# THERAPISTS' REPORTING PRACTICES AND BELIEFS ABOUT MANDATORY CHILD ABUSE REPORTING LAWS

CARRIE ANN HERDER

Bachelor of Art

University of Denver

1991

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
MASTER OF SCIENCE
December, 1997

OKLAHOMA STATE UNIVERSITY

THERAPISTS' REPORTING PRACTICES AND

BELIEFS ABOUT MANDATORY CHILD

ABUSE REPORTING LAWS

Thesis Approved:

Kathleen Bugge
Thesis Adviser

Charles C Henderson

Dana Fournier

Wayne B Powell
Dean of the Graduate College

ACKNOWLEDGMENTS

I wish to express my sincere appreciation to my major advisor, Dr. Kathleen Briggs, for her immense contribution to this project. Her support, encouragement, long hours, and vast experience were immeasurable. I would also like to thank Dr. Charles Hendrix for his participation and time spent discussing the importance of this research. I would like to thank Dr. Rex Culp for his participation in the early stages of this project, especially his suggestions regarding methodology and instrument construction. Further, I would like to thank Dr. Dave Fournier for agreeing to join my committee at such a late date, and for his large contribution to my professional growth. In addition, all three of these individuals deserve my thanks in providing the supervision and education necessary in my continued growth as a therapist.

I would also like to thank my friends and fellow marriage and family therapy students for their continued support and encouragement. I would also like to extend my appreciation for the hours of help they provided with some of the more tedious aspects of this research project.

Finally, I would like to thank my family. Their love and support have given me the strength and determination to make this endeavor possible.

TABLE OF CONTENTS

LIST OF TABLES

# CHAPTER I

## INTRODUCTION

The Children's Bureau of the National Center on Child Abuse and Neglect drafted the first child abuse reporting law in the United States in 1963 (Kalichman, 1993; Thompson-Cooper, Fugere, & Cormier, 1993). This law was created in response to work on child maltreatment by C. Henry Kempe and colleagues that described the battered child syndrome and encouraged the establishment of mandatory reporting laws for physicians as the first line of defense (Kalichman, 1993). By 1974, every state had established mandatory reporting legislation (Thompson-Cooper et al., 1993).

Since 1974, mandatory reporting statutes have undergone a number of revisions. One such change occurred in the type of professionals mandated to report. For example, in addition to physicians and other medical professionals, every state now requires mental health professionals to report cases of suspected abuse (Kalichman, 1993). Other revisions have included such issues as types of maltreatment requiring reports and circumstances requiring a report. Consequently, these statutes have become more inclusive and now include physical abuse, sexual abuse, emotional abuse, and neglect. These statutes have also given immunity to individuals making reports of abuse and have designated legal consequences for failure to report suspected abuse (Kalichman, 1993).

For example, in Oklahoma, the law includes various forms of abuse and neglect in their child abuse laws. These include any "harm or threatened harm" to a child under 18 years of age including but not limited to "nonaccidental physical or mental injury, sexual abuse, sexual exploitation, or negligent treatment or maltreatment including the failure to

provide adequate food, clothing, shelter, or medical care" (Child Abuse Act, 1992). In addition, Oklahoma mandates every citizen to report suspected child abuse. This mandate specifically includes health care professionals, teachers, and any other person who has reason to suspect child abuse of a child under 18 years of age. While all states have mandatory child abuse reporting laws, some variance exists in these laws across states. This study will use the Oklahoma law to define child abuse and identify mandated reporters.

Mandatory reporting laws were created for a number of reasons. Leong, Silva, and Weinstock (1992) stated that originally the primary goal of child abuse reporting laws was to protect children. Walters (1995) expressed that the interests and rights of parents are not always compatible with the interests and rights of their children. This suggests the need to balance the rights of parents to rear their children as they see fit with children's rights as human beings. Further, Walters (1995) indicated that the community must take an interest in protecting vulnerable children. Thus, these laws provide a safeguard at the societal level to protect children against further abuse and alleviate the detrimental effect of abuse they have already received from their parents (Walters, 1995).

Currently, these statutes serve more than just the purpose of protecting abused children from further abuse. Smith-Bell and Winslade (1994) indicated that they also serve to protect other children from becoming victims of abuse, provide treatment for already abused children, and provide punishment and treatment for the abusers. In other words, by identifying cases of suspected abuse we can take action to both prevent future abuse and treat those who have already been abused. Further, these laws protect

professionals who are working with these families by not placing these professionals in the position of deciding what is best for the child or trying to protect the child from further abuse. Instead, these laws establish for trained agencies to provide these services while the professional facilitates this process by providing treatment.

While many may agree that the above purposes are important, research has shown that many mental health professionals do not report suspected cases of child maltreatment (e.g. Kalichman, 1993; Kalichman & Brosig, 1993). Since protection of children is such an important goal, understanding why some cases of child maltreatment go unreported is critical.

Purpose

The purpose of this study was to investigate reporting practices of therapists and to examine some of the factors and beliefs about mandated reporting laws and the process of reporting which may influence the decision of whether to report suspected child abuse. In addition, this study was designed to examine the perceived impact on therapy of mandated reporting laws. Specifically, what is the perceived impact of reporting on the family, the therapist-client relationship, and the client's decision to continue or terminate therapy? In exploring this question, mediating behaviors of forewarning practices and the amount of involvement of clients in the reporting process are evaluated.

Hypotheses

1. Therapists who believe that mandated child abuse reporting laws are necessary and effective will be more likely to report suspected cases of child abuse than therapists who do not believe that these laws are necessary and effective.

2. Therapists who perceive that reporting has a positive impact will be more likely to report suspected cases of child abuse than therapists who perceive that reporting has a negative impact.

3. Therapists who forewarn clients of limits in confidentiality will be more likely to report suspected cases of child abuse than therapists who do not forewarn clients of limits in confidentiality.

4. Compared to therapists who do not forewarn, therapists who forewarn clients will be more likely to perceive that a positive therapist-client relationship is maintained and that clients continue therapy once a report is made.

5. Therapists who involve clients in the reporting process are more likely to perceive that they maintain a positive relationship with their clients and that clients will be less likely to terminate therapy than therapists who do not involve clients in the reporting process.

Conceptual Framework

This study will use Kohlberg's theory of moral development as the conceptual framework for this study. Specifically, Kohlberg's theory (Kohlberg, 1984) suggests that moral dilemmas exist when a situation entails more than one moral principle which are in conflict. In these cases, individuals make a moral judgment concerning which moral principle is more appropriate in resolving the conflict. In the case of mandated reporting laws, therapists are faced with moral dilemmas between the mandatory reporting law, the principle of autonomy and privacy of clients, and the principle of beneficence.

One dilemma that professionals face is the perceived conflict between the legal principle of confidentiality and the mandatory reporting laws (Walters, 1995). Butz (1985) has defined confidentiality as "an ethical standard of conduct that requires professionals to prevent disclosure to third parties of any information communicated by patients or clients in the course of the professional relationship -- assuming that the patient or client has not consented to such disclosure" (p. 84). The need for confidentiality is based on the principle of autonomy and the right to privacy of clients. However, there are times when the law requires that confidentiality be breached. The dilemma exists when a professional suspects child abuse, the law mandates that the professional breach confidentiality, yet clients may only disclose abuse to the professional because they believe that confidentiality is absolute. Therefore, when a professional makes a report of suspected child abuse, many clients feel betrayed by the professional who is in the position of helping them (Butz, 1985).

A second dilemma has to do with the principle of beneficence (Kennel & Agresti, 1995; MacNair, 1992; Stadler, 1989). This principle has to do with fostering good and preventing harm. Therapists are in disagreement as to whether reporting suspected child abuse helps to prevent further abuse and provides help to the family or does not protect the child from further abuse and is detrimental to the family's welfare (for example, Pope & Bajt, 1988; Van Eenwyk, 1990). Kennel and Agresti (1995) explained this dilemma by pointing out that while we attempt to protect the child by reporting abuse, we may actually harm the therapeutic relationship, the family, and possibly even the child victim. Consequently, therapists often take into account a number of factors other than just

strictly abiding by the law when they make the decision of whether to report suspected child abuse.

Definitions

Child Abuse. For the purpose of this study, child abuse is defined as any harm or threatened harm to a child under 18 years of age including but not limited to nonaccidental physical or mental injury, sexual abuse, sexual exploitation or negligent treatment or maltreatment including the failure to provide adequate food, clothing, shelter, or medical care (Child Abuse Act, 1992).

Reporter Status. There are three levels of reporter status used in this study. Consistent reporters are defined as those who have reported at least one case of suspected child abuse, and have never made the decision not to report a suspected case. The second group, inconsistent reporters, are defined as those who have made the decision not to report at least one case of suspected child abuse. Finally, the third group, non reporters, are defined as those who have had no history of reporting suspected child abuse due to not being exposed to a case of suspected child abuse.

# CHAPTER II

# LITERATURE REVIEW

This chapter will review the current literature concerning mandatory child abuse reporting laws. The review will discuss the existing statutes requiring mandated reporting of child maltreatment. Next, current reporting behavior of mental health professionals will be addressed. Then, factors influencing decisions to report will be considered. Further, potential mediating factors of forewarning and reporting practices will be addressed. Finally, limits of existing research will be addressed.

## Mandatory Reporting Laws

### Mandated Reporters

Mandatory reporting statutes have been expanded to include a wide range of professionals, in addition to physicians and other medical professionals, who are required to report suspected abuse. While there is some variation across states, every state requires mental health professionals to report suspected abuse (Kalichman, 1993). In addition, school teachers and administrators are mandated in all states to report child maltreatment (Crenshaw, Crenshaw, & Lichtenberg, 1995). Other mandated reporters often include child care providers, researchers, commercial film developers, pharmacists, or religious healers (Kalichman, 1993; Liss, 1994; Zellman, 1990).

Further, some statutes require any person who suspects abuse to report (Kalichman, 1993; Walters, 1995). Such statutes exist in Florida, Indiana, Kentucky, Minnesota, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, and Oklahoma (Child Abuse Act, 1992; Kalichman, 1993). Further, Canadian provinces and

territories require all persons to report suspicions of abuse (Walters, 1995). What this suggests for some professionals, such as those in Oklahoma, is that they are not just required to report in their capacity as a mental health professional, but are required to report suspected child abuse in all arenas of their life. This takes reporting of suspected child abuse outside the confines of the therapy office where there are expectations of confidentiality.

Types of Child Maltreatment to be Reported

Mandatory reporting statutes were originally developed to identify cases of physical abuse (Kalichman, 1993). As these statutes were revised, other types of child maltreatment requiring reports were identified to include physical abuse, sexual abuse, neglect, and emotional maltreatment. However, every state does not list all of these types of maltreatment in their reporting statutes. For example, some state reporting laws do not include poverty-related neglect, emotional maltreatment, educational neglect, or medical neglect in their definitions of abuse (Kalichman, 1993).

In addition, the way in which these types of maltreatment are defined can vary considerably from state to state (Kalichman, 1993). First, legal definitions of abuse are defined by either focusing on the actions of the abusive adult or signs of abuse displayed by the child. Second, legal definitions of abuse exist on a continuum from broad to narrow (Kalichman, 1993). These variations in reporting laws can cause difficulties for mandated reporters. For example, Kalichman (1993) found that broad definitions of abuse are likely to result in over-reporting with many cases going unfounded, whereas narrow definitions lead to underreporting of abuse.

Degree of Certainty

States have enacted legislation to describe the circumstances under which a report must be made. Most states only require that a professional have a reason to believe or reasonable cause to suspect that abuse is occurring (Kalichman, 1993). Consequently, professionals are not required to substantiate their suspicions of abuse before reporting to the appropriate authorities. Other states have enacted legislation that limits the conditions under which reports are to be made. For example, Wisconsin and Mississippi only require reporting of suspected abuse of a child personally seen by the professional (Kalichman, 1993). Thus, suspected child abuse indicated by any other source than the supposed abused child would not fall within the parameters of these narrow reporting laws (Kalichman, 1993). However, professionals are allowed to make voluntary reports of suspected child abuse that fall outside the limits of these narrow reporting guidelines (Kalichman, 1993).

Immunity for Professionals Reporting Abuse

Professionals are protected when they make reports in good faith and have an absence of malicious intent, regardless of whether or not abuse is substantiated when investigated (Kalichman, 1993). Individuals making good faith reports of suspected abuse are immune from any liabilities that may be associated with such a report (Kalichman, 1993; Thompson-Cooper et al., 1993; Walters, 1995). This immunity is provided to encourage professionals to report suspected cases without fear of prosecution if they are wrong (Kalichman, 1993).

Penalties for Failure to Report

There are a number of sanctions that may be imposed for failure to report abuse. Sanctions include being charged with a misdemeanor that can carry penalties of a fine or a jail sentence (Kalichman, 1993). Further, failure to report suspected abuse may result in suspension or revocation of professional licensure (Kalichman, 1993). In addition to criminal charges, civil action may be taken as well (Kalichman, 1993; Thompson-Cooper, 1993).

