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Case Examples in Clinical Supervision:
The Challenge of Mandated Child Abuse Reporting

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Abstract

Mandated reporting, while an ethical and legal requirement, often stirs emotions in mental health professionals that may prevent them from making the report. Fear, anxiety and countertransference may all interfere with good judgment. The Clinical Supervisor maintains the responsibility to ensure reports are made but must also address the clinician's emotional concerns. This article presents two case studies that illustrate ways a supervisor can support the supervisee through mandated reporting, and what can happen when a supervisee fails to comply with the legal mandate.

Keywords: mandated reporting, child maltreatment, clinical supervision, graduate training

**Case Examples in Clinical Supervision:
The Challenge of Mandated Child Abuse Reporting**

An ongoing challenge for any new mental health professional is mandated reporting, the ethical and legal responsibility to disclose child and adult maltreatment allegations to a state authority. Child maltreatment is defined as an act or series of acts, whether through an act of commission (abuse) or omission (neglect), by a caregiver that results in actual harm, potential harm, or threat of harm, to a child (42 U.S.C. §5106g). As for the prevalence of child maltreatment in the United States, in 2015 3.4 million children were the subject of at least one protective service report and 20% of those reports were substantiated as either abuse or neglect (U.S. Department of Health and Human Services, 2017). Due to the ongoing issue of professionals failing to report maltreatment, the study further concludes that rates of maltreatment are much higher than reported.

A prevailing barrier interfering with reporting is the fear of breaching confidentiality. Ethical codes for counselors, psychologists, marriage and family therapists, school psychologists, and social workers require that a mental health professional breach confidentiality when the welfare of the person is at risk (American Association for Marriage and Family Therapy, 2015; American Counseling Association,

2014; American Psychological Association, 2010; National Association of Social Workers, 2017; National Association of School Psychologists, 2010). The *American Counseling Association Code of Ethics* (2014) Section B2(a) explicitly provides for exceptions to confidentiality. Likewise, the American School Counselor Association's Code of Ethics (2016), under section A.2(c), provides similar guidance as to when it is acceptable to breach confidentiality. Across disciplines, the National Association of School Psychologists' (NASP) Principles for Professional Ethics (2010) also provides relevant ethical principles and standards, including Principle I.2 Privacy and Confidentiality, Standard I.2.2 and I.2.4, and Principle IV Responsibility to Schools, Families, Communities, the Professions, and Society.

Reporting suspected maltreatment is not only an ethical issue but is also a legal requirement for mental health professionals. Professionals who work with children and adolescents are charged with the duty to report any and all suspected child abuse and neglect to the appropriate state agency, a legal requirement referred to as mandated reporting (42 U.S.C. §13031). The history of this legal mandate stems in large part from the 1962 work of Drs. Kempe and Steele, a pediatrician and psychiatrist respectively, who raised awareness in the medical field on the topic of Battered Child Syndrome (Kalichman, 1993; Cruise & Horton, 2001; Myers, 2008). While child protection efforts were previously recognized as important as evidenced by the development of non-governmental groups dedicated to the protection of children, the 1960s witnessed a change in perspective, bringing child protection into the fold of government agencies (Cruise & Horton, 2001; Myers, 2008). Furthermore, due to awareness and advocacy efforts, by the late 1960s, child abuse reporting laws were in place across the nation (Cruise & Horton, 2001; Myers, 2008). Later, in 1974, Congress passed PL 93-247, or the Child Abuse Prevention and Treatment Act (Cruise & Horton, 2001; Myers, 2008). By the 1980s, reporting requirements were extended beyond the medical field to include school-based staff (Cruise & Horton, 2001; Myers, 2008).

The ramifications for the mental health professional for failing to report suspected abuse or neglect are severe and numerous. Possible outcomes may include a monetary fine, a loss of professional license, a felony charge of child endangerment, and possible incarceration (Child Welfare Information Gateway, 2014). Similarly, a mental health professional could be held civilly liable and face a monetary judgment should a child be injured based on the failure to act. The ramifications for the child are more severe, as ongoing injury or neglect may occur.

