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CHILD SEXUAL ABUSE CASES

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ABSTRACT

PROFESSIONAL JUDGMENTS RELATED TO
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Professionals are required by law to report all cases of suspected child sexual abuse. Previous research suggests that professionals tend to underreport sexual abuse. This two-part study was designed to understand factors that influence clinical decision-making related to reporting suspicions of child sexual abuse to the authorities.

In the first part of this study, six hundred forty four doctoral level pediatric psychologists were surveyed. Two hundred sixty nine returned completed surveys, representing a forty two per cent response rate. Subjects were presented with four vignettes which contained clinical presentations of child sexual abuse that systematically varied according to symptom specificity.

It was found that respondents were more likely to suspect and report abuse when symptom presentation was more versus less specific. There was more variability in professional judgments about suspicion and reporting child abuse when symptom presentation was less versus more specific. Clinical suspicion of sexual abuse did not necessarily lead to reporting, especially when symptom presentation was less specific. There was strong agreement among psychologists about their reasons for reporting their suspicions of abuse to the authorities. However, there was less

consensus among clinicians about the reasons that contribute to a clinical decision not to report child abuse. Female psychologists were more likely than male psychologists to suspect and report abuse at all levels of symptom specificity. Specialized training and experience in sexual abuse did not influence reporting behavior in this sample.

In the second part of this study, six sexual abuse experts were interviewed regarding their clinical opinions and behavior regarding reporting cases of sexual abuse. There was considerable agreement among the experts about the factors that would lead them to report abuse to the authorities one hundred per cent of the time. However, when clinical presentation is less specific, sexual abuse experts appear to use a fair amount of clinical discretion in their decision of whether and when to report sexual abuse to the authorities. This information was used to understand the survey findings and to suggest future avenues of research.

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INTRODUCTION

Child abuse reporting laws exist in every state of the union. These laws require professionals to report all cases of suspected child abuse. Legal charges can be imposed on professionals who fail to report cases of suspected abuse. Sexual abuse is a common form of child abuse, and is reportable under the existing laws. It can be difficult to diagnose because of the secrecy which accompanies sexual abuse and because sexually abused children often present with diffuse, nonspecific symptomatology. Sexual abuse is a serious social and mental health problem, which presents potential ethical, legal, and practical dilemmas for professionals, including psychologists.

Two approaches were utilized to add to knowledge regarding professional practices related to sexual abuse of children. First, a systematic survey study of pediatric psychologists was conducted. The objective of this survey study was to better understand how psychologists interpret presentations of sexual abuse in an evaluation setting. They were presented with clinical vignettes varying in symptom specificity, and were asked to indicate under what circumstances they would choose to report suspected abuse to the authorities. Second, a panel of sexual abuse experts was interviewed regarding professional thinking and practices to further illuminate state of the art thinking in this emerging and challenging area of professional concern.

LITERATURE REVIEW

Child Abuse Reporting Laws

History and Philosophy. Child abuse reporting laws are based on the concept that parents' interests and rights are not always coextensive with those of their children (Racusin, 1986). This concept found its legal precedent in seventeenth century England in the doctrine of parens patriae. The English courts ruled that parents' authority over their children emanated from the state (Fraser, 1976). For the first time, it was determined that the state had the ultimate authority over children and could revoke parental rights when there were overriding societal interests.

Until recently, child abuse protection laws in the United States were ineffectual and poorly enforced. In a 1962 conference on the "battered child syndrome," C. Henry Kempe and his colleagues brought the topic of child abuse into the public and political limelight (Radbill, 1980). In 1963, the Children's Bureau of the Department of Health, Education, and Welfare developed a model child abuse reporting law with the following features: a) Professionals should be expected to report all cases of suspected child abuse. b) Procedures for reporting should be clearly outlined. c) Professional reporters should be immune from liability. d) Patient privilege should not be grounds for excluding evidence. e) Anyone who does not report cases of suspected abuse should be charged with a misdemeanor (Silver et al, 1967). Within five years, all states had

enacted child abuse reporting laws which were generally based on these criteria.

To encourage compliance with mandated reporting laws, all states provide mandated reporters with immunity from liability for reports made in good faith. Most states have also added deterrents for disobeying the law. Forty-five states have a criminal penalty for willful failure to report suspected cases of child abuse (Saulsbury and Campbell, 1985).

Implications for Professionals. Prosecution of mandated reporters for failure to report suspected child abuse is a new and real concern. Diesenhouse (1988) reported that Massachusetts has begun legal proceedings in its first prosecution of a mandated reporter for failing to report suspected abuse. While this particular case involves school authorities, psychologists have been been charged in other states. Denton (1987) cited a case in which a California psychologist was charged with failure to report suspected abuse and neglect. Another case against a limited license psychologist in Michigan for failure to report suspected child abuse resulted in an extended legal battle. The psychologist's defense was that the reporting threshold (a reasonable cause to suspect) was vague and not objective, and he was found not guilty (Kavanaugh, 1989).

It is a common complaint among professionals that reporting thresholds as defined by the laws are completely subjective, and difficult to define. Other complaints by professionals charge that the laws are not specific enough about what behaviors constitute neglect or abuse (Kavanaugh, 1988; Misener, 1986; Faller, 1985). Faller, (1985) describes other dilemmas facing professionals when they consider reporting a case to the authorities. She notes that clinicians worry about the impact of reporting on the client-therapist relationship. She suggests that the

client may reach out to a professional for help and that the professional may provide a lifeline for the family. However, when the professional is obligated to report abuse, the formation of a trusting relationship with the family may be difficult and that the family may not "open up" in therapy. Kavanaugh (1988) agrees with Faller that mandated reporting laws involve an invasion of privacy and directly impact on issues of confidentiality in therapy. Kavanaugh suggests that most people would not enter therapy if they believed their therapists would report them to a state agency.

Other professionals feel that mandated reporting laws are protective of children and professionals. Koocher (1989) suggests that reporting laws are advantageous for the professional. He points out that psychologists do not have the legal authority to investigate or intervene in cases of child abuse. He acknowledges that reporting suspected abuse may anger a family but that disruption of the client-therapist relationship is not inevitable. Koocher points out that protection of the child is of utmost importance and that this duty is assigned to the state. Harper and Irvin (1985) concur that the filing of a child abuse report does not inevitably disrupt the therapeutic relationship or interfere with therapeutic goals.

The American Psychological Association is aware of the pressing legal and ethical dilemmas facing psychologists in the area of mandated reporting laws. It has formed the Child Abuse Policy Project to help formulate professional policy on issues related to child abuse. In a recent memo to APA division presidents, Lenore Walker (1988), the Project Chair, outlined the mission of the project and stated the need to

accumulate information on how psychologists respond to state child abuse reporting statutes.

Research Findings: Denton (1987) states that mental health professionals commonly fail to report suspected child abuse. Anecdotal evidence exists to support these claims, however there is little research on professional compliance with mandated reporting laws. A 1981 national incidence study cited by Faller (1985) reportedly found that mandated professionals only report one-fifth of the cases in which they suspect child abuse. Research findings on professionals' knowledge of and compliance with child abuse reporting laws will be reviewed.

There is a body of research which studies physicians' reporting behavior. In a dated study, Silver et al (1967) polled physicians about their knowledge of the "battered child syndrome" (Kempe et al, 1962) and their attitudes about reporting child abuse. Of the two hundred physicians polled, almost one fourth indicated he or she would not report a case of suspected abuse even if provided with legal protection against liability. The physicians in this study demonstrated lack of knowledge about the "battered child syndrome" and reporting procedures. One of the major impediments to reporting cited by the physicians was concern that their evidence would not stand up in a court of law.

A more recent study of professional reporting behavior suggests that physicians have become more informed about child abuse reporting laws and may be more likely to report when they suspect child abuse. Saulsbury and Campbell (1985) surveyed three hundred seven physicians who see pediatric patients in their practice. A large portion of these physicians had not detected or reported child abuse in the previous year. Most of these physicians indicated that they felt they were very likely to report all

cases of physical and sexual abuse they encounter in their work. Significantly fewer respondents felt they were likely to report all cases of neglect. The two most common reasons for not reporting were the reluctance to report before diagnosis is certain, and the belief that the respondent could work with the family to solve the problem outside of the legal system.

While most physicians may report identified child abuse as suggested by the Saulsbury and Campbell study, there is evidence to suggest that child abuse is frequently overlooked in medical settings. Kim (1986) surveyed one hundred twenty physicians who were involved in pediatric practice about their reporting behavior in the past six months. Kim found that physicians rarely detected or reported child abuse in their practice. Physicians in this study felt the following factors negatively influenced reporting behavior: lack of adequate information regarding reporting procedures, the inability of protective services to help children, and the risk to physicians in terms of time and prestige of getting involved in possible court proceedings. Sexual abuse, which is a particularly difficult form of child abuse to identify, is frequently overlooked in medical settings due to lack of knowledge about clinical presentation and misinterpretation of symptoms by physicians (Brant and Tisza, 1977; Hunter et al., 1985).

The above research suggests that physicians are knowledgeable about child abuse reporting laws and over the years have become more willing to report child abuse, but may be slow to identify cases of abuse. Research which looks at mental health professionals (Attias and Goodwin, 1985), found that they were also well-informed about child abuse reporting laws. They surveyed pediatricians, psychiatrists, psychologists, and family

counselors about their knowledge of child abuse reporting laws. Of the one hundred eight respondents, they found that 98% were aware of their obligation to report cases of incest to the authorities. In an earlier study, Swoboda et al. (1978) surveyed ninety-eight mental health practitioners including: 22 psychiatrists (M.D.), 31 psychologists (Ed.D/Ph.D), 35 social workers (MSW), and 10 case workers (B.A.). They found that over four-fifths of the practitioners were knowledgeable about child abuse reporting laws. Kalichman et al (1989) surveyed psychologists and found that the majority were aware of mandatory child abuse reporting laws. These studies suggest that the majority of clinicians are aware of their professional obligation to report child abuse.

Knowledge of child abuse reporting laws did not necessarily lead to reporting behavior in physicians. Is this also true among mental health clinicians? In the study cited above, Attias and Goodwin (1985) presented mental health professionals with a case history in which an eleven year old girl vividly described to her school counselor two years of on-going sexual activity between herself and her father. The respondents were asked to imagine that the case was referred to them for further evaluation and that during the evaluation the girl retracted her previous statements about the incest. The respondents were asked whether they would report this case to protective services. Despite the fact that retraction is a common phenomenon in sexually abused children, one-half of the psychiatrists and one-third of the other professionals stated that they would not report this case to the authorities. No information is offered about their reasons for not reporting.

It is especially unclear if nonreporting occurred because there was no suspicion of child abuse or because there was noncompliance with child

abuse reporting laws. This is an important distinction, and has far-reaching ramifications in the interpretation of professional nonreporting behavior. If lack of clinical suspicion is the major cause for nonreporting then one can assume there are individual or professional deficits in the ability to detect child abuse. If this is the case then further education or research might be necessary to heighten our clinical expertise. However, if professionals are intentionally defying the law, then nonreporting can be interpreted as an act of civil disobedience. If this is the case then it is necessary to understand why professionals are defying the law. Steps to either change the laws or educate professionals about the necessity of obeying the laws would be indicated.

There is some research which suggests that suspicion of sexual abuse alone is not considered sufficient cause for some professionals to report child abuse. Kalichman, Craig, and Follingstad (1989) surveyed two hundred seventy nine licensed psychologists using controlled clinical vignettes to study child abuse reporting behavior. They found that all psychologists indicated some suspicion of child abuse after reading the vignette, yet relatively few felt they would definitely report their suspicions to the authorities.

It is possible that clinicians do not make a black or white determination of whether they suspect abuse. Instead, suspicion of child abuse might be viewed by clinicians as existing on a continuum from high to low suspicion. If this were the case, the decision to report would be complicated by the need to determine what would constitute a reportable threshold of suspicion. The clinical decision would no longer be based simply on the absence or presence of a suspicion. There have been no studies which directly address this question. There are several studies

which appear to support the theory that clinicians rely on an accumulation of clinical "evidence" to reach what they consider to be a reportable threshold of suspicion. Kalichman et al (1989) found that psychologists were more likely to make a decision to report abuse if the father in the vignette admitted rather than denied having abused his child. It is possible that the father's admission of abuse was seen by respondents as additional evidence of abuse which intensified their level of clinical suspicion and led to increased reporting. However, it could be that clinicians reported more because they felt that the family would be more cooperative with the authorities given the father's admission of abuse.

In another related study, Kalichman et al (1988) surveyed one hundred one community mental health clinicians. In each vignette, a disclosure of abuse is made by the child to a teacher. The teacher refers the child for an abuse evaluation and relays the disclosure to the evaluator. Therefore according to the researchers, every vignette provides reasonable cause to suspect child abuse. However, respondents were more likely to report suspected abuse to the authorities when the child made a direct disclosure of abuse during the subsequent clinical interview than when the child became highly emotional and did not disclose abuse during the evaluation. One interpretation of these results is that clinicians are more likely to report abuse when they have a direct disclosure of abuse from a child because this heightens their of suspicion of abuse. It is also possible that the clinicians experienced no change in level of suspicion but instead became more fearful of legal repercussions for not reporting when there was a direct disclosure.