While these sanctions do exist, there is much variability in whether statutes define precise penalties for failure to report (Kalichman, 1993; Walters, 1995). In some jurisdictions, there are not clear penalties for failure to report even though this is seen as an offense (Walters, 1995). Further, even when clear sanctions do exist, many psychologists who fail to report suspected child abuse are not identified or receive no sanction for failure to report. Those who are identified are usually found not guilty due to the vagueness of reporting statutes as to what qualifies as a reportable case of abuse (Kalichman, 1993). Lack of legal sanctions may make the decision not to report suspected cases of child abuse easier for psychologists.

## Reporting Behavior of Professionals

A number of studies have identified professionals' tendency to report suspected cases of abuse in both actual and hypothetical cases (Beck & Ogloff, 1995; Brosig & Kalichman, 1992a; Crenshaw, Crenshaw, & Lichtenberg, 1995; Green & Hansen, 1989; Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Kalichman, Craig, & Follingstad, 1988, 1990; Kennel & Agresti, 1995; Pope & Bajt, 1988). The percentage of licensed

mental health professionals who stated that they would tend not to report hypothetical cases of abuse ranged from 18-32% (Green & Hansen, 1989; Kalichman & Craig, 1991; Kalichman et al., 1990). Further, when licensed mental health professionals discussed their own past reporting behavior, 12-39% admitted to not reporting a suspected case of child abuse (Beck & Ogloff, 1995; Brosig & Kalichman, 1992a; Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Kalichman et al., 1990; Kennel & Agresti, 1995; Pope & Bajt, 1988). The similarity of responses between reporting hypothetical and actual cases of suspected abuse provides validation for the accuracy of hypothetical cases in evaluating the reporting behavior of professionals.

Interestingly, Pope and Bajt (1988) conducted their study with psychologists' with notable background in ethics. These psychologists had been on ethics committees, written textbooks on legal or ethical aspects of psychology, or were diplomats of the American Board of Professional Psychology. One may assume that these individuals were well versed on child reporting laws and the accompanying sanctions and would be more likely to report due to their knowledge of ethics and legal issues. However, 21% of these psychologists admitted to not reporting cases of child abuse to the authorities. In each of these cases, the psychologists reported breaking the law due to concern for the client's welfare (Pope & Bajt, 1988). This study did not identify if the clients in these cases were the child victim or the perpetrator of abuse.

In commenting on this study, however, Van Eenwyk (1990) stated that not reporting suspected abuse may be harmful to clients by encouraging them to keep secrets and not take responsibility for their actions. He stated that not reporting suspected abuse

may actually undermine the therapeutic relationship instead of benefiting client's welfare as suggested by the reviewed study (Pope & Bajt, 1988; Van Eenwyk, 1990). Perhaps, this is due to an expectation on the client's part that a report would be made so that they can break the bonds of secrecy and get the help they need for coping with and stopping the abuse.

There appears to be some variability in professionals' tendency to report suspected cases of child abuse. Before making generalizations about the reporting behavior of mandated professionals, one must look at the characteristics that influence a decision to report suspected abuse. Only by examining factors associated with deciding whether to report or not to report suspected abuse, can one begin to understand why so many cases go unreported.

## Factors Influencing Decisions to Report

Brosig and Kalichman (1992b; see also Kalichman, 1993) developed a model of factors that influence professionals' reporting decisions of suspected child maltreatment. This model was adapted from a model regarding police officer compliance with mandatory child abuse reporting laws developed by Willis and Wells in 1988 (Kalichman, 1993). This model proposes that the decision to report suspected abuse is based on situational factors, legal factors, and clinician characteristics. Situational factors include victim attributes, type of abuse, severity of abuse, and available evidence. Legal factors include knowledge of the law, statutory wording, and legal requirements. Finally, clinician characteristics include years of experience, training, and attitudes and

experience of dealing with abuse (Brosig & Kalichman, 1992b). This model will be used to integrate the research regarding reporting practices of professionals.

Situational Factors

Victim Attributes. Age and gender of the victim are two characteristics that have been examined to discern if they influence reporting. First, a number of studies looked at gender of the victim because they hypothesized that professionals would be more likely to report suspected abuse if the victim was female, especially in cases of sexual abuse. Studies have found, however, that the gender of the victim does not influence the decision to report abuse (Brosig & Kalichman, 1992a; Crenshaw et al., 1995; Kalichman et al., 1989, 1990; Kennel & Agresti, 1995).

Second, there have been conflicting results concerning the influence of the victim's age on decisions to report. Crenshaw et al. (1995), who surveyed educators and school psychologists, and Kalichman et al. (1988), who surveyed various mental health professionals, found that victim age did not influence professionals' tendency to report suspected abuse when presented with hypothetical cases. However, Kennel and Agresti (1995) presented similar hypothetical cases to psychologists and found that younger victims are more likely to be reported than older victims when there is suspected child sexual abuse, suggesting perhaps that older victims are perceived as more responsible for the abuse and therefore not needing to be reported. On the other hand, Kalichman and Craig (1991) found that younger victims of suspected physical abuse were more likely to be reported than older victims, but that there was no difference between victim ages for suspected sexual abuse. In this study, professionals seemed more likely to report any case

of suspected sexual abuse, and reported younger victims of physical abuse more than older victims possibly because of a perception that younger victims were more vulnerable and in need of protection than older victims. One possible reason for these discrepant findings is the difference between the vignettes presented in each of these studies. In the Kennel and Agresti (1995) study the sexual abuse was fondling by an adult family friend, whereas in the Kalichman and Craig (1991) study the abuse, whether physical or sexual, was presented with physical bruises with the perpetrator being the father. Perhaps, fondling of a 15 year old by an adult family friend, especially when the age difference was not specified, is not seen as being that serious, while sexual abuse in the family that involves physical evidence is seen as very serious regardless of victim age. Therefore, more research needs to be done in this area to discern the effect of victim age and other potential mediating factors on reporting decisions.

Type of Abuse. There have been a number of studies that examined the influence of type of abuse on decision to report. Kalichman et al. (1988) found no difference between physical or sexual abuse in decisions to report. Kalichman and Craig (1991) found that there was no difference between these types of maltreatment when the child stated that they were abused. However, when there was no verbal disclosure of abuse to the clinician by the child, clinicians were more likely to report physical abuse than sexual abuse. Zellman (1990), on the other hand, found that professionals reported sexual abuse more than either physical abuse or neglect. While, Beck and Ogloff (1995) found that psychologists were more likely to report neglect and sexual abuse, and were less likely to report physical abuse, and were least likely to report emotional abuse. Finally, Crenshaw

et al. (1995) found that educators were most likely to report physical abuse followed by neglect, sexual abuse, and the least likely, emotional abuse. None of these studies looked at combinations of abuse such as a child who was both physically and sexually abused, as is often the case. Perhaps this is due to these studies mainly being vignette studies in which different types of abuse is one factor distinguishing presented vignettes from one another. Possibly these studies were limited in their ability to combine types of abuse in one vignette. Additional research in this area could focus more on actual cases of abuse and combinations of abuse. This may provide more understanding and help to explain these discrepant findings.

Severity of Abuse. Several studies have found that the more severe a case of suspected child abuse is perceived to be, the more likely the professional is to report the abuse (Crenshaw et al., 1995; Gracia, 1995; Green & Hansen, 1989; Kalichman & Brosig, 1993; Zellman, 1990). Gracia (1995) cautions against not reporting less severe cases of child maltreatment and suggested that the view of some cases of maltreatment as not serious enough does not represent the psychological impact on these children. This study found that even though these children did not appear to be under serious threat, they had more behavioral problems than children not suspected of being maltreated. These children were found to have difficulties with dependency, low self-esteem, emotional instability, and a negative world view (Gracia, 1995). Thus, using severity as a deciding factor in whether to report suspected abuse may leave children in these categories without the help they need.

Confidence that Abuse is Occurring. Studies have found that one of the greatest predictors of the decision to report suspected child abuse was confidence that abuse was occurring (Beck & Ogloff, 1995; Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Kalichman et al., 1988, 1989, 1990). Confidence that abuse was occurring included physical signs of abuse, child's verbal disclosure of abuse, and perpetrators' admitting to the abuse. Confidence was greater when the child provided a verbal account of the abuse (Kalichman & Craig, 1991; Kalichman et al., 1988), when the father who was the alleged abuser agreed to attend therapy (Kalichman & Craig, 1991), and when the father admitted to the abuse (Kalichman et al., 1989). Possibly, when therapists lack confidence that abuse has occurred, they are more influenced by maintaining client's autonomy and privacy and preventing harm which could occur from a false report. When therapists are confident that abuse has occurred, however, they may be more influenced by the need to uphold the law and prevent harm by stopping further abuse.

Legal Factors

Knowledge of the Law. Studies have suggested that the majority of professionals are aware of the mandatory reporting laws for suspected child abuse (Beck & Ogloff, 1995; Crenshaw et al., 1995; Kalichman et al., 1989). Further, when clinicians were made aware of reporting laws, their tendency to report increased (Brosig & Kalichman, 1992a). However, knowledge of reporting laws does not guarantee compliance (e.g. Kalichman et al., 1989). In this study, practicing psychologists were asked if they would report a given vignette of suspected child abuse. While between 76% of psychologists surveyed in one state to 96% of those surveyed in another state identified that they would

be required to report this case in their respective state, over 30% stated that they would still tend not to report this case, suggesting that there was more to their decision than simple compliance to the law (Kalichman et al., 1989).

Statutory Wording. There is variance in the wording of mandatory reporting laws across states, with definitions of abuse existing on a continuum from broad and general to narrow and specific (Brosig & Kalichman, 1992b). Brosig and Kalichman (1992a) found that when reporting laws are more narrow and specific this may lead to underreporting of abuse that does not fit into these narrow guidelines. Further, broad and general statutes may lead to over-reporting. Therefore, a case which would be clearly reportable in one state may not warrant a report in a different state because of variations in definitions. Thus, the wording of these statutes does appear to be significantly related to reporting of suspected child abuse (Brosig & Kalichman, 1992b).

Legal Requirements. Studies have found that a legal obligation to report suspected abuse appears to be an important factor in influencing professionals to report (Beck & Ogloff, 1995; Brosig & Kalichman, 1992a; Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Zellman, 1990). However, this factor does not hold the same level of influence for all professionals. Brosig and Kalichman, (1992b) found that professionals who consistently report all cases of suspected child abuse are more influenced by legal factors, whereas inconsistent reporters are more influenced by situational factors. Thus, there appears to be a relationship between the perceived importance of adherence to the law and professional's personal history of reporting. In relating this finding to Kohlberg's theory of moral development, perhaps consistent

reporters are more likely to view the law as the higher principle in resolving the dilemmas created by mandatory reporting laws. For inconsistent reporters, they may see the privacy of clients or the perceived negative impact on the client of reporting as the overriding principles in the decision not to report. Thus, professionals view some situational or client factors which warrant reporting, and others that do not. This hypothesis has yet to be fully tested by empirical research.

Clinician Characteristics

Years Experience. Kalichman and Brosig (1993) found no difference in years of experience between consistent and inconsistent reporters of suspected abuse. However, in a literature review conducted by Brosig and Kalichman (1992b), they found research which suggested that professionals with more work experience were more likely to report in some studies and less likely in others. Further, Beck and Ogloff (1995) found that master's level practitioners were more likely to report suspected abuse than doctoral clinicians. Other research has suggested that professionals with a higher level of education were more likely to report suspected abuse (Brosig & Kalichman, 1992b). More research is needed in this area to ascertain the impact of level of experience on tendency to report suspected abuse. One potential area for this research would be to look at whether professionals received their degrees before or after mandatory child abuse reporting laws came into effect. Perhaps timing of degree and not level of degree is the defining factor with professionals trained after mandated child abuse laws were written being more likely to report suspected abuse.

Training in Child Abuse. Kalichman and Brosig (1993) found that psychologists who attended workshops in child abuse training and continuing education regarding child abuse were less likely to report suspected cases of abuse than those who had not received such training. However, this does not suggest a causal relationship. There is a possibility that psychologists received additional training in child abuse after having failed to report a suspected case of child abuse (Kalichman & Brosig, 1993). Further, other research suggested that prior training in child abuse was associated with a greater tendency to report suspected abuse (Brosig & Kalichman, 1992b). To understand these findings, further research should look at the timing and scope of this training.

Reporting Experience. Clinician's history of reporting abuse has been found to be related to current tendency to report. Kalichman and Craig (1991) found that clinicians who had decided not to report a case of suspected child abuse in the past were significantly less likely to report the hypothetical case presented in the study than clinicians who had reported at least one case of suspected child abuse in the past. Thus, certain clinicians may be biased toward or against reporting as represented by their history of reporting (Brosig & Kalichman, 1992b).

Perceived Impact of Reporting. A relationship may exist between clinicians' past history of reporting abuse and their attitudes about the impact of reporting. If professionals believe that reporting will have a detrimental effect, they may not be as likely to report suspected cases of child abuse. For instance, some professionals have stated in the literature a belief that reporting may have a negative impact on the family (Brooks, Perry, Starr, & Teply, 1994; Newberger, 1983). Further, studies assessing

therapists' beliefs regarding reporting, have found that perceived negative impact on the family is one factor identified with failure to report suspected child abuse (Brosig & Kalichman, 1992a; Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Kalichman et al., 1989; Walters, 1995). In a study conducted by Kalichman et al., (1989), licensed psychologists were asked the impact on families as a result of their reporting child abuse. Thirty-seven percent of respondents perceived reporting would have a negative impact on the family, 14% of the psychologists in the study perceived that reporting would have a positive impact on the family, and 49% saw reporting as having a neutral impact on the family. In addition, this study found that when clinicians believed the impact of reporting to be positive for the family, they were more likely to report suspected abuse (Kalichman et al., 1989).