Nevertheless, many mental health professionals fail to report suspected abuse or neglect for a variety of reasons. In some cases, the professional lacks training in how to make reports (Alvarez, Kenny, Donohue & Carpin, 2004). Emotions also play a role in failure to report. The professional may fear the report will place the child at risk for greater harm or that the family will withdraw from treatment (Cruise & Horton, 2001). Other reasons cited throughout the research include concerns regarding the veracity of the allegation or lack of evidence, leading mental health professionals to delay or avoid reporting out of fear of making an inaccurate report (Herendeen, Blevins, Ansen, & Smith, 2014). Mental health professionals also fail to report based on previous

experiences with reporting agencies not taking action on the complaint (Bryant, 2009; Herendeen, Blevins, Ansen, & Smith, 2014). Finally, fear of confronting the parent or child after the report is made also acts as a barrier (Alvarez et al, 2004).

The initial burden for teaching mandated reporting requirements falls first to the graduate program. Accredited mental health graduate programs require students to be taught a course in ethics (CACREP, 2016; CSWE, 2008). Students may receive information regarding how to make an abuse or neglect report, but often rarely have to do so during their graduate education. The complicated issues that surround the process of mandated reporting remains theoretical for the new mental health professional and the professional is often blindsided by the emotional and procedural complications that arise when faced with making the report.

Graduate programs should address these issues at the practicum and internship level. These field based clinical training opportunities provide invaluable exposure to topics that may not be formally addressed within the confines of training (Newman, 2013). Because most therapists do not receive this experience, the job of preparing them for mandated reporting often falls to their first clinical supervisor.

Clinical Supervision

Clinical supervisors need to be aware of the legal and ethical ramifications of failing to report abuse and neglect, both for themselves and their supervisees. The *Approved Clinical Supervisor (ACS) Code of Ethics* (Center for Credentialing & Education, 2008) states that Clinical Supervisors ensure their supervisees inform clients of the limits of confidentiality and the code also requires Clinical Supervisors to intervene when a client is at risk (CCE, 2008). Clinical supervisors engage in several roles with their supervisee, including the role of counselor, gatekeeper, and teacher (Bernard & Goodyear, 2014). Each of these roles requires the supervisor to encourage growth while ensuring that clients and the profession are protected. Under the guise of the supervisory relationship, there are two critical elements of which all supervisees must be aware. The first is that the supervisee must understand when it is necessary to involve their supervisor. The second is that the supervisee must be aware of relevant safety and crisis plans in place at their sites (Jacob, Decker, & Hartshorne, 2011). These two issues are especially crucial when there is a threat or potential threat of maltreatment. Clinical supervisors also need a roadmap of how to work with supervisees who either fail to report or are reluctant to report and need further guidance.

Students training to be clinical and school-based mental health providers receive training in several content areas, in a variety of formats. One of the most critical is direct, individual supervision (Newman, 2013). Training programs are tasked with preparing graduates for the field, yet it is difficult for programs to cover all situations in both breadth and depth, so individual case supervision provides a bridge between theoretical and applied training, linking classroom-based training with field-based training. Supervision allows graduate students to receive directive feedback as

situations and opportunities present (Bernard & Goodyear, 2014). Unlike teaching and training which require a more structured approach with predetermined curricula and standards, supervision tends to be more needs based and is predicated on the situations a supervisee encounters in the field (Bernard & Goodyear, 2014). Supervision, particularly during the internship, is important for several reasons (Newman, 2013). It not only allows the supervisor to enhance the growth and development of the supervisee's skills, but when necessary it further allows the supervisor to preserve the integrity of the profession by delaying, or in some instances denying, a supervisee's entrance to the field (Newman, 2013, NASP 2010a, 2010b). Additionally, important to note is that the supervisor bears the ultimate responsibility to ensure the wellbeing of all clients served by the supervisee, such that in some instances the supervisor may need to directly intervene to preserve the welfare and best interest of the client (ACS, 2008; Bernard & Goodyear, 2014). Many of these aspects are illustrated in the case examples below.