It is not entirely clear what role clinical suspicion plays in the decision to report abuse. This is an essential piece of information since

reporting laws require reporting based on suspicion. Since child abuse laws use such a low threshold of suspicion, there is no legal ground for clinical discretion in reporting. Further research on this topic is necessary.

There are many other factors that might impact reporting behavior. These other factors can be loosely categorized as clinician variables (i.e. gender, professional training, sexual abuse experience), clinician beliefs about reporting (i.e. reporting causes families to flee from therapy, reporting is unethical because it constitutes a breech of client/therapist confidentiality, reporting is unnecessary as long as the family remains in treatment), clinician beliefs about protective services (i.e. protective services is harmful not helpful, protective services will screen out report due to lack of evidence), victim variables (i.e. gender, age), perpetrator variables (i.e. age, gender, relationship to victim), abuse variables (i.e. physical vs. sexual abuse, duration of abuse, intensity of abuse), and clinical presentation of abuse variables (i.e. directness of disclosure, symptom presentation, family reaction to disclosure). Researchers have begun to look at some of these factors.

Attias and Goodwin (1985) found significant differences in reporting behavior between male and female clinicians. They found that seventy nine percent of female professionals indicated they would report incest even when the child retracted, compared to sixty two percent of male professionals. Attias and Goodwin found that clinician gender differences were not confined to reporting behavior but were also apparent in their knowledge and attitudes about incest. They report that the respondent's gender was a more important predictor of response than was either the respondent's discipline, or the respondent's clinical experience. Male

professionals in their sample were more likely than female professionals to underestimate the seriousness and prevalence of incest and to overestimate the occurrence of false accusations by children. Eisenberg et al (1987) also found gender differences among professionals in the assessment of the seriousness of sexual abuse. They found that females perceived sexual abuse as more serious than did males. They found that both males and females underestimated the prevalence of sexual abuse.

Eisenberg et al's results should be viewed cautiously due to serious flaws in their sampling procedure which appear to have led to comparison among widely divergent groups. Their sample consisted of 299 respondents (82 males and 217 females) including home health visitors, nurses who work with sex offenders, and medical students. They acknowledge that the home health visitors were all female, and do not mention what proportion of the nurses and medical students were male or female. It is presumed that most of the medical students were male and most of the nurses were female. It is also presumed that home health visitors and nurses have far less formal education than medical students. It seems likely that gender is not the only variable that differentiated males and females in their sample. Kalichman et al (1989) found no significant gender differences in psychologists' reporting behavior. The research findings on clinician gender and reporting behavior suggest that females may be more likely than males to report abuse. Further study of this topic is warranted.

Professional training is another clinician variable which researchers have begun to explore in relation to reporting behavior. In a problematic study, Kalichman, Craig, and Follingstad (1988) found that professional status was thought to have an impact on reporting behavior. One hundred and one mental health workers with varying levels of clinical training

including B.A. level mental health technicians, M.A. level therapists, registered nurses, psychologists, and psychiatrists. In a frequency table provided by the researchers it was reported that: of 39 B.A. level mental health technicians, 3 (7%) did not report; of 41 M.A. level therapists, 13 (32%) did not report; of 11 registered nurses, 0 (0%) did not report; of 7 psychologists, 1 (17%) did not report; and of 2 psychiatrists, 1 (50%) did not report. The researchers report that higher level professionals were more likely to report than lower level professionals. However, the interpretation of these results seem questionable. Their interpretation of results are problematic for several reasons. There is a wide discrepancy between the number of professionals polled in each group, making comparison of these groups suspect. They do not give any clear indication which professionals were deemed higher or lower status. However, from my interpretation of the results it seems that psychiatrists, and M.A. level therapists were the least likely to report abuse, compared to psychologists, B.A. level mental health technicians, and nurses who were more likely to report abuse. There is not enough research available to make any conclusions about the impact of professional training on reporting behavior.

Professional beliefs about reporting child abuse seem likely to have a large impact on reporting behavior. In an exploratory study, Muehleman and Kimmons (1981) looked at psychologists' beliefs regarding child abuse reporting. During a face to face interview, psychologists were asked to rank the importance of three issues. The majority of respondents ranked the child's welfare first, confidentiality second, and child abuse reporting laws third. Those psychologists who gave primary consideration to obeying the law were significantly more likely to report a hypothetical

case involving on-going physical and emotional abuse to the authorities than those who ranked either the child's welfare first or confidentiality first. Muehleman and Kimmons found that there was little consensus among psychologists in their sample regarding ethical reasoning in child abuse reporting. They suggest that psychologists are not well versed in ethics, and that they struggle individually on a case by case basis to make complex ethical decisions. Jagim, Wittman and Noll (1978) surveyed a variety of mental health professionals regarding confidentiality and third party disclosure. They found that more than half of the clinicians would forego confidentiality under certain circumstances, including the reporting of child abuse. However, Jagim and his colleagues also found that virtually all clinicians felt that confidentiality was essential in maintaining a positive therapeutic relationship.

In an already cited study by Kalichman et al (1989), professional beliefs about child abuse reporting were explored. They found psychologists were less likely to report if they perceived that reporting would disrupt the therapeutic relationship. Kalichman and his colleagues also studied respondents' attitudes about child abuse reporting laws. Most respondents felt that child abuse reporting laws were necessary for child protection, but simultaneously felt the laws were ineffective and perhaps not the best alternative for handling child abuse cases. Clinical decision-making regarding child abuse reporting appears to be a difficult one, which calls for the professional to juggle and prioritize competing ethical beliefs.

Studies involving victim variables have found no differences in reporting behavior when victim age, or victim gender was varied (Kalichman et al 1988; Kalichman et al 1989). Similarly, no differences in reporting

were found when type of abuse was varied from physical to sexual (Kalichman et al 1989).

Sexual Abuse

Extent of Problem: Sexual abuse of children is a common phenomena. Finkelhor (1987) reported that the American Humane Association has noted a dramatic increase in the reporting of sexual abuse cases in the past decade. They estimated that 123,000 cases of sexual abuse were reported in the United States during 1985, compared to 7,559 cases in 1976. Despite this dramatic increase in reporting of sexual abuse, it is still presumed that a substantial number of cases remain unreported.

It is difficult to measure the exact incidence of sexual abuse. Incidence figures are generated by taking reported cases of sexual abuse and adding them to projections about the likely number of cases which go unreported each year. DeFrancis (1969) studied the reported incidence of sexual abuse in the New York City area. He estimated that one in two cases of sexual abuse are unreported. He projected an estimate of 300,000 cases of sexual abuse in the United States each year. Sarafino (1979) projected that reported cases represent only one-third to one-fourth of the actual cases of sexual abuse. He projected that the annual incidence of sexual offenses against children in the United States is 336,200. Sarafino's and DeFrancis' estimates are fairly close despite the fact that their projections for unreported cases are quite different. This is because DeFrancis' reported incidence rate was determined by New York City rates which are higher than the national average. Sarafino used diverse regions to determine reported incidence rate which may be more representative of national reporting rates. The point remains that

incidence rates reflect guesses about unreported cases and they are only estimates.

Prevalence studies are another way of trying to determine the occurrence of sexual abuse. Child sexual abuse prevalence studies are retrospective and involve the survey of adults about their experiences as children. The model prevalence study was conducted by Diana Russell (1986). In this well-designed, meticulously detailed study, 933 adult women from a probability sample of residents from San Francisco were interviewed about their sexual experiences as children. Russell found that 16% of the women reported incestuous abuse and 31% reported extrafamilial sexual abuse. In a similar study, Wyatt (1985) interviewed 248 women under the age of thirty six from the Los Angeles area. Over 40% of her sample reported unwanted sexual contact when under the age of eighteen. David Finkelhor (1979) studied 796 college undergraduates from six New England colleges. Subjects were asked to complete anonymous questionnaires about their childhood sexual experiences. Fifteen percent of the females and nine percent of the males reported having had sexual contact with someone five to ten years older than themselves when they were under sixteen years old.

Numerous other studies have surveyed various adult populations regarding their childhood sexual experiences. Finkelhor (1987) found that variations in prevalence rates ranged from 6% to 62% for women, and from 3% to 31% for men. The variations in prevalence rates found can be explained by a variety of factors including: different definitions of sexual abuse, different sampling procedures, and different methods of obtaining information from respondents. Prevalence studies give us an estimate of the occurrence of sexual abuse in the past.

There is some debate about whether the increase in reported cases of sexual abuse reflect increased awareness and therefore increased reporting or whether it reflects an increase in the occurrence of sexual abuse. It seems that both may be true. From the limited studies conducted on reporting, there appears to have been an increase in professional awareness of the problem. In addition, Russell's study (1986) suggests that the rates of both incest and extrafamilial sexual abuse have quadrupled over the past eighty years. While acknowledging that these figures could reflect greater "forgetting" by her older sample, she nevertheless concludes that these figures reflect a true increase in the phenomenon.

Historic Influences on Clinical Recognition and Diagnosis: Sexual abuse interested mental health practitioners from the onset of the profession. In 1896, Sigmund Freud, the founding father of modern psychiatry, first wrote about the psychological impact of incest in what is now termed his "seduction theory" (Masson, 1985). In his seduction theory, Freud postulated that sexual aggression against children had a lasting, profound impact on their emotional development. He asserted that sexual molestation during childhood was an etiologic component to hysteria in adulthood (Freud,1962).

Freud later retracted his seduction theory and replaced it with what would become the cornerstone of his Oedipal theory (Masson, 1985; Rosenfeld, 1977). Freud (1954) came to believe that the unconscious gives equal validity to reality and fantasy. Therefore symptoms that arose from childhood fantasies of incest were thought to be indistinguishable from symptoms that arose from the actual experience of incest. This shift in thinking was to have a great impact on the future practice of psychiatry

relative to the interpretation of sexual abuse allegations. This is especially true given Freud's subsequent Oedipal theory that postulates that all children experience incestuous fantasies as a part of normal development.

Freud's followers, with few exceptions accepted his theory of the sexual desires of children. Psychoanalysts began to routinely interpret child sexual abuse allegations as expressions of unconscious desires and regard them as having no basis in reality (Swanson and Biaggio, 1985). Some historians feel that popularization of Freud's theory led to misinterpretation of the original intention of his work. They suggest that Freud's intention was to develop a theory of the unconscious. They feel Freud is wrongly accused of discounting incest as a real and common phenomenon. These historians feel that Freud's theories did not address the reality of incest one way or the other and that his predecessors have inappropriately assumed that all incest allegations are an expression of fantasy with little or no basis in reality (Magal and Winnik, 1968; Swanson and Biaggio, 1985). Others feel that Freud knowingly suppressed information about the true prevalence incest. These historians feel that Freud knowingly engaged in a cover-up by ignoring the reality of sexual abuse and interpreting sexual abuse allegations as unconscious fantasies (Masson, 1985; Rush, 1980). Regardless of Freud's intentions, for all practical purposes his work has been used to continue the suppression of the acknowledgement of sexual abuse.

Aside from ignoring the reality of sexual abuse allegations in therapy, Freud's theories have been used in other ways to suppress the reporting of sexual abuse. In legal arenas his theories were and are frequently used to defend sexual offenders. They are heavily cited to

lend credibility to the defense that the victim imagined the abuse. Freud's theories are also used to support the image of a seductive victim/participant who invites sexual contact because of rampant unfulfilled sexual fantasies (Swanson and Biaggio, 1985). These legal strategies have made victims reluctant to come forward with their sexual abuse complaints.

There were some dissidents who did not blindly accept Freud's reformulation of the seduction theory. Sandor Ferenczi (1933) believed that sexual abuse of children was common and that it had a negative impact on ego development and contributed to various psychiatric symptoms. Ferenczi who was a peer to Freud was rejected by mainstream psychoanalysts as an extremist (Rosenfeld, 1977). In 1956, Litin et al. protested the common practice of therapists ignoring the reality of client's reports of sexual abuse. They felt that the failure of mental health professionals to acknowledge the validity of their clients sexual abuse experiences could cause incest victims to drop out of therapy and even worse could cause them to become psychotic. It was not until a decade later that these ideas were given any credence in the psychological literature.

The professional literature in the 1930's, 1940's, and 1950's generally did not address the topic of child sexual abuse (Rosenfeld, 1977). The assumption that incest was rare persisted. Incidence studies published during that era grossly underestimated the incidence of sexual abuse stating that there were only 1.1 to 1.9 incest cases per million (Weinberg, 1955). Much of the literature on incest that was published during this period was fraught with problems. For example, Bender and Blau (1937) suggested that children are often the initiators of their own abuse and are rarely emotionally harmed by incest. In the 1950's, several

articles appeared that attempted to outline the psychological impact of sexual abuse on the victims' emotional development, and to describe family patterns in which sexual abuse occurred (Kaufman et al 1954; Weinberg, 1955). However, for the most part, society and mental health practitioners continued to ignore the reality of child sexual abuse.

