Mandated Child Abuse Reporting for Mental Health Professionals: An Overview

Stefan C. Dombrowski, Ph.D.
Rider University

Cite as:

Dombrowski, S. C. (2003). Mandated reporting for mental health professionals: An overview. *Directions in Mental Health Counseling, 14*, 77-88.

Child abuse and neglect is an insidious crime and tremendous social tragedy. In addition to robbing children of their dignity and placing them at great developmental disadvantage, child maltreatment produces effects that persist well into adulthood. (Cicchetti & Toth, 1995; Cicchetti, Toth, & Maughan, 2000). As a result of the deleterious and persistent nature of child maltreatment, it has been appropriately labeled "soul murder" (Shengold 1989). The New York Society for the Prevention of Cruelty to Children (1875) was the first agency in the United States to condemn child abuse and neglect. This body, however, had no legislative authority and focused most of its resources on raising awareness of two very critical issues at the end of the nineteenth century: maternal health and infant mortality. It was not until after the publication of a landmark article on the battered-child syndrome nearly a century later that mandated reporting laws were established for the protection of children (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962).

Despite the existence of mandatory reporting laws for more than three decades, mental health professionals (e.g., counselors, psychologists, social workers, and family therapists) who provide therapeutic services to children are often reluctant to report suspected child abuse (Kalichman & Brosig, 1992, 1993; Reiniger, Robison, & McHugh 1995). There are numerous reasons for this reluctance. Some of the more commonly cited reasons include the following: 1) a misunderstanding of the reporting laws; 2) a fear of making an inaccurate report; 3) a poor impression of child protective services; 3) a fear that reporting will exacerbate an already tenuous situation for the child; 4) a fear of legal retribution; 5) a fear of retaliation; 6) a belief that "proof" is needed before a report should be made; 7) a lack of understanding of the indicators of maltreatment; and 8) a

lack of understanding of the process of reporting (Dombrowski, Ahia, & McQuillan, 2003; Kalichman, 1999; Kalichman & Brosig, 1992, 1993; Kalichman & Craig, 1991; Pope & Bajt, 1988).

As a result of the harmful effects of maltreatment, failure to report suspected abuse is illegal and violates professional ethical codes (Kalichman, 1999; Myers, 1986). Children who suffer maltreatment often face difficulties with psychological, behavioral, cognitive, and academic development (Kendall-Tackett, Meyer, & Finkelhor, 1993; Lamphear, 1986; Oddone, Genuis, & Violato, 2001). Although there is an abundance of available literature on the consequences of maltreatment, there is limited coverage of the process of mandated reporting for mental health professionals. Further, mental health professionals often have not had adequate training in this area during graduate school and thereafter while working as a practitioner. Considering the adverse impact of child abuse and neglect, the complexities of child abuse reporting, and the lack of training among mental health professionals in this area, there is significant need in the literature for a discussion of the nuances of mandated reporting for the mental health professional (Pope & Feldman-Summers, 1992; Wilson & Gettinger, 1989).

This paper will attempt to fill this needed niche by discussing several important issues. First, it will provide a brief overview of the consequences of maltreatment, which serves as the basis for the legal and ethical requirement to report. Second, it will include a discussion of the conflict between the mandate to report and the mandate to preserve confidentiality. Third, it will provide an explanation of how to discuss with clients and legal guardians the feelings/thoughts that might emerge as a result of being a subject of a Child Protective Services (CPS) report. Finally, this paper will provide an overview of

the following issues related to mandated reporting: 1) who is required to report; 2) when and under what circumstances is a report required; 3) why there might be reluctance to report; and 4) what will be the response of CPS to a report.

The Reason to Report: Adverse Consequences of Child Maltreatment

The impact of child maltreatment has been well documented in the literature. Numerous literature reviews have been conducted according to abuse subtype (e.g., physical, sexual, neglect, & emotional). Although abuse is studied and categorized according to subtype, it is noted that there is often overlap among the types of maltreatment. This makes it difficult to distinguish precisely the relationship of abuse to its harmful effects. Contributing to this difficulty, children who experience abuse may manifest outcomes in different ways. Some may be profoundly impacted and severely emotionally disturbed; others may be resilient and manifest minimal disturbance (Cicchetti & Toth, 1995). Generally speaking, maltreatment is a deleterious condition from which children should be protected. Abused or neglected children often experience difficulties with psychological, behavioral, cognitive, and academic functioning (Kendall-Tackett & Eckenrode, 1996; Kendall-Tackett et al., 1993; Oddone et al., 2001). These effects do not fit into discretely packaged categories: just as there is overlap among the types of maltreatment, there is overlap among effects of abuse (Cicchetti & Toth, 1995; Oddone et al., 2001). Yet certain types of abuse may contribute to particular psychological, cognitive, and behavioral outcomes with greater frequency (Kendall-Tackett et al., 1993; Malinosky-Rummell & Hansen, 1994).

