes of maltreatment were significant on these children's DS ($p\leq 0.01$) but not on their SDS rates ($p>0.05$). For *Zhuang* children, the effect of neglect on DS and SDS was significant ($p\leq 0.05$), but the effects of emotional abuse and physical abuse were not influential ($p>0.1$). Thus, H_2 cannot be rejected.

Ethnic Disparities in the Influencing Factors

Table 4 shows the effects of the influencing factors on child depression. The model without the interaction effect confirms that child depression increased with the frequency of all subtypes of maltreatment ($B=2.45\text{--}3.26$, $p\leq 0.01$). Good

intergenerational relationships had a protective effect on child depression, and increased parent–child trust ($B = -0.56$ to -0.49 , $p \leq 0.01$) and parent–child interaction ($B = -0.78$ to -0.55 , $p \leq 0.01$) could reduce children’s depressive mood. However, the social support factors were not effective in reducing maltreatment trauma. Family support ($p \geq 0.13$), community support ($p \geq 0.76$), and school/teacher support ($p \geq 0.23$) were all insignificant, and peer support even aggravated children’s depressive disorders ($B = 0.78$ – 0.82 , $p \leq 0.01$). In terms of these control variables, girls ($B = 0.59$ – 0.78 , $p \leq 0.01$), late adolescents ($B = 0.43$ – 0.48 , $p \leq 0.01$) and children whose parents have mental disorders (father: $B = -0.72$ to -0.61 , $p \leq 0.05$; mother: $B = -0.88$ to -0.61 , $p \leq 0.05$) were more likely to experience depression.

The results in Table 4 also show the moderation effect of ethnicity. Significant differences in the effect of physical abuse on child depression among the ethnicities were not found. However, the effect of emotional abuse on child depression among the *Hui* ($B = -2.39$, $p = 0.00$) and *Dongxiang* ($B = -2.21$, $p = 0.00$) were significantly less compared to the effect of emotional abuse on child depression among the *Han*. That is, *Han* children were more likely to suffer from depression than *Hui* and *Dongxiang* children after experiencing emotional abuse. Moreover, the effect of neglect on child depression among the *Dongxiang* ($B = -2.38$, $p = 0.00$) was also significantly less than the effect of neglect on child depression among the *Han*.

The results in Table 5 show ethnic disparities in the effect of the influencing factors on child depression. Although maltreatment was a common risk factor in all ethnicities ($B = 0.70$ – 2.66 , $p \leq 0.05$), the protective effect of family relationships on child depression had great ethnic differences. The data show that increased parent–child trust (*Han*: $B = -0.75$, $p = 0.00$; *Tibetan*: $B = -0.71$, $p = 0.07$) and parent–child interaction (*Han*: $B = -0.98$, $p = 0.01$; *Tibetan*: $B = -1.87$, $p = 0.02$) could significantly help reduce the possibility of child depression for *Han* and *Tibetan* children. However, such an effect was not found in other ethnicities. The influences of the social support factors on maltreatment trauma were varied among these ethnicities. The significant effect of peer support on maltreatment trauma was only found among *Han*, *Tibetan*, and *Miao* children; however, the effect of peer support was destructive and only worsened maltreatment trauma (*Han*: $B = 1.01$, $p = 0.02$; *Tibetan*: $B = 1.67$, $p = 0.02$; *Miao*: $B = 1.59$, $p = 0.03$). For *Hui*, *Dongxiang* and *Zhuang* children, neither family relationship factors nor social support factors were effective in reducing maltreatment trauma. Therefore, H_3 cannot be rejected.

