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Examination of clinical and legal issues relevant to child maltreatment reporting

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EXAMINATION OF CLINICAL AND LEGAL ISSUES RELEVANT TO CHILD MALTREATMENT REPORTING

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ABSTRACT

Examination of Clinical and Legal Issues Relevant to Child Maltreatment Reporting

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Mental health professionals have evidenced deficiencies in reporting child maltreatment, including knowledge about mandatory reporting laws, ability to accurately identify child maltreatment, child maltreatment reporting intentions, and clinical expertise in reporting child maltreatment (e.g., utilization of best practices in the management of clients throughout the reporting process). Therefore, the purposes of the given study were to develop and initially validate three inventories (i.e., Knowledge of Child Maltreatment Laws Screening Tool, Recognition of Child Maltreatment Screening Tool, and Clinical Expertise in Reporting Child Maltreatment Screening Tool) to assess reporting competence in mental health professionals and graduate students. Multistage validation supports the initial reliability and validity of the developed screening tools. Future directions regarding the utilization of these instruments are discussed.

TABLE OF CONTENTS

ABSTRACT iii

LIST OF TABLES viii

ACKNOWLEDGEMENTS ix

CHAPTER 1 INTRODUCTION 1
Hypotheses 3
Secondary Investigations 4

CHAPTER 2 LITERATURE REVIEW 6
Mandated Reporting Legislation 6
History of Mandated Reporting Legislation 6
Impact of Mandated Reporting Legislation 10
Current Child Maltreatment Statistics 10
The Reporting Problem 11
The Problem of Underreporting Child Maltreatment 12
Consequences of Under-Reporting 13
The Problem of Over-Reporting Child Maltreatment 14
Consequences of Over-Reporting 15
Reasons for Child Maltreatment Reporting Practice Problems 16
Lack of Knowledge and Understanding of Child Maltreatment 16
Conclusion 22
Important Child Maltreatment Knowledge 22
Mandatory Reporting Laws 22
Child Maltreatment as Defined by Law 23
Professions Mandated to Report 25
Legally Required Contents of Report 26
Reasonable Suspicion 26
Protection of Mandated Reporters 27
Report Must Be Made in a Timely Manner 27
Penalties for Failure to Report 28
Abuse Identification 28
Physical Abuse 29
Sexual Abuse 31
Emotional Abuse 33
Neglect 35
Clinical Expertise in the Reporting Process 37
Dealing with the Caregivers 38

Making the Report 39
Child Protective Service Procedures 41
Instruments Designed to Assess Child Maltreatment Competence 44
Educators 45
Medical Professionals 48
Various Professionals 49
Mental Health Professionals 50
Summary 54

CHAPTER 3 METHODOLOGY 56
Purpose 56
Stage 1 56
Purpose 56
Participants 57
Procedure 57
Literature Review 57
Development of Knowledge of Child Maltreatment Laws Screening Tool 58
Recognition of Child Maltreatment Screening Tool 60
Clinical Expertise in Reporting Child Maltreatment Screening Tool 63
Stage 2 64
Purpose 64
Participants 65
Procedure 66
Measures 67
Demographic Information 67
Child Maltreatment Reporting Experience 67
Knowledge of Child Maltreatment Laws Screening Tool 68
Recognition of Child Maltreatment Screening Tool 68
Clinical Expertise in Reporting Child Maltreatment Screening Tool 69
Assessment of Potential Influences on Reporting Child Maltreatment 69

CHAPTER 4 FINDINGS OF THE STUDY 70
Comparison of Recruited Samples 70
Stage 2 71
Knowledge of Child Maltreatment Laws Screening Tool 71
Means and Standard Deviations 71
Test-Retest Reliability 71
Responsiveness 72
Internal Consistency 73
Relationship of Laws Screening Tool and Training in Reporting Child Abuse 73
Recognition of Child Maltreatment Screening Tool 74
Means and Standard Deviations 74
Test-Retest Reliability 75
Responsiveness 75
Internal Consistency 76

Relationship of Recognition Screening Tool and Training in Reporting Child Abuse 76
Clinical Expertise in Reporting Child Maltreatment Screening Tool 76
Means and Standard Deviations 76
Test-Retest Reliability 77
Responsiveness 77
Internal Consistency 78
Relationship of Clinical Expertise Screening Tool and Training in Reporting Child Abuse 78
Secondary Investigations 79
Assessment of Potential Influences on Reporting Child Maltreatment 79
Relationships between Aspects of Child Maltreatment Reporting Knowledge 80
Estimating the Likelihood of Under-Reporting in Mental Health Professionals 80
Estimating the Likelihood of Over-Reporting in Mental Health Professionals 81
Exploration of Suspicion of Child Maltreatment 82

CHAPTER 5 DISCUSSION 83
Knowledge of Child Maltreatment Laws Screening Tool 83
Recognition of Child Maltreatment Screening Tool 85
Clinical Expertise in Reporting Child Maltreatment Screening Tool 87
Secondary Investigations 90
Assessment of Potential Influences on Reporting Child Maltreatment 90
Relationships between Aspects of Child Maltreatment Reporting Knowledge 90
Estimating the Likelihood of Under-Reporting in Mental Health Professionals 91
Estimating the Likelihood of Over-Reporting in Mental Health Professionals 92
Exploration of Suspicion of Child Maltreatment 93
Limitations and Future Directions 93

TABLES 95

APPENDIX A KNOWLEDGE OF CHILD MALTREATMENT LAWS 106

APPENDIX B RECOGNITION OF CHILD MALTREATMENT 109

APPENDIX C CLINICAL EXPERTISE IN REPORTING CHILD MALTREATMENT 113

APPENDIX D DEMOGRAPHIC INFORMATION 116

APPENDIX E CHILD MALTREATMENT REPORTING EXPERIENCE 118

APPENDIX F ASSESSMENT OF POTENTIAL INFLUENCES ON REPORTING CHILD MALTREATMENT 120

REFERENCES 124

VITA 144

LIST OF TABLES

Table 1 Participant Demographic Information 95
Table 2 Participant Child Maltreatment Experience Information 97
Table 3 Means and Standard Deviations of Laws Screening Tool Individual Items. ... 98
Table 4 Means and Standard Deviations of Pre-Test and Post-Test Screening Tool Scores. 100
Table 5 Means and Standard Deviations of Recognition Screening Tool Accuracy Scores. 101
Table 6 Means and Standard Deviations of Clinical Expertise Screening Tool Individual Items. 102
Table 7 Means and Standard Deviations of Factors Influencing Child Maltreatment Reporting. 104
Table 8 Means and Standard Deviations for Suspicion in Recognition Screening Tool Vignettes. 105

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CHAPTER 1

INTRODUCTION

Child maltreatment continues to plague our nation with the most recent statistics indicating over 3 million referrals, involving more than 5.5 million children, being made to child protective services in 2004 (U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2006). Unfortunately, though great gains have been made, reporting of child maltreatment is far from perfect. Vast amounts of literature reveal problems with both under-reporting and over-reporting. Although the statistics of maltreatment seem daunting, they are widely thought to be gross underestimates of the actual incidents of maltreatment. Similarly, literature illustrates startling statistics regarding the number of mandated reporters failing to report suspected maltreatment. Conversely, child protective services are often greatly overburdened due to the amount of unwarranted and unsubstantiated reports.

Indeed, literature continues to illustrate mandated reporters lack of competence regarding reporting child maltreatment as contributing to the aforementioned reporting problems. Areas outlined in the literature, and of particular importance to the current study, include knowledge of federal and state mandatory reporting laws, as well as recognition and identification of the signs and symptoms of maltreatment. Mandated reporters competence in the accuracy and efficacy of making a report is also illustrated. With regard to mental health professionals, the profession of interest in the current study,

literature outlines the importance of managing the client throughout the reporting process to maximize the protection of the child, as well as the treatment of the client.

Due to the awareness of the contribution of reporting incompetence to reporting system problems, researchers have developed instruments to examine various aspects of mandated reporters' knowledge, understanding, and abilities. Unfortunately, limited information is typically available with regard to these instruments structure, development, or psychometric properties. Furthermore, standardized instruments to assess mandated reporters' level of competence in reporting child maltreatment have yet to be developed. Such a tool would allow employers, professions, and training programs to quickly and accurately assess mandated reporters level of knowledge and competence in areas of child maltreatment, found in the literature, to be significant predictors of effective reporting.

Therefore, given these apparent needs, the primary purposes of the current study were (1) to systematically develop three inventories of child maltreatment reporting competence (i.e., Knowledge of Child Maltreatment Laws Screening Tool, Recognition of Child Maltreatment Screening Tool, and Clinical Expertise in Reporting Child Maltreatment Screening Tool) in assessing child maltreatment reporting knowledge and proficiency of professionals' and graduate students' in mental health fields; and (2) to initially examine the psychometric properties and clinical utility of each of these inventories. Additionally, the level of influence of various factors on reporting child maltreatment was investigated.

Hypotheses

1. The developed Knowledge of Child Maltreatment Laws Screening Tool will evidence adequate psychometric properties within a population of professionals and graduate students in mental health fields.
    a. Subsequent to initial development and validation, this screening tool will evidence adequate face and content validity.
    b. Upon further validation, the Knowledge of Child Maltreatment Laws Screening Tool will evidence adequate test-retest reliability and responsiveness. The internal consistency coefficient will evidence the heterogeneity necessary for this screening tool. Additionally, significant correlations will evidence relationships with respondents' number of workshops/trainings attended, approximate number of total hours of training received, and approximate number of instances of maltreatment reported to child protective services.
2. The developed Recognition of Child Maltreatment Screening Tool will evidence adequate psychometric properties within a population of professionals and graduate students in mental health fields.
    a. Subsequent to initial development and validation, this screening tool will evidence adequate face and content validity.
    b. Upon further validation, the Recognition of Child Maltreatment Screening Tool will evidence adequate test-retest reliability and responsiveness. Internal consistency will evidence the multidimensionality of the screening tool. Again, relationships will be supported by a significant correlation with

respondents' number of workshops/trainings attended, approximate number of total hours of training received, and approximate number of instances of maltreatment reported to child protective services.

3. The developed Clinical Expertise in Reporting Child Maltreatment Screening Tool will evidence adequate psychometric properties within a population of professionals and graduate students in mental health fields.
    a. Subsequent to initial development and validation, this screening tool will evidence adequate face and content validity.
    b. Upon further validation, the Clinical Expertise in Reporting Child Maltreatment Screening Tool will evidence adequate test-retest reliability and responsiveness. Low internal consistency will demonstrate the heterogeneous nature of a screening tool. Relationships will again be supported by a significant correlation with respondents' number of workshops/trainings attended, approximate number of total hours of training received, and approximate number of instances of maltreatment reported to child protective services, as well as number of years in the mental health field.

Secondary Investigations

1. The extent to which various factors impact mental health professionals' reporting of child maltreatment will be explored.
2. The relationships between the various aspects of child maltreatment reporting competence assessed in this study (i.e., knowledge of mandatory reporting laws, accurate identification/reporting, clinical management of child maltreatment reporting) will be explored.

3. Failure to report child maltreatment will be investigated via exploration of participants' accuracy in reporting child maltreatment, as measured by the reportable vignettes of the Recognition Screening Tool.
4. Over-reporting will be explored via investigation of participants' responses for the non-reportable vignettes of the Recognition Screening Tool.
5. The relationship between level of suspicion and reporting tendency will also be explored.

CHAPTER 2

LITERATURE REVIEW

Mandated Reporting Legislation

History of Mandated Reporting Legislation

Child maltreatment has been evidenced throughout the world and dating back to the beginnings of time. Indeed, infanticide appears to date back to 7000 BC, and this atrocious killing of children was legal until 318 AD (Corby, 2000). Additionally, in early times, children were seen as the property of their parents' and thus could be used as chattel, or as workers to pay off their parents' debt (Azar & Olsen, 2003). Interestingly, although child maltreatment is known to be a devastatingly, long-standing societal issue, child protection has only relatively recently gained attention.

Although there is some disagreement about when child protection first emerged in the United States, most historians believe the movement was spurred by the discovery of the egregious treatment of Mary Ellen Wilson in 1874. A nurse visiting Mary Ellen became outraged at the obvious physical abuse and very publicly insisted that Mary Ellen receive, at least, the same protection as an abused animal (Berg & Kelly, 2000). Due to dramatic public attention, the New York Court system intervened to protect Mary Ellen and in 1877 the first anticruelty organization for children was developed. This organization, the New York Society for the Prevention of Cruelty to Children (SPCC),

was formed by the American Humane Society (Kalichman, 1999). By the early 1900's, over 300 cruelty societies had been formed in the United States (Berg & Kelly, 2000).

Over the next several decades, attention continued, albeit less publicly, at the federal as well as state levels. In 1909, President Roosevelt held the first White House Conference on Children which focused on the welfare of state dependent children (Kalichman, 1999) and created the United States Children's Bureau to investigate child welfare issues. By 1921, Children's Bureaus were also enacted at the state level. Since this first meeting, similar conferences have been held every ten years. In 1935, the Social Security Act was created to protect and care for needy children, and in 1942, the Aid to Dependent Children (ADC) was added to this act in the hope that by providing aid to disadvantaged families, fewer children would require removal from their home.

Attention and interest in child maltreatment as a major social problem peaked in the 1960's, due partly to the social climate of the times though, mostly due to the seminal article written by Kempe, Silverman, Steele, Droegemueller, and Silver (1962). This article is thought of as "the single most influential report on child maltreatment" (Kalichman, 1999, p. 14). Kempe et al. (1962), utilizing physical and radiographic evidence, described a medical diagnosis of child abuse, which they coined, "The Battered Child Syndrome." This syndrome is characterized by evidence of physical abuse (e.g., soft tissue and skeletal injuries), as well as evidence of neglect (e.g., poor skin hygiene and maltreatment) (Kempe et al., 1962). In their article, Kempe et al. also pointed out that physicians were reluctant to report their suspicions of abuse to the appropriate authorities and thus child maltreatment was widely unreported. Thus, Kempe et al.'s article provided a means by which to identify child abuse, as well as called for a way in

which to hold professionals responsible for reporting child maltreatment, and thus marked the beginnings of legislative initiatives for mandatory reporting.

Kempe presented his article at several conferences held by the U.S. Children's Bureau, and in 1963 the first model child abuse reporting statute was outlined. In 1965, the American Medical Association, as well as the Council of State Governments drafted their own model statutes (Zellman & Faller, 1996). The goal of these early statutes was to provide protection for physically abused children by requiring physicians to report suspected cases of child maltreatment to social service agencies. As pointed out by Kempe et al. (1962), physicians were likely to come in contact with maltreated children and were thought to possess the training and experience needed to accurately identify symptoms of maltreatment (U.S. Department of Health and Human Services, 2002).

Reporting legislation was slow to make a start, however these statutes became rapidly and widely adopted. In 1963, the first reporting statute was drafted, by 1964 twenty states had enacted reporting laws, and 49 states had reporting laws by 1966 (Heymann, 1986). Nevada enacted child abuse and neglect reporting legislation in 1965. Hawaii was the last state to sanction reporting in 1967. Thus, in 1967, and only four years after the inception of the first statute, all 50 states had adopted formal child abuse reporting laws (Zellman, 1990). Fraser (1978) states that "no other type of legislation has so quickly gained acceptance, has been so widely proclaimed as panacea, and has been so often amended and rewritten in such a short period of time" (as cited by Thompson-Cooper, Fugere, & Cormier, 1993, p. 558).

Over the next decade as knowledge and understanding of child maltreatment increased, these early statutes gradually broadened in terms of the professions mandated

to report, as well as the types of maltreatment which required reporting. The early mandatory reporting laws required reporting only serious or non-accidental physical injuries (Besharov, 1994). As it became evident that maltreatment could be identified prior to the event of a serious injury, both the scope of professionals and the legal definitions of maltreatment were expanded. By 1986, virtually every state included nurses, police officers, teachers, and other mental health professionals as legally mandated reporters (Zellman & Faller, 1996). Statutes also expanded the concept of maltreatment to include not only physical abuse, but also sexual abuse, emotional abuse, and neglect.

In 1974, the Child Abuse Prevention and Treatment Act (CAPTA; P.L. 93-247) was enacted by Congress. CAPTA spurred the continued refinement of state statutes by requiring states to adopt reporting laws that met certain requirements in order to receive federal funding. This included increasing the scope of the definition of maltreatment and the professions mandated to report, as well as the establishment of specific reporting and investigative procedures (Zellman & Faller, 1996). CAPTA also established the National Center on Child Abuse and Neglect. This law was completely rewritten in the Child Abuse Prevention, Adoption and Family Services Act of 1988 (P.L. 100-294). Amendments continued in 1989, 1990, 1992, 1994, 1996, and most recently in 2003 by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36).

The Child Welfare Information Gateway (2004), which is mandated by CAPTA, summarizes the following roles and responsibilities of CAPTA. CAPTA currently provides federal funding to aid in the prevention, assessment, investigation, prosecution, and treatment of child maltreatment to those states which meet the requirements set forth

by CAPTA. Funding is also provided to public agencies and nonprofit organizations involved in any of the aforementioned areas of child maltreatment. CAPTA additionally designates the Federal role in supporting various types of research activities in the area of child maltreatment, as well as established the Office on Child Abuse and Neglect.

Impact of Mandated Reporting Legislation

The enactment of the above laws, coupled with media attention and increased public understanding of the issue of child maltreatment, led to a rather drastic increase in the number of child maltreatment reports (Pence & Wilson, 1994). Indeed, these drastic increases are evidenced in the literature. Stein (1984) points out that the number of reported child victims in 1963 (150,000) climbed more than twelve times in 1985 to over 1.9 million. Zellman and Faller (1996) agree that reporting legislation encouraged maltreatment identification and indicate that reports increased more than 225% from 1976 (669,000) to 1987 (over 2 million). The reporting rate in 1976 of 10.1 per 1000 children increased to 34.0 per 1000 children in 1987. The number of reports continued to climb and reached almost 3 million by 1993 (Zellman & Faller, 1996).

Current Child Maltreatment Statistics

In the most recent annual report conducted and analyzed through the National Child Abuse and Neglect Data System (NCANDS; U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2006), over 3 million referrals, involving over 5.5 million children, were made to child protective service agencies. This is equivalent to a national referral rate of 42.6 per 1,000 children. Of these referrals, 62.7% were investigated or assessed further by child protective agencies, which

resulted in 37.3 percent of these referrals not being accepted. Therefore, 3,503,000 children were involved in child maltreatment investigations, which revealed an estimated 872,000 victims of child abuse and neglect, and approximately 1500 child fatalities. Although child maltreatment statistics are widely available for the United States, statistics specific to Nevada are limited. The National Child Abuse and Neglect Data System (NCANDS; U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2006) includes only minimal statistics for Nevada. This report indicates that, in 2004, 19,960 children were referred to child protective services, with 13,062 accepted for further screening.

The Reporting Problem

Besharov (1994) points out that accurate reporting is key to the efficacy of child protection services and that, unfortunately, "...reporting today is far from accurate" (p. 137). Vast amounts of literature have delineated and investigated the two major problems of reporting: under-reporting and over-reporting. A substantial amount of research has illustrated the under-reporting of child maltreatment. Indeed, it is widely accepted that the identified child victims included in our national and state statistics, only represent a small proportion of the actual number of maltreated children. Thus, a great discrepancy exists between those children identified and in the child protective service system, and the actual number of children experiencing maltreatment (Cerezo & Pons-Salvador, 2004). Over-reporting, although it has received less attention in the literature, is also a significant problem in the reporting of child maltreatment. Many child maltreatment

reports are unwarranted and unsubstantiated, which overburdens and interferes with child protective agencies.

