To report or not to report: Factors that impact child abuse reporting behaviors of psychologists and the impact of discretionary reporting laws

Caitlin Wilpone-Jordan

Pacific University

Recommended Citation

This Dissertation is brought to you for free and open access by the College of Health Professions at CommonKnowledge. It has been accepted for inclusion in School of Graduate Psychology by an authorized administrator of CommonKnowledge. For more information, please contact CommonKnowledge@pacificu.edu.
To report or not to report: Factors that impact child abuse reporting behaviors of psychologists and the impact of discretionary reporting laws

Abstract
Child abuse is becoming an increasingly important issue for psychologists in the United States. Mandatory reporting laws have been instituted for psychologists in all states, but Oregon additionally allows psychologists discretion in reporting when abuse or neglect is learned through privileged communication. The goal of this project was to begin to examine reporting behaviors of psychologists in Oregon and Washington. Information on demographic variables and experiences as a psychologist was collected. Participants were also asked to read a randomly assigned vignette, and respond to several questions. Results indicate that respondents of the survey were demographically similar across states and in the number of past suspicions of abuse/neglect. Several variables were found to significantly impact reporting behaviors (age, number of years in practice, and gender).

Degree Type
Dissertation

Degree Name
Doctor of Psychology (PsyD)

Committee Chair
Michelle R. Guyton, PhD

Second Advisor
Robin L. Shallcross, PhD

Subject Categories
Psychiatry and Psychology

Comments
Library Use: LIH

This dissertation is available at CommonKnowledge: https://commons.pacificu.edu/spp/1129
Copyright and terms of use

If you have downloaded this document directly from the web or from CommonKnowledge, see the “Rights” section on the previous page for the terms of use.

If you have received this document through an interlibrary loan/document delivery service, the following terms of use apply:

Copyright in this work is held by the author(s). You may download or print any portion of this document for personal use only, or for any use that is allowed by fair use (Title 17, §107 U.S.C.). Except for personal or fair use, you or your borrowing library may not reproduce, remix, republish, post, transmit, or distribute this document, or any portion thereof, without the permission of the copyright owner. [Note: If this document is licensed under a Creative Commons license (see “Rights” on the previous page) which allows broader usage rights, your use is governed by the terms of that license.]

Inquiries regarding further use of these materials should be addressed to: CommonKnowledge Rights, Pacific University Library, 2043 College Way, Forest Grove, OR 97116, (503) 352-7209. Email inquiries may be directed to: copyright@pacificu.edu
TO REPORT OR NOT TO REPORT: FACTORS THAT IMPACT CHILD ABUSE REPORTING BEHAVIORS OF PSYCHOLOGISTS AND THE IMPACT OF DISCRETIONARY REPORTING LAWS

A DISSERTATION
SUBMITTED TO THE FACULTY OF SCHOOL OF PROFESSIONAL PSYCHOLOGY PACIFIC UNIVERSITY HILLSBORO, OREGON

BY CAITLIN WILPONE-JORDAN
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY

JULY 11, 2014

APPROVED BY THE COMMITTEE:
Michelle R. Guyton, PhD, ABPP
Robin L. Shallcross, PhD, ABPP

PROFESSOR AND DEAN:
Christiane Brems, PhD, ABPP
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
</tr>
<tr>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>REPORTING ABUSE AND/OR NEGLECT</td>
</tr>
<tr>
<td>THE DECISION-MAKING PROCESS</td>
</tr>
<tr>
<td>Reasons for Not Reporting</td>
</tr>
<tr>
<td>Clinician Demographic Variables</td>
</tr>
<tr>
<td>Clinician Perception Variables</td>
</tr>
<tr>
<td>Consequences of Reporting Suspected Abuse</td>
</tr>
<tr>
<td>Measuring Outcome Perception</td>
</tr>
<tr>
<td>Consequences of Reporting</td>
</tr>
<tr>
<td>REPORTING ABUSE AND/OR NEGLECT IN OREGON AND WASHINGTON</td>
</tr>
<tr>
<td>Laws and Statutes</td>
</tr>
<tr>
<td>Legal Decision-Making in Oregon</td>
</tr>
<tr>
<td>Ethical Considerations</td>
</tr>
<tr>
<td>Standards</td>
</tr>
<tr>
<td>Principles</td>
</tr>
<tr>
<td>RATES OF ABUSE/NEGLECT IN OREGON AND WASHINGTON</td>
</tr>
<tr>
<td>METHOD</td>
</tr>
<tr>
<td>Participants</td>
</tr>
<tr>
<td>Sample Size and Power Analysis</td>
</tr>
</tbody>
</table>
DECISIONS IN REPORTING ABUSE

Materials.................................................................................................................... 22
Measures..................................................................................................................... 23
Demographic Variables.............................................................................................. 24
Other Variables.......................................................................................................... 25
ANALYSES.................................................................................................................... 26
RESULTS....................................................................................................................... 27
  Demographic Variables............................................................................................ 28
    Age....................................................................................................................... 28
    Identified Gender................................................................................................. 28
    Ethnicity............................................................................................................... 28
    Degree earned..................................................................................................... 28
    Years in practice................................................................................................. 29
    Type of practice................................................................................................. 29
    State of practice................................................................................................. 29
    Number of suspicions....................................................................................... 30
    Number of reports............................................................................................. 30
    Attitudes towards CPS...................................................................................... 31
  Statistical Analyses............................................................................................... 33
  Relationship Analysis........................................................................................... 34
    T-tests.................................................................................................................. 36
    Chi-Square Tests............................................................................................... 37
DISCUSSION................................................................................................................. 42
  Review and Implications of Findings................................................................. 42
APPENDICES

A. VIGNETTE #1 ....................................................................................... 56

B. VIGNETTE #2 ....................................................................................... 57
DECISIONS IN REPORTING ABUSE

ABSTRACT

Child abuse is becoming an increasingly important issue for psychologists in the United States. Mandatory reporting laws have been instituted for psychologists in all states, but Oregon additionally allows psychologists discretion in reporting when abuse or neglect is learned through privileged communication. The goal of this project was to begin to examine reporting behaviors of psychologists in Oregon and Washington. Information on demographic variables and experiences as a psychologist was collected. Participants were also asked to read a randomly assigned vignette, and respond to several questions. Results indicate that respondents of the survey were demographically similar across states and in the number of past suspicions of abuse/neglect. Several variables were found to significantly impact reporting behaviors (age, number of years in practice, and gender).

Key words: child abuse reporting, discretionary reporting, mandatory reporting
ACKNOWLEDGEMENTS

Without the support, patience and guidance of the following people, this study would not have been completed. Thank you so much for all of your support.

Michelle Guyton, your mentorship and guidance throughout my graduate school career and this project has been immeasurable. You have pushed me to think about things more critically and encouraged me to find my own voice. My deepest gratitude.

Robin Shallcross, thank you for your thoughtful and ideas and insight into my project. Without your expertise and wisdom, this endeavor would have been much more treacherous.

To my parents, Seri Wilpone and Wesley Jordan and my husband Jeremy Gay, thank you for everything. I love you.
Child abuse and neglect is an ongoing problem in the United States. National rates of abuse and neglect have ranged from 681,000 to 872,000 children affected over the past 10 years (9.1 and 11.9 out of every 1,000, respectively; US Department of Health and Human Services, Administration on Children, Youth and Families, Children’s Bureau, 2000; US Department of Health and Human Services, Administration on Children, Youth and Families, Children’s Bureau, 2013). Child abuse, as defined by the United States Department of Health and Human Services is "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation;" or "an act or failure to act which presents an imminent risk of serious harm" (US Department of Health and Human Services, Administration on Children, Youth and Families, Children’s Bureau, 2010). Including all reported acts that conform to this definition, rates of reported and substantiated abuse have slowly risen since the mid 1990s (US Department of Health and Human Services, Administration on Children, Youth and Families, Children’s Bureau, 1996).

The number of referrals made to the Department of Health and Human Services has increased from the rate of 2.9 million in 1999 (US Department of Health and Human Services, Administration on Children, Youth and Families, Children’s Bureau, 2000). In the most recent report issued by the United States Department of Health and Human Services (2013), rates of reports in 2012 continued to increase, reaching 3.4 million in
2011, where 2.1 million of those reports were screened in\(^1\). This report also indicated that 19.1% of screened in cases were substantiated or indicated as abuse or neglect, totaling 3.8 million\(^2\) impacted children. In order to understand these increases over the past 13 years, research has been done on rates of subsequent referrals to CPS and other governing agencies regarding abuse/neglect.