Discussion

Based on an empirical survey of 1763 children in three ethnic counties in China, three important conclusions are found. First, child maltreatment poses a general threat to children’s psychological health in multi-ethnic areas. Our data show that all three subtypes of maltreatment, including neglect, emotional abuse, and physical abuse, have negative effects on children’s depression. The negative influence of maltreatment on children’s depressive mood may be universal among different countries and ethnicities. Similar to the research of Vugt et al. (2013), this result also shows that the effects of neglect and emotional abuse on Chinese children’s psychological

Table 2 Effects of maltreatment on child depression in multi-ethnic regions

Variable	Child maltreatment			Physical abuse			Emotional abuse			Neglect		
	No	Yes	F/ χ^2	No	Yes	F/ χ^2	No	Yes	F/ χ^2	No	Yes	F/ χ^2
Depression scores (DS, Mean)	2.94	6.18	189.63**	3.97	6.48	135.15**	3.97	6.72	165.41**	3.70	7.13	266.35**
Feeling depressed, irritable or hopeless	0.36	0.67	69.24**	0.48	0.68	34.14**	0.46	0.72	56.46**	0.43	0.76	90.39**
Not interested in doing anything	0.39	0.81	115.38**	0.53	0.84	73.23**	0.52	0.88	101.76**	0.50	0.92	144.59**
Difficulty falling asleep, not sleeping well, or sleeping too much	0.31	0.68	75.64**	0.43	0.71	55.19**	0.43	0.73	60.72**	0.40	0.79	107.94**
Poor appetite, weight loss, or overeating	0.27	0.58	58.80**	0.34	0.64	69.95**	0.37	0.64	54.43**	0.33	0.69	97.72**
Feeling tired or low energy	0.41	0.78	73.82**	0.53	0.82	51.77**	0.52	0.86	74.73**	0.48	0.92	133.89**
Feeling that you are a disappointment or a failure	0.43	0.93	110.73**	0.61	0.96	61.56**	0.61	0.99	76.56**	0.56	1.07	142.32**
Difficulty concentrating, such as homework, reading or watching TV	0.40	0.77	82.67**	0.50	0.83	76.76**	0.52	0.84	73.75**	0.53	0.83	64.91**
Slow movement, slow speech or restlessness	0.22	0.53	71.32**	0.30	0.57	65.69**	0.31	0.58	66.31**	0.30	0.61	90.10**
Sometimes wanting to hurt yourself	0.14	0.42	61.13**	0.24	0.44	36.39**	0.22	0.49	68.34**	0.19	0.54	120.46**
Severe depression symptoms (SDS, %)	2.2	8.4	22.81**	4.8	8.4	9.70**	3.4	10.3	34.11**	3.5	10.4	33.66**

** Represents $p \leq 0.01$, * represents $p \leq 0.05$, + represents $p \leq 0.1$

Table 3 The effects of maltreatment on child depression in different ethnicities

Ethnicities	Child maltreatment		Physical abuse		Emotional abuse		Neglect	
	DS	SDS	DS	SDS	DS	SDS	DS	SDS
<i>Han</i>	2.19 (5.91)**	1.1 (8.3) **	3.31 (6.07) **	3.9 (7.9)*	3.31 (6.59)**	1.8 (11.6)**	3.33 (6.65)**	2.7 (10.6)**
<i>Tibetan</i>	3.07 (6.18)**	4.4 (9.1)	3.77 (6.65)**	5.7 (9.6)	3.86 (6.94)**	5.2 (11.0) ⁺	3.53 (7.53)**	5.7 (10.2)
<i>Hui</i>	4.29 (7.77) **	3.9 (11.2)	5.31 (8.11) **	6.7 (11.5)	5.62 (8.17)**	6.7 (12.0)	5.27 (8.68)**	6.3 (12.7)
<i>Miao</i>	3.34 (6.04) **	1.5 (6.1)	4.16 (6.73)**	3.0 (7.1) *	4.08 (6.65)**	0.8 (9.4)**	3.43 (7.24)**	1.7 (8.1)*
<i>Zhuang</i>	4.16 (5.14)	4.0 (10.9)	4.37 (5.53)	10.0 (8.8)	4.20 (5.46)	8.2 (10.3)	3.89 (5.89)*	3.6 (14.8)*
<i>Dongxiang</i>	3.20 (6.32) **	0.0 (4.2)	4.63 (6.37)*	3.4 (3.5)	4.64 (6.66)**	1.3 (5.1)	4.01 (7.29)**	0.0 (6.4)*
<i>Others</i>	2.84 (5.69) **	1.8 (10.1) ⁺	4.03 (5.75)**	4.1 (11.3)	3.75 (6.12)**	4.9 (10.9)	3.46 (6.65)**	4.6 (11.5) ⁺