The Problem of Underreporting Child Maltreatment

Professionals mandated to report maltreatment often fail to identify probable maltreatment or fail to report suspected maltreatment (Hansen et al., 1997). For instance, the Department of Health and Human Services funded the 1986 National Incidence Study of Child Abuse and Neglect (NIS), which revealed that a large proportion of maltreatment, including serious and even fatal abuse, remained unreported by professionals or unidentified by child protective agencies (Finkelhor, 1990). According to NIS, less than half (46%) of suspected abuse cases were reported by professionals. Approximately 30% of sexual abuse cases, 15% of fatal or serious physical abuse cases, 40% of moderate physical abuse cases, 67% of fatal or serious physical neglect cases, and 75% of moderate physical neglect cases were not reported by mandated professionals (Besharov, 1994). As Besharov (1994) illustrates, this means professionals failed to report roughly 2,000 children maltreated to the point of requiring hospitalization, over 100,000 children with moderate physical injuries (e.g., bruises, depression), and more than 30,000 sexually abused children.

Literature has not only investigated failure to report across professions, moreover it has examined under-reporting specific to mental health professions. For instance, in 1978, Swoboda, Elsworth, Sales, and Levine found that 66 % of the social workers, psychiatrists, and psychologists sampled failed to report a hypothetical case of mental and physical abuse. Psychologists were found to be the most unfamiliar with maltreatment reporting laws and had an alarmingly high rate of reporting failure (87%).

Literature specifically investigating psychologists suggests failure to report rates ranging from 25 to 61 percent. Most studies report that approximately one-third of licensed psychologists fail to report suspected maltreatment cases. For instance, Kalichman, Craig, and Follingstad (1988) and Kalichman and Brosig (1992b) found that 29% and 32% of licensed psychologists, respectively, had failed to report suspected maltreatment. Strozier, Brown, Fennel, Hardee, and Vogel (2005) investigated the reporting attitudes and tendencies of 101 mental health professionals (social workers, family therapists, professional counselors, pastoral counselors, and psychologists) attending a state Family Therapy conference. Strozier et al. (2005) found that approximately 40% of the respondents had failed to report a case of suspected child maltreatment, as consistent with the other studies mentioned above.

Consequences of Under-Reporting

Under-reporting is unfortunate as maltreated children cannot be protected and treated until, and unless, they are identified. This is of particular importance when maltreatment is severe or when harm is imminent (Zellman & Faller, 1996). Identification must also occur for maltreating families to receive intervention and treatment. Indeed, mandated reporters must first identify and then report suspected cases of maltreatment to the appropriate authorities. Any and all failures to report undermine the child maltreatment reporting system and weaken its ability to effectively prevent, prohibit, and treat child maltreatment (Zellman & Faller, 1996).

Under-reporting not only hurts children, families, and the child protection system. It also provides an extremely distorted picture of child maltreatment in our nation and

dramatically decreases funding for child maltreatment programming (Goodwin & Geil, 1982; Zellman & Faller, 1996).

The Problem of Over-Reporting Child Maltreatment

Over-reporting of child maltreatment has received much less attention in the literature than has under-reporting. However, researchers typically agree that mandatory reporting is equally troubled by over-reporting (Besharov, 1994; Foreman & Bernet, 2000). Over-reporting first became a concern subsequent to the drastic reporting increase response to the enactment of mandatory reporting legislation, and more recently received attention due to research on the low rate of substantiated maltreatment reports.

Over-reporting began in the 1970's after the surge of public and political attention on child maltreatment. This is evidenced by the previously reported 225% increase in the number of reports from 1976 to 1987 (Zellman and Faller, 1996). More recently, researchers have become troubled by the discrepancy between the number of maltreatment cases reported and the number of cases initially screened out or later unsubstantiated. For example, the American Public Welfare Association (APWA) found that the substantiation rate in 1988 was 39%, indicating that 61% of reports made were unsubstantiated. Besharov (1988) has written substantially about over-reporting and agrees that "Nationwide, only about 40% of all reports are 'substantiated' (or a similar term) after investigation" (p. 2). The most recent statistics indicate that 37.3% of reports are initially screened out by child protective services, with 60.7% of the remaining reports subsequently unsubstantiated (U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2006). Therefore, in support of

Besharov (1988), only approximately 38% of all reports made in 2004 were substantiated.

Consequences of Over-Reporting

A "certain proportion of unsubstantiated reports [are] an inherent-and legitimate-aspect of reporting suspected child maltreatment and is necessary to ensure adequate child protection" (Besharov, 1994, p. 140). However, Besharov (1994) and others agree that the number of unsubstantiated cases is seriously unacceptable, and greatly overburden an already limited child maltreatment reporting system. Reports can be screened out during the initial report to child protective services, or can be unsubstantiated subsequent to an investigation. Thus, such reports clog the process, resulting in wasted utilization of limited resources (Kalichman & Brosig, 1992), thereby preventing child protective agencies from responding promptly and effectively, and endangering thousands of abused children. Unfortunately, due in large part to being extremely overloaded, child protective agencies are often criticized for being ineffective and much of the public and many professionals distrust the reporting system (Gullatt & Stockton, 2000). Families can also be negatively impacted by inappropriate or unsubstantiated reporting practices. Indeed, the experience of a child maltreatment investigation can cause significant distress to the child and the family and when unsubstantiated can create various challenges while supplying few if any aid or services (Kalichman & Brosig, 1992). Even with the immensity of the problem and negative ramifications, mandated reporters should always report when maltreatment is suspected, and trainings should never discourage the reporting of suspected maltreatment. Rather,

the goal is to provide mandated reporters with adequate training to enable greater reliability in suspecting maltreatment.

Reasons for Child Maltreatment Reporting Practice Problems

Inaccurate reporting practices occur for a variety of reasons. Indeed, lack of knowledge regarding child maltreatment has been found to be a leading factor in these reporting dilemmas (Besharov, 1987, 1988, 1994; Reiniger, Robison, & McHugh, 1995; Stein, 1984). Mandated reporters have been found to lack knowledge and understanding regarding the legal aspects of the law, abuse identification, and clinical expertise in reporting processes. In this regard, training of mandated reporters have focused on clarification of mandatory reporting laws, the accurate identification of maltreatment, and the process of effectively reporting child maltreatment while minimizing the negative therapeutic consequences .

Lack of Knowledge and Understanding of Child Maltreatment

Mandated reporters' lack of knowledge regarding child maltreatment in the aforementioned areas has received much attention in the literature. Due to this evidenced lack of knowledge, modern research has focused on the development of training programs to increase knowledge and thereby increase and improve reporting. For instance, Kleemeier, Webb, & Hazzard (1988) developed a training program for teachers and found that training increased child maltreatment knowledge. Furthermore, trained teachers applied their increased knowledge to hypothetical sexual abuse vignettes, as evidenced by improved identification of abuse indicators and greater appropriateness of reporting responses. Similarly, Kenny (2001, 2004) has extensively researched teachers'

lack of child maltreatment knowledge and worked to develop training programs for educators, particularly in child maltreatment identification and reporting procedures.

Mandated reporters of various professions have been found to lack child maltreatment knowledge (Reiniger, Robison, & McHugh, 1995) resulting in poor reporting behaviors. Cerezo and Pons-Salvador (2004) found that child maltreatment detection increased significantly in three Balearic Islands after the implementation of a training program. Results showed that as knowledge increased, the rate of detection increased, and the annual incidence of confirmed cases doubled.

Kalichman and Brosig (1993) point out that while training may result in "increased accuracy of making reporting decisions" (p. 91), only 23% of psychologists received graduate training in child maltreatment. This alarmingly severe lack of knowledge and training has been recognized by the American Psychological Association (APA), which called for enhancing psychologists' knowledge of child maltreatment through increased training (Champion, Shipman, Bonner, Hensley, & Howe, 2003). Unfortunately, appropriate action has not been taken and, as Champion et al. (2003) point out, training of future psychologists often fails to meet even the minimal level of competence recommended by APA. Moreover, even though psychologists' are aware of the lack of child maltreatment reporting competence, there has been no change in training (Champion et al., 2003, p. 211).

Lack of Knowledge of Mandatory Reporting Laws

Lack of knowledge of mandated reporting laws is seen as a major contributor to problems in reporting child maltreatment. This lack of knowledge stems from mandated reporters unfamiliarity of the reporting laws, as well as the vagueness and ambiguity of

the statutes. Thus, mental health professionals need not only be aware of the mandate, but also must understand the ambiguities and complexities embedded within the laws.

Ambiguity of reporting statutes contribute to the lack of reporting law knowledge found for mandated reporters, and is seen as leading to the current reporting problems (Foreman & Bernet, 2000; Kalichman & Brosig, 1992a). Reporting laws have been greatly criticized for their vagueness and magnitude (Agatstein, 1989; Besharov, 1988; Buchele-Ash, Turnbull, & Mitchell, 1995; Foreman & Bernet, 2000). Being that reporting laws are far from self-explanatory (Agatstein, 1989); familiarity alone will not expunge the issue. Mandated reporters awareness of the reporting mandate is only a beginning, as explication of such laws is necessary to increase comprehension.

Swoboda et al. (1978) found that 18% of psychiatrists and 32% of psychologists were unfamiliar with child maltreatment reporting laws. Even with the recent focus on the lack of knowledge and training, many mental health professionals continue to be unfamiliar with reporting statutes. Subsequent to a training session conducted by Reiniger, Robison, and McHugh (1995), mandated reporters were asked to indicate the extent of new information provided by the program. Half (50%) of the respondents indicated that they had "learned all or mostly new information, and 88% learned something new" with regard to their legal responsibilities (Reiniger et al., 1995, p. 66). Thus, mandated reporters, and specifically mental health professionals, perceive benefits of training in awareness and knowledge of child maltreatment reporting laws.

Lack of Maltreatment Identification Knowledge

Child maltreatment victims are typically unable to protect themselves (Besharov, 1994). Therefore, accurate identification of maltreatment signs and symptoms is the first

line of defense (Radford, 1998). It is "only by knowing which children are being abused [that they] can be treated and protected in the future" (Swoboda et al. 1978, p. 450). Unfortunately, mandated reporters have been found to be deficient in their ability to adeptly identify victims of child maltreatment.

This inability to accurately identify maltreatment endangers children, families, professionals, and the system by contributing to under- and over-reporting. Besharov (1985) points out that confusion regarding what does, and does not, constitute maltreatment leads to such reporting problems. The role of inaccurate maltreatment identification in under-reporting is apparent, in that mandated reporters must be able to accurately identify maltreatment to make a report. This influence has been discussed by numerous researchers (e.g., Abrahams, Casey, and Daro, 1992; Reiniger, Robison, & McHugh, 1995). Besharov (1985) reports that half of child maltreatment reports involve situations of poor child care not suitable for consideration of child maltreatment, and others (i.e., Faller, 1985) state reporters are wrong half the time.

In 1992, Abrahams, Casey, and Daro found that nearly two-thirds of teachers sampled felt that lack of abuse detection knowledge was a significant barrier to reporting. Similarly, Ashton, (1999) found that beginning humans service workers lacked the ability to identify and assess for child maltreatment. In 1995, Reiniger, Robison, and McHugh report that, subsequent to a training program, over 75% of mandated reporters learned something new about signs of physical, sexual, and emotional abuse and neglect. Notably, Hawkins and McCallum (2001b) found that mandated reporters not only increased their knowledge on abuse identification, but also were able to apply this new

knowledge in hypothetical vignettes and more accurately interpret behavioral and emotional signs of maltreatment.

Literature illustrates the importance of familiarity and understanding of the reporting statutes. However, unless mandated reporters are able to accurately identify maltreatment, the reporting statutes are meaningless (Reiniger et al., 1995). Certainly, literature supports the connection between the accurate abuse identification and reporting. Thus, it is essential that mandated reporters possess the ability to identify all types (i.e., physical, sexual, and emotional abuse, and neglect), and subtypes (e.g., educational neglect, medical neglect) of maltreatment to perform accurate reporting of child maltreatment (Faller, 1985).

Lack of Clinical Expertise in the Reporting Process

Another contributing factor to under-and over-reporting found in the literature is mandated reporters lack of clinical expertise in reporting procedures, to include managing clients throughout the process (Abrahams, Casey, & Daro, 1992; Besharov, 1987, 1988, 1994; Hawkins & McCallum, 2001). Indeed, many professionals fail to report (i.e., under-report) due to a lack of training and deficits in knowledge of reporting procedures (Stein, 1984). Conversely, a great number of unwarranted and incomplete reports are made as a result of the lack of a clear understanding of reporting procedures, and hence lead to over-reporting (Besharov, 1988). Knowledge regarding reporting procedures includes when, what, how, and to whom, to report, as well as what happens subsequent to a report. Of particular importance to mental health professionals are the knowledge and application of effective therapeutic practices in dealing with clients before, during, and after filing a report.

Literature outlines the need for mandated reporters' knowledge in all aspects of the reporting process. For instance, Besharov (1988) calls for the education of the public and professionals to include how to make a report, explication of the process following a report, and information on alternative resources for the child and/or family. In 1992, Wurtele and Schmitt found that child care workers, even those that had received child sexual abuse training, were lacking in their knowledge of reporting procedures. Similarly, Reiniger, Robison, and McHugh (1995) found that nearly 60% of mandated reporters participating in training gained all or mostly all new information on reporting procedures.

Knowledge regarding accurate and effective child maltreatment reporting is of obvious importance. However, understanding of child protective services screening, investigation, and decision-making procedures, as well as available aftercare services, have also been found to be important predictors of reporting (Compaan, Doueck, & Levine, 1997). Familiarity of the role of child protective agencies is particularly important for mental health professionals since they may work in conjunction with such agencies in prevention and treatment (Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2000), and more importantly to work more effectively with clients throughout the reporting and investigative processes.

The filing of a child maltreatment report by a mental health professional can place a strain on the therapeutic relationship. Therefore, it is important for mental health professionals to possess clinical proficiency with regard to methods designed to preserve therapeutic trust (Steinberg, 1997). Mental health professionals often fear that making an abuse report will result in the loss of the client (Kalichman, 1999). Therefore, awareness

of reporting methods that minimize client anger, resentment, or resistance and thereby protect the therapeutic relationship are of utmost importance (Steinberg, 1997). In the same regard, knowledge of ways to successfully manage clients in the aftermath of a report is crucial (Steinberg, 1997).

Conclusion

As illustrated, under- and over- reporting of child maltreatment are serious problems with devastating consequences. These problems are unfair to all involved, including children, families, and the reporting systems enacted to deal with child maltreatment. Though under- and over-reporting cannot be completely eliminated, they can be greatly reduced by increasing reporters' knowledge and understanding surrounding mandatory reporting laws and the reporting process, as well as increasing their ability to accurately recognize child maltreatment. The following sections will provide further pertinent information in the areas of child maltreatment reporting laws, child maltreatment identification, and child maltreatment reporting processes and procedures.

Important Child Maltreatment Knowledge

Mandatory Reporting Laws

As previously mentioned state laws must meet federal regulations set forth by CAPTA to receive federal resources and funding. Thus, although state statutes vary slightly, there are greater similarities than differences (Radford, 1998). State laws typically define child maltreatment, and specify who is required to report, what should be contained in a report, when to report, immunities for reporters, and penalties for failure to report (Koralek, 1992; Radford, 1998).

Child Maltreatment as Defined by Law

Child maltreatment is usually conceptualized in four major categories: physical abuse, sexual abuse, emotional abuse, and neglect. States vary in their definitions of each of the above categories. However, state definitions must meet the Federal minimum standards set by the Child Abuse and Prevention Treatment Act (CAPTA) (42 U.S.C.A. §5106g), and amended by the Keeping Children and Families Safe Act of 2003. According to CAPTA, child abuse and neglect is at a minimum, "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."

Physical abuse is usually defined as a physical injury resulting in harm regardless of whether harm was intended. Injuries can be caused by, but not limited to, such things as shaking, biting, kicking, hitting, or choking and range from minor bruising to death. Sexual abuse comprises any activities involving lewdness with a child and can include fondling, incest, rape, or sexual exploitation. Emotional abuse typically involves any pattern of behavior that obviously negatively affects a child's intellectual or psychological capacity, emotional growth, or self-esteem and can include threatening or continual criticism. Neglect entails a failure to meet the basic needs of a child physically (e.g., provide food, shelter, supervision), medically (e.g., necessary medical or mental health treatment), emotionally (e.g., allowing the child to use alcohol or drugs, negligence of emotional needs), or educationally (e.g., failure to substantially educate a child) (National Clearinghouse on Child Abuse and Neglect Information, 2004). It should

be noted that the above descriptions are general guidelines, and the examples provided may or may not be included in all State definitions.

Nevada Revised Statutes

Definitions of abuse and neglect vary by state. Therefore, it is crucial for mandated reporters to be aware of the particulars of the maltreatment definitions of the state, or states, in which they work. For instance, the Nevada Revised Statute (NRS 432B) defines abuse and neglect as any non-accidental physical or mental injury, sexual abuse or exploitation, and negligent treatment or maltreatment (NRS 432B.020). Physical abuse is defined as including,

> without limitation, 1) A sprain or dislocation; 2) Damage to cartilage; 3) A fracture of a bone or the skull; 4) An intracranial hemorrhage or injury to another internal organ; 5) A burn or scalding; 6) A cut, laceration, puncture or bite; 7) Permanent or temporary disfigurement; or 8) Permanent or temporary loss or impairment of a part or organ of the body" (NRS 432B.090).

Emotional abuse is marked by the occurrence of a mental injury, which is defined as an "injury to the intellectual or psychological capacity or the emotional condition of a child as evidenced by an observable and substantial impairment of his ability to function within his normal range of performance or behavior" (NRS 432B.070). Nevada defines sexual abuse as consisting of both sexual abuse (i.e., incest, lewdness with a child, sadomasochistic abuse, sexual assault, statutory sexual seduction, or mutilation of female genitalia; NRS 432B.100) and sexual exploitation (i.e., forcing, allowing, or encouraging child prostitution, or pornography; NRS 432B.110). Nevada uses the term negligent treatment or maltreatment, rather than neglect, and defines this as occurring

> if a child has been abandoned, is without proper care, control and supervision or lacks the subsistence, education, shelter, medical care or other care necessary for the well-being of the child because of the faults or habits of the person responsible for his welfare or his neglect or refusal to provide them when able to do so (NRS 432B.140).

Professions Mandated to Report

It is crucial that professionals are aware of their legal obligation to report child maltreatment. All states set forth specific professions that are legally required to report suspected maltreatment. These professions typically include those that work with, or are in contact with, children. Mental health professionals are included as mandated reporters. These include: psychiatrists, psychologists, marriage and family therapists, clinical social workers, alcohol or drug abuse counselors, social workers, and school counselors. Other professions mandated to report in Nevada include: physicians, dentists, dental hygienists, chiropractors, optometrists, podiatric physicians, medical examiners, professional or practical nurses, physician's assistants, other medical services licensed or certified in Nevada; personnel of a hospital or similar institution; coroners; clergymen; administrators, teachers, or librarians of a school; child care providers of private or public facility; any person licensed to conduct a foster home; officers or employees of a law enforcement agency or adult or juvenile probation officers; attorneys under certain circumstances; and volunteers for an agency which advises persons regarding child abuse or neglect (NRS 432B.220) (as cited in State of Nevada, Division of Child and Family Services, 2005, p. 4). Although, the above professions are legally required to report, any

person that has a reasonable cause to believe that abuse is occurring, or has occurred, may file a report with Child Protective Services or law enforcement.

Legally Required Contents of Report

Mandated reporters knowledge of the legally required contents of a report is important in cutting down the amount of time and energy spent by child protective agencies in screening out incomplete or inadequate reports. A report made in Nevada must contain, if obtainable, all of the following information:

> 1) the name, address, age, and sex of the child victim; 2) the name and address of the caregiver; 3) the nature and extent of the maltreatment; 4) any evidence of known or suspected previous maltreatment to the child or siblings; 5) the name, address, and relationship of the alleged perpetrator, if known; 6) any other information deemed necessary by the agency taking the report (NRS 432B.230).

Notably, when maltreatment is suspected a report is required even in the absence of all the information required. This is vital in terms of protecting the professional, yet also serves to provide summative information often needed to initiate investigations (Kalichman, 1999).