Health professionals in the US encounter child abuse/neglect in multiple settings. Medical doctors can encounter evidence of abuse during physical exams, psychiatrists may learn about failure to adhere to medication leading to adverse effects, and mental health professionals may learn about abuse during the course of an assessment or therapy session. While different health professionals may learn about abuse/neglect in different ways, all 50 states have laws mandating health professionals report suspected or known abuse/neglect\(^3\) to the proper governing agency in their state.

Not only do health professionals have legal obligations to report abuse/neglect, they are also bound by individual ethics codes to promote good and reduce harm. These legal and ethical codes have set out clear guidelines for what behaviors are expected; however, little is known about how current laws and ethical guidelines impact specific reporting behaviors. However, research on reporting behaviors of health professionals has been conducted to investigate factors that impact the likelihood of a report being made about suspected abuse and what makes a child more likely to be abused more than once.

---

\(^1\) Indicating a response needed by Child Protective Services (CPS)
\(^2\) This value counts each incident as a child, even if it was a second offense to the same child.
\(^3\) From this point forward, believed, suspected or known abuse/neglect will be simply called abuse and/or neglect.
Reporting Abuse and/or Neglect

Jonson-Reid, Emery, Drake, and Stahlschmidt (2010) conducted a study to determine factors that impact the likelihood of more than one report of child abuse or neglect affecting the same child/children and involving the same perpetrator. Participants included 6,412 children who were between birth and nine years of age at the time of the first report and who had at least four subsequent reports of abuse or neglect filed on their behalf. Results indicated that children with a developmental delay were more likely to have subsequent reports when compared to children without a developmental disorder. Similarly, children who were older at the time of the first report were more likely to have a second report filed; although, this trend was not true for any subsequent reports.

Jonson-Reid et al., (2010) also found family characteristics that increased rates of future reports. These characteristics included a caregiver with a less than twelfth grade education, families who received federal or state aid, and families with a caregiver that had been in foster care as a child (when predicting the fourth report only). Caregiver mental illness and prior substance abuse history were also found to be predictive of future reports. However, risk was diminished for children whose parents entered into treatment after the first report.

Information regarding child and family characteristics that increase the likelihood of a child experiencing more than one instance of abuse, allows health professionals to better understand risk factors of child abuse/neglect. However, this information does not address the laws or ethical codes that impact health professionals’ behaviors in regards to learning about or suspecting abuse/neglect.
The Decision-Making Process

Reasons for Not Reporting

Most physical and mental health care providers are legally bound in the US to report instances of suspected, believed or known abuse. Yet, some clinicians still choose not to report. Alvarez, Kenny, Donohue and Carpin (2004) conducted a literature review of the reasons professionals fail to instigate mandated reports. The authors identified four reasons frequently identified in the literature: lack of knowledge in identifying abuse/neglect, perceived negative consequences for the client(s), negative attitudes towards CPS and perceived negative consequences for the reporter.

First, Alvarez et al. (2004) reported that a lack of knowledge of the signs and symptoms of abuse/neglect is a reason for not reporting; this lack of knowledge was attributed to professionals’ lack of training in identifying abuse/neglect. Specifically, neglect was found to be frequently missed, as neglect tends to leave less overt signs than physical abuse. It was also found that some professionals lacked training in the reporting process as well as in the legal and ethical obligations of the profession of the reporter. Several studies cited by Alvarez et al. noted that while professionals typically feel confident in their knowledge about laws, ethical obligations and agency policy, there are erroneous beliefs that may adversely influence reporting behaviors.

Second, some professionals stated it was not in their client’s best interest to have added stress by an investigation, or the report would disrupt an already fragile family system. Mental health clinicians also argued against mandated reporting, stating that it was a violation of confidentiality. Third, many professionals evinced negative attitudes
towards CPS, or the governing body in their area, due to past experiences where it appeared that nothing happened as a result of their report. Fourth, clinicians have reported fears of losing rapport with clients/families, litigation for unfounded reports and retaliation from the client and/or family.

Other researchers have identified similar perceptions to reporting abuse/neglect as Alvarez et al. (2004; Badger, 1989; Beck & Ogloff, 1995; Jones et al., 2008; Kalichman & Brosig, 1993; Weinstein, Levine, Kogan, Harkavy-Friedman & Miller, 2001) as well as additional factors. These additional factors can be broken down into two categories: clinician demographic variables, perceptions of the clinician.

**Clinician Demographic Variables.** In the reviewed literature, clinicians with fewer than 10 years of practice tend to report 68% of the time they suspected abuse and/or neglect; however, clinicians with 10 or more years of experience tend to report 35% of the time (Brown & Strozier, 2004). Similarly, older clinicians were found to report less often than younger clinicians (Steinberg, Levine, & Doueck, 1997). The type of degree a clinician had also impacted rates of reporting; Master’s level clinicians were found to report more than doctoral level clinicians (Beck & Ogloff, 1995). Lastly, the review indicated that clinicians with their own history of abuse and/or neglect tend to report more often than clinicians without this background (Jankowski & Martin, 2003).

**Clinician Perception Variables.** The review of the previous literature also indicated that when clinicians perceive a positive treatment outcome in relation to reporting suspected child abuse and/or neglect, rates of reporting increase (Beck & Ogloff, 1995; Jones et al., 2008; Jankowski & Martin, 2003). Also, when clinicians have a strong identified responsibility or desire to protect a child/client, rates of reporting
similarly increase (Beck & Ogloff, 1995; Jankowski & Martin, 2003). As the level of certainty that abuse and/or neglect occurred (Beck & Ogloff,) and the perceived severity of the abuse (Zellman, 1990) increased, so did rates of reporting. Lastly, the more clinicians identify with a legal obligation to report suspected abuse, the more likely they were to report that suspected abuse and/or neglect (Jankowski & Martin, 2003).

In summary, clinicians’ perceptions about what will happen if suspected abuse or neglect is reported, may deter them from making reports, even in serious cases, to CPS or other governing agencies. Professionals endorsed trying to avoid negative impacts of making a report, specifically for the child (e.g., further abuse, retribution for telling) or an adult client (e.g., breaking confidentiality, loss of rapport), even when mandated by law. Perhaps most disturbingly, some clinicians reported avoiding child abuse reports to save negative consequences of their own practice or to avoid possible retribution from the involved family. All of these decisions are being made based on personal feelings, worries, past experiences and lack of knowledge, not on outcome data. While many researchers have identified characteristics of clinicians and perceptions that impact their decision to report abuse and/or neglect, little information was provided in these studies about actual outcomes when clinicians do choose to report.

Consequences of Reporting Suspected Abuse

Measuring Outcome Perception. Before we can begin discussing positive and negative outcomes in reports to CPS, an agreed upon definition is needed. Previous studies on report outcomes have similar definitions with several facets. Steinberg et al., (2007) and Weinstein et al., (2001) both describe positive outcomes as 1) a positive perception by the client, 2) continued treatment after the report was filed, and 3) increases
or no changes in the therapeutic alliance as reported by both the client(s) and the clinician. In the reviewed literature, negative outcomes were defined as fractures or declines in the therapeutic alliance, and withdrawal from treatment.

**Consequences of Reporting.** What are the consequences of reporting abuse or neglect? Several authors have examined outcomes of reporting abuse/neglect. As noted previously, many clinicians fear negative responses to reports of abuse/neglect. However, a study conducted by Steinberg, Levine and Doueck (1997) identified factors that contributed to positive outcomes to reporting abuse/neglect. Specifically, client age, role strain, rapport, informed consent procedures, and client composition were found to be significantly related to less negative outcomes of a report to CPS. Specifically, the review found that younger clients tend to have less negative reactions to a clinician making a report, though reactions became more negative as the client became older. Role strain, defined as the strain perceived by the clinician regarding the impact a report has on her/his identified role with the client, was also found to negatively impact perceptions of a report being filed. Clinicians with higher levels of perceived role strain had clients with more negative reactions to the report. This finding suggests that a clinician’s perception and ownership of making a report subsequently impacts the client’s perception of the report. It was also found that strong rapport prior to the report and a thorough informed consent procedure were indicative of positive perception of the report by the client. Lastly, when the client was an individual, as compared to when a family is the identified client, the child reported a more positive perception of the report.