These findings suggest that clinicians take more into account than just strict adherence to the law in making the decision to report suspected abuse. However, there has been no empirical research done to support whether the effect of reporting is positive or negative for the family, or if there are any intervening variables that help determine the effect of reporting on the family. Therefore, clinicians may make the decision not to report abuse when they perceive the effect will be negative, when in actuality there may be a positive effect on the family from reporting, especially if intervening variables are taken into account.

Further, while some professionals believe that reporting may have a negative impact on the family, many studies report professionals' belief of a positive impact for children in protecting them from further abuse (Beck & Ogloff, 1995; Brooks et al., 1994;

Brosig & Kalichman, 1992a; Kalichman & Brosig, 1993; Zellman, 1990). This finding is consistent with the original intention of these laws of protecting children from abuse. However, a caution in interpreting the results of these studies is imperative. Researchers based these findings regarding the impact of reporting on professionals' beliefs of perceived impact and not empirical data about the actual impact. Consequently, professionals may be basing their decision of whether to report suspected child abuse on inaccurate beliefs about the actual impact on the child and family, and therefore end up doing more harm than good.

In addition to the effects on the family or child, a number of studies have identified that clinicians perceive reporting abuse will have a negative impact on therapy and may result in clients terminating therapy (Ansell & Ross, 1990; Beck & Ogloff, 1995; Brooks et al., 1994; Finlayson & Koocher, 1991; Kalichman, 1990; Kalichman et al., 1989; Smith-Bell & Winslade, 1994; Weinstock & Weinstock, 1989a, 1989b). However, Van Eenwyk (1990) stated that not reporting abuse may be detrimental to the therapeutic relationship the therapist has with the abuser. He went on further to state that assuring the parents that the therapist would not report suspected abuse recreates the very conditions in which abuse occurs by placing oneself beyond the laws that are created to protect the victim, perpetuating secrecy and domination just as the abuser has by being abusive (Van Eenwyk, 1990). Therefore, reporting abuse may be more therapeutic for the family than not reporting the abuse (see also, Kennel & Agresti, 1995).

Before generalizations can be made about the impact of reporting, empirical research is needed to ascertain if professionals' beliefs about potential impact are

accurate. Further, mediating factors that influence the impact of reporting such as forewarning clients about the limits of confidentiality and involving clients in the reporting process need to be examined.

Confidentiality

Many articles have identified the dilemma that exists between upholding child abuse reporting laws and maintaining confidentiality (Agatstein, 1989; Butz, 1985; Crenshaw & Lichtenberg, 1993; Faustman & Miller, 1987; Finlayson & Koocher, 1991; Leong et al., 1992; MacNair, 1992; Miller & Weinstock, 1987; Smith & Meyer, 1984; Smith-Bell & Winslade, 1994; Stadler, 1989; Weinstock & Weinstock, 1989a, 1989b). In addition some research has found that therapists state this dilemma as one reason for not reporting cases of suspected child abuse (Ansell & Ross, 1990; Beck & Ogloff, 1995; Brosig & Kalichman, 1992a; Finlayson & Koocher, 1991; Leong et al., 1992; MacNair, 1992; Walters, 1995; Weinstock & Weinstock, 1989). The reason for this appears to be the importance placed on confidentiality in therapy to protect clients by preventing professionals' disclosure of information received in therapy to third parties, except as mandated by law.

Levine and Doueck (1995) examined professionals' beliefs and practices regarding confidentiality. The participants described confidentiality as an integral part of the therapeutic process. They stated that confidentiality encourages openness and disclosure of difficult material by respecting the client's right to privacy. They further believe that confidentiality helps provide an atmosphere of safety for clients to reveal

sensitive issues. Further, they stated that confidentiality is important in establishing trust between client and therapist (Levine & Doueck, 1995).

However, confidentiality is not the only important variable in establishing a positive therapeutic relationship. Brosig and Kalichman (1992a) have suggested that trust is the important variable in a therapeutic relationship rather than confidentiality. Further, if a trusting relationship between the therapist and client exists throughout the process of reporting, the therapeutic relationship may withstand this required breach in confidentiality (Brosig & Kalichman, 1992a). Thus, there is disagreement in the field as to the importance of confidentiality in reporting decisions. Further, while therapists state confidentiality as a reason for not reporting, there has been little if any empirical research to determine what the actual impact of breaching confidentiality is on the therapeutic process.

Forewarning Practices

Professionals have suggested that negative effects of reporting may be lessened by obtaining informed consent from families prior to treatment, and informing families that they are required to report suspected cases of child abuse (Brosig & Kalichman, 1992b; Butz, 1985; Faustman & Miller, 1987; Kalichman, 1993; Levine & Doueck, 1995; MacNair, 1992; Smith & Meyer, 1984; Stadler, 1989; Walters, 1995). The premise behind this is that informed consent shows respect for a client's autonomy (Levine & Doueck, 1995; MacNair, 1992; Stadler, 1989). However, this suggestion has received limited support in the literature because of the concern that clients will be discouraged from disclosing information and will not be able to form a trusting relationship with the

therapist for fear that information will be disclosed to someone else (Butz, 1985; Faustman & Miller, 1987; Levine & Doueck, 1995; MacNair, 1992; Smith & Meyer, 1984; Smith-Bell & Winslade, 1994). On the other hand, one has to question what the effect will be on a trusting relationship if a therapist reports suspected child abuse without first forewarning clients of this possibility. Clients who thought that confidentiality was absolute may feel betrayed by the therapist who reports them and will no longer trust the therapist. They may no longer feel that they can tell the therapist anything without this being disclosed to a third party.

Faustman and Miller (1987) argue that forewarning clients serves to diminish disclosure and reduces the likelihood of the therapist getting the necessary information about the abuse so that the abused child can be helped. However, these beliefs have not been empirically tested.

In fact, while there continues to be a debate regarding the effect of forewarning, little empirical research exists to test the actual effect of forewarning practices. In a preliminary survey, Crenshaw and Lichtenberg (1993) surveyed mental health professionals regarding their forewarning practices. Forewarning options were described as 1) providing written and/or oral statement about limits of confidentiality to all clients at the start of therapy, 2) forewarning clients only when clinician has suspicions of abuse, 3) discussing reporting only after disclosure of abuse is made, 4) seldom forewarning clients, or 5) not reporting abusive situations. They found that 36.9% of the surveyed mental health professionals forewarned all clients, and 36.4% forewarned at the point that suspicion of abuse occurred. An additional 20.6% informed clients only after disclosure

of abuse was made. Therefore, only 4.7% did not provide any warning, and less than 2% stated that they do not usually report abuse. While this study was illuminating in terms of forewarning practices, the study did not test the impact on therapy of these different approaches.

Another study by Faustman and Miller (1987) asked mental health professionals about their opinions regarding confidentiality and forewarning. Of their sample, only 18% stated that maintaining confidentiality was more important than the primary obligation of protecting the child. Further, 88% stated they felt full disclosure of abuse would not be likely when they forewarned clients regarding the limits of confidentiality.

However, if research could show that forewarning did not limit disclosure of abuse, more professionals may be likely to forewarn clients of the mandate to report suspected abuse. This forewarning may limit the negative impact on the therapeutic relationship once a report is made because clients would not feel betrayed by the professional due to a false belief that confidentiality was absolute. Then, the primary obligation of protecting the child through the process of reporting could be achieved.

Reporting Process

In addition to forewarning, Stadler (1989) has suggested that the process of reporting suspected abuse may be critical in therapy. By involving clients in the reporting process, clients can maintain a sense of autonomy and control while still having limitations placed on their behavior. In addition, therapists may be more likely to report when a report is made in the process of therapy where clients can be prepared for the potential consequences of the report. Through this process, MacNair (1992) stated that

clients would be more likely to value therapy and the support that they can receive during the reporting process.

Stadler (1989) has listed the following steps that clinicians can take when they suspect abuse to try to involve clients in reporting:

1. When abuse is suspected, clinicians should remind the clients of their duty to report.
2. The clients should be given the option to report the abuse themselves from the clinician's office.
3. If the client refuses, they should be given the option of being present while the clinician makes the report.
4. If client refuses, the report should be made after the client leaves, with or without the client's permission.

By following these guidelines, MacNair (1992) stated that reporting would be less likely to result in damaging the clinician-client relationship. If empirical research found that this reporting technique was effective in helping to maintain a positive clinician-client relationship, clinicians may be more likely to report suspected child abuse. This would serve the purpose of helping to protect the child from further abuse as intended by the reporting laws. This would also help to keep clients connected to therapy so that they could get necessary treatment.

## Limitations of Existing Research

Before making any generalizations, one needs to take into account the limitations of the existing research. First, a number of these studies used vignettes to measure reporting behavior. These results may not reflect the actual behavior of professionals for

real cases in which they come in contact. However, the percentages of reporting between hypothetical cases and actual cases are similar, suggesting the appropriateness of vignette studies.

Second, when professionals were asked if they had ever decided not to report a suspected case of child abuse, they were not questioned as to their reason for not reporting. This makes interpreting factors influencing reporting difficult if not impossible. In addition, a number of the articles were not empirical studies. In these cases, statements were made that reflected the authors' opinions and were not necessarily accurate statements based on empirical findings. Therefore, caution must be taken in making judgments about these statements. Further, samples usually consisted of participants from only one or two geographical areas in a given study. Thus, these may not be representative samples.

Finally, response rates for these studies ranged from 35% to 68%. Participants in these studies may feel that reporting laws are more important than those who did not participate, thus biasing the results.

While professionals suggest a potential negative impact on the therapeutic relationship as a reason for not reporting suspected abuse, little empirical research has explored the actual impact of reporting on the therapeutic relationship. In addition, Stadler (1989) suggested that the way one reports a suspected case of child abuse may be more crucial than the actual report. If therapists provide clients with informed consent regarding the limits of confidentiality and subsequently involve them in the reporting process, the results may be positive and not detrimental to the therapeutic relationship.

Therefore, research is needed to explore the actual impact on the therapeutic relationship of mandated reporting laws.

The present study was designed to begin to fill in the gaps of current research by exploring therapists' reporting practices, beliefs about reporting laws, the factors they consider in making the decision to report, and the impact they believe reporting has on therapy and the family. This will be done by asking therapists about their personal reporting experiences as opposed to vignette studies. In addition, this study will look at the forewarning and reporting practices of therapists and the perceived impact this has on therapy and the family.

# CHAPTER III

## METHOD

This study used a quasi-experimental design. This method was selected as a way to describe the reporting behavior and beliefs about reporting laws and practices of participants. Based on this method, a research instrument was developed to investigate reporting practices of therapists and to examine some of the factors and beliefs about mandated reporting laws and the process of reporting which may influence the decision of whether to report suspected child abuse.

### Participants

Participants consisted of a random sample of 450 therapists practicing in Oklahoma including 225 licensed marital and family therapists and 225 licensed psychologists. Marital and family therapists were chosen because they have not yet been widely researched in this area. Psychologists, on the other hand, were chosen because they are primarily the type of mental health professionals who were researched in previous literature on this topic, thus, serving as a good base comparison group.

Participants were selected through mailing lists, using a random generated number system, from the licensure boards for psychologists and for marital and family therapists. These lists were compared to eliminate duplicates. Of a total of 450 questionnaires mailed, nine were returned by the post office as undeliverable and 206 were returned, representing 47% of potential respondents. Of those, a total of 199 (45% response rate) questionnaires were filled out and were included in the final sample. Of the remaining seven which were returned, two stated that they were retired, one had a message on the

top stating that the individual no longer lived in the state, one stated they were closing their practice, two stated they were not providing direct service to clients, and one stated that they had never handled cases of child abuse and could not provide an informed response. The demographic and background characteristics of the final sample are summarized in Table 1.

Materials

The research instrument is a 41-item self report questionnaire (see Appendix B) which was adapted from existing measures by the author to obtain information on past reporting experience, factors influencing the decision to report, forewarning and reporting process, beliefs about mandated reporting laws, perceived impact of reporting, knowledge of the law, and demographic information. The demographic section includes 20 questions which ask about age, gender, ethnicity, professional degree, type of license, type of certification, place of employment, reporting policy of place of employment, years of experience, types of clients seen, previous training in child abuse, and professional organizations to which they belong.

The remaining 21 questions regarding mandatory reporting laws and reporting practices were based on findings from the literature review. The questions were designed to address the following six areas regarding mandated reporting:

1. Reporting Experience. Questions asking if the therapist had ever reported or decided not to report suspected child abuse were adapted from Kalichman and Craig (1991). These questions included, "Have you ever reported a case of suspected child

abuse?" and, "Have you ever suspected that a child was being abused but decided not to report this to the authorities?".

2. Factors Influencing Reporting Decision. Questions asking about factors considered when deciding whether or not to report were adapted from items previously studied in the literature (Brosig & Kalichman, 1992; Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Kalichman et al., 1989). Instead of looking at items separately, as was done in previous studies, participants were asked to rank from 1 to 10, with 1 being most important, 10 factors that they consider when making the decision to report suspected abuse and 10 factors that they consider when making the decision not to report suspected abuse. For reporting suspected abuse, factors included such items as upholding the law, protecting the child, protecting the parent, and severity of abuse. For deciding not to report suspected child abuse, factors included such items as the effects of reporting on the family, protecting the parent, not disrupting the process of therapy, and lack of solid evidence that abuse has occurred.

