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Mandatory Child Abuse Reporting: Factors Impacting the Therapeutic Relationship

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MANDATORY CHILD ABUSE REPORTING: FACTORS IMPACTING THE THERAPEUTIC RELATIONSHIP

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CHAPTER I

INTRODUCTION AND REVIEW OF RELATED LITERATURE

Child abuse is one of the most pressing social problems of modern society. Although more than 2.6 million cases of child abuse were reported in 1991, an increase of more than 6% over 1990 (Daro & McCurdy, 1992), it is well documented that professionals underreport suspected abuse, despite their legal mandate to report. Studies have consistently found that between 30% and 40% of practicing psychologists across various levels of experience and training, have at least at one time, failed to report suspected child abuse (Brosig & Kalichman, 1992b; Finlayson & Koocher, 1991; Swoboda, Elwork, Sales, & Levine, 1978).

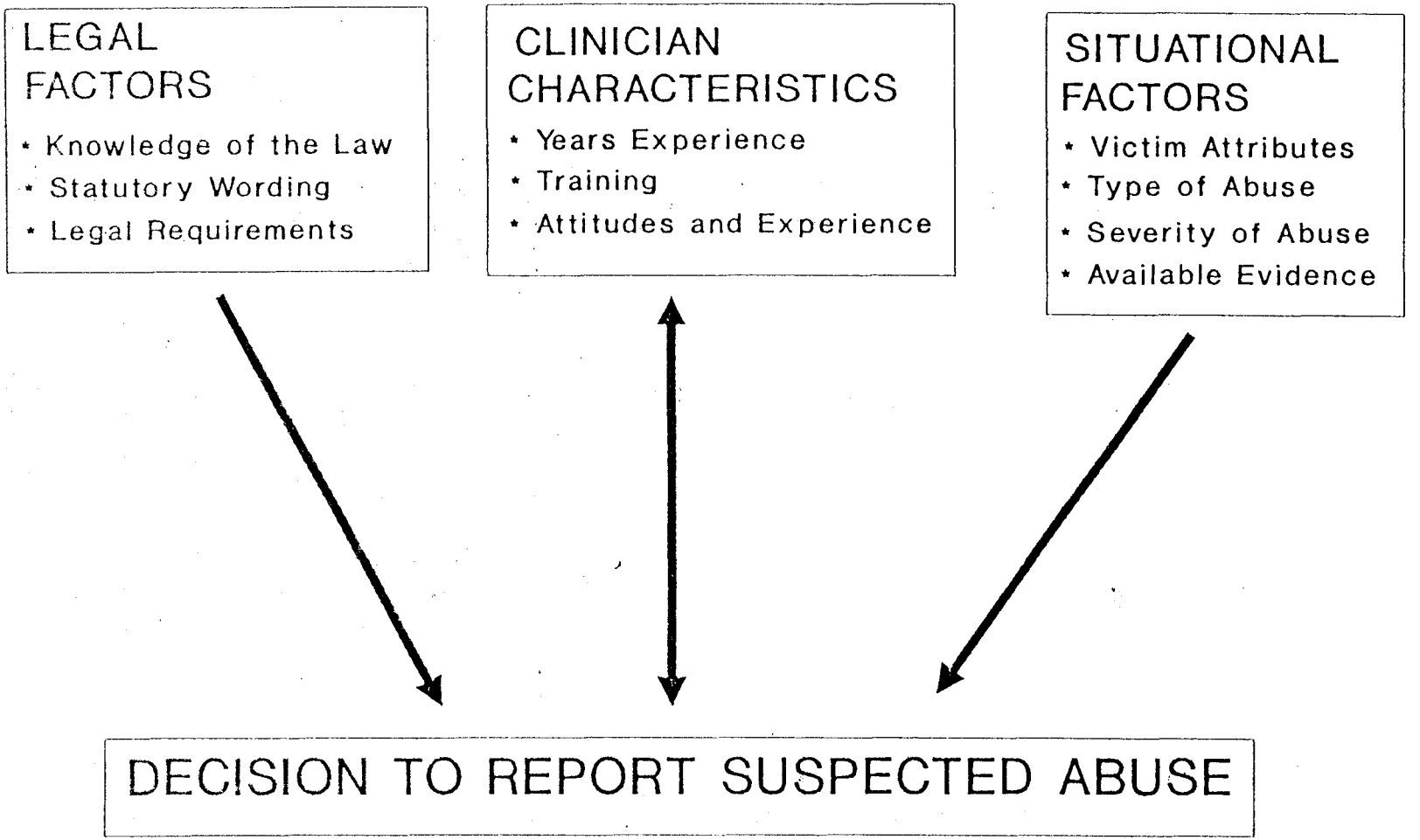
Most explanations for this substantial rate of unreported abuse have been inconsistent and incomplete. It has been suggested that several factors may influence reporting decisions, including characteristics of abusive families (Eckenrode, Powers, Doris, Munsch, & Bolger, 1988; Newberger, 1983); characteristics of reporters (Barksdale, 1989; Haas, Malouf, & Mayerson, 1988; Nightingale & Walker, 1986); type or severity of abuse (Green & Hansen, 1989; Wilson & Gettinger, 1989; Zellman, 1990b); certainty of the reporter that abuse is occurring (Camblin & Prout, 1983; Kalichman & Craig, 1991; Kalichman, Craig, & Follingstad,

1990); and vague wording of mandatory reporting laws (Jones & Welch, 1989; Kalichman & Brosig, 1993; Weisberg & Wald, 1984). In addition, some clinicians indicate failure to report due to conflicts concerning the maintenance of confidentiality within therapeutic relationships (Miller & Weinstock, 1987; Pope, Tabachnick, & Keith-Speigel, 1987). Others are concerned that by reporting, there will be more harm done than good, due to the poor quality of many child protective service agencies. Finally, others have expressed concerns that reporting abuse may result in the disruption or termination of therapy (Kalichman, Craig, & Follingstad, 1989; Muehleman & Kimmons, 1981; Swoboda et al., 1978).

In a recent review of the empirical literature, Brosig and Kalichman (1992b) proposed a model for clinicians' willingness to report child abuse. This model, which is depicted in Figure 1, serves to organize a fairly complex body of literature which has identified many factors that may influence psychologists' reporting decisions. The model organizes these factors into three groups: legal issues, clinician characteristics, and situational variables.

The first component of Brosig and Kalichman's (1992b) model consists of legal issues, such as knowledge of reporting laws, statutory terminology, and specificity of legal requirements. Swoboda et al. (1978) found that 32% of psychologists surveyed were unfamiliar with child abuse reporting laws, and thus were often noncompliant with them.

Figure 1. Model of Clinicians' Willingness to Report Child Abuse.



However, with the increase in public concern regarding the growing child abuse problem, now almost all clinicians are familiar with reporting laws. Nevertheless, knowledge of the law does not necessarily lead to compliance (Green & Hansen, 1989; Kalichman et al., 1989), even though clinicians may be legally prosecuted for failing to report suspected abuse (Denton, 1987; Gray, 1987). It appears that individual differences exist among clinicians, in that upholding the law is more important to some than others (Haas et al., 1988; Kalichman & Brosig, 1993; Wilson & Gettinger, 1989).

Brosig and Kalichman (1992b) concluded that knowledge of the law is less predictive of clinicians' reporting behaviors than clinicians' interpretations of statutory wording and legal requirements. The wording of reporting laws has been identified as a concern in mandatory reporting of abuse, with suggestions that vaguely worded statutes lead to under-reporting (Jones & Welch, 1989), as well as over-reporting of abuse (Solnit, 1982). Laws differ across states in their definitions of abuse, ranging from broad and general to narrow and specific. Laws also differ in the conditions under which professionals are required to report, from merely having reason to believe that abuse has occurred, to actually observing the child suspected of being abused. Reporting decisions, therefore, seem dependent upon an interaction between the law, specific characteristics of

clinicians, and the particular clinical situation. However, few studies have investigated the interactions between statutes and abusive situations in decisions to report suspected abuse.

To investigate the effects of statutory wording on clinicians' reporting, Kalichman and Brosig (1992) conducted two studies utilizing experimental vignettes. In one study, professional psychologists read a scenario of a child in therapy displaying signs of abuse. In a second study, an independent sample read a case of an adult male client depicted as being potentially abusive. In both studies, subjects were first asked to indicate their likelihood of reporting the case. They were then asked to read one of two reporting laws: a state law which required seeing the child suspected of being abused (Pennsylvania statute) or a law requiring any reasonable suspicions of abuse to be reported (Colorado statute). After reading the law, respondents were asked to indicate how likely they would be to report the case under that particular law.

Results from the first study showed that when presented with a child suspected of being abused, clinicians' likelihood of reporting increased after reading either the PA or CO law. There were no significant differences between the laws. However, in the second study, where a step-father was suspected of being abusive, participants who were presented with the PA law which required seeing the child

were less likely to report after reading the law, while participants in the CO law condition which required only a reasonable suspicion of abuse increased their reporting tendency. These results were replicated by Brosig and Kalichman (1992a) in a single study that directly compared a child case against an adult case under each of these same types of laws. Thus, it appears that statutory wording directly effects reporting decisions, and the impact may be case specific.

Another component of Brosig and Kalichman's (1992b) model is comprised of situational factors, such as attributes of the victim, type and/or severity of abuse, and the amount of evidence available regarding the occurrence of abuse. Although the victim's sex has not been found to affect clinicians' tendencies to report (Kalichman et al., 1989), victim age has, in that clinicians are more likely to report younger than older victims (Kalichman & Brosig, 1992; Kalichman & Craig, 1991). Race and social class of the victim are also important, as Newberger (1983) found under-reporting of abuse that occurred in white and affluent families. With respect to the type of abuse that is suspected, sexual abuse is more likely to be reported than neglect or emotional abuse (Nightingale & Walker, 1986; Wilson & Gettinger, 1989). In addition, abuse that is perceived as more severe is more likely to be reported (Green & Hansen, 1989), and level of severity is often

determined by the amount of evidence that is present (Kalichman & Brosig, 1992; Zellman, 1990b). Thus, clinicians are likely to seek evidence of abuse prior to reporting because they are unsure of the validity of their suspicions.

The final factor in Brosig and Kalichman's (1992b) model is composed of clinician characteristics, including years of experience, training in child abuse, and attitudes and experiences related to reporting abuse. This component of the model is bi-directional in that clinician characteristics influence tendency to report, and reporting decisions feed back to influence clinician attitudes. In terms of experience, some research suggests that more experienced clinicians are more likely to report suspected abuse (Barksdale, 1989); however, other findings indicate that those with less experience are more likely to report (Haas et al., 1988). Haas et al. suggested that more experienced clinicians may be more cynical regarding the benefits of reporting. Thus, at this point, although there does seem to be a correspondence between experience and tendency to report, the relationship is not clear. It may be that clinicians having aversive reporting experiences will be less likely to report in the future, while those having positive reporting experiences will be more likely to report, regardless of years of experience.

Training in child abuse is another clinician

characteristic that has been found to be related to reporting decisions. Nightingale and Walker (1986) found that workers with prior training in child maltreatment were more likely to report suspected abuse. In contrast, Kalichman and Brosig (1993) found that psychologists with prior training were less likely to report suspected abuse. However, causality was not assessed in Kalichman and Brosig's study. It may be that clinicians had a history of failure to report and then sought further training, rather than that because they had prior training, they were less likely to report.

Finally, clinicians' past history of reporting has been found to be related to their tendency to report hypothetical cases of abuse. Kalichman and Craig (1991) found that psychologists who in their clinical experience had suspected abuse but did not report were less likely to report a hypothetical case of abuse, whereas those psychologists who in their clinical experience always reported when they suspected abuse were more likely to report a hypothetical case. This suggests that clinicians present a consistency in their reporting behaviors, and may have biases toward or against reporting.

These biases toward or against reporting may be related to clinicians beliefs about the outcome of reporting. Kalichman et al. (1989) and Kalichman and Craig (1991) found that 42% and 31% of psychologists surveyed, respectively,

indicated that they believed reporting would have a negative impact on family therapy. Such beliefs about outcome have also been found to relate to clinicians' willingness to report. When therapists were presented with a case where the expected outcome of reporting was negative, they were less likely to report than if the expected outcome was positive (Kalichman et al., 1989). Similarly, Muehleman and Kimmons (1981) found that reporting likelihood depended on what clinicians foresaw as the consequences for the child and family. Respondents in several studies have indicated that they fail to report suspected abuse because they believe the therapeutic relationship would suffer from reporting (Haas et al., 1988; Swoboda et al., 1978).

Many clinicians are clearly concerned that reporting will harm the therapeutic relationship and result in the disruption or termination of therapy (Ansell & Ross, 1990; Brosig & Kalichman, 1992a; Kalichman et al., 1989; Muehleman & Kimmons, 1981; Swoboda et al., 1978). This concern may arise because reporting child abuse may require the clinician to break the confidentiality inherent in client-therapist relationships (Miller & Weinstock, 1987; Pope et al, 1987). However, it is not clear whether or not these concerns are warranted due to the limited amount of research on this topic.

In summary, research indicates that many clinicians are hesitant to report child abuse, despite their legal mandate

to do so. Reporting decisions seem to be influenced by a variety of complex factors which fall into three main categories: legal issues, situational variables, and clinician characteristics. Clearly, child abuse reporting is an area of great concern and difficulty. Further research is needed in order to gain a better understanding of how reporting decisions can be made and carried out in a way that is most helpful to children and families and least detrimental to the therapeutic relationship.

The Importance of Confidentiality in the Therapeutic Relationship

Concerns about breaking confidentiality stem from the belief that confidentiality is the cornerstone of the therapeutic relationship and an essential component of effective psychotherapy (Carlson, Friedman, & Riggert, 1987; Denkowski & Denkowski, 1982; Jagim, Wittman, & Noll, 1978; McGuire, 1974). It is argued that without absolute confidentiality, clients will not seek therapy because of a fear that their confidences will be revealed, resulting in delayed assistance to people who are in need of mental health services (DeKraai & Sales, 1984; McGuire, Toal, & Blau, 1985). In addition, if there are limits to or a lack of confidentiality, clients who do enter therapy may not divulge important information, thus hindering therapeutic progress (Derlega, Margulis, & Winstead, 1987; Kobocow, McGuire, & Blau, 1983; McGuire, Graves, & Blau, 1985).

Finally, an absence of or limits to confidentiality may result in the premature termination of therapy due to the client's lack of trust in the therapist (DeKraai & Sales, 1982; Dubey, 1974; Merluzzi & Brischetto, 1983).

The importance of confidentiality in the therapeutic relationship has been investigated in a number of studies targeting a variety of populations. Jagim et al. (1978) investigated professionals' attitudes toward confidentiality. Ninety-eight percent of the 64 mental health professionals surveyed indicated that confidentiality is essential in maintaining a positive therapeutic relationship. In addition, 95% of participants believed that clients expected confidentiality. However, a majority of respondents indicated that they would break confidentiality under certain circumstances, leading to potential conflicts with clients who are expecting confidentiality to be maintained. Jagim et al. (1978) concluded that such conflicts may be avoided by discussing the limits to confidentiality with the client at the outset of therapy.

Two studies investigated clients' beliefs about the importance of confidentiality. McGuire et al. (1985) interviewed 76 adult clients (50 outpatient and 26 inpatient) and 50 hospital employees who had never been in therapy. Results indicated that confidentiality was valued and expected, especially by the inpatients. However, 52% of

the participants were not able to define confidentiality, suggesting that clients are confused about confidentiality and need to be better informed about what it means.

Schmid, Appelbaum, Roth, and Lidz (1983) interviewed 30 psychiatric inpatients. Results indicated that confidentiality was highly valued. Seventy-seven percent of the participants said that it was important that the hospital staff not tell others what the clients revealed about themselves. Eighty percent indicated that knowing disclosures were confidential improved their relationships with the staff. If confidentiality were breached, 67% said they would be angry or upset, and 17% reported that they would leave therapy or stop talking to the person who had breached confidentiality. However, client response to a breach in confidentiality was less negative if the client perceived the breach to be in his or her best interest.

Two studies investigated non-clients' knowledge and beliefs about confidentiality. Miller and Thelan (1986) surveyed high school and college students, as well as former outpatient clients. Across groups, the majority (69%) believed that everything said in therapy is confidential. In addition, 74% indicated that all information in therapy should be confidential. However, if there were limits to confidentiality, 97% of the participants reported that if they were clients, they would want to be informed of these limits, preferably before therapy began. When asked how

they would react if limits of confidentiality were discussed, 42% said that the information would have a negative impact, 27% would have ambivalent feelings, 10% would discontinue therapy, but only 21% would react positively. Furthermore, 41% would not discuss information that was not considered confidential. Thus, although clients may want therapists to discuss the limits to confidentiality, such discussions may limit what is disclosed in therapy.

Rubanowitz (1987) conducted a phone survey of 200 adults in order to assess public attitudes toward confidentiality. Participants indicated that therapists should maintain confidentiality in most circumstances, but breach it for things like theft, suicide, murder, treason and child abuse. In addition, participants believed that other professionals and parents of child clients should have access to information without the clients' permission. Thus, it appears that the public expects confidentiality, but only in situations in which the interests of society are not at stake. Rubanowitz (1987) recommended that therapists discuss limits to confidentiality and obligations of therapists with their clients. Public education regarding confidentiality was also suggested.

Overall, the results of these studies indicate that confidentiality is valued and expected by clients and non-clients alike, which lends support to the belief that

confidentiality is the cornerstone of the therapeutic relationship. Although these studies provide useful descriptive data regarding attitudes about confidentiality, they are limited in that they do not directly assess how the presence or absence of confidentiality affects the therapeutic relationship and what is discussed by the client within it. Fortunately, several studies have been conducted which have experimentally manipulated conditions of confidentiality in order to empirically evaluate whether or not confidentiality is a necessary component of effective psychotherapy.

Merluzzi and Brischetto (1983) investigated the impact of breaching confidentiality on the perceived trustworthiness of counselors. Two hundred male undergraduates listened to an audiotape of a counselor and client which involved a decision by the counselor to breach or maintain confidentiality. In the confidential condition, the counselor decided to maintain confidentiality; in the nonconfidential condition, the counselor decided to breach confidentiality; in the control condition, confidentiality was not discussed. Results indicated that when counselors decided to breach confidentiality with clients who had serious problems, the counselors were perceived as less trustworthy. In addition, counselors in the nonconfidential condition were rated lower than those in the confidential or control conditions on degree of understanding of the client,

expected outcome of the counseling, and whether the subject would refer a friend to the counselor. Thus, Merluzzi and Brischetto (1983) concluded that confidentiality may directly affect perceived trustworthiness of counselors, thus influencing the quality of the therapeutic relationship.