According to research by Steinberg et al., (1997), a majority of clients have positive reactions to reports of abuse and/or neglect. Their research found that only 25%
of clients reported having a negative reaction. Several factors were found to impact the client’s perception. Specifically, clinicians who were more detailed in discussing the steps of making a report, had clients who reacted more positively to the report. Similarly, the stronger the clinician-client alliance was before the report was made, the better the outcome. Positive outcomes were also linked to clinicians who took individual responsibility for deciding to report, and not just stating that it was a legal or ethical duty to do so. Clinicians who have internal motivation (i.e., personal values or ethical codes) to report suspected abuse, tend to have clients who feel more positively towards any reports, when compared to clinicians who have more external motivations (i.e., “it’s the law”) regarding reporting.

Similarly to Steinberg et al., (1997), Weinstein et al. (2001), found that only 27.3% of cases of reported abuse and/or neglect resulted in negative outcomes. The factors that Weinstein et al. found to protect from a negative reaction were the quality of the clinician-client relationship prior to the report, and the length of time the client had been in treatment. The more strongly the rapport was between the client and clinician prior to the report, the more likely the client would not experience a fracture in the alliance. Similarly, clients who had been in treatment longer had more positive outcomes subsequent to a report of abuse/neglect when compared to clients who had been in treatment fewer weeks (i.e., 43 weeks and 18 weeks respectively). Moreover, when clinicians were more effective in how they handled the reporting process (i.e., they told the client before reporting and took ownership of the decision to report), there was a lower rate of negative outcomes.
Overall, research indicates that there are positive outcomes in approximately 75% of cases where abuse and/or neglect is reported (Steinberg et al., 1997; Weinstein et al., 2001), yet clinicians only report 35-68% of the time. This is strong evidence that many clinicians who believe that making a report to CPS will damage the client and/or the therapeutic relationship are relying on unfounded perceptions, and not outcome data.

This evidence suggests that psychologists and other clinicians have variable and inconsistent judgment due to personal feelings and misinformation when it comes to predicting outcomes of reporting abuse and/or neglect. As a result, this information begins to suggest that having discretion to report may result in more negative outcomes for clients, where making reports 100% of the time could lead to fewer negative outcomes to the children and families involved. As Oregon is the only state in the entirety of the US, including territories, with discretion of reporting for psychologists, further investigation of the actual reporting rates of psychologists and mandated reporters, as well as those with legal discretion, should be reviewed.
Reporting Abuse and/or Neglect in Oregon and Washington

Laws and Statutes

As of the early 1990s, all US states and territories have child abuse reporting laws for professionals; however, states vary in the language used in these statutes. Washington State utilizes the phrasing, “reason to believe” (Foreman & Bernet, 2000) as the legal definition for reporting and the state law outlines mandated reporting:

When all professionals including, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombudsman or any volunteer in the ombudsman's office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident. Washington State Statute: Abuse of Children (2005; lines 6-15).

In Oregon, professionals are mandated reporters of suspected child abuse/neglect if the abuse/neglect was learned in a non-privileged communication (Reporting Child Abuse, 2011). However, psychologists as well as psychiatrists, members of the clergy, attorneys and guardians ad litem have discretion whether to report abuse if the information is learned within a privileged conversation (Reporting Child Abuse, 419B.010, 2011). What makes psychologists better able to handle a discretionary law
when compared to other health professionals? What are the benefits and contraindications of such a law on outcomes of child abuse or neglect victims?

The first Oregon reporting law originated in 1993 and read:

any public or private official having reasonable cause to believe that any child with whom the official comes in contact has suffered abuse or that any person with whom the official comes in contact has abused a child shall immediately report or cause a report to be made in the manner required in section 15 of this 1993 Act. Nothing contained in ORS 40.225 to 40.295 shall affect the duty to report imposed by this section, except that a psychiatrist, psychologist, clergyman or attorney shall not be required to report such information communicated by a person if the communication is privileged under ORS 40.225 to 40.295”

(Reporting Child Abuse, 1993, section 14).

This was the first law regarding the criminality of child abuse and has remained the same in spirit since then (Reporting Child Abuse, 2011). Thus, mental health professionals in Oregon are mandated reporters, except in the specific case of psychologists (i.e., doctoral level, licensed professionals) and psychiatrists who have discretion to report suspected or known abuse/neglect if the information is learned during the course of a privileged conversation.
Legal Decision-Making in Oregon

In Oregon, the discretionary law creates a more complicated process than reporting in Washington and other states. Notably, there is no black-or-white citation, ethically or legally, that can be made regarding a psychologist’s decision-making process when deciding whether to report child abuse/neglect. Therefore, psychologists in Oregon must take extra care in describing their own values regarding child abuse/neglect and plainly lay out any steps to her/his specific decision-making process that may affect their clients at the time of informed consent. This requires psychologists to stay up to date on new versions of the laws and ethics code that govern reporting abuse and neglect in their state; as well as to inform their clients about the process that will ensue when abuse is learned about in the context of the therapeutic relationship and how that differs from learning about abuse/neglect in a non-privileged communication (e.g., in the waiting room, in public, during a non-therapeutic phone call, etc.).

Proponents of the discretionary laws for psychologists indicate that having the ability to handle cases of abuse or neglect in their offices instead of involving the authorities increases family adherence to treatment and bolsters the therapeutic alliance (H. Hetrick, personal communication, March 17, 2011; R. Shallcross, personal communication, May 4, 2011). However, no research has been conducted to determine the benefits or contraindications of discretionary laws and there was no published data found to date.

While laws governing professionals tend to be more clear regarding expected behavior, ethical obligations tend to have differing interpretation. When investigating reasons that health professionals fail to make mandated reports to CPS, ethical
obligations and interpretations are also important to investigate. Specific to psychologists, the American Psychological Association (APA) has the Ethical Principles of Psychologists and Code of Conduct, most recently amended in 2010. Following is an outline of the code and how it applies to psychologists’ obligations to report abuse/neglect.
Ethical Considerations

The APA Ethics Code is a document outlining regulations and aspirational guidelines that pertain to all practicing psychologists in the US. The aim of the code is to provide guidance in behavior and professional practice and to outline expectations for practice for the general public. The code is also intended to act as a tool, along with local and federal laws, agency policies, and community resources during the decision-making process. When a psychologist is faced with a case of suspected abuse/neglect, they are obligated to combine legal, ethical, and agency considerations when deciding whether to report to CPS.

Standards. Although psychologists in both Oregon and Washington are bound to the APA’s Ethics Code, in cases of suspected abuse/neglect, a careful investigation and weighing of the code is warranted. Standards 4.01 and 4.02 outline the importance of maintaining confidentiality and the limits to that confidentiality. Specifically, psychologists are ethically bound to keep clients’ information confidential within the bounds of treatment, except when contraindicated for the safety of the self or another being. Reporting child abuse arguably falls under the purview of the limitations to confidentiality, as the safety of both the child/children and the suspected perpetrator are in question.

Standard 3: Human Relations, states that clinicians must fully explain and ascertain their clients’ understanding of the expectations and limits to the therapeutic relationship and treatment process before beginning treatment (Standard 3.10, APA, 2010). At this point all limits to confidentiality (including when reports of abuse and/or neglect will be made) must be presented to the client. It is also expected that informed
consent is an ongoing process to be discussed at varying times during treatment. In Washington, this includes informing clients of the legal mandates to report suspected child abuse to the proper governing authorities in all cases. In Oregon, clinicians must be clear that while a mandated reporter, the law of discretion allows them to not report if the information was learned during a privileged conversation (i.e., during the course of treatment or a therapeutic interaction). Clinicians in Oregon must be clear about what discretion means and how it may impact the particular clinician’s decision-making process. While this is likely different across professionals, Standard 3 states that clinicians must be sure the client understands any limits to confidentiality and processes that will be taken to minimize harm.