3. Beliefs About Reporting Laws. Questions asking beliefs about reporting laws were also adapted from items previously studied in the literature (Brosig & Kalichman, 1992; Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Kalichman et al., 1989). For each item, respondents were asked to respond on a 5 point Likert-type scale how much they agreed with each item. For example, respondents were asked the degree to which they agreed or disagreed that "mandated child abuse reporting laws are effective in stopping abuse of a child."

4. Perceived Impact of Reporting. To identify therapists' perception of the impact of reporting on therapy, questions were written based on findings in the literature (Kalichman, 1990; Kalichman & Brosig, 1993; Kalichman et al., 1989). Respondents were asked to indicate on a 5 point scale the degree to which reporting had a positive or negative effect. For example, one item asked, "What is the most likely effect that reporting suspected abuse has on a family?".

5. Forewarning Practices. Further, the question asking about forewarning was adapted from the survey of Crenshaw and Lichtenberg (1993). An additional question asks about the impact of forewarning on disclosure. This question was based on the research of Faustman and Miller (1987).

6. Reporting Process. The question pertaining to how therapists report abuse was modified from the reporting options suggested by Stadler (1989). Respondents were asked to identify what percentage of time they have used each option of reporting, such as "therapist reports while client listens," to report suspected child abuse. Furthermore, there was a qualitative part asking open-ended questions about the respondents knowledge of the law and procedure used in reporting abuse.

Need for New Measure. The current instrument was developed because other measures were not comprehensive enough to gather information on reporting practices, beliefs about reporting, perceived impact of reporting, and the process of forewarning and reporting. Face validity for the instrument was obtained by having several professionals with backgrounds in both therapy and research examine the questionnaire and provide feedback. They evaluated the questionnaire for readability, comprehension, and

compatibility with the study objectives. The questionnaire was revised based on this evaluation.

Procedure

Therapist participants were selected using a randomized sample from licensing boards for psychologists and for marital and family therapists in Oklahoma. Participants were sent a packet which included a cover letter (see Appendix B) that described the study and requested their participation, the research instrument, and a self-addressed, stamped return envelope to help encourage their participation. Finally, ten days after the packet was sent, participants were sent a postcard (see Appendix B) thanking them for their participation and requesting those who had not yet participated to take the time to complete and return the survey.

The procedure for this study was adapted from the Total Design Method created by Dillman (1978) to increase response rate. This method was modeled in designing the questionnaire to be easily read, aesthetically pleasing, and less than 10 pages. This method also included suggestions for writing the cover letter and postcard in a way that would let prospective respondents know how important their participation was to the study, and creating the procedure for mailing. Dillman (1978) suggests a four step mailing procedure in which participants are sent the first mailing, then a reminder postcard, followed by another questionnaire for those who have yet to respond, finished with sending another questionnaire by certified mail to those who have yet to respond. Due to the importance of protecting the anonymity of participants in the current study, only the first two steps of the mailing procedure were followed.

Operational Hypotheses

Hypothesis 1. The first hypothesis stated that therapists who believe that mandated child abuse reporting laws are necessary and effective will be more likely to report suspected cases of child abuse than therapists who do not believe that these laws are necessary and effective. The dependent variable is reporter status of consistent reporters or inconsistent reporters. Non reporters were excluded as they have not had any exposure to cases of suspected child abuse. The independent variable consisted of three items from the questionnaire: effectiveness in stopping abuse, effectiveness in getting needed services to a family, and the necessity of the law.

Hypothesis 2. The second hypothesis stated that therapists who perceive that reporting has a positive impact will be more likely to report suspected cases of child abuse than therapists who perceive that reporting has a negative impact. The dependent variable is reporter status of consistent reporters or inconsistent reporters. Given the non exposure to cases of suspected child abuse, non reporters were excluded. The independent variable consisted of four items from the questionnaire: effect on the process of therapy, effect on the therapist-client relationship, effect on client's response to the therapist, and effect on a family.

Hypothesis 3. The third hypothesis stated that therapists who forewarn clients of limits in confidentiality will be more likely to report suspected cases of child abuse than therapists who do not forewarn clients of limits in confidentiality. The dependent variable is reporter status of consistent reporters or inconsistent reporters. Non reporters were excluded because they have not had any experience reporting suspected cases of

child abuse. Forewarning practice is the independent variable. For this hypothesis, forewarning was divided into three categories including those who forewarn at the beginning of therapy, those who forewarn only after they have suspicion or disclosure of abuse, and those who do not forewarn or report suspected cases of abuse.

Hypothesis 4. The fourth hypothesis stated that compared to therapists who do not forewarn, therapists who forewarn clients will be more likely to perceive that a positive therapist-client relationship is maintained and that clients continue therapy once a report is made. This hypothesis is broken down into two operational hypotheses. The first one includes perceived effect on the therapist-client relationship as the dependent variable, and forewarning practice as the independent variable. Forewarning was divided into three categories including those who forewarn at the beginning of therapy, those who forewarn only after they have suspicion or disclosure of abuse, and those who do not forewarn or report suspected cases of abuse.

The second part of this hypothesis includes perceived effect on client's continuation of therapy once a report is made as the dependent variable and forewarning practice as defined above as the independent variable.

Hypothesis 5. Finally, the fifth hypothesis stated that therapists who involve clients in the reporting process are more likely to perceive that they maintain a positive relationship with their clients and that clients will be less likely to terminate therapy than therapists who do not involve clients in the reporting process. Perceived effect on the therapist-client relationship and perceived effect on continuation of therapy once a report is made are the dependent variables. Reporting process is the independent variable.

Data Analysis

Once collected, the data was analyzed using the SPSS-X statistical package. An analysis of variance was conducted for the first four hypotheses. Analyses of variance were done to look for differences between groups. Correlations were run for hypothesis 5 to see if reporting process is related to perceived effect on the therapist-client relationship and perceived effect on continuation of therapy once a report is made. Significance level for all hypotheses was set at the .05 level. In addition to testing the hypotheses, factor analysis and reliability were run to provide additional information about the instrument.

# CHAPTER IV

## RESULTS

Identifying the factor structure of the questionnaire was done prior to testing the hypotheses in order to test the viability of the questionnaire. A factor analysis was done on participants' responses of their reporting practices and beliefs about mandated reporting laws. To identify the factor structure, the responses to the 15 items were subjected to principal components analysis with oblique rotations to orthogonal solutions. The two criteria for remaining a factor were: the factor met the Kaiser criterion and the factor included a minimum of two items with loadings of at least .50. After applying these criteria, the analysis yielded a four-factor solution that accounted for 61% of the variance. Eigenvalues of the rotated factors were 4.13, 1.88, 1.38, and 1.10. Factor loadings are depicted in Table 2. Factors included Importance of Reporting, Potential Impact of Reporting, Forewarning, and Importance of Confidentiality and the Law. An estimate of the questionnaires internal consistency reliability was calculated utilizing Cronbach's alpha coefficient. Alphas ranged from .61 to .77. All alphas were in the acceptable range. One item, "the effect on the continuation of therapy," was deleted from the Potential Impact factor raising the alpha from .14 to .72.

In order to test the five hypotheses, respondents were divided into three groups of reporter status. The first group, consistent reporters, included fifty-nine percent ($n = 118$) of respondents, were those who have reported at least one case of suspected child abuse, and have never made the decision not to report a suspected case. The second group, inconsistent reporters, included thirty-one percent ($n = 61$) of respondents, were those

who may or may not have reported a case of suspected child abuse, and have made the decision not to report at least one suspected case. Finally, the third group, non reporters, included ten percent ($n = 20$) of respondents, have no history of reporting suspected child abuse or of deciding not to report suspected child abuse. Preliminary analysis revealed no significant difference in gender, age, years of experience, hours of therapy practiced per week, or primary place of employment across the three groups of reporter status.

Hypotheses

Hypothesis 1. The first hypothesis stated that therapists who believe that mandated child abuse reporting laws are necessary and effective will be more likely to report suspected cases of child abuse than therapists who do not believe that these laws are necessary and effective. To test this hypothesis an analysis of variance was conducted with reporter status of consistent reporters or inconsistent reporters as the dependent variable. The independent variable consisted of three items from the questionnaire: effectiveness in stopping abuse, effectiveness in getting services to family, and the necessity of the law. A main effect was found significant, $F(12, 163) = 2.08$, $p < .05$ (see Table 3 for means and standard deviations), meaning that there is a significant difference between consistent reporters ($M = 6.50$, $SD = 2.33$) and inconsistent reporters ($M = 7.18$, $SD = 2.61$) when the three items concerning the law are combined. Thus, hypothesis one was supported in that those mandated reporters who view the law as necessary and effective in helping families stop abuse and access services are more likely to report abuse.

Hypothesis 2. The second hypothesis stated that therapists who perceive that reporting has a positive impact will be more likely to report suspected cases of child abuse than therapists who perceive that reporting has a negative impact. To test this hypothesis analysis of variance were conducted with reporter status as the dependent variable, and effect on the process of therapy, effect on therapist-client relationship, effect of client's response to the therapist, and effect on the family as the independent variables. Two significant results were found. First, perceived effect of client's response to the therapist following a report was significantly related to reporter status, $F(5, 171) = 2.69$, $p < .05$. Therapists who perceived that client's response to the therapist would be gratefulness following a report were more likely to consistently report ($M = 1.28$, $SD = .53$) than therapists who perceived the client's response to the therapist would be no response or would be either anger or gratefulness ($M = 1.61$, $SD = .71$). Second, an analysis of variance examining perceived effect on therapist-client relationship by reporter status was significant, $F(4, 190) = 2.92$, $p < .05$. Therapists who perceived that reporting would have a positive effect on the therapist-client relationship were more likely to consistently report abuse ($M = 1.39$, $SD = .58$) than those therapists who perceived that reporting would have a very negative effect on the therapist-client relationship ($M = 2.00$, $SD = .76$). Perceived effect on the family was not related to reporter status, $F(4, 171) = .41$, $p = .80$. Further, perceived effect on the process of therapy was not related to reporter status, $F(4, 170) = .93$, $p = .45$.

Hypothesis 3. The third hypothesis stated that therapists who forewarn clients of limits in confidentiality will be more likely to report suspected cases of child abuse than

therapists who do not forewarn clients of limits in confidentiality. To test this hypothesis, forewarning was divided into three categories including those who forewarn at the beginning of therapy, those who forewarn only after they have suspicion or disclosure of abuse, and those who do not forewarn or report suspected cases of abuse. Then an analysis of variance was conducted with reporter status as the dependent variable and forewarning practice as the independent variable. No significant differences were found between these variables, $F(2, 174) = 1.05$, $p = .35$. Table 4 presents the forewarning practices of participants in this study.

Hypothesis 4. The fourth hypothesis stated that compared to therapists who do not forewarn, therapists who forewarn clients will be more likely to perceive that a positive therapist-client relationship is maintained and that clients continue therapy once a report is made. To test this hypothesis two analysis of variance tests were conducted. The first test included perceived effect on the therapist-client relationship as the dependent variable, and forewarning practice as the independent variable. No significant differences were found between these variables, $F(2, 151) = 1.86$, $p = .16$. The second test included perceived effect on client's continuation of therapy once a report is made as the dependent variable and forewarning practice as the independent variable. No significant differences were found between these variables, $F(2, 149) = 1.27$, $p = .28$.

Further examination of this hypothesis found an interesting interaction. When comparing therapist's perception of the effect of forewarning on disclosure with perception of impact on therapist-client relationship post-report, however, significant differences were found, $F(3, 179) = 4.29$, $p < .01$. Therapists who perceived that

forewarning would increase likelihood of disclosure of abuse were more likely to perceive that a positive therapist-client relationship was maintained once a report was made than therapists who perceived that forewarning would decrease the likelihood of disclosure of abuse.

Hypothesis 5. Finally, the fifth hypothesis stated that therapists who involve clients in the reporting process are more likely to perceive that they maintain a positive relationship with their clients and that clients will be less likely to terminate therapy than therapists who do not involve clients in the reporting process. To test this hypothesis correlations were run between perceived effect on continuation of therapy once a report is made, perceived effect on the therapist-client relationship, and therapist's reporting practice. No significant results were found. One possible reason for this is that the standard deviations for each method of reporting were fairly high, suggesting wide variability in responses. Perhaps, due to lack of training in this area, there is no set standard of reporting for professionals. Table 5 presents the reporting practices of participants including mean percentages and standard deviations.

