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The development and evaluation of a child maltreatment reporting training program for mandated mental health professionals

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THE DEVELOPMENT AND EVALUATION OF A CHILD MALTREATMENT
REPORTING TRAINING PROGRAM FOR MANDATED MENTAL HEALTH
PROFESSIONALS

by

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Bachelor of Arts
University of Nevada, Las Vegas
2000

Master of Arts
University of Nevada, Las Vegas
2005

A dissertation submitted in partial fulfillment
of the requirements for the

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Department of Psychology
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ABSTRACT

Efficacy of Child Maltreatment Reporting Training for Mandated Mental Health Professionals

by

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Despite a legal mandate to report suspected child maltreatment, the literature has consistently reported a failure by mandated professionals to report suspected maltreatment. Lack of knowledge regarding child maltreatment, reporting requirements and possible consequences of reporting have been cited as impediments to reporting. Previous research has recommended the development of training programs to address these hindrances. However, empirically validated training programs specific to the reporting of child maltreatment in mental health professionals have yet to be developed. Therefore, this study is the first to examine the efficacy of a child maltreatment reporting training program which addresses knowledge of child maltreatment laws, reporting requirements, possible consequences of reporting, and therapeutic reporting procedures in mandated mental health professionals.

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CHAPTER 1

INTRODUCTION

Child maltreatment is a pervasive problem in the United States. In addition to the immediate physical and emotional effects of child maltreatment, research has reported potential long-term effects including difficulty with peers, academic failure, severe depression, and substance abuse (Hotaling, Finkelhor, Kirpatrick, & Strauss, 1988). In an attempt to protect children from both the immediate and long-term effects of maltreatment, all 50 states have enacted legislation requiring professionals, including mental health professionals, to report suspected child maltreatment. However, professionals often fail to comply with this mandate. The ramifications of this failure are considerable, as children who are not brought to the attention of Child Protective Services (CPS) may not receive appropriate intervention services.

Professionals have cited multiple reasons for not complying with the mandate. These decisions may be influenced by a lack of knowledge with regard to child maltreatment reporting requirements, possible consequences of reporting, and therapeutic reporting procedures. Researchers have suggested that training may increase knowledge in these areas and potentially increase the likelihood of reporting suspected maltreatment. Despite these recommendations, few training programs have been empirically developed and validated, the majority of which have been specifically developed for teachers and school employees. Indeed, not a single training program specific to mental health professionals

has been reported or evaluated in the literature. Training programs for mental health professionals are needed as these professionals experience distinct obstacles to reporting including perceived conflict between maintaining confidentiality and abiding by the legal mandate, as well as fear that reporting maltreatment will negatively impact the therapeutic alliance. Future research must address whether training programs for mental health professionals result in increased knowledge with regard to child maltreatment reporting requirements, possible consequences of reporting, and therapeutic reporting procedures.

This paper will address the need for empirically validated training programs for mental health professionals by reviewing the current knowledge base regarding child maltreatment reporting practices of mandated professionals and then examine existing training programs with respect to mandated child maltreatment reporting. The paper will begin by reviewing current maltreatment statistics and the legal mandate to report child maltreatment. Next, professionals' reporting practices and recommendations for training will be reviewed followed by an examination of existing training programs for mandated child maltreatment reporting. The executed controlled evaluation of a training program to assist mental health professionals in reporting child maltreatment will then be delineated, including the author's hypotheses, as well as the procedure and methods involved in the proposed study. Finally, results of the current study will be reported followed by a discussion of the findings and recommendations for future research.

Extent of Child Maltreatment

As previously noted, child maltreatment is a pervasive problem in the United States. This is reflected in the number of child maltreatment allegations reported annually. In 2004 alone, an estimated 3 million children were alleged to have been abused or neglected (NCCANI, 2006). From these allegations, approximately 872,000 children were determined to have been victims of maltreatment. Professionals were responsible for reporting 55.8% of the reports made to State and local child protection service (CPS) agencies. Mental health professionals specifically reported 3.8% of cases. The need for professionals to report suspected cases of maltreatment is underscored by substantiation rates. Reports by professionals accounted for approximately two-thirds of substantiated or indicated reports (67.3% and 63.8% respectively). Reporting may also serve to protect children from fatal injury. In 2004, an estimated 1,490 children died as a result of child abuse or neglect. Had these children been referred to CPS and received appropriate intervention, these fatalities may have been prevented.

The problem of child maltreatment also exists in Nevada. A total of 19,960 reports were made in Nevada during 2004 (NCCANI, 2006). Reports accepted by screeners totaled 13,062. Mental health professionals reported 342 (2.6%) of the cases accepted by State and local agencies. This data in addition to the national data clearly illustrates the prevalence of child maltreatment. However, it must be noted that these figures unquestionably underestimate the pervasiveness of child maltreatment, as many cases are not reported to authorities.

Reporting Mandate

The publication of Kempe and colleagues' article on the "battered child syndrome" in 1962 brought the problem of child physical abuse to the forefront of public awareness (NCCANI, 2002). The article described the physical presentation of non-accidental injury and commented on physicians' reluctance to bring these injuries to the attention of authorities. In response, the Children's Bureau of the National Center on Child Abuse and Neglect Information (NCCANI; 1963) and later the American Medical Association (1966) and the Program for State Governments (1966) drafted model reporting statutes which focused on physicians' reporting of physical abuse (NCCANI, 2002). By 1967, all states and the District of Columbia had enacted a mandatory reporting law.

Federal legislation followed with the Child Abuse Prevention and Treatment Act of 1974 (CAPTA; P.L. 93-247; U.S. Department of Health and Human Services, 2003). CAPTA required state legislatures to address child maltreatment prevention to qualify for federal grants. In response, the majority of state legislatures adopted federal requirements which included (1) coverage for all children under 18, (2) coverage of mental and physical injury, (3) abuse and neglect reports, (4) record confidentiality, (5) legal immunity for reporters of abuse and neglect, and (6) appointment of a guardian ad litem for children whose cases are adjudicated by the court (Brieland & Lemmon, 1977). CAPTA was reauthorized in 1978 through the Child Abuse Prevention and Treatment Act (CAPTA) and Adoption Reform Act (P.L. 95-266) and later amended in 1984 (P.L. 98-457) expanding coverage to include mandated reporting of medical neglect (NCCANI, 2003). In 1988, the Child Abuse Prevention, Adoption and Family Services Act (P.L. 100-294) directed the establishment of a national data system to collect

information pertaining to maltreatment reports. The Child Abuse, Domestic Violence, Adoption and Family Services Act of 1992 (P.L. 102-295) reauthorized CAPTA and provided for maltreatment prevention grants. CAPTA was again amended in 1996 (P.L. 104-235) setting minimum definitions of child abuse. The most recent reauthorization of CAPTA occurred in 2003 through the Keeping Children and Families Safe Act (P.L. 108-36) (NCCANI, 2003).

The state of Nevada legislates the CAPTA guidelines and additional guidelines through Nevada Revised Statute 432B (NRS 432B). This statute includes the addition of more specific information such as definitions of what constitutes varying types of maltreatment and the limitations of immunity for reporters. NRS 432B.220 requires that any person specifically identified as a mandated reporter who “in his professional or occupational capacity, knows or has reasonable cause to believe that a child has been abused or neglected” shall “report the abuse or neglect of the child to an agency which provides child welfare services or to a law enforcement agency; and make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the child has been abused or neglected.”

Professionals specifically identified as mandated reporters include psychiatrists, psychologists, marriage and family therapists, and alcohol or drug abuse counselors. Nevada’s Division of Child and Family Services provides a telephone hotline to which these professionals may report child maltreatment 24 hours a day, 7 days a week.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Lack of Reporting by Mandated Professionals

Despite the mandate to report suspected child maltreatment, professionals often fail to report child maltreatment (Butz, 1985; Finkelhor, Gomez-Schwartz, & Horowitz, 1984; James, Womack, & Strauss, 1978; Saulsbury & Campbell, 1985). Indeed, the literature has repeatedly demonstrated that approximately 40% of mandated reporters have failed to report at some point in time, and 6% consistently fail to report (Besharov, 1994; Camblin & Prout, 1983; Kenny & McEachern, 2002; Zellman, 1990a, 1990b). Failure to report maltreatment has been documented across professions with mental health professionals among those who fail to report.

In 1978, Swoboda and colleagues reported that 68% of mental health professionals had failed to report at least one instance of child maltreatment. These findings may not be particularly striking given that this study occurred shortly after the enactment of mandatory reporting legislation. However, the literature has consistently reported a failure by psychologists to report. Nearly ten years later, Pope and colleagues (1987) found 61% of psychologists had failed to report maltreatment. In an attempt to decipher whether this trend was present across experience level, Pope and Bajt (1988) surveyed psychologists who had served on ethics boards, the American Psychological Ethics Committee, had written texts on ethics or were diplomats of the American Board of

Professional Psychologists. Despite their distinguished training in ethics, 21% of the 60 psychologists surveyed reported failure to report maltreatment.

Larger samples of psychologists have also reported in similar findings. Kalichman and colleagues (1989) found a failure to report in 37% of their sample of 279 psychologists. Similarly, failure to report by 35-39% of psychologists has been documented in sample sizes ranging from 297 to 552 (Kalichman & Brosig, 1992; Kalichman & Craig, 1991). The most recent findings suggest this trend may be declining. In 1995, Kennel and Agresti reported that of 431 psychologists, 29% had failed to report. However, given that reporting of suspected child maltreatment is mandated, this continues to be a significant percentage. Mental health professionals' failure to report is concerning as it may place children at continued risk for maltreatment and hinder the provision of necessary intervention services to ensure their safety.

Reasons Professionals Fail to Report

Multiple factors influencing professionals' decision not to report have been identified in the literature. These factors generally fall into three categories: 1) lack of knowledge regarding reporting requirements, 2) fear of negative consequences for the client, and 3) fear of negative consequences for the professional. The following sections review the factors contributing to professionals' hesitancy to report maltreatment. In addition, information relevant to the barriers to reporting will be included where applicable.

Lack of Knowledge Regarding Reporting Requirements

Evidence of Maltreatment

Lack of evidence has been reported as perhaps the most influential factor in the decision by professionals not to report child maltreatment (Finlayson & Koocher, 1991; Kalichman, Craig, & Folingstad, 1989). Indeed, a majority of professionals have directly cited lack of certainty that maltreatment is occurring or insufficient evidence as a primary reason for not reporting (Badger, 1989; King, Reece, Bendel, & Patel, 1998; Saulsbury & Hayden, 1986; Zellman, 1990). The belief that evidence of maltreatment is necessitated for a report may be held by a majority of professionals including those in the mental health fields. In a survey of 121 licensed practicing psychologists, 57% believed they had a responsibility to find evidence of maltreatment prior to reporting (Kalichman & Brosig, 1993). Mandated reporters who subscribe to this notion may be less inclined to report maltreatment. Dale and Fellows (1999) reported that inconsistent reporters were more likely to view evidence gathering as their responsibility (66%) when compared to consistent reporters (53%).

Failure to report maltreatment due to lack of evidence is a clear violation of the law as no state requires proof of maltreatment, but rather suspicion to report (Burns & Lake, 1983; Sussman, 1974; Wagner, 1987). Indeed, most states require that a report be made when a professional has “reasonable suspicion” that maltreatment has occurred. For example, Nevada requires a report when there exists a “reasonable cause to believe” that maltreatment has occurred (Nevada Revised Statute 432B.121). The statute states that the decision to report be based on “the surrounding facts and circumstances which are known,” thus specifying that the professional is not responsible for further evidence

gathering. Therefore, if one suspects maltreatment, a report should be made (Harper & Irvin, 1985; Spencer, 1996). Only in the instance that the professional is certain that maltreatment has not occurred should one fail to report (Remley & Fry, 1993), and these circumstances should be thoroughly documented (Besharov, 1990).

Organizational Policy

Conflict between the legal mandate to report and organizational protocol may also lead to frustration when reporting (Nalepka, O;Toole, & Turbett, 1981). Professionals working within an organization are often instructed to review reports with supervisors prior to reporting to CPS. This requirement is generally appropriate as supervisors may be more knowledgeable and experienced in reporting procedures. Yet, the potential for conflict arises when a supervisor disagrees with the professional's decision to report (Hazzard, 1984). Some professionals have reported a lack of support by supervisors. In addition, some professionals have reported organizational policy that diverges from state laws (Kenny 2001a).