^aIn the statistics of the depression score (DS), the value outside the brackets is the score of children without maltreatment experiences, and the value inside the brackets is the score of maltreatment victims

^bIn the statistics of severe depression symptoms (SDS), the number outside the brackets is the proportion of children without maltreatment experiences, and the number inside the brackets is the proportion of maltreatment victims

^cRepresents $p \leq 0.01$, * represents $p \leq 0.05$, ⁺ represents $p \leq 0.1$

trauma are more significant than the effects of physical abuse. This finding suggests that the healing of psychological trauma rather than physical injury is more important in maltreatment trauma therapy. This could be related to the high tolerance of physical discipline in Chinese culture, under which children might rationalize such violent behaviors (Plus et al., 2019). This, in turn, reduces the risk for child post-traumatic depression (Duru et al., 2019). On the other hand, the significant effects of neglect and emotional abuse on child depression could be related to the fact that today, many children in China have been separated from their parents as left-behind children. Parental absence could result in more limited parent–child trust and is not conducive to developing an intimate parent–child relationship, which could make children more vulnerable (Kaur & Kearney, 2013; Lowell et al., 2014).

Second, ethnic disparities in maltreatment trauma are found in multi-ethnic regions. Among the different ethnic groups in our survey, the effect of maltreatment on child depression is most influential among *Han* people and least influential among *Zhuang* people, while other ethnic groups are in between these two groups. These ethnic disparities are also found in the effects of all three subtypes. Psychological trauma cannot be completely attributed to the severity of maltreatment itself (i.e., compared to other ethnic groups, the *Hui*, *Zhuang*, and *Dongxiang*, who have higher rates of maltreatment, do not show more psychological trauma). For different ethnic groups, perceptions or tolerance of child abuse (Drake & Jonson-Reid, 2011), the spiritual comfort derived from religion (Yuan et al., 2009) and the availability of child service resources (Qi et al., 2020) could together lead to differences in CM trauma. This also shows that the internalization of psychological trauma may be a process of self-repression (van Harmelen et al., 2010), and children's emotion regulation ability after adversity plays a mediating role in maltreatment and its consequences (Crow et al., 2014).

Third, ethnic disparities are also found in the effects of the protective factors on maltreatment trauma in multi-ethnic regions. The effect of family relationships on maltreatment trauma is deeply influenced by family cohesion. A good family relationship can help children develop secure attachment, moral competence, and prosocial values (van Harmelen et al., 2016; Zhou et al., 2020a, 2020b, 2020c), which could all help them better adjust their negative feelings and emotions. Specifically, the *Han* and *Tibetan* populations, who have more harmonious parent–child relationships, have a reduced likelihood of maltreatment trauma. For the *Hui*, *Zhuang* and *Dongxiang* populations, their lower intergenerational cohesion makes the potentially protective influences ineffective. These findings revise Wang and Kenny's conclusion that the reason for the limited protective effect of family is not only the severity of maltreatment but also parent–child cohesion. The protective effect of social support as suggested in the literature has not been found in our study. In multi-ethnic areas of China, social support factors are not influential among the *Hui*, *Zhuang*, and *Dongxiang* populations, and peer support factors increase the possibility of CM trauma among the *Han*, *Tibetan* and *Miao* populations. The reason for this may be non-professional psychological intervention skills, as Alisic (2012) mentioned. Currently, because China still fails to provide adequate social services for children in multi-ethnic areas, the formal support (including personnel, funds, training courses and technology) for Chinese teachers and social workers is very limited (Wan et al.,