There was an explosion of information and attention given to the phenomena of child physical abuse beginning in the 1960's following the startling information provided by Kempe and his colleagues on the high prevalence of the battered child syndrome (Radbill, 1980). This was accompanied by a national movement to create uniform child abuse reporting laws that would be enforced (Silver et al, 1967). However, sexual abuse was not routinely reported nor did it receive attention in the professional or popular literature until the 1970's (Bagley, 1983).

It seems that the social revolution which happened in the sixties, helped create a revolution in the acknowledgement of child sexual abuse. Some attribute this to the loosening of sexual inhibitions which occurred during the sexual revolution. Therapists began to discuss among themselves a subject that was previously taboo. This more open atmosphere led to the discovery that sexual abuse was a common complaint among female clients (Rosenfeld, 1977). Others give credit to the women's movement, because it created new forums, such as support groups, for women to discuss their experiences. Women discovered that they had common experiences including sexual abuse. The secret of sexual abuse was uncovered and women began to speak openly about their experiences (Rush, 1980; Herman and Hirshman, 1981; Bagley, 1983)). Simultaneously and perhaps not coincidently, psychoanalysis underwent a decline and other

therapies including cognitive, behavioral, family, feminist, and gestalt rose in popularity.

Clinical Recognition and Diagnosis: Mental health professionals are currently called upon to recognize and report all cases of suspected sexual abuse. Given the alarming statistics on the prevalence of child sexual abuse, it seems inevitable that psychologists will encounter cases involving sexual abuse in their work with children. Summit (1983) asserts that acceptance and validation of children's reports of sexual abuse are essential for victims' psychological survival. However, despite the undeniably high prevalence of sexual abuse, some adults, including some professionals, doubt the legitimacy of children's reports of sexual abuse and dismiss them as fantasy, confusion, or expression of children's unconscious desires. He proposes that some clinicians still do not suspect or believe in the possibility of sexual abuse. As noted above, the mental health professionals have a historical tradition in denying the existence of sexual abuse. This is compounded by a societal tendency to deny the existence of sexual abuse. Professionals who are unwilling to entertain the possibility of sexual abuse are thought to be less likely to uncover and report abuse in their practice.

Sgroi and her colleagues (1982) propose practical steps to help raise the conscience of professionals around the issue of sexual abuse. They suggest that all professionals who work with children should have specialized training in sexual abuse. They feel it is necessary for clinicians to become familiar with behavioral indicators of sexual abuse and to learn specialized techniques for the validation of sexual abuse.

Even with specialized training, diagnosing sexual abuse is not always a straightforward process. Summit and Kryso (1978) state, "Sexual abuse

is the most denied, concealed, distressing, and controversial form of child abuse". While some sexually abused children present with very specific symptoms (ie. direct statements about sexual experiences) other sexually abused children present with masked or nonspecific symptoms (Brant and Tisza, 1977; Hunter et al, 1985). Some examples of masked or nonspecific symptoms include: social withdrawal, increased aggression, behavioral regression, or unexplained school difficulties. These symptoms are vague and could easily be attributed to other causes, especially psychosocial stress. There is also great variability in the number of and intensity of symptoms exhibited by victims. Some sexually abused children remain asymptomatic, others exhibit one or two symptoms, and others exhibit clusters of symptoms. An additional problem for the diagnostician is that symptoms seem to vary with the age of the child and may interact with development (Sink, 1988; National Summit Conference on Diagnosing Child Sexual Abuse, 1985).

Sink (1988) discusses the ways in which sexual abuse evaluations may present new challenges to the diagnostician. She states that the involvement or potential involvement of the legal system greatly impacts diagnostic evaluations. Diagnosticians generally try to understand the client's perceptions of their experiences. Symptoms, coping styles, and defensive functioning are observed and historical information is documented. The diagnostician then makes statements about the probable impact of past events on the client's current functioning. In contrast, legal investigations center on the accumulation of facts and on establishing the reliability and credibility of the victim/witness. She points out that the legal criteria of "beyond a reasonable doubt" can leave diagnosticians in a difficult situation.

Conclusions: Research has determined that most clinicians are aware of child abuse reporting laws and yet there is a tendency for clinicians to underreport sexual abuse. It is unclear whether underreporting by clinicians is caused by lack of detection of abuse or lack of compliance with the laws. It seems plausible that underreporting by clinicians might be attributed to difficulty in detecting sexual abuse symptoms, especially when the clinical presentation of these symptoms is diffuse or nonspecific. If this were the case, then we would expect to see less suspicion as sexual abuse symptoms become less specific. In addition, we would expect that diminished suspicion would lead to diminished reporting.

It is also possible that underreporting is caused by clinician noncompliance with child abuse laws, and is not related to the detection of sexual abuse. Previous research suggests that mere suspicion of sexual abuse does not always lead to reporting. If this is the case, then we would expect to see suspicion at all levels of sexual abuse symptom specificity, without associated reporting.

It is also possible that underreporting is caused by both of these factors. If this were the case then we might see that clinicians do not rely on the mere presence of a clinical suspicion to report abuse, but instead use clinical discretion in when to report their suspicions of sexual abuse.

Clinical decision-making is a complex process which is influenced by many factors. Along with the above mentioned factors, clinician beliefs about reporting and nonreporting of child abuse likely play a role in decision-making. In addition, previous research has suggested that clinician variables such as gender, and professional status might impact suspicion and reporting behavior in child abuse.

FORMULATION OF RESEARCH STUDY AND HYPOTHESES

Two approaches were utilized to add to knowledge regarding professional practices related to sexual abuse of children. First, a systematic survey study of pediatric psychologists was conducted. The objective of this survey study was to better understand how psychologists interpret presentations of sexual abuse varying in symptom specificity, and under what circumstances they would choose to report suspected abuse to the authorities. Second, a panel of sexual abuse experts was interviewed regarding professional thinking and practices to further illuminate state of the art thinking in this emerging and challenging area of professional concern.

Survey Study

For the survey study, hypothetical clinical vignettes were used to study professional decision-making behavior regarding detection of and reporting of suspected child abuse. The level of sexual abuse symptom specificity was varied systematically within the four vignettes designed to correspond to a hierarchy of sexual abuse symptoms developed by Sink (1988). Sink proposes a hierarchical model for evaluating sexual abuse which offers clinical guidelines for assessing the certainty that sexual abuse has occurred. Sink's model contains four levels of decreasing clinical specificity of sexual abuse symptoms.

At Level 1, a child offers direct communication about sexual abuse. The clinician needs to assess whether the language used is

age-appropriate and whether the child can offer descriptive information about the abuse. This is the most specific level, and is most indicative that sexual abuse has occurred. This is the only level that is consistently accepted within the legal system as evidence that sexual abuse has occurred.

At Level 2, a child offers indirect communication about sexual abuse such as sexualized play, sexualized behavior, or retractions of prior disclosures of sexual abuse. This level is clinically very suggestive of sexual abuse, however, only occasionally holds weight in the legal system.

At Level 3, a child exhibits acute traumatic symptomatology such as fearfulness, enuresis, encopresis, sleep disorder, mood lability, and change in social/academic functioning. This post-traumatic stress response may be indicative that life-threatening, sadistic sexual abuse has occurred or may also result from other traumatic psychosocial stressors. At this level, both clinical and legal certainty of sexual abuse are questionable.

At Level 4, a child exhibits chronic symptoms of cumulative stress such as phobias, psychosomatic complaints, aggression, and suicidal ideation. Children at this level are least likely to directly disclose abuse. The symptoms may be caused by long-term sexual abuse but might be caused by other psychosocial stressors in the child's life. At this level, there is least clinical and legal certainty of sexual abuse.

After reading each vignette, respondents were asked to indicate their level of suspicion of abuse. Respondents were also asked to indicate the likelihood that they would report the case to protective

services. Further questions explored how clinicians' beliefs impacted their decision to report or not report each case.

Hypothesis 1: It was predicted that all respondents would suspect and report sexual abuse when symptoms were more specific compared to less specific. It was expected that more respondents would suspect and report abuse at Levels 1 and 2 than at Levels 3 and 4.

Hypothesis 2: It was expected that respondents would be more likely to suspect sexual abuse than to report sexual abuse. Respondents were expected to endorse higher levels of suspicion on Question 1 compared to their level of reporting on Question 3.

Hypothesis 3: Gender differences in clinical decision-making were expected. It was expected that females would be more likely than males to suspect and to report sexual abuse.

Hypothesis 4: It was predicted that specialized training and experience in sexual abuse would influence the degree of suspicion and reporting held by the respondent. Clinicians with more extensive training in sexual abuse were expected to be more likely compared to those with less training to suspect and report abuse.

Survey of Expert Opinion

In addition to the above mentioned research questions, interviews with six to ten clinicians who are considered experts in the field of sexual abuse were planned. The purpose was to understand with greater clarity and perhaps subtlety the dilemmas which face clinicians when considering whether to report sexual abuse to the authorities. The

assumption was made that those clinicians with extensive experience in sexual abuse would be able to elucidate factors that impact reporting behavior. To qualify as an expert, the clinician had to have extensive clinical experience in the field of sexual abuse (at least five years), to have published in the field or have trained other professionals in evaluating sexual abuse.

METHODS

Survey Study

Subjects: Doctoral-level psychologists who are members of the Society of Pediatric Psychology served as subjects for this study. Six hundred forty four (644) surveys were sent to all members of the Society of Pediatric Psychologists who were doctoral-level psychologists residing in the United States. Apparently a small number of these surveys were erroneously sent to graduate student members. Two surveys were completed by graduate students and were not used in the analysis.

Two hundred seventy eight (278) doctoral-level psychologists returned their surveys which represents 43.3% of potential respondents. Five respondents returned their surveys with a note stating that they were academic psychologists not clinical psychologists, and felt unqualified to complete the survey. This suggests that the return rate among clinicians in this sample was quite high. Four other surveys were dropped from the sample due to problems such as illegibility and incompleteness. A total of 269 surveys (41.9%) were included in the final sample.

Gender	#	% of sample
Females	143	53.2%
Males	124	46.1%
Unknown	2	.7%

Age	#	% of sample
28-29	2	.7
30-39	142	52.7
40-49	87	32.3
50-59	21	7.8
60-69	14	5.2
70	1	.4
unknown	2	.7

Females comprised 53.7% of those surveyed and males 47.9% thus there was no gender bias in response rate. The respondents ranged in age from 28-70 years old with a mean age of 40, and a standard deviation of 8.6 years.

Surveys were sent to 48 states, North Dakota and Wyoming were not represented in the membership list. Respondents came from 43 states. There was no apparent geographic bias in responding. Fifty per cent of the respondents came from Ohio, Massachusetts, California, New York, Illinois, North Carolina, and Texas, which represented 45% of the original population. No surveys were returned from subjects in: Hawaii, Kansas, New Mexico, South Dakota, and Vermont. This is not surprising since no more than four surveys were sent to members in each of these states. It should be noted that fourteen respondents did not divulge their state. It is possible that psychologists from smaller states felt their confidentiality might be compromised if they were to disclose their state.

Years Since Licensure

Yrs	Freq.	%
0	6	2.3
1-2	42	15.8
3-4	42	15.8
5-6	30	11.2
7-8	29	10.8
9-10	30	11.2
11-12	17	6.4
13-14	15	5.7
15-16	24	10.2
17-18	8	3.0
19-20	6	2.2
21-30	14	5.4
31-35	3	1.9

Clinical Hours/Week

Hrs	Freq	%
0	2	.7
1-10	39	14.5
11-20	79	29.4
21-30	70	26.0
Over 30	79	29.4

Clinical Setting

Setting	Freq	%
Medical Hospital	104	38.7
Psychiatric Hospital	6	2.2
University Clinic	18	6.7
Outpatient Clinic	38	14.1
Private Practice	80	29.7
Other	23	8.6

Ninety eight per cent of the respondents were licensed psychologists. The number of years since licensure ranged from 0-35 with a mean of 9 years. Forty four per cent of the sample worked 20 hours or less per week at clinical endeavors and 56% of the sample worked more than 20 hours per week at clinical endeavors. Thirty nine per cent of the sample worked in a medical hospital setting, 30% worked in private practice, 14% worked in an outpatient setting, and the remainder of the sample worked in psychiatric hospitals, university clinics, and other social service agencies.