Woods and McNamara (1980) investigated the effect of confidentiality on interviewee behavior. Sixty undergraduates participated in individual interviews in which they were asked questions about themselves. In the confidential condition, subjects were told that anything they said would be held in the strictest confidence. In the nonconfidential condition, subjects were told that their responses would be made available to other researchers and that a summary of their responses might be placed in their university file for further use. In the no expectation condition, subjects were given no expectations about confidentiality. Results indicated that subjects in the nonconfidential condition disclosed less than those in the confidential or no expectation conditions, suggesting that confidentiality in therapy will facilitate client self-disclosure.

Kobocow et al. (1983) investigated the influence of confidentiality on self-disclosure of early adolescents. Ninety seventh and eighth grade students were asked questions about their behavior. In the confidential

condition, subjects were told that their answers would be completely confidential. In the nonconfidential condition, subjects were told that their answers would be given to their teachers and principal. In the neutral condition, confidentiality was not discussed. Results did not support the hypothesis that adolescents would disclose more personal information under a condition of explicit confidentiality. Kobocow et al. (1983) speculated that the subjects may not have discriminated between conditions, and may have assumed confidentiality even though the instructions they were given indicated otherwise. In addition, the subjects may have previously disclosed information to adults that was not kept confidential, and therefore may not have trusted the interviewer's assurance of confidentiality. These results indicate that trust, not confidentiality itself, may be the key ingredient of a positive therapeutic relationship.

Finally, McGuire et al. (1985) investigated the effect of confidentiality on depth of self-disclosure. Ninety-six undergraduates were asked questions about their personal lives. In the high assured confidentiality condition, subjects were told that their answers would be held in strictest confidence. In the moderate assured confidentiality condition, subjects were told that their answers would be transcribed by the secretary and seen by another researcher within the psychology department. In the low assured confidentiality condition, subjects were told

that their answers would be transcribed by the secretary and would be made available to other faculty, graduate students, and authorized university personnel. Results did not support the hypothesis that depth of self-disclosure is directly related to degree of confidentiality that is perceived, and again suggest that verbal assurances of confidentiality may be less important than the client's perceived trustworthiness of the counselor.

Thus, although many clinicians believe that an assurance of confidentiality will lead to increased client self-disclosure and more effective psychotherapy, research findings indicate mixed results. Some clients may assume that absolute confidentiality exists even if the therapist does not guarantee this, and will self-disclose readily. Other clients may be reluctant to self-disclose, regardless of what the therapist says regarding confidentiality. It appears that trust in the therapist, rather than absolute confidentiality, is the cornerstone of effective psychotherapy (Slovenko, 1976).

Informed Consent and Limits to Confidentiality: The Effects on the Therapeutic Relationship

In order to build trust in the therapeutic relationship, it is recommended that clinicians discuss limits to confidentiality, including their obligation to report suspected child abuse, at the onset of therapy as part of the informed consent process (Bersoff, 1976; Bray, Shepherd,

& Hays, 1985; Denkowski & Denkowski, 1982; Everstine, Everstine, Heymann, True, Frey, Johnson, & Seiden, 1980; Miller & Thelan, 1987; Noll, 1976, 1981; Shah, 1970; Shapiro, 1983; Siegel, 1979; Watkins, 1989). This recommendation applies to both adult and child clients (McGuire, 1974). In fact, discussing limits to confidentiality is not only recommended, but it is required as part of the Ethical Principles of Psychologists and Code of Conduct: "Psychologists discuss with persons and organizations with whom they establish a scientific or professional relationship...the relevant limitations on confidentiality...Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant" (APA, 1992, p.1606).

Despite the ethical obligation to discuss limits to confidentiality, not all clinicians do so. Baird and Rupert (1987) found that although respondents agreed that clients should be informed of limits to confidentiality at the outset of therapy, 39% of the psychologists they surveyed did not do so in practice. Of those who did discuss confidentiality, only 66% listed specific limits, whereas 19% told clients that everything was confidential, and 15% merely alluded to limits. Similarly, Somberg, Stone, and Claiborn (1993) found that although respondents rated the discussion of limits to confidentiality as "very important,"

only 60% of the psychologists they surveyed informed all of their clients of the limits to confidentiality. A variety of reasons were given for not discussing this issue with clients, including: lack of relevance, forgetfulness, client already knows about it, negative impact on the therapeutic relationship, and client's inability to understand.

More positively, Nicolai and Scott (1994) found that 80% of the psychologists they surveyed told their clients that confidentiality may be breached in specific situations. Interestingly, those psychologists who always told their clients about limits to confidentiality, and provided specific information about these limits, were more likely to report a hypothetical case of abuse. Nicolai and Scott (1994) concluded that clinicians who told clients initially about specific limits to confidentiality, including their legal obligation to report suspected child abuse, may be more comfortable reporting because the clients were aware of this issue up front.

Due to clinicians' concerns that informing clients of the limits to confidentiality will damage the therapeutic relationship and limit the client's self-disclosure, several studies have been conducted to investigate the validity of these claims. Muehleman, Pickens, and Robinson (1985) invited mildly depressed undergraduates to attend an exploratory single session of individual therapy, in which they manipulated the type of consent form used. The short

form contained minimal information regarding limits to confidentiality, the long form contained more detailed information regarding limits to confidentiality, and the long form with rationale contained the same information as the long form, with an additional statement encouraging self-disclosure and the benefits for doing so. Results indicated that informing subjects of limits to confidentiality did not inhibit self-disclosure. In fact, providing subjects with encouragement and a rationale for self-disclosure resulted in more self-disclosure, despite the detailed information that was given regarding limits to confidentiality. The results of this study have positive implications for the discussion of this issue in actual therapy situations.

In a similar study, Haut and Muehleman (1986) interviewed single mothers, and varied the clarity and specificity regarding the limits to confidentiality in the type of consent form used. Results indicated that increasing levels of clarity and specificity did not alter the amount of information disclosed. In contrast to these results, when Haut and Muehleman (1986) surveyed clinical psychologists about their beliefs as to how much information would be disclosed depending on the type of consent form used, the psychologists predicted that as clarity and specificity of information regarding limits to confidentiality increased, clients would disclose less. Thus, the

concerns regarding the negative effects of discussing limits to confidentiality were salient to the psychologists surveyed, even though data from subjects indicated that such concerns may not be warranted.

Finally, Sullivan, Martin, and Handelsman (1993) investigated the effects of using an informed consent procedure on ratings of therapists. Undergraduates read a transcript of a client and therapist. The control transcript did not include a discussion of informed consent or limits to confidentiality. The informed-consent transcript included a discussion of risks of therapy, alternative treatments and limits to confidentiality. Results indicated that therapists who used the informed-consent procedure were rated as more trustworthy and having more expertise. In addition, subjects were more willing to refer a friend to the therapist who used the informed-consent procedure, and were also more willing to see that therapist themselves. Thus, using an informed-consent procedure that discusses limits to confidentiality does not necessarily damage the therapeutic relationship, and may in fact have positive effects.

Child Abuse Reporting and the Therapeutic Relationship

The research discussed to this point has implications for decisions to report suspected child abuse. Essentially, clinicians must breach confidentiality in order to comply with mandatory reporting laws (Chamberlain, Krell, & Preis,

1982). Many clinicians experience this situation as an ethical dilemma (Green & Hansen, 1989; Haas, Malouf, & Mayerson, 1986) involving a conflict of loyalties, in which their obligation to protect the privacy of the client is confronted by their duty to uphold the law and serve the general interests of society (Carlson et al., 1987; Guyer, 1982; Miller & Thelan, 1987; Shah, 1969; Shapiro, 1983).

Despite legal mandates to report suspected child abuse, many clinicians fail to do so and opt to maintain client confidentiality. Some argue that reporting laws put clinicians in the role of the police (Ansell & Ross, 1990; Heymann, 1988; Leong, Silva, & Weinstock, 1988; Siegel, 1979; Weinstock & Weinstock, 1988) and transform therapists into instruments of social control (Noll, 1976). Many clinicians fear that if they serve such roles by reporting, the trust in the therapeutic relationship will be damaged, resulting in clients terminating from therapy (Butz, 1985; Davidson, 1988; Finkelhor & Zellman, 1991; Finlayson & Koocher, 1991; Harper & Irvin, 1985; Meddin & Hansen, 1985; Zellman, 1990a).

Another concern about reporting is that if clients are aware that therapists must report suspected child abuse, clients will be less likely to disclose information regarding this issue, thus interfering with the treatment of offenders as well as victims (Butz, 1985; Kaplan, Abel, Cunningham-Rathner, & Mittleman, 1990; Kelly, 1987; Ney &

Herron, 1985; Rolde, 1977; Sherlock & Murphy, 1984; Wright, 1984). In addition, if a child is the person who discloses abuse, and a report is filed because of this, there is often a fear that the perpetrator will retaliate and the abuse will escalate (Butz, 1985; Garbarino, 1988; Wright, 1984).

Given the current state of the child protective services system, which is underfunded and understaffed, many clinicians worry that once a report is made, and clients go through what can often be a traumatic investigation, few families will actually receive the services that they need, or may receive services that are actually more harmful than helpful (Berger, Rolon, Sachs, & Wilson, 1989; Davidson, 1988; Finkelhor & Zellman, 1991; Garbarino, 1988; Meddin & Hansen, 1985; Newberger, 1983; Wells, 1988; Zellman, 1990b). As a result, there is often a belief by clinicians that they can better address the abuse within the context of therapy, rather than by filing a report (Bromley & Riolo, 1988; Davidson, 1988; Finkelhor & Zellman, 1991; Muehleman & Kimmons, 1981; Wells, 1988; Zellman, 1990a). In fact, numerous alternatives to mandated reporting have been proposed due to dissatisfaction with current reporting requirements. Such alternatives include: 1) flexible reporting based on the seriousness of the injury, whether or not the abuse is ongoing, and the experience and resources of the reporter (Ansell & Ross, 1990; Berger et al., 1989; Heymann, 1988; Newman, 1987; Weinstock & Weinstock 1988,

1989; Youngstrom, 1991); 2) deferred reporting if the child is not in danger and the family or perpetrator is already in treatment (Finkelhor & Zellman, 1991; Miller & Weinstock, 1987; Smith & Meyer, 1984); and 3) reporting based on the clinician's professional judgment of whether or not a report would be clinically harmful (Heymann, 1988; Weinstock & Weinstock, 1989; Zellman & Antler, 1990).

Given the vast number of concerns many clinicians have about the negative effects of reporting suspected child abuse, especially with regard to the therapeutic relationship, it is important to determine whether these concerns are grounded in empirical research or whether they are based solely on clinical folklore. It appears that clinical folklore has played a key role in perpetuating these concerns, as few studies have actually looked at the effects of reporting on the therapeutic relationship and client self-disclosure. In addition, the results of the studies that have been conducted are mixed, with some indicating that reporting does negatively affect the therapeutic relationship, others suggesting that reporting has no effect, and still others showing reporting can even have a positive effect. A review of these studies follows.

Berlin, Malin, and Dean (1991) investigated the effects of a change in a state reporting law on the number of abusive behaviors disclosed by adult patients in a sexual disorders clinic. In July 1988, a change in Maryland's

child abuse reporting statute required the reporting of abusive behaviors that occurred before the onset of therapy. Prior to this change, patients' disclosures during therapy about previous abusive behaviors did not have to be reported, and the average rate of such disclosures at the Johns Hopkins Sexual Disorders Clinic was 21 per year. Following the change in the law, during 1988, 1989, and 1990, no such disclosures were made by patients at the clinic. In addition, prior to the change in the law, an average of seven patients per year referred themselves to the clinic to address their problem of sexual activity with children. Following the change in the law, no patients were self-referred for treatment of this issue. Because the change in the law resulted in fewer abused children being identified and also deterred abusers from entering therapy, Berlin et al. (1991) concluded that mandated reporting for those who treat sexual offenders is counterproductive.

In a similar study, Taube and Elwork (1990) investigated the effects of knowledge regarding limits to confidentiality on patients' self-disclosures. Adult psychotherapy outpatients were given either limited or extensive information regarding limits to confidentiality prior to an interview in which they were asked questions about sensitive issues. Patients who were more informed about limits to confidentiality admitted to having fewer socially unacceptable sexual thoughts and behaviors than

patients who were uninformed. In addition, the more informed patients confessed to fewer child punishment and neglect behaviors than did uninformed patients. Taube and Elwork (1990) concluded that laws, such as child abuse reporting statutes, which limit client self-disclosure hinder treatment and fail to achieve their aim of protecting society.

In contrast to these more negative findings, Harper and Irvin (1985) suggested that reporting could have positive effects on the therapeutic relationship. They reviewed the mandated reporting status of 107 cases admitted to a child psychiatry inpatient psychosomatic service. In the 49 cases in which mandated reporting occurred, the effect of the report was classified as negative, positive, or neutral based on whether the parents' ability to engage with the therapist on the child's behalf decreased, increased or remained the same around the time of the report. Harper and Irvin (1985) found that reporting had a negative effect on the therapeutic alliance in only two cases. In 25% of the cases, reporting had no effect on the alliance, and in 71% of the cases, the effect of reporting on the alliance was positive. In addition, in only one case did reporting have a negative effect on the child's well being. In 10% of the cases, reporting had no effect on the child's well being, and in 88% of the cases, the effect of reporting on the child's well being was positive. Harper and Irvin (1985)

concluded that reporting can be viewed as a helpful intervention that sets limits and provides parents with a sense of relief that a difficult problem is being dealt with in a straightforward manner. While these findings are promising, they should be interpreted cautiously, as they are based on archival data. In addition, it is unclear whether independent raters were used to classify cases as positive, negative, or neutral. Finally, the criteria that were used in this study to classify outcomes as positive, negative, or neutral were not well defined.

Two other studies that looked at the effects of reporting on therapeutic relationships showed more mixed results. Watson and Levine (1989) reviewed 65 clinical records of outpatient psychotherapy cases in which 1) a mandated child abuse report was made or 2) a report was considered and communicated to the client, but was not filed. Each case involved a child in treatment, although one or more family members were also seen regularly. The outcome associated with the filing of the report (or discussion with clients of the need to report) was defined as positive if clients formed a stronger treatment alliance with their therapist as a result of the report. Evidence of a stronger treatment alliance was determined on the bases of the therapist's notes, indicating that the client had remained in treatment following the report, had shown increased self-disclosure or cooperation after the report,

or on the basis of the subjective evaluation of the therapist that the therapy seemed to improve after the report was filed. An outcome was defined as negative if there were signs of resistance or hostility toward the reporter or the therapy following the report, such as the client's failure to continue therapy, missed appointments, or lateness. In addition, therapist's notes indicating that the client was considering termination, that the client expressed anger or other evidence of hostility, or that the client had threatened violence during sessions were also viewed as evidence that the report had a negative effect on the therapeutic alliance. An outcome was defined as having no effect on the therapeutic alliance in the absence of specific indications of positive or negative effects or if a specific notation was made by the therapist in the clinical record that the report did not appear to have any impact on the therapy. Watson and Levine (1989) found that 24% of the 50 cases they reviewed which had complete data worsened following a mandated report of abuse, 74% of the cases did not change, and 2% actually improved, suggesting that the therapeutic relationship can survive even though confidentiality is breached when a report is made. Again, these results are encouraging, but should be viewed as preliminary, given that they are also based on archival data, and independent raters were not used to code cases in this study.

A final study which gathered additional information regarding the effects of reporting on the therapeutic relationship was conducted by Kalichman and Craig (1991). They surveyed clinicians and asked them to rate their perceived effects of reporting abuse on the therapeutic relationship on a 5-point scale, from very helpful to very harmful. Thirty-one percent of the clinicians they surveyed had experiences where reporting was perceived as very harmful or harmful to the therapeutic relationship, 13% had experiences where reporting was perceived as having no effect on the therapeutic relationship, and 56% had experiences where reporting was perceived as very helpful or helpful to the therapeutic relationship. Thus, it appears that reporting has different effects on different cases. However, it is unclear on the basis of this exploratory study what factors differentiate positive and negative outcomes of reporting.

Because reporting can have various effects on therapeutic relationships, clinicians have speculated about factors that would differentiate cases for which the effect of reporting was negative from cases for which the effect of reporting was positive. It has been suggested that it is not the report itself, but rather the manner in which the report is handled that determines the outcome of the therapeutic relationship (Watson & Levine, 1989). Guidelines for reporting have been proposed, and include: 1)

discussing limits to confidentiality, including the mandate to report suspected child abuse, prior to reporting, preferably at the outset of therapy (Barksdale, 1989; Bromley & Riolo, 1988; Butz, 1985; Guyer, 1982; Kelly, 1987; Leong et al., 1988; Levine & Doherty, 1991; Mappes, Robb, & Engels, 1985; Priest & Wilcoxon, 1988; Stadler, 1989; Weiner, 1985); 2) establishing more positive relationships with child protective services workers so that cases can be discussed prior to reporting in order to reduce the number of unnecessary reports (Besharov, 1991; Butz, 1985; Finlayson & Koocher, 1991); 3) making the report within the context of the therapeutic relationship so that the client is aware that the report is being made, can participate in the reporting process if desired, and can work through any feelings of anger or mistrust of the therapist (Barksdale, 1989; Carlson et al., 1987; Haas et al., 1986; Kelly, 1987; Mappes et al., 1985; Miller & Thelan, 1987; Racusin & Felsman, 1986; Slovenko, 1976; Stadler, 1989; Watson & Levine, 1989); 4) including in the report only the essential information needed to start the investigation in order to avoid assuming the "detective" role (Bromley & Riolo, 1988; Melton & Limber, 1989; Powell, 1991; Priest & Wilcoxon; 1988); and 5) assisting the clients throughout the child protective services investigation by offering them support and guidance and providing information regarding their rights and the investigative process (Bromley & Riolo, 1988;

Brosig & Kalichman, 1992b; Kelly, 1987; Powell, 1991). Although these guidelines are predicted to result in positive outcomes, they have not been empirically tested.