Table 4 Influencing factors for child depression in multi-ethnic regions

Variable	Model 1 (Physical abuse)		Model 2 (Emotional abuse)		Model 3 (Neglect)	
	Stage 1	Stage 2	Stage 1	Stage 2	Stage 1	Stage 2
<i>Main independent variables</i>						
<i>Tibetan (Han = ref.)</i>	0.68 (0.34)*	0.72 (0.38) ⁺	0.75 (0.33)*	0.87 (0.37)*	0.70 (0.33)*	0.86 (0.36)*
<i>Hui (Han = ref.)</i>	1.61 (0.38)**	1.81 (0.45)**	1.46 (0.38)**	2.16 (0.42)**	1.70 (0.37)**	1.70 (0.42)**
<i>Miao (Han = ref.)</i>	0.61 (0.36) ⁺	0.27 (0.41)	0.45 (0.36)	0.31 (0.40)	0.37 (0.36)	0.40 (0.40)
<i>Zhuang (Han = ref.)</i>	0.42 (0.46)	0.87 (0.54)	0.13 (0.45)	0.48 (0.55)	0.15 (0.45)	0.52 (0.52)
<i>Dongxiang (Han = ref.)</i>	0.59 (0.42)	0.58 (0.49)*	0.70 (0.41)*	1.23 (0.47)**	0.55 (0.41)	1.15 (0.46)*
<i>Others (Han = ref.)</i>	0.40 (0.37)	0.81 (0.43) ⁺	0.21 (0.37)	0.85 (0.42)*	0.11 (0.37)	0.73 (0.42) ⁺
Child maltreatment	2.97 (0.30)**	3.30 (0.56)**	2.45 (0.23)**	3.72 (0.45)**	3.26 (0.27)**	4.37 (0.53)**
IPV of parents	0.44 (0.22)*	0.42 (0.22)*	0.41 (0.21) ⁺	0.37 (0.21) ⁺	0.40 (0.21) ⁺	0.38 (0.21) ⁺
Parent-child trust	-0.56 (0.14)**	-0.56 (0.14)**	-0.52 (0.14)**	-0.47 (0.14)**	-0.49 (0.14)**	-0.46 (0.14)**
Parent-child interaction	-0.78 (0.21)**	-0.78 (0.21)**	-0.65 (0.21)**	-0.66 (0.21)**	-0.55 (0.21)**	-0.56 (0.21)**
Family support	-0.29 (0.25)	-0.31 (0.25)	-0.37 (0.25)	-0.33 (0.24)	-0.21 (0.24)	-0.19 (0.24)
Peer support	0.82 (0.27)**	0.82 (0.27)**	0.78 (0.27)**	0.77 (0.27)**	0.82 (0.26)**	0.80 (0.26)**
Community support	0.04 (0.27)	0.02 (0.27)	0.08 (0.27)	0.09 (0.27)	-0.04 (0.27)	0.01 (0.27)
School/teacher support	-0.18 (0.25)	-0.16 (0.25)	-0.17 (0.25)	-0.19 (0.24)	-0.30 (0.24)	-0.30 (0.24)
<i>Interaction terms</i>						
<i>Tibetan x Child maltreatment</i>		-0.21 (0.83)		-0.66 (0.75)		-0.95 (0.80)
<i>Hui x Child maltreatment</i>		-0.73 (0.91)		-2.39 (0.63)**		-0.37 (0.86)
<i>Miao x Child maltreatment</i>		2.10 (1.15) ⁺		0.40 (0.80)		-0.50 (0.92)
<i>Zhuang x Child maltreatment</i>		-2.31 (1.52)		-1.46 (0.95)		-1.82 (1.10) ⁺
<i>Dongxiang x Child maltreatment</i>		-0.05 (0.93)		-2.21 (0.75)**		-2.38 (0.82)**
<i>Others x Child maltreatment</i>		-1.77 (0.97) ⁺		-2.45 (0.73)**		-2.63 (0.85)**