In the event that conflict should arise, the professional must be cognizant that as the individual who suspected maltreatment, they may be liable for failure to report. Thus, mandated reporters must be aware of both their organization's policy and the state laws. Further, if disagreement occurs or the decision is made not to report, this decision and details relevant to the situation should be clearly documented.

Research Setting

Professionals may fail to report believing that information obtained in the context of research is not subject to reporting mandates (Kinard, 1985). This concern has no clear resolution as reporting requirements with regard to researchers vary by state. It is

important to note that only 9 states explicitly exclude researchers from a legal requirement to report (Liss, 1994). The majority of states do not provide clear guidance in this area, although these states may include a statement that indicates professionals (e.g., psychologist, social worker) are required to report when research is considered part of their professional activities (Kalichman, 1999; NRS 432B.)

Fear of Negative Consequences for Client

Failure to report often results from a desire to act in the best interest of the child (Finkelhor & Zellman, 1991; Wilson & Gettinger, 1989). Professionals may choose not to report or hesitate to report fearing further harm may befall the child (Alpert & Green, 1992; Harper & Irvin, 1985; Kim, 1986; Zellman, 1990a) and family (Bavoleck, 1983; Winefield & Castell-McGregor, 1987; Zellman, 1990a,b). Kalichman and Craig (1991) reported that as many as 31% of psychologists believe reporting adversely affects the client. These concerns are particularly relevant as professionals may struggle between wanting to report in attempt to improve circumstances for the client and fearing these efforts will result in further damage.

Negative Perception of CPS

A general negative perception of CPS may result in a reluctance to refer cases of child maltreatment (Alexander, 1990). Professionals may fear that CPS will handle a report in a manner that is likely to negatively impact clients. The effects of a CPS investigation in particular may serve as a concern for professionals. When an investigation is warranted, professionals may fear that the process will be detrimental to clients (Besharov, 1990). Specifically, children and families may experience interviews and home visits as accusatory or persecutory in tone. Professionals have suggested that

CPS agency officials often respond to reports in a manner that emphasizes criminal wrongdoing rather than provision of services (Melton, 2005). Further, delays in launching investigations may place children at risk for continued maltreatment (Kenny, 2001a). These negative perceptions have led some professionals to argue that CPS should have no involvement in the treatment process (Finkelhor & Zellman, 1991), and some cite a lack of responsiveness on behalf of CPS as an argument against a reporting mandate (Kalichman, 1999).

Given the potential problems associated with investigations, some professionals believe they are better suited to respond to maltreatment than CPS (King et al., 1998). These professionals may bargain with families to avoid CPS involvement. For example, professionals may promise not to report initial presentations of maltreatment, but threaten to report further instances of maltreatment (Kenny, 1998). Other professionals argue that the clients themselves fear CPS involvement and thus may hesitate in disclosing maltreatment (Faller, 1985; Kalichman, 1999). However, Watson and Levine (1989) suggested that families who experience CPS investigations generally experience them as positive rather than intrusive.

Meddin and Hanson (1985) reported that in a majority of substantiated cases, CPS was unable to provide services. Moreover, in a review of substantiated cases in New York, Salovitz and Keys (1988) found 55% were officially closed the same day that abuse was confirmed. Thus, there is a perception that resources are expended on investigation rather than prevention and intervention. However, as previously noted, families may receive services from other agencies and CPS may close cases when families are referred to outside agencies.

Therapeutic Relationship

The fear that reporting will damage the relationship between the client and the professional is a concern specifically noted by mental health professionals (Ansel & Ross, 1990; Smith & Meyer, 1984, Zellman, 1990). Kalichman and colleagues (1989) reported that 42% of licensed psychologists believed reporting negatively impacted family therapy. A third of licensed psychologists surveyed by Kalichman and Craig (1991) felt the reporting of child maltreatment to CP:S was harmful to the therapeutic process. This belief may impact reporting decisions as 1/3 of licensed psychologists rated safeguarding the therapeutic process as an important consideration in reporting (Kalichman, & Craig, 1991).

Despite the tendency for professionals to believe reporting will have deleterious effects on the therapeutic relationship, a few studies have challenged this view. Harper and Irvin (1985) reported that termination was unlikely when a report occurred concurrent with treatment. Brosig and Kalichman (1992b) surveyed psychologists who had both reported and failed to report maltreatment. No differences were found between reported and reported cases on the impact on child and family clients, outcome of therapy, and maintenance of trust. In addition, some studies have reported positive outcomes for reporting maltreatment. Watson and Levine (1989) reported that the majority of cases reviewed did not change as a result of reporting. Indeed, in approximately 30% of the cases, positive changes were experienced. Similarly, Weinstein and colleagues (2001) reported that 40% of reported cases resulted in unchanged relationships and 32% resulted in improved relationships. However, it must be noted that 27% of did experience some negative impact on the therapeutic relationship.

The outcome of reporting may be influenced by specific factors. Levine and Doeuck (1995) identified 6 factors that posed the greatest threat to the therapeutic alliance. These include: 1) degree of involvement of accused perpetrator to the therapeutic relationship, 2) whether the client was an adult or child, 3) the manner in which the report is presented to the client, 4) whether divorce or custody disputes were involved, 5) client's involvement in the reporting process, and 6) the nature of the alleged abuse. Steinberg, Levine, and Doucek (1997) reported that the outcome of reporting is closely associated to therapeutic relationship prior to reporting. Multiple variables appear to impact the outcome of reporting on the therapeutic alliance. Therefore, it may be an oversimplification to hold the act of reporting solely responsible for negative therapeutic outcomes.

Fear Negative Consequences to Professional

Professionals may fail to report maltreatment fearing they may experience negative consequences. They may not want to become involved in the reporting process or feel uncomfortable making the report (Faller, 1985; Tower, 1992) or may be reluctant to dedicate the time necessary for reporting cases (Willis & Horner, 1987) or participating in possible legal proceedings (Kim, 1986). Furthermore, professionals may not report child maltreatment because they lack experience (Willis & Horner, 1987) and fear they will appear incompetent (Kenny, 2001). Fear that reporting will lead to negative interactions between the professional and suspected perpetrator may also serve as a barrier to reporting. Professionals may hesitate to report someone who they know well, or who is well respected in the community (Tower, 1992). Multiple authors have also noted fear of physical retaliation on at the hands of the suspected perpetrator (Badger, 1989;

Kim, 1986). Professionals have expressed concern that a parent may become angry following a report and fear that their physical aggression may be directed at the individual making the report (Tower, 1982). This fear may be common among professionals as one survey found that approximately two-thirds hesitated to report due to fear of physical retaliation (Baxter & Beer, 1990).

Legal Consequences

Professionals may fail to report believing that they may encounter legal ramifications for reporting suspected maltreatment that is later unsubstantiated by CPS (Abrahams, Casey, Daro, 1992; Kenny 2001). They may also hesitate to reporting fearing that the client may become angry and involve them in civil and malpractice lawsuits in retaliation for the report (Badger, 1989). Baxter & Beer (1990) reported that as many as 26% of professionals fear legal retaliation for reporting suspected child maltreatment.

Immunity.

As a means of protecting professionals from legal ramifications of reporting, all 50 states provide mandated reporters immunity from civil or criminal liability as a result of making a report of maltreatment. States must provide immunity to mandated reporters to be eligible for federal grants (CAPTA, 1974). Some states (e.g., California) grant absolute immunity (Small, Lyons, & Guy, 2002), while most others limit immunity to reports made in “good faith” (NRS 432B.160). Small and colleagues (2002) reported that as recently as 2002, there were no reported cases where psychologists were denied immunity for failing to act in good faith when reporting maltreatment. Immunity clauses have even withstood state constitutional challenges. In the few cases where challenges

have been brought, the courts have upheld the immunity provisions (see Small, Lyons, & Guy, 2002).

Criminal liability.

Professionals who fail to report may face legal ramifications. Small and colleagues (2002) reported that all states with the exceptions of Maryland and Wyoming impose criminal liability for failure to report. Failure to report is a misdemeanor in most states with varying penalties including fines ranging from \$25 to \$5,000 and possible jail sentences ranging from 10 days up to a year (Small, Lyons, & Guy, 2002). Nevada Revised Statute (NRS 432B.240) specifies, “Any person who knowingly and willfully violates the provisions of NRS 432B.220 (i.e., reporting mandate) is guilty of a misdemeanor.” Thus professionals may be more justified in fearing legal ramifications for failure to report rather than for reporting where they are protected from liability.

Summary

Some concerns may be more influential than others in professionals’ consideration of reporting maltreatment. Kalichman and Brosig (1993) reported that psychologists’ concerns might distinguish between those who consistently report and those who inconsistently report. Consistent reporters were more likely to place importance on concerns about the law and protecting the child, whereas inconsistent reporters were more likely to place importance on characteristics of the abusive situation and the effects of reporting on the family. Therefore, general concern related to reporting may not necessarily preclude reporting. However, the concerns detailed in this section have been reported as influencing the decision not to report. Understanding the factors that

influence mental health professionals' reporting decisions provides a foundation for the development of maltreatment reporting training programs.

Overreporting by Mandated Professionals

The majority of the literature on professionals' reporting practices has focused on failure to report child maltreatment, yet authors have also noted the problem of overreporting by professionals (Besharov, 1994; Foreman & Bernet, 2000; Kalichman, 1999; Zellman and Faller, 1996). These authors suggest that the high rate of unsubstantiated cases (i.e., cases not found by CPS to involve maltreatment), reflect a tendency for mandated professionals to report instances which are not reflective of child maltreatment. The laws themselves have been criticized for leading to overreporting. Foreman and Bernet (2000) criticized child maltreatment laws for their vagueness and suggested that such nonspecific laws lead to the initiation of unnecessary reports by professionals. Similarly, Kalichman (1999) suggested that broad legal definitions of maltreatment cause professionals to overreport in attempt to comply with the legal mandate.

However, unsubstantiation rates may reflect more than overreporting by mandated reporters. For example, although 60.7% of the reports made nationally in 2002 were unsubstantiated, 67.3% of reports made by professionals were substantiated compared to 32.7% for other referral sources (NCCANI, 2006). Further, unsubstantiation may not suggest that families are not provided services or that maltreatment did not occur. Cases may be labeled as unsubstantiated when families are referred to outside agencies for services, or be closed if services are unavailable (Besharov, 1994). The difficulty in

obtaining evidence of maltreatment may also lead to unsubstantiation. Evidence of maltreatment may not be gathered in the time allotted by CPS for investigation, or if a family cannot be located (Besharov, 1994). Indeed, this process underscores the importance of reporting as investigators may need to respond to more than one report before finding evidence of maltreatment in less obvious cases. Besharov (1994) agreed that some degree of unsubstantiated reports might be inherent to the mission of safeguarding children, but that rates are much higher than optimal. He suggested that training might aid professionals in understanding the laws and improve the accuracy of their reporting. As the overwhelming number of reports received by CPS burden the system, training professionals to take certain precautions such as including all necessary information in reports may aid CPS in substantiating cases.

Child Maltreatment Reporting Training

Lack of Formal Training

Training in the recognition and reporting of maltreatment is a commonly offered solution for professionals' failure to report (Besharov, 1988; Faller, 1985; Kalichman, 1999). Lack of training in reporting procedures may impede reporting by professionals (Stein, 1984). Yet, most professionals lack training in child maltreatment in general and in specific reporting procedures such as when and how to report (Abrahams et al., 1992; Beck, Ogloff, & Corbishley, 1994; Hazzard, 1984; Kim, 1986; Plante, 1995).

This lack of training is evident in professional education as graduate programs rarely provide training in child maltreatment (Howe, Bonner, Parker, & Sausen, 1992; Kalichman, & Brosig, 1993; Pope & Feldman-Summers, 1992). In a survey of 142 APA-accredited clinical, counseling, and school psychology doctoral programs, only 11%

offered courses specific to child maltreatment (Champion, Shipman, Bonner, Hensley, & Howe, 2003). Further, 20% of programs failed to cover basic ethical and legal aspects of child maltreatment. Professionals do not appear to have a greater likelihood of receiving training during internship. Alpert & Paulson (1990) noted that recent graduates had received little training or experience in child maltreatment. For the few professionals who do receive training in graduate programs or during internship, training may be perceived as inadequate. A sample of psychologists reported their graduate training in maltreatment as poor and rated their internship training as only slightly better (Pope & Feldman-Summers, 1992). The majority of professionals who receive training are likely to do so through postgraduate or continuing education as less than 20% have reported receiving training in graduate school (Kalichman and Brosig (1993).