Summary and Hypotheses

The primary purpose of the present study was to identify factors in reporting situations that are associated with positive effects on therapeutic relationships as well as factors that are associated with negative effects on therapeutic relationships. In keeping with the literature, both clinician characteristics and situational factors were examined.

In the present study, practicing clinicians who have had experience reporting suspected child abuse were surveyed by mail. Participants were asked to provide basic information about their backgrounds and experience in dealing with child abuse. They were also asked to reflect on situations in which they reported child abuse suspicions and to evaluate the impact of their reports on the therapeutic relationship. Specifically, they were asked to recall a case in which reporting had a positive impact on the therapeutic relationship and a case in which reporting had a negative impact on the therapeutic relationship. For each case, they responded to a series of questions designed to examine in detail a range of situational factors such as characteristics of the client, characteristics of the abuse, characteristics of the therapy, and type of reporting

procedures used. Based on previous research and reporting guidelines that have been proposed, the following hypotheses were examined:

(1) It was expected that if reporting was perceived to have had a positive effect on the therapeutic relationship, clinicians would more often have involved clients in the reporting procedure, whereas if reporting was perceived to have had a negative effect on the therapeutic relationship, clinicians would more often have made the report without the clients' knowledge.

(2) It was expected that if reporting was perceived to have had a positive effect on the therapeutic relationship, clinicians would more often have informed the clients of the limits of confidentiality from the outset of treatment, whereas if reporting was perceived to have had a negative effect on the therapeutic relationship, clinicians would more often have informed the clients of the limits of confidentiality at the time that a report was required.

(3) It was expected that if reporting was perceived to have had a positive effect on the therapeutic relationship, the reporting clinician would have been more likely to have had a positive experience with Child Protective Services in the case, whereas if reporting was perceived to have had a negative effect on the therapeutic relationship, the reporting clinician would have been more likely to have had a negative experience with Child Protective Services in the

case.

(4) In cases in which reporting was perceived to have had a positive effect on the therapeutic relationship, it was expected that the client in treatment would more likely have been the alleged victim, whereas in cases in which reporting was perceived to have had a negative effect on the therapeutic relationship, it was expected that the client in treatment would more likely have been the alleged perpetrator.

(5) In cases in which reporting was perceived to have had a positive effect on the therapeutic relationship, it was expected that the report would more likely have been made after the client had been in treatment for a relatively long period of time, whereas in cases in which reporting was perceived to have had a negative effect on the therapeutic relationship, it was expected that the report would more likely have been made after the client had been in treatment for a relatively short period of time.

In addition to these hypotheses, exploratory analyses were conducted regarding the impact of these situational factors: characteristics of the victim, evidence of abuse, confidence that abuse was occurring, trust in the therapeutic relationship, outcome of the report, and reporting procedures used (whether the client or therapist made the report; whether the client was present or absent when the report was made; whether the clinician consulted

with anyone before making the report).

In terms of clinician characteristics, specific questions were asked about the quality and amount of training participants have had in child abuse assessment, treatment, and reporting, as well as the number of years of experience they have had in the field. The specific hypotheses regarding these factors and their impact on therapeutic relationships following mandatory child abuse reports were as follows:

(1) It was expected that clinicians who indicated having a higher proportion of cases in which they perceived reporting to have had a positive impact on the therapeutic relationship than cases in which they perceived reporting to have had a negative impact on the therapeutic relationship, would have more years of experience in reporting child abuse.

(2) It was expected that clinicians who indicated having a higher proportion of cases in which they perceived reporting to have had a positive impact on the therapeutic relationship than cases in which they perceived reporting to have had a negative impact on the therapeutic relationship, would have more high-quality training in child abuse assessment, treatment, and reporting.

Finally, exploratory data were gathered regarding the impact of these clinician characteristics: gender, therapeutic orientation, primary place of employment,

percentage of clients who are children, and general attitudes about reporting.

CHAPTER II

METHOD

Participants

The American Psychological Association's Office of Demographics, Employment, and Educational Research was contacted to obtain a random sample of APA members who met the following inclusion criteria: a) were licensed clinical psychologists, b) specified clinical child psychology as a specialty area, and c) specified a clinical setting as the primary work setting. Materials were sent to one thousand psychologists (500 men and 500 women); 281 responded, a 29% response rate. A summary of respondents' overall demographic characteristics is presented in Table 1. The majority of the respondents were Caucasian (89%) and had Ph.D.'s (89%). Although men and women were well represented, there was a higher percentage of women (58%). All major theoretical orientations were represented, but the highest percentage reported a dynamic orientation (33%). Participants reported employment in a range of clinical settings, but the majority (64%) were private practitioners who were fairly experienced clinicians (mean age = 43.90, SD = 8.94; mean years of experience = 14.19, SD = 7.85).

Materials

Each participant received a cover letter requesting

Table 1

Percentages and Frequencies of Demographic Characteristics of Respondents

Characteristic		
Gender		
Male	42%	(n=117)
Female	58%	(n=164)
Ethnicity		
Caucasian	89%	(n=250)
African Amer	1%	(n=2)
Asian Amer	2%	(n=5)
Hispanic Amer	1%	(n=4)
Other	<1%	(n=1)
Degree		
Ph.D.	89%	(n=250)
Ed.D.	2%	(n=5)
Psy.D.	8%	(n=23)
M.A./M.S.	1%	(n=3)
Orientation		
Systems	13%	(n=37)
Dynamic	33%	(n=93)
Humanistic	4%	(n=10)
Cognitive	16%	(n=45)
Behavioral	10%	(n=27)
Eclectic	14%	(n=39)
Other	7%	(n=20)
Employment		
Academic institution	<1%	(n=1)
Medical facility	11%	(n=30)
Psychiatric hospital	6%	(n=17)
Private practice	64%	(n=180)
School	2%	(n=7)
Outpatient mental health	11%	(n=30)
Other	5%	(n=13)

Note. Columns may not sum to 100% or overall n's due to missing data.

Table 1 (cont.)

Characteristic		
Training--abuse assessment		
Graduate school	39%	(n=110)
Internship	53%	(n=148)
Workshops	70%	(n=197)
Continuing education	69%	(n=195)
Other	24%	(n=68)
None	2%	(n=7)
Training--abuse treatment		
Graduate school	31%	(n=88)
Internship	52%	(n=145)
Workshops	61%	(n=171)
Continuing education	66%	(n=185)
Other	23%	(n=66)
None	7%	(n=19)
Training--abuse reporting		
Graduate school	29%	(n=82)
Internship	45%	(n=127)
Workshops	46%	(n=130)
Continuing education	57%	(n=143)
Other	33%	(n=92)
None	6%	(n=16)
Mean age (SD)	43.90	(8.94)
Mean yrs experience (SD)	14.19	(7.85)
Mean hrs therapy/week (SD)	21.63	(10.47)
% of clients-child (SD)	64.35	(25.78)
% of clients-adult (SD)	34.57	(25.19)
Mean # cases reported (SD)	19.28	(32.67)
Mean # cases not reported (SD)	4.74	(11.80)

participation (see Appendix A) and a survey (see Appendix B) asking him/her to provide information regarding his/her professional experiences with child abuse reporting. The survey was divided into two sections. In section one, participants provided general background information about themselves and their practices (e.g. gender, age, degree earned, year degree was earned, theoretical orientation, number of hours of therapy conducted per week, percentage of child clients, and percentage of adult clients). They were also asked to rate the quality of their training in child abuse assessment, treatment, and reporting, and to indicate the extent of their training in each area by selecting from a list of training opportunities all that applied to them. Finally, they were asked to specify the number of cases of child abuse they had reported, as well as the number of cases in which they suspected abuse but decided not to report.

In section two, Part A, participants were first asked to indicate if they had ever reported a case of suspected child abuse during the course of therapy and felt that reporting had a positive effect on the therapeutic relationship. If they responded "yes," they were also asked to indicate what percentage of their reported cases resulted in a positive outcome. Participants who responded "yes" were then asked to think about the case where they felt reporting had the <u>most positive effect</u> on the therapeutic

relationship and to respond to a series of questions about the case, the reporting procedure, and the outcome of the report.

In terms of characteristics of the case, participants were asked to indicate the age and gender of the victim and perpetrator, the type and duration of the abuse, the length of time they had been in practice at the time of the report, and the number of sessions with the client prior to the report. In addition, by checking the appropriate responses from lists of alternatives, they were asked to indicate who the client was and what led them to suspect abuse, and were also asked to rate the degree of confidence they had that abuse was occurring. Finally, participants were given a list of factors and asked to rate the importance of each factor in their assessment that the effect of reporting on this case was positive.

In terms of the reporting procedure, participants were asked if they consulted with anyone prior to the report, and to check from a list of alternatives all consultation sources used. They were then asked to indicate if limits to confidentiality were discussed with the clients in this case, and if so, to check appropriate responses to indicate when and how these limits were discussed. Finally, participants were given a list of possible reporting procedures and asked to check the procedure they used when making the report.

In terms of the outcome of the report, participants were given 5-point Likert scales and asked to rate the client's supportiveness/resistance to the report being made, the client's initial reaction to the report, the level of trust between client and clinician prior to the report, and the level of trust between client and clinician following the report. Participants were then given a list of possible immediate outcomes following the report (e.g. formal investigation begun; legal charges filed against perpetrator) and asked to check all that applied from the possible alternatives. In addition, they were asked to rate on 5-point Likert scales the quality of their experience with Child Protective Services in this case, as well as the overall effect of the report on the child, the family, and the cessation of abuse.

Finally, participants were asked to indicate if their experience in this case made them more willing to report, less willing to report, or had no effect on their subsequent willingness to report. They were further asked if they changed their reporting procedures or their procedures for discussing limits to confidentiality based on their experience in this case, and if so, to indicate what changes were made.

On a separate page, in Part B of section two, participants were first asked to indicate if they had ever reported a case of suspected child abuse during the course

of therapy and felt that reporting had a negative effect on the therapeutic relationship. If they responded "yes," they were also asked to indicate what percentage of their reported cases resulted in a negative outcome. Participants who responded "yes" were then asked to think about the case where they felt reporting had the most negative effect on the therapeutic relationship and to respond to the same set of questions about the case, reporting procedure, and outcome that were asked in Part A.

Instrument Development

A preliminary draft of the survey was developed by reviewing the literature on child abuse reporting. Questions were designed to gather information on a variety of situational factors as well as clinician characteristics that were predicted to be related to the outcome of a report, based on the results of earlier studies. The preliminary survey was distributed to ten clinical psychologists, who were asked to read the survey and provide feedback on the clarity and relevance of questions. Based on the comments provided by the pilot sample, several questions were reworded, others were deleted, and still others were added. A final draft of the survey, which would be distributed to the actual sample, was then composed.

Procedure

The American Psychological Association's Office of Demographics, Employment, and Educational Research was

contacted to obtain mailing labels of licensed clinical child psychologists whose primary places of employment were in clinical settings (independent practice, hospitals, clinics, and other human service settings). One thousand psychologists (500 men and 500 women) were randomly selected. Each psychologist was sent one survey, a cover letter that described the study, and a request to participate. Participants also received (a) a stamped postcard that was to be returned separately from the survey that entitled them to the results of the study as an incentive and debriefing, and (b) a self-addressed, stamped return envelope, for separate return of the survey. Participants were asked not to put any identifying information on the survey in order to ensure anonymity. In addition, all responses were kept confidential.

CHAPTER III

RESULTS

Preliminary Analyses

The primary purpose of this study was to identify characteristics associated with positive and negative outcomes of reporting child abuse. In addition to providing data about themselves, their training in child abuse, and their general experiences in reporting, participants recalled the case with the most positive outcome (if they had reported positive outcomes) and answered a series of questions about the case. They also recalled the case with the most negative outcome (if they had reported negative outcomes) and answered a series of questions about this case. Thus, depending on their experiences, participants may have provided data about a positive case, a negative case, both a positive and a negative case, or neither. The major analyses involved comparisons of the positive and negative cases in terms of case characteristics, reporting procedures, and outcome, as well as comparisons of participants who reported primarily positive reporting experiences to those who reported primarily negative reporting experiences. Prior to conducting these analyses, however, two sets of preliminary analyses were conducted. First, participants were grouped based on their reporting

experiences, and compared on demographic characteristics. Second, the factors that participants indicated were important in their feeling that the effect of the report was positive were compared with the factors that participants indicated were important in their feeling that the effect of the report was negative.

Comparison of participants reporting positive versus negative cases. Participants were grouped based on their reporting experiences: those indicating only positive reporting experiences (19%, n=52); those indicating only negative reporting experiences (18%, n=51); those indicating both positive and negative reporting experiences (46%, n=129); and those indicating neither positive nor negative reporting experiences (17%, n=49). A complete summary of demographic characteristics for these four groups is presented in Table 2. No differences were noted between groups on gender, ethnicity, highest degree earned, theoretical orientation, primary place of employment, and training in child abuse reporting.

Significant differences emerged on a number of variables; for the most part, these differences seemed to represent a difference between the neither group and other groups. The group with neither positive nor negative reporting experiences had more years of experience than those with both experiences, $t(163) = 4.62$, $p<.0001$, than those with positive only experiences, $t(91) = 2.11$. $p<.037$,

Table 2

Demographic Characteristics of Respondents With Positive, Negative, Both or Neither Reporting Experiences

Characteristic	Pos 19% (n=52)	Neg 18% (n=51)	Both 46% (n=129)	Neither 17% (n=49)
Gender				
Male	46% (n=24)	37% (n=19)	45% (n=58)	33% (n=16)
Female	54% (n=28)	63% (n=32)	55% (n=71)	67% (n=33)
Ethnicity				
Caucasian	98% (n=47)	87% (n=40)	96% (n=117)	98% (n=46)
African Amer	---	---	1% (n=1)	2% (n=1)
Asian Amer	2% (n=1)	7% (n=3)	1% (n=1)	---
Hispanic Amer	---	4% (n=2)	2% (n=2)	---
Other	---	2% (n=1)	---	---
Degree				
Ph.D.	90% (n=47)	92% (n=47)	85% (n=110)	94% (n=46)
Ed.D.	2% (n=1)	---	2% (n=3)	2% (n=1)
Psy.D.	6% (n=3)	6% (n=3)	12% (n=15)	4% (n=2)
M.A./M.S.	2% (n=1)	2% (n=1)	1% (n=1)	---

Note. Columns may not sum to 100% or overall n's due to missing data.

Table 2 (cont.)

Characteristic	Pos 19% (n=52)	Neg 18% (n=51)	Both 46% (n=129)	Neither 17% (n=49)
Orientation				
Systems	13% (n=7)	13% (n=7)	13% (n=17)	12% (n=6)
Dynamic	27% (n=14)	31% (n=16)	34% (n=44)	40% (n=19)
Humanistic	10% (n=5)	2% (n=1)	3% (n=4)	---
Cognitive	17% (n=9)	16% (n=8)	18% (n=23)	10% (n=5)
Behavioral	4% (n=2)	16% (n=8)	7% (n=9)	17% (n=8)
Eclectic	23% (n=12)	16% (n=8)	15% (n=19)	---
Other	6% (n=3)	6% (n=3)	9% (n=12)	4% (n=2)
Employment				
Academic institution	---	---	1% (n=1)	---
Medical facility	12% (n=6)	12% (n=6)	11% (n=14)	8% (n=4)
Psychiatric hospital	6% (n=3)	6% (n=3)	9% (n=11)	---
Private practice	64% (n=32)	65% (n=33)	59% (n=76)	80% (n=39)
School	6% (n=3)	4% (n=2)	2% (n=2)	---
Outpatient mental health	6% (n=3)	8% (n=4)	15% (n=19)	8% (n=4)
Other	6% (n=3)	6% (n=3)	4% (n=5)	4% (n=2)

Table 2 (cont.)

Characteristic	Pos 19% (n=52)	Neg 18% (n=51)	Both 46% (n=129)	Neither 17% (n=49)
Training--abuse assessment				
Graduate school	33% (n=17)	31% (n=16)	48% (n=62)	31% (n=15)
Internship	42% (n=22)	33% (n=17)	69% (n=89)	41% (n=20)
Workshops	67% (n=35)	57% (n=29)	78% (n=101)	65% (n=32)
Continuing education	64% (n=33)	59% (n=30)	79% (n=102)	61% (n=30)
Other	19% (n=10)	16% (n=8)	28% (n=36)	29% (n=14)
None	---	4% (n=2)	---	10% (n=5)
Training--abuse treatment				
Graduate school	17% (n=9)	29% (n=15)	45% (n=58)	12% (n=6)
Internship	42% (n=22)	43% (n=22)	67% (n=87)	29% (n=14)
Workshops	65% (n=34)	43% (n=22)	74% (n=95)	41% (n=20)
Continuing education	67% (n=35)	47% (n=24)	77% (n=99)	55% (n=27)
Other	21% (n=11)	14% (n=7)	29% (n=37)	22% (n=11)
None	4% (n=2)	12% (n=6)	---	22% (n=11)

Table 2 (cont.)