Instrument: Respondents were provided with a hypothetical clinical situation, and were asked to assume that a seven year old girl was being referred to them by the school for psychological evaluation. Pertinent background information was provided including: family constellation, significant life changes, and symptom presentation. In addition there was a description of a clinical encounter with the child in which symptom presentation was further elucidated. This hypothetical clinical

situation was used to develop four controlled clinical vignettes (See Appendix C). In each vignette, child and family variables were held constant and symptom presentation varied. Using Francis Sink's (Sink, 1988) hierarchical model for the evaluation of child sexual abuse, symptoms were varied in a step-wise fashion from most to least specific. A brief description of symptom presentation for each vignette is described below.

At Level 1 (Direct communication), the child in the vignette exhibits diminished appetite, nightmares, mood change, and makes a specific statement about abuse during the clinical interview.

At Level 2 (Indirect communication), the child in the vignette exhibits sudden on-set pervasive behavior problems, sexual acting out with peers, and engages in sexually explicit doll play during the clinical interview but does not make a specific statement about abuse.

At Level 3 (Acute traumatic symptomatology), the child exhibits diminished academic performance, nocturnal enuresis, general fearfulness, separation anxiety, and makes vague statements about a bad man during the clinical interview but does not make a specific statement about abuse.

At Level 4 (Cumulative stress symptomatology), the child exhibits chronic, unexplained stomach pain, diminished school performance, social withdrawal, and expresses concern during the clinical interview about her sister's well-being should she die but does not make a specific statement about abuse.

After each vignette a set of six questions was presented. Respondents were asked to indicate on a four-point scale their level of clinical suspicion that child abuse was occurring. Then they were asked to indicate their level of certainty (from 0-100%) that child abuse was

occurring. Using a four-point scale they were asked to indicate the likelihood that they would report the case to the authorities. Subsequently they were asked to indicate on a four-point scale their likelihood of reporting the case if the mother of the child refused to schedule another appointment. Finally, the responents were asked to rate the impact of a variety of factors on their decision to report or not report the case.

To assure face validity, the vignettes were presented to four clinicians who work extensively in the field of sexual abuse. They were asked to sort the vignettes in hierarchical order. All four experts sorted the vignettes correctly. These highly experienced clinicians were also asked to comment on all other aspects of the vignettes, including the clinical integrity of each vignette, the wording of each vignette, the wording of each question. Useful feedback was obtained. For example, several experts advised that some of the symptoms in the vignettes were not age appropriate. Alternative comparable symptoms were suggested and substituted.

The revised vignettes with accompanying questions, professional background information sheet and instructions were then presented to eight psychology trainees and other mental health professionals including social workers and psychologists. The respondents were encouraged to disguise their identifying information on the professional background sheet to ensure anonymity. They were asked to time how long it took to complete all four vignettes. They were also asked to respond to pretest questionairres which asked about the clarity of the wording of the vignettes, and the clarity of the task. After several minor changes in the wording of the vignettes were made based on their comments, the same

procedure was repeated to another sample of eight psychology trainees and other mental health professionals. On this trial the respondents reporting having little difficulty in completing or understanding the task. All respondents in both conditions were able to read the four vignettes and answer accompanying questions in less than one-half hour.

Procedure: Six hundred forty four packets were mailed to potential respondents. Each packet contained a cover letter, an instruction sheet, a set of four vignettes with accompanying questions, a professional background information sheet, and a self-addressed stamped return envelope (See appendix for copies of the contents of each packet). All potential respondents were sent a follow-up thank you/reminder post card (See Appendix E).

The cover letter (See Appendix A) explained the nature of the research project and invited voluntary anonymous participation. On the instruction sheet (See Appendix B), respondents were instructed to read the child abuse statute that appeared on that same page and to use that statute to help guide their clinical decision-making. Then they were asked to read one vignette at a time and to respond to the accompanying questions before continuing on to the next vignette. To avoid order effects, the vignettes were presented in a completely crossed random order and subjects were instructed to complete the questions related to each vignette prior to reading the following vignette.

The professional background information sheet (See Appendix D) collected demographic information such as: gender, age, state, years since licensure. In addition, respondents were asked about the amount of training and clinical experience they had in child sexual abuse.

Interviews of Experts

Experts: Six professionals served as experts in this study. To qualify as an expert, the professional needed to have a minimum of five years clinical experience in child sexual abuse, and to have published or trained other professionals in the evaluation of sexual abuse.

Half of the experts were already familiar with this researcher. They were contacted by telephone and were invited to participate in this study. All three experts contacted by telephone agreed to participate in this study. The other half were unfamiliar with the researcher. These professionals were sent a letter requesting participation in this study. They were asked to return a self-addressed stamped return post card if they were interested in participating in this study. Six letters were sent to potential participants, three agreed to participate.

Gender		Training	
Female	5	Psychiatrist (M.D.)	1
Male	1	Psychologist (Ph.D.)	2
		Social Worker (M.S.W.)	3

# of Child Sexual Abuse Evaluations Conducted Over Course of Career		% of Clinical Time Spent in Treatment or Evaluation of Child Sexual Abuse	
Expert 1	35-50	Expert 1	70%
Expert 2	200-250	Expert 2	90%
Expert 3	200-250	Expert 3	25%
Expert 4	300-400	Expert 4	35-50%
Expert 5	300-400	Expert 5	5-10%
Expert 6	Over 500	Expert 6	33%

# of Hours each Week Spent in Direct Clinical Contact with Clients		# of Cases of Suspected Sexual Abuse Reported to the Authorities Over Course of Career	
Expert 1	20 hrs.	Expert 1	3
Expert 2	10 hrs.	Expert 2	40
Expert 3	20 hrs.	Expert 3	50
Expert 4	20 hrs.	Expert 4	125
Expert 5	25 hrs.	Expert 5	75
Expert 6	35 hrs.	Expert 6	40

Most of the experts were female. They hold a variety of degrees in the mental health field. The experts are all practicing in the eastern part of the United States (four states were represented). Most of the experts have had experience with over two hundred cases involving the evaluation of child sexual abuse. Expert 1 has less direct clinical contact than the other experts, but also has exposure to sexual abuse cases in the role of clinical supervisor. Most of the experts spend a minimum of one-quarter of their clinical time in the treatment of or evaluation of child sexual abuse. Due to a recent job change, Expert 5 has less extensive clinical contact with child sexual abuse currently, although for years worked extensively in this field.

The experts in this sample were clinically active, carrying from 10-35 clinical hours per week. In addition, Experts 1, 2, 3, and 4 maintain active supervisory roles. They have all personally reported cases of child sexual abuse. All of the experts pointed out that in their role as supervisor they have additional experience in reporting. They all stated that the majority of child sexual abuse cases they encounter have already been reported to the authorities.

All of the experts have multiple publications in the area of child sexual abuse and have extensive experience in training other professionals in child sexual abuse issues. In addition, all six experts

have had faculty appointments in major university hospitals where they served as child sexual abuse experts. Four of the six continue to work in university hospitals, while one works in a community hospital, and one works in private practice.

Instrument: A structured interview format was designed to study the experts opinions and behaviors regarding reporting in sexual abuse cases (See Appendix F). The interview was divided into five sections.

In order to understand the composition of the expert sample, the first section gathered clinical background information about the experts. The experts were asked to describe the number of hours and settings of their current clinical practice. They were also asked about their experience in evaluating sexual abuse cases and the portion of their clinical time committed to sexual abuse cases.

The second section was designed to elicit the experts thinking regarding reporting sexual abuse and to describe their thinking regarding the interplay of legal and clinical decision-making. The first portion of this section polled the experts about their knowledge of mandated reporting laws and their previous reporting behavior. In the second portion of this section, open-ended questions were used to try to understand each expert's approach to reporting. They were asked to define the factors that influence reporting behavior, and to list factors that would lead to reporting in all cases. They were asked to provide their opinion about what would legally constitute full evidence to confirm a finding of sexual abuse. This was followed by a series of questions which explored if and how clinical discretion impacts reporting behavior.

The third section was designed to systematically explore the impact of specific factors on reporting behavior. Twenty-one factors were listed that theoretically could impact reporting behavior. These factors included victim variables, perpetrator variables, family reaction variables, clinician belief variables, and clinician reporting experience variables. The experts were asked to evaluate if and how each of those factors might impact their reporting behavior.

The fourth section, quizzed the experts about their opinion about the efficacy of protective services in sexual abuse cases. This seemed particularly pertinent since reporting behavior may be related to clinical perception about the outcome of reporting for the child.

The fifth section, gave the experts an opportunity to comment on the existing child abuse reporting laws and to offer suggestions for alterations in these laws. It was hoped that the experts could provide information about the strengths and weaknesses of child abuse reporting laws related to clinical practice.

Procedure: Five of the six interviews were conducted in person, and one was conducted over the phone. The researcher read each question, one question at a time, to each expert. Occasionally follow-up questions were necessary to clarify the meaning of the response. The researcher wrote down the response to each question. The entire interview took between forty minutes to one hour. Following the interview, the nature of the research project was described to the expert.

RESULTS

Survey Study

Hypothesis 1: It was predicted that respondents would be more likely to suspect and report abuse at Levels 1 and 2 where symptom presentation was more specific to sexual abuse than at Levels 3 and 4 where symptom presentation was less specific to sexual abuse. Questions 1 and 2 both pertain to the issue of suspicion, and Questions 3 and 4 pertain to the issue of reporting.

Question 1: My clinical impression is that there is _____ reason to suspect child abuse.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no	0	0%	0	0%	13	5%	24	9%
little	0	0%	10	3%	92	34%	120	45%
moderate	22	8%	118	44%	136	51%	116	43%
substantial	247	92%	141	52%	27	10%	9	3%
no or little	0	0%	10	3%	105	39%	144	53%
mod. or subst.	269	100%	259	96%	163	61%	125	46%

There was a significant difference in how the subjects responded at each level of symptom presentation. Using a one-way repeated measures analysis of variance, the F value (df 3,804) of 713.298 was significant at alpha .0001. Using the Tukey test of familywise corrections for pairwise comparisons with an alpha level of .01, it was determined that respondents were significantly more likely to form a clinical suspicion

of child abuse when symptoms were more versus less specific. That is to say that respondents were more suspicious at Level 1 than at Level 2, at Level 2 than at Level 3, and at Level 3 than at Level 4. At Levels 1 and 2 respondents had moderate to substantial suspicion, while at Levels 3 and 4 respondents tended to have little to moderate suspicion.

Question 2: I feel _____% certain that child abuse is occurring in this case.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
100-75%	228	85%	143	53%	24	9%	15	6%
74-50%	36	13%	89	33%	77	29%	64	24%
49-25%	5	2%	27	10%	73	27%	51	19%
24-0%	0	0%	9	3%	93	35%	139	52%

There was a significant difference in respondents' level of confidence across all levels symptom presentation, F (df 3,804) = 713.298, alpha .0001. The Tukey test with an alpha of .01 indicated that respondents were significantly more confident that child abuse was occurring at Level 1 than at Level 2, at Level 2 than at Level 3, and Level 3 than at Level 4. At Levels 1 and 2, 69% of respondents had a confidence level of 75% or higher, and 23% had a confidence level between 50% and 74% that child abuse was occurring. At Levels 3 and 4, 26% had a confidence level between 50% and 74%, while 66% had a confidence level of 50% or less that child abuse was occurring.

Question 3: I would _____report this case to the authorities.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
definitely not	0	0%	6	2%	70	26%	110	41%
unlikely	9	3%	57	21%	152	56%	128	48%
likely	62	23%	123	46%	38	14%	26	10%
definitely	198	74%	83	31%	6	2%	5	2%
def.not/unlikely	9	3%	63	23%	222	82%	238	88%
likely/def.	260	97%	206	77%	44	16%	31	11%

There was a significant difference in respondents' level of reporting across all levels of symptom presentation F (df 3,795) = 747.469, alpha .0001. The Tukey test with an alpha of .01, found that respondents were significantly more likely to report child abuse at Level 1 compared to Level 2, at Level 2 compared to Level 3, and at Level 3 compared to Level 4. At Levels 1 and 2, 87% of the respondents said they would definitely or likely report the case to the authorities. At Levels 3 and Level 4, 86% of respondents said they would definitely not or unlikely report this case.

Question 4: If (the child's) mother refused to schedule another appointment stating that she had decided to handle (the child's) problems within the family, I would _____ report this case to the authorities.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
definitely not	0	0%	2	1%	44	16%	72	27%
unlikely	2	1%	23	8%	121	45%	129	48%
likely	38	14%	85	32%	78	29%	52	19%
definitely	229	85%	159	59%	24	9%	15	6%
def.not/unlikely	2	1%	25	9%	165	61%	201	75%
likely/def.	267	99%	244	91%	102	38%	67	25%

There was a significant difference in reporting at all levels of symptom presentation when additional clinical information was supplied, F (df 3,795) = 641.462, alpha .0001. Again, using a Tukey with an alpha of .01, it was determined that respondents were more likely to report abuse at Level 1 compared to Level 2, at Level 2 compared to Level 3, and at Level 3 than at Level 4 when faced with the possibility of discontinued contact with the child. Ninety five per cent of respondents reported they would likely or definitely report under these conditions at Level 1 and 2, compared with 31% at Levels 3 and 4.