Although training is most likely to be gained through continuing education (Alpert & Paulson, 1990; Kalichman & Brosig, 1993; Wilson, Thomas, & Schuette, 1983), few professionals may be educated in this manner. Some states require training for specific professionals (Barber-Madden, 1983), yet few of these states mandate training for mental health professionals (Alexander, 1990; Pagel & Pagel, 1993; Reiniger, Robison, & McHugh, 1995). Therefore, training is likely to be sought out by mental health professionals who are self-motivated to obtain training specific to reporting requirements and procedures. Despite a general lack of training, many states require knowledge of reporting requirements (e.g., mandate, time frame, confidentiality, civil protection for reporters) for mental health professionals seeking licensure or renewal.

In discussing training in child maltreatment it is important to differentiate between general training in assessment and treatment of child maltreatment and specific training

in reporting procedures. Professionals may receive training in child maltreatment and yet still not understand the intricacies of reporting requirements and procedures or feel confident in reporting. For example, a sample of physicians surveyed by Kenny (2001) reported receiving adequate training in child maltreatment yet was unfamiliar with reporting requirements. Training specific to the reporting of child maltreatment may be necessary to increase professionals' likelihood of referring maltreatment to child protective services. Indeed, King and colleagues (1998) reported greater lifetime reporting percentages for those who had received training.

Training Content

To address professionals' reluctance to report child maltreatment, training should include information both on child maltreatment in general and specific to reporting requirements and procedures. The American Psychological Association's Public Interest Directorate and the Division of Child, Youth, and Family Services (1996) developed guidelines for the content of training in child maltreatment (Champion, Shipman, Bonner, Hensley, & Howe, 2003). These guidelines included definitions, prevalence rates, consequences of maltreatment, theories related to the development of child maltreatment behaviors, recognition and reporting of child maltreatment, responses by CPS, legal involvement, medical and mental health intervention, and prevention of maltreatment. Recommendations for academic course offerings covering different forms of maltreatment (e.g., neglect, sexual abuse) were included in the guidelines. In addition to training recommendations, the APA suggested that licensing boards require knowledge reflecting these guidelines for licensure and renewal. These recommendations, however, may be more appropriate for graduate programs and licensing boards as workshop

training formats may have less time in which to address these areas. Instead, workshops should aim to include practical information to guide the professional through the reporting process. The content of said training should include an overview of reporting including definitions and indicators of maltreatment, applied information on how to initiate a report, and how to best serve the client in the reporting process.

Identification of Maltreatment

Definitions of maltreatment.

To address both failure to report and overreporting by professionals, training programs should include an overview of the different types of maltreatment, and relevant definitions and indicators of child maltreatment should be reviewed in training programs. Professionals are often unclear as to what constitutes child maltreatment, thus Walters (1995) suggested dividing maltreatment into subcategories (i.e., sexual abuse, physical abuse, emotional abuse, neglect). This is beneficial as specific acts within subcategories of abuse such as sexual abuse (e.g., exposure to adult content) may be omitted from training programs (Alpert & Paulson, 1990). Similarly with physical abuse, professionals may recognize acts resulting in physical injury as reportable, yet may fail to report potentially injurious acts (e.g., shaking, kicking); which may be reportable offenses in some states (Besharov, 1987). Emotional or psychological abuse is also difficult to define, as some constitute any act that psychologically injures children as abusive (Hyman & Snook, 1999). Neglect, although the most commonly occurring form of maltreatment (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, 2003), may be the most difficult to define. One way of defining neglect is as a failure by caretakers that results in significant harm or a potential

for significant harm (Dubowitz, 2003). A broader definition involves a situation in which a child's basic needs are unfulfilled (e.g, food, clothing, education). As legal definitions vary in the terminology used to define types of maltreatment, reportable acts are difficult to define. To address this difficulty, the definitions utilized in training should reflect the definitions set forth by the state in which the training is conducted.

Indicators of maltreatment.

In addition to definitions, training programs should review basic indicators of child maltreatment (Besharov, 1994). Professionals with an understanding of these indicators may experience less difficulty in determining whether an incident warrants reporting. While the presence of these indicators alone may not warrant reporting, they may guide the professional to obtain more information regarding an incident. Maltreatment may be indicated through both physical and behavioral manifestations that vary depending on the type of maltreatment.

Physical abuse is most frequently indicated through injury to soft tissue such as bruises and welts (Ayoub, Grace, & Newberger, 1990; Kalichman, 1999). Less frequently, burns and scalds may also result from physical abuse (Kalichman, 1999). Although these symptoms may result from accidental injury, multiple injuries in various stages of healing, injuries reflecting specific patterns (e.g., hand, cigarette), and injuries that are inconsistent with the explanation provided by the client may reflect intentional maltreatment (Wissow, 2006). However, mental health professionals may not encounter these indicators within the therapeutic context as they may be concealed by clothing. Behavioral and emotional indicators of physical abuse are more likely to be presented in the course of therapy, thus these must also be emphasized in training. Physically abused

children tend to display greater externalizing behavior problems (Malinosky-Rummel & Hansen, 1994). These behaviors include aggressive or violent outbursts, tantrums, and difficulty interacting with peers (Ammerman, Cassisi, Hersen, & Van Hasselt, 1986; Kinard, 1980; Wolfe & Mosk, 1983). Older children may engage in substance abuse and display greater academic and legal difficulties (Eckenrode, Laird, & Doris 1993; Lamphear, 1986).

Physical indications of sexual abuse generally require a medical examination to be detected, thus training should focus on behavioral and emotional manifestations that have a greater probability of presentation in therapy. Behavioral indicators include sexually descriptive statements and sexualized behavior such as self-stimulation, sexual aggression, and inappropriate contact with others (Adams, 1991; Friedrich, Grambsch, Damon, Hewitt, Koverola, Lang, et al., 1992; Herbert, 1987). Sexually abused children are also more likely to exhibit internalizing symptoms (Kendall-Tackett, Mayer, & Finkelhor, 1993). They may display depressive symptomology, withdrawal, difficulty sleeping, anxiety, and low self-esteem (Adams, 1991; Browne & Finkelhor, 1986; Herbert, 1987; Oddone, Genuis, & Violato, 2001).

Neglected children may show clearly observable indications of maltreatment. Children who appear malnourished, inappropriately clothed (e.g., ill fitting or seasonally inappropriate clothing), or display poor hygiene may be experiencing neglect. However, professionals should be informed that other manifestations may be exhibited. Similar to physically abused children, neglected children may display aggression, behavior problems, and poor social skills and academic performance (Kendall-Tackett & Eckenrode, 1996; Lamphear, 1986). Yet, neglected children may also present low

intelligence and cognitive or speech impairment (Cahill, Kaminer, & Johnson, 1999). Neglected children may also experience emotional manifestations similar to physically or sexually abused children such as depression, withdrawal, and anxiety (Geraldo & Sanford, 1987; Hoffman-Plotkin & Twentyman, 1984).

Indicators of emotional or psychological abuse have not received much attention in the literature. Kalichman (1999) suggested that the lack of a universally accepted definition of emotional or psychological abuse contributes to the limited indicators presented in the literature. Witnessing parents belittle, humiliate, or ignore their child may be the clearest indication of emotional or psychological abuse. However, training should also address less obvious indicators of this type of abuse. For instance, a lack of attachment between parent and child may reflect a pattern of emotional or psychological abuse (Bailey & Bailey, 1986). In addition, psychological or emotional abuse may be indicated by a child's self-destructive or aggressive behavior (Melton & Davidson, 1987).

Knowledge of the indicators of maltreatment may aid professionals in the recognition of maltreatment (Hawkins & McCallum, 2001b; Tiltan, 1994). The presence of maltreatment indicators may aid professionals who have formed hypotheses or "hunches" regarding maltreatment to suspect maltreatment and report (Brosig & Kalichman, 1992). However, these indicators are not specific to maltreatment and are present in children who have not experienced any form of abuse. Thus, training must emphasize that the presence of behavioral and emotional indicators in particular is not sufficient to warrant reporting.

Consultation.

The determination of whether an incident should warrant suspicion is often difficult process for professionals. Thus, training should also include a recommendation for professionals to seek consultation when unsure of whether an incident warrants suspicion (Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2000). As the term suspicion suggests that another individual privy to the same information would suspect maltreatment, conferring with another professional may help in the determination of whether a report is necessitated (Brosig & Kalichman, 1992). Training should also inform professionals that they may contact CPS with the relevant details of an incident to decipher whether a report is necessitated without providing identifiable information (MacKinnon & James, 1992). Understanding these options may serve to protect children at risk as consultation has been more frequently cited by professionals who have self-reported never failing to report (Kalichman & Brosig, 1993), as well as those known to have made reports (Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2000). In addition, consultation with CPS may increase the accuracy of reporting through the reporting of appropriate incidents (Brosig & Kalichman, 1992)

Reporting Requirements and Procedures

Legal requirements.

To address underreporting due to lack of evidence and fear of negative consequences to the professional, relevant legal requirements should be reviewed in training. Such training on legal responsibilities has been suggested to be the “single most effective method of encouraging more complete and more accurate reporting” (Besharov, 1994, p. 143). First and foremost, professionals should be reminded of their legal obligation to

report child maltreatment. Additionally, it should be emphasized that professionals are not required to prove the occurrence of maltreatment in order to report to CPS (Tower, 1992). Indeed, the majority of states require only “reasonable suspicion” to necessitate a report (Burns & Lake, 1983; Kalichman, 1999). Professionals should be reminded that their role is to report maltreatment. It is then the responsibility of child protective services to investigate and substantiate maltreatment.

To dissuade professionals from failing to report for fearing civil or criminal liability, they should also be informed that all 50 states provide legal immunity when reporting in “good faith” (Beezer, 1985; Besharov, 1994; Nalepka et al., 1981). When reports are made without malicious intent professionals are provided immunity regardless of the outcome of the investigation (Kalichman & Brosig, 1993). Legal immunity may serve to alleviate professionals’ concerns regarding legal retaliation for reporting maltreatment (Kenny, 1998). Alternatively, professionals should be aware that failure to report may result in legal consequences including fines, potential jail time, civil liability, and may even lead to sanctions by licensing boards. Legal immunity for mandated professionals has withstood legal challenges, however, multiple cases of legal action for failing to report have been documented in the literature (Kalichman, 1999; Small, Lyons, & Guy, 2002). Therefore, training should emphasize legal consequences for failure to report suspected maltreatment. Professionals unsure of whether a report is necessitated should be encouraged to consult with colleagues (Remley & Lincoln, 1986) and document any decision not to report to protect oneself from legal ramifications (Besharov, 1990).

Reporting Procedures

Specific procedures for reporting maltreatment should also be reviewed in training (Weinstein et al., 2000). These procedures vary across states, thus training should review procedures relevant to the state in which training is conducted. The majority of states require an oral report to be made as soon as possible or no later than 24 hours following suspicion of maltreatment (Tower, 1992). Oral reports are generally made to either child protective services or law enforcement (Meriwether, 1986) as dictated by state reporting requirements. Some states require an additional written report generally to be filed 1 to 7 days after the oral report. The nature of written reports required by states varies with some states providing specific forms and others requiring written statements. Training should specifically address the requirements of the state in which the training is conducted. The information to be included in oral and written reports generally includes the child's identifying information (i.e., name, age, gender), the parents' names and address, the nature of the report, and the reporter's name and contact information (Kalichman, 1999; Tower, 1992). At the time of training professionals should be informed of the information required for reporting and be provided with any relevant phone numbers and reporting forms. Familiarity with reporting procedures may better facilitate the reporting process should the need to report arise.