For instance, physically abused children often display high levels of externalizing behavior problems (Malinosky-Rummell & Hansen, 1994). These difficulties include

noncompliance/compulsive compliance (Crittenden & DiLalla, 1988), poor impulse control, increased tantrums, aggression, impaired peer relationships, emotional problems, and hostile intent attributions (Crick & Dodge, 1994; Crittenden & DiLalla, 1988; Lamphear, 1986; Wolfe, 1999). Physically abused children also display social incompetence, less empathy, have greater problems with substance abuse, and experience greater academic and legal difficulties (Eckenrode, Laird, & Doris, 1993). Sexually abused children, on the other hand, have a high degree of internalizing problems, self-mutilation, suicidal ideation, mood lability, and sexualized behaviors (Kendall-Tackett et al., 1993). Sexual abuse also fosters a high level of fears, posttraumatic stress disorder, depression/anxiety, and poor self-esteem (Browne & Finkelhor, 1986; Oddone et al., 2001). Child neglect, the most prevalent form of maltreatment, is the least researched. Neglected children experience some outcomes that are consistent with those experienced by physically abused children: aggression, behavior problems, and social incompetence (Lamphear, 1986). Neglected children are also at risk for mild delays in cognitive/intellectual functioning, increased school suspensions, grade repetitions, language delays, and academic difficulties (Cahill, Kaminer, & Johnson, 1999; Kendall-Tackett & Eckenrode, 1996). Child neglect receives less attention than other types of abuse and might therefore seem less horrific. The long-term consequences, however, can be just as devastating (Kendall-Tackett & Eckenrode, 1996).

Child maltreatment represents a situation that jeopardizes children's safety and potentially endangers children's lives. Accordingly, it is common for children exposed to maltreatment of any type to display symptoms characteristic of PTSD (Terr, 1991). However, there is no defined post–child abuse syndrome, making it difficult to predict

the precise outcome of maltreatment. With this caveat in mind, it can be generally stated that maltreatment of any subtype may predispose a child to significant long-term psychological, behavioral, cognitive, and academic difficulties (Cicchetti & Toth, 1995). A high percentage of adult substance abusers, inmates incarcerated for violent as well as nonviolent crimes, depressed adults, individuals attempting suicide, prostitutes, and inpatient populations have experienced some form of maltreatment (Bryant & Range, 1996; Malinosky-Rummell & Hansen, 1993; Silverman, Reinherz, & Giaconia, 1996). Thus, child maltreatment is a significant social problem with far-reaching consequences for children and society. Mental health professionals are in a unique position to protect children (and society) from this insidious condition through recognizing and then reporting maltreatment when it has been reasonably suspected (Kalichman, 1999; Slavenas, 1998; Small, Lyons, & Guy, 2002).

Who is Required to Report?

All mental health professionals are legally and ethically required to report when a reasonable suspicion threshold has been met (Foreman & Bernet, 2000; Meyers, 1986). In most states, therefore, failure to report suspected child abuse could bring legal sanctions as well as ethical charges that jeopardize professional licensure/certification (Myers, 1998). There is good reason for both the ethical and legal mandate to report when abuse has been suspected. As briefly reviewed in this paper, both the short and long term consequences of maltreatment can be devastating.

Competing Mandates: Confidentiality vs. Mandated Reporting

Along with the legal mandate to report, mental health professionals have an ethical obligation to hold in confidence what is discussed during therapy (Kalichman, 1999; Myers, 1998). The privileged nature of communication between the therapist and client is the foundation upon which therapy rests (Watkins, 1989). Thus, the mandate to report and the mandate to preserve confidentiality may often seem to conflict and cause considerable anxiety for therapists. Nonetheless, the therapist has a duty to protect that supersedes the mandate to maintain confidentiality. Reasonable suspicion of child maltreatment is one condition that falls under a duty to protect and therefore requires a therapist to break confidentiality.

At the beginning of a therapeutic relationship, therapists are ethically required to discuss the limits of confidentiality (APA, 1992; ACA Code of Ethics). This discussion fosters trust and sets the stage for therapeutic progress. Unfortunately, clients may only be furnished with a vague explanation of the limits to confidentiality with respect to mandated child abuse reporting. This lack of client understanding has the potential to harm the therapeutic process, impair trust, and distort the public's perception of the therapy in general.