Emotional support is also a critical aspect of clinical supervision (Williams, Helm, & Clemens, 2012). Several terms have been used over time to refer to the potential for professional burnout including the cost of caring, compassion fatigue, vicarious traumatization, ripple effect, and secondary traumatic stress. These terms have in common the emphasis that must be placed on the emotional wellbeing of practitioners, and highlight the importance of providing "care for the caregiver" (Cruise & Horton, 2001; Harvey & Struzziero, 2008). Furthermore, the need for emotional support is not limited to graduate students or new professionals, but extends to more experienced and seasoned practitioners as well through peer supervision (Harvey & Struzziero, 2008; Newman, 2013).

A clinical supervisor needs to choose a theoretical model that will provide support while also incorporating the roles of teacher, counselor, and gatekeeper. Using a Cognitive-Behavioral approach that confronts assumptions and challenges unrealistic expectations can be effective for individuals faced with making abuse or neglect reports (Azar, 2000), as can developmental models, which fit best with graduate students and new professionals (Lambie & Sias, 2009).

Case Examples

Below are two case examples written in first person describing a clinical supervision interaction around child maltreatment mandated reporting. The cases are intended to depict in vivo situations and how, in the moment and aftermath, the clinical supervisors attempted to balance the multiple roles of teacher, supervisor and gatekeeper with the ethical, legal, and emotional issues surrounding mandated reporting. Each case example will demonstrate a supervisee's challenge with reporting abuse and neglect, and then describe how the clinical supervisor addressed the ethical, legal, and emotional issues to find resolution and ensure child safety.

Case Example #1: Counselor Education - Practicum Student

“One of my roles in the counselor education program is to run a practicum clinic and provide group and individual supervision. A new practicum counselor, Alice, was in her early twenties and, prior to entering practicum, had discussed her history of physical abuse, mentioning she never wanted to have to file an abuse report. During her practicum experience, she received individual supervision from a Licensed Professional Counselor adjunct faculty member who had worked in the child welfare system. As Clinical Director, I provided both group supervision and on site, as-needed supervision.

Alice was assigned a client through the clinic. In this instance the client was a 14-year-old female who lived with her father and stepmother due to prior neglect by her mother. During treatment, the 14-year-old client disclosed that she smoked marijuana with her mother and cousins during a weekend visit.

Clinic procedure requires student counselors to obtain immediate supervision if a client makes an allegation of abuse or neglect. Alice did not come out of the session to report the incident and said nothing after the session concluded. Later, during her one hour individual supervision session, the supervisor watching the tape realized that the child’s statement required a protective services report. Her supervisor walked Alice through the procedures of writing and filing the report, which Alice did without complaint. Several days later, Alice came into my office and stated, “I feel like crap, I’ve ruined her life”.

Alice expressed fear that the client would never return for counseling, and fear that the client would hate her. She reported imagining all sorts of consequences including that the child’s father would no longer allow the child to see her mother and that the child would no longer disclose information if she returned to counseling. She questioned her decision to make an abuse or neglect report and reported feeling angry at her supervisor.

Alice’s reaction was consistent with reactions reported in the literature and did not bode well for future ethical practice. Alice and I discussed the issue first from a legal standpoint. I reminded her that as a mandated reporter she must make the report or risk her license and possible criminal charges. We then addressed the issues from an ethical perspective, reviewing the ethical codes including welfare to client, confidentiality, boundaries, and multiple relationships. I challenged Alice on viewing herself as the child’s protector and taking responsibility for her happiness. I linked her reaction to her own personal history and discussed how her countertransference impeded her ability to make ethical decisions.

Finally, we processed her feelings, relating them back to her own history of abuse and focused on how that history brought up pain and fear. While she seemed to express an understanding of her role as a counselor and acknowledged how her feelings were impeding her judgment, her difficulty with the situation continued. The next time she met with her client, the client stated “someone called protective services and I had to talk to them” and Alice said nothing. She did not admit to making the report

and appeared uncomfortable and nervous in the videotaped session. The client made several statements during the session trying to get Alice to admit her role in the neglect report, but Alice shut down and said nothing.