Characteristic	Pos 19% (n=52)	Neg 18% (n=51)	Both 46% (n=129)	Neither 17% (n=49)
Training--abuse reporting				
Graduate school	33% (n=17)	22% (n=11)	33% (n=43)	22% (n=11)
Internship	42% (n=22)	29% (n=15)	57% (n=73)	35% (n=17)
Workshops	48% (n=25)	28% (n=14)	53% (n=69)	45% (n=22)
Continuing education	48% (n=25)	35% (n=18)	60% (n=77)	47% (n=23)
Other	35% (n=18)	33% (n=17)	33% (n=42)	31% (n=15)
None	2% (n=1)	12% (n=6)	5% (n=7)	4% (n=2)
Mean age (SD)	43.78 (8.79)	43.35 (10.27)	41.99 (6.71)	46.47 (10.00)
Mean yrs experience (SD)	14.04 (7.19)	12.96 (8.08)	11.89 (6.02)	17.86 (10.13)
Mean hrs of therapy per week (SD)	23.06 (11.05)	20.27 (10.17)	24.50 (10.01)	18.69 (10.63)
% of clients-child (SD)	63.85 (25.96)	68.84 (25.27)	67.21 (23.41)	57.49 (28.49)
% of clients-adult (SD)	35.37 (25.51)	30.27 (25.09)	32.26 (23.16)	40.37 (26.98)
Mean # cases reported (SD)	15.94 (21.71)	6.90 (6.82)	45.28 (71.86)	9.09 (30.30)
Mean # cases not reported (SD)	6.16 (14.95)	2.02 (3.00)	9.36 (25.42)	1.43 (3.82)

and than those with negative only experiences, $t(91) = 2.59$, $p<.011$. The neither group also did fewer hours of therapy per week than those with both experiences, $t(175) = 3.44$, $p<.001$ and than those with positive only experiences, $t(98) = 2.01$, $p<.047$. The neither group saw a higher percentage of adult clients than the both group, $t(175) = 1.99$, $p<.048$, and the negative only group, $t(98) = 1.94$, $p<.05$, and a lower percentage of child clients than the both group, $t(176) = 2.33$, $p<.021$, and the negative only group, $t(98) = 2.11$, $p<.037$. Respondents in the neither group were more likely to indicate having no training in child abuse assessment than those in the both group, X^2 (1, $N = 178$) = 13.54, $p<.0002$, and those in the positive only group, X^2 (1, $N = 101$) = 5.58, $p<.018$. Those in the neither group were also more likely to indicate having no training in child abuse treatment than those in the both group, X^2 (1, $N = 178$) = 30.87, $p<.0001$, and those in the positive only group, X^2 (1, $N = 101$) = 7.78, $p<.005$. Overall, respondents in the neither group were less likely to have reported abuse than the both group, X^2 (1, $N = 178$) = 71.88, $p<.0001$, the positive only group, X^2 (1, $N = 101$) = 35.26, $p<.0001$, and the negative only group, X^2 (1, $N = 100$) = 34.69, $p<.0001$. Fifty-one percent ($n=25$) of the neither group indicated that they had never reported child abuse. Because the present study aimed to target clinicians with experience in child abuse reporting, and required comparison of positive versus

negative reporting experiences, the neither group was excluded from further data analyses.

Criteria for defining cases as positive or negative.

Before presenting results regarding formal hypotheses, it is important to clarify the criteria respondents used to classify cases where they perceived reporting to have a positive effect on the therapeutic relationship versus those cases where they perceived reporting to have a negative effect on the therapeutic relationship. Respondents were asked to rate the importance of several factors on their feeling that the effect of the report on the therapeutic relationship was positive or negative, including: the client's interest in continuing in therapy; the client's effort to change after the report; the client's attitude toward therapy after the report; the client's willingness to self-disclose after the report; and the client's trust in the therapist after the report. Respondents rated each of these factors on a 4-point scale, from "1=extremely important" to "4=not important."

The relative importance of these factors in positive cases was investigated by grouping all positive cases together (including responses from participants in the both group as well as those from participants in the positive only group). A within subjects multivariate analysis of variance (MANOVA) was conducted, and was significant, F, $(4,168) = 21.59$, $p<.0001$. Follow-up dependent t-tests using

the Bonferroni correction for inflated error ($p<.005$) were then performed. Results of these ratings are presented in Table 3. The most important factor in clinicians' feeling that the effect of the report on the therapeutic relationship was positive was the client's trust in the clinician following the report. This factor was rated more important than the client's interest in continuing in therapy, $t(179) = 7.00$, $p<.0001$, than the client's effort to change following the report, $t(174) = 8.07$, $p<.0001$, than the client's attitude toward therapy following the report, $t(179) = 6.17$, $p<.0001$, and than the client's willingness to self-disclose following the report, $t(178) = 6.35$, $p<.0001$. The least important factor was the client's effort to change following the report. This factor was rated less important than the client's interest in continuing therapy, $t(175) = 3.17$, $p<.002$, than the client's attitude toward therapy following the report, $t(175) = 4.86$, $p<.0001$, and than the client's willingness to self-disclose following the report, $t(173) = 4.31$, $p<.0001$.

The relative importance of these factors in negative cases was investigated by grouping all negative cases together (including responses from participants in the both group as well as those from participants in the negative only group). A within subjects multivariate analysis of variance (MANOVA) was performed and was significant, $F(4,163) = 21.03$, $p<.0001$. Follow-up dependent t-tests using

Table 3

Percentages and Frequencies of Factors Important in Clinicians' Perceptions that Reporting Had a Positive Effect on the Therapeutic Relationship

	Clinician's response				
Factors	Ext imp (1)	Very imp (2)	Some imp (3)	Not imp (4)	Mean Rating (SD)
Client's interest in continuing therapy	30% (n=54)	43% (n=77)	21% (n=37)	6% (n=11)	2.03 (.87)
Client's effort to change post report	26% (n=46)	33% (n=58)	25% (n=43)	16% (n=27)	2.29 (1.03)
Client's attitude toward therapy post report	32% (n=57)	47% (n=84)	19% (n=34)	2% (n=4)	1.92 (.77)
Client's willingness to self-disclose post report	39% (n=69)	36% (n=64)	20% (n=36)	5% (n=9)	1.92 (.89)
Client's trust post report	58% (n=103)	30% (n=54)	11% (n=19)	1% (n=3)	1.56 (.75)

the Bonferroni correction for inflated error ($p<.005$) were then performed. Results of these ratings are presented in Table 4. There were no significant differences between the client's interest in continuing therapy, the client's attitude toward therapy, the client's willingness to self-disclose, and the client's trust in the clinician following the report in terms of level of importance in negative cases; these factors were rated equally important. However, the least important factor in clinicians' feeling that the effect of the report on the therapeutic relationship was negative was the client's effort to change following the report. This factor was rated less important than the client's interest in continuing therapy, $t(169) = 7.43$, $p<.0001$, than the client's attitude toward therapy following the report, $t(169) = 9.31$, $p<.0001$, than the client's willingness to self-disclose following the report, $t(168) = 7.11$, $p<.0001$, and than the client's trust in the clinician following the report, $t(167) = 7.58$, $p<.0001$.

Most Positive versus Most Negative Cases

Following these preliminary comparisons, two sets of analyses were conducted to test the main hypotheses about case characteristics, reporting procedures, and the impact of reporting, and to investigate exploratory variables. Between-subject analyses were performed to compare data from participants having only negative experiences (negative only group) to data from participants having only positive

Table 4

Percentages and Frequencies of Factors Important in Clinicians' Perceptions that Reporting Had a Negative Effect on the Therapeutic Relationship

	Clinician's response				
Factors	Ext imp (1)	Very imp (2)	Some imp (3)	Not imp (4)	Mean Rating (SD)
Client's interest in continuing therapy	49% (n=86)	25% (n=45)	14% (n=24)	12% (n=22)	1.90 (1.06)
Client's effort to change post report	24% (n=40)	25% (n=43)	20% (n=35)	31% (n=52)	2.59 (1.16)
Client's attitude toward therapy post report	47% (n=84)	30% (n=53)	14% (n=25)	9% (n=16)	1.85 (.99)
Client's willingness to self-disclose post report	44% (n=78)	31% (n=55)	13% (n=23)	12% (n=20)	1.91 (1.02)
Client's trust post report	48% (n=83)	31% (n=54)	10% (n=18)	11% (n=20)	1.86 (1.01)

experiences (positive only group). Within-subjects analyses were also conducted on the same variables to investigate responses from participants who indicated that they had both positive as well as negative reporting experiences (both group).

Case characteristics. Several variables were investigated with regard to case characteristics that may be associated with positive or negative cases. Between-subjects comparisons of case characteristics are presented in Table 5 and within-subjects comparisons of case characteristics are presented in Table 6. Between-subjects and within-subjects analyses revealed similar findings. Both sets of analyses indicated that there were no significant differences in the gender or age of the victim, gender or age of the abuser, presence of physical abuse, presence of emotional abuse, or presence of neglect in positive or negative cases. Between-subjects analyses indicated that the occurrence of sexual abuse was more likely in cases where reporting was perceived to have had a positive effect on the therapeutic relationship, X^2 (1, N = 99) = 6.33, $p<.01$. This finding was not significant within-subjects.

Both between-subjects and within-subjects analyses revealed that there were no significant differences between positive and negative cases with regard to the frequency or duration of the abuse, or the relationship between the

Table 5

Between-Subject Comparisons of Case Characteristics for Respondents with Positive Only or Negative Only Reporting Experiences

Characteristic	Positive	Negative	Test
Gender of victim			X^2 = .89
Male	34% (n=17)	43% (n=22)	
Female	66% (n=33)	57% (n=29)	
Mean age victim(SD)	9.71 (3.97)	9.25 (3.81)	t = .58
Gender of abuser			X^2 = 5.56
Male	83% (n=43)	67% (n=34)	
Female	13% (n=7)	31% (n=16)	
Both	4% (n=2)	2% (n=1)	
Mean age abuser(SD)	34.54 (11.39)	33.78 (9.33)	t = .36
Type of abuse			
Physical	40% (n=20)	53% (n=26)	X^2 = 1.70
Sexual	68% (n=34)	43% (n=21)	X^2 = 6.34 **
Emotional	42% (n=21)	31% (n=15)	X^2 = 1.39
Neglect	6% (n=3)	12% (n=6)	X^2 = 1.17
Occurrence of abuse			X^2 = 2.48
Single	15% (n=7)	28% (n=13)	
Ongoing	83% (n=39)	70% (n=32)	
Episodic	2% (n=1)	2% (n=1)	
Duration of abuse			X^2 = .90
0 - 6 months	21% (n=8)	25% (n=6)	
7 - 12 months	26% (n=10)	21% (n=5)	
13 - 24 months	21% (n=8)	29% (n=7)	
Over 2 years	32% (n=12)	25% (n=6)	
Relationship of abuser to victim			X^2 = 2.09
Parent	62% (n=31)	70% (n=36)	
Sibling	8% (n=4)	4% (n=2)	
Extend family	10% (n=5)	10% (n=5)	
Acquaintance	18% (n=9)	16% (n=8)	
Stranger	---	---	
Other	2% (n=1)	---	

Note. Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001

Table 5 (cont.)

Characteristic	Positive	Negative	Test
Clients in case			X^2 = 6.51
Child victim	65% (n=33)	49% (n=25)	
Abuser	2% (n=1)	8% (n=4)	
Child victim & abuser	23% (n=12)	23% (n=12)	
Child victim & non-abus par	6% (n=3)	16% (n=8)	
Child victim & family	4% (n=2)	2% (n=1)	
Other	---	2% (n=1)	
Factors leading to suspicion of abuse			
Phys evidence	8% (n=4)	14% (n=7)	X^2 = .92
Emot signs	37% (n=19)	31% (n=16)	X^2 = .39
Verbal account-victim	86% (n=44)	61% (n=31)	X^2 = 8.51 **
Verbal account-abuser	16% (n=8)	18% (n=9)	X^2 = .07
Verbal account-family member	45% (n=23)	33% (n=17)	X^2 = 1.48
Other	10% (n=5)	8% (n=4)	X^2 = .12
Confidence that abuse was occurring			
1 Extremely	51% (n=26)	45% (n=23)	
2 Very	43% (n=22)	25% (n=13)	
3 Somewhat	6% (n=3)	16% (n=8)	
4 Not confident	---	14% (n=7)	
Mean confidence rating	1.55	1.98	t = 2.47 **

Note. Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001

Table 6

Within-Subject Comparisons of Case Characteristics for Respondents with Both Positive and Negative Reporting Experiences

Characteristic	Positive	Negative	Test
Gender of victim			X^2 = .14
Male	40% (n=52)	37% (n=48)	
Female	60% (n=77)	63% (n=81)	
Mean age victim(SD)	8.95 (3.72)	9.44 (4.38)	t = 1.01
Gender of abuser			X^2 = .01
Male	71% (n=91)	71% (n=90)	
Female	25% (n=32)	24% (n=30)	
Both	4% (n=5)	5% (n=7)	
Mean age abuser(SD)	33.36 (11.24)	33.93 (11.55)	t = .32
Type of abuse			
Physical	56% (n=71)	61% (n=78)	X^2 = .73
Sexual	60% (n=77)	50% (n=64)	X^2 = 3.67
Emotional	41% (n=53)	42% (n=54)	X^2 = .01
Neglect	13% (n=17)	17% (n=22)	X^2 = .42
Occurrence of abuse			X^2 = .66
Single	17% (n=21)	16% (n=20)	
Ongoing	80% (n=100)	82% (n=102)	
Episodic	3% (n=4)	2% (n=2)	
Duration of abuse			X^2 = .36
0 - 6 months	22% (n=20)	24% (n=19)	
7 - 12 months	13% (n=12)	17% (n=13)	
13 - 24 months	18% (n=17)	10% (n=8)	
Over 2 years	47% (n=43)	49% (n=39)	
Relationship of abuser to victim			X^2 = 3.44
Parent	69% (n=89)	75% (n=96)	
Sibling	4% (n=5)	7% (n=9)	
Extend family	12% (n=15)	8% (n=11)	
Acquaintance	13% (n=17)	8% (n=10)	
Stranger	1% (n=1)	---	
Other	2% (n=2)	2% (n=2)	

Note. Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001

Table 6 (cont.)

Characteristic	Positive	Negative	Test
Clients in case			X^2 = 2.62
Child victim	56% (n=72)	44% (n=57)	
Abuser	2% (n=3)	8% (n=10)	
Child victim & abuser	28% (n=36)	29% (n=37)	
Child victim & non-abus par	12% (n=16)	11% (n=15)	
Child victim & family	---	4% (n=5)	
Other	2% (n=2)	4% (n=5)	
Factors leading to suspicion of abuse			
Phys evidence	18% (n=23)	17% (n=22)	X^2 = .01
Emot signs	44% (n=57)	52% (n=67)	X^2 = 2.25
Verbal account-victim	84% (n=108)	77% (n=99)	X^2 = 1.83
Verbal account-abuser	18% (n=23)	12% (n=16)	X^2 = 1.16
Verbal account-family member	36% (n=47)	40% (n=52)	X^2 = .29
Other	7% (n=9)	5% (n=7)	X^2 = .75
Confidence that abuse was occurring			
1 Extremely	63% (n=81)	43% (n=55)	
2 Very	32% (n=41)	38% (n=49)	
3 Somewhat	4% (n=5)	16% (n=20)	
4 Not confident	1% (n=2)	3% (n=4)	
Mean confidence rating	1.44	1.79	t = 4.04 ***

Note. Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001

abuser and the victim. Contrary to what was predicted by hypothesis 4, no differences were found with respect to who the clients in treatment were. Clients in positive cases were not more likely to be the alleged victims and clients in negative cases were not more likely to be the alleged perpetrators. However, given the small number of cases in which the client was the alleged perpetrator, it is difficult to draw strong conclusions about what the impact of the report would be in cases in which the client was not a child victim.

In terms of factors leading to the suspicion of abuse, between-subjects and within-subjects analyses indicated that there were no significant differences between positive and negative cases on the presence of physical evidence, emotional indicators, verbal account from the alleged abuser, or verbal accounts from other family members. Between-subjects analyses revealed that a verbal account from a victim was more likely to be present in cases where the report was perceived to have a positive effect, X^2 (1, N = 102) = 8.51, $p<.004$. This finding was not significant within-subjects. To assess clinicians' level of confidence that abuse was occurring, a mean confidence rating was calculated for positive cases and negative cases based on clinicians' ratings from a 4-point Likert scale, and these means were then compared. In general, clinicians indicated being more confident that abuse was occurring in cases where

the report was perceived to have had a positive effect. This finding was significant between-subjects, $t(100) = 2.47$, $p<.01$, as well as within-subjects $t(127) = 4.04$, $p<.0001$.

Reporting procedures. Several factors related to reporting procedures were investigated to determine if there were differences between these factors in positive versus negative cases. Between-subjects analyses and within-subjects analyses again revealed similar results. Between-subjects comparisons are presented in Table 7 and within-subjects comparisons are presented in Table 8. Contrary to what was predicted by hypothesis 5, there was no difference between positive and negative cases in terms of the number of therapy sessions held prior to the report; reports for positive cases were not more likely to be made later in treatment and reports for negative cases were not more likely to be made earlier in treatment.

Several questions were asked about procedures surrounding the report. With regard to consultation prior to the report, between-subjects data and within-subjects data indicated that of all types of consultation sought, in both positive and negative cases, clinicians were most likely to have consulted with a colleague prior to the report. No differences were found between-subjects or within-subjects with regard to consultation with the child abuse hotline, supervisors, or state laws in positive versus

Table 7

Between-Subject Comparisons of Factors Related To Reporting Procedures for Respondents with Positive Only or Negative Only Reporting Experiences

Factor	Positive	Negative	Test
Mean # sessions prior to report (SD)	8.16 (9.14)	10.42 (14.43)	t = .94
Consultation prior to report			
Abuse hotline	19% (n=10)	18% (n=9)	X^2 = .04
Colleague	40% (n=21)	47% (n=24)	X^2 = .47
Supervisor	21% (n=11)	27% (n=14)	X^2 = .56
Attorney	4% (n=2)	2% (n=1)	X^2 = .32
State law	10% (n=5)	18% (n=9)	X^2 = 1.41
Eth principles	8% (n=4)	8% (n=4)	X^2 = .00
Treatment team	4% (n=2)	14% (n=7)	X^2 = 3.15
Literature	8% (n=4)	---	X^2 = 4.08 *
Other	6% (n=3)	10% (n=5)	X^2 = .59
Limits to confidentiality discussed			X^2 = 1.69
Yes	94% (n=47)	86% (n=44)	
No	6% (n=3)	14% (n=7)	
Limits to confidentiality discussed			
At outset	72% (n=34)	60% (n=29)	X^2 = 1.51
At report	53% (n=25)	56% (n=27)	X^2 = .09
During treatment	21% (n=10)	23% (n=11)	X^2 = .04
Other	2% (n=1)	---	X^2 = 1.03
Procedure for discussing limits to confidentiality			
Written	26% (n=11)	33% (n=15)	X^2 = .53
Verbal	93% (n=39)	71% (n=32)	X^2 = 6.84***
Videotape	---	---	
Other	---	---	

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

Table 7 (cont.)

Factor	Positive	Negative	Test
Reporting procedure			X^2 = 14.41**
Made w/o client knowledge	4% (n=2)	20% (n=10)	
Made w/client knowledge, in client pres	61% (n=31)	67% (n=35)	
Made w/client knowl, not in client pres	14% (n=7)	2% (n=1)	
Client made rpt in my pres	4% (n=2)	2% (n=1)	
Client made rpt not in my pres	---	2% (n=1)	
Other	18% (n=9)	6% (n=3)	
Quality of relationship with child protection agency			
1 Very good	27% (n=14)	2% (n=1)	
2 Good	46% (n=24)	28% (n=14)	
3 Fair	17% (n=9)	22% (n=11)	
4 Poor	10% (n=5)	22% (n=11)	
5 Very Poor	---	26% (n=13)	
Mean quality rating	2.10	3.42	t = 6.24 ***

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

Table 8

Within-Subject Comparisons of Factors Related To Reporting Procedures for Respondents with Both Positive and Negative Reporting Experiences.