**Principles.** In addition to the standards of informed consent and confidentiality discussed in the Ethics Code (2010), there are other guiding principles psychologists are asked to uphold. Specifically, they are the principles of Beneficence and Nonmaleficence (Principle A), Fidelity and Responsibility (Principle B), Integrity (Principle C), Justice (Principle D) and Respect for People’s Rights and Dignity (Principle E). While Beneficence compels psychologists to only do good, Nonmaleficence requires clinicians to, above all else, do no harm. Principle B encourages clinicians to again be clear in the decision-making process regarding the decision to report child abuse/neglect, and clarify any roles they may have that impact the therapeutic relationship. It has also been noted that the principle of Fidelity and Responsibility gives clients the right to “loyalty, faithfulness, and promise keeping” (Haverkamp & Daniluk, 1993, p. 134) within the therapeutic or professional context. Principle C, Integrity, compels psychologists to act in a truthful manner and not engage in inaccuracies, fraud, or misrepresentation of fact. The
principles previously outlined, encourage psychologists to make client knowledge and understanding of the process a top priority. While loyalty, faithfulness, and promise keeping may suggest to some that withholding information from outside parties is the ethical decision (i.e., not reporting), the other principles encourage psychologists to do good and outline the limits to confidentiality, therefore, keeping faithful to their promises to report suspected abuse and/or neglect to protect all parties involved.

Justice refers to fairness within the treatment process and the right of equality. Within the treatment context, when abuse or neglect is suspected, there is no longer a balance in the treatment and the client (assuming the client is the suspected abuser) is in danger of harming themselves and others. The principle of Justice also pertains to others who will be impacted by the profession of psychology (e.g., family members, communities, individuals unable to speak or advocate for themselves, etc.). This is a compelling argument for initiating a report to CPS of suspected abuse/neglect. Specifically, an adult engaging in harm to a child is at risk for a criminal charge while the child involved is at risk for mental, emotional, and physical injury. Justice in this case would include making a report to CPS to protect the welfare of all individuals involved.

Lastly, Respect for People’s Rights and Dignity, while allowing clients the right to have confidentiality within the therapeutic context also includes the rights and dignities afforded to persons or communities that are susceptible to harm. Specifically it notes, “psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision-making” (American Psychological Association, 2010, Principle E, line 2). This statement allows for clinicians to break confidentiality in order to safeguard individuals
or groups of people who are unable to advocate for themselves, as is the case in suspected child abuse/neglect. Children, by law, are dependents and in all or most cases, are considered unable to make autonomous decisions.

Taken together, the standards and principles outline an argument for reporting suspected or known child abuse/neglect. All clients should be aware of the legal and ethical limitations to confidentiality in regards to reports of child abuse/neglect. It is also psychologists’ duties to uphold truth and information, suggesting that when it is learned that a child is being abused/neglected, the proper governing agency should be notified. Lastly, while client confidentiality is an important standard, both the standard and principles allow for violations of confidentiality to protect a client or another vulnerable individual. In the context of reports of abuse/neglect, clinicians have the obligation to keep a child safe from harm, regardless of the impact that it may have on the therapeutic relationship.

In conclusion, psychologists in all 50 states are bound by state laws, the APA Ethics Code, and agency policies. While state laws vary in language, the spirit of the laws is all the same, and all psychologists are mandated reporters of suspected or known abuse/neglect. However, psychologists in Oregon are given an additional legal provision, discretion, allowing clinical judgment to be a factor in whether to report child abuse/neglect. Despite these legal nuances, the APA Ethics Code outlines a compelling argument in favor of reporting child abuse/neglect, regardless of legal discretion. Therefore, the purpose of this project is to investigate differing reporting behaviors of psychologists in Oregon and Washington and collect much needed data regarding the impacts of the discretionary reporting law in Oregon.
Rates of Abuse/Neglect in Oregon and Washington

In 2012, there were 23,972 cases of abuse and/or neglect screened-in to CPS in the state of Oregon and 37,422 in Washington; this equates to 1% of the child population in both states (US Department of Health and Human Services, Administration on Children, Youth and Families, Children’s Bureau, 2011). Oregon and Washington also had relatively equal rates of total referrals made to CPS in 2012 suggesting similar rates of both reported and substantiated abuse/neglect. Therefore, it will further be assumed that rates of abuse/neglect reporting and substantiated claims are similar across the two states allowing for comparison between professional groups and their actions regarding child abuse reporting and outcomes.

In summary, multiple researchers have investigated the decision-making process of mental health workers in reporting abuse/neglect (Alvarez et al. 2004; Badger, 1989; Beck & Ogloff, 1995; Jones et al., 2008; Kalichman & Brosig, 1993; Weinstein et al., 2001); however, no one has researched the impact of legal discretion or how psychologists respond to suspected child abuse when compared to other health professionals. Results of research studying the broad category of health care providers show four main categories of variables related to whether a clinician reports the abuse: clinician variables, perceptions of the abuse, opinions regarding legal obligations, and perceived treatment outcome. Results also show that even when psychologists are ethically and legally bound to report instances of suspected, believed or known abuse, some clinicians still choose not to report. In addition, no information could be found regarding the impact of discretionary reporting laws on rates of reporting and the outcome of reporting abuse/neglect cases.
Therefore, the aim of this study was to collect information from licensed psychologists in Oregon and Washington regarding basic demographic variables, past encounters or suspicions of abuse/neglect, and responses about reporting decisions in relation to suspected abuse and/or neglect.

Demographic information was collected as well as the respondents’ reported attitudes towards CPS, history with suspecting and reporting child abuse/neglect, and responses to a vignette. There were four main hypotheses. 1) It was hypothesized, based on the reviewed literature, that psychologists who were older and/or had more years in practice would endorse making a report\(^4\) to CPS less frequently than younger psychologists, or those who have practiced fewer years. 2) It was hypothesized that psychologists with better reported attitudes towards CPS would report more often than those with poorer attitudes towards CPS. 3) It is hypothesized that psychologists in Washington will report more often, due to more strict laws on reporting, than the psychologists in Oregon. 4) Exploratory analyses will be conducted to determine any other differences in reporting based on collected demographic and historical data.

---

\(^4\) Reporting behaviors measured by responding to a vignette that was the same for all participants.
Method

Participants

Participants will include a random selection of licensed psychologists from Oregon and Washington states. As noted previously, both Oregon and Washington have similar geographic locations, demographic characteristics, and specifically, similar rates of reported abuse/neglect each year. Overall, there were 245 participants who consented to participate in the survey and reported that they were active, licensed psychologists. There were 100 psychologists who were licensed in the state of Oregon and 117 from the state of Washington. There were 10 psychologists who reported dual licensure in Oregon and Washington. Due to the small respondent rate of this particular group, these participants were removed when comparing responses by state. Additionally, of the 245 participants, there were varying rates of responses to each question on the questionnaire; therefore, numbers of respondents for each variable will be reported individually.
Sample Size and Power Analysis

Two power analyses were conducted utilizing the software G*Power (Faul, Erdfelder, Buchner & Lang, 2009). First, a power analysis was conducted to determine the sample size needed for a simple ANOVA. As no research on this topic has been found, a small effect size will be used as a conservative estimate for the analyses. For the analysis four groups were indicated with an \textit{a-priori} \textit{p}-value set to .05, one degree of freedom and power of .95; the reported sample suggested was 651 participants. A second power analysis was conducted with a medium effect size (i.e., .5; all other values were kept the same). The reported sample with a medium effect size is 210 participants.
Materials

Each participant was contacted via e-mail and asked to fill out a questionnaire and respond to a vignette after reviewing and signing informed consent. Questions included demographic questions, as well as information on several other variables (See Appendix A for questionnaire). Subjects were informed that their participation was voluntary and anonymous; they were also allowed to skip any questions they chose not to answer, and/or stop participating at any point without penalty.
Measures

As noted above, a survey was provided via a web link to all participants. The questionnaire was developed to collect demographic information in addition to information on the predictor variables (Appendix B). The website SurveyMonkey.com was utilized for convenient and accurate data collection; the primary researcher was the only person with access to this information and no tracking information was collected from participants to ensure anonymity in responding. The questionnaire was open for three months and participants were recruited in two batches to allow for the maximum number of participants to complete the survey. At this time, the information was downloaded from the SurveyMonkey website and uploaded to SPSS for statistical analyses.