Therefore, from the beginning of the therapeutic relationship, when not contraindicated, it is essential that therapists apprise clients and legal guardians of the obligation to report suspected child abuse. It is important to bear in mind that clients, regardless of age, should be informed about the duty to report. This way, both the minor and the legal guardian will be less inclined to feel a sense of betrayal should a future report be warranted (Herlithy & Corey, 1996). Within this discussion, it will be important to provide a variety of circumstances under which a therapist is required to

break confidentiality and file a CPS report. This discussion might include examples, hypothetical situations, and clarification of client questions. Some may argue that such detailed clarification may result in parental coercion directed at the child to prevent abuse disclosure or even removal of the child from the therapeutic process (Levine & Doeuck, 1995). There may be a risk in this occurring. However, it is important to be explicit about the nature of mandated reporting so that clients and their legal guardians have a clear understanding of the boundaries of the therapeutic relationship.

There is the common perception that unequivocal confidentiality is necessary to engender trust and therefore progress in therapy (Watson & Levine, 1989). This perception may have intuitive appeal, but the limited research available suggests otherwise. Research indicates that the act of filing a CPS report may be less harmful to the relationship than what is commonly perceived (Watson & Levine, 1989). In fact, some research indicates that it is the notion of trust, rather than unequivocal confidentiality, that preserves and even fosters the therapeutic relationship (Watson & Levine, 1989). This line of research even holds that trust may be preserved, if not gained, following a mandated report that is appropriately handled. Thus, it is important to notify clients and legal guardians in an explicit fashion of the duty to report. It is also essential that an allowance be made within the therapeutic context for a discussion of why the report was made and what might be expected from the mandated report.

When Reporting is Required: The Reasonable Suspicion Threshold

Many mental health professionals may have difficulty discerning what constitutes reasonable suspicion of abuse (Kalichman, 1999; Pope & Feldman-Summers, 1992; Wilson & Gettinger, 1989). As noted in the introduction, this difficulty may be related to

either a lack of experience or lack of training in child maltreatment and abuse reporting (Pope & Feldman-Summers, 1992). Mental health professionals are both ethically and legally required to become intimately familiar with the child-abuse reporting laws and requirements of their state. Each state distributes free pamphlets that contain some of this information. However, the information contained within these pamphlets is often general and does not provide a sufficient background on child maltreatment. The mandated reporting laws of most states are often ambiguous and intentionally vague. Given the high cost of maltreatment to children and society, states wish to cast a wide net attempting to capture all potential cases of maltreatment. Thus, guidelines are left intentionally vague, attempting to elicit a report when the minimal threshold of reasonable suspicion has been met (Small et al., 2002). Unfortunately, vague and ambiguous guidelines may pose problems. Quite a number of mental health professionals lack a sufficient understanding of the signs and symptoms of child maltreatment, especially what might constitute reasonable suspicion. The ability to distinguish reasonable from unreasonable suspicion is predicated upon an awareness of the indicators of child maltreatment (Dombrowski et. al., 2003). Lacking graduate training, extensive clinical experience, and post graduate exposure in this area, many mental health professionals may be ill prepared to recognize the signs of abuse and unable to navigate the nuances of child-abuse reporting (Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Wilson & Gettinger, 1989).

Although there is considerable ambiguity regarding states' reporting requirements, the laws of most states clearly specify that the legal standard for reporting entails *reasonable suspicion* of abuse (Foreman & Bernet, 2000; Kalichman, 1999; Myers,

1986). Thus, mental health professionals are legally required to report when the threshold of reasonable suspicion has been met. It is not necessary to "prove" abuse, nor should there be a trespass of professional boundaries by attempting to substantiate the probability of abuse through in-depth investigation (Kalichman, 1999).

Unfortunately, there may be significant reluctance to report suspected maltreatment (Kalichman & Brosig, 1992; Kalichman & Craig, 1991). One of the more common reasons is that mandated reporting brings about involvement of the CPS system. Some mandated reporters believe that Child Protective Services (CPS) creates more problems for the child (and the family) than it resolves (Grossoehme, 1998). Failure to report using this rationalization is illegal, ethically prohibited, and a violation of professional guidelines. Mental health professionals are cautioned that they are not afforded professional discretion and legal flexibility when a reasonable-suspicion threshold has been met (Myers, 1986; 1998). Instead, they have a duty to report. Moreover, some of the limited empirical evidence available suggests that the outcome of CPS intervention may be less deleterious than commonly perceived. Watson and Levine (1989) suggested that families who experienced CPS investigations found these investigations to be generally positive rather than intrusive. Overall, mental health professionals should not hesitate filing a report when maltreatment has been suspected. Mental health professionals are also cautioned to avoid haste in reporting when the indicators of abuse seem unreasonable or based solely on biased third-party account. It is therefore important to understand those factors (or indicators) that give rise to reasonable suspicion of abuse. Mental health professionals who have had specialized training providing

services to maltreated children may have a different conception of reasonable suspicion than someone who has not benefited from such experience or training.