Hypothesis 2: It was predicted that respondents would be more likely to suspect sexual abuse than to report sexual abuse. Using a paired t-test for repeated measures the following results were obtained.

Levels 1-4

Variable	N	X	S.D.	S.E.	t	df	p
Question 1	266	3.12	.41	.03	20.52	265	.001*
Question 3		2.60	.49	.03			

Respondents were significantly more likely to suspect abuse than to report abuse. This was true when all levels were combined, and when each level was analyzed separately.

Hypothesis 3: It was hypothesized that females would be more likely than males to suspect and report abuse. One-tailed probability t-tests were used to determine whether there were significant differences between males and females across all levels. Since there was homogeneity of variance, pooled variance estimates were used. When analyzing each question across all levels, the Bonferroni inequality test for overall

alpha was used. An alpha level of .013 was applied to decrease the probability of spurious results (Type I errors). In subsequent analyses an alpha level of .05 was set if the original t-score was significant using the Bonferroni.

Levels 1-4

Variable	Sex	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	F	142	3.20	.37	.03			
	M	124	3.03	.43	.04	3.41	264	.0005*

Females were significantly more likely than males to suspect child sexual abuse.

Variable	Sex	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question Two	F	143	58.61	15.23	1.27			
	M	124	52.72	15.06	1.35	3.17	265	.001*

Females were significantly more confident than males that child sexual abuse was occurring.

Variable	Sex	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question Three	F	141	2.64	.47	.04			
	M	123	2.56	.51	.05	1.48	262	.070

There was a trend for females to report abuse more than males, however this was not statistically significant.

Variable	Sex	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question Four	F	142	3.00	.48	.04			
	M	122	2.84	.54	.05	2.62	262	.004*

When faced with the possibility of discontinued contact with the child, females were significantly more likely than males to report abuse.

Item Analysis of Gender Differences

Level 1

Variable	Sex	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	F	143	3.94	.24	.02			
	M	124	3.90	.31	.03	1.24	265	.108
Question Two	F	143	87.99	11.34	.95			
	M	124	82.71	13.92	1.25	3.42	265	.0005*
Question Three	F	143	3.73	.49	.04			
	M	124	3.66	.57	.05	1.13	265	.130
Question Four	F	143	3.90	.31	.03			
	M	124	3.78	.45	.04	2.16	265	.008*

Level 2

Variable	Sex	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	F	143	3.55	.57	.05			
	M	124	3.42	.57	.05	1.81	265	.036*
Question Two	F	143	73.04	18.97	1.59			
	M	124	66.47	21.78	1.96	2.64	265	.004*
Question Three	F	143	3.13	.76	.06			
	M	124	2.97	.80	.07	1.73	265	.042*
Question Four	F	143	3.57	.63	.05			
	M	124	3.41	.72	.07	1.87	265	.032*

Level 3

Variable	Sex	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	F	142	2.76	.68	.06			
	M	124	2.55	.76	.07	2.40	264	.008*
Question Two	F	143	40.71	24.41	2.04			
	M	124	34.31	23.39	2.10	2.18	265	.015*
Question Three	F	141	1.96	.68	.06			
	M	123	1.89	.73	.07	.73	262	.234
Question Four	F	142	2.40	.83	.07			
	M	123	2.21	.88	.08	1.81	263	.036*

Level 4

Variable	Sex	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	F	143	2.55	.66	.06			
	M	124	2.27	.70	.06	3.44	265	.0005*
Question Two	F	143	32.71	24.64	2.06			
	M	124	27.39	22.10	1.98	1.84	265	.033*
Question Three	F	143	1.77	.72	.06			
	M	124	1.69	.70	.06	.96	265	.169
Question Four	F	143	2.14	.81	.07			
	M	123	1.94	.85	.08	2.03	264	.022*

Hypothesis 4: It was predicted that respondents with extensive training in sexual abuse would be more likely than those with limited training in sexual abuse to suspect and report abuse. The sample was divided into thirds according to experience level. The high experience groups and low experience groups were compared using one-tailed probability t-tests.

Levels 1-4

Variable	Exp.	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	Hi	73	3.11	.40	.05			
	Lo	79	3.08	.44	.05	.40	150	.3455
Question Two	Hi	73	56.00	15.64	1.83			
	Lo	79	53.68	14.38	1.62	.95	150	.1715
Question Three	Hi	71	2.62	.50	.06			
	Lo	79	2.52	.44	.05	1.32	148	.095
Question Four	Hi	72	2.92	.53	.06			
	Lo	79	2.84	.53	.06	.83	149	.2035

No significant differences were found in level of suspicion or reporting between respondents with a high level of sexual abuse training and those with a low level of training in sexual abuse. There was a trend for respondents with more sexual abuse training to report more than those with less sexual abuse training. This trend was nonsignificant.

Item Analysis of Sexual Abuse Experience Differences

Level 1

Variable	Exp.	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	Hi	73	3.93	.25	.03			
	Lo	79	3.90	.30	.03	.72	150	.237
Question Two	Hi	73	86.52	11.16	1.31			
	Lo	79	83.80	13.82	1.56	1.33	150	.093
Question Three	Hi	73	3.77	.49	.06			
	Lo	79	3.63	.56	.06	1.57	150	.059
Question Four	Hi	73	3.85	.40	.05			
	Lo	79	3.80	.40	.05	.80	150	.2135

Level 2

Variable	Exp.	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	Hi	73	3.44	.53	.06			
	Lo	79	3.42	.61	.07	.22	150	.4125
Question Two	Hi	73	69.23	22.27	2.60			
	Lo	79	68.77	20.00	2.25	.13	150	.4465
Question Three	Hi	73	3.11	.81	.10			
	Lo	79	2.94	.72	.08	1.39	150	.083
Question Four	Hi	73	3.50	.69	.08			
	Lo	79	3.37	.74	.08	.97	150	.167

Level 3

Variable	Exp.	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	Hi	73	2.62	.72	.08			
	Lo	79	2.61	.76	.09	.07	150	.4705
Question Two	Hi	73	35.90	23.78	2.78			
	Lo	79	35.46	23.03	2.59	.12	150	.453
Question Three	Hi	71	1.90	.68	.08			
	Lo	79	1.87	.65	.07	.26	148	.3985
Question Four	Hi	72	2.28	.86	.10			
	Lo	79	2.25	.82	.09	.18	149	.429

Level 4

Variable	Exp.	N	$\bar{X}$	S.D.	S.E.	t	df	p
Question One	Hi	73	2.44	.73	.09			
	Lo	79	2.40	.71	.08	.40	150	.3465
Question Two	Hi	73	32.33	25.89	3.03			
	Lo	79	26.70	22.45	2.53	1.44	150	.0765
Question Three	Hi	73	1.71	.77	.09			
	Lo	79	1.65	.66	.07	.57	150	.2835
Question Four	Hi	73	2.03	.87	.10			
	Lo	79	1.96	.79	.09	.49	150	.3135

Questions 5 and 6: There were no specific hypotheses formulated regarding Questions 5 and 6. Respondents answered either Question 5 or 6 depending on their response to Question 3. If a respondent indicated that he or she would definitely not or unlikely report the case to the authorities, then Question 5 was answered, if the respondent indicated that he or she would likely or definitely report the case to the authorities, then Question 6 was answered. Therefore only a portion of all respondents answered Questions 5 or Question 6 at each level.

5. Rate the impact that each of the following factors had on your decision not to report this case to the authorities.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
Answered #5	9	3%	63	23%	223	83%	237	88%
Did Not Answer #5	260	97%	206	77%	46	17%	32	12%

Most respondents would likely or definitely report child abuse to the authorities at Levels 1 and 2, and therefore did not answer Question 5. However, most respondents would unlikely or definitely not report

child abuse to the authorities at Levels 3 and 4, and therefore did answer Question 5. Significance tests were not performed because of disproportianate cell sizes.

5a. Little or no clinical suspicion of child abuse in this case.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	4	44%	26	42%	40	18%	31	13%
little impact	3	33%	14	23%	41	19%	34	14%
moderate impact	1	11%	17	27%	52	24%	70	30%
strong impact	1	11%	5	8%	87	40%	101	43%
no/little imp.	7	88%	40	64%	81	37%	65	27%
mod/strong imp.	2	22%	22	36%	139	63%	171	73%

At Levels 3 and 4, the lack of clinical suspicion had moderate to strong impact on the decision to not report abuse, but this seems less true at Levels 1 and 2.

5b. Evidence does not warrant the breaking of client/therapist confidentiality.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	0	0%	16	26%	56	26%	53	22%
little impact	5	56%	16	26%	40	18%	42	18%
moderate impact	2	22%	15	24%	61	28%	62	27%
strong impact	2	22%	15	24%	62	28%	79	33%
no/little imp.	5	56%	32	52%	96	44%	95	40%
mod/strong imp.	4	44%	30	48%	123	56%	141	60%

At all levels, clinicians seemed fairly evenly divided between those who felt that client/therapist confidentiality had little or no impact vs. moderate to strong impact on their decision not to report a case.

5c. Lack confidence in the ability of the authorities to adequately evaluate and or protect in cases of child abuse.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	3	33%	22	35%	105	48%	117	50%
little impact	1	11%	19	31%	55	25%	57	24%
moderate impact	5	56%	16	26%	38	17%	37	16%
strong impact	0	0%	5	8%	21	10%	24	10%
no/little imp.	4	44%	41	66%	160	73%	174	74%
mod/strong imp.	5	56%	21	34%	59	27%	61	26%

At Levels 3 and 4, lack of confidence in the authorities had little or no impact on most respondents decision not to report. At Levels 1 and 2 this factor seemed to have somewhat more impact.

5d. Concern that premature reporting of child abuse may interrupt the uncovering or disclosure of additional details of the abuse.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	1	11%	3	5%	41	19%	58	25%
little impact	0	0%	3	5%	33	15%	38	16%
moderate impact	2	22%	25	40%	62	28%	61	26%
strong impact	6	67%	31	50%	83	38%	79	33%
no/little imp.	1	11%	6	10%	74	34%	96	41%
mod/strong imp.	8	89%	56	90%	145	66%	140	59%

Concern that premature reporting may interrupt disclosure had a moderate/strong impact on clinical decision making at all levels. However, this effect was most evident at Levels 1 and 2.

5e. Concern that premature reporting of child abuse may cause the family to flee from the evaluation.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	2	22%	11	18%	51	23%	64	27%
little impact	1	11%	10	16%	44	20%	50	22%
moderate impact	2	22%	14	23%	56	26%	53	23%
strong impact	4	45%	27	43%	68	31%	67	28%
no/little imp.	3	33%	21	34%	95	43%	114	49%
mod/strong imp.	6	67%	41	66%	124	57%	120	51%

Respondents were divided about the impact that premature reporting would have on the therapist/family relationship. About half of the respondents felt it had little or no impact and the other half felt it had moderate to strong impact on their decision to not report a case to the authorities. At Levels 1 and 2 there was a tendency for respondents to report a stronger impact of this factor on clinical decision-making.

6. Rate the impact that each of the following had on your decision to report this case to the authorities.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
Answered #6	260	97%	206	77%	46	17%	32	12%
Did Not Answer #6	9	3%	63	23%	223	83%	237	88%

6a. Clinical suspicion of child abuse in this case.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	0	0%	0	0%	0	0%	0	0%
little impact	0	0%	1	0%	0	0%	1	3%
moderate impact	16	6%	27	14%	16	36%	10	32%
strong impact	244	94%	178	86%	27	64%	20	65%
no/little imp.	0	0%	1	0%	0	0%	1	3%
mod/strong imp.	260	100%	205	100%	43	100%	30	97%

Virtually all respondents reported that clinical suspicion had moderate to strong impact on their decision to report abuse at every level.

6b. Confidence in the ability of the authorities to adequately evaluate and or protect in cases of child abuse.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	72	28%	56	27%	12	28%	10	32%
little impact	106	41%	96	47%	18	43%	9	29%
moderate impact	61	23%	37	18%	8	19%	7	23%
strong impact	20	8%	16	8%	4	10%	5	16%
no/little imp.	178	69%	152	74%	30	71%	19	61%
mod/strong imp.	81	31%	53	26%	12	29%	12	39%

The majority of respondents at all levels stated that this factor had little or no impact on their decision to report this case to the authorities.

6c. Ethical/moral obligation to report.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	0	0%	0	0%	0	0%	1	3%
little impact	8	3%	8	4%	2	5%	0	0%
moderate impact	35	13%	39	19%	12	28%	10	32%
strong impact	217	84%	159	77%	29	67%	20	65%
no/little imp.	8	3%	8	4%	2	5%	1	3%
mod/strong imp.	242	97%	198	96%	41	95%	30	97%

Ethical/moral obligation appears to have an extremely strong impact on decision-making at all levels.