Alice knew she had performed poorly in the session and returned for more supervision. We processed the situation again, linking her fear of losing rapport and taking responsibility as a professional to her own fear of being perceived as incompetent. I then directed Alice to tell her client that she made the report and remind her client that adults make mistakes and when they do the client should receive an apology. Alice followed through with this directive. The child responded well to the apology and the rapport between counselor and client improved.

This case study illustrates the difficulty therapists' face when having to make a mandated abuse or neglect report. Alice's actions mirrored two of the reasons cited for failing to report; negative consequences for the client and negative consequences for the therapist (Alvarez, et al. 2004). She acknowledged fearing that the CPS report would result in the client's mother retaliating against her and she feared losing the rapport with the client and confronting both the client and parent. Thus, she allowed her own feelings to override her ethical responsibilities to the client and almost destroyed client rapport by lying to her client. In this example, the clinical supervisor needed to act as a teacher, counselor, and gatekeeper (Bernard & Goodyear, 2014) and use two theoretical approaches; CBT and developmental theory (Azar, 2000). The gatekeeper role involved reviewing the *ACA Code of Ethics* (2014) regarding how to breach confidentiality and how to follow the law. Gatekeeping required using a cognitive theoretical approach to help Alice identify her thoughts, actions and emotions that initially led to her failure to act. The teacher role involved demonstrating how to correct the situation with specific interventions that would be effective and give the practicum student counselor control. Teaching involved using a developmental theoretical approach by identifying the counselor's current growth stage and challenging her to move beyond it through implementing an intervention with the client. Finally, the counselor role involved providing empathy and support for Alice's feelings and helping her increase her self-awareness of how her own challenges interfered with her ability to be effective. Emotional support from a clinical supervisor is vital to preventing vicarious trauma and burnout (Williams, Helm & Clemens, 2012).

Case Example #2: School Counseling - New Professional

Maggie is a school counselor at a kindergarten through middle school, receiving group supervision to complete her licensed professional counselor requirements for state licensure. It was brought to her attention that a nine-year-old male was caught in the bathroom engaging in oral sex with another male student. Maggie met with the child to explore the reasons for this behavior and his understanding of his actions. During her meeting, the child stated he does this with his uncle. His uncle (maternal sibling) is an adult male, residing with the child and the child's single mother.

During group supervision, Maggie shared the case and explained that she contacted the mother, requesting her presence at the school immediately to discuss this

serious situation. During the meeting with the mother, Maggie recommended that the mother request her brother, the uncle, move out of the home. Maggie had not reported the incident to child protective services (CPS). During this group session, I directed Maggie to contact CPS immediately after group supervision. Approximately two hours later, I contacted Maggie to review her progress in reporting the abuse. Maggie was not available, but later sent me a text stating she would contact me in the morning.

Maggie did not report the abuse after group supervision. She planned to wait until the next day when she had the child's school file in front of her, but due to a snow day and school closures, Maggie believed she did not have to report the abuse. After following up again and upon finding out Maggie again failed to report, I ordered Maggie to file a report. I also reminded Maggie that her actions were unethical and illegal, were jeopardizing the safety of the child, and risking the supervisor's license and Maggie's own school and limited licenses.

Maggie failed to be truthful about the case and the extent of her knowledge. She had known about the alleged sexual abuse for at least a week. Thus, as Maggie's supervisor, I contacted CPS to report the sexual abuse. While I did not have the full name and address of the child, I submitted a preliminary report to initiate a file and case number. I provided the name and cell phone number of my supervisee who failed to report the abuse and I explained the situation to the best of my knowledge.