Indicators of Maltreatment

As a general rule, the greater the combination of signs of maltreatment, the more likely a reasonable suspicion threshold may have been met (Dombrowski et. al, 2003). Contributing to difficulty in discerning when a reasonable threshold has been met, child maltreatment and its associated effects do not necessarily fit into discrete categories. There is often overlap among the types (i.e., physical or sexual) and indicators (i.e., sexualized behavior or antisocial behavior) of maltreatment (Wolfe, 1999). Thus, the existence of indicators of abuse does not bear a linear relationship with maltreatment. Furthermore, there are often cultural differences that might be misinterpreted as potentially abusive (Merali, 2002; Sue & Sue, 1999). These cultural factors must be considered, but they do not eliminate one's legal and ethical obligation to report when maltreatment has been reasonably suspected. Just because a parenting practice is generally accepted in a different culture does not justify failure to report when a reasonable suspicion threshold has been met. Finally, maltreated children often recant stories of abuse (Perlis, 1999; Sorenson & Snow, 1991). This sometimes contributes to hesitancy in filing a CPS report (Zellman, 1992). Despite the propensity of children to recant stories of abuse, follow-up investigations often substantiate the disclosure of abuse (Jones and McGraw 1987). In fact, one study indicates that fewer than 10 percent of children who report abuse make false allegations (Everson & Boat, 1989). Therefore, mental health professionals should not be dissuaded from making a report when a child

recants his or her allegation of maltreatment. To facilitate understanding of this complex topic, it is important to discuss some of the potential indicators of abuse according to subtype.

Indicators of Physical Abuse

Some signs of physical abuse are more directly observed while others are subtle. The more obvious signs include bruise marks, scratches, welts, lacerations, swollen limbs, marks from belts, and verbal disclosure of abuse. Across many states, physical discipline that is intense enough to leave a mark, cut, or bruise generally meets the threshold for reasonable suspicion (Kuest & Winter, 2000; Myer, 1986). When asked about these marks or bruises, physically abusive individuals may claim that the marks or bruises were the result of the child falling or slipping. This is a common and possible explanation; however, it is important to bear in mind that accidental marks as a result of falling or slipping generally occur in specific areas of the body (e.g., elbows, chin, rear end). On the other hand, the existence of patterned marks in more obscure areas of the body should raise suspicion (e.g., back, thighs, side of face, stomach) (Monteleone, 1994). There are also subtle signs of physical abuse that should be noted but not necessarily reported. These signs includes a sudden onset of academic or social problems at school, aggression or extreme compliance when reprimanded, and hypervigilance while around perceived threatening situations. As children who have not experienced maltreatment may also exhibit some of these characteristics, it is important to avoid hastily reporting unless additional indicators of abuse accumulate. Finally, the use of coercive parenting practices by caregivers or coercive interactional styles by children should also raise

suspicion in mandated reporters. When children are exposed to coercive caregiver tendencies, they may learn abusive tendencies from the caregiver and internalize coercion as a style of relating with peers and siblings (Crick & Dodge, 1994).

Indicators of Sexual Abuse

Sexual abuse of children is much more difficult to substantiate (Conte, 1992; Ferrara, 2002). It usually requires an evidentiary exam by a physician or nurse (usually within 72 hours) or an admission by a perpetrator. Outside of these direct indications of sexual abuse, there are more indirect signs. One of the more common signs is verbal disclosure by a child or adolescent (Conte, Sorenson, Fogarty, & Rosa, 1991). Additional signs of possible sexual abuse include sexualized behavior, sexual acting out with peers, inappropriate sexual talk, developmentally advanced knowledge of adult sexual practices, or sexual self-stimulation at a developmentally inappropriate age (Browne & Finkelhor, 1986; Ferrara 2002). Some sexually abused children may also display homophobic concerns as well as inappropriate interpersonal boundaries, including touching peers and adults in a sexualized manner (Sebold, 1987). Other possible indicators include sexualized play with dolls, sexualized drawings, and enuresis/encopresis (Monteleone, 1994). Adolescents might also display sexually provocative behavior or dress (Ferrara, 2002), borderline tendencies (Weaver & Clum, 1993), and eating disorders (Gleaves & Eberentz, 1993). In both children and adolescents, anal or vaginal discomfort, or exaggerated fear response surrounding situations that trigger memories of the sexual abuse, may also point to possible abuse.