6d. Concern that the child is at risk for further abuse.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	1	0%	0	0%	0	0%	0	0%
little impact	0	0%	1	0%	0	0%	0	0%
moderate impact	7	3%	15	7%	6	14%	10	32%
strong impact	252	97%	190	93%	37	86%	21	68%
no/little imp.	1	0%	1	0%	0	0%	0	0%
mod/strong imp.	259	100%	205	100%	43	100%	31	100%

Concern for the child's safety also seems to be an extremely strong motivating factor for reporting child abuse at all levels.

6e. Fear of prosecution for failure to report.

	Level 1		Level 2		Level 3		Level 4	
	N	%	N	%	N	%	N	%
no impact	104	40%	86	42%	18	42%	18	58%
little impact	91	35%	72	35%	17	39%	7	23%
moderate impact	34	13%	32	16%	5	12%	3	9%
strong impact	30	12%	14	7%	3	7%	3	10%
no/little imp.	195	75%	158	77%	35	81%	25	81%
mod/strong imp.	64	25%	46	23%	8	19%	6	19%

Fear of prosecution had little or no impact on the clinical decision to report in the majority of the respondents at all levels.

Interviews of Experts

The experts were asked to describe how they decide whether to report a case to the authorities. Each clinician had an individual strategy for making this determination. Most experts rely heavily on the child's statement of abuse when deciding whether to make a child abuse report. They assess if the child's statement is believable, whether the child's affective presentation is consistent with the disclosure, and whether there are accompanying behavioral indicators of abuse. Most experts also evaluate the parent-child relationship, and assess how protective the nonoffending parent is of the child, and how cooperative the nonoffending parent is with the evaluation process. Finally, most experts also assess how much the child is at risk for further abuse, by determining if the alleged perpetrator has continued contact with the child.

The experts were asked to list specific factors that would lead them to report sexual abuse 100% of the time. There were certain signs and symptoms that all of the experts would report 100% of the time including: a direct, believable statement of abuse from the child; a diagnosis of a

sexually transmitted disease; a genital injury without alternate explanation. Several of the experts also felt that aggressive sexualized acting out with peers is reportable 100% of the time.

The sexual abuse experts interviewed appear to use a fair amount of clinical discretion when deciding whether and when to report sexual abuse. The experts were asked if there are times when they report abuse when they do not have full evidence to support a finding of sexual abuse. All of the experts interviewed agreed that there are times that they report abuse when they do not have full evidence to support a finding of sexual abuse. Most of the experts indicated that they have occasionally reported abuse when they only had vague or diffuse evidence. They were also asked if they have ever suspected abuse and not reported it to the authorities. All of the experts recalled specific cases where they had suspected abuse but did not report the abuse to the authorities.

Experts were asked if there was a difference between a clinical suspicion of child abuse and a legal suspicion of child abuse. They uniformly agreed that in legal settings a higher threshold of evidence to confirm a suspicion of sexual abuse is required than is true in clinical settings. Experts felt that within the legal system, a definitive statement of abuse from a child holds the most credence. They felt that clinically relevant information such as symptom presentation, and caretaking dynamics were largely ignored in legal settings. One expert explained that people within the legal system are not trained to understand the dynamics of sexual abuse, and therefore are more likely to overlook clinically relevant information and rely solely on concrete facts. Other experts noted that there is more at stake when a suspicion

of abuse is confirmed in a legal setting compared to a clinical setting, and therefore a higher burden of proof is required.

The experts were polled about the impact of a variety of factors on their clinical decision to report including: victim variables, perpetrator variables, clinician beliefs, and clinical presentation variables. They were asked about the impact of victim gender on reporting behavior. All of the experts felt that the victim's gender did not impact their decision of whether to report. However, half of the experts felt that the victim's age did impact their decision to report. Three of the six experts stated they tend to report more quickly when very young children (under age 5) are involved, while the other three experts felt that the child's age did not impact their decision.

The experts were polled about the impact of several perpetrator variables on their clinical decision of whether to report a case to the authorities. All of the experts agreed that the gender of the alleged perpetrator did not affect their reporting behavior. Most of the experts felt they were also not influenced by the alleged perpetrator's relationship to the child. Half of the experts did feel that the age of the alleged perpetrator could influence their clinical decision of whether to report abuse to the authorities. These experts felt that they would not report cases to protective services when there was a very young perpetrator who was close in age to the victim and where there was no evidence of force or coercion. In these cases, the experts preferred to recommend treatment for the young perpetrator. However, half of the experts felt that the age of the perpetrator did not impact their reporting decision.

Clinical presentation seems to affect reporting behavior. All of the experts agreed that reporting is affected by the perceived safety of the child. They agreed that they report more quickly, and urgently if they perceive the child is currently at risk for abuse. However, if they perceive that there is low risk, they are more likely to engage in an extended sexual abuse evaluation before contacting the authorities. Another aspect of clinical presentation that was explored relates to the clinical presentation of the nonoffending parent. The experts uniformly take into consideration the clinical presentation of the nonoffending parent in their reporting decision. These experts all rely heavily on the nonoffending parent's reaction to the abuse as a barometer of risk to the child. If the nonoffending parent is not able to contemplate the possibility that sexual abuse has occurred, is not perceived as being protective, or is not cooperative with the evaluation, the the experts are more likely to feel that the child is at continued risk for abuse and will make a more immediate, and adamant report to the authorities.

Experts were polled about their opinions about the impact of reporting on the therapeutic relationship. Most of the experts interviewed felt that reporting abuse does not adversely affect their therapeutic relationship with the child. In fact, several of the experts felt that reporting abuse can serve to strengthen their therapeutic relationship because the child perceives that the therapist has acted to keep the child safe.

They were also polled about whether their reporting is impacted by concerns the premature reporting could lead to retraction of allegations by the child. Most of the experts do not alter their reporting behavior to accommodate for possible retraction of allegations by the child. They

feel that retraction is a common phenomenon and protective services workers should be educated about the meaning of retraction. Two of the experts did indicate that they sometimes delay reporting abuse in order to get a full statement from the child, so that their evaluation can be used as evidence in case the child retracts allegations when protective services is contacted.

The experts were asked if they felt they could protect the child without protective services involvement. All of the experts felt that they have no capacity to protect children without the help of protective services. However, the majority of the experts stated reservations about the skillfulness of protective services workers to evaluate sexual abuse, and the capacity of protective services to protect children. Four of the experts admitted that they sometimes delay reporting in order to collect as complete a disclosure as possible before involving the authorities. However, two of the experts stated that despite their reservations about the clinical skills of the protective services workers, they report abuse and then work within the system to advocate for the child. All of the experts have established personal strategies for maximizing their power within the protective services system. It seems that most experts engage in active, persistent communication with protective services workers and if necessary with higher ranking protective services workers to ensure that clients are adequately served by protective services.

The experts were asked if they had any complaints about child abuse reporting laws. All of the experts agreed that child abuse reporting laws are useful and necessary. Several experts felt the mandated reporting laws lack operational definitions for reporting criteria. But in general, all of the experts agreed in theory with reporting laws.

All experts felt that there are systemic problems in the implementation of child abuse reporting laws. For instance, several experts felt that inadequately trained or overworked staff at protective services leads to gross mismanagement of cases once they are reported. Fragmentation of services, turf issues, inconsistent handling of cases, and inadequate follow-up were other criticisms of the protective services system.

There was a loud cry from the experts that protective services departmental regulations are not consistent with the letter of the law but the regulations are implemented as if they are the law. For instance, child abuse reporting laws require that all child abuse be reported. However, in many states, protective services regulations limit departmental intervention to cases where the perpetrator of the abuse is a parent or a caretaker. Professionals are mandated to report all cases of suspected abuse, even though many of these cases are automatically screened out under departmental regulations. Experts advocated for a broadening of protective services regulations to include abuse by noncaretakers.

Experts felt that there are several gaps in the law that need clarifying. They felt there is no clear policy regarding reporting abuse that has happened in the past which is disclosed after the fact. Several experts also wanted the laws to be more specific about procedures for handling cases where the child abuse occurs in one state and is reported in another state. Several experts wanted a broadening of the laws to regulate the management of cases involving juveniles as perpetrators.

DISCUSSION

Hypothesis 1

Part A: Suspicion

As expected, psychologists in this study were significantly more likely to suspect child abuse when symptoms associated with sexual abuse were more specific rather than less specific. Virtually all respondents had a substantial degree of suspicion when the child made a direct statement regarding abuse. The respondents' degree of suspicion decreased as the clinical presentation of sexual abuse became less and less specific to sexual abuse. Similarly, psychologists were significantly more likely to feel a higher degree of certainty that child abuse was occurring when clinical presentation of sexual abuse symptoms was more rather than less specific.

This study does not illuminate the reasons for these findings. One possible explanation is that as symptoms become less specific, there are more competing explanations for the child's symptom presentation. When a child makes a direct statement about abuse there are few competing explanations for this behavior. However, when a child exhibits sexualized behavior there are competing explanations for the behavior including possible nonabusive exposure to sexually explicit behavior. When acute traumatic symptoms appear, exposure to any traumatic event (abusive or nonabusive) must be considered. Cumulative stress symptoms can be explained by numerous other childhood disorders which are not associated with abuse.

There may be other reasons why clinicians suspect less when symptom presentation is less versus more specific. For example, some psychologists might be more knowledgeable of highly explicit indicators of sexual abuse than of less explicit indicators of sexual abuse and may suspect sexual abuse only when specific indicators of abuse are present. It is also possible that some psychologists have adequate knowledge about sexual abuse symptom presentation but are unwilling to contemplate the possibility of sexual abuse unless there are overt sexual cues in the clinical material.

It was expected that nonspecific versus specific clinical presentations of sexual abuse would arouse less clinical suspicion of abuse. Nonetheless, it is concerning since nonspecific sexual abuse symptoms can be indicative of severe or pervasive types of sexual abuse. In fact, acute traumatic symptoms, as exhibited at Level 3, are often seen in children who were sexually abused in terrifying and overwhelmingly traumatic ways (Sink, 1988). Cumulative stress symptoms as exhibited at Level 4, are commonly seen in children who have experienced sexual abuse over a long period of time (Sink, 1988). Further research is necessary to better understand what factors influence the formation of clinical suspicion in cases of sexual abuse.

As the specificity of symptoms diminished, there was more discrepancy among respondents in their clinical interpretation of the meaning of these symptoms related to abuse. There was almost complete unanimity among clinicians about the meaning of symptoms when there was a direct communication of abuse. When there was indirect communication, clinician opinions were somewhat more diverse but 96% had either moderate or substantial suspicion. However, at the two less specific symptom

presentation levels (acute traumatic symptoms and cumulative stress symptoms without a statement of abuse) respondents endorsed a range of responses varying from no suspicion to substantial suspicion. There was also considerable variation among clinicians in their level of certainty when sexual abuse indicators were nonspecific versus specific.

Currently there is not professional agreement about the meaning of nonspecific sexual abuse symptoms. Our understanding of clinical presentations of sexual abuse symptoms is in its infancy. Currently, there is no research which helps us understand what proportion of children who exhibit nonspecific sexual abuse symptoms have actually been sexually abused. Since our current knowledge is inadequate, there is considerable room for individual biases and variations in clinical interpretation. It is important to improve our knowledge in this area since the formation of a clinical suspicion of sexual abuse is a necessary prerequisite for child protection.

Part B: Reporting Behavior

Respondents were more likely to report to the authorities when sexual abuse symptoms were more rather than less specific. There was less consensus among psychologists about reporting as symptom specificity decreased. In addition, psychologists were more willing to report when they had reason to expect discontinuation of contact with the child than when there was an assumption of an on-going relationship.

There was considerable agreement among psychologists in this sample that a direct statement of abuse from the child should be reported to the authorities. This was true either when there was an assumption of on-going or discontinuation of contact with the child. The sexual abuse experts that were interviewed in this study held similar beliefs. All of

the experts felt that a direct statement of abuse from a child was adequate reason to report 100% of the time.

When there was indirect communication of sexual abuse, psychologists were significantly less likely to report, especially if there was an assumption of on-going contact with the child. Despite the decline in reporting behavior at this level of symptom specificity, 76% of the psychologists surveyed reported they would likely or definitely report their suspicions of abuse to the authorities when there was an assumption of on-going contact. An even higher 91% reported they would likely or definitely report their suspicions of abuse when there was an assumption of discontinued contact with the child. Some of the sexual abuse experts reported that they felt that aggressive sexual acting out with peers (which was evident in the vignette at this level) was reportable 100% of the time. However, the experts were not specifically polled about their opinions on this topic and therefore it is unclear whether there is consensus among them about this topic.

There was a dramatic drop in reporting behavior when sexual abuse symptom presentation became less specific (acute traumatic symptoms and cumulative stress symptoms versus direct communication and indirect communication). The vast majority of the psychologists presented with acute traumatic symptoms and cumulative stress symptoms stated they would unlikely or definitely not report. While they were unlikely to report at either nonspecific symptom level, they were significantly less likely to report at the least specific level of symptom presentation (cumulative stress symptoms). Respondents were also less likely to report if there was an assumption of on-going versus discontinued contact with the child.