Table 4 (continued)

Variable	Model 1 (Physical abuse)		Model 2 (Emotional abuse)		Model 3 (Neglect)	
	Stage 1	Stage 2	Stage 1	Stage 2	Stage 1	Stage 2
<i>Control variables</i>						
Child's gender	0.78 (0.21)**	0.79 (0.21)**	0.59 (0.21)**	0.58 (0.21)**	0.64 (0.21)**	0.63 (0.21)**
Child's age	0.47 (0.09)**	0.47 (0.09)**	0.48 (0.09)**	0.47 (0.09)**	0.43 (0.08)**	0.43 (0.08)**
Father's education experience	-0.17 (0.14)	-0.17 (0.14)	-0.14 (0.14)	-0.13 (0.14)	-0.17 (0.14)	-0.17 (0.14)
Mother's education experience	0.25 (0.13) ⁺	0.26 (0.13) ⁺	0.20 (0.13)	0.17 (0.13)	0.23 (0.13) ⁺	0.22 (0.13)
Father is public servant (Jobless = ref.)	-0.70 (0.72)	-0.74 (0.72)	-0.81 (0.72)	-1.15 (0.72)	-0.55 (0.71)	-0.73 (0.71)
Father is non-public servant	-0.86 (0.55)	-0.84 (0.55)	-0.93 (0.55) ⁺	-1.04 (0.54) ⁺	-0.92 (0.54) ⁺	-1.00 (0.54) ⁺
Mother is public servant (Jobless = ref.)	0.07 (0.68)	0.08 (0.68)	-0.07 (0.68)	0.15 (0.68)	-0.11 (0.68)	-0.02 (0.67)
Mother is non-public servant	0.41 (0.36)	0.41 (0.36)	0.47 (0.36)	0.51 (0.35)	0.60 (0.35) ⁺	0.67 (0.35)
Father's depressive mood	-0.72 (0.30)*	-0.69 (0.30)*	-0.69 (0.30)*	-0.71 (0.30)*	-0.66 (0.29)*	-0.66 (0.29)*
Mother's depressive mood	-0.88 (0.30)**	-0.90 (0.30)**	-0.75 (0.30)*	-0.77 (0.30)**	-0.61 (0.29)*	-0.63 (0.29)*
Father's alcohol dependence	-0.38 (0.19)*	-0.38 (0.19)*	-0.37 (0.19)*	-0.33 (0.19) ⁺	-0.37 (0.19)*	-0.39 (0.19)*
Mother's alcohol dependence	0.01 (0.32)	-0.03 (0.32)	0.03 (0.32)	-0.01 (0.32)	0.79 (0.32)	0.05 (0.32)
Adjusted R Square	0.19	0.19	0.19	0.20	0.21	0.21

B value is outside the brackets, S.E. is inside the brackets, ** represents $p \leq 0.01$, * represents $p \leq 0.05$, + represents $p \leq 0.1$