Indicators of Neglect and Emotional Abuse

Neglect is the most prevalent form of child maltreatment and denotes deficiencies in caregiving that harm a child's psychological or physical well-being (Dubowitz, Black, Starr, & Zuravin, 1993). There are several kinds of neglect: educational, emotional, physical, and medical. Educational neglect includes failure to assure that children attend schooling on a regular basis. Physical neglect often includes failing to provide for a child's basic needs, such as food, shelter, and clothing. It might also include allowing a child to be dirty and hungry continually. Emotional neglect might include extreme detachment from a child in which the child is left unsupervised or deprived of developmentally appropriate nurturing. Allowing a child to engage in adult-like activities prematurely (e.g., permitting a child to view pornography at age 8 or consume significant quantities of hard alcohol at age 9) should also raise suspicion of caregiver neglect. Medical neglect includes the failure to provide children with needed medical or dental services.

Like neglect, emotional abuse is another form of maltreatment that has long-term consequences. Emotional abuse includes chronic, intense, and inappropriate criticism or rebuke of a child such as derogatory name-calling and humiliation (McGee & Wolfe, 1991). Psychologically terrorizing a child such as threatening to harm the child's pet should also be construed as emotional abuse. Finally, exposure to caregiver domestic violence or substance abuse might also raise suspicion of maltreatment. Caregivers who abuse substances often have difficulty providing for their children's physical and emotional needs as they can become consumed by their relationship with the substance (Wolock & Magura, 1996).

Uncertainty about the Threshold: How to Proceed

Despite knowledge of the signs and symptoms of abuse, mental health professionals may still be uncertain over whether sufficient information exists to file a CPS report. In this situation, the professional may consult with a colleague knowledgeable about child maltreatment. The most appropriate and legally conservative course of action, however, may be to contact CPS and request guidance regarding whether a report is necessary (Kuest & Winter, 2000). CPS is generally knowledgeable about these matters and will provide appropriate feedback. Through a call to CPS, the mental health professional will also be legally protected, ethically grounded, and may be preventing further harm to the child.

Therefore, when uncertain, it is important to contact CPS and request feedback as to how to proceed. When a report is made in good faith, then the mental health professional is generally immune from criminal and civil sanctions (Myers, 1998). On the other hand, every state, with the exception of four, imposes criminal penalties on mental health professionals who fail to report suspected child maltreatment (Pence & Wilson, 1994). Moreover, child-abuse reporting procedures vary depending on the relationship between the child and suspected abuser. CPS should be contacted when the suspected abuser is thought to be the child's caregiver or legal guardian. On the other hand, law enforcement should be contacted when the alleged abuser is someone other than the child's caregiver or legal guardian (e.g., neighbor or relative) (Pence & Wilson, 1994).

What to Include in a Report

When gathering information for a report, it is important for therapists to remain cautious about crossing professional boundaries by assuming an investigative role Kalichman, 1999; Kuest & Winter, 2000). The threshold for reporting is reasonable suspicion; therefore, the mental health professional should not attempt to find irrefutable evidence before to making a report. Substantiation of maltreatment remains with the purview of CPS and the legal system. Extensive investigation represents a violation of the professional's legal and ethical mandate.

As paraphrased from Dombrowski et al (2003), information provided in a report might include the following:

• who (e.g., information about the child, the alleged perpetrator and anyone else who may have either witnessed the event or be at-risk for maltreatment, including siblings);

• what (e.g., information about the nature of abuse);

• when (e.g., a description of when the abuse occurred and how many times it occurred); and

• where (e.g., a description of where on the body and where geographically the abuse took place).

The filing of a CPS report carries with it the obligation to notify the legal guardian or client of the need to break confidentiality. Although clients may become angry upon notification of the therapist's intent to report, some of this anger may be dispelled with appropriate discussion of the limits to confidentiality at the onset of therapy. There may be times where it is prudent to allow CPS to begin its investigation prior to informing the suspected perpetrator of a possible investigation. This situation might arise when premature notification would risk further harm to the child (e.g., the perpetrator may

leave the area or use coercive means in attempt to conceal the maltreatment) (Kalichman, 1999). Otherwise, the mental health professional has an ethical duty to notify clients and legal guardians of the need to break confidentiality and file a report.