Reasonable Suspicion

Confusion often exists for mandated reporters when it comes to reasonable suspicion (Kalichman & Brosig, 1993). All states use a similarly vague term to indicate that the mandated reporter is not responsible for validating the maltreatment. The mandated reporter must only "suspect" or "have reasonable cause to believe" that abuse is occurring or has occurred. That being said, mandated reporters are professionals working with children and should receive significant training in child maltreatment. Thus, their

suspicion would be based on, and guided by, their knowledge of, and training in, child maltreatment. In Nevada, the term utilized is "reasonable cause to believe" and holds that given the facts and circumstances known, a reasonable person would believe that maltreatment occurred or is occurring (NRS 432B.121).

Protection of Mandated Reporters

Research has found that some mandated reporters are unaware of the legal immunity allotted to them and are thus concerned about legal ramifications of reporting. Indeed, Reiniger, Robison, and McHugh (1995) found that the highest percentage of respondents (over 27%) stated that they learned all new information in the workshop training component of "immunity for mandated reporters." All states, including Nevada, provide both civil and criminal immunity to any person making a maltreatment report. This is qualified by stating that the report may not be made maliciously and thus any person acting "in good faith" is protected (NRS 432B.160).

Report Must Be Made in a Timely Manner

It is imperative that mandated reporters are aware of their own state statute with regard to appropriate timeframes for reporting in order to avoid legal ramifications. All states specify a given time frame in which a report must be made subsequent to the mandated reporters' suspicion. States vary in what they consider a "timely manner," however this typically ranges from 24 hours to 7 days (Alvarez, Kenny, Donohue, & Carpin, 2004). In accordance with Nevada statutes, an oral, written or electronic report must be made as "soon as reasonably practicable" (NRS 432B.121) but "not later than 24 hours after the person knows or has reasonable cause to believe that the child has been abused or neglected" (NRS 432B.220). If this report is taken orally, the person who

receives the report "must reduce it to writing as soon as reasonably practicable" (NRS 432B.220). This statute does not afford adequate time for a mandated reporter to gather evidence, and thus illustrates that it is not the responsibility of the mandated reporter to substantiate abuse.

Penalties for Failure to Report

States have enacted penalties for mandated reporters that fail to act within the statutes. This is in particular response to the high frequency of mandated reporters that fail to report or that fail to act within the "reasonably practicable" amount of time described above. In most states, failure to act in accordance with the statutes leads to criminal prosecution, and if convicted can result in a fine of up to $1,000 and/or a jail sentence of up to one year. In Nevada, a mandated reporter who "knowingly and willingly" fails to report, or otherwise acts outside of the statutes, is guilty of a misdemeanor (NRS 432B.240).

Abuse Identification

Literature points to the need for, and importance of, increasing mandated reporters' ability to adequately identify child maltreatment. Greater accuracy in maltreatment identification will help deal with the current reporting problems, as well as assist in the "prevention of maltreatment, and increase positive outcomes for families and professionals" (Hansen, et al., 1997, p. 331). For these reasons, mandated reporters should have adequate knowledge of the signs and symptoms indicative of maltreatment.

Maltreatment or the risk of maltreatment may be indicated by a variety of factors including physical manifestations, behavioral indicators, environmental situations, and adult or child characteristics. Mandated reporters must be careful not to assume that the

presence or absence of a single indicator signifies maltreatment. Rather, it is more likely that a pattern of these indicators are suggestive of maltreatment (Meddin & Rosen, 1986). Nevertheless, such indicators do provide valuable clues and vital corroborative evidence of maltreatment and qualified professionals may find "some alarming and unusual child behaviors [that] may, in and of themselves, warrant a report" (Besharov, 1987, p. 10).

Physical Abuse

Although physical abuse is not the most common form of abuse, it is the easiest abuse type to identify due to the obvious physical manifestations which often accompany such abuse (Radford, 1998). Literature explicating the physical manifestations of physical abuse is vast (Radford, 1998; Spencer, 1996; Smith, 1985). "Important considerations in the identification of physical abuse include the age of the child and the location, extent, severity, and age of the injuries" (Ayoub, Grace, & Newberger, 1990, p. 239). It is also important that reporters suspicion of physical abuse always take into account both the developmental context of an injury and its location, as well as the likelihood of the injury occurring as described by the child or an adult (Spencer, 1996).

Younger children are particularly susceptible to physical abuse. Hence, it has been found that children under the age of three make up approximately two-thirds of children reported for abuse (Ayoub, Grace, & Newberger, 1990). Unfortunately, young children are extremely dependent on their caregivers and thus highly vulnerable to injury. Very young children have a higher incidence of burns, hemorrhages, and fractures and children between the ages of 0 to 12 months have the highest incidence of injuries to the skull and brain (Felsen, Johnson, & Showers, 1985). For preambulatory children, any bruising or

abrasions should raise questions. The most common physical signs of abuse for young children are soft tissue injuries to the buttocks, genitals, cheeks, thighs, neck, and back (Ayoub, Grace, & Newberger, 1990). Unfortunately, many of these areas are not visible by the mental health professional and thus injuries to the extremities and the face will more likely be seen.

Unlike younger children, toddlers and ambulatory children often have self-inflicted bruises and abrasions. Injuries to the elbows, back of lower arms, hands, knees, shins, and perhaps the face are areas of the body in which self-injury typically occurs (Spencer, 1996). Thus, injuries to other parts of the body and particularly signs of repeated injury, such as bruises, abrasions, or fractures at various stages of healing may warrant greater suspicion (Smith, 1985).

Burns or bruises with unique or specific patterns are highly indicative of abuse (Monteleone, 1994; Smith, 1985). For instance, burns that are oval or cigarette shaped, or leave the imprint of a stove burner may be inflicted. Self-inflicted and/or accidental burns typically cover only a small section of skin (Meddin & Rosen, 1986). Therefore, burns covering a larger area should warrant greater suspicion. Indeed, younger children are often "dunked" or immersed in hot liquids and may exhibit burns on their lower extremities and buttocks (Ayoub, Grace, & Newberger, 1990). Distinct bruising patterns (e.g., shaped like a switch, paddle, belt, fingers, or hand) should also warrant suspect. As previously mentioned, a variety of burns and/or bruises, particularly when at varying stages of healing, should raise suspicion on the part of the mental health professional.

Sexual Abuse

Current research suggests that 10 to 17% of boys and 25 to 33% of girls will be sexually abused by the age of 18; however, due to the "conspiracy of silence" associated with sexual abuse, most believe it to be the most under-reported form of maltreatment (State of Nevada, Division of Child and Family Services, 2005). Unfortunately, unlike physical abuse, sexual abuse "most often presents itself in a veiled way, with relatively few florid features (Porter, 1984)" (Powell, 1991, p. 77). The most obvious indicator of sexual abuse is a direct statement from the child. Regrettably, it has been found that most children do not directly report sexual abuse (Berliner, 1993). In fact, a verbal disclosure is only made in approximately one-third of sexual abuse cases (Kalichman, 1999). However, when children do directly discuss sexual abuse, it is common for this information to appear unreliable or inaccurate. As discussed by Berliner (1993), child abuse, particularly sexual abuse, may generate an accommodation syndrome. This syndrome, as described by Summit (1983), includes "delayed and conflicted disclosure, inconsistent reports, retraction, and continuing protective and positive feelings for the offending parent as logical and predictable responses to the abusive environment" (Berliner, 1993, p. 20). Professionals' awareness of these characteristics is crucial given that research has found that mandated reporters often fail to make a report when a direct admission of abuse is later recanted (Zellman, 1985).

Due to lack of verbal disclosure and physical evidence, mental health professionals more typically suspect sexual abuse based on behavioral or emotional signs. Developmentally inappropriate or excessive sexual behavior and/or knowledge are perhaps the most salient markers of sexual abuse. These behaviors are thought of as

"high probability" (Radford, 1998, p. 297) or "specific" (Ayoub, Grace, & Newberger, 1990, p. 243) indicators. In young children, these include sexual acting out behaviors and sexualized play demonstrating a more advanced sexual understanding than appropriate for their age (Krugman, 1993). In older children, this can consist of precocious sexual knowledge, excessive masturbation, promiscuity, sexual invitations to younger or older persons, or even perpetration of sexual abuse towards other children (Ayoub, Grace, & Newberger, 1990; Radford, 1998).

A variety of additional behavioral and emotional indicators are discussed in the literature. However, it is widely held that the "use of behavioral indicators is a tricky business because they have many alternative explanations that are not related to sexual abuse" (Besharov, 1994, p. 151). Thus, such behavioral indicators should be used with caution, and suspicion of sexual abuse should be based on a combination of verbal accounts, physical and medical manifestations, and behavioral indicators. Krugman (1993) gives the following lists of nonspecific indicators of sexual abuse: sleep disturbances, appetite disturbances, neurotic or conduct disorders, withdrawal, guilt or depression, temper tantrums, aggressive behavior, suicidal or runaway threats or behaviors, hysterical or conversion reactions, school problems, and substance abuse (p. 370). Other common emotional symptoms associated with sexual abuse include regression, fear, anxiety, anger, hostility, and shame (Ayoub, Grace, & Newberger, 1990; Braga, 1993). Although these symptoms can be symptomatic of sexual abuse, they can also indicate a variety of other stressful circumstances. Thus, factors that have been found to increase the probability of sexual abuse include "the sudden and unexplained occurrence of symptoms, the relation of particular fears and anxiety to factors often

associated with sexual victimization (i.e., fear of men, anxiety about getting undressed), and the presence of physical indicators of sexual abuse" (Powell, 1991, p. 78).

Physical indicators of sexual abuse include somatic problems and medical conditions. Sexually transmitted diseases in very young children are high probability indicators (Krugman, 1993). Other physical indicators highly suggestive of sexual abuse include genital, anal or urethral trauma, enlarged anal or oral openings, and discharge or bleeding (Powell, 1991). Although such physical symptoms are rather clear indicators of sexual abuse, particularly in children, such signs are even less common than verbal disclosures (Kalichman, 1999). Additionally, it will be unlikely that mental health professionals become aware of these sorts of symptoms. Somatic complaints, however, may be more readily presented to mental health professionals. Sexually abused children often suffer from pain or irritation in the genital or anal regions, difficulty sitting or walking, encopresis or enuresis, headaches, muscle tension, and chronic abdominal pain or other gastrointestinal symptoms (Kalichman, 1999; Kruger, 1993; Powell, 1991).

Emotional Abuse

Emotional abuse is thought to be the most prevalent form of maltreatment; however, it is also the most difficult to identify with confidence (Ayoub, Grace, & Newberger, 1990). Although emotional abuse can occur in isolation, it very typically occurs in combination with physical or sexual abuse. Unfortunately, unlike physical and sexual abuse, little is known regarding the signs of emotional abuse. Suspicions of emotional maltreatment most commonly occur from verbal disclosures or direct observations of emotional abuse (Kalichman, 1999). Regrettably, verbal disclosures or direct observation do not occur in the majority of emotional abuse cases.

Both child and parent behaviors can lead to the suspicion of emotional abuse. Direct observation of a parent humiliating, rejecting, corrupting, exploiting, degrading, terrorizing, or threatening a child would obviously warrant suspicion and thus a report (Kalichman, 1999). However, more subtle parent behaviors may also lead to suspicion. This could include parents who always speak very critically, or are "genuinely surprised or highly skeptical if the clinician points out positive traits" about their child (Radford, 1998, p. 295). Parents who continually fail to provide adequate nurturance or affection is also indicative of emotional abuse.

The definition of a mental injury includes "an injury to the intellectual or psychological capacity or the emotional condition of a child as evidenced by an observable and substantial impairment of his ability to function within his normal range of performance or behavior" (NRS 342B.070). Behavioral and emotional indicators of emotional abuse include behavioral extremes (e.g., excessively compliant or overly aggressive, extremely angry or passive), anxiety, depression, withdrawal, low self-esteem, social maladjustment, and sudden changes in school performance, behavior, or general functioning (Besharov, 1990; Kalichman, 1999; Radford, 1998). Young children may show physical, emotional, or psychological developmental delays, and at an extreme this can result in failure-to-thrive. Failure-to-thrive is more typically associated with neglect and therefore is discussed in more detail in the next section. Older children often engage in more obstinate behaviors, and may repeatedly run away from home or make suicidal gestures or attempts (Kalichman, 1999).

As mentioned with regard to the other forms of maltreatment, the aforesaid behavioral manifestations overlap substantially with various nonabusive circumstances

thereby complicating the use of such indicators to validate abuse suspicion. Thus, another sign that may prove useful to mental health professionals is the response of the parent to the emotionally or behaviorally disturbed child. As Besharov (1990) illustrates,

> The parents of an emotionally disturbed child generally accept the existence of a problem. They are concerned about the child's welfare and are actively seeking help. The parents of an emotionally maltreated child often blame the child for the problem (or ignore its existence), refuse all offers of help, and are unconcerned about the child's welfare. (p. 117-118)

Neglect

Neglect, dissimilar to other types of maltreatment, typically involves an omission of care. Neglect is typically divided into the categories of physical, medical, educational, and safety or supervision neglect, and includes caregivers' failure to provide adequate supervision, nurturance, shelter, nutrition, clothing, education, or medical or surgical care (Spencer, 1996).

Identification of neglect is often challenging. Kalichman (1999) points out that there exists a scarcity of information on the indicators of neglect, particularly when independent of physical abuse. Additionally, the indicators illustrated in the literature are often missed due to their subtly. Similarly, the symptoms can be cumulative in nature and thus overlooked in the beginning stages (Ayoub, Grace, & Newberger, 1990). Due to these complexities, "suspicions of neglect with sufficient evidence for reporting requires awareness of the child's life circumstances and parental behaviors, usually through observation, home visits, or the child's description of the living situation" (Kalichman, 1999).

Younger children are more susceptible to neglect being that they are not capable of meeting the needs denied to them, and typically suffer more severe consequences. The most severe indicator of neglect is nonorganic failure-to-thrive syndrome, also called "acutely malnourished," that is, the child falls below the third percentile of weight, height or motor development (Radford, 1998). This results from extreme malnourishment, which unfortunately is an indicator not often identified, due to it's subtly and cumulative nature, until the child begins to evidence rather severe problems.

A variety of behavioral markers exist for the varying categories of neglect. For example, obvious signs of physical neglect include not only signs of malnutrition (e.g., low weight, stature), but also problems with physical hygiene (e.g., the child is very dirty or smells badly, has poor dental hygiene), inadequate or inappropriate dressing (e.g., mis-sized, dirty, or tattered clothing), and inadequate shelter (e.g., unsanitary or hazardous environment) (Ayoub, Grace, & Newberger, 1990; Besharov, 1990). Medical neglect includes failure to provide preventive (e.g., immunizations), diagnostic (e.g., medical examinations), remedial (e.g., regular medication), or prosthetic care (e.g., eye glasses) (Besharov, 1990). Notably, medical neglect involves the failure to provide sufficient care for both physical and emotional illness (Ayoub, Grace, & Newberger, 1990). Therefore, caregivers' that fail to adequately provide mental health services to an emotionally troubled child would need to be reported by mental health professionals. Signs of educational neglect are rather straightforward and include chronic absence or truancy in school. At times, children's lack of school attendance may not seem serious; however school absences or truancies often denote additional and more serious neglect issues (Besharov, 1990). Lastly, signs of abandonment, and care, control, or supervision neglect

may include accounts of abandonment or unsupervised periods inappropriate to the developmental level of the child, and descriptions of "accidental" injuries suggestive of caregiver inattention, particularly those injuries which occur repeatedly (e.g., a baby repeatedly falling off a high bed) (Besharov, 1990).

Clinical Expertise in the Reporting Process

Once mandated reporters are aware of their legal obligation to report and possess the ability to accurately identify maltreatment, they must then know how to competently report such maltreatment to maximize the protection of the child, family, and themselves. Mental health professionals' also must possess sufficient clinical expertise in managing clients throughout this extremely challenging and often confusing process. As previously mentioned, literature illustrates mandated reporters lack of knowledge with regard to reporting procedures.

In the only investigation of mental health professionals competence in handling the process of reporting with a client, Weinstein, Levine, Kogan, Harkavy-Friedman, and Miller (2001) found that the quality of the relationship prior to reporting was the greatest predictor of outcome, with a better alliance indicating more positive therapeutic outcomes for reporting. Results also indicated that the effective handling of a report significantly differentiated between positive and no-change outcomes. Effective handling of the report in this case indicates that the therapist is straightforward regarding the report and communicates ownership regarding the decision to report. More specifically, this entails "informing the client before, rather than after the report is made; informing the client oneself instead of having the supervisor or team inform the client; and explaining the reason for making the report in terms of one's clinical assessment versus a

requirement imposed from elsewhere" (Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2001, p. 229). A statistical trend was also evidenced with regard to therapist comfort in making a report and a positive reporting outcome. The authors also state the usefulness of informing clients of the helpful, as well as authoritative, role of CPS, and the therapists' willingness to provide support throughout this process. Weinstein, Levine, Kogan, Harkavy-Friedman, and Miller (2001) feel that these findings are "encouraging" in that these are behaviors that are "potentially modifiable through awareness and training" (p. 230).

Dealing with the Caregivers

Involving caregivers in the reporting process has received attention in the literature. Unfortunately, involving perpetrating caregivers has received scant research attention, and thus the involvement of non-perpetrating caregivers will be of focus. Indeed, literature supports the involvement of non-perpetrating caregivers in the reporting process.

Research encourages mental health professionals to inform caregivers of their intent to report prior to making such a report. Indeed, Racusin and Felsman (1986) see the failure to inform caregivers' of the intent to report suspected maltreatment as an act of deception, which violates the moral code and undermines therapeutic intentions. Thus, Racusin and Felsman (1986) hold that notifying caregivers' of the report is, in most cases, "both ethically required and clinically sensible" (p. 435). However, fear that informing caregivers' of the intent to report will trigger further maltreatment is a valid concern, which should be addressed on a case by case basis (Alvarez, Donohue, Kenny, Cavanagh, & Romero, 2004; Alvarez et al., 2004).

Research supporting the involvement of the non-perpetrating caregiver also points out the importance of allowing the caregiver to participate in the reporting process. This can include allowing the caregiver to make the report themselves (Berliner, 1993) or allowing them to be present while the mental health professional reports the suspected maltreatment (Levine, Doueck, & Anderson, 1995). Donohue, Carpin, Alvarez, Ellwood, and Jones (2002) developed empirically based guidelines for involving non-perpetrating caregivers in the reporting process. These guidelines include systematically informing the client of the intent to report, their rights throughout the process, the professional's legal and ethical obligations, the reporting and investigatory processes of child protective services, possible outcomes or consequences, and ways to maximize the safety of the child.

Making the Report

State statutes specify at least one agency in which reports of suspected maltreatment are received (e.g., Department of Social Services, Department of Human Resources, Division of Family and Children's Services, Child Protective Services) (Koralek, 1992). It is important for mental health professionals to know the appropriate reporting agencies in their area. In Nevada, the Division of Child and Family Services (DCFS) is responsible for child welfare services and maintains a toll-free 24 hour, 7 days a week hotline to receive any reports of child abuse or neglect in the state. Law enforcement departments may also receive reports of child maltreatment.

Once a mental health professional obtains sufficient information to warrant suspect, they are required to make either an oral and/or a written report. The contents of the report mandated by law are included in the previous section. While state definitions delineate

specific mandated information, additional information may benefit child protection by providing a more detailed report, as well as provide further protection for mental health professionals. Information helpful to child protective services in their determination of further proceedings includes the presence and ages of other children in the home, as well as any other persons aware of the maltreatment and the report (Kalichman, 1999).

In order for child protective services to appropriately screen and, if necessary, investigate a report, the information provided must allow for a determination to be made with regard to whether the indicators meet state definitions of abuse, as well as provide sufficient information on the whereabouts of the child and caregivers (Kalichman, 1999). Kalichman (1999) points out the importance of maximizing the protection of the child victim while minimizing breaches of confidentiality. In this regard, mental health professionals must work within Standard 5.02a of the *Ethical Principles of Psychologists and Code of Conduct* (1992) to minimize intrusions and provide "only [that] information germane to the purpose for which the communication is made".