Other Findings

In addition to the hypotheses, statistics were run to look at how respondents ranked their reasons for reporting or not reporting suspected cases of child abuse. This was further broken down by reporter status. See Table 6 and Table 7 for means and standard deviations. Analyses of variance were done to look for differences on rankings by reporter status. Two significant differences were found. First, confidence that abuse was occurring was significantly related to reporter status, $F(2, 182) = 4.67$, $p < .05$, with

inconsistent reporters (M = 3.71, SD = 1.84) ranking confidence that abuse was occurring significantly higher than consistent reporters (M = 4.75, SD = 2.25). This suggests that inconsistent reporters, as compared to consistent reporters, need more evidence that abuse is occurring before they will make a report of suspected child abuse. Second, having a supervisor advise to report suspected child abuse was significantly related to reporter status, $F(2, 157) = 5.19$, $p < .01$. Consistent reporters ranked this factor significantly higher (M = 7.68, SD = 1.99) than non-reporters (M = 8.86, SD = 0.86). Thus, consistent reporters believe that consulting their supervisor prior to making a report is more important than do non-reporters who have no experience with making reports. Interestingly, protecting the child was ranked as the most important factor when deciding to report suspected child abuse (M = 1.39, SD = 1.11) and when making the decision not to report suspected child abuse (M = 2.56, SD = 1.68). This may help to account for why 29.6% of the respondents have both reported suspected child abuse in some cases and made the decision not to report suspected child abuse in others. Perhaps in each case the respondent believed their decision of whether to report was in the best interest of the child.

Finally, analyses of variance were run comparing the factors generated by factor analysis with reporter status. Importance of reporting was not related to reporting status, $F(2, 190) = 1.82$, $p = .17$. Potential impact of reporting was related to reporting status, $F(2, 190) = 6.67$, $p < .01$, with consistent reporters perceiving the potential impact of reporting on therapy as more positive than inconsistent reporters or non-reporters. This finding provides additional support for hypothesis two that perceived impact of reporting

is related to reporter status. Importance of confidentiality and the law was significantly related to reporter status, $F$ (2, 188) = 4.80, $p$ = .01. Consistent reporters saw upholding the law and being mandated reporters as more important than inconsistent reporters or non-reporters.

# CHAPTER V

# DISCUSSION

The purpose of this study was to examine therapists' reporting behavior and beliefs about mandated child abuse reporting laws. The current chapter will provide possible interpretations of the results. In addition, implications of the findings will be discussed. Finally, suggestions for future research are offered.

## Hypotheses

Hypothesis 1. The first hypothesis that therapists who believe that mandated child abuse laws are necessary and effective will be more likely to report than those who do not believe that these laws are necessary and effective was supported. Those who more strongly agreed that these laws were effective in stopping abuse, effective in getting needed services to families, and necessary were more likely to consistently report than those who believed these laws were less necessary and effective. Possibly, those with more favorable views regarding the necessity and effectiveness of mandated child abuse reporting laws have had more favorable results from reporting and are therefore more likely to consistently report. While this finding is significant, one interesting result is that when groups of consistent reporters and inconsistent reporters were combined, the majority of respondents agreed that these laws are necessary and effective. Sixty-one percent of the respondents agreed that reporting laws are effective in stopping abuse. Sixty percent of the respondents agreed that these laws are effective in getting needed services to a family. Finally, ninety-three percent of the respondents agreed that reporting laws are necessary. This suggests that while there are differences between

groups by reporter status, most therapists believe that mandated child abuse reporting laws are important and necessary. Thus, even though the majority of participants agreed that the laws are important and necessary, this does not mean that they will consistently report suspected child abuse. Instead, inconsistent reporters appear to see other factors as more important in making the decision to report such as protecting the child and confidence that abuse has occurred.

Further, respondents were asked two open-ended questions regarding their knowledge of the law including what type of abuse should be reported and how a report should be made. Most respondents stated that all types of abuse should be reported to the Department of Human Services. This suggests that respondents are aware of the law, meaning that lack of knowledge is not a factor in the decision to report.

Hypothesis 2. The second hypothesis that therapists who perceive that reporting has a positive impact will be more likely to report suspected cases of child abuse than therapists who perceive that reporting has a negative impact received partial support. First, therapists who perceived that client's response to the therapist following a report would be gratefulness were more likely to consistently report than therapists who perceived the client's response to the therapist would be anger. This suggests that some therapists may decide not to report merely because of a perception that the client will respond in anger toward them. Training is critical to help prepare therapists for a potentially angry response from their clients, help them learn to see that this response may be appropriate based on the situation, and help them to separate the client's response to the therapist from the decision to report. Second therapists who perceived that

reporting would have a positive effect on the therapist-client relationship were more likely to consistently report abuse than those therapists who perceived that reporting would have a very negative effect on the therapist-client relationship. Perhaps, those who believe the effect of reporting to be positive report suspected abuse differently than those who believe the effects to be negative. Consistent reporters may take more time to discuss the need for a report with their clients, involve their clients in the reporting process, and take more time to explain the potential consequences of a report to the clients before reporting. In addition, these therapists may perceive that there is a more positive therapist-client relationship prior to the report which may serve to buffer the impact of reporting on the client.

Further, the perceived impact on the process of therapy and on the family were not related to reporter status. First, therapists may see the therapist-client relationship as the important aspect of therapy which influences the reporting decision, and not just therapy per se. Second, the majority of respondents saw the effect of reporting on the family as positive regardless of reporter status. Since therapists primarily see the effect of reporting as positive, they may not see the potential effect of reporting on the family as a factor that would dissuade them from reporting suspected child abuse.

Hypothesis 3. The third hypothesis that therapists who forewarn clients of limits in confidentiality will be more likely to report suspected cases of child abuse than therapists who do not forewarn clients of limits in confidentiality was not supported. Perhaps this is due to the fact that the majority of therapists (80.1 %) do provide an oral and/or written statement regarding the limits of confidentiality to their clients at the start

of therapy. The number of therapists who forewarn was much higher than the 36.9% reported by Crenshaw and Lichtenberg (1993). In addition the current study found that 14.3% forewarned at the point that suspicion of abuse occurred, 1.5% forewarned only after disclosure of abuse was made, 3.1% seldom discussed warning, and 1.0% stated they do not usually report abuse. Thus, the current study did not replicate the findings of Crenshaw and Lichtenberg (1993) regarding forewarning practice. This suggests that forewarning clients of the limits of confidentiality at the beginning of therapy is becoming a more common practice regardless of whether the therapist is a consistent or inconsistent reporter. Potentially, therapists who do not forewarn clients were less likely to participate in this study because they may have negative views toward forewarning and the reporting law. Therefore, therapists who do not forewarn may not be represented in this sample. Further, even though the majority of therapists who responded to the questionnaire are forewarning their clients of the limits of confidentiality in regards to reporting suspected child abuse, they do not necessarily follow through with this warning when abuse is suspected. The implication of this incongruence between forewarning and reporting is that therapists are repeating the same type of secrecy that allowed abuse to occur in the first place. Both perpetrators and victims of abuse know that the abuse is wrong but secrecy continues to override disclosure. Therapists who choose not to report even after forewarning are perpetuating the secrecy and giving their clients a message that this is acceptable.

Hypothesis 4. The fourth hypothesis was not supported. There were no differences in perceptions of the effect on the therapist-client relationship and continuity

of therapy post report between therapists who forewarn and those who do not. Again, this finding may be due to the fact that the majority of therapist do forewarn all of their clients of the limits of confidentiality regardless of their beliefs regarding the impact of reporting.

Likelihood of disclosure of abuse following forewarning, however, was significantly related to perception of therapist-client relationship following a report. Therapists who perceive that forewarning will increase the likelihood of disclosure are more likely to perceive that a positive therapist-client relationship is maintained than therapists who perceive that forewarning will decrease the likelihood of disclosure. Perhaps therapists are forewarning clients of limits in confidentiality because this is the policy of their place of employment, even when they believe reporting may have a negative impact on potential for disclosure of abuse. Thus, therapists' belief about the impact of forewarning on disclosure may be a better indicator of the perceived effect of forewarning on subsequent therapist-client relationship following a report of suspected abuse than is forewarning practice. In addition, therapists who perceive that forewarning will reduce disclosure of abuse may also be negatively biased against the reporting process increasing the likelihood that they will perceive negative effects from reporting. Because of their views, they may also be more likely to report in such a way as to lead to a more negative effect on the therapist-client relationship.

Hypothesis 5. Finally, the fifth hypothesis that therapists who involve clients in the reporting process are more likely to perceive that they maintain a positive relationship with their clients and that clients will be less likely to terminate therapy than therapists

who do not involve clients in the reporting process was not supported. Perhaps this is due to the fact that there is more to the reporting process than merely the amount of client involvement. This could include things such as number of sessions prior to the report, quality of therapist-client relationship prior to the report, the consequences of the report, characteristics of the clients, and skills of the therapist.

Overall, these findings suggest that consistent reporters perceive reporting suspected child abuse to be an effective way of increasing the family's resources and stopping abuse. Consistent reporters also find that the majority of clients respond in a positive manner to having a report made. Further, this seems to be true regardless of whether one forewarns or the amount of client involvement in the reporting process. Therefore, reporting is the important factor rather than how one forewarns or reports. On the other hand, inconsistent and non-reporters are anticipating a negative response from the client if they report and may therefore make the decision not to report. Since consistent reporters are finding reporting to be positive and effective, perhaps what inconsistent and non-reporters need is further education on how the prepare for and address clients' responses to reporting. Therapists need to be trained on how to remove their perceptions of client reactions to therapists from the decision making process for reporting. Ironically, most respondents in this study reported clients would benefit both short-term and long-term from reporting the abuse. Yet, clients reactions to therapists appeared to outweigh the benefits received. Therapist need to examine their role and relationship with clients and the extent to which the therapist personalizes clients

response. The consequence of therapists being immobilized by fear of client anger in protecting the safety and welfare of children is great.

Other Findings

Thirty-one percent of respondents ($n = 61$) in this study indicated having failed to report at least one case of suspected child abuse. This finding is consistent with previous studies (Beck & Ogloff, 1995; Brosig & Kalichman, 1992a; Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Kalichman et al., 1990; Kennel & Agresti, 1995; Pope & Bajt, 1988). What is interesting about this finding is that only two of the respondents who have chosen not to report a case of suspected child abuse, had never reported any of their cases of suspected child abuse. This suggests that therapists who choose not to report are not entirely opposed to reporting, but take other factors into account when deciding if a particular case should be reported.

One such factor may include the best way to protect the child, which was ranked by all respondents as the most important reason to report suspected abuse as well as the preferred reason not report suspected abuse. Perhaps in some cases, inconsistent reporters believe that reporting will be the best way to protect the child while in other cases they believe not reporting will be the best way to protect the child. Another factor may include confidence that abuse is occurring which inconsistent reporters ranked as the second most important factor to consider when reporting suspected child abuse. Further, another factor which inconsistent reporters saw as important was child's verbal disclosure of abuse. Inconsistent reporters were more likely to report when reporting will protect the child from further abuse, the child has made a verbal disclosure of abuse, and the

therapist is confident that abuse has occurred. Additionally, inconsistent reporters decide not to report when they believe this will protect the child, there is a lack of solid evidence that abuse has occurred, and there is potential for the abuse to stop without reporting. Consistent reporters rated protecting the child and child's verbal disclosure of abuse as the most important factors in deciding to report a case of suspected abuse.

When comparing how consistent and inconsistent reporters ranked their reasons for deciding to report abuse, two significant results were found. First, inconsistent reporters ranked confidence that abuse has occurred as significantly more important than consistent reporters. This finding is contradictory to the results found by Kalichman and Brosig (1993) who found no significant differences on this factor between consistent and inconsistent reporters. Perhaps this difference can be accounted for by the fact that the current study had participants rank this factor on a scale of 1 to 10, in relation to nine other factors, with 1 being most important, while Kalichman and Brosig (1993) rated each factor separately using a 4-point Likert-type scale ranging from not important to extremely important.

Second, consistent reporters ($M = 7.68$, $SD = 1.99$) ranked "supervisor advised to make a report" as significantly more important than did inconsistent reporters ($M = 8.41$, $SD = .89$) or non-reporters ($M = 8.86$, $SD = .86$). Perhaps consistent reporters are more likely to consult with their supervisors before making a report. However, one should note that no group saw this factor as very important in the decision making process.

No other significant differences were found between consistent and inconsistent reporters on how they ranked the various factors in their reporting decisions. This finding

is in contrast to Kalichman and Brosig (1993) who found additional differences between these two groups including upholding the law, protecting the child, potential for abuse to stop without reporting, and the effects of reporting on the family. Again, caution in interpreting these discrepant results is necessary since the two studies used different scales to rate these factors. After examining the results found by Kalichman and Brosig (1993), however, while their findings were significant, there really was not that much actual difference between how consistent and inconsistent reporters responded. The means they reported in their study for their two reporter groups on any one factor were within 0.4 of one another on a 4-point scale, suggesting that the results are significant but potentially meaningless.

In addition, caution is warranted in the current study of comparing reasons for deciding to report with reasons for deciding not to report a suspected case. This is due to the fact that different items were ranked in each question. Although some similarities did exist, many of the items were different (see questions #22 and #24 of questionnaire). Perhaps, this research could be enhanced by having respondents rank the same items in order of importance in making the decision to report and making the decision not to report suspected cases of child abuse. This would allow for more direct comparison between the two questions.

Finally, when comparing the factors generated by factor analyses, two significant results were found. First, potential impact of reporting was significantly related to reporting status with consistent reporters perceiving the potential impact of reporting as more positive than inconsistent reporters or non-reporters. Perhaps consistent reporters

have found a positive impact on therapy following a report of suspected abuse which helps to influence them to consistently report suspected cases, while inconsistent reporters have had mixed or negative results. Further, non-reporters may anticipate a negative impact on therapy without the reporting experience needed to know if this is an accurate prediction. Further, there may be differences in how consistent reporters make reports of suspected child abuse which increases the potential positive impact on therapy, as compared to inconsistent reporters.