After a Report has been filed

Following a mandated report, CPS will decide the severity of the alleged maltreatment. If a CPS intake worker decides that a child is in imminent risk of further maltreatment, then the intake worker will immediately send out an investigative team (Kuest & Winter, 2000). In this circumstance, CPS may act swiftly by removing the child from the home and placing the child in protective custody. Otherwise, CPS will decide whether or not to investigate. If decision is made not to investigate, the information provided will be retained in a file by the agency in the event of future allegations. When the decision is made to investigate, then trained CPS workers will visit the parties involved within 24 to 48 hours to conduct a risk assessment (Kuest & Winter, 2000). One potential result of a risk assessment might be to remove the child from the current placement. The other result might be to provide intervention services to the family while maintaining the child's current placement. It is noted that CPS does not automatically remove a child from caregiver custody when a report has been filed. This may occur when a child's safety or life is in danger. However, CPS attempts to preserve the family structure and should attempt to do so if it is in the best interests of the child (Kalichman, 1999).

Following the CPS Report: Discussion with Clients and Legal Guardians

Just as it is important for mental health professionals to file a CPS report when abuse has been reasonably suspected, mental health professionals are ethically required to notify clients and legal guardians of the need to break confidentiality either before or shortly after filing a CPS report (APA & ACA Code of Ethics). When notification might jeopardize the safety of the child, it is advisable to allow CPS to investigate prior to discussing the mandate to report. Otherwise, both clients and legal guardians should be informed of the CPS report within a reasonable time period (i.e., around the time the report is/was made). There may be angry reactions and a sense of betrayal following a CPS report. An explicit discussion of the limits to confidentiality at the onset of therapy might serve to mitigate some of these feelings. Nonetheless, even following appropriate informed consent procedures, clients/legal guardians will still need time to process the feelings that emerge as a result of a CPS report. Processing of this nature is best done with the guidance of the therapist within a therapeutic context. As part of this discussion, the therapist should convey to clients and legal guardians that the professional was acting out of concern for the child's welfare and in accordance with professional legal and ethical mandates. This assurance may assist, to some degree, with processing feelings of betrayal and anger, although processing will vary according to individual client/legal guardian.

The therapist will also need to explain what is to be expected from the CPS investigation. Many individuals may feel that CPS is a branch of law enforcement, and may therefore have concerns that they will be incarcerated or criminally prosecuted. While this is certainly possible depending upon the gravity of abuse, the focus of CPS is restorative, rather than punitive. CPS is interested in preserving the family structure and

providing appropriate resources to caregivers. There is the possibility that client will drop out or be removed from therapy. This is one of the potential risks of mandated reporting. However, processing of the feelings/thoughts surrounding a mandated report can also be educative and used as a vehicle to discuss effective parenting practices and the harmful consequences of abuse. Child maltreatment is an unacceptable aspect of parenting that disturbs child development and promotes a multigenerational cycle of abuse (Wolfe, 1999). This cycle needs to be broken. Mandated reporting, though not fail-safe, is an approach that attempts to rid society of child maltreatment, a costly and insidious condition.

1. Which of the following is true regarding mandated child abuse reporting?

A. Given the high number of mandated reports coming into CPS each day, mental health professionals should use professional discretion regarding a decision to report.
B. Mental health professional should seek irrefutable evidence prior to making a report, so not to stress an already overburdened CPS system.
C. Mental health professionals are legally mandated to report when they reasonably suspected child maltreatment, regardless of the pressures facing CPS.
D. Mental health professionals should consult with colleagues regarding a decision to report when they suspect maltreatment.

Answer: C

2. Based on this article, the following is most appropriate response regarding child abuse and neglect:

A. There is a linear relationship between the signs of maltreatment and the occurrence of abuse.
B. There is a greater probability of abuse when numerous signs of abuse are evident, although one must be cautious about concluding that abuse has occurred solely based on the existence of these signs.
C. Child neglect is a much milder form of maltreatment than sexual abuse or physical abuse
D. Children and adolescents have a tendency to fabricate stories of maltreatment for secondary gain.

Answer: B

3. When mental health professionals file a mandated report on a client or legal guardian, the client or legal guardian is likely to experience feelings of anger and betrayal. How might the mental health professional most appropriately assist the client or legal guardian in processing these feelings?

A. Remind the client/legal guardian that the mental health professional is a mandated reporter and then move to a discussion of a more therapeutically relevant issue. Remain neutral when providing this information.
B. As a mandated report is confidential, the best course of action would be to allow CPS to deal with assisting the client/legal guardian in working through these issues.
C. Tell the client/legal guardian that CPS is not akin to law enforcement and will likely not do very much with the report as they are already overburdened.
D. Inform both clients and legal guardians at the onset of therapy that the mental health professional is a mandated reporter and has a duty to report. During this discussion, provide numerous examples of circumstances that will require a report and allow the client/legal guardian to ask questions.