As expected, the psychologists in this study were most likely to report when there was a direct statement from the child about abuse. Kalichman et al. (1988) found that clinicians were significantly more likely to report abuse when there was a direct statement of abuse than when the child did not make a statement about abuse. Sink (1988) points out that only highly specific sexual abuse symptoms, such as a direct statement of abuse from the child, is routinely accepted within legal circles as evidence that abuse has occurred. Less specific sexual abuse symptoms may have clinical validity but are less reliably accepted within legal contexts as evidence of abuse. It is possible that clinicians feel that once a report has been made to the authorities that it changes from a clinical to a legal case. That is, they no longer perceive the case primarily as a clinical case where there is little emphasis on gathering evidence or placing blame. Instead, they come to perceive it as a legal case where they will be called upon to contribute to the process of gathering evidence and establishing guilt or innocence. Therefore they may feel reluctant to report suspicions of abuse unless they feel that they have legally binding evidence.

Not surprisingly, there is not agreement among psychologists regarding reporting child abuse when symptom presentation is nonspecific. This finding is parallel to the previous finding regarding the formation of clinical suspicion in cases where there is nonspecific symptom presentation. As was suggested above, further information is needed about the meaning of nonspecific clinical presentation of sexual abuse symptoms, before we can expect to see greater agreement among psychologists on this topic.

Psychologists were more willing to report when there was an assumption of discontinued versus continued contact with the child. This general shift in reporting behavior might be explained by a variety of factors. One possibility is that some psychologists suspected abuse when there was an assumption of continued contact with the child, but chose to delay reporting in order to obtain a fuller clinical picture before reporting or to establish better rapport with the child or family before reporting. However, when the assumption of continued contact with the child was removed, the process of reporting was simply speeded up because further clinical contact was not possible. This seems quite plausible since several of the experts interviewed disclosed that they use clinical discretion in the timing of their report of sexual abuse suspicions.

Another possibility is that the mother's termination behavior was interpreted as a sign of avoidance or noncooperation with the evaluation process by some psychologists. If this were the case, the discontinued contact condition led psychologists to experience an increased level of suspicion that abuse was occurring in the family, which led to an increased likelihood of reporting. The expert interviews also suggest that this is a plausible explanation. All of the experts acknowledge that they are more likely to report if they perceive that the nonoffending parent is not cooperative with the evaluation process.

There is a third possibility. Perhaps some psychologists never planned to report their suspicions of abuse as long as there was an assumption of on-going clinical contact with the child. That is, they felt that they could adequately protect the child without outside intervention. It was only when they were confronted with discontinued contact with the child that they chose to involve the authorities. This

is the least plausible possibility. The fact that virtually all respondents would likely or definitely report when there is a direct statement of abuse regardless of assumptions of continued contact with the child argues against this explanation. Also, all of the experts interviewed strongly stated that they do not believe that they can protect the child without protective services intervention.

Hypothesis 2

Clinicians in this study were more likely to suspect abuse than to report abuse at every level of symptom presentation. This effect became more pronounced as symptom presentation became less specific. At the most specific level, 92% of clinicians had substantial suspicion of abuse, and only 74% would definitely report. While there was some lag between reporting and suspicion at this level, the majority of respondents would definitely or likely report. At the least specific level of symptom presentation (cumulative stress symptoms), 46% of respondents had a moderate or substantial clinical suspicion that child abuse was occurring, however, only 11% would likely or definitely report their suspicions of abuse to the authorities. Three quarters of those clinicians with clinical suspicion chose not to report their suspicions when sexual abuse symptom presentation was nonspecific.

The formation of a clinical suspicion of child abuse does not seem to be enough to spur many clinicians into reporting those suspicions to the authorities. Virtually all psychologists endorsed some level of suspicion of child abuse at all levels of symptom presentation. Child abuse reporting laws mandate that psychologists report all suspected child abuse. However, the vast majority of psychologists would not

report their suspicions of abuse at Levels 3 and 4 where symptom presentation was least specific, and a significant minority of psychologists maintained a nonreporting stance at Level 2 when symptom presentation was more specific.

There are several plausible explanations for professional nonreporting when there is a suspicion of sexual abuse. It is possible that nonreporting by some professionals is an act of civil disobedience. If this is the case, we can assume that some psychologists are aware that they have a suspicion of sexual abuse and that the law requires them to report their suspicions of abuse. However, they consciously decide to disobey the law. This civil disobedience might be fueled by different motivations. It is conceivable that some psychologists have a blatant disregard for the law and choose a nonreporting stance because they feel they are above the law. This is not a plausible explanation since the majority of clinicians were willing to report under some conditions.

Civil disobedience might be motivated by other more noble intentions. Clinicians may experience some sort of ethical dilemma surrounding reporting. Their decision to not report their suspicions may be motivated by a desire to achieve some higher good, or to avoid some harm. If this is the case, then these professionals may feel that disobeying the law is a morally correct decision, which represents the lesser of two evils. There is support for this explanation. Kalichman et al (1989) found that psychologists in their sample were dissatisfied with the effectiveness of child abuse reporting laws. In fact, they found that psychologists often felt that acting to further the child's welfare was not necessarily related to reporting abuse. Most of the sexual abuse experts reported that sometimes factors other than suspicion

motivated by a lack of clinical suspicion. This was a curious finding since many of the same respondents had endorsed having a moderate to substantial clinical suspicion on an earlier question at the same level of symptom presentation. This discrepancy in answers might be explained by their different perceptions of the term "suspicion" in these different contexts. In addition, the sexual abuse experts that were interviewed agreed that there is a difference between a legal and a clinical suspicion of sexual abuse. This lends credence to the argument that "suspicion" is perceived as a relative term which can vary from context to context. The experts pointed out that legal suspicion requires a higher threshold of evidence. Some psychologists might feel that a legal threshold of suspicion is necessary when reporting child abuse. Or perhaps there is a reporting threshold of suspicion which is exclusive of clinical or legal suspicion altogether.

Psychologists appear to feel most comfortable in a nonreporting stance when they have some element of doubt about their suspicions of sexual abuse. It is still unclear what factors contribute to this nonreporting stance. However, the fact that psychologists were less likely to report when there was a presumption of continued versus discontinued contact with the child suggests that some clinicians are willing to take some responsibility for child protection under some circumstances. Further exploration of psychologists' perceptions of the role of reporting and nonreporting in child abuse cases is necessary. There are numerous functions that reporting and nonreporting in child abuse cases can serve. Defining these numerous factors and understanding their relative impact in complex clinical decision-making would be helpful in our understanding of reporting behavior in professionals.

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Hypothesis 3

Female psychologists were more sensitive detectors of sexual abuse than their male counterparts. Female respondents were more likely than male respondents to suspect abuse. Gender differences were less apparent when the clinical presentation of sexual abuse was most direct and specific (direct communication). This might be a ceiling effect, since virtually all respondents, regardless of gender, had substantial clinical suspicion. Females were also more confident than males that abuse was occurring, regardless of the specificity of symptom presentation.

Females appear to be more likely than males to report abuse to the authorities. When respondents assumed an on-going relationship with the client, there was only a nonsignificant trend for females to report more than males. However, when the assumption of an on-going relationship with the client was removed (mother terminated evaluation), then females were significantly more likely than males to report to the authorities at all levels.

There have been mixed research findings about gender differences in child abuse reporting behavior. The results of this study, suggest that there are significant differences between male and female professionals in their perception of and reporting of sexual abuse.

The reasons for these differences are not clear. One possibility is that female professionals may be more sensitive to signs of victimization than males due to their socialization as females in our culture. This may be partly due to the fact that females, relative to males, are taught to be sensitive to the emotional needs of others. This increased sensitivity to the emotional need of others may be useful in detecting emotional indicators of victimization. Another aspect of female

socialization which may explain this finding is that females have less status than males in our society. Females are socialized to accept an inferior role, which is often accompanied by victimization such as sexual abuse, rape, and domestic violence. Since being a victim is a feminine role in this culture, female professionals may feel more personally familiar with emotional aspects of victimization than males. This may enhance the female professional's sensitivity to indicators of victimization. It is also possible that female professionals feel more personally, politically, and emotionally motivated than male professionals to detect and stop the victimization of females.

It may be that females are not particularly perceptive about detecting victimization, but instead that male professionals are particularly poor detectors of victimization. There are a variety of reasons why this might be the case. Perhaps male professionals have more denial related to sexual abuse symptoms. It is conceivable that male denial could exist to help cope with feelings of guilt, shame, or responsibility for their gender identification with the aggressor. It is also possible that male professionals are more likely to believe that sexual abuse is a relatively rare or innocuous phenomena and therefore are less attentive to indicators of abuse. There is evidence to suggest that male professionals tend to underestimate the prevalence of sexual abuse and tend to underestimate the emotional impact of sexual victimization (Attias and Goodwin, 1985).

It is also possible that there was a confounding factor in the design of this study that can explain the gender differences found. The child in all of the clinical vignettes presented to the respondents was female. Perhaps the detected gender differences reflect sensitivity to

same-gender clients rather than sensitivity to indicators of victimization. While this may be the case, it does not negate the need for male professionals to be sensitive to signs of sexual victimization in female clients. This is especially true since the majority of victims of sexual abuse are females.

Hypothesis 4

It was expected that specialized training in sexual abuse treatment and evaluation would impact clinical decision-making. However, significant training effects were not found. Psychologists with extensive experience and training in child sexual abuse were no more likely than those psychologists with little training in child sexual abuse to suspect or report abuse.

There are ambiguous findings in previous research regarding the impact of professional training on reporting behavior. In this study no differences were found based on specialized sexual abuse training. It is possible, but not plausible that professional training does not impact clinical decision-making regarding child abuse reporting. Perhaps there is some inadequacy in sexual abuse training as it currently exists. That is, the current "infant" state of research in this area, can not adequately inform clinicians about appropriate clinical decision-making in this area. Therefore it is possible that clincians are receiving training that does not directly impact their clinical behavior.

It seems more likely that professional training differences in this study were masked due to the choice of sample population. The subjects in this study were all doctoral-level pediatric psychologists, who come from a relatively homogeneous training background. Obviously, all

respondents had interests and training in issues pertaining to children, including child abuse. It is possible that once clinicians reach a high level of training, additional training in a particular issue, such as sexual abuse, may not have a major influence on decision-making. Haas et al (1988) who sampled predominantly doctoral level psychologists found that formal ethics training did not have an impact on decision-making regarding ethical dilemmas. They suggest that there is a common core of clinical knowledge that is obtained through training and that this core is most critical in future decision-making. It would be helpful to sample a less homogeneous group of psychologists, and also other mental health professionals using this same survey to determine if training differences can be determined.

Clinician Beliefs Related to Reporting and Nonreporting

There was significant agreement among psychologists about the factors that impacted their decision to report, regardless of the specificity of symptoms being reported. Respondents felt their decision to report to the authorities in any given case was highly influenced by their clinical suspicion of child abuse. They were also highly motivated by their perception that the child was at risk for further abuse and a very strong sense of ethical/moral obligation. Respondents strongly denied that their decision to report was influenced by a fear of prosecution for failure to report. Their decision to report was not based on a feeling of confidence that protective services would adequately handle the case. It seems that the decision to report is motivated by concerns for the child's safety, although clinicians appear to have doubts about the ability of protective services to adequately intervene.

On the other hand, there was less consistency across conditions and among psychologists in their reasons for not reporting abuse. Psychologists who chose not to report when the presentation of sexual abuse symptoms was more specific tended to endorse different reasons for their decisions not to report than those psychologists who chose not to report when the presentation of sexual abuse symptoms was less specific. When sexual abuse symptoms were more specific, the decision not to report appeared to be motivated by clinical concerns including fears that premature reporting would interrupt the disclosure process, and that premature reporting might cause the family to flee from the evaluation. There was no clear tendency for these clinicians to endorse or deny the importance of client/therapist confidentiality or confidence in the authorities to adequately handle the case in their nonreporting decision. Their nonreporting decision was not motivated by a lack of clinical suspicion.

When the presentation of sexual abuse symptoms was less specific there was less uniformity in clinical reasoning. Clinicians agreed that their nonreporting decision was motivated by a lack of clinical suspicion. This was a curious finding since many of the same respondents had endorsed having a moderate to substantial clinical suspicion on an earlier question at the same level of symptom presentation. It is unclear if this reflects a "forgetting" process or whether clinicians perceive that the definition of a clinical suspicion changes when the concept of reporting is introduced. Nonreporting at this level was not due to a lack of confidence in protective services to handle the case adequately. The slim majority of clinicians did feel that clinical concerns impacted their nonreporting decision including feeling that: the

evidence did not warrant the breaking of client/therapist confidentiality; the premature reporting of abuse might interrupt the disclosure process; and the premature reporting of abuse might cause the family to flee from the evaluation. However, a significant minority of clinicians denied that these clinical factors impacted their nonreporting decision.