Mental health professionals are encouraged to take a number of precautions to protect themselves from liability. Although some states allow mandated reporters to make an anonymous report, anonymous reporting is not recommended in that it fails to provide a record of a report with child protective services. When making a report, mental health professionals should always obtain the name, position, identification number, and contact information of the child protection worker receiving the report. Additionally, documentation of the entire process is of utmost importance. This includes all the factors which contributed to the mandated reporter's decision to report or not to report (Walters, 1995). Similarly, all information conveyed to the worker should be documented by the

mental health professional as to supply an accessible record of the contents of the report, and include verbatim accounts of the abuse whenever possible (Berliner, 1993).

Child Protective Service Procedures

Once a report is made, the goal of the child protection agency is to determine whether maltreatment has occurred, and then, if so, to develop and execute an individualized treatment plan for the child, family, and/or perpetrator (Chamberlain, Krell, & Preis, 1982). In this regard, child protective service caseworkers must make a variety of decisions which result in various actions.

Initial Screening and Risk Assessment

Caseworkers must first make a determination of whether the information provided via the report meets the appropriate state definitions of abuse and thus warrants further action. In this initial screening process, caseworkers may immediately decide that the report is unnecessary and may convey this to the mandated reporter making the call. If a determination cannot be as readily made, caseworkers engage in a more formalized risk assessment, which usually includes the following factors delineated by the National Association of Public Child Welfare (NAPCWA; 1988): caregiver action or omission, impact of the action/omission on the child, severity, frequency and recency of alleged abuse, child's age and location, credibility of the reporter, significance (e.g., type and amount) of evidence, relationship of alleged perpetrator to child, and parental willingness and ability to protect the child (Alvarez et al., 2004). This evaluation of risk must be conducted and completed within 3 days of receipt of the report (NRS432B.260).

If the initial risk assessment determines that the report is unworthy of further investigation, further action may be terminated completely or the report may be referred

to another agency or person for counseling, training, or other services (NRS 432B.260). All references of reports weeded out at this point are often deleted and thus any record of the report is removed by the caseworker. Typically, mandated reporters can ask for a report to remain on file lest a future report be made on the same family and also to ensure official documentation exists regarding the report (Kalichman, 1999). Additionally, child welfare service agencies in Nevada "may, at any time, reverse the determination and initiate an investigation" (NRS 432B.260).

Initial Acceptance and Investigation

If a report is accepted by child protective services, further evaluation and then investigation ensues. The timeliness of this investigation varies according to the priority given to the report. Reports determined to be of high-priority are typically investigated within 3 to 24 hours (Alvarez et al., 2004). In accordance with Nevada Revised Statute 432B.260, an investigation is immediately initiated if a report indicates that the child victim is five years old or younger, is at high risk of serious harm, is dead or seriously injured, or has visible signs of abuse. Those reports not considered high-priority typically require a response within a few days to a few weeks depending on the state statute (Alvarez et al., 2004). In Nevada, those reports determined to warrant an investigation, but that do not fall under the immediate response category, must be investigated no later than three days after the risk assessment is completed (NRS 432B.260). Investigations typically include interviews of the child, family, witnesses, alleged perpetrators, and/or any other involved parties, as well as photographs or X-rays of the victim, and any other medical tests deemed necessary (Alvarez et al., 2004).

Determinations of an Investigation

Subsequent to an investigation, the child protective agency will make a determination on whether or not maltreatment was confirmed. The agency will make a finding that the maltreatment is either unsubstantiated or substantiated. Unsubstantiation of an allegation of maltreatment can occur for a variety of reasons. Maltreatment can be unsubstantiated due to the allegation failing to meet state definitions of abuse or neglect, the inability of child protective agencies to prove or disprove the allegation, or a failure to locate the child or alleged perpetrator (State of Nevada, Division of Child and Family Services, 2005). Thus, unsubstantiation can, but does not necessarily, mean that maltreatment did not occur. It can also signify that the "preponderance of evidence resulting from the investigation does not meet the standards required for substantiation" (Kalichman, 1999). Substantiation of abuse means that the agency was able to find sufficient evidence of the occurrence of abuse or neglect.

Allegations of maltreatment substantiated by the child protection agency are assessed for services and a treatment plan specific to the child and/or family is developed and implemented. Services provided and/or mandated may include transportation, home visits, day care, self-help groups, big brother/sister, medical or physical care, individual and family counseling, parenting classes, occupational training, foster care, and/or adoptive services (Alvarez et al., 2004; Koralek, 1992). Child protective services aim to keep the family unit intact whenever possible, thus contrary to the opinions of many, only a small percentage of children are removed from their homes (Alvarez et al., 2004; Goodwin & Geil, 1982, Koralek, 1992). The files of unsubstantiated allegations are closed by the social service agency, and either no further action is taken or the case is

referred to another agency for future, typically voluntary, services for the child and family.

Instruments Designed to Assess Child Maltreatment Competence

Researchers have investigated a variety of professions with regard to knowledge of maltreatment reporting laws, ability to identify maltreatment, and reporting tendencies and decisional processes. In this regard, instruments investigating various aspects of child maltreatment reporting competence and behavior are evidenced throughout the literature. The vast majority of instruments discussed in the literature were developed solely for the purposes of a single research question or training evaluation, and are thus often only very briefly discussed. Since many of the measures are only mentioned, no information is available with regard to its content or structure. When this information is available, little to no psychometric validation is conducted. Thus, for purposes of this review, only highly relevant measures which provide information on the instruments development or validation will be discussed.

Similarly, significant research has utilized hypothetical maltreatment scenarios in the investigation of the influence of differing variables on professionals reporting tendencies. Literature evidences the systematic manipulation of signs of abuse (e.g., Kalichman & Brosig, 1992), abuse type (e.g., Kalichman, Craig, & Follingstad, 1988; Zellman, 1990), symptom specificity (e.g., Finlayson & Koocher, 1991), victim age (e.g., Kalichman & Brosig, 1992; Kalichman, Craig, & Follingstad, 1988), victim and perpetrator sex (e.g., Wagner, Aucoin, & Johnson, 1993), verbal abuse disclosure (Kalichman & Brosig, 1992), and socioeconomic status (e.g., Zellman, 1990). Although all of the literature

utilizing hypothetical abuse scenarios will not be included, these measures have been reviewed and served as models for the development of vignettes in the current study.

A review of instruments designed to assess mandated reporters' knowledge, maltreatment identification abilities, and/or clinical expertise in reporting, which also includes information on the instruments development and/or validation, follows. Mandated reporters receiving the greatest attention in the literature include educators, specifically teachers, medical professionals, and mental health professionals. Therefore, instruments discussed in the following sections will be grouped in terms of the professions of focus for each study.

Educators

Kenny (2001; 2002; & 2004) developed the Educators and Child Abuse Questionnaire (ECAQ) to investigate "teachers' self-reported knowledge of the signs and symptoms of child maltreatment, reporting procedures, legal issues surrounding child abuse, and their attitudes toward corporal punishment" (Kenny, 2004, p. 1311). The initially developed instrument was given to two panels of experts, which included five teachers and five child psychologists, for review and comment. Experts completed the measure and then were asked for their opinion of the questionnaire, and to ask any questions or provide any feedback regarding the instrument or the study procedures. Based on the experts' feedback, several items were edited for readability (Kenny, 2001). After revisions, the final ECAQ includes 12 statements related to "(a) competence in identifying and assessing various types of child abuse, (b) knowledge regarding procedures, and (c) attitudes toward corporal punishment" (Kenny, 2004, p. 1313). Each statement is followed by a 5-point Likert scale ranging from (1) strongly agree to (5)

strongly disagree. A factor analysis was performed and extracted the following four factors: "(1) Awareness of signs and symptoms, (2) Knowledge of reporting procedures, (3) Attitudes toward discipline, and (4) Seriousness of child abuse" (Kenny, 2004, p. 1314). These four factors accounted for 62% of the variance. Since the instrument consists of only 12 items, each of the factors includes few items. The three items comprising the first factor (e.g., "I am aware of the signs of child sexual abuse") have a Cronbach's alpha of .85, the second factor includes five items (e.g., "I am aware of my school's procedures for child abuse reporting") and evidenced a Cronbach's alpha of .72, the three item third factor (e.g., "Teachers should be allowed to use corporal punishment with students") had a coefficient alpha of .64, and the fourth factor only included one item (i.e., "Child abuse is a serious problem in my school") and thus an internal consistency coefficient is not available. Although, this instrument is one of very few with any evidenced psychometric validation, it should be noted that this validation is minimal. Similarly, the items are asking participants to self-report on their child maltreatment reporting knowledge, rather than asking specific questions designed to assess such knowledge.

Hazzard (1984) developed the Child Abuse Survey, which includes two scales designed to investigate teachers' knowledge of, and feelings toward, child maltreatment. Only the knowledge scale will be discussed due to its relevance to the current study. This scale was developed via a pilot test in which 41 pilot subjects and a 10 expert panel completed the 39-item true-false instrument. Five items were removed due to "lack of expert agreement, inadequate distributions, or inadequate item-total scale correlations" (Hazzard & Rupp, 1986, p. 220). Items assessed child maltreatment definitions,

characteristics, causes, effects, reporting requirements, and treatment alternatives. Each item includes a 5-point Likert scale ranging from strongly agree to strongly disagree, with correct responses scored a 4 and incorrect a 0 to combine for a maximum total score of 136. The final 34-item revised version evidenced a coefficient alpha of .80. This instrument was initially utilized with teachers (Hazzard, 1984), however, Hazzard and Rupp (1986) subsequently included pediatricians, mental health professionals, and college students.

In a study on the efficacy of a teacher training workshop on child sexual abuse prevention, Kleemeier, Webb, and Hazzard (1988) developed the Teacher Knowledge Scale, Teacher Opinion Scale, Teacher Vignettes Measure, Teacher Prevention Behavior Measure, and Workshop Evaluation. Only the Teacher Knowledge Scale and Teacher Vignettes Measure will be discussed due to their relevance to the current study. The Teacher Knowledge Scale includes 30 items to assess teachers' child sexual abuse knowledge, specifically addressing maltreatment definitions, prevalence, identification, prevention, reporting, and treatment. Response alternatives included true, false, and I don't know, with true responses being scored as correct. Pilot testing was conducted during a previous teacher training with the instrument sufficiently differentiating between trained and control teachers. Item-total correlations were above .25 for 27 out of the 30 items, with two week test-retest reliability of .90, and a coefficient alpha of .84 for the entire scale. In order to assess teachers' ability in identifying and dealing with abusive situations, the authors developed the Teacher Vignettes Measure. This includes eight vignettes, four of which teachers are asked to "identify behavioral indicators of potential sexual abuse, to decide on an appropriate course of action, and to suggest how to initiate

a conversation with the hypothetical child" (Kleemeier, Webb, & Hazzard, 1988, p. 557). In the remaining four vignettes, children disclose sexual abuse and teachers are prompted, in an open-response format, to indicate how they would respond to each disclosure. This scale evidenced a coefficient alpha of .78, and interrater reliability of .99.

Medical Professionals

Two studies of interest investigated medical professionals with regard to various characteristics which influence the recognition and reporting of child maltreatment. Of interest to the current study, is that this literature developed and utilized hypothetical maltreatment scenarios. For instance, O'Toole, O'Toole, Webster, and Lucal (1993) developed vignettes by utilizing a computer-generated randomization of seven variables (e.g., type of act, level of seriousness, age of victim). A computer program was created to randomly select components of the vignettes from lists of alternative dimensions for each variable. Similarly, Warner-Rogers, Hansen, and Spieth (1995) developed a set of 16 vignettes varying in terms of injury severity and explanation, as well as delay in seeking medical attention. The vignettes were created to resemble summaries of injured childrens' emergency room medical records. Definitions of injury severity were taken from national incidence studies to construct injury descriptions. These vignettes were reviewed in terms of appropriate use of medical terminology and accuracy of injury severity and explanation by a panel of four physicians. The instrument was then administered to five medical students for pilot testing, whom completed the instrument and then asked to provide any opinions of the instrument, question any study component, and give feedback regarding the study procedures (Warner-Rogers, et al., 1995).

Although these research studies provide good models of hypothetical vignette development, the vignettes themselves are relevant specifically to medical professionals and therefore are not appropriate for utilization with mental health professionals.

Various Professionals

Shor and Haj-Yahia (1996) developed an instrument to investigation future professionals' perceptions of maltreatment, knowledge of signs of maltreatment, awareness of risk factors, and willingness to report. This instrument was utilized among Social Work, Psychology, Education, and Medical students in two universities in Israel. The instrument was initially pilot tested in Israel with 30 undergraduate and graduate mental health and health students with a goal of improving item clarity and wording, as well as instrument structure. The graduate students were also asked to comment on the necessity and relevance of each item. These procedures are deemed by the authors to adequately "assure the face validity of the instrument and to some extent its content validity (e.g., Kerlinger, 1986)" (Shor & Haj-Yahia, 1996, p. 427). The final version of the instrument includes 10 short vignettes designed to investigate perceptions of child maltreatment. These vignettes were constructed to represent the main categories of abuse (i.e., physical, psychological, and sexual) and neglect (i.e., physical, medical, and educational) discussed in the literature. Following the vignettes respondents are asked to indicate, with either a "yes," "no," or "undecided", whether they deem each scenario as indicative of child maltreatment. To investigate respondents' awareness of child maltreatment indictors a list of 12 signs of child maltreatment, drawn from the literature, are included. Respondents are asked to indicate if each sign is indicative of child maltreatment, with the same three options as the above vignettes. Twelve risk factors,

evidenced in the literature, are included to assess awareness of child maltreatment risk factors, with respondents indicating their belief of whether each is a risk factor for child maltreatment. The final section of the instrument includes 12 situations of child maltreatment, developed under the same categories as the previous vignettes, in which respondents indicate their willingness to report child maltreatment. Reporting willingness is again investigated by utilizing the response options of "yes," "no," and "undecided".

Mental Health Professionals

The Crenshaw Abuse Reporting Survey (CARS-M; Crenshaw, 1990) was developed to investigate mental health providers' sexual abuse reporting tendencies. The CARS-M is an 11-page booklet which includes demographic questions, as well as four vignettes followed by questions regarding reporting behavior. Three of the vignettes describe observed or disclosed physical, sexual, or emotional abuse, and one describes a suspected sexual abuse scenario. Subsequent to each vignette respondents are asked to indicate their reporting response. These response options originally included only report and non-report options, however, many respondents felt those responses were too limiting and thus "hold off" and "self-report" responses were added to "guard against the stigma of simply not reporting and [to increase] the clinical realism of the options (Crenshaw, Lichtenberg, & Bartell, 1993, p. 27). These response options, though more socially desirable, are still obvious violations of mandatory reporting statutes, and thus only the report option was scored as correct. Respondents are also asked to rate 15 decisional items according to the influence of each on their reporting decision for each vignette. In the final section, respondents are provided the following statement: "K.S.A. 38-1522 mandates that mental health providers with knowledge or suspicions of child abuse

report the same to SRS or law enforcement officials" (Crenshaw, Lichtenberg, & Bartell, 1993, p. 27). Respondents were then asked to indicate which of the following best describes themselves: (1) "I was already familiar with the law and what it means to me; (2) "I knew about the law but wasn't sure how it pertained to me"; (3) "I thought such a law existed, but wasn't sure"; and (4) "I didn't know the law existed" (Crenshaw, Lichtenberg, & Bartell, 1993, p. 27). The final section includes a question regarding respondents' attitude toward the mandatory reporting law, as well as 5 statements in which respondents indicate their level of agreement. Variations of the above questionnaire have been created to increase its relevance with educators (Crenshaw, Crenshaw, & Lichtenberg, 1995), and for use outside of Kansas, particularly in Australia (Hawkins & McCallum, 2001a; 2001b). Although a vast amount of information is available with regard to the contents of the CARS-M, it appears that psychometric support is lacking as no information was available with regard to the instruments reliability and validity.

Beck, Ogloff, and Corbishley (1994) developed an instrument to assess teachers' knowledge of, opinions toward, and experience and compliance with British Colombia child abuse reporting laws. Beck and Ogloff (1995) revised this instrument for use with psychologists. The later instrument will be of primary focus due to its relevance to the current study. Knowledge regarding child abuse reporting laws was assessed by nine multiple-choice questions developed by the authors, one of which possesses a law degree, in accordance with British Colombia's reporting legislation. Item clarity and complexity were assessed via pilot testing with eight graduate students and faculty. Section 2 consists of questions regarding respondents experience with reporting,

including types of abuse reported, and reasons for reporting or failing to report. In order to assess differential reporting based on type of abuse, four child maltreatment vignettes, which systematically manipulated abuse type, were included in the third section. Following each vignette, respondents were asked to indicate, on a 7-point Likert scale ranging from (1) definitely not certain/definitely would not report to (7) definitely certain/definitely would report, their level of certainty of the occurrence of child maltreatment, as well as their likelihood of making a report. The last section examined respondents' opinions of child abuse reporting with five statements concerning British Colombia's child abuse mandated reporting law and system. Although, the content and the development of this instrument are explicated, the goal of the instrument is to examine the knowledge and compliance of psychologists with regard to mandatory reporting. Therefore, standardization of the instrument, including its psychometric properties are not available.

Renninger, Veach, and Bagdade (2002) developed an instrument to assess licensed psychologists' knowledge and opinions of child maltreatment laws, as well as the decisional criteria for, and tendencies of, reporting. Respondents are first asked to self-report their level of knowledge regarding mandated reporting laws, as well as how they learned about such laws. Ten multiple-choice items follow and more objectively assess broad knowledge in 10 aspects of reporting laws. Opinions of the laws are assessed via a single open-ended question. Eight hypothetical vignettes, four different vignettes repeated once with a different perpetrator, are included to examine application of the laws and decisional criteria. All vignettes are standardized in terms of length and number of previous therapy sessions. Vignettes vary in terms of the identified client (i.e., two

include child victims and two with adult perpetrators), type of abuse (i.e., two include sexual abuse and two with physical abuse), and accurate reporting decision (i.e., six require reporting and two do not require reporting). Each vignette is followed by four questions regarding whether the abuse is reportable as stated by the law, whether the respondent would report, how the respondent would make their reporting decision, and the severity of the scenario based on a 6-point Likert-type scale. The authors provide detailed information with regard to the content of the instrument, and comment that the instrument was developed based on existing literature and surveys. Unfortunately, no information with regard to the psychometric properties of the instrument is available.

Weinstein, Levine, Kogan, Harkavy-Friedman, and Miller (2001) developed the only instrument found to investigate mental health professionals' effective handling of making a report. This instrument assessed Relational Factors with the following three scales: 1) Confidentiality Issues; 2) Reporting Issues; and 3) Quality of the Relationship. The Confidentiality Issues scale includes three questions regarding if, how, and the extent to which clients were informed about the limits of confidentiality. Of greatest relevance is the Reporting Issues scale, which includes questions concerning "a) when the client was informed about the report (i.e., before or after the report or not at all); b) by whom (i.e., therapist or other person); and c) how the report was explained (i.e., therapist emphasis on the perception of its importance or done because of the law)" (Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2001, p. 223-224). The Quality of the Relationship was measured by the Working Alliance Inventory, a 12-item self-report instrument designed to assess the quality of the therapeutic alliance.

Summary

Instruments designed to investigate various mandated reporters and diverse aspects of reporting competence are evidenced in the literature. However, all of these instruments were developed to answer a specific research question (e.g., attitudes or opinions of reporting, reporting behavior or tendencies), or to determine efficacy of particular developed child maltreatment training programs. Therefore, little to no information is available with regard to the development of the instrument, and even less attention is paid to instrument standardization and validation. Consequently, no instrument has been rigorously developed, standardized, and validated for purposes of assessing individual mandated reporters' competence in child maltreatment reporting. Similarly, no standardized instrument exists that specifically assesses mental health professionals' knowledge and expertise in accurately and effectively reporting child maltreatment.