Factor	Positive	Negative	Test
Mean # sessions prior to report (SD)	9.47 (14.17)	10.45 (13.64)	t = .58
Consultation prior to report			
Abuse hotline	19% (n=24)	18% (n=23)	X^2 = 1.00
Colleague	33% (n=42)	45% (n=58)	X^2 = 5.92 **
Supervisor	21% (n=27)	18% (n=23)	X^2 = .35
Attorney	1% (n=1)	5% (n=7)	X^2 = 3.12 *
State law	9% (n=12)	10% (n=13)	X^2 = 1.00
Eth principles	3% (n=4)	8% (n=11)	X^2 = 3.91 *
Treatment team	13% (n=17)	21% (n=27)	X^2 = 4.26 *
Literature	3% (n=4)	2% (n=3)	X^2 = 1.00
Other	6% (n=8)	9% (n=12)	X^2 = .35
Limits to confidentiality discussed			X^2 = .73
Yes	98% (n=125)	96% (n=123)	
No	2% (n=3)	4% (n=5)	
Limits to confidentiality discussed			X^2 = 1.26
At outset	82% (n=104)	81% (n=100)	
At report	68% (n=86)	62% (n=77)	
During treatment	24% (n=31)	20% (n=25)	
Other	---	2% (n=2)	
Procedure for discussing limits to confidentiality			X^2 = .12
Written	42% (n=51)	44% (n=53)	
Verbal	87% (n=105)	87% (n=103)	
Videotape	1% (n=1)	---	
Other	1% (n=1)	---	

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

Table 8 (cont.)

Factor	Positive	Negative	Test
Reporting procedure			X^2 = .09
Made w/o client knowledge	4% (n=5)	10% (n=13)	
Made w/client knowledge, in client pres	69% (n=88)	68% (n=88)	
Made w/client knowl, not in client pres	13% (n=17)	8% (n=11)	
Client made rpt in my pres	4% (n=5)	2% (n=2)	
Client made rpt not in my pres	---	2% (n=2)	
Other	10% (n=13)	10% (n=13)	
Quality of relationship with child protection agency			
1 Very good	29% (n=37)	13% (n=17)	
2 Good	43% (n=56)	30% (n=39)	
3 Fair	22% (n=28)	30% (n=39)	
4 Poor	4% (n=5)	13% (n=16)	
5 Very Poor	2% (n=3)	13% (n=17)	
Mean quality rating	2.08	2.82	t = 6.93 ***

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

negative cases. Between-subjects analyses indicated no difference between positive and negative cases with regard to consultation with colleagues, attorneys, the ethical principles, or treatment teams. However, within-subjects analyses indicated that respondents were more likely to have consulted with colleagues, X^2 (1, N = 129) = 5.92, $p<.01$, attorneys, X^2 (1, N = 129) = 3.12, $p<.05$, the ethical principles, X^2 (1, N = 129) = 3.91, $p<.05$, and treatment teams, X^2 (1, N = 129) = 4.26, $p<.05$, prior to the report in negative cases. Between-subjects analyses indicated that in positive cases, clinicians were more likely to have consulted with the child abuse literature, X^2 (1, N = 103) = 4.08, $p<.04$. This finding was not significant within-subjects.

Another procedure that was investigated was the discussion of the limits to confidentiality. Between-subjects and within-subjects data indicated that a majority of clinicians discussed limits to confidentiality with their clients. Between-subjects data summary revealed that in 94% of cases defined as positive and in 84% of cases defined as negative, limits to confidentiality were discussed, which did not represent a significant difference between positive and negative cases. Within-subjects comparisons revealed that in 98% of cases defined as positive and in 96% of cases defined as negative, limits to confidentiality were discussed, which did not represent a significant difference

between positive and negative cases. Contrary to hypothesis 2, limits to confidentiality were not more likely to be discussed at the outset of treatment in positive cases and at the time of the report in negative cases. Between-subjects and within-subjects analyses revealed no significant differences between positive and negative cases; in a majority of positive and negative cases, limits to confidentiality were discussed at the outset of treatment and again at the time of the report. The most common format for discussion of limits to confidentiality was verbal, although a written explanation of limits was often used in conjunction with the verbal discussion. Between-subjects analyses indicated that a verbal discussion was used more in positive cases than in negative cases, $\underline{X}^2$ (1, $\underline{N}$ = 87) = 6.84, $\underline{p}$<.001.

Respondents were asked specifically about the procedure they used when making the report. Between-subjects data and within-subjects data indicated that the most common reporting procedure in both positive and negative cases was to inform the client of the report and then to make the report in the client's presence. Between-subjects analyses revealed that reporting procedures differed in positive and negative cases, $\underline{X}^2$ (5, $\underline{N}$ = 102) = 14.41, $\underline{p}$<.01. As predicted by hypothesis 1, reports that were made without the client's knowledge were more likely to be associated with a negative effect on the therapeutic relationship.

This finding was not significant within-subjects.

To assess the quality of the clinician's relationship with the child protection agency, a mean quality rating was calculated for positive and negative cases based on clinicians' ratings from a 5-point Likert scale, and these means were then compared. Between-subjects and within-subjects analyses indicated that in cases where reporting was perceived to have had a positive effect on the therapeutic relationship, the quality of the reporting clinician's relationship with the child protection agency in the case was rated better than in cases where reporting was perceived to have had a negative effect on the therapeutic relationship, $t(100) = 6.24$, $p<.0001$ (between-subjects), and $t(127) = 6.93$, $p<.0001$ (within-subjects), as predicted by hypothesis 3.

Impact of reporting. Several questions were asked regarding numerous factors thought to relate to the impact of the report. Using 5-point Likert scales, clinicians' rated the client's supportiveness/resistance to the report, the client's initial reaction to the report, the level of trust between client and clinician prior to the report, the level of trust between client and clinician following the report, the effect of the report on the outcome for the child, the family, and the cessation of the abuse, and their subsequent willingness to report following their experience in this case. For the purpose of analyses, ratings were

treated as interval data. Mean ratings for each factor were calculated for positive and negative cases, and these means were then compared. Between-subjects data are presented in Table 9 and within-subjects data are presented in Table 10. Between-subjects and within-subjects analyses suggested that clients were more supportive of the report in positive cases than in negative cases, $\underline{t}(98) = 5.04$, $\underline{p}<.0001$, and $\underline{t}(125) = 11.39$, $\underline{p}<.0001$, respectively. Clients also had a more positive initial reaction to the report in positive cases than in negative cases, $\underline{t}(97) = 5.54$, $\underline{p}<.0001$ (between-subjects) and $\underline{t}(123) = 10.80$, $\underline{p}<.0001$ (within-subjects). Between-subjects analyses indicated that there was no difference between positive and negative cases in clinicians' perceived level of trust in the therapeutic relationship prior to the report; within-subjects analyses, however, revealed that clinicians perceived a higher level of trust in the therapeutic relationship prior to the report in positive cases, $\underline{t}(126) = 4.79$, $\underline{p}<.0001$. Both between-subjects analyses and within-subjects analyses indicated that, following the report, clinicians perceived less trust in the therapeutic relationship in negative cases than in positive cases, $\underline{t}(100) = 9.85$, $\underline{p}<.0001$, and $\underline{t}(123) = 18.07$, $p<.0001$, respectively.

With regard to the immediate outcome following the report, in the majority of positive and negative cases, a formal investigation was begun. Between-subjects and

Table 9

Between-Subject Comparisons of Factors Related to the Impact of the Report for Respondents with Positive Only or Negative Only Reporting Experiences

Factor	Positive	Negative	Test
Client's support/ resistance to rpt			
1 Very support	29% (n=15)	2% (n=1)	
2 Some support	25% (n=13)	16% (n=8)	
3 Neutral	12% (n=6)	12% (n=6)	
4 Some resist	25% (n=13)	35% (n=17)	
5 Very resist	8% (n=4)	35% (n=17)	
Mean support rating	2.57	3.84	t = 5.04 ***
Client's initial reaction to rpt			
1 Very positive	25% (n=13)	2% (n=1)	
2 Some positive	22% (n=11)	13% (n=6)	
3 Neutral	14% (n=7)	4% (n=2)	
4 Some negative	29% (n=15)	29% (n=14)	
5 Very negative	10% (n=5)	52% (n=25)	
Mean initial reaction rating	2.76	4.17	t = 5.54 ***
Trust level pre-rpt			
1 Extreme trust	17% (n=9)	17% (n=9)	
2 Moderate trust	67% (n=35)	55% (n=28)	
3 Neutral	14% (n=7)	16% (n=8)	
4 Mod distrust	2% (n=1)	12% (n=6)	
5 Ext distrust	---	---	
Mean trust rating pre-report	2.00	2.22	t = 1.44
Trust level post-rpt			
1 Extreme trust	31% (n=16)	2% (n=1)	
2 Moderate trust	56% (n=29)	16% (n=8)	
3 Neutral	6% (n=3)	14% (n=7)	
4 Mod distrust	7% (n=4)	30% (n=15)	
5 Ext distrust	---	38% (n=19)	
Mean trust rating post-report	1.90	3.86	t = 9.85 ***

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

Table 9 (cont.)

Factor	Positive	Negative	Test
Immediate outcome post report			
Rept not accept	---	6% (n=3)	X^2 = 3.15
Report logged, not invest	15% (n=8)	22% (n=11)	X^2 = .65
Invest begun	83% (n=43)	75% (n=38)	X^2 = 1.02
Child removed from home	6% (n=3)	10% (n=5)	X^2 = .56
Legal charges vs. perp	18% (n=9)	4% (n=2)	X^2 = 4.83 *
Outcome for child			
1 Very positive	36% (n=19)	7% (n=3)	
2 Some positive	56% (n=29)	26% (n=12)	
3 No effect	8% (n=4)	15% (n=7)	
4 Some negative	---	41% (n=19)	
5 Very negative	---	11% (n=5)	
Mean child outcome	1.71	3.24	t = 8.32 ***
Outcome for family			
1 Very positive	19% (n=10)	2% (n=1)	
2 Some positive	56% (n=29)	17% (n=8)	
3 No effect	19% (n=10)	15% (n=35)	
4 Some negative	4% (n=2)	46% (n=21)	
5 Very negative	2% (n=1)	20% (n=9)	
Mean family outcome	2.13	3.63	t = 7.77 ***
Impact on cessation of abuse			
1 Very positive	67% (n=35)	27% (n=10)	
2 Some positive	23% (n=12)	30% (n=11)	
3 No effect	10% (n=5)	35% (n=13)	
4 Some negative	---	5% (n=2)	
5 Very negative	---	3% (n=1)	
Mean effect on cessation of abuse	1.42	2.27	t = 4.74 ***

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

Table 9 (cont.)

Factor	Positive	Negative	Test
Impact on subsequent willingness to rpt			
1 Much more will	12% (n=6)	4% (n=2)	
2 Somewhat more	19% (n=10)	4% (n=2)	
3 No effect	65% (n=34)	53% (n=27)	
4 Somewhat less	4% (n=2)	27% (n=14)	
5 Much less	---	12% (n=6)	
Mean effect on willingness to report	2.62	3.39	t = 4.79 ***
Change in reporting procedure			X^2 = 13.6 ***
Yes	---	24% (n=12)	
No	100% (n=51)	76% (n=39)	
Change in discussion of limits to confidentiality			X^2 = .51
Yes	16% (n=8)	22% (n=11)	
No	84% (n=42)	78% (n=40)	

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

Table 10

Within-Subject Comparisons of Factors Related to the Impact of the Report for Respondents with Positive and Negative Reporting Experiences

Factor	Positive	Negative	Test
Client's support/ resistance to rpt			
1 Very support	32% (n=40)	4% (n=5)	
2 Some support	33% (n=42)	7% (n=9)	
3 Neutral	5% (n=6)	13% (n=17)	
4 Some resist	25% (n=32)	34% (n=43)	
5 Very resist	5% (n=7)	42% (n=53)	
Mean support rating	2.39	4.02	t = 11.39 ***
Client's initial reaction to rpt			
1 Very positive	16% (n=20)	1% (n=2)	
2 Some positive	39% (n=49)	8% (n=10)	
3 Neutral	9% (n=12)	9% (n=11)	
4 Some negative	27% (n=34)	39% (n=49)	
5 Very negative	9% (n=11)	43% (n=54)	
Mean initial reaction rating	2.76	4.15	t = 10.80 ***
Trust level pre-rpt			
1 Extreme trust	15% (n=19)	6% (n=8)	
2 Mod trust	62% (n=79)	51% (n=65)	
3 Neutral	18% (n=23)	22% (n=28)	
4 Mod distrust	5% (n=7)	17% (n=22)	
5 Ext distrust	---	3% (n=4)	
Mean trust rating pre-report	2.13	2.60	t = 4.79 ***
Trust level post-rpt			
1 Extreme trust	41% (n=52)	1% (n=2)	
2 Mod trust	47% (n=60)	17% (n=21)	
3 Neutral	3% (n=4)	5% (n=6)	
4 Mod distrust	8% (n=10)	41% (n=51)	
5 Ext distrust	1% (n=1)	36% (n=44)	
Mean trust rating post-report	1.81	3.92	t = 18.07 ***

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

Table 10 (cont.)

Factor	Positive	Negative	Test
Immediate outcome post report			
Rept not accept	1% (n=1)	5% (n=6)	X^2 = .13
Report logged, not invest	13% (n=17)	23% (n=30)	X^2 = 3.51
Invest begun	74% (n=96)	63% (n=80)	X^2 = 4.00 *
Child removed from home	18% (n=23)	15% (n=19)	X^2 = .11
Legal charges vs. perp	22% (n=29)	18% (n=23)	X^2 = .69
Outcome for child			
1 Very positive	47% (n=60)	5% (n=6)	
2 Some positive	46% (n=59)	27% (n=33)	
3 No effect	3% (n=4)	14% (n=17)	
4 Some negative	4% (n=5)	39% (n=59)	
5 Very negative	---	15% (n=19)	
Mean child outcome	1.66	3.36	t = 14.65 ***
Outcome for family			
1 Very positive	31% (n=39)	---	
2 Some positive	44% (n=56)	16% (n=19)	
3 No effect	10% (n=13)	16% (n=20)	
4 Some negative	13% (n=16)	45% (n=55)	
5 Very negative	2% (n=3)	23% (n=28)	
Mean family outcome	2.15	3.75	t = 12.78 ***
Impact on cessation of abuse			
1 Very positive	65% (n=83)	22% (n=26)	
2 Some positive	22% (n=28)	30% (n=35)	
3 No effect	10% (n=13)	32% (n=37)	
4 Some negative	1% (n=1)	9% (n=10)	
5 Very negative	1% (n=1)	7% (n=8)	
Mean effect on cessation of abuse	1.53	2.50	t = 8.61 ***

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

Table 10 (cont.)

Factor	Positive	Negative	Test
Impact on subsequent willingness to rpt			
1 Much more will	8% (n=10)	---	
2 Somewhat more	20% (n=26)	3% (n=4)	
3 No effect	70% (n=91)	84% (n=108)	
4 Somewhat less	2% (n=2)	11% (n=14)	
5 Much less	---	2% (n=3)	
Mean effect on willingness to report	2.66	3.12	$t = 6.76$ ***
Change in reporting procedure			$X^2 = .30$
Yes	6% (n=7)	12% (n=15)	
No	94% (n=120)	88% (n=114)	
Change in discussion of limits to confidentiality			$X^2 = .12$
Yes	5% (n=6)	9% (n=11)	
No	95% (n=123)	91% (n=116)	

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001.

within-subjects analyses did not reveal significant differences between the percentages of positive and negative cases in which the report was not accepted, the report was logged but not investigated, or the child was removed from the home. However, between-subjects analyses indicated that legal charges against the perpetrator were more often filed in positive than in negative cases, X^2 (1, N = 103) = 4.84, $p<.03$. Within-subjects analyses indicated that for clinicians with both positive and negative reporting experiences, a formal investigation was more likely to have occurred following the report in positive cases, X^2 (1, N = 128) = 4.00, $p<.05$.

Between-subjects and within-subjects analyses indicated that compared to cases defined as negative, in cases defined as positive, the effect of the report was more positive for the overall outcome for the child, $t(96) = 8.32$, $p<.0001$, and $t(122) = 14.65$, $p<.0001$, respectively; for the overall outcome for the family, $t(96) = 7.77$, $p<.0001$, and $t(121) = 12.78$, $p<.0001$, respectively; and for the cessation of abuse, $t(87) = 4.74$, $p<.0001$, and $t(113) = 8.61$, $p<.0001$, respectively.

With regard to the impact of the report on the clinician's subsequent willingness to report, between-subjects and within-subjects data summary indicated that for a majority of respondents, the report had no effect on subsequent reporting tendencies. However, between-subjects

and within-subjects analyses indicated that if the reporting experience was positive, clinicians were likely to be more willing to report in the future, and if the reporting experience was negative, clinicians were likely to be less willing to report in the future, $t(101) = 4.47$, $p<.0001$, and $t(128) = 6.76$, $p<.0001$, respectively.

With regard to the impact of the report on the clinician's subsequent change in his/her reporting procedure, between-subjects analyses revealed that clinicians were more likely to change their reporting procedure following negative cases, X^2 (1, $N = 102$) = 13.60, $p<.0001$. This finding was not significant within-subjects. With regard to the impact of the report on the clinician's change in his/her procedure for discussing limits to confidentiality, between-subjects and within-subjects analyses did not indicate significant differences between positive and negative cases.

Clinician Characteristics Related to Reporting Outcomes

To address the specific hypotheses regarding clinician characteristics, respondents were divided into two groups: (1) those who indicated having only positive reporting experiences or a greater percentage of positive than negative cases, and (2) those who indicated having only negative reporting experiences or a greater percentage of negative than positive cases. Participants in the primarily positive group were compared to participants in the

primarily negative group on years of experience as well as training in child abuse assessment, treatment, and reporting. Training experiences in graduate school, internship, workshops, continuing education, and other sources for each area were coded and summed: (1) if the clinician had training and (2) if the clinician did not have training. Clinicians' mean sum for each area could thus range from 5.00 (if they indicated training from all possible listed sources) to 10.00 (if they indicated training in none of the listed sources). Means were calculated for positive and negative groups and then compared. Quality of training in these three areas was assessed by comparing means for positive and negative groups based on the ratings from 5-point Likert scales. These results are presented in Table 11.