Second, importance of the law was significantly related to reporter status with consistent reporters seeing upholding the law and being a mandated reporter as more important than inconsistent reporters or non-reporters. This finding is consistent with the results found by Kalichman and Brosig (1993) who compared consistent and inconsistent reporters. This finding suggests that consistent reporters are more concerned with upholding the law while inconsistent reporters may be more influenced by situational factors such as confidence that abuse is occurring and potential for abuse to stop without reporting.

In terms of moral development, these findings suggest that consistent reporters and inconsistent reporters may view the moral dilemmas created by reporting differently. Consistent reporters appear to see upholding the law and protecting the child from further abuse as compatible. They also perceive that reporting may have positive effects on the therapeutic relationship and the family. Consequently, consistent reporters are able to uphold the law and still view that they are fostering good and preventing harm.

Inconsistent reporters, on the other hand, are not as concerned with upholding the law and do not see the law as being as necessary and effective as consistent reporters do. While they view that reporting may protect the child from further abuse, they are concerned that clients will be angry with them and the therapeutic relationship will be harmed. Therefore, inconsistent reporters appear to report suspected cases only when presented with more severe forms of abuse. Otherwise, they seem to be more concerned with the clients response to them and not upholding the law or fostering good and preventing further harm.

Limitations of the Study

The first limitation has to do with the design of the questionnaire of questions 35 to 41 regarding the perceived effects of reporting and forewarning. These questions were designed to look at therapists' perceptions about reporting and forewarning across all types of abuse, types of clients, and situations to achieve a global assessment of the perceived impact of reporting and forewarning. Several respondents, however, wrote comments on the questionnaire asking if the client in question was the child or the perpetrator and reported their responses would change accordingly. Many reported that the effects of reporting would be more negative for the family and in therapy if the client was the perpetrator, and more positive for the family and in therapy if the client was the child. They also wrote comments asking if the questions were looking at short-term or long-term effects. They reported that the short-term effects of reporting would be negative, but the long-term results of reporting would be positive for the family and in therapy. Finally, other respondents wrote comments that the effect of reporting depends

on multiple factors including the presenting situation, qualities of the therapist, and how the therapist handles the report. Consequently, there is some difficulty in knowing how respondents interpreted these questions. Future research could be more specific in ascertaining the distinct contribution of these various factors in the decision making process of reporting.

The second limitation of the current study is the participant response rate. Given the guarantee of confidentiality and privacy of respondents, there is no way of knowing how those who chose not to participate in the study differ from those who did participate. Perhaps those who did participate are more concerned with child abuse reporting laws than those who chose not to participate. There may be a number of therapists who choose never to report a case of suspected child abuse because they do not believe in the law. These same therapists may not have responded to the survey because they have strong beliefs against mandatory child abuse reporting laws. In addition, based on calls received by the researchers and questionnaires returned with reasons listed why they were not completed, some non respondents chose not to answer because they were retired, were currently living outside of the state, were not currently carrying a caseload, or were not dealing with any issues of child abuse in their practice.

Further, there is no way of knowing if the percentages of consistent and inconsistent reporters found in this study are truly representative of the percentages found in the general population of psychologists and marital and family therapists. Perhaps inconsistent reporters are more likely to be non-respondents than consistent reporters.

Implications

Despite agreement that mandated child abuse reporting laws are necessary and the belief that therapists should be mandated to report suspected cases, thirty-one percent of the therapists in this study admitted to not reporting a case of suspected child abuse. These therapists saw protecting the child, child's verbal disclosure of abuse, confidence that abuse is occurring, and potential for abuse to stop without reporting as more important than upholding the law. This suggests that for some, the law is not the only consideration. The most important factor in deciding to report suspected child abuse was protecting the child from further abuse. This supports the reason these laws were created in the first place. Protecting the child, however, was also listed as the most important reason not to report abuse. Consequently, some therapists seem to be basing the determination of what is in the child's best interest on their own clinical judgment and not the judgment of the Department of Human Services.

This finding is concerning for two reasons. First, therapists who base their judgments on limited information received during therapy may not have all the information necessary to make such an important decision as to what is in the best interest of the child. In therapy, especially when clients are forewarned regarding the limits of confidentiality, therapists may have only been given some of the information about what the abuse incurred. This would mean that more serious abuse could be missed by a well-meaning therapist who decided that the abuse was not severe enough.

Second, 20.4% of participants in this study do not feel well trained to identify suspected cases of child abuse. Consequently, these therapists may overlook important

information as the indicators of, the seriousness of, and the impact of the abuse. Therefore, a therapist would be better off reporting all cases of suspected abuse, regardless of therapist's confidence that abuse has occurred, so that child welfare workers with more comprehensive training in child abuse could make the decision as to what is in the best interest of the child. This training could also include providing standards and information on forewarning and reporting practices, educating on the potential impact in therapy on the therapeutic relationship, and strategies for how to deal with this.

Suggestions for Future Research

The next step in this research would be to modify and re-administer the questionnaire with suggested changes from current respondents. While the current study provided information on how respondents perceive the effect of reporting in general, the next logical step would be to gather specific information for various scenarios. The changes in the questionnaire would include more specific questions including the effects of reporting for various types of abuse, types of clients, short-term versus long-term effects, and various aspects of therapy. The questionnaire could be administered to a broader range of mental health professionals including those with other licenses or those not yet licensed. In addition, research could look at the reporting behavior and beliefs about reporting of non professionals such as lay persons who are mandated to report abuse. Finally, research could evaluate the law and provide suggestions for making reporting laws more effective.

The current study found that there is a relation between belief regarding necessity and importance of law and reporter status. The implication of this finding is that those

who do not see the laws as necessary and important may be less likely to report unless there is enough evidence to support that particular cases of suspected abuse are severe enough that action is more imminent. Future research could add to this finding by attaining information from therapists on what they believe would make the reporting law more effective and worthwhile. One such suggestion is for flexible reporting where a therapist could consult with the Department of Human Services without providing them with identifying information about the child or alleged abuser unless immediate action by the Department of Human Services was needed (Finkelhor & Zellman, 1991). Researchers would need to evaluate the potential impact of such a system, the training needed by a therapist in order to qualify for flexible reporting status, and ways to help therapists and the Department of Human Services work together more effectively.

Another finding of this study is that perceived impact on the therapist-client relationship is related to reporter status. Future research would include gathering more information as to specific scenarios of abuse including who discloses (e.g. perpetrator, child, or third party), the type of abuse, and the severity of abuse. This research could be further enhanced by looking at short-term versus long-term effects, therapist-client relationship prior to the report, characteristics of the client, skills of the therapist, and manner in which report is made to see how these factors may serve as mediating factors. For example, question 37 asked "What is the most likely effect that reporting suspected child abuse has on the therapist-client relationship?" This question could be asked in more than one way by adding "What is the most likely (short-term or long-term) effect that reporting suspected (sexual abuse or physical abuse or neglect) has on the therapist

client relationship when the client is the (abused child or perpetrator or related third party)?" With this information, we would have better information to know the best way of reporting while minimizing the negative impact of reporting on therapy. This would potentially increase the potential of keeping clients in therapy once a report is made and providing them the help necessary to cope with and stop the abuse.

## REFERENCES


Agatstein, D. J. (1989). Child abuse reporting in New York state: The dilemma of the mental health professional. New York Law School Law Review, 34, 115-168.

Ansell, C., & Ross, H. L. (1990). Reply to Pope and Bajt. American Psychologist, 45, 399.

Beck, K. A., & Ogloff, J. R. P. (1995). Child abuse reporting in British Columbia: Psychologists' knowledge of and compliance with the reporting law. Professional Psychology: Research and Practice, 26, 245-251.

Brooks, C. M., Perry, N. W., Starr, S. D., & Teply, L. L. (1994). Child abuse and neglect reporting laws: Understanding interests, understanding policy. Behavioral Sciences and the Law, 12, 49-64.

Brosig, C. L., & Kalichman, S. C. (1992a). Child abuse reporting decisions: Effects of statutory wording of reporting requirements. Professional Psychology: Research and Practice, 23, 486-492.

Brosig, C. L., & Kalichman, S. C. (1992b). Clinicians' reporting of suspected child abuse: A review of the empirical literature. Clinical Psychology Review, 12, 155-168.

Butz, R. A. (1985). Reporting child abuse and confidentiality in counseling. Social Casework, 66, 83-90.

Child Abuse Act, Sec. 845, Oklahoma State Law (1992).

Child Abuse Act, Sec. 846, Oklahoma State Law (1992).

Crenshaw, W. B., & Lichtenberg, J. W. (1993). Child abuse and the limits of confidentiality: Forewarning practices. Behavioral Sciences and the Law, 11, 181-192.

Crenshaw, W. B., Crenshaw, L. M., & Lichtenberg, J. W. (1995). When educators confront child abuse: An analysis of the decision to report. Child Abuse & Neglect, 19, 1095-1113.

Deisz, R., Doueck, H. J., & George, N. (1996). Reasonable cause: A qualitative study of mandated reporting. Child Abuse & Neglect, 20, 275-287.

Dillman, D. A. (1978) Mail and Telephone Surveys: The Total Design Method. New York, NY: John Wiley & Sons, Inc.

Faustman, W. O., & Miller, D. J. (1987). Considerations in prewarning clients of the limitations of confidentiality. Psychological Reports, 60, 195-198.

Finkelhor, D., & Zellman, G. L. (1991). Flexible reporting options for skilled child abuse professionals. Child Abuse & Neglect, 15, 335-341.

Finlayson, L. M., & Koocher, G. P. (1991). Professional judgment and child abuse reporting in sexual abuse cases. Professional Psychology: Research and Practice, 22, 464-472.

Gracia, E. (1995). Visible but unreported: A case for the "not serious enough" cases of child maltreatment. Child Abuse & Neglect, 19, 1083-1093.

Green, S. L., & Hansen, J. C. (1989). Ethical dilemmas faced by family therapists. Journal of Marital and Family Therapy, 15, 149-158.

Kalichman, S. C. (1990). Reporting laws, confidentiality, and clinical judgment: Reply to Ansell and Ross. American Psychologist, 45, 1273.

Kalichman, S. C. (1993). Mandated reporting of suspected child abuse: Ethics, law, and policy. Washington, DC: American Psychological Association.

Kalichman, S. C., & Brosig, C. L. (1993). Practicing psychologists' interpretations of and compliance with child abuse reporting laws. Law and Human Behavior, 17, 83-93.

Kalichman, S. C., & Craig, M. E. (1991). Professional psychologists' decisions to report suspected child abuse: Clinician and situation influences. Professional Psychology: Research and Practice, 22, 84-89.

Kalichman, S. C., Craig, M. E., & Follingstad, D. R. (1988). Mental health professionals and suspected cases of child abuse: An investigation of factors influencing reporting. Community Mental Health Journal, 24, 43-51.

Kalichman, S. C., Craig, M. E., & Follingstad, D. R. (1989). Factors influencing the reporting of father-child sexual abuse: Study of licensed practicing psychologists. Professional Psychology: Research and Practice, 20, 84-89.

Kalichman, S. C., Craig, M. E., & Follingstad, D. R. (1990). Professionals' adherence to mandatory child abuse reporting laws: Effects of responsibility attribution, confidence ratings, and situational factors. Child Abuse & Neglect, 14, 69-77.

Kennel, R. G., & Agresti, A. A. (1995). Effects of gender and age on psychologists' reporting of child sexual abuse. Professional Psychology: Research and Practice, 26, 612-615.

Kohlberg, L. (1984). The Psychology of Moral Development: The Nature and Validity of Moral Stages. San Francisco, CA: Harper & Row.

Leong, G. B., Silva, J. A., & Weinstock, R. (1992). Reporting dilemmas in psychiatric practice. Psychiatric Annals, 22, 482-486.

Levine, M., & Doueck, H. J. (with Anderson, E. M., Chavez, F. T., Deisz, R. L., George, N. A., Sharma, A., Steinberg, K. L., & Wallach, L.). (1995). The Impact of Mandated Reporting on the Therapeutic Process: Picking up the Pieces. Thousand Oaks, CA: Sage Publications.

Liss, M. B. (1994). Child abuse: Is there a mandate for researchers to report? Ethics & Behavior, 4, 133-146.

MacNair, R. R. (1992). Ethical dilemmas of child abuse reporting: Implications for mental health counselors. Journal of Mental Health Counseling, 14, 127-136.

Newberger, E. H. ( 1983). The helping hand strikes again: Unintended consequences of child abuse reporting. Journal of Clinical Child Psychology, 12, 307-311.

Pope, K. S., & Bajt, T. R. (1988). When laws and values conflict: A dilemma for psychologists. American Psychologist, 43, 828-829.

Smith, S. R., & Meyer, R. G. (1985). Child abuse reporting laws and psychotherapy: A time for reconsideration. International Journal of Law and Psychiatry, 7, 351-366.

Smith-Bell, M., & Winslade, W. J. (1994). Privacy, confidentiality, and privilege in psychotherapeutic relationships. American Journal of Orthopsychiatry, 64, 180-193.