The vignette described a minor client reporting physical\(^5\) contact and verbal shaming by caregivers and asks the reader to respond as if they were the clinician. Two versions of the vignette were developed and the versions were randomized by the survey settings within the questionnaire (version 1 and version 2, Appendices A and B respectively). The two versions were developed to help identify any response bias due to the reported sex of the child in the vignette. Participants were asked to review the vignette and allowed to review this information as they answered follow-up questions in response to the vignette.

---

\(^5\) Physical abuse was selected as the literature reviewed suggests that there is more variability in report making-decisions when health professionals assumed physical abuse occurred rather than other types of abuse (Kalichman & Brosig, 1993; Alvarez, Kenny & Donohue, 2004). Variability in reporting behaviors will allow for the most accurate model to be developed.
Demographic variables. The demographic variables included age, ethnicity, degree earned (i.e., PsyD, PhD, or EdD), and total years practicing psychology as a licensed psychologist. Participants were also asked what type of agency they practice in, in what states they are licensed, and how long they have been licensed.
Other Variables.

Outcome. Participants were asked to state whether they would or would not report suspected abuse/neglect in regards to the case outlined in the vignette. This was measured on a dichotomous scale, yes vs. no.

Identified Abuse. Participants were asked whether they believed that abuse/neglect occurred in the vignette. This variable was dichotomous, yes vs. no.

Practice. Participants were asked to identify the type of agency/practice they work in. Choices listed included: private practice, group practice, community mental health agency, hospital/doctor’s office, and other. Participants selecting the other option, were asked to describe the type of agency where they practice.

Prior training. Information was also collected about any prior training in child abuse/neglect each participant had. Choices included: master’s level training, doctoral level training, training at a workshop, training via continuing education credits or other. If other was selected, participants were asked to identify what type of training they had received. Participants could select all options that applied.

Attitudes towards CPS. A five point Likert-scale was provided ranging from not helpful (1) to helpful (5), rating the participant’s attitude towards Child Protective Services. Higher scores indicate more positive attitudes towards CPS.

Confidence. As confidence in the participant’s suspicion of child abuse can affect decisions to report the suspected abuse/neglect. Each participant was also asked to rate how confident she/he was that abuse occurred in the vignette on a scale of 0-100%.
Analyses

Independent samples $t$-tests were conducted to determine the differences between the total number of reports made, based on the vignette, when comparing psychologists in Oregon and Washington. All other hypotheses were tested with independent sample $t$-tests or chi-square tests of independence, as appropriate.
Results

This research study focused on child abuse reporting behaviors of psychologists from Oregon and Washington. As little information was found in previous research on decision-making and reporting behaviors in regards to psychologists and child abuse, information about several demographic variables was also collected to determine relationships between these variables and the reporting variables.

In total, there were 245 psychologists who participated in the study; 100 identified as practicing in Oregon and 117 identified as practicing in Washington. Ten participants stated that they were licensed in both Oregon and Washington; these participants remained in most analyses, but were not utilized for state-to-state comparisons. Two outliers were identified and were removed from further analyses. Additionally, one participant reported being retired, excluding her/him from participation. Therefore, 225 participants were included in all further analyses; 98 reported practicing in Oregon, 117 reported practicing in Washington, and 10 with dual licensure.
Demographic Variables

Age. Participants were given a free text box to report their age. There were 223 participants who answered this question; two individuals included in the analysis chose not to answer this question. The mean age was 54.84, $SD = 11.20$; the minimum age was 30 and the maximum was 84. The mode was 63 and the median was 57. See Figure 1 for spread and frequency information.

Identified gender. Participants were given a free text box to report their identified gender. The term gender will therefore be used to describe these comparisons. There were 223 participants who answered this question; two individuals included in the analysis chose not to answer this question. 135 (60.0%) participants identified as female, and 88 as male (39.1%). No other gender identities were reported by participants.

Ethnicity. Participants were given a free text box to report their identified ethnicity. There were 219 participants who answered this question; six individuals chose not to answer this question. 210 of those individuals identified as white or of European decent, two as African American, four as multi-racial, one as Asian, one as a minority, and one as Hispanic. Due to the large discrepancy in white or European decent participants versus all other reported ethnicities, no predictive or relational analyses were conducted with this information.

Degree earned. Participants were asked to report the highest degree they had earned in the field of psychology. All of the 225 participants answered this question. There were 55 (24.4%) participants who reported earning a Psy.D., 167 (74.2%)

---

6 The term sex will be used when discussing findings by other researchers who reported differences in sex vs. gender.
participants who reported earning a Ph.D., and the remaining three participants reporting earning an Ed.D.

**Years in practice.** Participants were asked to report the number of years they had been practicing psychology as a licensed psychologist. There were 222 participants who answered this question; three individuals included in the analysis chose not to answer this question. The mean number of years in each participant had been practicing as a licensed psychologist was 19.33, $SD = 10.74$; the minimum number of years in practice was six months and the maximum was 47. The mode was 15 and the median was 19. See Figure 2 for spread and frequency information.

**Type of practice.** Participants were also asked to report the type of practice they belong to. There were 221 participants who answered this question and four who chose not to answer. Most of the participants identified as working in private practice ($N = 139, 61.8\%$); 11 (4.9\%) reported working in a group practice setting; 9 (4.0\%) reported working in community mental health; 16 (7.1\%) reported working in a hospital, doctor’s office, or other medical setting; 16 (7.1\%) reported working in a college or university counseling center; 21 (9.3\%) reported working both in private practice and one additional setting; and 10 (4.0\%) reported working in some other setting type (i.e., forensic setting, children’s specialty clinic, government/military medical center, employee assistance program, court, alcohol and drug treatment, residential treatment center, church).

**State of practice.** Participants were asked to report the states in which they are currently licensed and practice. All 225 participants were required to answer this question. There were 98 (43.6\%) participants who reported practicing in the state of Oregon and 117 (52.0\%) who reported practicing in the state of Washington; 10 (4.4\%)
participants reported being licensed and practicing in both Oregon and Washington. As there were only a few participants who reported dual licensure, these participants were not included in the statistical analyses comparing respondents by state. Additionally, as an active practice was a requirement for participation in the study, the individual who reported being retired was also removed from all further analyses.

**Number of suspicions.** Participants were also asked to report the number of times in their licensed career they had suspected a client had been the victim of or perpetrator of child abuse. 194 participants chose to answer this question while 33 chose to skip this question. Responses ranged from zero to 1200. There were two participants who reported more than 250 suspicions (i.e., 998 and 1200 suspicions); these responses were considered outliers and these participants were removed from further analyses. Therefore, the total number of responses included in the analysis was 192; the mean was 28.19 (SD = 115.11), the mode was zero, and the median was five.

When examining the range of responses to this question, the participants who reported 998 and 1200 suspicions were found to be outliers. Therefore, these participants were removed from further analyses. The updated mean for this variable with the outliers removed is 17.04, SD = 33.92; the mode and median were unchanged. Responses ranged from zero to 250.

**Number of reports.** In addition to asking participants how many times in their licensed career they have suspected a client be involved in child abuse, participants were also asked to report the number of times they had reported suspicions to the appropriate reporting agency. 194 of the originally included participants chose to respond to this
question while 34 chose to skip this item. Responses ranged from zero to 100; the mean was 8.70, $SD = 18.14$; the mode was zero and the median was 3.

One of the participants who noted they had made 100 reports, was the same participant who noted they had suspected 998 instances of child abuse in their licensed career. When examining this variable with the outliers removed, responses still ranged from zero to 100, but the mean and standard deviation changed slightly; the updated mean for the 192 included participants was 8.16, $SD = 16.96$. The mode and median were unchanged.

**Attitudes towards CPS.** Participants were asked to rate their attitude towards Child Protective Services (CPS) on a five-point Likert-scale (1 = bad, 2 = kind of bad, 3 = neither bad nor good, 4 = kind of good, 5 = good). There were 193 participants who chose to answer this question with 32 who chose to skip this question. The mean was 3.54, $SD = 1.03$; the mode and median were both 4.