Table 5 Influencing factors for child depression in different ethnicities

Variable	Model 4 (<i>Han</i>)	Model 5 (<i>Tibetan</i>)	Model 6 (<i>Hui</i>)	Model 7 (<i>Miao</i>)	Model 8 (<i>Zhuang</i>)	Model 9 (<i>Dongxiang</i>)	Model 10 (<i>Others</i>)
Child maltreatment	1.65 (0.18) **	1.20 (0.29) **	1.35 (0.34) **	2.66 (0.36) **	1.71 (0.52) **	1.38 (0.31) **	0.70 (0.31) *
IPV of parents	0.02 (0.34)	0.11 (0.58)	0.63 (0.67)	-0.41 (0.68)	1.20 (0.72) +	0.87 (0.78)	-0.04 (0.65)
Parent-child trust	-0.75 (0.23) **	-0.71 (0.39) +	-0.24 (0.44)	-0.41 (0.39)	-0.54 (0.56)	-0.07 (0.46)	-0.73 (0.40) +
Parent-child interaction	-0.98 (0.38) **	-1.87 (0.78) *	-1.43 (0.86) +	-0.27 (0.37)	-0.57 (0.64)	0.17 (1.00)	-0.12 (0.60)
Family support	0.32 (0.39)	-1.07 (0.65)	0.42 (0.88)	-0.48 (0.65)	-0.73 (0.94)	-0.24 (0.84)	-0.56 (0.69)
Peer support	1.01 (0.42) *	1.67 (0.70) *	0.73 (0.82)	1.59 (0.74) *	-1.06 (1.23)	0.42 (1.01)	-1.51 (0.77) +
Community support	0.39 (0.41)	0.19 (0.72)	-0.97 (0.91)	-0.02 (0.77)	-0.87 (1.23)	0.08 (0.93)	0.70 (0.75)
School/teacher support	-0.76 (0.40) +	-0.51 (0.66)	0.38 (0.83)	0.38 (0.65)	0.62 (1.04)	0.15 (0.76)	-0.24 (0.69)
Child's gender	0.61 (0.34) +	0.64 (0.58)	0.06 (0.68)	1.64 (0.57) **	-1.43 (0.89)	0.06 (0.72)	2.75 (0.62) **
Child's age	0.42 (0.14) **	0.51 (0.24) *	0.29 (0.29)	0.04 (0.22)	0.34 (0.32)	0.46 (0.27) +	0.95 (0.25) **
Father's education experience	-0.26 (0.23)	-0.50 (0.38)	-0.36 (0.45)	0.19 (0.37)	-0.46 (0.62)	0.34 (0.43)	0.88 (0.42) *
Mother's education experience	0.03 (0.22)	0.09 (0.38)	1.07 (0.43) *	0.78 (0.36) *	0.77 (0.53)	-0.37 (0.50)	-0.48 (0.37)
Father is public servant	1.83 (1.22)	-1.61 (1.89)	-1.21 (2.46)	-3.57 (1.83) +	1.31 (3.69)	-2.82 (2.21)	2.95 (3.08)
Father is non-public servant	0.58 (1.00)	-1.52 (1.48)	-2.05 (1.69)	-0.67 (1.40)	3.40 (3.11)	-2.84 (1.79)	-1.78 (1.42)
Mother is public servant	0.09 (1.03)	0.25 (2.00)	2.03 (2.27)	2.51 (1.93)	0.16 (1.60)	-1.74 (2.64)	-0.90 (2.66)
Mother is non-public servant	0.84 (0.57)	0.57 (0.87)	1.88 (1.26)	1.59 (1.00)	0.04 (1.80)	0.66 (1.45)	0.44 (0.89)
Father's depressive mood	-1.51 (0.57) **	-0.17 (0.94)	-0.01 (0.79)	0.34 (0.81) **	0.87 (1.34)	1.29 (0.77) +	-1.07 (1.00)
Mother's depressive mood	-0.40 (0.49)	-1.79 (0.91) *	-0.55 (0.82)	-0.55 (1.03)	0.65 (1.12)	-1.90 (0.81) *	-2.24 (1.03) *
Father's alcohol dependence	0.01 (0.29)	-0.35 (0.54)	-0.60 (0.98)	-0.95 (0.45) *	0.53 (0.67)	0.17 (0.87)	-0.23 (0.51)
Mother's alcohol dependence	0.62 (0.50)	-0.20 (0.91)	0.95 (0.95)	-2.03 (0.85) *	-1.34 (1.61)	2.04 (1.20) +	0.60 (1.05)
Adjusted <i>R Square</i>	0.26	0.27	0.15	0.32	0.11	0.17	0.25

B value is outside the brackets, *S.E.* is inside the brackets, ** represents $p \leq 0.01$, * represents $p \leq 0.05$, + represents $p \leq 0.1$

2020). Without proper training or education, the current counseling services provided by teachers and community workers are neither self-initiating nor professional in most multi-ethnic communities. Peer support may even enhance children's depression due to the effects of empathy when the left-behind rate is high (Leshem et al., 2016).