Contrary to hypothesis 1, there were no significant differences between groups on number of years experience; clinicians with more positive cases did not have more experience than clinicians with more negative cases. However, as expected by hypothesis 2, there were significant differences between groups on the amount of child abuse training in several areas. Specifically, those with more positive reporting experiences had more training than those with more negative reporting experiences in abuse assessment, $t(201) = 2.76$, $p<.006$; in abuse treatment, $t(201) = 3.68$, $p<.0001$; and in abuse reporting, $t(201) =$

Table 11

Between-Subject Comparisons of Clinician Characteristics for Respondents with Higher Percentage of Positive Reporting Experiences and Respondents with Higher Percentage of Negative Reporting Experiences

Characteristic	Primarily Positive Experiences	Primarily Negative Experiences	Test
Mean years experience (SD)	12.29 (5.95)	13.47 (8.26)	t = 1.15
Training--abuse assessment			
Grad school	42% (n=52)	38% (n=30)	
Internship	61% (n=76)	42% (n=33)	
Workshops	77% (n=96)	66% (n=52)	
Continuing ed.	73% (n=91)	66% (n=52)	
Other	23% (n=29)	22% (n=17)	
None	---	3% (n=2)	
Mean sum (assessment)	7.23	7.94	t = 2.76 **
Quality of abuse assessment training			
1 Very good	38% (n=47)	28% (n=22)	
2 Good	37% (n=45)	35% (n=73)	
3 Fair	23% (n=28)	27% (n=21)	
4 Poor	2% (n=3)	9% (n=7)	
5 Very poor	---	1% (n=1)	
Mean quality rating (assessment)	1.89	2.20	t = 2.37 *
Training--abuse treatment			
Grad school	33% (n=41)	35% (n=28)	
Internship	58% (n=72)	48% (n=38)	
Workshops	75% (n=93)	49% (n=39)	
Continuing ed	76% (n=94)	56% (n=44)	
Other	26% (n=32)	18% (n=14)	
None	2% (n=2)	8% (n=6)	
Mean sum (treatment)	7.32	7.94	t = 3.68 ***

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001; for mean sums, higher numbers indicate less training, as each variable was coded (1) yes, (2) no.

Table 11 (cont.)

Characteristic	Primarily Positive Experiences	Primarily Negative Experiences	Test
Quality of abuse treatment training			
1 Very good	36% (n=44)	17% (n=13)	
2 Good	41% (n=49)	35% (n=27)	
3 Fair	20% (n=24)	37% (n=28)	
4 Poor	3% (n=4)	7% (n=5)	
5 Very poor	---	4% (n=3)	
Mean quality rating (treatment)	1.90	2.44	t = 4.18 ***
Training--abuse reporting			
Grad school	32% (n=40)	25% (n=20)	
Internship	50% (n=62)	35% (n=28)	
Workshops	59% (n=73)	33% (n=26)	
Continuing ed.	61% (n=75)	41% (n=32)	
Other	33% (n=41)	29% (n=23)	
None	3% (n=4)	11% (n=9)	
Mean sum (reporting)	7.65	8.37	t = 4.32 ***
Quality of abuse reporting training			
1 Very good	40% (n=48)	24% (n=19)	
2 Good	42% (n=50)	47% (n=37)	
3 Fair	13% (n=16)	15% (n=12)	
4 Poor	3% (n=3)	3% (n=3)	
5 Very poor	2% (n=2)	9% (n=7)	
Mean quality rating (reporting)	1.83	2.26	t = 2.94 **

Note: Columns may not sum to 100% or overall n's due to missing data; *p<.05, **p<.01, ***p<.001; for mean sums, higher numbers indicate less training, as each variable was coded (1) yes, (2) no.

4.32, $p<.0001$. Also as predicted by hypothesis 2, those with more positive reporting experience indicated higher quality abuse assessment training, $t(200) = 2.37$, $p<.02$; higher quality abuse treatment training, $t(195) = 4.18$, $p<.0001$; and higher quality abuse reporting training, $t(195) = 2.94$, $p<.004$, than those with more negative reporting experiences.

Summary

In sum, a number of situational variables were found to be significantly different in cases where the effect of the report on the therapeutic relationship was perceived to have been positive compared to cases where the effect of the report on the therapeutic relationship was perceived to have been negative. Table 12 presents a summary of significant results from between-subjects analyses and within-subjects analyses. With respect to case characteristics, between-subjects analyses indicated that positive cases were more likely to involve sexual abuse. In addition, between-subjects analyses also indicated that positive cases were more likely to involve a verbal account of the abuse by the victim. Finally, both sets of analyses indicated that clinicians with positive cases were more confident that abuse was occurring. Of note, contrary to what was predicted, positive and negative cases were not differentiated based on whether the client in treatment was the alleged victim or the alleged perpetrator. However,

Table 12

Summary of Significant Results

	Between	Within
Case Characteristics		
Presence of sexual abuse	*** (P)	n.s.
Verbal account--victim	*** (P)	n.s.
Confidence that abuse occurred	*** (P)	*** (P)
Reporting Procedures		
Consultation--colleagues	n.s.	*** (N)
Consultation--attorneys	n.s.	*** (N)
Consultation--ethical principles	n.s.	*** (N)
Consultation--treatment team	n.s.	*** (N)
Consultation--literature	*** (P)	n.s.
Limits to confidentiality discussed verbally	*** (P)	n.s.
Report made without client's knowledge	*** (N)	n.s.
Quality of relationship with Child Protective Services	*** (P)	*** (P)
Impact of Reporting		
Client's supportiveness of report	*** (P)	*** (P)
Client's initial reaction to report	*** (P)	*** (P)
Trust--pre-report	n.s.	*** (P)
Trust--post-report	*** (P)	*** (P)

Note: *** indicates a significant difference between positive and negative cases; (P) indicates factor is more likely to be associated with positive cases; (N) indicates factor is more likely to be associated with negative cases; n.s. indicates comparison was not significant.

Table 12 (cont.)

	Between	Within
Impact of Reporting (cont).		
Legal charges filed vs. perpetrator	*** (P)	n.s.
Formal investigation begun	n.s.	*** (P)
Outcome--child	*** (P)	*** (P)
Outcome--family	*** (P)	*** (P)
Outcome--cessation of abuse	*** (P)	*** (P)
Subsequent willingness to report	*** (P)	*** (P)
Subsequent change in reporting procedure	*** (N)	n.s.

Note: *** indicates a significant difference between positive and negative cases; (P) indicates factor is more likely to be associated with positive cases; (N) indicates factor is more likely to be associated with negative cases; n.s. indicates comparison was not significant.

there were only a few cases in which the client was not a child victim, so a strong comparison could not be made.

With respect to factors related to reporting procedures themselves, a number of findings should be highlighted. A majority of clinicians discussed limits to confidentiality with clients, most often in an oral format. Between-subjects analyses indicated that an oral format was used more often in positive cases. Contrary to what was predicted, positive and negative cases were not distinguished based on when limits to confidentiality were discussed; in the majority of all cases, limits to confidentiality were discussed at the outset of treatment.

When considering whether or not to make a report, clinicians consulted a variety of sources. Most often, in positive as well as negative cases, they consulted with colleagues. Between-subjects analyses revealed that clinicians were more likely to consult the child abuse literature in positive cases than in negative cases. Within-subjects analyses indicated that clinicians were more likely to consult colleagues, attorneys, the ethical principles, and treatment teams in negative cases than in positive cases.

With regard to how the report was made, once the conclusion was reached that a report was necessary, clinicians most often informed the client that a report would be made and then made the report in the client's

presence. As predicted, in cases where the report was perceived to have had a negative effect on the therapeutic relationship, between-subjects analyses indicated that the report was more likely to have been made without the client's knowledge. Although not statistically significant, a similar pattern was found within-subjects. Contrary to what was predicted, the length of the therapeutic relationship prior to the report being made did not distinguish between positive and negative cases. However, as predicted, the quality of the clinician's relationship with child protective services did distinguish between positive and negative cases; in cases where the report was perceived to have had a positive effect on the therapeutic relationship, clinicians reported having more positive relationships with child protective services.

With regard to factors related to the impact of the report, a number of significant differences were found between positive and negative cases. Clinicians perceived that clients were more supportive of the report being made, and also perceived that clients had more positive initial reactions to the report in positive compared to negative cases. In positive cases, clinicians perceived a higher level of trust between themselves and their clients prior to the report. This level of trust continued, even after the report was made, which was not true in negative cases, where the level of trust was perceived to have declined following

the report.

Following a report, clinicians indicated that the most common immediate outcome was the start of a formal investigation, which within-subjects analyses indicated occurred more often in positive cases than in negative cases. Although a less frequent occurrence than the start of a formal investigation, legal charges were sometimes filed against the perpetrator, and this occurred more often in positive cases than in negative cases, according to between-subjects analyses. In terms of overall outcomes, both sets of analyses indicated that in positive cases, clinicians perceived better outcomes for the child, the family, and for the cessation of abuse.

With regard to the impact of the report on the clinician's subsequent willingness to report, both sets of analyses indicated that in positive cases, clinicians indicated that they would be more willing to report in the future, whereas in negative cases, clinicians indicated that they would be less likely to report in the future. Between-subjects analyses indicated that more clinicians were likely to change their reporting procedures following negative cases. There were no differences between positive and negative cases on clinicians' tendencies to change their procedures for discussing limits to confidentiality.

Finally, with regard to clinician characteristics, contrary to what was expected, clinicians who indicated

having a higher proportion of positive cases than negative cases did not have more years of experience than clinicians who indicated a higher proportion of negative cases than positive cases. However, as predicted, clinicians who indicated having a higher proportion of positive cases than negative cases had more high-quality training in abuse assessment, reporting, and treatment than clinicians who indicated having a higher proportion of negative cases than positive cases.

CHAPTER IV

DISCUSSION

The results of this study highlight the fact that, contrary to some clinicians' beliefs (Ansell & Ross, 1990; Brosig & Kalichman, 1992a; Muehleman & Kimmons, 1981), mandatory reporting of child abuse does not necessarily damage the therapeutic relationship. Only 18% of respondents in this study indicated having solely negative reporting experiences. Some respondents (19%) indicated having only positive reporting experiences. The largest group of the sample (46%) indicated that they had been involved with cases where reporting had a positive effect on the therapeutic relationship, and had also been involved with cases where reporting had a negative effect on the therapeutic relationship. These results are consistent with previous research (Harper & Irvin, 1985; Kalichman & Craig, 1991; Watson & Levine, 1989). It is important to highlight that although data in the present study were analyzed both between-subjects and within-subjects, a majority of the findings were consistent across both sets of analyses, lending stronger support to the findings. In addition, even when results were not statistically significant across both sets of analyses, the pattern of the between-subjects data when compared with the within-subjects data was similar.

Factors Differentiating Positive versus Negative Cases

Given that the majority of respondents indicated having both positive and negative reporting experiences, it is important to highlight factors that differentiated between positive and negative cases. With respect to case characteristics, between-subjects analyses indicated that positive cases were more likely to involve sexual abuse, and were also more likely to involve a verbal account of the abuse by the victim. In positive cases, clinicians felt more confident that abuse was occurring, possibly because they may have had more salient evidence (such as victims' reports) to support their suspicions of abuse in these cases. These findings are consistent with previous research, which suggests that clinicians are more likely to report suspected abuse when they have more evidence to substantiate their suspicions (Kalichman & Brosig, 1992; Zellman, 1990b). The results of the present study suggest that when clinicians have more salient indicators of abuse and are confident that abuse is occurring, the effect of the report on the therapeutic relationship is more likely to be positive. It is possible that when a clinician is confident that abuse is occurring and that a report is necessary, the act of making a report may be viewed by the client as helpful and therapeutic, whereas if a clinician is not confident that abuse is occurring and is unsure if a report is necessary, but still files a report, the client may view

the clinician in an authoritarian rather than therapeutic way.

It was predicted that the client in treatment was more likely to be the alleged victim in positive cases, and more likely to be the alleged perpetrator in negative cases. It was thought that alleged perpetrators who were clients would feel more betrayed by clinicians who reported them, resulting in a negative effect on the therapeutic relationship, whereas alleged victims who were clients would feel more supported by clinicians who reported suspected abuse, resulting in a positive effect on the therapeutic relationship. This hypothesis was not supported. It should be noted that the clinicians sampled in this study worked primarily with children, and the percentage of respondents who saw adult perpetrators in their practices was relatively low. Had respondents seen a larger number of clients who were alleged perpetrators, a stronger comparison could have been made between positive and negative cases with regard to who the client in treatment was, and the result may have been significant. Alternatively, who the client in treatment is may not be relevant; rather, it may be the level of trust that the client (victim or perpetrator) has in the clinician, as well as the amount of support that the client feels from the clinician throughout the reporting process that is important, as suggested by previous research (Kobocow et al., 1983; McGuire et al., 1985; Slovenko,

1976).

Results of the present study do indicate that trust between client and clinician is essential to the maintenance of a therapeutic relationship following a mandatory child abuse report. Respondents indicated that the client's trust in them following the report was the most important factor in their feeling that the effect of the report on the relationship was positive. Similarly, respondents indicated that the client's lack of trust in them following a report was one of the most important factors in their feeling that the effect of the report on the relationship was negative. In positive cases, clinicians perceived that clients were more supportive of the report being made, and also perceived that clients had more positive initial reactions to the report compared to negative cases. This difference is likely a function of the higher level of trust that existed between client and clinician prior to the report in positive cases.

Because trust appears to be such a significant factor in maintaining a positive therapeutic relationship following a mandatory child abuse report, it is important to identify ways that clinicians create a sense of trust with their clients and maintain it throughout the reporting process. The discussion of limits to confidentiality is important in this regard. Results of this study indicated that nearly all clinicians discussed limits to confidentiality with

their clients, which is in contrast to previous research which suggested that a significant number of clinicians did not discuss limits to confidentiality with clients (Baird & Rupert, 1987; Somberg et al., 1993). It was predicted that the discussion of limits to confidentiality would be more likely to occur at the outset of treatment in positive cases, and at the time of the report in negative cases. This hypothesis was not supported; nearly all clinicians verbally discussed limits to confidentiality at the outset of treatment, and again at the time of the report, which again differs from previous research. This change in clinicians' practices with regard to discussing limits to confidentiality is promising, as Nicolai and Scott (1994) suggested that when limits to confidentiality, including clinicians' mandate to report suspected child abuse, are discussed at the outset of treatment, clinicians are often more comfortable reporting later on. This change in practice may reflect clinicians' closer adherence to the requirements regarding this issue that are outlined in the Ethical Principles of Psychologists and Code of Conduct (APA, 1992).

Another factor that may be related to maintaining client trust is the amount of careful consideration that clinicians engage in prior to making a report. Clearly, the decision to report suspected child abuse is not made lightly. Although there were some differences in the

between-subjects analyses compared with the within-subjects analyses with respect to the type of consultation sought, overall results indicated that in a high percentage of cases, clinicians sought some form of consultation prior to making a report. Most often, in positive as well as negative cases, clinicians sought consultation from a colleague. In negative cases, within-subjects analyses indicated that clinicians were more likely to consult other sources, including attorneys, the ethical principles, and treatment teams, than in positive cases. Although more types of consultation were associated with negative cases, this does not necessarily indicate that the consultation had a negative effect on the case. It may be that the cases in which the report was perceived to have had a negative effect on the therapeutic relationship were more complicated than cases in which the report was perceived to have had a positive effect on the therapeutic relationship, and thus, clinicians required additional consultation. In addition, the cases in which clinicians sought additional consultation may have been the cases in which they were less confident that abuse was actually occurring.

Once the conclusion was reached that a report was necessary, clinicians in this study most often informed the client that a report would be made and then made the report in the client's presence, which is consistent with recommendations made in previous literature. Such a

procedure likely helped to maintain the client's sense of trust in the clinician. Results indicated that, as predicted, when a report was made without the client's knowledge, the report was more likely to have a negative effect on the therapeutic relationship. In such instances, the client may have felt betrayed by the clinician, and any sense of trust that he/she had in the clinician was most likely damaged.

It was predicted that if a report was made after a client had been in treatment for a relatively long period of time, the effect of the report was more likely to be positive, and if a report was made after a client had been in treatment for a relatively short period of time, the effect of the report was more likely to be negative. It was thought that if the therapeutic relationship had developed over time, the client would have more trust in the clinician, and the clinician would be in a better position to assist the client through the reporting process. This hypothesis was not supported. It appears that the level of trust between client and clinician is not determined by the length of the therapeutic relationship. This finding is encouraging, particularly as clinicians are moving to shorter treatment models as a result of managed care.

It has been suggested that a report is less likely to have a negative effect on the therapeutic relationship if the clinician assists the client throughout the reporting

process by providing him/her with information about his/her rights and the investigative process itself (Bromley & Riolo, 1988; Brosig & Kalichman, 1992b; Kelly, 1987; Powell, 1991). To do this, it has been recommended that clinicians establish more positive relationships with child protective services workers (Butz, 1985; Finlayson & Koocher, 1991). Results of the present study support these recommendations. As predicted, in cases where the report was perceived to have had a positive effect on the therapeutic relationship, clinicians reported having more positive relationships with child protective services workers, and in cases where the report was perceived to have had a negative effect on the therapeutic relationship, clinicians reported have more negative relationships with child protective services workers. It is likely that when clinicians have more positive relationships with child protective services workers, they are able to discuss cases prior to reporting, and unnecessary reports may be screened out. In addition, if a clinician has a positive relationship with a child protective services worker, the clinician is more likely to be kept informed throughout the investigative process, and will thus be in a better position to assist the client. Finally, child protective workers in positive cases may be more competent and work in more therapeutic and supportive fashions than workers in negative cases.