Answer: D

4. An adolescent you have been counseling for the past month indicates that her stepfather sometimes comes into her bedroom and touches her in a sexualized manner. She seems somewhat hesitant and distraught when reporting this to you. When you begin to ask more specific details, she states that she "was just making up the story." What should you do?

A. Do not press the matter as she will eventually come around and open up to you.
B. Before making a report to CPS, contact the stepfather and ask him if what the girl is saying is true.
C. Contact CPS, explain the situation, and request procedural clarity.
D. A reasonable suspicion threshold has not been met. You should not report to CPS for risk of breaking confidentiality and impairing the therapeutic relationship.

Answer: C

References

American Counseling Association (ACA) Code of Ethics and Standards. (n.d.) Retrieved December 16, 2002 from http://www.counseling.org/resources/ethics.htm#eb.

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

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*(1): 66–77.

Bryant, S. L., & Range, L. M. (1995). Suicidality in college women who were sexually and physically abused and physically punished by parents. *Violence & Victims, 10*(3): 195–201.

Cahill, L. T., Kaminer, R. K., & Johnson, P. G. (1999). Developmental, cognitive, and behavioral sequelae of child abuse. *Child & Adolescent Psychiatric Clinics of North America, 8*(4): 827–43.

Cicchetti, D., &. Toth, S. L. (1995). A developmental psychopathology perspective on child abuse and neglect. *Journal of the American Academy of Child & Adult Psychiatry,34*(5): 541–65.

Cicchetti, D.,Toth, S. L., & Maughan, A. (2000). An ecological-transactional model of child maltreatment. In A. J. Sameroff and M. Lewis (Eds.)., *Handbook of developmental psychopathology (2nd Ed).*,(pp. 689–722). New York: Kluwer Academic/Plenum.

Conte, J. R. (1992). Has this child been sexually abused? Dilemmas for the mental health professional who seeks the answer. *Criminal Justice and Behavior, 19,* 54-73.

Conte. J. R., Sorenson, E., Fogarty, L., & Rosa, J. D. (1991). Evaluating childrens' reports of sexual abuse: Results from a survey of professionals. *American Journal of Orthopsychiatry, 61,* 428-435.

Crick, N. R., & Dodge, K. A. (1994). A review and reformulation of social information processing mechanisms in children's social adjustment. *Psychological Bulletin, 115*(1), 74-101.

Crittenden, P. M., & DiLalla, D. L. (1988). Compulsive compliance: The developmental

of an inhibitory coping strategy in infancy. *Journal of Abnormal Child Psychology, 16,* 585-599.

Dombrowski, S. C, Ahia, C. E., & McQuillan, K. (2003). Protecting children through mandated child abuse reporting. The Educational Forum, 67(2), 76-85. https://www.doi/10.1080/00131720308984549

Dubowitz, H., Black, M., Starr, R. H., & Zuravin, S. (1993). *Criminal Justice and Behavior, 20*(1): 8–26.

Eckenrode, J., Laird, M., & Doris, J. (1993). School performance and disciplinary problems among abused and neglected children. *Developmental Psychology, 29*(1): 53–62.

Everson, M. D., & Boat, B. W. (1989). False allegations of sexual abuse by children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 28*(2), 230-235.

Ferrara, F. F. (2002). *Childhood sexual abuse: Developmental effects across the lifespan*. Pacific Grove, Calif.: Brooks/Cole.

Foreman, T., & Bernet, W. (2000). A misunderstanding regarding the duty to report suspected abuse. *Child Abuse & Neglect: The International Journal, 25*(2), 190–96.

Gil, E. (1996). *Treating abused adolescents*. New York: Guilford.

Gleaves, D. H., & Eberenz, K. P. (1993). Eating disorders and additional psychopathology in women: The role of prior sexual abuse. *Journal of Child Sexual Abuse, 2,* 71-80.

Grossoeheme, D. H. (1998). Child abuse reporting: Clergy perceptions. *Child Abuse & Neglect*, *22*(7), 743-747.

Herlithy, B., & Corey, G. (1996). ACA ethical standards casebook (5th Edition). Alexandria, VA: American Counseling Association.

Jones, D. P. H., & McGraw, J. M. (1987). Reliable and fictitious accounts of sexual

abuse to children. *Journal of Interpersonal Violence, 2*(1), 27-45.

Kalichman, S. C. (1999). *Mandated reporting of suspected child abuse: Ethics, law & Policy (2nd Edition)*. Washington D. C.: American Psychological Association.