Client Involvement

Training should address professionals' concerns that reporting may damage the therapeutic relationship by instructing professionals on how to involve clients in the reporting process as a means of maintaining the relationship (Bromley & Riolo, 1988). Knowledge of these techniques has been categorized as both "crucial" and of "utmost

importance” (Steinberg, Doucek, & Levine, 1997). Further, Weinstein and colleagues (2000) reported that more positive outcomes resulted when professionals informed clients of the decision to report.

Informed consent.

Involving the client in the reporting process may begin at the outset of therapy through the presentation of the informed consent. Training in the reporting process should include a recommendation to review the limits of confidentiality with clients during the informed consent process (Weinstein et al., 2000). In addition to being ethically bound to review the limitations of confidentiality with clients (American Psychological Association, 2002), professionals may experience less upset by clients when later informed of an intent to report. Indeed, Steinberg (1994) reported a relationship between detailed review of the limits of confidentiality with clients and positive outcomes to reporting. Professionals who review the limits of confidentiality with clients may also be more comfortable reporting maltreatment if necessary. Nicolai and Scott (1994) reported that professionals who routinely reviewed the limits of confidentiality were more likely to indicate intent to report hypothetical cases of maltreatment. Therefore, professionals should be instructed to inform clients of the limitations of confidentiality as soon as possible in the therapeutic process, preferably at the outset of the first session (Keith-Spiegel & Koocher, 1985; Weinstein, et al., 2000).

Report initiation.

Client involvement in the reporting process may be especially imperative when the professional has made the decision to report maltreatment. Taylor and Adelman (1998) recommended providing the client with an explanation of why the professional intends to

report, the possible outcomes of reporting, and initiating a discussion of how to proceed with the report. Stadler (1989) suggested a hierarchy of client involvement where first the client is presented with the option of initiating the report. If the client declines, the professional may offer to initiate the report in the presence of the client. If the client is uncomfortable with the first two options, the professional may suggest reporting outside the presence of the client while the client waits or following the conclusion of the session.

Donohue and colleagues (2002) included some of these suggestions as well as the recommendations of other authors in the development of an empirically based checklist of ways to address the report with clients to be utilized in training (See Review of Existing Training Programs). The checklist may also be utilized in the presence of the client to increase the likelihood of a positive outcome when informing them of the decision to report. However, this checklist was developed for addressing the involvement of a non-perpetrating caregiver.

Guidelines for involving perpetrating caregivers have not been established. Thus, professionals must be informed that a decision to involve perpetrating caregivers in the reporting process should be made through clinical judgment on a case-by-case basis. Involving the suspected perpetrator may not be appropriate if the professional believes that the abuse is at such a level of severity that the disclosure of the intent to report could result in immediate harm to the child (Berliner, 1993). Similarly, client involvement in the reporting process may not be appropriate if the professional believes that the suspected perpetrator will threaten the child, or respond violently (Stadler, 1989). However, as professionals may overestimate the likelihood of a violent response, training

should include a statement that only an approximated 4% of clients respond with threats or attempts to harm professionals (Weinstein et al. 2000).

The decision to inform clients of the intent to report and provide the opportunity for collaboration in the reporting process may be difficult for professionals given documented concern regarding the effects of reporting on the therapeutic process. Therefore, training should emphasize that professionals who have involved clients in the reporting process have reported greater success in maintaining the therapeutic relationship (Strozier, Brown, Fennell, Hardee, Vogel, & Bizzell, 2005). Additionally, professionals should be informed that the therapeutic relationship might be damaged by the decision not to inform the client when the client becomes aware of a report (Berliner, 1993).

CPS process.

Training should include a review of the reporting process that follows the initiation of the report to CPS (Compaan, Doueck, & Levine, 1997; Levine, & Doueck, 1995; Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2001). Compaan, Doueck, and Levine (1997) found an understanding of the CPS process to be an important predictor of reporting maltreatment. In addition, professionals informed about the process are better prepared to guide clients through the process (Brosig & Kalichman, 1992) and provide support.

Professionals should be informed that when reporting child maltreatment, CPS will make a determination whether to accept or “screen out” the report (Pence & Wilson, 1994). If the report is accepted, CPS will assess whether the child is in immediate danger for further harm (Kuest & Winter, 2000). If the child is believed to be in imminent risk,

CPS may initiate removal of the child from the home into protective custody. Otherwise, CPS will determine whether the report warrants investigation.

If an investigation is not recommended by the CPS agent, the report is typically filed for reference in the event that another incident is reported. However, if an investigation is deemed necessary, the agency is generally required to start the process immediately or within 48 hours (Heymann, 1986). Training should emphasize that the goals of an investigation are both to decipher whether maltreatment has occurred and whether the child is at risk for further harm (Kuest & Winter, 2000); as well as develop an appropriate treatment plan for the child and family (Chamberlain, Krell, & Preis, 1982). Professionals should be informed during training that they may request information regarding the outcome of an investigation or aid clients in obtaining information from CPS (Berliner, 1993).

If maltreatment is substantiated through an investigation, CPS may choose to provide the family with services, remove the child from the home into temporary custody, or seek termination of parental rights (Buchele-Ash, Turnbull, & Mitchell, 1995). However, as previously mentioned, some cases in which maltreatment is unsubstantiated may still receive services or referrals for services from other agencies. Professionals should be informed that the likelihood of families receiving services is greater when referred to CPS by professionals. Although many families may voluntarily agree to participate in the recommended services, CPS has the authority to seek a court order to mandate the family's participation in services (Rubin, 1992).

The fear that families may be separated or prosecuted as a result of a substantiated maltreatment should be addressed in training. As professionals may fail to report as a

result of these fears, it is important that the likelihood of these events be reviewed.

Federal legislation requires that social services attempt to refrain from removing the child from the home when possible (Adoption Assistance & Child Welfare Reform Act, 42 U.S.C.A. sec. 672, 1992). Therefore, children are only removed from the home when deemed to be at risk of imminent harm. Further, when children are temporarily removed from the home efforts are made to place them with family members (Buchele-Ash, Turnbull, & Mitchell, 1995; Pence, & Wilson, 1994). Similarly, prosecution occurs only in a minority of situations. Substantiated sexual abuse has the greatest rate of criminal charges at approximately 17% compared to 1% to 3% for other types of child maltreatment (Tjaden & Thoennes, 1992). Knowledge that families are more likely to receive services than experience separation or prosecution may allay some fears professionals may experience when deciding whether to report suspected maltreatment.

Review of Existing Training Programs

Academic Programs

Some academic institutions include child maltreatment training programs within their curriculum. For example, New York University offered two graduate courses in child sexual abuse (Alpert & Paulson, 1990). One course was available to multiple disciplines (i.e., psychology, nursing, education) and focused on research and theory. The second was available only to doctoral students in the school psychology program and included a practicum in mental health and organizational consultation. These courses incorporated child maltreatment reporting in their content and provided a forum for students to discuss attitudes regarding child maltreatment and mandated reporting. However, the article did not describe the information specific to maltreatment reporting included in the course,

with the exception of the discussion of attitudes. It is also unclear how, if at all, student learning and knowledge was assessed as this was not presented by the authors.

The Illinois School of Professional Psychology also addressed training specific to sexual abuse. The institution offered a predoctoral minor in child sexual abuse for students in the clinical psychology doctoral program (Liefer, Cairns, Connors, Lawrence, Gruenhut, & Womack, et al., 1995). The program included two practica and seminars, as well as an internship. In addition, students attended workshops presented by professionals in the area of sexual abuse and were required to conduct a clinical research project relevant to the topic. The description of the program explained that curricula included recognizing ethical issues relevant to child maltreatment, but did not specify to what degree maltreatment reporting was covered in the training. The authors did not report outcome data relevant to student learning.

Training in academic settings has not been limited to the topic of sexual abuse. Gallmeier and Bonner (1992) described 10 university child maltreatment training programs which were funded by the National Center on Child Abuse and Neglect in 1987 in an effort to include child maltreatment training in graduate curriculum. The programs included clinical experience via practicum, and some required students to conduct a research in the area of child maltreatment. Students attended two semesters of seminars addressing topics such as fatal child maltreatment, sexual abuse, and prevention of child maltreatment. The programs also included a discussion of ethical issues relevant to child maltreatment. However, similar to other program descriptions, the degree to which the programs reviewed issues relevant to mandated reporting is unclear and student learning and knowledge were not addressed in the description of these programs.

A more detailed description of a child maltreatment training program was presented in Harrington's (1984) review of the University of Kansas's training module. The School of School Psychology offered a 6-hour training module that was subsumed within the Seminar in School Psychology course and was a requirement for doctoral and non-doctoral students. The seminar specifically addressed maltreatment and reporting through a review of child maltreatment definitions, indicators, statistics, factors contributing to maltreatment, and discussion of attitudes toward maltreatment. In addition, laws and ethical standards requiring reporting were presented. The training format utilized audiovisual materials to supplement the course content. These materials included audiotapes defining the problem of maltreatment and videos of interviews with a lawyer and a social worker regarding maltreatment. This program did assess student learning both continually through study guide questions and at the end of the year by a final exam. However, outcome data was not reported by Harrington, thus the effect of the training is unknown.

The first training program to conduct a controlled evaluation of a training program in an academic setting was conducted by Donohue and colleagues (2002). Through collaboration with the University of Nevada School of Medicine, a medical student was trained to notify a non-perpetrating caregiver of the intent to report maltreatment and enlist their involvement in the reporting process. As a means of facilitating training, an empirically based skills checklist was developed to prompt physicians to effectively and diplomatically address the reporting process. Included in the checklist were twenty-nine behaviors relevant to the initiation of the reporting process with nonperpetrating caregivers (e.g., inform abuse is suspected, inform why abuse is suspected, state that it is

law to report suspected child abuse), and 9 behaviors relevant to resolving nonperpetrating caregivers' upset in the reporting process (e.g., do not attribute blame throughout the interaction, make an empathetic statement).

A multiple baseline design was utilized to evaluate skill acquisition across behaviors. Outcomes were assessed via participant role-play performance involving simulated incidents in which child maltreatment was indicated. Blind raters and experts in the field of child maltreatment indicated improvements in interpersonal skills related to reporting as a result of the training. Specifically, for the skills component of initiating a child abuse report with nonperpetrating caregivers, the participant improved from approximately 20% of actions performed during baseline (Sessions 1 and 2), to about 85% of actions performed consequent to training (Sessions 3, 4, 5, 6). These gains were maintained at the 45-day follow-up session. Skills relevant to resolving the upset of nonperpetrating caregivers during the reporting process increased as a result of training from 30% while reviewing state laws (i.e., baseline Sessions 1 and 2), to 50% while learning to initiate a child maltreatment report (i.e., baseline Sessions 3 and 4), and finally to approximately 90% (Sessions 5,6). A slight regression in skills relevant to upset was evidenced at the 45-day follow-up session.

Macleod, Dornan, Livingstone, McCormack, Less, & Jenkins (2003) described a child maltreatment and neglect workshop developed for junior-level medical doctors specializing in pediatric emergency medicine at Antrim Hospital in Northern Ireland. The workshop included large and small group training and question and answer sessions facilitated by pediatric consultants and a child protection nurse. In addition, written materials were provided to supplement training. At the time of the article, 57 junior

medical doctors had completed the workshop at different times. The authors reported improvement in both recognition of maltreatment (90%) and reporting (92%). Post workshop interviews also indicated increased confidence in responding to child maltreatment. However, the authors did not report whether knowledge outcomes were obtained via self-report or an objective measure. Further, the authors did not report what aspects of the reporting process were reviewed. Thus, whether training included information beyond a duty to report is unclear.

Professional Programs

The majority of child maltreatment training programs developed for professionals have been conducted with educators. Hazzard (1984) developed a 6-hour training workshop for elementary and junior high school teachers. The workshop included a rationale for training and reviewed definitions and myths of maltreatment, maltreatment identification, relevant family dynamics, personal concerns, communication with the child, legal issues, and CPS referrals. Information was presented through discussion, role-play, videotape, and a question and answer session. Teachers who attended the workshop increased knowledge scores in an unstandardized self-report instrument by 10 points from pretest to posttest, whereas control participants' scores were unchanged across time. Trained teachers also later reported greater perceived knowledge of maltreatment, increased empathy toward abusive parents ($p < .0005$), increased class discussion of maltreatment, decreased use of corporal punishment in the classroom, and increased consultation with colleagues. Results indicated that teachers applied their training to the classroom, yet training may not have affected reporting as groups did not differ on the number of maltreatment reports initiated following training.