With regard to the immediate outcome following a report, results of this study indicated that most often, a formal investigation was begun. However, within-subjects analyses indicated that this occurred more often in positive cases than in negative cases. Legal charges, a less frequent occurrence, were also more often filed against the perpetrator in positive than in negative cases, according to between-subjects analyses. It may be that in positive cases, there was more salient evidence of abuse, resulting in clinicians being more confident that abuse was occurring. With more evidence and the strong convictions of the reporting clinician, child protective services workers may have felt more compelled to open an investigation. In addition, because positive cases were more likely to involve sexual abuse, legal charges against perpetrators may have been more likely to have been filed. The fact that some kind of action was taken in these cases may have enhanced the clinician's sense that the effect of the report was positive, and perhaps enhanced the client's sense that a report was a necessary and constructive intervention.

With regard to the overall outcome of the report, it is not surprising that in positive cases, clinicians perceived better outcomes for the child, the family, and for the cessation of abuse than in negative cases. It is important to highlight that even in cases perceived as negative, a majority of respondents indicated that the report had a

positive effect on the cessation of abuse. In addition, in negative cases, the report did not always have a detrimental impact on the outcome for the child or family, and sometimes even had a positive effect. This finding is encouraging because it suggests that even if the report negatively affects the therapeutic relationship, it can have a positive impact on other areas of clients' lives.

Impact of Positive versus Negative Reporting Experiences

As previously found, a clinician's reporting experiences can influence his/her subsequent willingness to report (Kalichman et al., 1989). Results of the present study indicated that in positive cases, clinicians were more willing to report in the future, whereas in negative cases, clinicians indicated that they would be less likely to report in the future. Despite their hesitancy to report following a negative reporting experience, clinicians seemed aware that the manner in which a report was made could impact the effect that the report had on the therapeutic relationship. Between-subjects analyses indicated that more clinicians changed their reporting procedures following negative cases. The changes they made, including thoroughly discussing limits to confidentiality at the outset of treatment, informing the client prior to the report, involving the client in the reporting process, consulting with someone before reporting, and developing better relationships with child protective service workers, which

are consistent with recommendations made in the literature, would likely foster client trust and increase the likelihood that the report would have a positive effect on the therapeutic relationship. Thus, findings suggest that despite having some negative reporting experiences, clinicians appear committed to finding ways of fulfilling their obligations as mandatory reporters that maintain the therapeutic relationship.

Clinician Characteristics

Previous research has shown mixed results with regard to the relationship between clinician characteristics and the likelihood of reporting abuse. In the present study, however, it was predicted that clinician characteristics would relate to reporting experiences. Specifically, clinicians who indicated having a higher proportion of positive cases than negative cases would have more years of experience than clinicians who indicated having a higher proportion of negative cases than positive cases. It was thought that with more years of experience, clinicians would learn more effective ways of reporting that would increase the likelihood that the effect of the report on the therapeutic relationship would be positive. This hypothesis was not supported. Clinicians with a higher proportion of positive than negative cases did not have more years of experience. It is likely that over time, as the number of positive cases the clinician experiences increases, so does

the number of negative cases, despite the clinician's added skill.

Rather than experience per se, results highlight the importance of training. As predicted, clinicians who indicated having a higher proportion of positive cases than negative cases had more high-quality training in child abuse assessment, reporting, and treatment than clinicians who indicated having a higher proportion of negative cases than positive cases. Such training likely facilitated the clinician's ability to maintain the therapeutic relationship throughout the reporting process.

Limitations and Directions for Future Research

Several limitations of this study should be noted. With regard to the sample, the response rate (29%) was somewhat low, compared to other survey research (Brosig & Kalichman, 1992a; Kalichman & Brosig, 1992), thus potentially limiting the representativeness of the participants as well as the generalizibility of the findings. However, this response rate may be lower than previous studies in part, due to the fact that previous studies included clinicians in academia, who may have had more time and interest in participating in research, whereas the current study targeted psychologists who worked primarily in clinical settings.

It appears that the clinicians who returned the survey may be more concerned and more sensitive to issues related

to child abuse than other clinicians, as they were highly experienced and well trained in the area of child abuse. They also practiced recommended procedures regarding informing clients of the limits of confidentiality and reporting child abuse. This reduced range of variability, particularly in terms of procedural factors, may have impacted the analyses, in that it may have been more difficult to detect differences in positive and negative cases. However, given that some analyses were significant despite the reduced range of variability, future research is warranted to explore these issues more thoroughly.

In addition to the limited representativeness of the sample, because respondents were asked to answer questions based on a case where reporting had the most positive effect on the therapeutic relationship and a case where reporting had the most negative effect on the therapeutic relationship, it is unclear whether these responses are representative of what happens in more typical, less extreme cases. Furthermore, because respondents only answered questions regarding positive or negative cases, no data were gathered regarding cases in which the report was perceived to have had no effect on the therapeutic relationship. In addition, because participants provided retrospective data, the detailed information that they recalled about cases may not have been completely accurate.

Finally, responses were provided in a multiple choice

format, which limits the amount of information that can be gained. Results of this study offer initial insights in terms of important factors such as consulting with colleagues, receiving training in child abuse, and building positive relationships with child protective service workers. Results also highlight the need to discuss limits of confidentiality with clients and the importance of informing clients if a report needs to be made. Although clinicians indicated that maintaining trust between themselves and their clients was critical in terms of the effect of a child abuse report being positive, it is unclear just how clinicians go about creating and maintaining this sense of trust. Future research, using more open-ended questions in a semi-structured interview format, would allow for the gathering of richer descriptions of effective reporting procedures and other ways of maintaining trust while making reports.

Summary and Conclusions

Overall, the findings of the present study have important implications for clinical practice. Results indicate that reporting suspected child abuse does not necessarily have adverse effects on the therapeutic relationship, and often has a positive impact on the child, the family, and the cessation of abuse. If clinicians are made aware of this, they may be more willing to report in the future, thus potentially resulting in more abused

children being identified and protected from further abuse.

Results further indicate that the manner in which the report is made is important. Although reporting guidelines, including discussing limits to confidentiality at the outset of treatment, informing the client of the report and involving them in the reporting process, and establishing positive relationships with child protective services workers have been suggested previously, there has been no empirical support for these recommendations until now. Results of the present study indicate that these procedures were more likely to be used in cases where the effect of the report on the therapeutic relationship was perceived as positive. Thus, if clinicians were trained according to these guidelines, it is likely that there would be more cases in which reporting had positive effects. Specialized training for clinicians in the areas of abuse assessment, treatment, and reporting is certainly important, and is likely to further increase the likelihood that the effect of a child abuse report will be positive.

Finally, results of the present study indicate that above all, what appears to be the most important factor in determining whether the effect of a report will be positive or negative, is the level of trust between client and clinician. If the clinician is able to create a sense of trust in the client from the beginning of the relationship, and works to maintain it throughout the reporting process,

the therapeutic relationship is less likely to be damaged, and the overall outcome of the case is more likely to be positive.

APPENDIX A

COVER LETTER

APPENDIX A

COVER LETTER

Dear Psychologist:

I am a graduate student in clinical child psychology who needs your help to conduct dissertation research about a sensitive and important professional practice issue. If you choose to participate, you will be asked to answer questions about your experiences of reporting suspected child abuse. The survey is divided into two sections. In Section I, I will ask you to provide some general background information about yourself. In Section II, I will ask you questions about specific cases in which you have reported suspected abuse. Specifically, in Part A, I will ask you to think of one case where reporting had a positive effect on the therapeutic relationship and to answer questions about this one positive case. In Part B, I will then ask you to think of one case where reporting had a negative effect on the therapeutic relationship and to respond to questions about this one negative case.

Depending on your experiences in reporting child abuse, there may be certain questions that you will not need to answer. However, I ask that you read the entire survey carefully and complete all questions as directed. Begin with page one and proceed one page at a time. All information you provide is anonymous and confidential. **DO NOT PUT ANY IDENTIFYING INFORMATION ON THE SURVEY.**

Please return the survey in one of the enclosed self-addressed stamped envelopes. If you would like to receive the results of this survey, please fill out the enclosed coupon on the bottom of this page, detach it from the page, and mail it **SEPARATELY FROM THE SURVEY** in the other enclosed envelope.

Any future correspondence may be addressed to Cheryl L. Brosig, M.A., Psychology Department, Loyola University Chicago, 6525 North Sheridan Road, Chicago, IL, 60626.

Thank you for your time.

Sincerely,

Cheryl L. Brosig, M.A.
Clinical Psychology
Graduate Student

Patricia A. Rupert, Ph.D.
Dissertation Supervisor

I would like to receive the results of this survey. Please send them to: _____

_____

_____

_____

_____

_____

_____

_____

APPENDIX B

SURVEY

APPENDIX B

SURVEY

This survey is composed of two sections. Depending upon your experiences, you may be asked to answer all questions in each section or just some of them. Please follow the directions carefully in each section.

SECTION I: GENERAL BACKGROUND

Please answer the following questions about yourself.

1. Please check your gender. ____ Male ____ Female

2. What is your age? _____ years
3. Please list your ethnic background: _____

4. Please check your highest degree earned.
____ Ph.D. ____ Ed.D. ____ Psy.D. ____ MA/MS
____ BA/BS ____ Other _____

5. In what year did you earn your degree? _____

6. How would you describe your therapeutic orientation? Please check one.
___ Systems ___ Psychodynamic ___ Humanistic ___ Cognitive
___ Behavioral ___ Other _____

7. Where are you primarily employed? Please check one.
___ Academic institution ___ Medical facility ___ Psychiatric hospital ___ Private practice
___ School system ___ Outpatient Mental Health Clinic ___ Other _____

8. How many hours per week do you conduct therapy?_____

9a. Of the clients you see, what percentage are children?
_____% b. What percentage are adults? _____%

10. Have you been trained in the assessment of child abuse? Check all that apply.
___ Graduate School ___ Intern-ship ___ Work-shops ___ Continuing Education
___ Other ___ None

11. How would you rate the quality of your training in the assessment of child abuse? Please check.
___ Very Good ___ Good ___ Fair ___ Poor ___ Very Poor

12. Have you been trained in the treatment of child abuse? Check all that apply.

___ Graduate School	___ Internship	___ Workshops	___ Continuing Education
___ Other	___ None		

13. How would you rate the quality of your training in the treatment of child abuse? Please check.

___ Very Good ___ Good ___ Fair ___ Poor ___ Very Poor

14. Have you been trained in how to report child abuse? Check all that apply.

___ Graduate School	___ Internship	___ Workshops	___ Continuing Education
___ Other	___ None		

15. How would you rate the quality of your training in the reporting of child abuse? Please check.

___ Very Good ___ Good ___ Fair ___ Poor ___ Very Poor

16. Approximately how many cases have you worked with where you reported child abuse? Please specify the number of reports made when working with each of the following types of clients.

____ Child victim	____ Suspected abuser	____ Child victim and suspected abuser
____ Other (please list: _____)		

17. Approximately how many cases have you worked with where you suspected abuse but decided <u>NOT</u> to report? Please specify the number of reports made when working with each of the following types of clients.

____ Child victim	____ Suspected abuser	____ Child victim and suspected abuser
____ Other (please list: _____)		

SECTION II: PART A -- POSITIVE IMPACT ON THE THERAPEUTIC RELATIONSHIP

1. Have you ever reported a case of suspected child abuse during the course of therapy where you felt that reporting had a POSITIVE effect on the therapeutic relationship?
___ Yes ___ No

2a. If Yes, in approximately what percentage of the cases when you reported abuse did child abuse reports have a POSITIVE effect on the therapeutic relationship? _____%
b. How many cases is this? _____ cases

If you answered Yes to the above question, please complete the following section and then proceed to PART B on page 7. If you answered No, please skip to PART B of this section on page 7.

Think about THE ONE CASE where you felt reporting had the MOST POSITIVE EFFECT ON THE THERAPEUTIC RELATIONSHIP. Please answer the following questions regarding this one case.

3. a) How old was the victim? _____ years
b) What was the gender of the victim? ____ M ____ F
c) How old was the abuser? _____ years
d) What was the gender of the abuser? ____ M ____ F
e) What type of abuse occurred: (check all that apply):
____ physical ____ sexual ____ emotional ____ neglect
f) Was abuse a single occurrence or ongoing?_____
If ongoing, how long did it last? _____
g) How was the abuser related to the victim? The abuser was a(n): (please check)
____ parent ____ sibling ____ extended family member
____ trusted acquaintance ____ stranger

4. How long had you been in practice when you made this report? _____

5. Who was/were the client(s) in this case? (please check)
Child victim ____ Abuser ____ victim and abuser ____ Other:_____

6. For approximately how many sessions had you been seeing the client(s) when the report was made?____ sessions

7. What led you to suspect that abuse was occurring? Check all that apply.
___● Physical evidence ____ Emotional indicators
____ Verbal account (victim) ____ Verbal account (abuser)
____ Verbal account (other family member)
____ Other: _____

8. How confident were you that abuse was occurring? Please check.

____ Extremely confident ____ Very confident
____ Somewhat confident ____ Not confident

Please keep this "POSITIVE OUTCOME" CASE in mind as you answer the remaining questions in this section.

9. In this case, how important were the following in your feeling that the effect on the relationship with the client(s) you indicated above was POSITIVE?

Extremely Important	Very Important	Somewhat Important	Not Important
1	2	3	4
a. Client's interest in continuing therapy			
1	2	3	4
b. Client's effort to change after report			
1	2	3	4
c. Client's attitude toward therapy after report			
1	2	3	4
d. Client's willingness to self-disclose after report			
1	2	3	4
e. Client's trust in you after report			
1	2	3	4
f. Other (please list):_____			
1	2	3	4

10. Did you consult with anyone/anything before making the report? Check all that apply.

____ Abuse hotline ____ Colleague ____ Supervisor
____ Attorney ____ State law ____ Ethical Principles
____ Treatment team ____ Child abuse literature
____ Other:_____

11. Were limits to confidentiality discussed? ___ Yes ___ No
If Yes, when were they discussed? Please check.

____ At the outset of treatment as part of informed consent procedure
____ At the time of the report
____ At other times during therapy
____ Other:_____

12. If limits to confidentiality were discussed as part of informed consent, how was this done? Please check.

____ In written format ____ Verbal discussion
____ Videotape ____ Other _____

13. Please check the procedure used to make the report.
____ I made report without client(s)' knowledge.
____ I made report with client(s)' knowledge, but not in client(s)' presence
____ I made report with client(s)' knowledge, in client(s)' presence
____ Client(s) made report in my presence
____ Client(s) made report, not in my presence
____ Other:_____

14. How supportive or resistant was/were the client(s) to a report being made?
____ Very supportive ____ Somewhat supportive ____ Neutral
____ Somewhat resistant ____ Very resistant

15. What was the client(s)' initial reaction to the report? Please check.
____ Very positive ____ Somewhat positive ____ Neutral
____ Somewhat negative ____ Very negative

16. Please rate the level of trust between you and the client(s) prior to the report. Please check.
____ Extreme trust ____ Moderate trust ____ Neutral
____ Moderate distrust ____ Extreme distrust

17. Please rate the level of trust between you and the client(s) following the report. Please check.
____ Extreme trust ____ Moderate trust ____ Neutral
____ Moderate distrust ____ Extreme distrust

18. What was the immediate outcome following the report? Check all that apply.
____ Report was not accepted
____ Report was logged, but not formally investigated
____ Formal investigation was begun
____ Child was removed from the home
____ Legal charges were filed against the perpetrator

19. What effect did the report have on the following factors? Please circle the appropriate numbers.

	Very Positive	Somewhat Positive	No Effect	Somewhat Negative	Very Negative
a. The overall outcome for the child	1	2	3	4	5
b. The overall outcome for the family	1	2	3	4	5
c. The cessation of abuse	1	2	3	4	5

20. Describe the quality of your experience with Child Protective Services in this case. Please check.
____ Very good ____ Good ____ Fair ____ Poor ____ Very poor

21. How did your experience in this case influence your subsequent willingness to report? Please check.
____ Made me much more willing
____ Made me somewhat more willing
____ No change
____ Made me somewhat less willing
____ Made me much less willing

22. Did you change your reporting procedure in subsequent cases due to your experience in this case? ___ **Yes** ___ **No**
If Yes, how did it change? _____
_____

23. Did you change your procedure for discussing limits to confidentiality based on your experience in this case?
___ **Yes** ___ **No**
If Yes, how did it change? _____
_____

SECTION II: PART B -- NEGATIVE IMPACT ON THE THERAPEUTIC RELATIONSHIP

1. Have you ever reported a case of suspected child abuse during the course of therapy where you felt that reporting had a NEGATIVE effect on the therapeutic relationship?
___ Yes ___ No

2a. If Yes, in approximately what percentage of the cases when you reported abuse did child abuse reports have a NEGATIVE effect on the therapeutic relationship? _____%
b. How many cases is this? _____ cases

If you answered Yes to the above question, please complete the following section. If you answered No, you have completed the survey. Please return it in one of the postage-paid envelopes.

Think about THE ONE CASE where you felt reporting had the MOST NEGATIVE EFFECT ON THE THERAPEUTIC RELATIONSHIP. Please answer the following questions regarding this one case.

3. a) How old was the victim? _____ years
b) What was the gender of the victim? ____ M ____ F
c) How old was the abuser? _____ years
d) What was the gender of the abuser? ____ M ____ F
e) What type of abuse occurred: (check all that apply):
____ physical ____ sexual ____ emotional ____ neglect
f) Was abuse a single occurrence or ongoing?_____
If ongoing, how long did it last?_____
g) How was the abuser related to the victim? The abuser was a(n): (please check)
____ parent ____ sibling ____ extended family member
____ trusted acquaintance ____ stranger

4. How long had you been in practice when you made this report? _____

5. Who was/were the client(s) in this case? (please check)
Child victim ____ Abuser victim ____ and abuser ____ Other:_____

6. For approximately how many sessions had you been seeing the client(s) when the report was made?____ sessions

7. What led you to suspect that abuse was occurring? Check all that apply.
____ Physical evidence ____ Emotional indicators
____ Verbal account (victim) ____ Verbal account (abuser)
____ Verbal account (other family member)
____ Other: _____

8. How confident were you that abuse was occurring? Please check.

____ Extremely confident ____ Very confident
____ Somewhat confident ____ Not confident

Please keep this "NEGATIVE OUTCOME" CASE in mind as you answer the remaining questions in this section.

9. In this case, how important were the following in your feeling that the effect on the relationship with the client(s) you indicated above was NEGATIVE?