Stadler, H. A. (1989). Balancing ethical responsibilities: Reporting child abuse and neglect. The Counseling Psychologist, 17, 102-110.

Thompson-Cooper, I., Fugere, R., & Cormier, B. M. (1993). The child abuse reporting laws: An ethical dilemma for professionals. Canadian Journal of Psychiatry, 38, 557-562.

Van Eenwyk, J. R. (1990). When laws and values conflict: Comment on Pope and Bajt. American Psychologist, 45, 399-400.

Walters, D. (1995). Mandatory reporting of child abuse: Legal, ethical, and clinical implications within a Canadian context. Canadian Psychology, 36, 163-182.

Weinstock, R., & Weinstock, D. (1989a). Clinical flexibility and confidentiality: Effects of reporting laws. Psychiatric Quarterly, 60, 195-214.

Weinstock, R., & Weinstock, D. (1989b). Preserving clinical flexibility and confidentiality: Strategies and limitations. Psychiatric Annals, 19, 158-161.

Zellman, G. L. (1990). Report decision-making patterns among mandated child abuse reporters. Child Abuse & Neglect, 14, 325-336.

# APPENDIXES

# APPENDIX A

# TABLES 1-7

TABLE 1

Demographics and Background Characteristics of Respondents

| Characteristic | n | % |
|---|---|---|
| Gender | | |
| Male | 97 | 48.7 |
| Female | 98 | 49.2 |
| Unknown | 4 | 2.0 |
| Age | | |
| 26-35 years | 10 | 5.0 |
| 36-45 years | 53 | 26.6 |
| 46-55 years | 88 | 44.2 |
| 56+ years | 48 | 24.1 |
| Race | | |
| White | 187 | 94.0 |
| Other | 11 | 5.5 |
| Unknown | 1 | .5 |
| License* | | |
| Psychologist | 113 | 56.8 |
| LMFT | 97 | 48.7 |
| LCSW | 9 | 4.5 |
| LPC | 43 | 21.6 |
| Other | 16 | 8.0 |
| Primary Employment | | |
| Academic institution | 25 | 12.6 |
| Medical institution | 17 | 8.5 |
| Psychiatric hospital | 11 | 5.5 |
| Church | 5 | 2.5 |
| Community agency | 16 | 8.0 |
| Private practice | 80 | 40.2 |
| School system | 9 | 4.5 |
| Non profit agency | 16 | 8.0 |
| Other | 18 | 9.0 |
| Unknown | 2 | 1.0 |
| Sources of Information About Abuse | | |
| Course in graduate school | 53 | 26.6 |
| Clinical internship | 82 | 41.2 |
| Worked for child welfare | 14 | 7.0 |
| Practica in graduate college | 102 | 51.3 |
| Supervision in graduate college | 118 | 59.3 |
| Workshops | 176 | 88.4 |
| Books | 142 | 71.4 |
| Other | 37 | 18.6 |

* Some respondents had multiple licenses

TABLE 2

Factor Loadings and Alphas for Rotated Factor Matrix of Items 27-41

| Factor and Items | Factor Loadings | | | |
|---|---|---|---|---|
| | Factor 1 | Factor 2 | Factor 3 | Factor 4 |
| Importance of Reporting (.77) | | | | |
| 27. Stopping abuse | .72 | | | |
| 28. Services to family | .76 | | | |
| 29. Law necessary | .60 | | | |
| 30. Law best alternative | .61 | | | |
| 31. DHS effective | .78 | | | |
| Potential Impact (.72) | | | | |
| 36. Process of therapy | | .85 | | |
| 37. Therapist-client relationship | | .89 | | |
| 38. Response to therapist | | .58 | | |
| Forewarning (.65) | | | | |
| 40. Forewarning practice | | | .86 | |
| 41. Effect disclosure | | | .56 | |
| Importance of Confidentiality and the Law (.61) | | | | |
| 32. Should be mandated | | | | .56 |
| 33. Maintain client confidentiality | | | | .86 |
| 34. Upholding the law | | | | .88 |

Note. Kaiser-Meyer-Olkin Measure of Sampling Adequacy = .90 and Bartlett's Test of Sphericity = 6975.0, $p < .01$.

TABLE 3

Means and Standard Deviations by Reporter Status on Factors Related to Therapists' Beliefs About Mandatory Child Abuse Reporting Laws

| Item | Reporters | Inconsistent Reporters | Non Reporters | Total |
|---|---|---|---|---|
| 27. Stopping abuse | 2.59 (1.18) | 2.74 (1.15) | 3.05 (1.23) | 2.68 (1.18) |
| 28. Services to families | 2.57 (1.13) | 2.95 (1.22) | 2.50 (1.00) | 2.68 (1.15) |
| 29. Law necessary | 1.35 (0.87) | 1.49 (0.83) | 1.40 (0.68) | 1.40 (0.84) |
| 30. Law best alternative | 2.50 (1.16) | 2.82 (1.21) | 2.75 (0.85) | 2.63 (1.15) |
| 31. DHS effective | 3.41 (1.13) | 3.59 (1.26) | 3.15 (0.99) | 3.44 (1.16) |
| 32. Should be mandated | 1.48 (0.98) | 1.98 (1.21) | 1.95 (1.28) | 1.69 (1.11) |
| 33. Maintain client confidentiality | 3.24 (1.46) | 3.07 (1.36) | 2.70 (1.38) | 3.13 (1.43) |
| 34. Upholding the law | 1.86 (0.95) | 2.18 (0.94) | 2.10 (1.07) | 1.99 (0.97) |
| 35. Effect on family | 3.03 (1.06) | 3.10 (1.11) | 3.10 (1.41) | 3.06 (1.11) |
| 36. Effect process of therapy | 2.74 (1.04) | 3.05 (1.12) | 3.45 (1.05) | 2.91 (1.09) |
| 37. Therapist-client relationship | 2.78 (1.03) | 3.05 (1.15) | 3.45 (1.05) | 2.93 (1.08) |
| 38. Response to therapist | 3.57 (1.42) | 3.92 (1.28) | 4.35 (1.09) | 3.76 (1.37) |
| 39. Continuation of therapy | 3.40 (1.38) | 3.15 (1.53) | 2.56 (1.62) | 3.24 (1.47) |
| 41. Effect disclosure | 2.24 (0.71) | 2.13 (0.70) | 2.00 (0.97) | 2.18 (0.73) |

TABLE 4

Forewarning Practice of Participants

| Forewarning Practice | n | % |
|---|---|---|
| Oral and Written Statement | 96 | 49.0 |
| Written Statement | 27 | 13.8 |
| Oral Statement | 34 | 17.3 |
| Discuss with Suspicions of Abuse | 28 | 14.3 |
| Discuss with Clear Disclosure of Abuse | 3 | 1.5 |
| Seldom Discuss Reporting | 6 | 3.1 |
| Do Not Usually Report | 2 | 1.0 |

TABLE 5

Mean Percentages and Standard Deviations for Methods of Reporting

| Reporting Method | Reporter N = 108 | Inconsistent N = 59 | Total N = 167 |
|---|---|---|---|
| Client reports self in presence of therapist | 22.0% (29.6) | 19.1% (28.6) | 21.0% (29.1) |
| Client reports self from home | 4.2% (12.4) | 8.6% (19.9) | 5.7% (15.5) |
| Therapist reports while client listens | 21.3% (27.3) | 22.5% (27.9) | 21.6% (27.4) |
| Therapist reports while client waits | 4.6% (13.5) | 4.2% (14.6) | 4.9% (14.9) |
| Therapist reports after session with client's knowledge | 36.8% (38.3) | 34.3% (36.5) | 35.7% (37.6) |
| Therapist reports after session without client's knowledge | 8.5% (19.6) | 8.5% (20.3) | 8.5% (19.8) |
| Someone else in facility makes the report | 0.6% (3.0) | 2.8% (10.5) | 1.4% (6.7) |

TABLE 6

Means and Standard Deviations of Rankings for Decision to Report

| **Factor** | Reporter | Inconsistent | Non Reporters | Total |
|---|---|---|---|---|
| Protect child | 1.43 (1.28) (n = 116) | 1.37 (0.86) (n = 60) | 1.17 (0.51) (n = 18) | 1.39 (1.11) (n = 194) |
| Child disclosed | 3.81 (2.23) (n = 112) | 3.83 (2.31) (n = 59) | 4.71 (2.00) (n = 17) | 3.90 (2.24) (n = 188) |
| Ethics | 4.03 (1.94) (n = 117) | 4.52 (1.81) (n = 58) | 3.33 (1.88) (n = 18) | 4.11 (1.92) (n = 193) |
| Law | 4.02 (2.23) (n = 116) | 4.69 (2.14) (n = 58) | 3.82 (1.78) (n = 17) | 4.20 (2.18) (n = 191) |
| Confidence* | 4.75 (2.25) (n = 111) | 3.71 (1.84) (n = 58) | 4.31 (1.89) (n = 16) | 4.38 (2.15) (n = 185) |
| Severity | 5.19 (2.12) (n = 108) | 4.44 (1.91) (n = 59) | 5.38 (1.93) (n = 16) | 4.96 (2.06) (n = 183) |
| Trust | 5.74 (1.96) (n = 110) | 6.05 (1.81) (n = 57) | 5.63 (1.67) (n = 16) | 5.83 (1.89) (n = 183) |
| Protect parent | 7.25 (2.02) (n = 108) | 7.24 (1.91) (n = 58) | 7.73 (1.67) (n = 15) | 7.29 (1.95) (n = 181) |
| Supervisor advised** | 7.68 (1.99) (n = 97) | 8.41 (0.89) (n = 49) | 8.86 (0.86) (n = 14) | 8.01 (1.70) (n = 160) |
| Other | 8.86 (2.06) (n = 35) | 9.11 (2.23) (n = 19) | 9.14 (1.57) (n = 7) | 8.97 (2.04) (n = 61) |

* $p < .05$

** $p < .01$

TABLE 7

Means and Standard Deviations of Rankings for Decision to Not Report

| **Factor** | Reporter | Inconsistent | Non Reporters | Total |
|---|---|---|---|---|
| Protect child | 2.73 (2.02) (n = 30) | 2.61 (1.56) (n = 57) | 1.67 (0.87) (n = 9) | 2.56 (1.68) (n = 96) |
| Lack solid evidence | 3.17 (2.47) (n = 29) | 2.66 (2.09) (n = 59) | 2.33 (1.87) (n = 9) | 2.78 (2.18) (n = 97) |
| Potential abuse to stop | 3.67 (2.75) (n = 30) | 3.40 (2.14) (n = 57) | 4.13 (1.36) (n = 8) | 3.55 (2.29) (n = 95) |
| Effect on family | 5.00 (2.30) (n = 29) | 4.43 (2.17) (n = 56) | 4.88 (1.89) (n = 8) | 4.65 (2.18) (n = 93) |
| Not disrupt therapy | 5.18 (2.04) (n = 28) | 5.11 (1.78) (n = 53) | 5.63 (1.30) (n = 8) | 5.18 (1.82) (n = 89) |
| Maintain confidentiality | 5.04 (2.33) (n = 28) | 5.96 (2.05) (n = 52) | 4.88 (1.89) (n = 8) | 5.57 (2.16) (n = 88) |
| Ability of DHS | 5.93 (4.02) (n = 30) | 5.89 (2.60) (n = 53) | 6.29 (3.15) (n = 7) | 5.93 (3.14) (n = 90) |
| Other | 7.50 (3.66) (n = 12) | 6.75 (4.08) (n = 20) | 7.00 (5.20) (n = 3) | 7.03 (3.91) (n = 35) |
| Protect parent | 7.19 (1.52) (n = 27) | 6.96 (2.12) (n = 51) | 8.00 (1.20) (n = 8) | 7.13 (1.88) (n = 86) |
| Supervisor against | 7.42 (1.96) (n = 26) | 7.93 (2.06) (n = 44) | 7.71 (2.69) (n = 7) | 7.74 (2.07) (n = 77) |

# APPENDIX B

# QUESTIONNAIRE, COVER LETTER, AND POSTCARD

**Child Abuse Reporting Survey**

1. Gender: _____ Male _____ Female

2. Age:
   - _____ 25 years or younger
   - _____ 26-35 years
   - _____ 36-45 years
   - _____ 46-55 years
   - _____ 56 years or older

3. Ethnicity/ Race:
   - _____ African American
   - _____ Asian American
   - _____ Hispanic
   - _____ Native American
   - _____ White (non-Hispanic)
   - _____ Other: _____

4. Religion
   - _____ Assembly of God
   - _____ Baptist
   - _____ Catholic
   - _____ Christian
   - _____ Other: _____
   - _____ Episcopal
   - _____ Jewish
   - _____ Lutheran
   - _____ Methodist

5. What type of license(s) do you have? Check all that apply. If more than one license, circle the primary one.
   - _____ Licensed Psychologist
   - _____ Licensed Clinical Social Worker
   - _____ Licensed Marital and Family Therapist
   - _____ Licensed Professional Counselor
   - _____ Other: _____

6. In what type of settings have you worked since you received your professional degree? Check all that apply.
   - _____ Academic institution
   - _____ Medical institution
   - _____ Psychiatric hospital
   - _____ Church
   - _____ Other: _____
   - _____ Community agency
   - _____ Private practice
   - _____ School system
   - _____ Non-profit agency