Table 1

<table>
<thead>
<tr>
<th>Demographic Variables, Total and by State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Years Licensed</td>
</tr>
<tr>
<td>Number of Suspicions</td>
</tr>
<tr>
<td>Number of Reports</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Category</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Multiracial</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Minority</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Type of Degree</td>
</tr>
<tr>
<td>Psy.D.</td>
</tr>
<tr>
<td>Ph.D.</td>
</tr>
<tr>
<td>Ed.D.</td>
</tr>
<tr>
<td>Type of Practice</td>
</tr>
<tr>
<td>Private Practice</td>
</tr>
<tr>
<td>Group Practice</td>
</tr>
<tr>
<td>CMH</td>
</tr>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>University</td>
</tr>
<tr>
<td>Private Pract &amp; Other</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Attitude Towards CPS</td>
</tr>
<tr>
<td>Bad</td>
</tr>
</tbody>
</table>
Kind of Bad        23 (10.10)  12 (12.20)  11 (9.40)
Neither           57 (25.1)  24 (24.50)  29 (24.80)
Kind of Good      74 (32.6)  31 (31.60)  38 (32.50)
Good              34 (15.0)  14 (14.30)  18 (15.40)

Statistical Analyses

Several comparative analyses were conducted to determine differences in several variables between psychologists who reported practicing in Oregon and those in Washington. T-tests were conducted with the continuous variables of interest and chi-square tests were conducted with the categorical variables.

Independent samples t-tests were conducted to determine if age, number of years in practice, number of suspicions of child abuse, and number of reports of child abuse differed between the respondents in Oregon and Washington. No significant differences were found in these analyses; see Table 2.

Table 2

Demographic Variable Comparison by State

<table>
<thead>
<tr>
<th>Variable</th>
<th>t (df)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.98 (211)</td>
<td>.33</td>
</tr>
<tr>
<td>Years Practicing</td>
<td>-.97 (210)</td>
<td>.33</td>
</tr>
<tr>
<td>Number of Suspicions</td>
<td>.57 (181)</td>
<td>.57</td>
</tr>
<tr>
<td>Number of Reports</td>
<td>.52 (180)</td>
<td>.60</td>
</tr>
</tbody>
</table>

Note: No significant differences between groups.
Relationship Analysis

There were 190 participants who reported on their suspicions of abuse/neglect occurring in the presented vignette (35 missing cases) and 188 (37 missing cases) who stated whether they would report any suspicion to CPS. Of the 190 participants who responded to this the item regarding suspicion of abuse, 173 stated they did suspect abuse/neglect and six who did not suspect any foul play. Additionally, of the 188 responses regarding reporting to CPS, 121 stated they would report, where 67 stated they would not report. Information regarding participants’ confidence that abuse occurred was also collected and compared to reporting behaviors. Participants who reported had significantly different levels of confidence that abuse occurred, than those participants who said they would not report, Pearson $\chi^2 (10, N = 188) = 53.90, p < .001.$
Table 3

Confidence Abuse Occurred vs. Reporting Status

<table>
<thead>
<tr>
<th>Confidence Abuse Occurred</th>
<th>Reporters</th>
<th>Non-Reporters</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>10%</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>20%</td>
<td>2</td>
<td>23</td>
</tr>
<tr>
<td>30%</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>40%</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>50%</td>
<td>25</td>
<td>13</td>
</tr>
<tr>
<td>60%</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td>70%</td>
<td>30</td>
<td>4</td>
</tr>
<tr>
<td>80%</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>90%</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>100%</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Additional analyses were conducted to determine if the age of the participant, the number of years they had been practicing as a licensed psychologist, the number of suspicions of child abuse or neglect they had over their career, or the number of times they reported child abuse or neglect to CPS differed based on whether the participant decided to report their suspicion of child abuse or neglect based on the presented vignette.
**T-tests.** An independent samples \( t \)-test was conducted to determine if the mean age differed between the psychologists who said they would report their suspicion of abuse in the vignette and those who said they would not report (i.e., reporters vs. non-reporters). The test was significant, \( t(185) = -2.84, p = .005 \); these results were congruent with the hypotheses. Specifically, psychologists who said they would report were statistically younger (\( M = 53.09, SD = 10.98 \)), than those participants who said they would not report (\( M = 57.95, SD = 11.60 \)). Effect size was calculated and found to be small; \( \eta^2 = .046 \), and indicates that 4.6% of the variance in the decision to report based on the vignette was accounted for by the age of the participant.

An independent samples \( t \)-test was also conducted to determine if the mean number of years participants had been practicing psychology differed between the reporters and non-reporters. The test was significant, \( t(181) = -2.33, p = .021 \). These results were congruent with the hypotheses and suggest that psychologists who said they would report had statistically fewer years in practice (\( M = 18.11, SD = 11.02 \)), than those participants who said they would not report (\( M = 21.94, SD = 10.20 \)). Effect size was calculated and found to be small, \( \eta^2 = .033 \), and indicates that 3.3% of the variance in the decision to report based on the vignette was accounted for by how many years the participant had been practicing psychology.

Additionally, an independent samples \( t \)-test was conducted to determine if the mean number of suspicions of abuse or neglect participants had since they began practicing psychology differed between the reporters and non-reporters. The test was not significant, \( t(182) = .74, p = .46 \); these results were incongruent with the hypotheses. Specifically, there was no mean difference in number of suspicions a psychologist had
between psychologists who said they would report \((M = 18.95, SD = 39.18)\) and those participants who said they would not report \((M = 14.98, SD = 23.49)\).

Lastly, an independent samples \(t\)-test was conducted to determine if the mean number of reports to CPS differed between the reporters and non-reporters. The test was significant, \(t(171.76) = 2.63, p = .009\) and congruent with the hypothesis that psychologists who had historically made more reports to CPS \((M = 10.27, SD = 20.24)\), would report, compared to those who said they would not report \((M = 4.70, SD = 8.31)\). Effect size was calculated and found to be small, \(\eta^2 = .033\); thus, 3.3\% of the variance in the decision to report based on the vignette was accounted for by how many times the participant had reported to CPS in the past.

**Chi-Square Tests.** A chi-square test of independence was conducted to determine if the gender of the child in the vignette differed between the reporters and non-reporters. The two variables were not found to be significantly related; Pearson \(\chi^2 (1, N = 188) = .21, p = .65\). However, this result was congruent with the hypotheses and suggests no gender bias in reporting behaviors of the participants.

A second chi-square test of independence was conducted to determine if the mean rating of perceived attitude towards CPS differed between the reporters and non-reporters. The two variables were not found to be significantly related; Pearson \(\chi^2 (4, N = 184) = 6.9, p = .14\), this result was not congruent with the hypotheses. Instead, it suggests that attitude towards CPS did not impact participants’ decision to report based on vignette or not. Effect size was calculated, \(\phi = .01\). See Figure 3 for frequency counts of total sample and Table 4 for frequency counts of attitudes towards CPS based on reporting status.
Table 4

*Decision to Report Compared to Attitude Towards CPS*

<table>
<thead>
<tr>
<th>Attitude Towards CPS</th>
<th>Reporters</th>
<th>Non-Reporters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Kind of Bad</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Neither</td>
<td>31</td>
<td>23</td>
</tr>
<tr>
<td>Kind of Good</td>
<td>53</td>
<td>17</td>
</tr>
<tr>
<td>Good</td>
<td>19</td>
<td>13</td>
</tr>
</tbody>
</table>

A third chi-square test of independence was conducted to determine if the state in which the participant was licensed had an impact on the reporters and non-reporters. There were 116 participants who stated they would report suspicion of abuse/neglect based on the vignette; 48 from Oregon (41.34%) and 68 from Washington (58.62%). There were 63 participants who stated they would not report; 18 from Oregon (28.57%) and 32 from Washington (27.4%). The two variables were not found to be significantly related; Pearson $\chi^2 (1, N = 116) = 1.04, \ p = .31$. This result was incongruent with the hypotheses. Instead, this result suggests that psychologists in Oregon and Washington have similar reporting behaviors despite differing state laws that govern reporting behaviors. Effect size was calculated, $\varphi = .08$.

Of the participants who reported that they suspected abuse/neglect occurred in the vignette, 113 stated they would report that suspicion (68.90%) and 49 stated they would not. When breaking this down into state-by-state comparisons, 47 of the 113 reporters
were from Oregon and 66 were from Washington. There were 49 participants who indicated they would not report, despite suspecting abuse occurred in the vignette; 25 were from Oregon and 24 were from Washington. See table 5 for further comparisons.