Extremely Important	Very Important	Somewhat Important	Not Important
1	2	3	4

a. Client's interest in continuing therapy
1 2 3 4

b. Client's effort to change after report
1 2 3 4

c. Client's attitude toward therapy after report
1 2 3 4

d. Client's willingness to self-disclose after report
1 2 3 4

e. Client's trust in you after report
1 2 3 4

f. Other (please list):_____
1 2 3 4

10. Did you consult with anyone/anything before making the report? Check all that apply.

____ Abuse hotline ____ Colleague ____ Supervisor
____ Attorney ____ State law ____ Ethical Principles
____ Treatment team ____ Child abuse literature
____ Other:_____

11. Were limits to confidentiality discussed? ___ Yes ___ No
If Yes, when were they discussed? Please check.

____ At the outset of treatment as part of informed consent procedure
____ At the time of the report
____ At other times during therapy
____ Other:_____

12. If limits to confidentiality were discussed as part of informed consent, how was this done? Please check.

____ In written format ____ Verbal discussion
____ Videotape ____ Other _____

13. Please check the procedure used to make the report.
____ I made report without client(s)' knowledge.
____ I made report with client(s)' knowledge, but not in client(s)' presence
____ I made report with client(s)' knowledge, in client(s)' presence
____ Client(s) made report in my presence
____ Client(s) made report, not in my presence
____ Other:_____

14. How supportive or resistant was/were the client(s) to a report being made?
____ Very supportive ____ Somewhat supportive ____ Neutral
____ Somewhat resistant ____ Very resistant

15. What was the client(s)' initial reaction to the report? Please check.
____ Very positive ____ Somewhat positive ____ Neutral
____ Somewhat negative ____ Very negative

16. Please rate the level of trust between you and the client(s) prior to the report. Please check.
____ Extreme trust ____ Moderate trust ____ Neutral
____ Moderate distrust ____ Extreme distrust

17. Please rate the level of trust between you and the client(s) following the report. Please check.
____ Extreme trust ____ Moderate trust ____ Neutral
____ Moderate distrust ____ Extreme distrust

18. What was the immediate outcome following the report? Check all that apply.
____ Report was not accepted
____ Report was logged, but not formally investigated
____ Formal investigation was begun
____ Child was removed from the home
____ Legal charges were filed against the perpetrator

19. What effect did the report have on the following factors? Please circle the appropriate numbers.

Very Positive	Somewhat Positive	No Effect	Somewhat Negative	Very Negative
1	2	3	4	5

a. The overall outcome for the child
1 2 3 4 5

b. The overall outcome for the family
1 2 3 4 5

c. The cessation of abuse
1 2 3 4 5

20. Describe the quality of your experience with Child Protective Services in this case. Please check.
____ Very good ____ Good ____ Fair ____ Poor ____ Very poor

21. How did your experience in this case influence your subsequent willingness to report? Please check.
____ Made me much more willing
____ Made me somewhat more willing
____ No change
____ Made me somewhat less willing
____ Made me much less willing

22. Did you change your reporting procedure in subsequent cases due to your experience in this case? ___ **Yes** ___ **No**
If Yes, how did it change? _____
_____

23. Did you change your procedure for discussing limits to confidentiality based on your experience in this case?
___ **Yes** ___ **No**
If Yes, how did it change? _____
_____

YOU HAVE COMPLETED THE SURVEY. PLEASE RETURN IT IN ONE OF THE ENCLOSED POSTAGE-PAID ENVELOPES. THANK YOU FOR PARTICIPATING!!

REFERENCES

American Psychological Association (1992). Ethical principles of psychologists and code of conduct. American Psychologist, 47, 1597-1611.

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

Baird, K.A., & Rupert, P.A. (1987). Clinical management of confidentiality: A survey of psychologists in seven states. Professional Psychology: Research and Practice, 18, 347-352.

Barksdale, C. (1989). Child abuse reporting: A clinical dilemma? Smith College Studies in Social Work, 59, 170-182.

Berger, D.K., Rolon, Y., Sachs, J., & Wilson, B. (1989). Child abuse and neglect: An instrument to assist with case referral decision making. Health and Social Work, 14, 60-73.

Berlin, F.S., Malin, H.M., & Dean, S. (1991). Effects of statutes requiring psychiatrists to report suspected sexual abuse of children. American Journal of Psychiatry, 148, 449-453.

Bersoff, D.N. (1976). Therapists as protectors and policemen: New roles as a result of Tarasoff. Professional Psychology, 7, 267-273.

Besharov, D. (1991). Child abuse and neglect reporting and investigations: Policy guidelines for decision making. Child and Youth Services, 15, 35-50.

Bray, J.E., Shepherd, J.N., & Hays, J.R. (1985). Legal and ethical issues in informed consent to psychotherapy. American Journal of Family Therapy, 13, 50-60.

Bromley, M.A., & Riolo, J.A. (1988). Complying with mandated child protective reporting: A challenge for treatment professionals. Alcoholism Treatment Quarterly, 5, 83-96.

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: The Journal of Contemporary Social Work, 66, 83-90.

Camblin, L.D., & Prout, H.T. (1983). School Counselors and the reporting of child abuse: A survey of state laws and practices. School Counselor, 30, 358-367.

Carlson, R.J., Friedman, L.C., & Riggert, S.C. (1987). The duty to warn/protect: Issues in clinical practice.

Bulletin of the American Academy of Psychiatry and the Law, 15, 179-186.

Chamberlain, M., Krell, H., & Preis, K. (1982). Legal aspects of child abuse and child neglect. American Journal of Forensic Psychiatry, 3, 151-158.

Daro, D., & McCurdy, K. (1992). Current trends in child abuse reporting and fatalities: The results of the 1991 annual fifty state survey. Washington, DC: National Committee for the Prevention of Child Abuse.

Davidson, H. (1988). Failure to report child abuse: Legal penalties and emerging issues. Sexual Medicine, 9, 93-102.

DeKraai, M.B., & Sales, B.D. (1982). Privileged communications of psychotherapists. Professional Psychology, 13, 372-388.

DeKraai, M.B., & Sales, B.D. (1984). Confidential communications of psychotherapists. Psychotherapy, 21, 293-317.

Denkowski, K.M., & Denkowski, G.C. (1982). Client-counselor confidentiality: An update of rationale, legal status, and implications. Personnel and Guidance Journal, 60, 371-75.

Denton, L. (1987, October). Michigan child report law ruled unconstitutional. APA Monitor, 18, 23.

Derlega, V.J., Margulis, S.T., & Winstead, B.A. (1987). A social-psychological analysis of self-disclosure in

psychotherapy. Journal of Social and Clinical Psychology, 5, 205-215.

Dubey, J. (1974). Confidentiality as a requirement of the therapist: Technical necessities for absolute privilege in psychotherapy. American Journal of Psychiatry, 131, 1093-1096.

Eckenrode, J., Powers, J., Doris, J., Munsch, J., & Bolger, N. (1988). Substantiation of child abuse and neglect reports. Journal of Consulting and Clinical Psychology, 56, 9-16.

Everstine, L., Everstine, D.S., Heymann, G.M., True, R.H., Frey, D.H., Johnson, H.G., & Seiden, R.H. (1980). Privacy and confidentiality in psychotherapy. American Psychologist, 35, 828-840.

Finkelhor, D., & Zellman, G.L. (1991). Flexible reporting options for skilled child abuse professionals. Child Abuse and 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.

Garbarino, J. (1988). Ethical obstacles to professional reporting of child maltreatment. In A. Maney & S. Wells (Eds.), Professional responsibilities in protecting children: A public health approach to child sexual abuse (pp.45-53). New York: Praeger.

Gray, A. (1987, August). North Carolina experience. In

L. Pantano (Chair), Duty to warn, protect, and report: Criminal and civil implications. Symposium conducted at the 95th Annual Convention of the American Psychological Association, New York.

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

Guyer, M.J. (1982). Child abuse and neglect statutes: Legal and clinical implications. American Journal of Orthopsychiatry, 52, 73-81.

Haas, L.J., Malouf, J.L., & Mayerson, N.H. (1986). Ethical dilemmas in a psychological practice: Results of a national survey. Professional Psychology: Research and Practice, 17, 316-321.

Haas, L.J., Malouf, J.L., & Mayerson, N.H. (1988). Personal and professional characteristics as factors in psychologists' ethical decision making. Professional Psychology: Research and Practice, 19, 35-42.

Harper, G., & Irvin, E. (1985). Alliance formation with parents: Limit setting and the effect of mandated reporting. American Journal of Orthopsychiatry, 55, 550-560.

Haut, M.W., & Muehleman, T. (1986). Informed consent: The effects of clarity and specificity on disclosure in a clinical situation. Psychotherapy, 23, 93-101.

Heymann, G.M. (1988). Mandated child abuse reporting and the confidentiality privilege. In L. Everstine & D.S.

Everstine (Eds.), Psychotherapy and the Law (pp. 145-155). Orlando, FL: Grune & Stratton.

Jagim, R., Wittman, W., & Noll, J. (1978). Mental health professionals' attitudes toward confidentiality, privilege, and third-party disclosure. Professional Psychology, 9, 458-466.

Jones, J., & Welch, B. (1989). Mandatory reporting of child abuse: Problems and proposals for solutions. In L. Walker, J. Alpert, E. Harris, & G. Koocher (Eds.), Report to the APA Board of Directors from the Ad Hoc Committee on Child Abuse Policy. Washington, DC: American Psychological Association.

Kalichman, S.C., & Brosig, C.L. (1992). The effects of child abuse reporting laws on psychologists' reporting behavior: A comparison of two state statutes. American Journal of Orthopsychiatry, 62, 284-296.

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 abuse: Clinician and situation influences. Professional Psychology: Research and Practice, 22, 84-89.

Kalichman, S.C., Craig, M.E., & Follingstad, D. (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. (1990). Professionals' adherence to mandatory child abuse reporting laws: Effects of responsibility attribution, confidence ratings, and situational factors. Child Abuse and Neglect, 14, 68-77.

Kaplan, M.S., Abel, G.G., Cunningham-Rathner, J., & Mittleman, M.S. (1990). The impact of parolees' perception of confidentiality of their self-reported sex crimes. Annals of Sex Research, 3, 293-303.

Kelly, R.J. (1987). Limited confidentiality and the pedophile. Hospital and Community Psychiatry, 38, 1046-1048.

Kobocow, B., McGuire, J.M., & Blau, B.I. (1983). The influence of confidentiality conditions on self-disclosure of early adolescents. Professional Psychology: Research and Practice, 14, 436-43.

Leong, G.B., Silva, J.A., & Weinstock, R. (1988). Ethical considerations of clinical use of Miranda-like warnings. Psychiatric Quarterly, 59, 293-305.

Levine, M., & Doherty, E. (1991). The fifth amendment and therapeutic requirements to admit abuse. Criminal Justice and Behavior, 18, 98-112.

Mappes, D.C., Robb, G.P., & Engels, D.W. (1985). Conflicts between ethics and law in counseling and psychotherapy. Journal of Counseling and Development, 64, 246-252.

McGuire, J.M. (1974). Confidentiality and the child in psychotherapy. Professional Psychology, 5, 374-379.

McGuire, J.M., Graves, S., & Blau, B. (1985). Depth of self-disclosure as a function of assured confidentiality and videotape recording. Journal of Counseling and Development, 64, 259-263.

McGuire, J.M., Toal, P., & Blau, B. (1985). The adult client's conception of confidentiality in the therapeutic relationship. Professional Psychology: Research and Practice, 16, 375-384.

Meddin, B.J., & Hansen, I. (1985). The services provided during a child abuse and/or neglect case investigation and the barriers that exist to service provision. Child Abuse and Neglect, 9, 175-182.

Melton, G.B., & Limber, S. (1989). Psychologists' involvement in cases of child maltreatment: Limits of role and expertise. American Psychologist, 44, 1225-1233.

Merluzzi, T.V., & Brischetto, C.S. (1983). Breach of confidentiality and perceived trustworthiness of counselors. Journal of Counseling Psychology, 30, 245-251.

Miller, D.J., & Thelan, M.H. (1986). Knowledge and beliefs about confidentiality in psychotherapy. Professional Psychology: Research and Practice, 17, 15-17.

Miller, D.J., & Thelan, M.H. (1987). Confidentiality in psychotherapy: History, issues and research. Psychotherapy, 24, 704-711.

Miller, R.D., & Weinstock, R. (1987). Conflict of interest between therapist-patient confidentiality and the duty to report sexual abuse of children. Behavioral Sciences and the Law, 5, 161-174.

Muehleman, T., & Kimmons, C. (1981). Psychologists' views on child abuse reporting, confidentiality, life, and the law: An exploratory study. Professional Psychology, 12, 631-638.

Muehleman, T., Pickens, B.K., & Robinson, F. (1985). Informing clients about the limits to confidentiality, risks, and their rights: Is self-disclosure inhibited? Professional Psychology: Research and Practice, 16, 385-397.

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

Newman, R. (1987). The psychotherapist's duty to report child abuse and the legislature's duty to strike a better balance. Unpublished manuscript.

Ney, P.G., & Herron, J.L. (1985). Mandatory reporting of child abuse. Community Mental Health in New Zealand, 1, 32-43.

Nicolai, K.M., & Scott, N.A. (1994). Provision of confidentiality information and its relation to child abuse reporting. Professional Psychology: Research and Practice, 25, 154-160.

Nightingale, N., & Walker, E. (1986). Identification

and reporting of child maltreatment by Head Start personnel: Attitudes and experiences. Child Abuse and Neglect, 10, 191-199.

Noll, J.O. (1976). The psychotherapist and informed consent. American Journal of Psychiatry, 133, 1451-1453.

Noll, J.O. (1981). Material risks and informed consent to psychotherapy. American Psychologist, 8, 915-916.

Pope, K.S., Tabachnick, B.G., & Keith-Speigel, P. (1987). The beliefs and behaviors of psychologists as therapists. American Psychologist, 42, 993-1006.

Powell, M.B. (1991). Investigating and reporting child sexual abuse: Review and recommendations for clinical practice. Australian Psychologist, 26, 77-83.

Priest, R., & Wilcoxon, S.A. (1988). Confidentiality and the child sexual offender: Unique challenges and dilemmas. Family Therapy, 25, 107-113.

Racusin, R.J., & Felsman, J.K. (1986). Reporting child abuse: The ethical obligation to inform parents. Journal of the American Academy of Child Psychiatry, 25, 485-489.

Rolde, E.J. (1977). Negative effects of child abuse legislation. Child Abuse and Neglect, 1, 167-171.

Rubanowitz, D.E. (1987). Public attitudes toward psychotherapist-client confidentiality. Professional Psychology: Research and Practice, 18, 613-618.

Schmid, D., Appelbaum, P.S., Roth, L.H., & Lidz, C. (1983). Confidentiality in psychiatry: A study of the

patient's view. Hospital and Community Psychiatry, 34, 353-355.

Shah, S.T. (1969). Privileged communications, confidentiality, and privacy: Privileged communications. Professional Psychology, 1, 56-69.

Shah, S.T. (1970). Privileged communications, confidentiality, and privacy: Confidentiality. Professional Psychology, 1, 159-164.

Shapiro, D. (1983). The psychologist and the potentially violent patient: Guidelines in professional practice. American Journal of Forensic Psychology, 1, 13-27.

Sherlock, R., & Murphy, W. (1984). Confidentiality and therapy: An agency perspective. Comprehensive Psychiatry, 25, 88-95.

Siegel, M. (1979). Privacy, ethics, and confidentiality. Professional Psychology, 10, 249-257.

Slovenko, R. (1976). On confidentiality. Contemporary Psychoanalysis, 12, 109-139.

Smith, S.R., & Meyer, R.G. (1984). Child abuse reporting laws and psychotherapy: A time for reconsideration. International Journal of Law and Psychiatry, 7, 351-366.

Solnit, A. (1982). Children, parents, and the state. American Journal of Orthopsychiatry, 52, 496-505.

Somberg, S.R., Stone, G.L., & Claiborn, C.D. (1993). Informed consent: Therapists' beliefs and practices.

Professional Psychology: Research and Practice, 24, 153-159.

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

Sullivan, T., Martin, W.L., Jr., & Handelsman, M.M. (1993). Practical benefits of an informed-consent procedure: An empirical investigation. Professional Psychology: Research and Practice, 24, 160-163.

Swoboda, J.S., Elwork, A., Sales, B.D., & Levine, D. (1978). Knowledge of and compliance with privileged communication and child abuse reporting laws. Professional Psychology, 9, 448-457.

Taube, D.O., & Elwork, A. (1990). Researching the effects of confidentiality law on patients' self-disclosures. Professional Psychology: Research and Practice, 21, 72-75.

Watkins, S.A. (1989). Confidentiality: An ethical and legal conundrum for family therapists. American Journal of Family Therapy, 17, 291-302.

Watson, H., & Levine, M. (1989). Psychotherapy and mandated reporting of child abuse. American Journal of Orthopsychiatry, 59, 246-256.

Weiner, B.A. (1985). Legal issues raised in treating sex offenders. Behavioral Sciences and the Law, 3, 325-350.

Weinstock, R., & Weinstock, D. (1988). Child abuse reporting trends: An unprecedented threat to

confidentiality. Journal of Forensic Sciences, 33, 418-431.

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

Weisberg, R., & Wald, M. (1984). Confidentiality laws and state efforts to protect abused or neglected children: The need for statutory reform. Family Law Quarterly, 18, 143-212.

Wells, S.J. (1988). On the decision to report suspected child abuse or neglect. Sexual Medicine, 9, 191-202.

Wilson, C.A., & Gettinger, M. (1989). Determinants of child abuse reporting among Wisconsin school psychologists. Professional School Psychology, 4, 91-102.

Woods, K.M., & McNamara, J.R. (1980). Confidentiality: Its effect on interviewee behavior. Professional Psychology, 11, 714-721.

Wright, R.H. (1984). They did it again. Psychotherapy in Private Practice, 2, 89-95.

Youngstrom, N. (1991). Mandatory reporting deters sex treatment. APA Monitor, 22, 24-25.

Zellman, G.L. (1990a). Child abuse reporting and failure to report among mandated reporters: Prevalence, incidence and reasons. Journal of Interpersonal Violence, 5, 3-22.

Zellman, G.L. (1990b). Report decision-making patterns among mandated child abuse reporters. Child Abuse and

Neglect, 14, 325-36.

Zellman, G.L., & Antler, S. (1990). Mandated reporters and child protective services: A study in frustration. Public Welfare, 48, 30-37.

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