Kleemeier and colleagues (1988) developed a 6-hour training workshop for elementary school teachers, which focused specifically on child sexual abuse prevention. The workshop is facilitated by psychologists and presented information through didactic presentation, videotape, role-play, group discussion, and a question-and-answer session with a CPS worker. In a controlled trial, trained teachers increased knowledge scores on a 30-item scale from an average of 14.8 to 23.3, compared to control participants whose scores decreased from an average of 14.2 to 13.6 (condition $p < .001$, time $p < .00001$). The authors also reported increased knowledge of indicators of abuse, reporting procedures, treatment alternatives, as well as increased prevention measures for trained teachers, as compared with control participants. In addition, attitudes shifted, with trained teachers reporting greater acknowledgement of the severity of maltreatment, less blaming of the victim, greater likelihood to view CPS as helpful, greater support of prevention services, and greater confidence in providing help ($p < .001$). Trained teachers were also better able to respond appropriately to hypothetical cases of maltreatment ($p < .0001$) on an 8-item vignette post-test assessing identification of behavioral indicators of maltreatment, applicability of recommended action, and degree of warmth and openness. A 6-week follow-up produced no differences between groups in preventative behaviors such as reporting sexual abuse to authorities. The authors suggested that the lack of differences might have resulted from the short duration of the follow-up period.

Randolph and Gold (1994) presented Kleemeier and colleagues' (1988) 6-hour child sexual abuse prevention workshop to K-12 teachers. The workshop was altered in presentation from one 6-hour presentation to three 2-hour presentations on 3 consecutive days. Results were similar to those of the original study with training participants

significantly increasing knowledge scores ($p < .001$), and significantly differing from controls on attitudes toward sexual abuse ($p < .001$) and effectively responding to hypothetical cases of sexual abuse ($p < .001$). As the lack of long-term differences in the original study was thought to have resulted from a short follow-up period, the follow-up period was increased to 3 months. At that time, differences in reporting were observed with trained teachers having made 7 reports to the Department of Social Services compared to 0 reports made by controls. The authors suggested that increases in knowledge of sexual abuse and confidence in reporting gained through training might increase the likelihood of reporting suspected maltreatment.

Not all professional programs have been developed specifically for teachers. McCauley, Jenckes, and McNutt (2003) developed ASSERT (ask, sympathize, safety, educate, refer, treat), a 35-minute training video on interpersonal violence for professionals in hospital settings (e.g., physicians, nurses, social workers). In addition to child maltreatment, topics included elder, sexual, and domestic abuse. The video reviewed information on epidemiology, patient presentation, legal reporting requirements, and treatment options. Role-plays of ASSERT responses to presentations of interpersonal violence scenarios were also included.

As a result of the training, professionals were significantly more likely to identify physical indicators of maltreatment than at pretest ($p < .001$). Although not significant, professionals also showed improvement in knowledge of legal reporting requirements from pre-test to post-test. The authors suggest that this improvement was not significant due to professionals' previous awareness with legal reporting requirements. Attitudes

were also altered as a result of the training. Professionals reported greater comfort and less fear associated with screening patients for interpersonal violence.

The outcomes of this training program suggest brief training can serve to improve knowledge of and comfort with issues related to maltreatment reporting. Unlike many other programs, this video included a strategy for responding to presentations of child maltreatment. However specific steps in the reporting process were not reviewed. Further, although knowledge of indicators of maltreatment and attitudes were assessed, ability to respond to instances of maltreatment was not.

Certain state licensing boards (e.g., California, New York) have implemented mandatory child maltreatment training for professionals seeking licensure. Training is often available through live workshops or via the Internet. For example, Sonoma State University's website provides the required training for California via their website (www.sonoma.edu), and Access Continuing Education, Inc. (www.accesscontinuingeducation.com) offers online training to fulfill the requirements of California, Florida, New York, and Washington. These programs generally provide an overview of the indicators of maltreatment, reporting mandate, reporting procedures, and legal liability. However, the majority of these programs do not report outcome support with regard to the impact of training on knowledge or reporting behavior. Indeed, only two training programs have been evaluated in the literature, one of which is an Australian program.

The Southern Australia Education Department Mandated Notification Training program is required for employment within the State education system. The 1-day training program was developed with the intention to increase educators' awareness of

personal variables influencing responses to maltreatment, child perspective taking ability, recognition of maltreatment, and knowledge of legal reporting requirements and reporting procedures. Educators who had previously received training, recently received training, and those who were waiting to receive training were compared on a number of variables. Those in the recent and previous training groups reported significantly more confidence in their ability to recognize indicators of abuse than those who had not received training. A greater number of participants in the recent training group (93%) indicated perceived preparation to report child maltreatment than the no training group (81%), and significantly more participants in these groups indicated perceived preparation than the previous training group ($p < .001$). Awareness of reporting responsibilities was greater for trained groups than for untrained groups ($p < .05$). However, the recent training group provided significantly more appropriate responses to hypothetical situations of maltreatment than no training and previous training groups ($p < .05$), suggesting some decay in training effects over time. The effect of training on reporting behavior is less straightforward. The previous training group had made significantly more maltreatment reports compared to the no training ($p < .0001$) and recent training groups ($p < .001$). The difference in reporting behavior between the previous training and recent training groups is probably due to the extended opportunity for those who received past training to encounter maltreatment following training. However, no significant differences were reported among groups for having failed to report cases that were suspected of child maltreatment. Yet, this may reflect an inability for those without training to recognize instances of maltreatment.

In a separate publication, Hawkins and McCallum (2001b) reported participant responses to a modified version of the Crenshaw Abuse Reporting Survey (Crenshaw, Crenshaw, & Lichtenberg, 1995). Participant responses were assessed within the aforementioned study (Hawkins and McCallum; 2001a), although published separately. Participants who were presented the modified Crenshaw Abuse Reporting Survey which was comprised of 5 vignettes depicting maltreatment. No significant differences were reported among training groups (i.e., no training, recent training, previous training) for certainty or likelihood of reporting for vignettes of suspected neglect, suspected physical maltreatment, and disclosed physical maltreatment. Indeed, all groups reported a general willingness to report these scenarios. However, recent training participants were significantly more likely ($p < .001$ for both) to identify the emotional maltreatment vignette as a maltreatment scenario and reported significantly greater willingness to report than the no training ($p < .01$) or previous training groups ($p < .01$). The recent training group was also more likely to identify sexual maltreatment in vignettes ($p < .01$ for both), although groups did not differ in willingness to report.

The aforementioned results suggest training may aid professionals in identifying forms of maltreatment which otherwise may have been overlooked. Training may also aid in overcoming barriers to reporting as untrained participants were more likely to report difficulty with lack of observable evidence and identifying symptoms as impediments to reporting emotional and sexual maltreatment. In addition, untrained participants reported less of a desire to observe reporting requirements than recently trained.

The only evaluation of a national State mandated training program was conducted by Reiniger, Robison, and McHugh (1995). The Identification and Reporting of Child Abuse Maltreatment program is a prerequisite for professionals seeking licensure (e.g., psychologists, physicians, social workers, teachers, etc.; NYS Law, 1988) in New York State. Researchers mailed surveys to professionals who had completed the 2-hour course that reviews indicators of abuse, the mandate to report, procedures for reporting, legal liability, and consequences for failing to report. A total of 536 participants who had finished the training program (40% of sample) completed and returned a questionnaire assessing the degree of information learned from the training.

Results indicated that almost 90% of respondents learned something new from the information on reporting procedures and legal liabilities, with nearly 60% reporting the information as new or mostly new. With regard to information on legal responsibilities, 88% of respondents reported learning something new, with 50% reporting learning all or mostly new information. Professionals also reported learning information related to indicators of maltreatment with approximately 75% learning something new. Researchers further contrasted information related to reporting requirements and indicators of child maltreatment across professionals (psychologists, physicians, nurses, psychiatrists, teachers, optometrists, podiatrists, and chiropractors). Psychologists reported the greatest levels of previous knowledge for both areas. However, all professionals reported greater previous knowledge of indicators of maltreatment than reporting requirements. With regard to reporting requirements, psychologists, physicians, nurses, and psychiatrists reported greater previous knowledge than the sample average.

The results of this study indicate that training may be beneficial in increasing professionals' knowledge regarding child maltreatment reporting. Yet, the accuracy of these findings is unclear. The methodology implemented relied solely on participant self-report without an objective measure of knowledge. Further, responses were obtained between 5 to 20 months following training completion, which may limit accuracy due to faulty recall. In addition, only 40% of the initial sample responded to the survey increasing the possibility of sample bias.

Purpose of Present Study

Despite the legal mandate to report child maltreatment, many professionals have failed to report instances of maltreatment. The literature has extensively examined reasons professionals are failing to report and the outcome of reporting. However, the development and empirical validation of training programs has received little attention. At present, an empirically validated training program for mental health professionals does not exist, despite the specific concerns such as confidentiality and the therapeutic relationship. The purpose of the present study is to develop and empirically validate a child maltreatment reporting training program for mental health professionals and graduate students that includes these specific considerations in the curriculum. Through the utilization of standardized training workshop conditions, this study seeks to empirically validate a child maltreatment reporting training program which will increase knowledge regarding the identification of maltreatment, legal reporting requirements, reporting procedures, and methods of maintaining the therapeutic relationship when reporting.

Hypotheses

The main hypotheses for the study are as follows:

1. Participants in the child maltreatment reporting workshop condition will evidence greater improvements in knowledge of child maltreatment reporting laws than participants in the ethnic cultural consideration control condition from pre-workshop to post-workshop.
2. Participants in the child maltreatment reporting workshop condition will evidence greater accuracy in reporting intent from pre-workshop to post-workshop as compared with participants in the ethnic cultural consideration control condition.
3. Participants in the child maltreatment reporting workshop condition will evidence greater clinical management of child maltreatment reports than participants in the ethnic cultural consideration control condition from pre-workshop to post-workshop.

CHAPTER 3

METHODOLOGY

Participants

Mental health professionals with a Bachelors level degree or above, and graduate students in mental health programs (i.e., psychology, counseling, social work, educational psychology) were recruited for participation in 5 workshop offerings. Mental health professionals licensed through Nevada's Social Work, Marriage and Family Therapy, and Psychology boards received continuing education credit hours for their participation (i.e., 2.75 CEU hours). Graduate student and non-licensed participants receive a certificate of training completion.

A total of 55 participants were recruited for participation in the study. Following participation, 1 participant's information was excluded from the sample as a result of incomplete post-treatment measures. The remaining sample of 54 participants included 45 females (83.3%) and 8 males (14.8%), with 1 participant declining to provide gender information (1.9%). The sample was predominately Caucasian (75.9%), 11.1% were African American, 5.6% were Hispanic, 3.7% were Asian, 1.9% chose "other", and 1.9% did not provide racial information. Participants ranged in age from 23 to 69 years of age ($M=38.32$, $SD=11.72$). Graduate students comprised 27.8% of the sample, social workers 27.8%, therapist/counselors 25.9%, licensed psychologists 7.4%, psychological assistants 1.9%, and 1.9% did not provide their occupation information. The majority of

participants indicated that they provided services through a government agency (59.3%), with an additional 25.9% through a university, 7.4% through a community agency, 3.7% chose “other,” and 3.7% did not provide occupational setting information. Thirty had received previous training in reporting child maltreatment (55.6%), where 24 had not received previous training (44.4%).

Measures

Demographic Information

Demographic information including education, occupation, and occupational setting was assessed by a demographic questionnaire. Each participant’s gender, age, and ethnicity were also obtained (see Appendix II).

Child Maltreatment Reporting Experience Form

Given the absence of psychometrically validated measures of child maltreatment reporting, a questionnaire was developed to determine participants’ previous experience with child maltreatment reporting. To ascertain previous training in child maltreatment reporting, participants answered questions regarding quantity of previous training in child maltreatment reporting (i.e., number of trainings attended, approximate number of hours of previous training), the context of previous training (i.e., work or school requirement, interest, continuing education credits, other), and the reason for attendance (i.e., work requirement, school requirement, interest, continuing education credits, other).