Table 5
Reporters vs. Nonreporters by State and Suspicion

<table>
<thead>
<tr>
<th></th>
<th>Reporters</th>
<th>Non-Reporters</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspected Abuse</td>
<td>47 (65.28)</td>
<td>25 (34.72)</td>
<td>72</td>
</tr>
<tr>
<td>Did Not Suspect Abuse</td>
<td>1 (50)</td>
<td>1 (50)</td>
<td>2</td>
</tr>
<tr>
<td>Washington</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspected Abuse</td>
<td>66 (73.33)</td>
<td>24 (26.67)</td>
<td>90</td>
</tr>
<tr>
<td>Did Not Suspect Abuse</td>
<td>2 (50)</td>
<td>2 (50)</td>
<td></td>
</tr>
</tbody>
</table>

A fourth and final chi-square test of independence was conducted to determine if the gender of the participant had an impact on the reporters and non-reporters. The two variables were found to be significantly related, though it was hypothesized that there would be no gender differences in the decision to report or not; Pearson $\chi^2 (1, N = 187) = 5.97, p = .015$. Specifically, males were found to be more likely to report than females (Table 6). Effect size was calculated, $\varphi = .18$ and found to be small to medium.
Table 6

*Gender of Participant vs. Decision to Report*

<table>
<thead>
<tr>
<th>Gender of Participant</th>
<th>Reporters</th>
<th>Non-Reporters</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$N$ (%)</td>
<td>$N$ (%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>66 (57.39)</td>
<td>49 (42.6)</td>
<td>115</td>
</tr>
<tr>
<td>Male</td>
<td>54 (75)</td>
<td>18 (25)</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td>120 (64.17)</td>
<td>67 (35.83)</td>
<td>187</td>
</tr>
</tbody>
</table>

Due to the gender differences found between the reporters and nonreporters, additional analyses were conducted to determine if there were other gender differences within the demographic variables in the sample. No differences were found in the number of suspicions, the number of reports to CPS, ethnicity, degree, type of practice, or state of practice, when comparing the female and male participants. However, significant differences were found in the participants’ age, number of years in practice, and attitude towards CPS, when comparing the female and male participants. Specifically, the female ($M = 52.46$) participants tended to be younger than the male ($M = 58.61$) respondents as well as having fewer reported years in practice ($M = 16.14$ vs. $M = 24.09$). See Table 7 for statistical significance.
Table 7

Gender Differences in Demographic Variables.

<table>
<thead>
<tr>
<th>Variable</th>
<th>$t$ (df)</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-4.15 (209.89)</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Years Practicing</td>
<td>-5.76 (218)</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Number of Suspicions</td>
<td>1.01 (188.78)</td>
<td>.31</td>
</tr>
<tr>
<td>Number of Reports</td>
<td>.61 (188)</td>
<td>.54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>$\chi^2$ (N, df)</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td>5.06 (218, 5)</td>
<td>.41</td>
</tr>
<tr>
<td>Degree</td>
<td>4.78 (223, 2)</td>
<td>.09</td>
</tr>
<tr>
<td>Type of Practice</td>
<td>3.01 (219, 6)</td>
<td>.81</td>
</tr>
<tr>
<td>State of Practice</td>
<td>.01 (223, 2)</td>
<td>.99</td>
</tr>
<tr>
<td>Attitude Towards CPS</td>
<td>15.61 (192, 4)</td>
<td>.004**</td>
</tr>
</tbody>
</table>

*significant at .05 level

**significant at .01 level
Discussion

Review and Implications of Findings

One of the main purposes of this study was to begin to explore the characteristics of psychologists that relate to their likelihood to report suspected child abuse/neglect. Results indicate that the respondents of the survey were demographically similar across states; there were no differences in age, number of years in practice, or the number of times a participant suspected or reported abuse. While the number of suspicions a participant stated she had in her career was not related to whether the participant stated she would report abuse or not, the number of reports the participant had in her career was.

Specifically, those who had made more previous reports to CPS were more likely to report in the study. It is possible that these participants with more experience with CPS have a more realistic understanding of the outcomes of reporting abuse than those who have less experience. As negative attitudes towards CPS have impacted rates of reporting in previous studies, if this is the case, those with more experience with CPS may have better attitudes towards them. Post-hoc analysis show that those who had more reports to CPS had slightly higher, but not statistically different, attitudes towards CPS. As only 176 people reported their attitudes towards CPS, it is possible that this comparison was not powerful enough to determine a difference. This relationship should be evaluated further in the future to determine if the number of reports to CPS mediates or moderates a person’s attitude towards CPS.

Overall, results of this study show no significant differences between rates of reporting of psychologists in Oregon and Washington. This suggests that psychologists in both states follow similar paths in regards to reporting child abuse and/or neglect. This
finding was not hypothesized originally, based on differing state laws. While the psychologists in Oregon, as a whole, reported more than not (60% vs. 40%), psychologists in Washington tended to follow the same pattern (68% reporters vs. 32% nonreporters). This finding suggests two things. First, it suggests that psychologists in Oregon are more likely than not to report suspected child abuse, despite having legal discretion to make the report. Second, it suggests that psychologists in Washington, despite mandated reporting laws, are not making reports to CPS 32% of the time. Based on this information and the 2012 statistics on the number of reports made to CPS in Washington, it is likely that approximately 12,000\(^7\) cases of suspected abuse and/or neglect go unreported every year in the state.

Results also confirm previous research on age differences and how length of time in practice impacts rates of reporting. This study found that younger psychologists, and those with fewer years in practice indicated being more likely to report suspected abuse/neglect, when compared to their older and more tenured colleagues. As mandatory child abuse reporting laws did not take effect in Oregon and Washington until 1993 (Reporting Child Abuse, 1993) and 1988 (Children and Developmentally Disabled Persons–Reports of Abuse or Neglect–Case Planning and Consultation, 1988), respectively, it is possible that some of the older psychologists who have been practicing for more than 20-25 years, were not mandated reporters when they first entered the field. This suggests they did not receive training on identifying or reporting suspected abuse in their formal education, and possibly not until much later when continuing education on

\[7 \text{ 32\% of the 37,422 cases screened in by CPS in Washington state in 2012 (US Department of Health and Human Services, Administration on Children, Youth and Families, Children’s Bureau, 2013)}\]
this topic became available. This delay in training, could impact their current decisions to report child abuse, despite now being mandated reporters.

Additionally, this result may suggest that younger or less experienced practitioners are more likely to seek additional help in dealing with a client or family when abuse or neglect is suspected. Whether this is through consulting with a colleague or with Child Protective Services, seeking additional support in making a decision is likely to increase the likelihood of making a report (Jones et al., 2008). These factors should be considered and highlighted in continuing education classes for psychologists to help both groups understand their legal and ethical obligations in reporting child abuse/neglect.

One finding, that was not expected, was gender differences in the reporters vs. the nonreporters. Specifically, the men who participated in the study indicated a stronger adherence to report than the women. Previous literature reviewed did not show a sex/gender difference in reporting. Additional analyses were conducted to determine other demographic differences between the female and male participants. Specifically, results showed that the male participants were significantly older, had more years in practice, and had different attitudes towards CPS than the female participants. As the male participants were statistically older and had more years in practice, two variables that are highly suggestive of nonreporters, it is interesting that males reported more in this study. It is possible that other variables that were not measured in this study (e.g., history of own childhood abuse) occurred more often in the male respondents. Research regarding sex differences in moral reasoning suggests some differences between female and male participants. A study conducted by Pratt, Golding, Hunter, and Sampson,
(1988) found that when presented with a dilemma, women tend to focus more of the personal relationship problems, where men in the study focused more on the nonrelational aspects of the dilemma. If participants within this study followed a particular trend, it is possible that the men in the study focused on different aspects of the dilemma (e.g., legal obligations) than the impact on the relationship, making a report more desirable. Future research should include aspects of moral reasoning and relational impact to determine any decision making differences impacted by this phenomenon.