Indeed, a psychometrically validated instrument to assess mandated reporters knowledge and understanding would make a significant contribution to the field. Research measures designed to assess mandated reporters knowledge and understanding are vastly inadequate. Specifically, measures assessing and evaluating mental health professionals' knowledge, understanding, and correct implementation of reporting laws, processes, and procedures, as well as their ability to adequately and adeptly identify victims of abuse, are necessary. Such a measure could be utilized to objectively assess the efficacy of child maltreatment trainings. Additionally, a measure of this type could be utilized by professions, programs, or employers to assess mandated reporters' knowledge and identify those persons necessitating further training. These measures could also be utilized to address individuals' areas of particular strength or weakness. In this regard,

individuals could receive or be required to obtain training in a specific area in which knowledge and or understanding is lacking.

CHAPTER 3

METHODOLOGY

Purpose

The development of standardized measures to assess child maltreatment reporting competence of mental health professionals is greatly needed. Therefore, the purposes of this study were to (1) systematically develop three screening tools to assess knowledge of mandatory child maltreatment reporting laws, ability to accurately identify child maltreatment, and clinical expertise in reporting child maltreatment; and (2) initially examine the psychometric properties and clinical utility of each of the developed inventories in a sample of mental health professionals and graduate students pursuing careers in mental health. Although not a prime aim in this study, mental health professionals' perceptions regarding various influences on, or impediments to, reporting child maltreatment were also examined in secondary analyses.

Stage 1

Purpose

The initial stage of this study focused on developing a series of questions relevant to assessing competence in knowledge of child maltreatment reporting laws, ability to identify child maltreatment, and clinical expertise in reporting child maltreatment.

Participants

Four individuals with experience in reporting child maltreatment (i.e., experience reporting child maltreatment, enrollment in coursework relevant to child maltreatment reporting, participation in training workshops relevant to child maltreatment reporting, publishing in child maltreatment reporting), participated in focus groups to develop initial items for the screening tools. These individuals included three advanced graduate students and one licensed psychologist who were members of a clinical psychology doctoral program. Participants also included two child maltreatment reporting experts employed by the child protective service branch of Clark County Nevada's Division of Child and Family Services (caseworker, supervisor) who were recruited to assist in validating the appropriateness of pooled items, and breadth of content areas. The caseworker and supervisor were recruited from different units of CPS to control inherent dual-relationship issues, and to limit similarity in ideology due to parallel training.

Procedure

Literature Review

The first step of item development involved extensive literature reviews performed independently by 2 of the aforementioned graduate student participants. Literature review searches were conducted utilizing PsycINFO from 1960 to 2006, with various keyword combinations specific to mandatory reporting laws, definitions of child maltreatment with an emphasis in the determination of child maltreatment, and established clinical skills relevant to child maltreatment reporting practices. Perceived and experienced consequences of child maltreatment were examined in separate reviews,

including how various factors influence reporting behavior of mental health professionals.

Development of Knowledge of Child Maltreatment Laws Screening Tool

The Knowledge of Child Maltreatment Laws Screening Tool was developed to assess participants' knowledge of Federal laws and Nevada State Statutes relevant to child maltreatment reporting, including item generation and validation through 1) the aforementioned literature review, and subsequent discussions of findings in focus groups involving the four professionals with experience in child maltreatment reporting, and 2) item validation by the Child Protective Service experts.

Initial Item Development

The initial items for the Laws Screening Tool were developed based on review of both Federal laws and Nevada State Statutes pertaining to child maltreatment reporting. Two focus groups were conducted with the goal of developing 15 to 20 items to sample a broad range of relevant areas. Items were relevant to State and federal child maltreatment reporting laws. Focus groups were lead by a moderator, who directed the conversation and kept comprehensive notes of the process (Ritchie & Lewis, 2003). Members were provided with the relevant Federal and Nevada Revised Statutes for consultation. It was determined that approximately 50% of the items would be relevant to Federal Laws and 50% would be State-specific items. To support the accuracy and comprehensiveness of the screening tool, members individually reviewed the Federal Laws and Nevada Revised Statutes to identify areas important to include in the screening tool (DeVellis, 2003). Brainstorming pertinent content areas was encouraged as it allowed members an opportunity to reflect upon and then refine the items based on discussion with other

members (Ritchie & Lewis, 2003). Areas included maltreatment definitions, reporting timelines, reporting procedures, and reporting consequences.

Subsequent to initial item development, another focus group was conducted that was focused on extensively reviewing and refining items with regard to wording, grammar, clarity, and avoidance of redundancy. Item redundancy was avoided as the intent of the instrument was conceptualized to broadly cover the various and extensive child maltreatment reporting laws. The focus group generated 15 items, with seven items pertaining to Federal legislation and eight State-specific items. All items utilize a four alternative multiple-choice response format. Four response alternatives (i.e., 3 incorrect, 1 correct) were chosen to reduce error in measurement related to guessing, while maintaining parsimony and practicality (Murphy & Davidshofer, 2001).

Validation by CPS Experts

The resulting items were reviewed by CPS experts to verify correct interpretation and coverage of child maltreatment reporting laws, and thus assess face and content validity. Two CPS experts (i.e., one caseworker and one supervisor) initially validated the Laws Screening Tool via independent completion of the items. Experts' responses were reviewed and the results indicated 100% agreement in the selection of theorized correct responses. Items were then discussed with regard to item wording, clarity, and redundancy. The results of this discussion led to minimal refinement, with no additional items being developed, and no items being removed. Additionally, discussion was initiated regarding the depth and breadth of all aspects relevant to child maltreatment reporting laws (DeVellis, 2003). CPS experts were provided with the Federal and State Laws, and asked to review these laws to ensure appropriate coverage within the Laws

Screening Tool. CPS experts reported the depth and breadth of coverage as sufficient, with no suggestions for further assessment. Thus, the final version of the Laws Screening Tool includes 15 multiple-choice items covering a broad range of child maltreatment reporting laws. Seven items pertain to Federal child maltreatment laws, and eight items are specific to Nevada Revised Statues (see Appendix A).

Recognition of Child Maltreatment Screening Tool

The Recognition of Child Maltreatment Screening Tool was developed for the purpose of assessing ability to accurately report, and thus identify, child maltreatment.

Initial Item Development

In three focus groups the aforementioned four professionals with experience in child maltreatment developed brief hypothetical vignettes depicting child maltreatment scenarios and non-maltreatment scenarios. Item structure and response format were developed by investigation of existing measures and focus group input (Johnston, Leung, Fielding, Tin, Ho, 2003).

Abuse indicators of child maltreatment from the literature review were employed during the focus groups to create an initial pool of 19 vignettes. At least four vignettes for each type of maltreatment (i.e., six for physical abuse, five for neglect, four for sexual abuse, four for emotional abuse) were developed to maximize the chances of inclusion of two reportable vignettes and two non-reportable vignettes for each abuse type in the final version. An example of a vignette is "Joan, a woman that you have been seeing for several months discloses that she is concerned about her husband's actions. She and her husband have a 2 ½ -year-old daughter, and she is concerned that her husband frequently

showers with the child. She says that her daughter loves to shower with her father and hears the child playing in the tub as the father showers."

Methods to assess child maltreatment recognition often include items assessing the extent to which an individual suspects abuse for various vignettes, as well as their likelihood of reporting child maltreatment in these vignettes (e.g., Ashton, 2004; Finlayson & Koocher, 1991; Hansen, et al., 1997). Therefore, for each vignette, the participant is prompted to indicate the likelihood of suspicion of maltreatment, as well as the likelihood of reporting child maltreatment to authorities. Response alternatives for both items include a 7-point Likert-type scale ranging from (1) *Highly Unlikely* to (7) *Highly Likely*. These items were included in this study to secondarily investigate the relationship between mental health professionals' suspicion of maltreatment and child maltreatment reporting behavior. However, since the purpose of this measure is to ensure accurate child maltreatment reporting, only the items assessing the likelihood of reporting child maltreatment will be employed to investigate psychometric support.

Initial Item and Screening Tool Validation

The CPS experts previously described validated items in the Recognition Screening Tool. Nineteen vignettes were administered in a randomized order to the experts. They were instructed to determine whether each vignette contained sufficient evidence to suspect maltreatment, and thus warrant a report. Experts rated each vignette as "Report" or "Do not report." For the vignettes deemed reportable, each expert was asked to classify the hypothetical scenarios by type of maltreatment (i.e., physical, sexual, or emotional abuse, or neglect). Subsequent to independent examination of the 19 vignettes, the CPS experts' responses were reviewed to ensure that at least one vignette in each

category (e.g., non-reportable neglect scenario, reportable neglect scenario) received 100% agreement by the experts. All categories included at least one vignette which received 100% agreement (5 for physical abuse, 4 for emotional abuse, 3 for sexual abuse, and 3 for neglect). The four vignettes, which did not receive 100% agreement by the raters, were eliminated from further discussion (i.e., 1 for physical abuse, 1 for sexual abuse, and 2 for neglect). Though agreement from the CPS experts was important, vignettes also needed to reflect complex, and often challenging, real-life child maltreatment reporting decisions. Thus, a detailed discussion of each vignette ensued, with three physical abuse, two emotional abuse, one sexual abuse, and one neglect vignette were eliminated. During this discussion, CPS experts were asked to comment on the likelihood of each scenario, as well as to provide experiences or knowledge that could improve the vignette. Additionally, CPS experts assisted in revising vignettes to ensure each was consistent with reporting laws. For each reportable vignette, CPS experts were also asked specifically to review the appropriateness of abuse indicators. CPS experts also provided feedback regarding wording and readability, which resulted in minor revisions. For instance, CPS experts recommended adding various descriptors (e.g., "long and linear" bruise) to better indicate physical abuse. Vignettes were chosen for inclusion in the final measure based on the feedback provided in this discussion session.

The final version of the Recognition Screening Tool includes eight vignettes describing hypothetical scenarios. These vignettes include two scenarios for each abuse type (i.e., physical, sexual, and emotional abuse, and neglect), with one depicting a reportable child maltreatment scenario, and one describing a non-reportable scenario.

Items following each vignette include "From the information provided, how likely are you to suspect maltreatment?" and "Regardless of your answer to the previous question, how likely are you to make a report?" Response alternatives for both items include a 7-point Likert-type scale ranging from (1) *Highly Unlikely* to (7) *Highly Likely* (see Appendix B).

Clinical Expertise in Reporting Child Maltreatment Screening Tool

The Clinical Expertise in Reporting Child Maltreatment Screening Tool was developed to assess mental health professionals' ability to effectively report child maltreatment. This includes awareness and utilization of techniques designed to maximize the protection of the child (e.g., involving non-perpetrating caregiver, awareness of CPS response to reports) while minimizing negative therapeutic consequences (e.g., client distrust, client dropout).

Initial Item Development

Item stems and response formats for the Clinical Expertise Screening Tool were developed in one focus group, with the aforementioned four mental health professionals experienced in reporting child maltreatment, consequent to their reviews of published literature espousing procedural recommendations and best practices in reporting child maltreatment. Subsequent to independent examination of the literature review, areas important to include in the screening tool were delineated, including methods of discussing the making of a child maltreatment report with caregivers (i.e., explaining reporting process and CPS procedures, involving caregiver in report). Item stems and response alternatives were subsequently developed in brainstorming led by a moderator. This resulted in twenty items and response alternatives relevant to clinical expertise in

reporting (e.g., "Mental health providers are always encouraged to discuss the making of a report with: a) the client, b) a friend, c) a colleague (Correct), or d) all of the above).")". Each item included four multiple-choice response alternatives, with one correct and three incorrect alternatives. Four response alternatives were included to reduce error, while maintaining parsimony (Murphy & Davidshofer, 2001).

Initial Item and Screening Tool Validation

The Clinical Expertise Screening Tool was inspected by the two CPS experts. The experts independently completed each of the items, and were subsequently encouraged to comment on item accuracy, wording, clarity, and suggest methods of eliminating redundancy. Items that were redundant were omitted due to the extent of the topic area, and the goal of the screening tool to practically and broadly assess competence in managing child maltreatment reporting. Experts were also asked to assess the depth and breadth of the Clinical Expertise Screening Tool. Minimal revisions regarding wording were made, and five items were removed due to redundancy. The final version of the Clinical Expertise Screening Tool includes 15 items, each with a four alternative multiple-choice format (see Appendix C).

Stage 2

Purpose

The purpose of the second stage of this study was to assess the initial psychometric properties of the Knowledge of Child Maltreatment Laws Screening Tool, Recognition of Child Maltreatment Screening Tool, and Clinical Expertise in Reporting Child Maltreatment Screening Tool, including test-retest reliability, responsiveness, internal

consistency, and relationships with previous training and experience. Additionally, mental health professionals' perceptions of various influences on child maltreatment reporting were investigated.

Participants

Participants included 76 professionals and graduate students in mental health fields recruited from a university, mental health clinics, and governmental agencies. Fifty-five individuals completed study measures in the pre-treatment phase of a controlled outcome study investigating the efficacy of training workshops designed to enhance skills relevant to child maltreatment reporting competence and cultural competence in therapy. Twenty-one individuals were recruited outside of the outcome study (i.e., university and governmental agencies) to complete the developed inventories.

As illustrated in Table 1, eighty-two percent of participants were female ($N = 62$) and participants ranged in age from 22 to 69 years ($M = 38.11$ years). Most participants (i.e., 55 or 72.4%) were Caucasian, and from the field of Psychology ($N = 33$ or 43.4%), or Social Work ($N = 29$ or 38.2%). Nineteen (25%) of the participants were current graduate students, while 56 participants were professionals. Professionals included individuals working in a mental health field and holding Bachelor's ($N = 8$ or 14.3%), Master's ($N = 32$ or 57.2%), or Doctoral ($N = 15$ or 26.8%) degrees. Almost all graduate students ($N = 16$ or 84%) were enrolled in Doctoral programs. The mean number of years in the field for graduate students was almost 6 years ($SD = 3.7$), while the mean for professionals was almost 12 years ($SD = 7.6$).

Participants training and experience in child maltreatment reporting varied significantly. Approximately half ($N = 43$ or 56.6%) of the participants reported

receiving training in child maltreatment reporting, with twenty (46.5%) of those participants reporting the receipt of training within the context of work, while only 16 (37.2%) reported training within graduate school. The number of child maltreatment workshops ranged from 0 to 10 ($M = 1.26$, $SD = 1.88$), with the number of training hours ranging from 0 to 40 ($M = 5$, $SD = 8.92$). Approximately 78% ($N = 59$) of the participants had previously reported child maltreatment. The number of child maltreatment reports ranged from 0 to 100 ($M = 9.29$, $Mdn = 3.00$, $SD = 18.88$), with a mean of 5.76 ($Mdn = 3.00$, $SD = 7.58$) reports being accepted by CPS. Only eight of the participants (10.5%) endorsed failure to report child maltreatment. See Table 2 for further information regarding participants' child maltreatment training and reporting experience.

Procedure

Recruitment of participants occurred through flyers recruiting professionals and graduate students in mental health fields for a study evaluating the efficacy of two training workshops (i.e., Child Maltreatment Reporting Workshop, Ethnic Cultural Considerations in Therapy Workshop), and related measures. Flyers were posted at, and faxed to, a local university, as well as local mental health clinics ($N = 4$), hospitals ($N = 2$), and governmental agencies ($N = 2$), as well as emailed to graduate student and state psychological association list-serves for individuals within Clark County Nevada. Additionally, participants' received 2.75 hours of continuing education credit for participation in this study to satisfy partial fulfillment of licensing requirements in psychology, social work, or counseling, when applicable. The aforementioned

recruitment strategies resulted in 55 participants. The remainder of the participants' were recruited via personal contact solely for the purposes of this study ($N = 21$).

Informed consent was obtained prior to participation for all participants. Upon the provision of informed consent, participants completed questionnaires developed to ascertain demographic information, as well as their experience and previous training in child maltreatment reporting (see Appendix D and E). Participants were then administered the developed Knowledge of Child Maltreatment Laws Screening Tool, Recognition of Child Maltreatment Screening Tool, and Clinical Expertise in Reporting Child Maltreatment Screening Tool, as well as an instrument designed to explore influences on child maltreatment reporting. Most participants completed informed consent and completion of the questionnaires in approximately 30 minutes.

Measures

Demographic Information

Items on the demographic questionnaire include information regarding participants' gender, age, ethnicity, parental status, and income, as well as mental health background and career (e.g., occupation, setting, number of years in the mental health field, degree credentials, licensure status). This questionnaire is included as Appendix D.

Child Maltreatment Reporting Experience

To ascertain familiarity with, and experiences in, child maltreatment reporting, participants' completed questions relevant to their participation in trainings on child maltreatment reporting, experience in reporting child maltreatment, and experience with, and perception of, child protective services. To assess previous child maltreatment reporting training, participants were asked about the quantity of previous trainings

received in child maltreatment reporting (i.e., number of workshops/trainings/seminars, approximate number of hours), as well as the context or setting of such trainings (e.g., school, work, conference) and the reason for attendance (i.e., work or school requirement, interest, continuing education credits, other). Questions also examined participants' experience in reporting child maltreatment (e.g., "Have you ever reported suspected child maltreatment"), and reporting behaviors (e.g., "Have you ever suspected child maltreatment and elected not to report?"). Additionally, participants were instructed to rate their overall experience with, and perception of, CPS on a 7-point Likert type scale ranging from 1 (*Extremely Negative*) to 7 (*Extremely Positive*). This questionnaire is included as Appendix E.

Knowledge of Child Maltreatment Laws Screening Tool

The Laws Screening Tool includes 15 items designed to measure respondents' knowledge of mandatory reporting laws. Eight items are relevant to Federal legislation and seven are relevant to State-legislation. Participants are prompted to choose from four alternatives, with one being the correct response. An example item and response format in this inventory includes, "The Nevada Revised Statutes mandates that a suspicion of child abuse or neglect must be reported no later than: a) 12 hours, b) 24 hours, c) 36 hours, or d) 72 hours." The Laws Screening Tool is provided in Appendix A.

Recognition of Child Maltreatment Screening Tool

The Recognition Screening Tool includes eight hypothetical maltreatment vignettes, followed by items designed to assess participants' ability to accurately report child maltreatment. Two vignettes for each type of maltreatment are included, with one vignette depicting a reportable scenario and the other representing a non-reportable

scenario. An example of a vignette is "Joan, a woman that you have been seeing for several months discloses that she is concerned about her husband's actions. She and her husband, have a 2 ½ -year-old daughter, and she is concerned that her husband will frequently shower with the child. She says that her daughter loves to shower with her father and hears the child playing in the tub as the father showers." Following each vignette participants are asked to endorse "how likely are you to make a report?" on a 7-point Likert-type scale ranging from (1) *Highly Unlikely* to (7) *Highly Likely.* Participants' responded on the same 7-point Likert-type scale. The Recognition Screening Tool is included as Appendix B.

Clinical Expertise in Reporting Child Maltreatment Screening Tool

The Clinical Expertise Screening Tool includes 15 items examining respondents' expertise in reporting child maltreatment, including appropriate client and caregiver management. Items include a four-response multiple-choice format. Items include "Mental health providers are always encouraged to discuss the making of a report with: a) the client, b) a friend, c) a colleague, or d) all of the above." The Clinical Expertise Screening Tool is attached as Appendix C.

Assessment of Potential Influences on Reporting Child Maltreatment

Twenty item stems, each conceptualized to influence child maltreatment reporting were originated to explore relative influences on child maltreatment reporting (e.g., "Fear client will terminate therapy" and "Unfamiliarity of reporting laws."). Participants were asked to examine the item stem, and indicate the extent each impedes them from reporting child maltreatment on a 7-point Likert-type scale ranging from (1) *Never Influenced* to (7) *Always Influenced.* This questionnaire is attached as Appendix F.