Immediately following the CPS report, I contacted Maggie to inform her of the initiated report and told her to contact CPS immediately, giving her the case number as a reference for the report. I also informed Maggie of two other things: 1. that she was named in the initiated report for failure to report abuse; and 2. that as her supervisor and gatekeeper for the counseling profession, I was obligated to file a complaint with the relevant licensing boards regarding her failure to act as a mandated reporter. Maggie's response indicated she was more concerned about losing her employment and license than about the child who was being sexually abused. Unfortunately, Maggie was not able to grow from this experience and I realized that I could not continue to work with a supervisee who knowingly placed children at risk. I informed both Maggie and the licensing board that I terminated the supervisory relationship. Client care takes precedence over the supervisory relationship. As supervisor, I ultimately want to assist the supervisee in the areas of problem solving and making critical decisions as an independent and effective counselor. However, modeling client care and ethical practice teaches supervisees how to effectively problem solve and make sound critical decisions.

In this case example, the school counselor's actions mirror three reasons cited for failure to report; a negative attitude toward CPS, negative consequences for professionals, and lack of training (Alvarez et al, 2004). Maggie's actions suggest she thought the school could do a better job than the government in addressing the needs of the child and she lacked the desire to complete the paperwork or deal with the repercussions from the family. Similarly, despite having training in graduate school her actions in the public school support that the school did not provide adequate training on

CPS procedures. This case also demonstrates the vicarious liability and level of responsibility outlined in the ACS Code of ethics sections 9, a clinical supervisor must “intervene in any situation where the supervisee is impaired and clients may be at risk” (2008) and Section 13, a clinical supervisor “shall ultimately be responsible for the welfare of the supervisees’ clients” (2008). This experience was a cautionary tale for my own practice. In hindsight, I should have required Maggie to make the call to CPS during the supervision session. The circumstances could have been used as a direct teachable moment for Maggie and the others in the group supervision session. We could have discussed the urgency of the case and worked through any emotional barriers, ultimately leading to modeling compliance with the necessary ethical, legal, and professional actions to address a child living in dangerous situation.

Conclusion

Clinical supervisors are clinical practitioners, dedicated to client care through their work as supervisors. They serve as teachers, provide emotional support, and act as gatekeepers who must demonstrate and enforce the ethical and legal practices of the mental health helping professions (Bernard & Goodyear, 2014). Clinical supervisors are, themselves, mandated reporters and are held accountable for their own client care actions, as well as, their supervisees’ client actions (Riess & Herman, 2008). Therefore, it is critical for the clinical supervisor to ensure supervisees have a clear informed consent that outlines the need for mandated reporting in specific and clear language (Steinberg, Levine & Doueck, 1997). The expectations of the supervision relationship must also be clearly outlined (Riess & Herman, 2008), including implications for unethical behavior. The supervisee must understand that lack of follow through with responsibilities regarding any type of client care, can have serious legal implications, including termination of supervision.

The case examples address the complicated interplay between ethics, legal requirements, and emotional reactions, as well as how clinical supervision must support all three to increase likelihood of compliance with the role of mandated reporter. The cases directly highlight that supervision is an ongoing process that can occur at any time so supervisors must be prepared. They can provide direct content through coursework and other activities such as role play. They can provide supervision with respect to procedural elements as well. Taken together the cases demonstrate the prevalence of the struggle, providing a reminder that this is not just an issue for students. Students and new professionals reacted out of fear and countertransference. The second case demonstrated that even a Clinical Supervisor may experience difficulties managing an unexpected situation. To varying degrees, the Clinical Supervisor in each case addressed the need to balance the role of teacher and counselor with the gatekeeping role. Gatekeeping around the ability to comply with ethical and legal responsibilities remains one of the most important roles of a Clinical Supervisor, but gatekeeping needs to be tempered with support, therapeutic processing, and consistency.

Mandated reporting, while an ethical and legal requirement, often stirs emotions in mental health professionals that may prevent them from making a report. Fear, anxiety, and countertransference may all interfere with good judgment. The Clinical Supervisor maintains the responsibility to ensure reports are made but must also address the emotional concerns. This article presented two case studies to illustrate ways a supervisor can support the supervisee through the mandated reporting process, and highlighted what can happen when a supervisee fails to comply with the legal mandate.

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