It is worth noting that social demographic factors such as age, gender, and parental depression have significant effects on child post-traumatic depression. Our results support that compared to boys, girls have higher risks for CM (Evans et al., 2013). We also find that maltreatment trauma does not necessarily decrease as a child matures (Dunn et al., 2017). The increasing academic pressure and burden experienced by Chinese upper-grade children could make them more vulnerable than younger children (Zhou et al., 2020a, 2020b, 2020c). Our results also support that child depression is highly related to parents' depressive mood (Ingersoll & Hambrick, 2011). These findings suggest that in practice, there is a need to pay more attention to those children at higher risk, including those who have parents with psychological disorders.

Policy Implications

This study has profound implications for child policy in China. Traditionally, CM has been regarded as a necessary way to discipline children and maintain family order (Peng et al., 2015). Therefore, CM trauma is easily overlooked and not taken seriously by many Chinese parents in multi-ethnic areas. Moreover, the current child welfare system in China is orphan-based, and over 200 million Chinese non-orphans are actually excluded (Wan et al., 2020). The current child policy in China has not been effective in intervening in the family parenting process and in regulating the abusive behaviors of parents. Since 2010, the Chinese government has begun to cooperate with UNICEF and has established 120 child welfare demonstration villages in five provinces; they aimed to provide universal welfare services such as temporary guardianship and psychological counseling for all children (UNICEF, 2015). However, by 2015, only 100 thousand children were covered by this program (UNICEF, 2015), and most Chinese children are unable to receive high-quality child welfare services (Jiang et al., 2019). Some unofficial projects, such as Hong Kong's "P.A.T.H.S. Project", have been experimented with in certain cities and have shown good intervention effects, but these still have not been widely implemented in mainland China (Zhu & Shek, 2020). Thus, professional family and child services are difficult to obtain, especially in underdeveloped multi-ethnic areas (Man et al., 2017). For the *Han* and *Tibetan*, the improvement of parent-child cohesion could reduce children's depression to a certain extent, while the abused children among the *Hui* and *Dongxiang* who are raised in high-risk families might only be able to rely on themselves to deal with adversity. It is urgent to provide universal child welfare services to children in multi-ethnic areas.

Contributions and Limitations

Our study mainly aims to reveal the potential Chinese ethnic disparities in CM trauma as few studies have explored the relationship between ethnicity and CM trauma in multi-ethnic regions. The results of this study not only indicate a correlation between ethnicity and maltreatment trauma in China but also respond to important issues in the international debate. Our results show that the current social support for abused children in the multi-ethnic regions of China is highly insufficient. It is urgent to reform the current residual orphan-based child welfare system and provide universal child welfare services to children in multi-ethnic areas.

Admittedly, there are some limitations of this study. First, considering the difficulties in obtaining reliable and valid data, we do not further our study to draw a link with ethnic culture and family values; therefore, we are unable to determine the extent to which the existing ethnic disparities in CM trauma are related to cultural factors. Second, we do not further the study to address the issue of whether there might be a correlation between who the maltreatment is from and where the support is from. Third, given the sensitivity of reporting sexual abuse experiences in East Asia, this study did not include sexual abuse in the survey. Fourth, due to the unavailability of official and public data, this study did not fully consider the influence of the potential differences of the general depression rate among ethnicities. In the future, studies should further explore the ethnic disparities in sexual abuse and their influence on child depression, and they should also examine the possible influence of regional factors such as different depression rates and regional social expenditures on child services.

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Declarations

Conflict of interest We have no known conflicts of interest to disclose.

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