CHAPTER 4

FINDINGS OF THE STUDY

Comparison of Recruited Samples

Prior to combining the groups for further data analyses, differences between the groups were examined on demographic and clinical variables to determine significant differences that might have been introduced through the recruitment procedure. Lack of significant differences would support combining these groups for subsequent analyses. Thus, to determine the extent to which the sample recruited for workshop participation and the sample recruited solely for this study were homogenous on demographic and training relevant to mandated child maltreatment reporting training, Chi-squared and t-test analyses were performed. Relative similarities between these groups would support the pooling of these participants. The results indicated the groups were statistically similar in age ($t = .03$, $p = .98$, $d = .05$), gender ($t = .24$, $p = .81$, $d = .01$), ethnicity ($t = -.23$, $p = .82$, $d = -.05$), graduate student status ($t = -.46$, $p = .65$, $d = -.11$), occupation ($t = .18$, $p = .86$, $d = .05$), number of years in the mental health field ($t = 1.1$, $p = .32$, $d = .27$), and number ($t = -.15$, $p = .88$, $d = -.05$) or hours of child maltreatment training experiences($t = -1.7.$, $p = .09$, $d = -.41$). Thus, the lack of significant differences between the groups on these important demographic and clinical variables supports combining the groups for analysis purposes.

Stage 2

Knowledge of Child Maltreatment Laws Screening Tool

Means and Standard Deviations

The Laws Screening Tool includes 15 multiple-choice items, each with one correct answer. Participants' correct responses were scored "1," with incorrect responses receiving a score of "0," for a total possible score of 15. Participants' Law Screening Tool total scores ranged from 9 (60%) to 15 (100%), with a mean of 12.61 (81.07%) and a standard deviation of 1.38. Additionally, means and standard deviations were conducted for each of the 15 items. Item difficulty is the percentage of individuals who answer an item correctly, and, in this case, is equal to the item mean. For example, an item with a mean of .85, has an item difficulty of 85% (i.e., 85% of participants answered the item correctly). Item means ranged from .47 to .99. Thus, professionals were particularly accurate in their knowledge of certain aspects of Federal and State laws regarding suspicion of maltreatment requiring a report, as well as the provision of immunity for reports made in good faith. Table 3 provides the mean and standard deviation of all items on the Laws Screening Tool. Items are ordered from most to least difficult.

Test-Retest Reliability

To determine the stability of the Laws Screening Tool, test-retest reliability was calculated in a subsample of 27 individuals completing a workshop with no relevance to the content measured by the Laws Screening Tool (i.e., the previously mentioned cultural competence in therapy workshop). These individuals completed the Laws Screening Tool before and after their participation in this 2 hour workshop. The Laws Screening Tool

evidenced very good test score stability ($r = .88$; $p < .01$), indicating this screening measure is stable across administrations (DeVellis, 2003).

Responsiveness

Responsiveness, or the ability to which an instrument can detect change in the direction hypothesized, was assessed on the basis of a pre- and post- intervention comparison of individuals who participated in a training workshop that was expected to lead to improvement in the measure, and a workshop that was not expected to lead to improvements in the measure. Along these lines, the participants in this study were randomly assigned to receive either the aforementioned 2 hour workshop in ethnic consideration in therapy or a 2 hour workshop focused on learning skills relevant to reporting child maltreatment. Responsiveness, or instructional sensitivity, is evidenced when individuals receiving training improve, while scores of individuals remaining uninstructed score similarly across administrations (Johnston, et al., 2003). Table 4 provides the pre- and post-test means and standard deviations of the Laws Screening Tool. A 2 x 2 repeated measures analysis of variance (ANOVA) was conducted to assess responsiveness of the Laws Screening Tool. Workshop condition (e.g., child maltreatment reporting, cultural competence training) served as the between-subjects independent variable and time (e.g., pre- and post-Laws Screening Tool total scores) served as the within-subjects independent variable. The Workshop x Time interaction was significant, $F(1, 52) = 21.01, p < .01$, with greater improvements on the measure being found for participants in the child maltreatment reporting condition. Thus, training specific to child maltreatment reporting led to significant increases in knowledge, as measured by the Laws Screening Tool, while knowledge remained constant for those not

receiving child maltreatment training. These results support the sensitivity/responsiveness of the Laws Screening Tool.

Internal Consistency

Internal consistency assesses the homogeneity of test items. Optimal levels of test homogeneity vary significantly among disciplines, as well as content areas (Kehoe, 1995), and estimating reliability using internal consistency is not always deemed appropriate (Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984). Also important, low internal consistencies in screening measures have been indicated to suggest the instrument is doing what it was intended to do, i.e., quickly and non-redundantly assess a wide array of responses (Schmitt, 1996). Along these lines, Cronbach's (1951) alpha coefficient was low (Cronbach's alpha = .18). Alternative, albeit compatible, explanations include heterogeneity within child maltreatment reporting laws, and brevity of the screening tool.

Relationship of Laws Screening Tool and Training in Reporting Child Abuse

To examine the relationship between knowledge of child maltreatment laws and previous child maltreatment experience, Pearson-product moment correlations were conducted between the Laws Screening Tool total scores and the following items: "approximate number of workshops/trainings attended," "approximate number of total hours of training received," and "approximate number of instances of maltreatment reported to CPS." Significant correlations were not found between total score and approximate number of trainings ($r = .03$; $p = .79$), number of training hours ($r = -.31$; $p = .30$), or number of maltreatment reports ($r = .09$; $p = .44$). A one-way ANOVA was utilized to further investigate the lack of relationship between knowledge of child

maltreatment laws and previous child maltreatment training. The ANOVA ($F(1, 74) = .29, p = .59$) revealed that Laws Screening Tool scores of participants with previously child maltreatment training ($M = 12.32$, $SD = 1.43$) did not significantly differ from those with no previous training ($M = 12.06$, $SD = 1.32$). These results suggest a lack of relationship between Laws Screening Tool scores and training as assessed in this study.

Recognition of Child Maltreatment Screening Tool

Means and Standard Deviations

In responding to the Recognition of Child Maltreatment Screening Tool, respondents indicated their likelihood of making a child maltreatment report for both reportable and non-reportable scenarios as determined by the CPS experts on a 7-point Likert-type scale (7 indicating high likelihood of making a report). For scenarios determined to be reportable by CPS experts, higher participants' scores indicated greater accuracy or consistency with CPS experts. For scenarios determined to be non-reportable by CPS experts, lower participants' scores were determined to be more accurate or more consistent with CPS experts. To make these scores easier to interpret, scores for non-reportable scenarios were reversed scored. Thus, lower scores for both reportable and non-reportable scenarios represented more accurate reporting decisions (e.g., "0" = total agreement with CPS experts or most accurate score, "6" = total disagreement with CPS experts or most non-accurate score). The mean for the total accuracy score was 15.68 ($SD = 4.20$), with a total possible accuracy score of 48. Additionally, the mean and standard deviation were conducted for each of the eight items, with a possible accuracy score of up to 6 for each item. Item means ranged from .78 ($SD = 1.09$) to 3.30 ($SD = 1.96$), with an average item mean of 1.76. Table 5 provides the means and standard

deviations for each of the items on the Recognition Screening Tool, with vignettes ordered from least to most accurately reported. These results support that professionals are relatively able to accurately report certain situations of child maltreatment.

Test-Retest Reliability

To determine the stability of the Recognition Screening Tool, test-retest reliability was investigated utilizing the subsample of 27 participants completing a 2 hour workshop unrelated to child maltreatment reporting (i.e., cultural competence in therapy). The test-retest reliability was acceptable for the Recognition Screening Tool ($r = .75$; $p < .01$), indicating that participants scores remained consistent across administrations. Thus, the Recognition Screening Tool evidenced adequate temporal stability.

Responsiveness

The responsiveness of the Recognition Screening Tool was assessed on the basis of a pre/post comparison of individuals participating in training workshops (Johnston, et al., 2003). A repeated measures analysis of variance (ANOVA) was conducted to determine whether Recognition Screening Tool scores of individuals receiving training in child maltreatment improve, while scores of uninstructed individuals remain the same. This was evidenced, with a significant Workshop x Time interaction ($F(1, 52) = 4.11$, $p < .05$). Examination of means indicated participants in the child maltreatment relevant workshop demonstrated significantly improved scores relevant to the non-relevant workshop ($p < .05$; see Table 4). Thus, training specific to child maltreatment reporting led to significant increases in accurate child maltreatment reporting, as measured by the Recognition Screening Tool, while remaining constant for those not receiving child maltreatment training.

Internal Consistency

As mentioned previously, Cronbach's (1951) alpha coefficients are not always deemed appropriate estimates of internal consistency, particularly when performed on multidimensional screening instruments (Adeleye & Yusuf, 2006). For the Recognition Screening Tool, the alpha coefficient (Cronbach's alpha = .10) most likely evidences the multidimensionality and brevity of the vignettes and screening tool (Schmitt, 1996).

Relationship of Recognition Screening Tool and Training in Reporting Child Abuse

Pearson-product moment correlations were calculated to investigate relationships between Recognition Screening Tool total scores with the following items: "number of workshops/trainings attended," "approximate number of total hours of training received," and "approximate number of instances of maltreatment reported to CPS." No significant correlations were found between total scores and approximate number of trainings (r = .12; p = .33), number of training hours (r = .00; p = .99), or maltreatment reports (r = .08; p = .50). Additionally, a one-way ANOVA revealed that prior training did not significantly differentiate Recognition Screening Tool scores, $F(1, 73) = .01$, $p = .93$, as means for those receiving previous training was 15.64 (SD = 4.32), and for those not receiving previous training was 15.73 (SD = 4.11). Therefore, these findings suggest no relationship between Recognition Screening Tool scores and child maltreatment training as assessed in this study.

Clinical Expertise in Reporting Child Maltreatment Screening Tool

Means and Standard Deviations

The Clinical Expertise Screening Tool includes 15 multiple-choice items, each with one correct answer. Similar to the Laws Screening Tool, participants' responses were

scored "1" for correct and "0" for incorrect, with a possible total score of 15. Clinical Expertise Screening Tool total scores ranged from 4 (26.67%) to 14 (93.33%), with a mean of 10.53 (70.20%, $SD = 1.72$). Means and standard deviations were also conducted for each of the 15 items. Again, item difficulty is the percentage of individuals who answer an item correctly, and, in this case, is equal to the item mean (e.g., $M = .85$; Item difficulty = 85%). Item means ranged from .20 to .99. Table 6 provides the mean and standard deviation of all items on the Clinical Expertise Screening Tool, with items ordered from most to least difficult.

Test-Retest Reliability

To assess stability of the Clinical Expertise Screening Tool over time, test-retest reliability was assessed in a subsample of 27 individuals that completed the Clinical Expertise Screening Tool before and after a cultural competence workshop. This workshop did not provide information relevant to items on the Clinical Expertise Screening Tool. The instrument evidenced excellent test-retest reliability ($r = .92$; $p < .01$), indicating consistency of Clinical Expertise Screening Tool scores across time.

Responsiveness

A 2 x 2 repeated measures analysis of variance (ANOVA) was conducted to assess the sensitivity of the Clinical Expertise Screening Tool in detecting changes in knowledge. Participants (N =55) were randomly assigned to receive a 2 hour workshop in ethnic cultural considerations in therapy or child maltreatment reporting. The repeated measures (within-subjects) factor was workshop condition, with a between-subjects factor of time (pre- and post-test scores). The interaction was significant, $F(1, 52) = 44.12$, $p < .01$. Thus, significant differences in Clinical Expertise Screening Tool scores

were evidenced as individuals receiving child maltreatment instruction received higher post-test scores, than those receiving unrelated instruction ($p < .05$; see Table 4). This result indicated the Clinical Expertise Screening Tool evidenced sensitivity or responsiveness to change in items it was purported to measure.

Internal Consistency

Cronbach's (1951) alpha coefficients were calculated for the total score of the Clinical Expertise Screening Tool. Due to the content heterogeneity of the Clinical Expertise Screening Tool, and because it was designed to be a screening tool, coefficient alpha was deemed an inappropriate measure of internal consistency (e.g., Newborg et al., 1984, Adeleye & Yusuf, 2006). Thus, as expected, the alpha coefficient was low (Cronbach's alpha = .09), suggesting the measure covers a broad range of areas found to be effective in managing child maltreatment reporting.

Relationship of Clinical Expertise Screening Tool and Training in Reporting Child Abuse

Pearson-product moment correlations were conducted between the Clinical Expertise Screening Tool total score and the items of "number of workshops/trainings attended," "approximate number of total hours of training received," and "approximate number of instances of maltreatment reported to CPS." Additionally, research has found that "therapist comfort" is associated with better management of the reporting process, and that amount of experience is associated with greater comfort (Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2001). Therefore, a Pearson-product moment correlation was calculated between the Clinical Expertise Screening Tool total score and "number of years in the mental health field." Significant correlations were not found between Clinical Expertise Screening Tool total score and number of training ($r = -.11$; $p = .93$),

number of training hours (r = .05; p = .71), number of maltreatment reports (r = .05; p = .67), nor number of years in the mental health field (r = -.13; p = .29). A one-way ANOVA was utilized to further explore the relationship between the Clinical Expertise Screening Tool and previous training. Previous training was not found to be significantly related to clinical expertise in child maltreatment, $F(1, 74) = .01$, $p = .93$, with trained participants (M = 10.51, SD = 1.82) and untrained participants (M = 10.55, SD = 1.92) performing equally. Therefore, relationships do not exist between the clinical management of child maltreatment reporting, and training and experience in child maltreatment, or amount of experience within the mental health field.

Secondary Investigations

Assessment of Potential Influences on Reporting Child Maltreatment

Level of knowledge and competence in child maltreatment reporting appears to have devastating consequences for accurate reporting (Reineger et al., 1995). However, research also points to additional factors (e.g., fear of physical retaliation), which negatively influence mental health professionals decision to report child maltreatment (e.g., Agatstein, 1989, Strozier et al., 2005). Therefore, secondary analyses were conducted to assess the level of influence of various factors found in the literature to negatively affect child maltreatment reporting. In this regard, participants were asked to endorse the extent to which each of 20 factors contributed to decisions not to report child maltreatment. Participants response alternatives ranged from 1 (*Never Influenced*) to 5 (*Always Influenced*). Means and standard deviations were calculated for each of the 20 items individually (see Table 7). The average mean of all items was 1.76 with means

ranging from 1.22 to 2.77. These findings suggest minimal influence of the included factors regarding failure to report. However, instructions for this inventory read "Please indicate the extent each of the following have influenced you *not* to report suspected child maltreatment." Therefore, low levels of endorsed influence may be due to the low number of participants ($N = 8$) who endorsed failure to report suspected child maltreatment.

Relationships between Aspects of Child Maltreatment Reporting Knowledge

Relationships between the various aspects of mandated reporters' child maltreatment knowledge assessed in the current study (i.e., laws, recognition, and clinical expertise) were explored via Pearson-product moment correlations to support the construct validity of these measures. Correlations were conducted between the Laws Screening Tool, Recognition Screening Tool, and Clinical Expertise Screening Tool. The Recognition Screening Tool did not evidence significant correlations with the Laws, or the Clinical Expertise, Screening Tools ($r = -.04, p = .74$; $r = -.19, p = .10$, respectively). A significant correlation was evidenced between scores on the Laws Screening Tool and Clinical Expertise Screening Tool ($r = .27, p = .02$). These findings fail to support a relationship between accurate reporting, and knowledge of laws or clinical management of the reporting process. However, a relationship between mental health professionals' knowledge of mandatory reporting laws and clinical expertise in child maltreatment reporting is evidenced, and supports the construct validity of these measures.

Estimating the Likelihood of Under-Reporting in Mental Health Professionals

Participants Recognition Screening Tool responses for the four vignettes depicting reportable child maltreatment scenarios were examined to investigate an estimate of the

likelihood of under-reporting. To reflect consistency between the CPS experts' decisions and the participants' responses, an accuracy scores ranging from "0" (accurate reporting decision) to "6" (inaccurate reporting decision), as described above, was calculated for each vignette. Unfortunately, actual reporting behavior cannot be perfectly predicted from this data. However, for the purpose of the current analyses we arbitrarily indicated that professionals endorsing likelihood to report greater than neutral responses (i.e., endorsement of scores representing 5, 6, 7) would make a child maltreatment report. Thus, assuming that accuracy scores of "0" to "2" lead to a child maltreatment report, correct reporting decisions for each of the vignettes were estimated as follows: Neglect vignette = 77.6%; Physical abuse vignette = 61.8%; Sexual abuse vignette = 52.6%; and Emotional Abuse = 27.6%. This indicates that a mean of 54.9% of mental health professionals accurately reported scenarios depicting child maltreatment.

Estimating the Likelihood of Over-Reporting in Mental Health Professionals

Additionally, mental health professionals' tendency to over-report was investigated through further examination of participants' responses to the four, non-reportable vignettes. As explained above, accuracy scores of "0" to "2" were again utilized to indicate an accurate reporting decision, which in this case is a decision not to report the incident. Correct reporting decisions for each of the vignettes were as follows: Emotional Abuse = 89.5%; Neglect vignette = 77.6%; Physical abuse vignette = 68.4%; and Sexual abuse vignette = 62.7%. This results in a mean accurate reporting rate of 74.6%, indicating that 25.4% of mental health professionals reported an incident not necessitating a report.

Exploration of Suspicion of Child Maltreatment

Participants were asked to endorse their level of suspicion, as well as their likelihood of making a report, for each of the vignettes on the Recognition Screening Tool, to allow for investigation of the relationship between suspicion and reporting behavior. Means and standard deviations for the level of suspicion were conducted for each of the vignettes. Table 8 provides the means and standard deviations of the level of suspicion for each vignette, ranked from lowest to highest level of suspicion. Means ranged from 2.47 (SD = 1.54) to 5.67 (SD = 1.30), with a possible range of 1 to 7. Additionally, a Pearson-product moment correlation was conducted to investigate the extent to which mental health professionals' suspicion and reporting behavior were related. The accuracy score of the Recognition Screening Tool items for "how likely are you to suspect child maltreatment?" and "how likely are you to make a report?" were utilized. A significant correlation ($r = .71, p < .01$) was found between likelihood of suspicion and reporting. Therefore indicating that level of suspicion significantly impacted reporting decisions.

CHAPTER 5

DISCUSSION

Child maltreatment continues to devastate our nation. Unfortunately, inaccurate reporting, with regard to under-reporting (e.g., Weinstein et al., 2000) and over-reporting (e.g., Foreman & Bernet, 2000), have been substantially illustrated in the literature. Indeed, lack of child maltreatment knowledge is cited as a leading factor in these reporting dilemmas (e.g., Besharov, 1994). Research identifies concerns regarding mental health professionals' lack of knowledge and competence in the legal aspects of child maltreatment (e.g., Hawkin & McCallum, 2001), identification of child maltreatment (e.g., Hawkins & McCallum, 2001b), and clinical management of the reporting process (e.g., Weinstein et al., 2000). Therefore, the purposes of the current study were to develop and initially validate screening tools to assist in tailoring workshops to more efficiently address deficits in child maltreatment reporting, and to be utilized as outcome measures in treatment outcome studies.

Knowledge of Child Maltreatment Laws Screening Tool

Foreman and Bernet (2000) found mental health professionals' lack of knowledge regarding mandatory child maltreatment reporting laws has been shown to negatively impact adequate child maltreatment reporting. Indeed, Swoboda et al. (1978) found that 32% of psychologists were unfamiliar with child maltreatment reporting laws.

Additionally, Renninger et al. (2002) found that a sample of licensed psychologists received a mean score of 67% on a multiple-choice test assessing mandatory reporting law knowledge. Current findings are slightly more optimistic than previous research, with a Laws Screening Tool mean of 81.07%. The present study found that approximately 85.5% ($N = 65$) of participants earned 70% or higher on the Laws Screening Tool. Participants clearly possessed knowledge regarding several aspects of child maltreatment reporting laws. For instance, practically all participants knew that a report is required for suspected abuse, and that immunity is granted for unsubstantiated cases made in "good faith." This is important knowledge as it may encourage mental health professionals "to report even when they are uncertain and may keep them from seeking further evidence, thus maintaining clear therapy boundaries (Melton et al, 1995)" (as cited in Renninger et al., 2002). In contrast, over 50% of participants were unfamiliar with the Nevada law definition of "reasonable cause to believe." This is alarming, as the lack of knowledge regarding this definition, (i.e., "when a reasonable person would believe abuse or neglect is or has occurred") could have vast implications on the protection of children. Additionally, over half of the mental health professionals were unaware of their status as the only profession mandated to report under all circumstances. Thus, child maltreatment trainings could benefit from a greater emphasis on those aspects of the laws found here to be lacking in mental health providers.