Participants were also presented with questions regarding previous experience in the reporting of child maltreatment including reporting tendencies and perception of child protective services. Specifically, participants were asked whether they have reported

suspected child maltreatment as well as whether they have ever elected not to report suspected child maltreatment. Those who indicated they had previously reported were asked the “approximate number of instances of maltreatment reported to CPS,” the “approximate number of instances of maltreatment accepted by CPS,” and “in general, what was the motivating factor in your decision to report?” In addition, participants were asked to rate their “overall experience with CPS” on a 7-point Likert-type scale ranging from 1 (Extremely Negative) to 7 (Extremely Positive). Participants who reported having ever elected not to report suspected child maltreatment were queried with regard to the “approximate number of instances of maltreatment you have elected not to report,” and “in general, what was the motivating factor in your decision not to report?” Finally, participants were asked regardless of whether they have reported suspected child maltreatment, to rate their overall perception of child protective services on the aforementioned 7-point Likert-type scale (see Appendix III).

Knowledge of Child Maltreatment Reporting Laws

A psychometrically validated measure of knowledge relevant to child maltreatment reporting laws was not available at the time this study was conducted. Thus, an inventory was developed to assess participants’ knowledge of child maltreatment laws. The initial step in development involved extensive literature reviews conducted independently by 2 graduate students and reviews of Federal and Nevada State Statutes relevant to child maltreatment reporting. Two focus groups were then conducted to with the goal of developing a 15 to 20 item sample. Focus groups were facilitated by a moderator who directed the discussion and documented the process (Ritchie & Lewis, 2003). Participants were provided with copies of Federal and Nevada Revised Statutes for individual review

during focus groups to identify pertinent content (DeVellis, 2003). Content areas were then discussed to allow for refining items (Ritchie & Lewis, 2003). Participants agreed that approximately 50% of items should reflect Federal Law and 50% should reflect Nevada Statutes. Further, areas of inclusion were determined to be maltreatment definitions, reporting timelines, reporting procedures, and reporting consequences. After initial item development, a second focus group was conducted to review and refine items' wording and clarity.

Following the initial item generation through focus groups, items were reviewed by CPS to verify correct interpretation of law. Two CPS professionals independently completed items and later evaluated items for face and content validity. Items which did not result in 100% agreement between CPS professionals were discarded.

The resulting inventory is comprised of 15 items (i.e., questions) utilizing a multiple-choice response format. Four responses were provided to reduce error while maintaining parsimony (Murphy & Davidshofer, 2001). Seven items are specific to Federal Legislation and 8 items are specific to Nevada State Statutes. Item stems query participants on laws specific to child maltreatment reporting including definitions of maltreatment, mandate, reporting timeline, method of report, immunity and criminal liability (see Appendix IV).

Recognition and Intent to Report Child Maltreatment

A psychometrically validated measure of recognition and intent to report child maltreatment does not currently exist. Therefore, an inventory was developed to assess participants' ability to accurately report child maltreatment scenarios. Separate literature reviews conducted by 2 graduate students were utilized to identify indicators of child

maltreatment for review in focus groups. Participants developed the structure and format of items through investigation of existing measures and participant input (Johnston, Leung, Fielding, Tin, Ho, 2003). Items were presented through vignettes with subsequent 7-point Likert-type responses ranging from 1) Highly Unlikely to 7) Highly Likely with regard to suspicion of maltreatment and likelihood of reporting to authorities. As a result of the focus groups, an initial pool of 19 vignettes was developed with a minimum of 4 vignettes addressing each type of maltreatment (i.e., physical abuse, neglect, sexual abuse, emotional abuse), with some scenarios necessitating a mandated report, and some not necessitating a mandated report for each type of maltreatment.

The initial pool of 19 scenarios was presented in random order to two independent CPS professionals for the purpose of validation. These professionals rated whether the scenarios reflected sufficient indication of child maltreatment to warrant a report. The professionals were also asked which type of child maltreatment was reflected in each of the scenarios. Scenarios with 100% agreement between professionals were considered for inclusion in the inventory. In the event that more than the necessary two scenarios for a given maltreatment type were selected through this process, scenario inclusion was determined by random selection.

The resulting inventory is comprised of 8 child maltreatment scenarios and subsequent items assessing participants' suspicion that child maltreatment is occurring in the scenario and hypothetical intent to report child maltreatment. The child maltreatment scenarios reflect one scenario necessitating a mandated report and one scenario not necessitating a mandated report for each of the four types of child maltreatment (i.e., neglect and physical, sexual, and emotional abuse; see Appendix V).

Clinical Expertise in Reporting Child Maltreatment

The Clinical Expertise Inventory was developed to assess participants' understanding of information relevant to safeguarding the therapeutic relationship when making a report. Content was obtained by literature reviews conducted independently by 2 graduate students. This content was then reviewed in a focus group facilitated by a moderator to generate item stems and response formats. An initial sample of 20 items was generated with a multiple choice response format. Four response alternatives were provided to limit error (Murphy & Davidshofer, 2001).

Following initial sample development, two CPS professionals independently reviewed the items for accuracy and clarity. Items with 100% agreement between professionals were considered for inclusion in the inventory. Items then deemed redundant were excluded from the sample, resulting in exclusion of 5 items. The resulting inventory is comprised of 15 items utilizing a multiple-choice response format (see Appendix VI).

Course Evaluation

An evaluation of tool was utilized to assess participants' satisfaction with the training workshop condition to which they were randomly assigned. The course evaluation form presented to participants was required by the Nevada Board of Psychological Examiners and approved by the Social Work and Marriage and Family Boards. Participants were presented with 26 statements assessing multiple aspects of the workshops (e.g., classroom environment, audio-visual and handout materials, registration process). Participants responded to these statements via a 5-point Likert-type scale ranging from 1 (Poor) to 5

(Excellent). For the purpose of this study only one item assessing “overall course” was utilized (see Appendix VII).

Procedure

Mental health professionals were informed of the study through emails, flyer postings and verbal correspondence with administrators and employees in mental health clinics ($N = 4$), hospitals ($N = 2$), and government agencies ($N = 2$). Potential participants were informed of the nature and purpose of the study and encouraged to notify other mental health professionals of the study. Graduate students in mental health fields were invited to participate via emails to list-serves, flyer postings, and course announcements at a local university. Participants were directed to contact the student investigator directly to volunteer for participation in this study. Upon contact, the student investigator determined whether individuals interested in participation met criteria for the study (i.e., enrolled in a graduate program in the mental health fields or bachelor’s degree level or higher profession employed in the mental health fields for a minimum of 20 hours per week). Individuals who met criteria were scheduled to participate in the study.

Upon entering the facility, participants were instructed to complete the study informed consent, participants were instructed to complete study measures (i.e., demographic questionnaire, Child Maltreatment Reporting Experience Form, Knowledge of Child Maltreatment Laws, Recognition and Intent to Report Child Maltreatment, and Clinical Expertise in Reporting Child Maltreatment). Measures were presented to each participant in random order to minimize order effects. Subject confidentiality was protected via utilization of identification numbers (i.e., names were not recorded on study

measures). Upon random assignment, participants received their respective intervention workshops (see Workshop Conditions below).

Participants randomly assigned to the child maltreatment reporting workshop condition received training specific to child maltreatment reporting. Participants randomly assigned to the ethnic cultural considerations control condition received training specific to incorporating cultural considerations in therapy. Workshops were facilitated by graduate students enrolled in a clinical psychology doctoral program with specific knowledge in the relevant content areas. Standardized agendas and checklists were utilized to enhance fidelity.

Upon completion of the workshops, participants again completed the assessment measures (i.e., Knowledge of Child Maltreatment Laws, Recognition and Intent to Report Child Maltreatment, and Clinical Expertise in Reporting Child Maltreatment) in addition to a consumer satisfaction survey. As done previously, measures were presented in random order to minimize order effects. Graduate student participants received a certificate of completion and licensed mental health professionals received 2.75 credits of continuing education credits for participation in the study.

Workshop Conditions

Child Maltreatment Reporting Workshop

The facilitator introduced themselves to participants, and provided an agenda for the training seminar (see Appendix VIII). Recent prevalence rates of child maltreatment were presented in addition to information on legal reporting requirements as set forth by Nevada State Statutes (NRS 432b) and Federal Legislation. Next, definitions and

indicators of child maltreatment were presented. Information was then presented regarding appropriate procedures in the initiation of a child maltreatment report. The facilitator presented strategies to involve the client in the reporting process which serve to protect the therapeutic relationship.

Following the presentation of the aforementioned information, the facilitator presented a videotaped role-play scenario in which a “therapist” informs a “client” of intent to report child maltreatment, provides the “client” with options for involvement in the reporting process, and initiates a child maltreatment report to CPS. Specifically, the “therapist” informs the “client” that his/her child has disclosed an incident which has led the “therapist” to suspect child maltreatment and that a report to child protective services will be initiated. The videotape was paused and participants were informed that the following scenario would depict a differing “client” response. The videotape presentation then continued depicting the “client” responding with upset to the situation, the “therapist’s” response to the “client,” the “therapist’s” presentation of options to involve the “client” in the report, and the initiation of a report to CPS. At the conclusion of the video, participants were asked, “What did you like about the video scenario?” and “What would you do to make it fit your style?” Participants were then divided into pairs and instructed to role-play the techniques presented in the videotape utilizing a checklist, but reflecting one’s personal style. The facilitator then provided a final opportunity for questions and discussion.

Ethnic Cultural Considerations in Therapy Workshop

The facilitator introduced themselves to participants and provided an agenda for the training seminar (see Appendix IX). The facilitator presented information from published

literature emphasizing the importance of considering ethnic culture in the therapeutic process (e.g., respect for ethnic culture, knowledge of ethnic culture, interest in clients' ethnic culture), and discussed limitations involved in teaching mental health professionals to be ethnically sensitive in therapeutic situations. Participants were presented with an explanation of a behavioral approach to demonstrating cultural competence. The Semi-Structured Interview for Consideration of Ethnic Culture in Therapy Scale (SSICECTS; Donohue, Strada, Rosales, Taylor-Caldwell, Ingham, Ahmad, et al., in press) and the Consideration of Ethnic Culture in Therapy Scale (CECTS; Donohue, Strada, Rosales, Taylor-Caldwell, Ingham, Ahmad, et al., in press) were then briefly described.

The facilitator then presented a videotaped role-play scenario depicting a “therapist” instructing a “client” to complete the CECTS, conducting the SSICECTS with a “client,” and facilitating a dialogue relevant to the “client’s” ethnic culture. Following presentation of the video, the facilitator prompted discussion by asking, “How can you make this work for you?” Participants were provided with the items from the CECTS and instructed to complete the measure. Following completion of the items, participants were divided into pairs and instructed to role-play the techniques presented in the video. Participant’s experience of the role-play was discussed along with a presentation of the clinical utility of the CECTS and SSICECTS. The facilitator then provided a final opportunity for questions. Participants were then asked to complete outcome study measures relevant to the experimental condition. Finally, participants were provided a copy of the CECTS and SSICECTS for personal use as well as contact information for the student investigator, should questions have arose.

CHAPTER 4

DATA ANALYSES

Protocol Adherence

Protocol adherence was assessed utilizing percentage agreement methods (Donohue, Allen, Maurer, Ozols, & DeStephano, 2004; Donohue, Miller, Beisecker, Houser, Valdez, & Tiller, et al., 2006). Protocol checklists were utilized to obtain estimates of reliability and validity for the two training conditions. Facilitators indicated on the respective protocol checklist whether each task was performed. In addition, independent raters observed the training conditions and indicated on separate protocol checklists whether the facilitator completed each task. Independent raters were blind to the nature of the study and trained in the respective training. Protocol checklists completed by the facilitator and independent rater were compared to calculate a reliability estimate. Reliability was calculated by dividing the total number of agreements by the total number of agreements plus disagreements. The result was then multiplied by 100 to produce a percentage score. Validity estimates were determined solely by the facilitators' protocol checklist. A validity estimate was calculated by dividing the number of completed tasks by the total number of possible tasks. The result was then multiplied by 100 to produce a percentage score. A percentage agreement of 100% resulted demonstrating perfect agreement between the blind rater and the workshop presenter. Therefore, workshop presenters were assessed to implement workshop protocol as prescribed.