A second hypothesis is that there are actual gender differences in the rates of reporting behaviors when comparing men and women.
Strengths and Limitations

**Strengths.** The strengths of this study lie most notably in the exploratory nature of the research and in the sample size. As no research previously has focused on how psychologists differ or fall in line with other health professionals in the decision to report suspected abuse and/or neglect, this study outlines some basic findings that will be helpful to further the literature. Also, with 245 participants, several analyses were able to be conducted and find true differences between groups. Additionally, many of the findings had small to medium effect sizes; helping to determine needed sample sizes for future studies.

Another strength of this study was the format. The survey was easily disseminated via e-mail allowing participants from multiple areas in large states to participate. The anonymous nature of the survey also likely encouraged open and frank communication of factors that are often not addressed in face-to-face, or non-confidential mediums. When assessing adherence to state laws, many participants may not be willing to admit to non-adherence in another format, therefore, this online format should be considered when conducting similar future research.

**Limitations.** Several limitations should be noted. First, as no other study was found examining these variables, the author of the study developed all of the materials, limiting the known reliability and validity of all instruments. It is possible that the chosen wording or order of the questionnaire biased respondents. Notably, many respondents of this study answered most or all of the questions in the first half of the survey, but chose to discontinue participation, or answer fewer questions towards the last half of the survey. As the vignette occurred in the last section of the survey, future research may want to
randomize the presentation of the questions to minimize this effect. Second, in being mindful of the length of the survey, several variables of interest were not collected. Historical information, such as the psychologists’ own experience of childhood abuse and/or neglect, was not collected, despite being a previous predictor variable in the reporters vs. nonreporters.

Third, individuals who participated in this study were overwhelmingly Caucasian. Of the 227 people who disclosed their ethnicity, 212 identified as Caucasian, leaving only nine participants identifying as African American, multi-racial, Asian, Hispanic or as a minority. Thus, this variable could not be used to determine any meaningful differences in reporting behaviors. While this variable could not be used to compare between reporting groups, it is likely that the percentage of psychologists in Oregon and Washington that are Caucasian is similar, suggesting a representative sample. Therefore, as a whole, the results of this study are likely generalizable to the psychologists of Oregon and Washington. When looking at possible responses from psychologists in other states, readers and researchers should carefully assess the percentage of Caucasian participants, compared to other ethnicities, before generalizing these findings.
Implications for Future Research

Future research should attempt to replicate these findings to corroborate the similarities and differences found in reporting behaviors of psychologists in Oregon and Washington. Additionally, other demographic variables that were left out of this study should be investigated for a more broad perspective of the factors that may impact reporting behaviors of psychologists. As the format and/or wording of some of the items of the survey may have impacted response styles, it is suggested that future research pilot several questions and/or formats to find a survey that best represents the constructs being measured.

Additionally, future research should begin to investigate some of the findings that were unexpected, or not supported by previous studies. Notably, future research should investigate the gender differences between the reporters and nonreporters further to determine any mediators, moderators, or real differences in men and women’s reporting behaviors.

More broadly, as several factors have now been found to impact reporting behaviors, future research should explore factors that encourage clinicians to report suspected abuse such as specific trainings or laws. The research should also be expanded to include information based on real cases, not relying on a vignette, as decision-making becomes more complicated as relationships are closer or considered more real.

Lastly, outcome data for specific reports and non-reports of suspected child abuse and/or neglect should be collected to fill the gap on outcome potential for psychologists. As a therapeutic relationship is different from that of a teaching relationship or doctor-
patient relationship, it is possible that outcome data will be different when compared to the previous literature.

In relation to the discretionary law in Oregon, future research in this area should focus on psychologists’ ability to make these decisions in the best interest of the client. Past research highlighted in this study suggests many of the reasons that health care professionals decide not to report child abuse are related to personal preference or fear of personal consequence, not based on the possible consequence to the suspected victim. These personal factors alone should not be sufficient in the decision-making process; instead, as stated in the Ethical Guidelines for psychologists, beneficence and nonmaleficence are primary considerations in all professional work, especially as they relate to vulnerable clients.

Future research on the outcomes of psychologists reporting suspected child abuse/neglect are needed to better educate the community on outcomes of reporting. These results may also be helpful to state law makers in determining the most appropriate state laws that govern mandated reporters in psychology and other health care fields.
Conclusion

The results of this study highlight the need for more information about child abuse reporting behaviors by psychologists. This study found that while most psychologists are capable of correctly identifying suspected abuse, there are variables that impact their likelihood to report. Some of those findings were age, number of years in practice, and gender. More research is needed to determine the strength of impact as well as factors that increase likelihood of reporting as past research has highlighted the positive impacts of reporting suspected abuse.

Also, when investigating rates of reporting, this study followed patterns shown in previous research. Similarly to other studies on rates of reporting, 68% (65% from Oregon, 73% from Washington) of respondents in this survey who believed abuse occurred in the vignette stated that they would report that abuse. These results are consistent with previous research findings (68%; Brown & Strozier, 2004) on how often health professionals report suspected child abuse/neglect despite state laws requiring mandatory reporting. While it is encouraging to see that most respondents in the survey stated that they would report the suspected abuse from the vignette, it is interesting to find that 32%, while believing abuse occurred, stated they would not report. As previously discussed, it is possible that other factors such as fear of negative consequences to the psychologist, the idea that it is not in the best interest of the client to make a report, the psychologist’s own abuse history, the perception of the low severity of the abuse, or a lack of identification with legal obligations decreased participants willingness to report the abuse indicated. It would have been interesting to ask participants why they chose not to report, and/or to measure the level of severity the
participants’ place on the described abuse in the vignette as ways to better explain this lack of responding, despite legal obligations.

Future research should focus on expanding this study to determine factors that contribute to, or hinder, reporting suspected child abuse/neglect as well as to collect more information about reasons why psychologists choose not to report suspected child abuse/neglect.
References


Reporting Child Abuse, Oregon Revised Statute, Senate Bill 1051, (1993)
Reporting Child Abuse, Oregon Revised Statute, Chapter 419B, § 419B.010-.035, (2011).


Appendix A

**Vignette #1:** Felicia is your 11 year old client in treatment for anxiety and a parent child relational problem. Her mother, Tammy, is a single parent in her 30s and describes herself as “Bipolar”. Felicia and her younger brother Sam live with their mother and receive some social/parental support from their grandmother who lives down the street. Tammy has wanted to be an active member of Felicia's treatment, though seems to dominate the time describing her frustrations when family sessions are held. You have been working the Tammy on more appropriate communication skills and ways to manage her stress. Felicia's treatment has revolved around minimizing her anxiety in social situations and improving communication with her mother. You have seen Felicia for a total of 10 sessions over the past two and a half months.

Today during your session Felicia reports that she doesn’t like spending the night at her grandmother’s house. When inquired about why, she reports that her grandma yells at her and Sam when Tammy isn't around. She also reported that this past week, grandma “grabbed” Felicia on the arm and "dragged" her to bed. When you look at Felicia's arm, you see 5 small bruises the size of finger prints on her upper right arm. Felicia states that she is afraid that if you tell, her mother and grandmother will be mad.
Appendix B

**Vignette #2:** Sam is your 11 year old client in treatment for anxiety and a parent child relational problem. His mother, Tammy, is a single parent in her 30s and describes herself as “Bipolar”. Sam and her younger sister Felicia live with their mother and receive some social/parental support from their grandmother who lives down the street. Tammy has wanted to be an active member of Sam's treatment, though seems to dominate the time describing her frustrations when family sessions are held. You have been working the Tammy on more appropriate communication skills and ways to manage her stress. Sam's treatment has revolved around minimizing his anxiety in social situations and improving communication with his mother. You have seen Sam for a total of 10 sessions over the past two and a half months.

Today during your session Sam reports that he doesn’t like spending the night at his grandmother’s house. When inquired about why, he reports that his grandma yells at him and Felicia when Tammy isn't around. He also reported that this past week, grandma “grabbed” Sam on the arm and "dragged" him to bed. When you look at Sam's arm, you see 5 small bruises the size of finger prints on his upper right arm. Sam states that he is afraid that if you tell, his mother and grandmother will be mad.
Figure 1. Histogram depicting frequency counts of reported age of participants.
Figure 2. Histogram depicting frequency counts of reported number of years each participant has been practicing as a licensed psychologist.
Figure 3. Histogram depicting frequency counts of reported attitudes towards child protective services; reported attitudes rated on a 5-point Likert scale where higher values indicated more positive attitudes.