Kalichman, S. C., & Brosig, C. L. (1992). Practicing psychologists' interpretations of and compliance with child abuse reporting laws. *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*(1), 83-93.

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

Kempe, C., Silverman, F., Steele, B., Droegemueller, W., & Silver, H. (1962). The Battered-child syndrome. *Journal of the American Medical Association, 181*(1), 17-24.

Kendall-Tackett, K. A., & Eckenrode, J. (1996). The effects of neglect on academic achievement and disciplinary problems: A developmental perspective. *Child Abuse & Neglect, 20*(3), 161-169.

Kendall-Tackett, K. A., Meyer, L. W., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*(1), 164-180.

Kuest, D., & Winter, M. (2000). *The California child abuse & neglect reporting law: Issues and answers for mandated reporters*. Sacramento: Office of Child Abuse Prevention, State of California.

Lamphear, V. (1986). The impact of maltreatment on children's psychosocial adjustment: A review of the research. *Child abuse & Neglect, 9*(2), 251-263.

Levine, M., & Doueck, H. J. (1995). *The impact of mandated reporting on the therapeutic process: Picking up the pieces*. Newbury Park, CA: Sage.

Malinosky-Rummell, R., & Hansen, D. J. (1993). Long-term consequences of childhood physical abuse. *Psychological Bulletin, 114*(1), 68-79.

McGee, R. A., & Wolfe, D. A. (1991). Psychological maltreatment: Toward an operational definition. *Development and Psychopathology, 3*, 3–18.

Merali, N. (2002). Culturally informed ethical decision making in situations of suspected child abuse. *Canadian Journal of Counseling, 36*(3), 233–44.

Myers, J. E. B. (1986). A survey of child abuse reporting laws. *Journal of Juvenile Law, 10*(1), 1–72.

Myers, J. E. B. (1998). *Legal issues in child abuse and neglect practice (2nd Edition).* Thousand Oaks, Calif.: Sage.

Monteleone, J. A. (1994). *Child abuse*. New York: G. W. Medical Publishing, Inc.

Oddone, E., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology, 135*(1), 17-36.

Pence, D. M., & Wilson, C. A. (1994). Reporting and investigating child sexual abuse. *The Future of Children, 4*(2), 70–83.

Perlis, S. (1999). Victim recantation in child sexual abuse cases: A team approach to prevention, investigation, and trial. *Journal of Aggression, Maltreatment & Trauma, 2*(2), 105–40.

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

Pope, K. S., & Feldman-Summers, S. (1992). National survey of psychologists' sexual and physical abuse history and their evaluation of training and competence in

these areas. *Professional Psychology: Research and Practice, 23*, 353-361.

Reiniger, A., Robison, E., & McHugh, M. (1995). Mandated training of professionals: A means for improving reporting of suspected child abuse. *Child Abuse & Neglect, 19*(1), 63-69.

Sebold, J. (1987). Indicators of child sexual abuse in males. *Social Casework: The Journal of Contemporary Social Work, 68*(2), 75–80.

Shengold, L. (1989). *Soul murder: The effects of childhood abuse and deprivation.* New Haven, CT: Yale University Press.

Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse & Neglect: The International Journal, 20*(8), 709–23.

Slavenas, R. (1988). The role and responsibility of teachers and child care workers in identifying and reporting child abuse and neglect. *Early Child Development & Care, 31*(1–4), 19–25.

Small, M. A., Lyons, P. M., & Guy, L. S. (2002). Liability issues in child abuse and neglect reporting statutes. *Professional Psychology, Research & Practice, 33*(1), 13–18.

Sorenson, T., & Snow, B. (1991). How children tell: The process of disclosure in sexual abuse. *Child Welfare, 70*, 3-15.

Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd Ed.). New York: John Wiley & Sons, Inc.

Terr. L. C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*, 10-20.

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*(2), 246–56.

Weaver, T. L., & Clum, G. A. (1993). Early family environments and traumatic experiences associated with borderline personality disorder. *Journal of Consulting and Clinical Psychology, 61,* 1068-1075.

Wilson, C. A., & Gettinger, M. (1989). Determinants of child-abuse reporting among Wisconsin school psychologists. *Professional School Psychology, 4*(2), 91-102.

Wolfe, D. A. (1999). *Child abuse: Implication for child development and psychopathology*. Thousand Oaks, CA: Sage Publications.

Wolock, I., & Magura, S. (1996). Parental substance abuse as a predictor of child maltreatment re-reports. *Child Abuse & Neglect: The International Journal,20*(12), 1183–93.

Zellman, G. (1992). The impact of case characteristics on child abuse reporting decisions. *Child Abuse and Neglect, 16*, 57-74.