Equivalence of Workshop Conditions at Baseline

To determine equivalence between the experimental and control conditions prior to receipt of treatment, a series of one-way ANOVAs were conducted utilizing age and scores on pretreatment measures as dependent variables. In addition, Chi Square tests were conducted to assess equity between workshop conditions on discontinuous variables, including gender, ethnicity, occupation (e.g., graduate student, social worker, licensed psychologist), occupational setting (e.g., government agency, university), and previous training. Workshop conditions did not significantly differ at pretreatment on the aforementioned variables (all p 's $>.05$).

Knowledge of Child Maltreatment Reporting Laws

Means and Standard Deviations

To determine participants' knowledge of reporting laws, 15 multiple-choice items with one correct answer on the Knowledge of Child Maltreatment Reporting Laws inventory were scored. Participant responses were scored a "1" for a correct answer, and a "0" for an incorrect answer. Possible total scores ranged from "0" (i.e., 0% correct) to "15" (100% correct). Table 1 provides the pre- and post-test means and standard deviations for participants in both workshop conditions on the Knowledge of Child Maltreatment Reporting Laws inventory.

Psychometric Properties of Measure

As the psychometric properties of the Knowledge of Child Maltreatment Reporting Laws inventory have not previously been examined, this study investigated the internal consistency and test-retest reliability of this measure. A test of internal consistency was conducted to assess homogeneity of test items. A low Cronbach's (1951) alpha coefficient resulted (Cronbach's alpha = .18). Low internal consistency in screening measures has been suggested to indicate an appropriate implementation of a measure assessing a variance of responses (Schmitt, 1996). Similarly, heterogeneity in the laws specific to child maltreatment reporting and the few number of items contained in the inventory may explain the resulting Cronbach's alpha.

To determine the stability of the measure, test-retest reliability was calculated in subsample of 27 participants who completed the control workshop (i.e., cultural competence) which had no content relevant to the measure. These participants completed the measure prior to and directly following the completion of the 2 hour workshop. The results suggested very good stability in test scores ($r = .88, p < .01$), and thus stability across administration (DeVellis, 2003).

Response to Training

To evaluate the hypothesis that participants in the experimental condition would evidence greater improvements in knowledge of child maltreatment reporting laws than participants in the control condition from pre-workshop to post-workshop, a 2 x 2 repeated measures analysis of variance (ANOVA) was conducted. Workshop condition (i.e., child maltreatment reporting, cultural competence) served as the independent variable, where the variable of time (i.e., Knowledge Scale scores) served as the

dependent variable. A statistically significant interaction of Workshop x Time resulted: $F(1,52) = 21.01, p < .01$, where participants who received the experimental workshop condition evidenced greater improvements at post-test. Thus, results would indicate that the training provided in child maltreatment reporting led to greater improvement in knowledge of child maltreatment reporting laws than training in cultural competence.

Recognition of Child Maltreatment

Means and Standard Deviations

To assess participants' accuracy in recognizing child maltreatment, the Recognition and Intent to Report Child Maltreatment measure utilized 8 items. Items provided participants with a 7-point Likert-type scale to indicate their likelihood of reporting scenarios determined by CPS to be either reportable or non-reportable. Greater scores indicated a greater likelihood of making a report. For scenarios depicting reportable child maltreatment as determined by CPS, greater scores reflected greater accuracy. For scenarios which were determined by CPS to reflect non-reportable incidents, greater scores reflected lesser accuracy. Thus, for ease of analysis and interpretation, reverse scoring was utilized for non-reportable scenarios. As a result, lower scores for all items indicated greater accuracy in intent to report child maltreatment. Possible total scores ranged from 0 (i.e., 100% agreement with CPS), to 48 (i.e., 0% agreement with CPS). Table 1 provides the means and standard deviations for both workshop conditions at pre- and post-test.

Psychometric Properties of Measure

As the psychometric properties of the Recognition and Intent to Report Child Maltreatment inventory have not previously been examined, this study investigated the internal consistency and test-retest reliability of this measure. A test of internal consistency was conducted to assess homogeneity of test items. A low Cronbach's (1951) alpha coefficient resulted (Cronbach's alpha = .10). Low internal consistency in screening measures has been suggested to indicate an appropriate implementation of a brief measure to assess multiple areas (Schmitt, 1996).

To determine the stability of the measure, test-retest reliability was calculated in subsample of 27 participants who completed the control workshop (i.e., cultural competence) which had no content relevant to the measure. These participants completed the measure prior to and directly following the completion of the 2 hour workshop. The resulting test-retest reliability was acceptable ($r = .88, p < .01$), and thus the measure evidenced adequate stability across administration (DeVellis, 2003).

Response to Training

To evaluate the hypothesis that participants in the child maltreatment reporting workshop condition would evidence greater recognition of child maltreatment than participants in the ethnic cultural consideration control condition from pre-workshop to post-workshop, a 2 x 2 repeated measures analysis of variance (ANOVA) was conducted. Workshop condition (i.e., child maltreatment reporting, cultural competence) served as the independent variable, where the variable of time (i.e., pre-test to post-test) served as the dependent variable. A statistically significant interaction of Workshop x Time resulted: $F(1, 52) = 4.73, p < .05$, where participants who received the experimental

workshop condition evidenced greater improvements at post-test than participants who received the control workshop condition. Thus, results would indicate that the training provided in child maltreatment reporting workshop led to greater improvement in accuracy of reporting child maltreatment scenarios than training in cultural competence.

Clinical Expertise in Reporting Child Maltreatment

Means and Standard Deviations

To examine participants' clinical management in reporting child maltreatment, the Clinical Expertise in Reporting Child Maltreatment inventory was utilized. Participants' responses to 15 multiple-choice items with one correct answer were scored. Participant responses were scored a "1" for a correct answer, and a "0" for an incorrect answer. Possible total scores ranged from "0" (i.e., 0% correct) to "15" (100% correct). Table 1 provides the pre- and post-test means and standard deviations for both workshop conditions on the Clinical Expertise in Reporting Child Maltreatment inventory.

Psychometric Properties of Measure

As the psychometric properties of the Clinical Expertise in Reporting Child Maltreatment inventory have not previously been examined, this study investigated the internal consistency and test-retest reliability of this measure. A test of internal consistency was conducted to assess homogeneity of test items. A low Cronbach's (1951) alpha coefficient resulted (Cronbach's alpha = .00). Low Cronbach's alpha coefficients in screening measures have been suggested to reflect assessment of multiple areas (Schmitt, 1996).

To determine the stability of the measure, test-retest reliability was calculated in a subsample of 27 participants who completed the control workshop (i.e., cultural competence) which had no content relevant to the measure. These participants completed the measure prior to and directly following the completion of the 2 hour workshop. The resulting test-retest reliability was excellent ($r = .92, p < .01$), and thus the measure evidenced stability across administration (DeVellis, 2003).

Response to Training

To evaluate the hypothesis that participants in the child maltreatment reporting workshop condition would evidence greater clinical management of child maltreatment reports than participants in the cultural consideration control condition from pre-workshop to post-workshop, a 2 x 2 repeated measures analysis of variance (ANOVA) was conducted. Workshop condition (i.e., child maltreatment reporting, cultural competence) served as the independent variable, where the variable of time (i.e., pre-test to post-test) served as the dependent variable. A statistically significant interaction of Workshop x Time resulted: $F(1, 52) = 41.82, p < .01$, where participants who received the experimental workshop condition evidenced greater improvements at post-test than participants who received the control workshop condition. Thus, results would indicate that the training provided in child maltreatment reporting workshop led to greater improvement in clinical management of child maltreatment reporting than training in cultural competence.

Course Evaluation

To assess participants' evaluation of the workshop conditions, means and standard deviations were calculated from an item assessing "overall course" on the course evaluation form. A total of 14 participants (50%) randomly assigned to the child maltreatment reporting workshop completed the course evaluation item. Their mean evaluation score was 4.86 (SD = .53). A total of 16 participants (57%) randomly assigned to the cultural competence workshop completed the course evaluation item. Their mean evaluation score was 4.63 (SD = .50). Possible responses ranged from "1" to "5" where 1 = Poor, and 5 = Excellent. Comparisons on these mean scores between workshop conditions were not significantly different ($p < .05$). Thus, both workshops were favorably evaluated by participants.

CHAPTER 5

DISCUSSION

Most mental health professionals will experience a clinical case that requires them to report child maltreatment. However, professionals mandated to report child maltreatment often lack knowledge in child maltreatment reporting laws (Besharov, 1994), skill in accurately identifying child maltreatment (Hawkins & McCallum, 2001b; Tiltan, 1994), and clinical expertise in managing reporting procedures with clients (Bromley & Riolo, 1988; Steinberg, Doucek, & Levine, 1997; Weinstein et al., 2001).

The development of training programs for professionals has been recommended by investigators in the literature to address the problem of reporting inaccuracy (Besharov, 1988; Faller, 1985; Kalichman, 1999). However, training programs targeting mandated reporting methods in mental health professions have yet to be evaluated in randomized controlled trials. Therefore, the current study sought to develop a training program specific to mandated child maltreatment reporting for mental health professionals. This study was chiefly conducted to evaluate the efficacy of this program relative to a control group. Training was designed to 1) increase participants' knowledge of child maltreatment reporting laws, 2) improve accuracy of reporting child maltreatment, and 3) improve clinical management of child maltreatment reports.

Knowledge of Child Maltreatment Laws

As expected, participants in the child maltreatment reporting workshop demonstrated significant improvement in knowledge of child maltreatment reporting laws as compared to participants in the cultural competence workshop. Previously, Hazzard (1984) reported significant improvements in teachers' knowledge of reporting child maltreatment. However, the extent to which these improvements were relevant to knowledge of child maltreatment laws was indiscernible. McCauley, Jenckes, and McNutt (2003) did not find significant improvements in knowledge of reporting laws following training with teachers. The results of these studies may have been compromised due to an absence of a validated measure of child maltreatment laws. Although this was not as much an issue in the present study, the utilized measure of laws in this study warrants full psychometric evaluation, particularly in regards to its validity.

Recognition of Child Maltreatment

Participants in the child maltreatment reporting workshop demonstrated significant improvement in accuracy of recognition of child maltreatment as compared to participants in the cultural competence workshop. Previous trainings provided to teachers have also evidenced improvement in recognition of child maltreatment with regard to response to hypothetical cases of child maltreatment (Hawkins & McCallum, 2001a; Kleemeier, et al., 1988). Similarly, physicians, nurses and social workers who received training in a study by Mc Cauley, Jenckes, and McNutt (2003) were found to be significantly more likely to identify physical indicators of maltreatment. However, unlike previous studies, the current study assessed accuracy in correctly distinguishing scenarios

necessitating a report from those not warranting a report. Accuracy in distinguishing reportable from non-reportable scenarios theoretically reflects an ability to recognize and appropriately respond to instances of child maltreatment. This is a significant improvement over previous studies which have generally focused on identification of child maltreatment or indicators of abuse in reportable scenarios. As results were examined through the use of simulated scenarios, it is unclear as to what extent this training would impact actual reporting behavior by mental health professionals. However, it should be mentioned, Donohue and colleagues (2002) showed changes in reporting behavior following training in a controlled study of this approach. Reporting accuracy is further supported in the current study through the initial validation of the Recognition and Intent to Report Child Maltreatment measure, including systematic development of the measure through an extensive literature review, utilization of focus groups for item development, and validation by CPS experts support face and content validity. In addition, adequate test-retest reliability was evidenced.

Clinical Expertise in Reporting Child Maltreatment

As expected, significant increases in clinical expertise were evidenced for participants in the child maltreatment workshop compared with participants in the cultural competence workshop. Thus, following training, participants in the child maltreatment reporting workshop demonstrated greater understanding of methods for safeguarding the therapeutic relationship, and including the client in the reporting process when appropriate. Indeed, this is the first randomized controlled study to examine clinical expertise as a component of training in child maltreatment reporting. Most other studies

have emphasized reporting laws and/or recognition of maltreatment, while failing to address methods for making diplomatic and effective reports. Only one other study has addressed clinical expertise in teaching mental health professionals to report child maltreatment (Donohue, et al., 2002). Utilizing a controlled, multiple baseline methodology, a participant was able to demonstrate utilization of clinical skills consequent to training in behavioral assessment and child maltreatment reporting. The initial results of the current study provide support for dissemination of these skills in a cost-effective workshop format. Findings are further supported by face and content validity of the Clinical Expertise in Reporting Child Maltreatment measure resulting from development utilizing an extensive literature review, focus group development of items, and validation by CPS experts. Further, an examination of the measure evidenced excellent test-retest reliability.