7. In what type of settings do you work <u>currently</u>? Check all that apply.
   - _____ Academic institution
   - _____ Medical institution
   - _____ Psychiatric hospital
   - _____ Church
   - _____ Other: _____
   - _____ Community agency
   - _____ Private practice
   - _____ School system
   - _____ Non-profit agency

8. What is your <u>primary</u> work setting? Check only one.
   - _____ Academic institution
   - _____ Medical institution
   - _____ Psychiatric hospital
   - _____ Church
   - _____ Other: _____
   - _____ Community agency
   - _____ Private practice
   - _____ School system
   - _____ Non-profit agency

9. To what professional organizations do you belong? Check all that apply.
_____ Oklahoma/ American Association of Marriage and Family Therapists (OAMFT or AAMFT)
_____ Oklahoma/ American Association of Social Workers (OASW or AASW)
_____ Oklahoma/ American Counselors Association (OAC or AAC)
_____ Oklahoma/ American Association of Professional Counselors (OAPC or AAPC)
_____ Oklahoma/ American Psychological Association (OPA or APA)
_____ Oklahoma/ American Association of Pastoral Counselors (OAPC or AAPC)
_____ American Association for Sex Educators, Counselor and Therapists (AASECT)
_____ International Professional Society for Child Abuse and Neglect (IPSCAN)
_____ Other: _____
_____ None

10. When did you receive your masters degree?
_____ Before 1974
_____ Between 1974 and 1988
_____ 1989 or later
_____ I do not have a masters degree

11. When did you receive your doctoral degree?
_____ Before 1974
_____ Between 1974 and 1988
_____ 1989 or later
_____ I do not have a doctoral degree

12. How many years have you practiced therapy? _____

13. On the average, how many hours of therapy do you conduct each week? _____

14. Approximately what percentage of your practice is spent working with the following clients?
a) Individual adults (ages 18 years and older): _____ %
c) Individual adolescents (ages 13-17 years): _____ %
b) Individual children (ages 0-12 years): _____ %
d) Couples: _____ %
e) Families: _____ %
f) Groups: _____ %

15. Approximately what percentage of your practice do you spend dealing with issues of child abuse? _____ %

16. What type of formalized training have you had in child abuse? Check all that apply.
_____ Course in graduate school
_____ Clinical internship
_____ Worked for child welfare
_____ Other: _____
_____ No formal training in child abuse
_____ Discussed in practica in graduate school
_____ Discussed in supervision in graduate school
_____ Workshops
_____ Books (self-trained)

17. How well trained do you feel you are to identify cases of child abuse?
_____ Very well trained
_____ Well trained
_____ Somewhat trained
_____ Minimally or not at all trained

18. How well trained do you feel you are to treat cases of child abuse?
_____ Very well trained
_____ Well trained
_____ Somewhat trained
_____ Minimally or not at all trained

19. Does your place of employment have a written policy regarding the procedure for reporting cases of suspected child abuse? _____ Yes _____ No

20. According to the policy of your place of employment, if you were to suspect a case of child abuse, would you be responsible for making the report, or would someone else be responsible for reporting these suspicions?
_____ I would make the report
_____ Someone else in the facility would make the report.
(If so, what is the job title of the person who would make the report?
_____)
_____ No report would be made

21. Have you ever reported a case of suspected child abuse? _____ Yes _____ No
If yes, approximately how many cases of suspected child abuse have you reported?
_____ One
_____ 2-5 Cases
_____ 6-10 Cases
_____ 10-20 Cases
_____ More than 20 Cases

22. If you decided to report suspected child abuse, please rank from 1 to 10 the following issues in order of importance in making the decision to report suspected child abuse with 1 being most important, and 10 being least important.
_____ Upholding the law
_____ Protecting the child
_____ Protecting the parent
_____ Upholding ethical standards
_____ Maintaining trust in therapy
_____ Confidence that abuse has occurred
_____ Severity of abuse
_____ Supervisor advised to make a report
_____ Child verbally discloses being abused
_____ Other: _____

23. Have you ever suspected that a child was being abused but decided not to report this to the authorities? _____ Yes _____ No
If yes, approximately how many cases of suspected child abuse have you decided not to report?
_____ One
_____ 2-5 Cases
_____ 6-10 Cases
_____ 10-20 Cases
_____ More than 20 Cases

24. If you decided not to report suspected child abuse, please rank from 1 to 10 the following issues in order of importance in making the decision not to report suspected child abuse with 1 being most important, and 10 being least important.
_____ Supervisor advised against making a report
_____ The effects of reporting on the family
_____ Protecting the child
_____ Protecting the parent
_____ Not disrupting the process of therapy
_____ Maintaining client confidentiality
_____ Lack of solid evidence that abuse has occurred
_____ Potential for abuse to stop without reporting
_____ Ability of the Department of Human Services to deal with abuse
_____ Other: _____

25. Of cases you have reported, approximately what percentage of the time were each of the following the primary source of information for a report of suspected child abuse:
_____ % the actual victim of the abuse was the primary source of information
_____ % the perpetrator of the abuse was the primary source of information
_____ % third parties who knew about the abuse were the primary source of information
_____ I have never reported a case of suspected child abuse

26. If you have reported suspected child abuse, approximately what percentage of the time did you use each of the following methods to report suspected child abuse to the authorities?
_____ % Client reports him- or herself to the authorities in the presence of the therapist
_____ % Client goes home to report him- or herself to the authorities
_____ % Therapist reports while the client listens
_____ % Therapist reports from another room while the client waits
_____ % Therapist reports after the session with client's knowledge
_____ % Therapist reports after the session without client's knowledge
_____ % Someone else in the facility makes the report

**For items 27-34, please circle the number which indicates the degree to which you agree or disagree with the statement.**

| Strongly agree | Somewhat agree | Neutral | Somewhat disagree | Strongly disagree |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

27. Mandated child abuse reporting laws are effective in stopping abuse of a child.

1 2 3 4 5

28. Mandated child abuse reporting laws are effective in getting needed services to a family.

1 2 3 4 5

29. Mandated child abuse reporting laws are necessary.

1 2 3 4 5

30. Mandated child abuse reporting laws as they exist are the best alternative in addressing cases of child abuse.

1 2 3 4 5

31. The Department of Human Services is effective in handling cases of suspected child abuse.

1 2 3 4 5

32. Mental health professionals should be mandated to report cases of suspected child abuse to the authorities.

1 2 3 4 5

33. Maintaining client-therapist confidentiality is important when making a decision to report a case of suspected child abuse to the authorities.

1 2 3 4 5

34. Upholding the law is important in making the decision to report a case of suspected child abuse.

1 2 3 4 5

35. What is the most likely effect that reporting suspected child abuse has on a family?

_____ Very positive effect
_____ Somewhat positive effect
_____ Neither positive nor negative effect
_____ Somewhat negative effect
_____ Very negative effect

36. What is the most likely effect that reporting suspected child abuse has on the process of therapy?

_____ Very positive effect
_____ Somewhat positive effect
_____ Neither positive nor negative effect
_____ Somewhat negative effect
_____ Very negative effect

37. What is the most likely effect that reporting suspected child abuse has on the therapist-client relationship?

_____ Very positive effect
_____ Somewhat positive effect
_____ Neither positive nor negative effect
_____ Somewhat negative effect
_____ Very negative effect

38. What is the most likely effect that reporting suspected child abuse has on client's response to the therapist?

_____ Clients express a great deal of anger toward the therapist
_____ Clients express some anger toward the therapist
_____ Clients show no emotional response
_____ Clients express some gratefulness toward the therapist
_____ Clients express profound gratefulness toward the therapist

39. What is the most likely effect that reporting suspected child abuse has on the continuation of therapy once a report is made?

_____ Clients decide to completely terminate therapy
_____ Clients decide to terminate therapy with present therapist but ask for referral to a new therapist
_____ Clients return for a few more therapy sessions to discuss the report and then terminate therapy
_____ Clients remain in therapy until therapeutic goals are reached
_____ Therapist decides to terminate therapy and refers client to another therapist
_____ Therapist decides to terminate therapy but does not refer client to another therapist because the Department of Human Services in now handling this case

40. Please check the one statement that best describes your forewarning practices regarding confidentiality and suspected child abuse.

_____ I provide an <u>oral and written</u> statement of the limits of confidentiality regarding suspected child abuse reporting to all my clients before therapy begins
_____ I provide a <u>written</u> statement of the limits of confidentiality regarding suspected child abuse reporting to all my clients before therapy begins
_____ I provide an <u>oral</u> statement of the limits of confidentiality regarding suspected child abuse reporting to all my clients before therapy begins
_____ I discuss reporting with my clients when I begin having suspicions of child abuse
_____ I discuss reporting with my clients only after I have a clear disclosure of abuse
_____ I seldom discuss reporting with my clients
_____ I do not usually report suspected child abuse

41. If clients are forewarned about the limits of confidentiality with respect to mandated child abuse reporting laws, how likely will they be to disclose child abuse in the course of therapy?

_____ Forewarning will greatly reduce likelihood of disclosure
_____ Forewarning will somewhat reduce likelihood of disclosure
_____ No effect from forewarning on disclosure
_____ Forewarning will somewhat increase likelihood of disclosure
_____ Forewarning will greatly increase likelihood of disclosure

42. What types of child abuse should be reported according to Oklahoma state law?

43. What do you believe is the correct procedure for reporting a case of suspected child abuse in Oklahoma?

September 30, 1997

Dear:

You are one of a small number of therapists being asked to participate in a study about child abuse reporting. Currently, a debate exists in the field of mental health as to whether reporting suspected child abuse is the best way of handling this societal problem. Consequently, you are being asked to participate in a master's thesis research project to find out your views regarding child abuse reporting.

Your name was drawn in a random sample of licensed psychologists and licensed marital and family therapists. Your completion and return of this questionnaire is important in order that the results will truly represent professionals in your field.

You may be assured of complete anonymity. An identification number will be placed on your questionnaire only after the questionnaire is returned. Please do not put your name on the questionnaire or envelope. To help assure anonymity, your questionnaire will be placed in a locked filing cabinet and will only be seen by the two primary researchers. No individual results will be reported. We will only report group results.

The results of this research will help to further our understanding of how therapists handle suspected cases of child abuse. While your participation in this study is voluntary, we ask that you please take a few minutes to fill out and return this questionnaire. A postage-paid return envelope has been included for your convenience.

If you have any questions about this study, please contact Dr. Kathleen Briggs, faculty advisor, at (405) 744-8354. This study has been approved by the Oklahoma State University Institutional Review Board, and any concerns may be directed to them by calling (405) 744-5700.

Sincerely,

Carrie A. Herder

Kathleen Briggs, Ph.D.
Associate Professor, FRCD
Faculty Advisor

POSTCARD

Last week a questionnaire was mailed to you regarding the reporting of suspected child abuse. Your name was drawn in a random sample of licensed psychologists and marital and family therapists.

If you have already completed and returned this questionnaire to us please accept our sincere thanks. If not, please do so today. Because this questionnaire has been sent to only a small, but representative, sample of licensed professionals, your participation is important so that the results will accurately represent the views of professionals in your field.

If by some chance you did not receive the questionnaire, or it got misplaced, please call us today at (405) 744-5058 and we will get another one in the mail to you today.

Sincerely,

Carrie Herder

# APPENDIX C

# INSTITUTIONAL REVIEW BOARD APPROVAL FORM

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

**Date:** 09-18-97 **IRB#:** HE-98-005

**Proposal Title: THERAPISTS' REPORTING PRACTICES AND BELIEFS ABOUT MANDATORY CHILD ABUSE REPORTING LAWS**

**Principal Investigator(s):** Kathleen Briggs, Carrie Herder

**Reviewed and Processed as:** Exempt

**Approval Status Recommended by Reviewer(s):** Approved

ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING, AS WELL AS ARE SUBJECT TO MONITORING AT ANY TIME DURING THE APPROVAL PERIOD.
APPROVAL STATUS PERIOD VALID FOR DATA COLLECTION FOR A ONE CALENDAR YEAR PERIOD AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.
ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

---

**Comments, Modifications/Conditions for Approval or Disapproval are as follows:**

Signature: _____ Date: September 19, 1997
Chair of Institutional Review Board
cc: Carrie Herder

VITA

Carrie Ann Herder

Candidate for the Degree of

Master of Science

Thesis: THERAPIST'S REPORTING PRACTICES AND BELIEFS ABOUT MANDATORY CHILD ABUSE REPORTING LAWS

Major Field: Family Relations and Child Development

Biographical:

Personal Data: Born in Denver, Colorado on March 16, 1969, the daughter of Gerald and Josephine Herder.

Education: Graduated from Highland High School, Thornton, Colorado in May of 1987; received Bachelor of Arts degree in Psychology from University of Denver, Denver, Colorado in June of 1991; completed the requirements for the Master of Science degree with a major in Family Relations and Child Development with a Specialization in Marriage and Family Therapy at Oklahoma State University December, 1997.

Experience: Internship at The Center For Family Services, Stillwater, Oklahoma, 1996 to 1997; internship at Moore Family Institute, Moore, Oklahoma 1997.

Professional Memberships: Phi Beta Kappa, Student Member of the American Association of Marriage and Family Therapy, Student Member of Oklahoma Association of Marriage and Family Therapy.