The goal of the Laws Screening Tool is to provide a child maltreatment law screen, with adequate coverage of the numerous and varied mandatory reporting laws. Initial validation of the Laws Screening Tool is supported by the extensive development procedures (e.g., exhaustive literature review, focus group item development, CPS expert

validation), strong test-retest reliability, and sufficient responsiveness. Internal consistency estimates were low as expected, suggesting that the screening tool is succinctly assessing the diverse content laws relevant to child maltreatment laws. Interestingly, the Laws Screening Tool and extent of training and number of child maltreatment reports made were unrelated. This finding may have occurred for a variety of reasons. For instance, the measure of training experiences may have poorly defined training experience thus leading to misinterpretation of what constitutes training. Although these findings may represent inadequacies in the Laws Screening Tool, its systematic development and apparent face and content validity found in this study lend support to the interpretation that contemporary child maltreatment training programs may be contributing little to mental health professionals' knowledge of mandatory reporting laws. Moreover, these findings support the contention that mental health professionals may be acquiring their knowledge of laws that are relevant to child maltreatment reporting outside of professional training contexts. Interestingly, it should be emphasized that an average of almost 20% of participants incorrectly answered the items of this screening tool, which is insufficient in the protection of children from maltreatment. These findings call for vast improvements in child maltreatment trainings, and therefore support the need for systematically developed and validated instruments to assist in the measurement of child maltreatment reporting law knowledge.

Recognition of Child Maltreatment Screening Tool

Proper recognition of child maltreatment is vital to the protection of children, families, professionals, and the child protective system. Regrettably, research indicates

substantial deficits in mandated reporters' ability to identify child maltreatment resulting in under- and over- reporting (e.g., Hawkins & McCallum, 2001). Abuse identification and accurate reporting were examined utilizing the Recognition Screening Tool. Interestingly, participants were both most and least accurate in reporting the emotional abuse vignettes, with approximately 60% of mental health professionals accurately endorsing "high unlikelihood" of reporting a non-reportable vignette. In contrast, only 5% of participants accurately endorsed "high likelihood" of making a report for the reportable emotional abuse vignette. This would appear to indicate that mental health professionals' are more likely to fail to accurately identify incidents of emotional abuse. These findings are consistent with previous research espousing emotional abuse as the type of abuse least likely to be reported (i.e., Beck & Ogloff, 1995; Beck et al., 1994). Given that emotional abuse is one of the most prevalent forms of abuse (Ayoub et al., 1990), professionals would likely benefit from training in this area.

The Recognition Screening Tool was developed to assess ability to accurately identify situations that do, and do not, necessitate a child maltreatment report. The extensive literature review, item development via numerous focus groups, and further validation by CPS experts strongly support the face and content validity. The Recognition Screening Tool also evidenced adequate test-retest reliability, and significant sensitivity, with instructed participants improving their scores, and uninstructed participants remaining constant in their scores, from pre- to post-test administration. The reasons for lower test-retest reliability for the Recognition Screening Tool cannot be determined. Possibilities include greater level of participant anxiety negatively effecting performance during the pre-administration as compared with post-

administration. This screening tool, unlike the Laws or Clinical Expertise Screening Tools, includes a greater emphasis on judgment, rather than skill, and therefore participant anxiety may have decreased upon subsequent administration (i.e., more comfortable after meeting with the instructors). Additionally, the response set included a 7-point Likert-type scale, with a potentially difficult to interpret neutral response (i.e. what does "neutral" mean when considering likelihood of making a report). It may be important to examine the response set in future studies. The internal consistency of the Recognition Screening Tool was low due to the diverse and contrasting nature of the items. Similar to the Laws Screening Tool, relationships were not evidenced for the Recognition Screening Tool and quantity or number of hours of training, or number of maltreatment reports filed. Again, these findings may indicate inadequacies of the items requesting participants' child maltreatment reporting training and experience, or in a lack of validity of the Recognition Screening Tool. Alternatively, these findings may illustrate shortcomings of child maltreatment trainings, as previously trained and untrained participants performed similarly on the Recognition Screening Tool. Thus, supporting the necessity of a reliable and valid tool to assess accurate identification of child maltreatment.

Clinical Expertise in Reporting Child Maltreatment Screening Tool

Clinical expertise in the reporting process includes the knowledge and application of effective practices for managing child maltreatment within a therapeutic setting. The Clinical Expertise Screening Tool was developed to investigate mental health professionals' competence in the clinical management of child maltreatment reporting.

Current findings indicate significant variation among participants' clinical expertise in reporting maltreatment, with 25% (N=19) of participants receiving scores in the 27% to 60% range. All but one participant possessed knowledge regarding the possibility of children making false child maltreatment allegations. Furthermore, a large portion of participants evidenced knowledge regarding the aim of CPS in keeping the family unit intact. This information can be utilized to reduce caregiver, or client, anxiety, as many assume that a CPS report means removal of the child from the home (Donohue et al., 2002). Moreover, mental health professionals appear to obtain adequate training regarding methods to protect themselves professionally, as over 90% correctly identified such items (i.e., appropriate documentation of reporting decision process; progress note documentation of maltreatment report). In contrast, over 80% of participants incorrectly responded to the item asking with whom mental health professionals are always encouraged to discuss the making of a child maltreatment report. Seventy-four percent of participants indicated that "the client" should always be involved in a discussion. Though research supports involvement of children in some cases, serious consideration regarding a child's involvement is warranted, with a decision being made on a case-by-case basis (Alvarez et al., 2004). These findings support increased training in this regard for mental health professionals.

The Clinical Expertise Screening Tool was developed specifically to assess the clinical expertise of mental health professionals in child maltreatment reporting. Again, the face and content validity are supported by the literature review, focus group item development, and validation by CPS experts. Excellent test-retest reliability was evidenced, thereby supporting the temporal stability. Additionally, the Clinical Expertise

Screening Tool demonstrated sufficient responsiveness, or instructional sensitivity, with scores of those receiving child maltreatment reporting instruction improving, and scores of those receiving non-related instruction (e.g., cultural competence) remaining constant. Due to the heterogeneity within effective practices regarding the clinical management of child maltreatment reporting, the Cronbach's alpha coefficient was low (Kehoe, 1995). As previously mentioned, relationships were not found between clinical expertise and previous child maltreatment training or reporting experience. Possible explanations for these findings include inadequacies in the items requesting child maltreatment reporting training and experience, or a lack of validity in the Clinical Expertise Screening Tool in assessing the clinical management of the reporting process. Alternatively, these findings could indicate insufficient training in the clinical management of child maltreatment reporting. Additionally, the relationship between clinical expertise in child maltreatment reporting and number of years in the mental health field was investigated. Previous research has suggested that "therapist comfort," which increases with amount of experience, is associated with better management of the reporting process (Weinstein et al., 2001). However, a significant relationship was not found between Clinical Expertise scores and number of years in the mental health field. Unfortunately, previous training was found to have no impact on clinical management of the reporting process, and illustrates the importance of improving training for all professionals in this regard.

Secondary Investigations

Assessment of Potential Influences on Reporting Child Maltreatment

Secondary investigation included exploration of factors found in the literature to influence child maltreatment reporting behavior. As previously mentioned, findings from this study indicate relatively low levels of mental health professionals' endorsing failure to report suspected child maltreatment. Therefore, this data should be interpreted cautiously. The item with the greatest influence in child maltreatment reporting for the sample was "Unsure the situation warrants a report." Likewise, this item also evidenced the highest mean when examining the responses of the eight participants' endorsing failure to report suspected abuse. Indeed, this supports the entire premise of this study: the importance of assessing and increasing knowledge and competence in child maltreatment reporting to improve the accuracy of reporting. Other items with relatively high means include: "Lack of evidence of suspected child maltreatment," "Fear maltreatment may heighten due to a report," "Fear that CPS involvement will lead to worse outcome," and "Unfamiliarity with reporting laws." These findings identify fears and perceptions which decrease accurate reporting. Training in child maltreatment reporting should include identification and discussion of the influence and consequences of these factors. Conversely, training may not need to address fear of incarceration of the caregiver, possible civil/criminal litigation, or physical retaliation as these were minimally endorsed as influencing reporting decisions.

Relationships between Aspects of Child Maltreatment Reporting Knowledge

Mental health providers' ability to accurately report child maltreatment, as measured by the Recognition Screening Tool, evidenced no relationship with their knowledge in

mandatory reporting laws or clinical management of child maltreatment reporting. It may be that only certain aspects of the laws, such as legal definitions of maltreatment are related to accurate identification. Thus, future research could examine the relationship between various aspects of child maltreatment laws and recognition of child maltreatment. However, a significant relationship was found between participants' Laws Screening Tool and Clinical Expertise Screening Tool scores. Therefore, knowledge of child maltreatment reporting laws appears to be related to clinical expertise in managing the reporting process, suggesting the construct validity of these screening tools. Future research should examine these relationships further.

Estimating the Likelihood of Under-Reporting in Mental Health Professionals

Failure to report child maltreatment, or under-reporting, was investigated through further examination of Recognition Screening Tool responses. Accuracy ratings were calculated for each of the four vignettes which legally necessitated a report, with participants most accurately reporting neglect and least accurately reporting emotional abuse. The mean indicates approximately 55% of mental health professionals accurately reported child maltreatment. Therefore, almost half of mental health professionals' did not report child maltreatment scenarios which legally necessitated a report to CPS. Swoboda et al. (1978) reported 66% of a sample of mental health professionals failed to report a hypothetical case of abuse. More recently, Strozier et al. (2005) found failure to report rates in hypothetical scenarios of approximately 40%. Thus, these findings are consistent with previous literature that espouses high rates of failure to report suspected child maltreatment.

The above finding also provides information with regard to participants' endorsement of failing to report suspected child maltreatment. Only 10.5% (n = 8) of mental health providers' endorsed failure to report suspected child maltreatment. Assuming correct endorsement of participants' and a representative sample, these findings could evidence improved awareness, education, and training of mental health professionals'. However, due to current and previous findings regarding rates of failure to report, it would appear this is a vast underestimate of true failure to report rates. Therefore, professionals may have reported reduced failure to report rates due to social desirability, memory errors, or unawareness. Indeed, failure to report child maltreatment can occur due to lack of adequate suspicion of child maltreatment. In this case, participants' would be unaware of their failure to report. Current results indicating a failure to report rate of almost 50%, support the latter explanation. Thus emphasizing the need to address awareness and identification of abuse indicators in child maltreatment training workshops.

Estimating the Likelihood of Over-Reporting in Mental Health Professionals

To assess the level of over-reporting, participants' responses of the four vignettes portraying non-reportable scenarios were examined further. Approximately 75% of mental health professionals' accurately responded to these scenarios. Though this finding is more optimistic than that cited for underreporting, over 25% of mental health participants reported a vignette which did not legally necessitate a report. Though mental health professionals are encouraged to err on the side of caution, trainings could assist in improving accurate detection of child maltreatment, thereby decreasing over-reporting.

Exploration of Suspicion of Child Maltreatment

To investigate the relationship between suspicion and reporting behavior, participants were asked to endorse their level of suspicion, as well as their likelihood of making a report, for each of the Recognition Screening Tool. Results indicate a significant relationship between mental health providers' level of suspicion and reporting tendency. Literature utilizing hypothetical vignettes often cites the questionable assumption that responses to vignettes match actual clinical behavior. Though this cannot be guaranteed, the significant relationship found between suspicion and reporting, support the generalizability of these responses to actual behavior.

Limitations and Future Directions

Several limitations of the current study should be addressed. The sample size utilized was relatively small. Further validation of the developed screening tools should include a sample of more than 150 (i.e., 10 times the number of items of the Laws and Clinical Expertise Screening Tools) mental health professionals. Additionally, the utilized sample of mental health professionals was rather heterogeneous in education, occupation, work setting, and extent of child maltreatment reporting and training. Although some heterogeneity is important to investigate group differences, a more homogeneous sample could assist in further psychometric validation of the screening tools. Future research could employ more stringent exclusion criteria to increase the homogeneity and representativeness of the sample. This could include administering the developed screening tools to professional groups (e.g., CPS caseworkers), as well as non-professional groups to further examine differences in knowledge. The validity of these

measures would be further supported if professional groups evidenced significantly higher scores, in the developed measures, as compared with non-professional groups. In summary, the Laws Screening Tool, Recognition Screening Tool, and Clinical Expertise Screening Tool evidenced adequate reliability and validity. Future research should continue to evaluate these measures in assessing child maltreatment knowledge and competence.

Table 1.

Participant Demographic Information (Stage 2; N = 76).

Demographic	Number	Percentage
Workshop Participation		
None	21	27.6
Child Maltreatment	27	35.5
Cultural Competence	28	36.8
Gender		
	Female	62 years 81.6
Male	13	17.1
Missing	*1*	*1.3*
Age (in years) *(M* = 38.11, *SD* = 11.25)		
22 to 30	24	31.6
31 to 40	22	29.0
41 to 50	16	21.1
51 to 60	8	10.5
61 to 70	3	3.9
Missing	*3*	*3.9*
Ethnicity		
African-American	7	9.2
Asian	5	6.6
Caucasian	55	72.4
Hispanic	6	7.9
Other	1	1.3
Missing	*2*	*2.6*
Occupation		
Graduate Student	19	25.0
Psychology Assistant	2	2.6
Psychologist (Licensed)	9	11.8
School Counselor/Psychologist	1	1.3
Social Worker	20	26.3
Therapist/Counselor	17	22.4
Other	7	9.2
Missing	*1*	*1.3*

Occupational Setting		
Community Agency	5	6.6
Government Agency	36	47.4
Hospital	7	9.2
Private Practice	3	3.9
University	19	25.0
Other	3	3.9
Missing	*3*	*3.9*
Highest Degree Completed		
B.A./B.S.	14	18.4
M.A./M.S.	45	59.2
Psy.D.	3	3.9
Ph.D.	12	15.8
Missing	*2*	*2.6*
Number of years in mental health field (M = 10.06, SD = 7.26)		
0 to 5 years	20	26.3
6 to 10 years	27	35.5
11 to 15 years	10	13.2
16 to 20 years	8	10.5
21 to 25 years	4	5.3
26 to 30 years	0	0.0
31 to 35 years	2	2.6
Missing	*5*	*6.6*
Gross Annual Income (in dollars)		
$0 to $30K	13	17.1
$31K to $60K	12	15.8
$61K to $90K	17	22.4
$91K to $120K	13	17.1
$121K to $150K	8	10.5
$151K and above	8	10.5
Missing	*5*	*6.6*

Table 2.

Participant Child Maltreatment Experience Information (Stage 2; N = 76).

Experience	Number	Percentage
Previous Child Maltreatment Training		
Yes	43	56.6
No	33	43.4
Number of Child Maltreatment Trainings ($M = 1.26$, $SD = 1.88$)		
0	32	42.1
1	18	23.7
2	8	10.5
3	3	3.9
4	3	3.9
5	3	3.9
7	1	1.3
10	1	1.3
Missing	*7*	*9.2*
Context of Child Maltreatment Trainings		
Graduate School	16	37.2
Work Training	20	46.5
Conference	2	5.7
Other	3	7.1
Missing	*2*	*4.8*
Number of Hours of Child Maltreatment Training		
0 hours	32	42.1
1 to 5 hours	19	25.0
6 to 10 hours	4	5.3
11 to 15 hours	2	2.6
16 to 20 hours	5	6.6
20+ hours	4	5.3
Missing	*10*	*13.2*
Previously Reported Child Maltreatment		
Yes	59	77.6
No	17	22.4
Failed to Report Suspected Child Maltreatment		
Yes	8	10.5
No	68	89.5

Table 3.

Means and Standard Deviations of Laws Screening Tool Individual Items (N = 76).

Laws Screening Tool Item	Mean	SD
Which of the following occupations are mandated to report under all circumstances: mental health professionals.	.43	.50
"Reasonable cause to believe" as defined by Nevada law refers to: when a reasonable person would believe abuse or neglect is or has occurred.	.47	.50
The Nevada Revised Statutes mandates that a suspicion of child abuse or neglect must be reported no later than: 24 hours	.66	.48
Nevada law allows for a child maltreatment report to be made: via telephone, FAX, or email.	.67	.48
According to Nevada Revised Statutes, the filming, photographing, or recording of a child's genitals is considered which of the following: sexual exploitation.	.72	.45
In the state of Nevada, a mandated reporters who fails to report suspected child maltreatment is: guilty of a misdemeanor.	.75	.44
Mandated reporters may initiate a child maltreatment report to: either CPS or law enforcement.	.90	.31
You are ONLY required to report child maltreatment inflicted on individuals: under the age of 18 years.	.91	.29
Which of the following is NOT included in the Nevada Revised Statutes definition of "abuse or neglect of child": Physical or mental injury of an accidental nature	.92	.27
According to the Nevada Revised Statutes, the following must be reported: excessive corporal punishment resulting in physical or mental injury	.93	.25

The Nevada Revised Statutes definition of "Negligent treatment" includes all of the following EXCEPT: lack of caregiver employment.	.93	.25
If a person makes a report of suspected child abuse in "good faith," and the case is NOT substantiated, the person reporting is: immune from civil or criminal liability.	.95	.23
In order to report child maltreatment, one MUST: suspect child maltreatment has occurred or is occurring.	.96	.20
As a mandated reporter you are to: report suspected child abuse and neglect.	.99	.15
Mandated reporters can be held criminally liable for reporting suspected child maltreatment only if they: make a false report that is intended to harm another.	.99	.15

Table 4.

Means and Standard Deviations of Pre-Test and Post-Test Screening Tool Scores (Stage 2; N = 56).

Screening Tool	Pre-Test		Post-Test	
Workshop	Mean	SD	Mean	SD
Laws Screening Tool				
Child Maltreatment	12.11	1.58	13.93***	1.54
Cultural Considerations	12.21	1.34	12.15	1.38
Recognition Screening Tool				
Child Maltreatment	15.54	4.54	13.67	4.57
Cultural Considerations	16.25	4.30	16.96	4.73
Clinical Expertise Screening Tool				
Child Maltreatment	10.19	1.98	13.26***	2.85
Cultural Considerations	10.14	1.58	10.26	1.66

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 5.

Means and Standard Deviations of Recognition Screening Tool Accuracy Scores ($N = 75$).

Recognition Screening Tool Vignette	Mean	SD
Vignette #5: Emotional Abuse – Reportable	3.30	1.53
Vignette #2: Sexual Abuse – Reportable	2.30	1.74
Vignette #3: Physical Abuse – Reportable	2.26	1.76
Vignette #6: Sexual Abuse – Non-reportable	1.95	1.67
Vignette #1: Physical Abuse – Non-reportable	1.87	1.66
Vignette #8: Neglect – Non-reportable	1.62	1.87
Vignette #4: Neglect – Reportable	1.57	1.47
Vignette #7: Emotional Abuse – Non-reportable	.78	1.09

Table 6.

Means and Standard Deviations of Clinical Expertise Screening Tool Individual Items ($N = 76$).

Clinical Expertise Screening Tool Item	Mean	SD
Mental health providers are always encouraged to discuss the making of a report with: a colleague.	.20	.50
The greatest predictor of a positive therapeutic outcome subsequent to the making of a child maltreatment report is: the quality of the therapeutic relationship prior to reporting.	.43	.50
The likelihood that a suspected perpetrator will respond to a therapist's intent to report by threatening or attempting to harm the therapist is approximately: 4%	.46	.50
In most situations, when a client is a suspected perpetrator of child maltreatment, the therapist should: Neither a nor b.	.51	.50
In most situations, when making a report of child maltreatment, mental health providers should allow non-perpetrating caregivers to: all of the above.	.62	.49
In most situations, mental health providers should attempt to inform non-perpetrating caregivers of a report to child protective services: prior to making a report.	.64	.48
If a decision to report suspected child neglect is made, it is usually a good idea to inform the non-perpetrating caregiver of the child victim of: CPS's screening process and the possibility of a CPS investigation.	.65	.48
If a child is removed from the home, CPS will first attempt to place the child: with family members.	.71	.46
A child client has just disclosed an instance of child abuse. You should make sure to do all of the following except: interview the child in an attempt to investigate the validity of the disclosure.	.79	.41

To protect therapists from false and inconsistent allegations, the following information should be included when documenting the circumstances of a child maltreatment report in progress notes: all of the above.	.92	.27
Which of the following should NOT be included in a report to CPS: the alleged child victim's treatment plan.	.93	.25
When a report to CPS is made the non-perpetrating caregiver may think that their child/ren is/are going to automatically be removed from their home. This belief: If CPS determines that child maltreatment has occurred: may be true depending on the findings of the investigation.	.93	.25
If CPS determines that child maltreatment has occurred: CPS generally works towards reunification and treatment for the family.	.95	.23
Mental health providers should thoroughly document (i.e., in progress notes): all of the above	.98	.13
Which statement is true? Some children tell false stories about being abused and neglected.	.99	.12

Table 7.