Limitations and Future Implications

This study represents the first randomized controlled evaluation of a method of training mental health professionals to report child maltreatment which includes training in the areas of reporting laws, accuracy in maltreatment recognition, and methods of conducting a report by which the therapeutic relationship is safeguarded. However, the interpretation of these findings is not without limitations. The sample utilized in this study, although diverse, was selected from a single community, limiting generalizability of findings. Further, limits in the sample size did not permit examination of the degree to which level of training (e.g., graduate student, master's level professional, doctorate level professional) or professional background (e.g., psychology, social work) may have

influenced study results. An investigation of which subgroups are most likely to benefit from this training program would assist in parsimoniously determining target groups for training.

Training, for the most part, was developed based on issues relevant to Federal Law (e.g., mandate to report, immunity). However, State law per use in this training program was adapted from the State of Nevada. Although, the majority of these State laws are consistent with other states, there may be some areas which require alteration of workshop content. Therefore, it is recommended that the training protocol be reviewed by legal staff when considering this program in other states. Along a different vein, despite high course evaluation ratings in this study for both experimental training formats, it is important to note that the evaluation questions utilized were copied on the front and back pages of the questionnaire, and many of the participants failed to complete the back side of the evaluation. It is likely these participants overlooked the second page, making it difficult to draw conclusions from the results of this measure.

Future Directions

Despite the aforementioned limitations, the implications of this study are promising. As this training is conducted in a 2-hour workshop format, it is both practical and cost effective. The method of presentation through power point presentation may easily be incorporated into graduate coursework, or presented at a staff or professional association meeting. Training could easily be presented to new workers in the mental health field, or to assist professionals in continuing education credits. The presentation may also be provided online to facilitate access by those in rural areas or for individuals seeking self-guided training. Additionally, as the workshop is organized by content area, the training

could meet specific training needs through selective administration of content as deemed necessary through assessment or recommendations by employers. Regardless of the method of presentation, through implementation of this training program, mental health professionals will likely enhance their decision-making in responding to instances of child maltreatment, thereby limiting the long-term negative consequences of child maltreatment.

Table 1.

Means and Standard Deviations of Pre-Test and Post-Test Scores and Workshop by Time Interactions Relevant to Reporting Laws, Recognition of Child Maltreatment, and Clinical Expertise (N=54).

Measure Workshop	Pre-Test		Post-Test		Interaction		
	Mean	SD	Mean	SD	F	DV	P
Reporting Laws [†]					21.01	1,52	.000
Child Maltreatment	12.11	1.58	13.93	1.54			
Cultural Considerations	12.15	1.32	12.15	1.38			
Recognition of Maltreatment ^{††}					4.73	1,52	.034
Child Maltreatment	15.37	4.53	13.67	4.57			
Cultural Considerations	16.48	4.20	16.96	4.72			
Clinical Expertise [†]					41.82	1,52	.000
Child Maltreatment	10.19	1.98	13.26	2.85			
Cultural Considerations	10.04	1.51	10.26	1.65			

[†]Greater scores indicate greater knowledge

^{††}Lesser scores indicate greater knowledge

APPENDIX I

CHILD MALTREATMENT REPORTING CHECKLIST

Skills Involved in the Initiation of the Child Abuse Reporting Process with Nonperpetrating Caregivers

1. Excuse everyone but caregiver.
2. Indicate that it is important to talk to caregiver privately about (suspected maltreatment)
3. Inform abuse is suspected.
4. Inform why abuse is suspected.
5. State that it is law to report suspected child abuse.
6. Indicate that report must be submitted within 24 hours to Child Protective Services (CPS).
7. State that your position is not to determine whether or not abuse has occurred.
8. State that CPS may conduct an investigation to determine whether or not abuse occurred.
9. State that report may not be accepted if there is incomplete information or failure of incident to meet abuse criteria.
10. State that CPS may accept report but not investigate.
11. State that if report is accepted, CPS may conduct an investigation of child maltreatment with other involved persons.
12. State that CPS may go to the child's school or home for interview.
13. Advise caregiver to be cooperative and respectful with CPS investigator.
14. State that caregiver may be present during call to CPS.
15. State that caregiver may speak privately with CPS after you make the report.
16. State that caregiver may speak with CPS after you make the report, in your presence.
17. State that the caregiver has an option not to be involved in the report.
18. Ask how caregiver would like to be involved in the report, if at all.
19. Tell caregiver to call CPS if any questions or concerns arise.
20. Ask if additional information should be included in the report.
21. Ask how report will be disclosed to perpetrator, if at all.
22. Ask how the perpetrator will respond to report and possibly investigation.
23. Ask how each person in home will respond to report and possibly investigation.
24. Assess safety of each person living in the home.
25. Confirm caregiver's statement that each person will be safe and/or initiate safety precautions.

26. State that a follow-up call will be made by professional.
27. Establish safety codes with patient to be used at time of follow-up call.
28. Ask the caregiver if there is anything else that can be done.
29. State that call to CPS will be initiated.

Skills Involved in Resolving Upset of
Nonperpetrating Caregivers in the Child Abuse Reporting Process

1. Do not attribute blame throughout the interaction.
2. Make an empathetic statement.
3. Assess concerns of caregiver (e.g., “What are you concerned about?”).
4. Solicit potential solutions from caregiver (e.g., “What can I do to help?”).
5. State concern for at least one of the family members (other than the child).
6. State concern for the child suspected of abuse.
7. Acknowledge caregiver cares about child (e.g., “You want what’s best for your child”).
8. State that the report may not be accepted.
9. State that the caregiver may be present during the report.

APPENDIX II

DEMOGRAPHICS

Please answer the questions below. The information you provide will be coded numerically and will in no way be associated with you. 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
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APPENDIX III

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. 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 2 3 4 5 6 7
Extremely Unbeneficial Neutral Extremely Beneficial

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

1 2 3 4 5 6 7
Extremely Unenjoyable Neutral 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 IV

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 V

RECOGNITION AND INTENT TO REPORT 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.

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 #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 VI

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 VII

COURSE EVALUATION

Course Title _____
Sponsoring Organization _____
Location _____
Instructor(s) _____
Date(s) _____

Number of Approved _____ Your Professional/Job Title _____
CEU Contact Hours _____

Please answer all of the following questions to evaluate the quality of course content, instructional methods and materials, classroom environment, registration process and achievement of instructional objectives.

Rate the following on a 1-5 scale where:

1 = Poor 2 = Fair 3 = Average 4 = Above Average 5 = Excellent

CLASSROOM ENVIRONMENT

Circle One

1 2 3 4 5 Physical facilities were appropriate for course presentation

1 2 3 4 5 Accessible, hassle-free parking

1 2 3 4 5 Overall classroom environment

Comments: _____

AUDIO-VISUAL AND HANDOUT MATERIALS

Circle One

1 2 3 4 5 Materials used were practical

1 2 3 4 5 Relevant to course

1 2 3 4 5 Well organized and completed

1 2 3 4 5 Overall audio-visual and handout materials

Comments: _____

REGISTRATION PROCESS

Circle One

- 1 2 3 4 5 Organized and efficient
- 1 2 3 4 5 Helpful and considerate staff
- 1 2 3 4 5 Overall registration process

Comments: _____

REGISTRATION FORM

Circle One

- 1 2 3 4 5 Easy to complete
- 1 2 3 4 5 Understandable
- 1 2 3 4 5 Overall registration form

Comments: _____

COURSE CURRICULUM CONTENT

Circle One

- 1 2 3 4 5 Met stated objectives
- 1 2 3 4 5 Increased professional knowledge and skill
- 1 2 3 4 5 Was the right length
- 1 2 3 4 5 Syllabi materials/handouts were available
- 1 2 3 4 5 Would recommend this course to others

Comments: _____

INSTRUCTIONAL METHODS

Circle One

- 1 2 3 4 5 Course was presented in a well-prepared/organized and effective fashion
- 1 2 3 4 5 Instructor was knowledgeable and skilled in the content area
- 1 2 3 4 5 Educational materials and instruction were comprehensible
- 1 2 3 4 5 Course objectives, learning methods and evaluation requirements were made clear
- 1 2 3 4 5 Would enroll in another course taught by the instructor
- 1 2 3 4 5 Overall instructional methods

Comments: _____

ACHIEVEMENT OF INSTRUCTIONAL OBJECTIVES

Circle One

1 2 3 4 5 Instructional objectives were met

Comments: _____

PROGRAM

Circle One

1 2 3 4 5 Overall course

Comments: _____

APPENDIX VIII

CHILD MALTREATMENT REPORTING WORKSHOP

- I. Facilitator introduction**
- II. Training agenda**
- III. Child maltreatment statistics**
- IV. Legal Requirements**
 - a. Mandate (NRS 432b.220)
 - i. Confidentiality privilege (NRS 432b.250)
 - b. Suspicion (NRS 432b.121)
 - c. Immunity (NRS 432b.160)
 - i. Good faith clause (NRS 432b.160)
 - d. Criminal Liability (NRS 432b.240)
 - e. Documentation
- V. Identification**
 - a. Child Maltreatment Definitions
 - i. Physical abuse (NRS 432b.090)
 - ii. Sexual abuse (NRS 432b.100)
 - iii. Sexual exploitation (NRS 432b.110)
 - iv. Negligent treatment (NRS 432b.140)
 - v. Mental injury (NRS 432b.070)
 - b. Child Maltreatment Indicators
 - i. Physical abuse
 - ii. Sexual abuse
 - iii. Neglect
 - iv. Psychological/Emotional abuse
 - c. Consultation
 - i. Colleagues
 - ii. CPS
- VI. Reporting Procedures**
 - a. Verbal report procedure (NRS 432b.200)
 - b. Timetable for reporting (NRS 432b.220)
 - c. Report contents (NRS 432b.230)
- VII. Client Involvement**
 - a. Informed consent/Limits of confidentiality
 - b. Report initiation
 - i. Informing client of intent to report
 - 1. Donohue, et al. (2002) checklist

- ii. Providing client with options for report initiation
 - iii. Considerations for perpetrating caregivers
 - c. CPS process
 - i. Screening
 - ii. Investigation
 - iii. Substantiation
 - iv. Service Provision
 - 1. Voluntary
 - 2. Mandated
 - v. Child Placement
 - 1. Adoption Assistance and Child Welfare Reform Act
 - 2. Temporary placement
 - 3. Permanent placement
 - vi. Prosecution
 - 1. Statistics

VIII. Videotaped role-play

- a. Intent to report
- b. Client involvement
- c. Report initiation

IX. Participant role-play of client involvement

- a. Intent to report
- b. Client involvement
- c. Report initiation

X. Final discussion and questions

XI. Participant completion of measures

XII. Supplemental material

- a. Donohue, et al. (2002) checklist
- b. Reporting hotline contact information
- c. Student investigator contact information

APPENDIX VI

ETHNIC CULTURAL CONSIDERATIONS IN THERAPY WORKSHOP

- I. Facilitator introduction**
- II. Training agenda**
- III. Review of relevant literature**
 - a. Techniques for incorporating ethnic culture in therapy
- IV. Solicitation of previous training experiences**
 - a. Previous training
 - b. Limitations
- V. Description of intervention**
 - a. CECTS (Donohue, et al., in press)
 - b. SSICECTS (Donohue, et al., in press)
- VI. Videotaped role-play**
 - a. CECTS completion role-played
 - b. SSICECTS utilization role-played
 - c. Discussion
- VII. Participant completion of items**
 - a. CECTS
- VIII. Participant role-play**
 - a. CECTS completion role-played
 - b. SSICECTS utilization role-played
- IX. Discussion of role-play**
 - a. Previous study results (Donohue, et al., in press)
 - b. Participant experience
- X. Participant completion of outcome study measures**
- XI. Supplemental material**
 - a. CECTS
 - b. Student investigator contact information

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