Means and Standard Deviations of Factors Influencing Child Maltreatment Reporting ($N = 74$).

Influence	Mean	SD
Unsure whether situation warrants a report	2.77	1.18
Lack of evidence of suspected child maltreatment	2.51	1.23
Fear maltreatment may heighten due to a report	2.31	1.15
Fear CPS involvement will lead to worsen outcome	2.01	1.00
Unfamiliarity of reporting laws	1.96	1.05
Fear of secondary trauma to the victim caused by investigation proceedings	1.65	1.02
Inadequate training in the identification of maltreatment	1.89	1.13
Thought child maltreatment had been previously reported	1.77	.97
Fear loss of trust in the therapeutic relationship	1.70	.80
Unfamiliarity of reporting laws	1.70	1.04
Fear the disruption of family unit	1.69	.98
Fear report will undermine treatment	1.68	.91
Fear client will terminate therapy	1.57	.78
Fear the child will be removed from the home	1.57	.83
View the investigate process as an intrusion into intimate family matters	1.46	.86
Fear negative consequences to professional relationships	1.46	.76
Fear of physical retaliation	1.34	.60
Fear of possible civil/criminal litigation	1.31	.70
Fear of incarceration of the caregiver	1.30	.66
Unable/unwilling to dedicate the time necessary for the reporting process	1.22	.58

Table 8.

Means and Standard Deviations for Suspicion in Recognition Screening Tool Vignettes ($N = 76$).

Vignette	Mean	SD
Neglect – Non-reportable	2.47	1.54
Emotional Abuse – Non-reportable	2.74	1.47
Sexual Abuse – Non-reportable	3.44	1.52
Physical Abuse – Non-reportable	3.46	1.53
Emotional Abuse – Reportable	4.92	1.40
Physical Abuse – Reportable	4.95	1.47
Sexual Abuse – Reportable	5.28	1.18
Neglect – Reportable	5.67	1.30

APPENDIX A

KNOWLEDGE OF CHILD MALTREATMENT REPORTING LAWS

Please read the following questions and circle the response that best answers the questions. Questions 1 through 7 pertain to federal legislation, while questions 8 through 15 are specific to Nevada law. Please complete every item regardless of the certainty of your answer.

FEDERAL LAW: Please answer questions 1-7 according to federal legislation.

1. If a person makes a report of suspected child abuse in "good faith," and the case is NOT substantiated, the person reporting is:
   a) guilty of a misdemeanor.
   b) guilty of a felony.
   c) open to civil lawsuit.
   d) immune from civil or criminal liability.

2. As a mandated reporter you are to:
   a) report suspected child abuse and neglect.
   b) interpret evidence of abuse and neglect.
   c) investigate child abuse and neglect.
   d) diagnose child abuse and neglect.

3. In order to report child maltreatment, one MUST:
   a) observe the incident.
   b) suspect child maltreatment has occurred or is occurring.
   c) have evidence of the incident.
   d) have a disclosure of child maltreatment by the child.

4. Mandated reporters can be held criminally liable for reporting suspected child maltreatment only if they:
   a) make a report about an incident that occurred more than five years ago.
   b) make a report based only on suspicion.
   c) make a false report that is intended to harm another.
   d) make a report that cannot be substantiated.

5. Mandated reporters may initiate a child maltreatment report to:
   a) local law enforcement.
   b) child protective services.
   c) hospitals.
   d) either a and b.

6. Which of the following occupations are mandated to report under all circumstances:
    a) clergymen
    b) attorneys
    c) mental health professionals
    d) all of the above

7. You are ONLY required to report child maltreatment inflicted on individuals:
    a) under the age of 5 years.
    b) under the age of 16 years.
    c) under the age of 18 years.
    d) under the age of 21 years.

STATE SPECIFIC: The following questions pertain specifically to the Nevada Revised Statutes: Chapter 432B – Protection of Children from Abuse and Neglect

8. Which of the following is NOT included in the Nevada Revised Statutes definition of "abuse or neglect of child":
    a) Physical or mental injury of an accidental nature
    b) Sexual abuse
    c) Sexual exploitation
    d) Negligent maltreatment

9. "Reasonable cause to believe" as defined by Nevada law refers to:
    a) when the mandated reporter suspects abuse or neglect is or has occurred.
    b) when a reasonable person would believe abuse or neglect is or has occurred.
    c) when a mandated reporter is told by a reasonable person that abuse or neglect is or has occurred.
    d) the time a reasonable person would act if abuse or neglect is or has occurred.

10. According to Nevada Revised Statutes, the filming, photographing, or recording of a child's genitals is considered which of the following:
    a) sexual assault.
    b) statutory rape.
    c) lewd acts upon a child.
    d) sexual exploitation.

11. In the state of Nevada, a mandated reporter who fails to report suspected child maltreatment is
    a) guilty of a misdemeanor.
    b) guilty of a felony.
    c) immune from civil lawsuit.
    d) immune from criminal liability.

12. The Nevada Revised Statutes definition of "Negligent treatment" includes all of the following EXCEPT:
    a) improper supervision.
    b) lack of appropriate education.
    c) lack of caregiver employment.
    d) failure to provide for mental health needs.

13. The Nevada Revised Statutes mandates that a suspicion of child abuse or neglect must be reported no later than:
    a) 12 hours.
    b) 24 hours.
    c) 36 hours.
    d) 72 hours.

14. According to the Nevada Revised Statutes, the following must be reported:
    a) Any instance of corporal punishment
    b) Excessive corporal punishment resulting in physical injury
    c) Excessive corporal punishment resulting in mental injury
    d) Both b and c

15. Nevada law allows for a child maltreatment report to be made:
    a) via telephone.
    b) via FAX.
    c) via email.
    d) all of the above.

APPENDIX B

RECOGNITION OF CHILD MALTREATMENT

Please read each of the vignettes and answer the questions that follow as honestly as possible. The information you provide will be coded numerically and will in no way be associated with you.

VIGNETTE # 1

Six-year-old Stephanie enters your office with a long and linear bruise on her upper arm, and back of her thigh. She tells you that she fell down on the sidewalk over the weekend. You recall noticing similar bruises on her upper arms on at least one other occasion. When you confront the mother about Stephanie's current injury, she tells you Stephanie fell on the sidewalk and comments on her clumsiness.

From the information provided, how likely are you to suspect child maltreatment?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

Regardless of your answer to the previous question, how likely are you to make a report?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

VIGNETTE #2

You are the therapist to Lisa, a 30-year-old woman struggling with her husband's relationship with his daughter. Lisa's husband, Martin, has a 10-year-old daughter, Theresa. For years, Lisa has felt that Martin and Theresa are "too close" and she is uncomfortable with their relationship. She reports that Martin is extremely protective of his daughter and does not allow her to play with other children. She describes Theresa as timid and reports that she has recently began complaining of frequent stomach aches. Lisa also discloses that she has seen him leaving Theresa's room early in the morning several times this week.

a. From the information provided, how likely are you to suspect child maltreatment?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

b. Regardless of your answer to the previous question, how likely are you to make a report?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

VIGNETTE # 3

Shaunte is a 13-year-old female who has been referred to you by her school counselor for treatment of test anxiety. During a session you notice multiple scratches on her shoulder. You inquire about the scratches on her arm. She reports she was having an argument with her mother and as she turned to walk out of the room her mother grabbed her by the shoulder and accidentally scratched her. Her mother apologetically recounted the same story.

a. From the information provided, how likely are you to suspect child maltreatment?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

b. Regardless of your answer to the previous question, how likely are you to make a report?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

VIGNETTE #4

Jason is a 9-year-old male who has been seeing you for 3 months. You notice that Jason has a burn on the inside of his hand. When asked about the injury, Jason reports that he burned himself by grabbing a hot pan when cooking his dinner last night. Upon further discussion, he reports that his mother is never home because she is either at work or gambling with her friends. Jason informs you that there is food in the house and the bills are paid, but he is almost always alone in the house.

a. From the information provided, how likely are you to suspect child maltreatment?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

b. Regardless of your answer to the previous question, how likely are you to make a report?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

VIGNETTE #5

You have been seeing the Parkers for family therapy for 4 months due to their recent failure in elementary school. The parents often make derogatory comments to the children during the session. They call them names (e.g., idiot, stupid) and blame them for the problems of the family. When you point out the children's positive traits, Mr. and Mrs. Parker act genuinely surprised or are highly skeptical.

a. From the information provided, how likely are you to suspect child maltreatment?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

b. Regardless of your answer to the previous question, how likely are you to make a report?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

VIGNETTE #6

Joan, a woman that you have been seeing for several months discloses that she is concerned about her husband's actions. She and her husband, have a 2 ½ -year-old daughter, and she is concerned that her husband will frequently shower with the child. She says that her daughter loves to shower with her father and hears the child playing in the tub as the father showers.

a. From the information provided, how likely are you to suspect child maltreatment?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

b. Regardless of your answer to the previous question, how likely are you to make a report?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

VIGNETTE #7

Patrick and Rhonda are attending marriage counseling. Rhonda is extremely critical of Patrick and their 16-year-old son, Charlie. Charlie is excelling in school, is the Junior Class President, and has many friends. Rhonda recently yelled at Charlie for not doing his homework, and told him he'd never amount to anything if he didn't do his homework.

a. From the information provided, how likely are you to suspect child maltreatment?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

b. Regardless of your answer to the previous question, how likely are you to make a report?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

VIGNETTE #8

James is a 41-year-old client who you have been seeing in therapy for 2 sessions. He reports to you that he is worried he will not be able to pay his rent, and because this has happened before he may get evicted. James reports if he gets evicted he has nowhere he can go and no place that his two children can stay until he finds another place to live.

a. From the information provided, how likely are you to suspect child maltreatment?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

b. Regardless of your answer to the previous question, how likely are you to make a report?

1	2	3	4	5	6	7
Highly Unlikely			Neutral			Highly Likely

APPENDIX C

CLINICAL EXPERTISE IN REPORTING CHILD MALTREATMENT

Please read the following questions and circle the response that best answers the questions. Please complete every item regardless of the certainty of your answer. The information you provide will be coded numerically and will in no way be associated with your identity.

1. The greatest predictor of a positive therapeutic outcome subsequent to the making of a child maltreatment report is:
    a. the age of the client.
    b. the quality of the therapeutic relationship prior to reporting.
    c. the nature of the alleged abuse.
    d. the level of involvement of the client in the reporting process.

2. Mental health providers are always encouraged to discuss the making of a report with:
    a. the client.
    b. a friend.
    c. a colleague.
    d. all of the above.

3. In most situations, mental health providers should attempt to inform non-perpetrating caregivers of a report to child protective services:
    a. prior to making a report.
    b. while making the report.
    c. after making the report.
    d. subsequent to an investigation.

4. In most situations, when making a report of child maltreatment, mental health providers should allow non-perpetrating caregivers to:
    a. be present while making the call to CPS.
    b. speak with CPS after the report is made.
    c. choose not to be involved.
    d. all of the above.

5. In most situations, when a client is a suspected perpetrator of child maltreatment, the therapist should:
    a. treat the client similar to a non-perpetrating caregiver
    b. always inform the suspected perpetrator of an intent to report
    c. Both a and b
    d. Neither a nor b.

6. A child client has just disclosed an instance of child abuse. You should make sure to do all of the following EXCEPT:
    a. remain calm and be open and honest.
    b. interview the child in an attempt to investigate the validity of the disclosure.
    c. stress that it is not the child's fault.
    d. listen carefully and remain supportive.

7. Which statement is true?
    a. Children never tell false stories about being abused and neglect
    b. Some children tell false stories about being abused and neglected.
    c. Most children tell false stories about being abused and neglected.
    d. All children tell false stories about being abused and neglected.

8. The likelihood that a suspected perpetrator will respond to a therapist's intent to report by threatening or attempting to harm the therapist is approximately:
    a. 4%
    b. 8%
    c. 16%
    d. 32%

9. Mental health providers should thoroughly document (i.e., in progress notes)
    a. all incidences in which a suspected child maltreatment report is made.
    b. consultations with a supervisor regarding child maltreatment.
    c. all incidences in which a decision not to report is made.
    d. all of the above.

10. Which of the following should NOT be included in a report to CPS:
    a. the name, age, and location of the child victim.
    b. the name, relationship, and location of the perpetrator.
    c. the name and location of the primary caregiver, whether alleged to have perpetrated abuse or not.
    d. the alleged child victim's treatment plan.

11. If a decision to report suspected child neglect is made, it is usually a good idea to inform the non-perpetrating caregiver of the child victim of:
    a. CPS's screening process.
    b. possibility of a CPS investigation.
    c. both a and b.
    d. neither a nor b.

12. To protect therapists from false and inconsistent allegations, the following information should be included when documenting the circumstances of a child maltreatment report in progress notes:
    a. the name, age, and location of the child victim.
    b. the location from which the mandated reporter is making the call.
    c. the name, position, identification number of the CPS worker contacted.
    d. all of the above.

13. If a child is removed from the home, CPS will first attempt to place the child:
    a. in a previously determined safe house.
    b. in a monitored CPS facility.
    c. with family members.
    d. either a or b.

14. When a report to CPS is made the non-perpetrating caregiver may think that their child/ren is/are going to automatically be removed from their home. This belief:
    a. is true and you should inform the client their children will be taken from their home.
    b. may be true depending on the findings of the investigation.
    c. is true in cases of suspected sexual abuse.
    d. is true for cases in which the children are under the age of 10.

15. If CPS determines that child maltreatment has occurred:
    a. CPS generally works towards reunification and treatment for the family.
    b. CPS generally works towards foster care placement.
    c. CPS generally works towards termination of parental rights.
    d. CPS generally determines if the perpetrator will be sentenced.

APPENDIX D

DEMOGRAPHIC INFORMATION

Please answer the questions below. The information you provide will be coded numerically and will in no way be associated with you or your child. Please feel free to skip an item if you don't feel comfortable answering, however it is hoped that you will respond honestly to all items.

1. Gender: (circle one) M F

2. Age: _____

3. Occupation: (please circle)

   Graduate Student | Licensed Psychologist | Mental Health Technician | School Counselor/ Psychologist | Social Worker | Psychology Assistant | Therapist/ Counselor | Other: _____

   a. Setting: (please circle)

      Community Agency | Government Agency | Hospital | Private Practice | School | University | Other: _____

   b. Number of years in the mental health field: _____

   c. If Graduate Student: Field of study: _____ Degree Sought: _____

4. Highest completed degree: (circle one) B.A./B.S M.A./M.S. Ph.D. Psy.D. Ed.D. Other_____

5. Field in which highest degree completed: (please circle)

   Counseling | Psychology: General | Psychology: Clinical | Psychology: Counseling | Psychology: Educational | Psychology: School | Social Work | Other: _____

6. Licensed in Nevada: (circle one) Yes No

   a. If yes: Licensed as (e.g., LCSW, LMFT, etc.): _____

7. Licensed in Other States: (circle one) Yes No

   a. If yes: Please list the states: _____ Licensed as: _____

8. Race/Ethnicity: (circle one)

   African American | Asian | Caucasian | Hispanic | Pacific Islander | Other: _____

9. Do you have any children? Yes No

a. If yes: Number of children in the following age groups:

0 to 4 Years: _____ 10 to 13 Years: _____

5 to 9 Years: _____ 14 to 18 Years: _____

11. Average annual household income: (please circle)

$0 to $30,000	$31,000 to $60,000	$61,000 to $90,000	$91,000 to $120,000	$121,000 to $150,000	$151,000 and above

APPENDIX E

CHILD MALTREATMENT REPORTING EXPERIENCE

Please answer the questions below. The information you provide will be coded numerically and will in no way be associated with you or your child. Please feel free to skip an item if you don't feel comfortable answering, however it is hoped that you will respond honestly to all items.

1. Have you previously received training in child maltreatment reporting? (circle one) Yes No

   a. If yes, please complete the following:

      i. Number of workshops/trainings attended: _____

      ii. Context(s) of workshop(s)/training(s) (e.g., graduate school, work training, conference seminar, etc):

      _____

      iii. Reason for participating in workshop(s)/training(s): (circle one)

      Work Requirement | School Requirement | Interest | Continuing Educ. Credits | Other: _____

      iv. Approximate number of total hours of training received: _____

      v. Overall, how **beneficial** did you find your previous training? (circle one)

      1 Extremely Unbeneficial | 2 | 3 | 4 Neutral | 5 | 6 | 7 Extremely Beneficial

      vi. Overall, how **enjoyable** did you find your previous training? (circle one)

      1 Extremely Unenjoyable | 2 | 3 | 4 Neutral | 5 | 6 | 7 Extremely Enjoyable

      vii. Please list specific aspects of your previous training that you found **most** beneficial:_____

      _____

      viii. Please list specific aspects of your previous training that you found **least** beneficial:_____

      _____

2. Have you ever reported suspected child maltreatment? Yes No

   a. If yes, please complete the following:

      i. Approximate number of instances of maltreatment **reported** to CPS: _____

      ii. Approximate number of instances of maltreatment **accepted** by CPS: _____

      iii. In general, what was the motivating factor in your decision to report? _____

      _____

      iv. Please rate your overall experience with CPS: (circle one)

1	2	3	4	5	6	7
Extremely Negative			Neutral			Extremely Positive

3. Have you ever suspected child maltreatment and elected not to report? Yes No

   a. If yes, please complete the following:

      i. Approximate number of instances of maltreatment you have elected not to report: _____

      ii. In general, what was the motivating factor in your decision not to report? _____

      _____

4. Regardless of whether you have made a report of maltreatment or not, please rate your overall perception of CPS: (circle one)

1	2	3	4	5	6	7
Extremely Negative			Neutral			Extremely Positive

   a. Please explain: _____

   _____

   _____

   _____

Additional comments: (optional)

_____

_____

APPENDIX F

ASSESSMENT OF POTENTIAL INFLUENCES ON

REPORTING CHILD MALTREATMENT

Please indicate the extent each of the follow have influenced you *not* to report suspected child maltreatment. Your name will not be recorded with your responses to ensure your confidentiality (i.e., numerical coding will be used to protect your confidentiality).

1. Fear loss of trust in the therapeutic relationship

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

2. Fear client will terminate therapy

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

3. Fear report will undermine treatment

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

4. Fear the child will be removed from the home

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

5. Fear of secondary trauma to the victim caused by investigation/legal proceedings

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

6. View the investigation process as an intrusion into intimate family matters

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

7. Fear the disruption of family unity

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

8. Fear incarceration of the caregiver

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

9. Fear maltreatment may heighten due to a report

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

10. Unsure whether situation warrants a report

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

11. Unfamiliarity of reporting laws

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

12. Unfamiliarity with reporting procedures

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

13. Inadequate training in the identification of maltreatment

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

14. Lack of evidence of suspected child maltreatment

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

15. Fear negative consequences to professional relationships

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

16. Unable/unwilling to dedicate the time necessary for the reporting process

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

17. Fear of possible civil/criminal litigation

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

18. Fear of physical retaliation

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

19. Fear Child Protective Service (CPS) involvement will lead to worse outcome

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

20. Thought child maltreatment had been reported previously

1	2	3	4	5
Never Influenced	Rarely Influenced	Sometimes Influenced	Usually Influenced	Always Influenced

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