Reasons for Caution in Making Inferences from this Study

Forty three per cent of potential subjects returned their surveys. Bulk mailing did not allow for undelivered surveys to be returned to the researcher. Therefore it is impossible to know how many surveys actually reached potential subjects. It is possible that the return rate was deflated by this factor.

It is possible that the sample of respondents versus nonrespondents was biased in some fashion. One factor that clearly influenced completion of the survey relates to whether the subject had clinical experience. As noted previously, some members of the Society of Pediatric Psychology are academic psychologists and do not engage in clinical work, and therefore were not suited to complete the survey. Another potential bias is that responders may have been more interested in the topic of child sexual abuse than nonresponders and therefore felt more motivated to return their surveys.

When making inferences from this study the issue of generalizability should be considered. The sample used in this study does not represent all psychologists, or even all psychologists who encounter child abuse cases. Therefore caution should be used when drawing conclusions from this study and applying it to psychologists in general. This study also does not include professionals other than psychologists and is of limited

use in understanding the clinical decision-making of other mental health professionals. Further research would be necessary to understand whether the current results are generalizable to all psychologists and other mental health professional.

It is unclear the degree to which the respondents' answers on this survey were consistent with their behavior in clinical practice. It is possible that respondents answered in a biased fashion. It seems most plausible that if biased responding occurred, it would be in the direction of heightened detection and heightened reporting. In actual clinical cases, harboring a suspicion or filing a report of child abuse are complicating factors that inevitably impact the course of therapy and require increased clinical time and energy. Since there is no impact on the clinician when responding to an anonymous survey, they may be more willing to recognize their suspicions and indicate they would report them. It is possible that the results obtained in this study are somewhat inflated compared to the actual practice of clinical psychology. Further research is necessary to study actual cases involving clinical decision-making regarding the reporting of sexual abuse symptoms.

This study required respondents to make decisions based on a one-time encounter with a client. Hypothetical vignettes are quite limited in the information they provide. It is possible that clinicians would encounter this in their practice of clinical psychology, but it is not usual. In actual clinical practice, there is almost always more opportunity to obtain important information from the child, the child's parent, and the school than was afforded them in this survey study. Many respondents made comments on the survey that they needed more information to make a clinical decision. Also in actual clinical

practice, clinicians have a wealth of information available to them including physical presentation, nonverbal communication, and interaction style. Obviously the arbitrary nature of a survey study, limits the type of information that is provided to the clinician and places restraints on the realism of the clinical dilemma posed. Again, more research which involves the study of actual cases of suspected sexual abuse would be helpful.

SUMMARY AND CONCLUSIONS

Psychologists in this study were significantly more likely to suspect child abuse when symptoms associated with sexual abuse were more specific rather than less specific. There was agreement among pediatric psychologists and the sexual abuse experts interviewed that overt disclosures of sexual abuse would cause them to have substantial suspicion of child abuse that would lead them to report suspected abuse to the authorities. As the specificity of sexual abuse symptom presentation decreased the respondents' degree of suspicion and willingness to report decreased. Currently, it seems that a direct communication of abuse is the standard which is accepted among psychologists for reporting suspicions of sexual abuse to the authorities.

There was a distinct tendency for psychologists in this study to under-report their suspicions of sexual abuse. They were more likely to suspect abuse than to report abuse at every level of symptom presentation. It appears that psychologists feel most comfortable in a nonreporting stance especially when they have some element of doubt about their suspicions of sexual abuse. Also, psychologists appear to be less willing to report to the authorities when there is an assumption of continued versus discontinued contact with the child. Further study of psychologists' motives for under-reporting child sexual abuse is necessary. It is important to understand whether psychologists make a distinction between "suspicion in a clinical context" versus "suspicion

in a reporting context". In addition, it would be useful to know whether psychologists perceive that they are disobeying the law, and if so, their reasons for doing so.

There is more variability in professional judgements about suspicion and reporting of child abuse when symptom presentation is less versus more specific. There is not professional agreement about the meaning of nonspecific sexual abuse symptoms. Further research is necessary to better understand the meaning of nonspecific sexual abuse symptoms in children. It would also be interesting to understand why some clinicians form a high level of clinical suspicion when presented with nonspecific clinical indicators of abuse and others form little or no clinical suspicion.

There was strong agreement among psychologists about their reasons for reporting their suspicions of abuse to the authorities. These factors include: having a clinical suspicion of child abuse, having a perception that the child is at risk for further abuse, and a feeling of ethical/moral obligation to report. Reporting among psychologists is not impacted by fear of prosecution for failure to report or by a feeling of confidence that protective services will adequately handle the case.

There is less consensus among clinicians about the factors that contribute to a clinical decision not to report child abuse. The reasons for nonreporting appear to be different when symptom presentation is more versus less specific to sexual abuse. It seems that clinical concerns including fears that premature reporting would interrupt the disclosure process or might cause the family to flee from the evaluation are pivotal factors when symptom presentation is more specific. When symptom

presentation is less specific, lack of clinical suspicion is a strong motivating factor for nonreporting.

The gender of the psychologist seems to significantly impact professional decision-making regarding suspicion and reporting of child abuse. Female psychologists were more likely than male psychologists to suspect and report abuse. It would be interesting to understand if female professionals are better detectors of other types of victimization, as well. Male professionals may benefit from consciousness-raising type activities regarding sexual abuse to increase their ability to suspect and report sexual abuse symptoms.

Surprisingly, psychologists with extensive experience and training in child sexual abuse were no more likely than those with little training in child sexual abuse to suspect or report abuse. It is possible that training differences were masked in this study. However, further research is necessary in order to determine whether sexual abuse training impacts clinical decision-making regarding suspicion and reporting of sexual abuse symptoms.

APPENDICES

DEPARTMENT OF PSYCHOLOGY

June, 1989

Dear Colleague:

We are certain you will agree that sexual abuse of children is an important clinical and social issue. Recent court decisions have generated considerable discussion among mental health professionals regarding the proper threshold for responding to state laws mandating the reporting of such abuse to authorities. We ask your help in an effort to study the decision-making process used by pediatric psychologists in making decisions about when to file such reports.

Louise M. Finlayson, a doctoral candidate at Michigan State University, is conducting a survey on clinical decision-making in this arena. We would very much appreciate and value your participation, which should only take between fifteen and thirty minutes. Your responses will remain completely anonymous. If you choose to participate, your informed consent will be assumed.

If you would like to receive a summary of my results, please write to Ms. Finlayson, c/o the Department of Psychology, Michigan State University, 129 Psychology Research Building, East Lansing, MI 48824.

Thank you in advance for your help in this important survey.

Sincerely,

Gerald P. Koocher, Ph.D.
Chief Psychologist
Associate Professor
Harvard Medical School

Louise M. Finlayson, M.A.
Clinical Fellow in Psychology

JUDGE BAKER CHILDREN'S CENTER *and* THE CHILDREN'S HOSPITAL
295 Longwood Avenue
Boston, Massachusetts 02115
(617) 232-8390

300 Longwood Avenue
Boston, Massachusetts 02115
(617) 735-6680

APPENDIX B

PLEASE CAREFULLY READ THE FOLLOWING SET OF INSTRUCTIONS BEFORE READING OR COMPLETING THIS SURVEY.

1) Please read the child abuse reporting law below. When responding to the questions in this survey, assume that this law exists in the state in which you are practicing psychology.

2) Turn to the next page and read the clinical vignette presented on that page. Then respond to the questions accompanying the clinical vignette. When responding to the questions please rely on your clinical experience and respond in a manner that is consistent with your actual practice of psychology.

3) Turn to the next page and read the second clinical vignette and respond to the accompanying questions. Continue on to the third and then the fourth vignette.

IT IS IMPORTANT THAT YOU READ ONE VIGNETTE AT A TIME AND RESPOND TO THE ACCOMPANYING QUESTIONS BEFORE CONTINUING ON TO READ THE NEXT VIGNETTE.

4) Please provide the requested information about your professional background on the final page.

5) Return the survey in the envelope provided. Please send requests for research results in a separate envelope to preserve your anonymity.

Thank you for your participation in this study.

Child Abuse Reporting Law

Any psychologist who in his or her professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering serious physical or emotional injury resulting from abuse inflicted upon him or her including sexual abuse, or from neglect including malnutrition shall immediately report such condition to the department. Any such person who is required to make such report and fails to do so shall be punished by a fine not more than $1,000. No such person so required to report shall be liable in any civil or criminal action by reason of such report. Any privileged communication or confidential communication shall not prohibit the filing of a report.

APPENDIX C

The Case of Anne

Anne (age 7) was referred for psychological evaluation by school officials. Anne's mother reports that Anne has complained of stomach pain over the past year, although her physician has been unable to determine any medical cause for the pain. Anne's mother has noticed that in the past year, Anne has become more socially withdrawn, for instance she seldom plays with her friends and often chooses to spend time alone in her room. Anne's grades have fallen and she seems uninterested in school.

Anne lives with her sister (age 4), mother, and step-father. Her mother denies any traumatic events or significant life changes in the past year. She reports that Anne's behavior began to change several months after she started her part-time evening job. She admits that she has less time to spend with Anne but feels comforted that her husband cares for the children while she works.

During the child interview, Anne appears listless, and sad. She seems disinterested in the many toys in your office. Anne is polite and compliant. She offers brief responses to your questions about school, and home. You ask Anne about her stomach pain, and she responds, "It feels like someone is stabbing me". You ask her if she has any worries or concerns, and she states, "I worry about what will happen to my sister if I die". You ask Anne to tell you more about that, and she states, "I'm the only one who can take care of my sister". She becomes quiet and withdrawn and you are unable to elicit further information from her.

1) Given the above information, my clinical impression is that there is: (please check one)

_____ a) no reason to suspect child abuse
_____ b) little reason to suspect child abuse
_____ c) moderate reason to suspect child abuse
_____ d) substantial reason to suspect child abuse

2) Given the above information, I feel _____% certain that child abuse is occurring in this case.

(place an X on the continuum)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3) Given the above information, I would: (please check one)

_____ a) definitely not report this case to the authorities
_____ b) be unlikely to report this case to the authorities
_____ c) be likely to report this case to the authorities
_____ d) definitely report this case to the authorities

4) If Anne's mother refused to schedule another appointment, stating that she had decided to handle Anne's problems within the family, I would: (please check one)

_____ a) definitely not report this case to the authorities
_____ b) be unlikely to report this case to the authorities
_____ c) be likely to report this case to the authorities
_____ d) definitely report this case to the authorities

**If your answer on question 3 was a or b, please answer question 5.
**If your answer on question 3 was c or d, please answer question 6.

5. Rate the impact that each of the following factors had on your decision not to report this case to the authorities.

0 = no impact on decision
1 = little impact on decision
2 = moderate impact on decision
3 = strong impact on decision

a) Little or no clinical suspicion of child abuse in this case _____

b) Evidence does not warrant the breaking of client/therapist confidentiality _____

c) Lack confidence in the ability of the authorities to adequately evaluate and/or protect in cases of child abuse _____

d) Concern that premature reporting of child abuse may interrupt the uncovering or disclosure additional details of the abuse _____

e) Concern that premature reporting of child abuse may cause the family to flee from the evaluation _____

f) Other (please describe)_____ _____

g) Other (please describe)_____ _____

6. Rate the impact that each of the following factors had on your decision to report this case to the authorities:

0 = no impact on decision
1 = little impact on decision
2 = moderate impact on decision
3 = strong impact on decision

a) Clinical suspicion of child abuse in this case _____

b) Confidence in the ability of the authorities to adequately evaluate and/or protect in cases of child abuse _____

c) Ethical/moral obligation to report _____

d) Concern that the child is at risk for further abuse _____

e) Fear of prosecution for failure to report _____

f) Other (please describe) _____ _____

g) Other (please describe) _____ _____

The Case of Tracy

Tracy (age 7) was referred for psychological evaluation by school officials. Tracy's mother reports that Tracy has become more difficult to manage over the past several months. She states that Tracy has become noncompliant at home and at school, and her behavior seems driven and wild. She also reports that she has received reports from other parents that Tracy has forced other children to pull down their pants.

Tracy lives with her sister (age 4), mother, and step-father. Her mother denies any traumatic events or significant life changes in the past year. She reports that Tracy's behavior began to change several months after she started her part-time evening job. She admits that she has less time to spend with Tracy but feels reassured that her husband cares for the children while she works.

During the child interview, Tracy is very active and distracted. She erratically explores the room and seems reluctant to talk with you about her school or home life. During her play at the dollhouse, Tracy places a male doll on top of a female doll and says, "The man is poking the girl. She's crying". Tracy breaks from the play and begins singing loudly. You ask her to tell you more about the man poking the girl, and she emphatically states that she does not want to talk anymore. You are unable to elicit any further information by the end of the session.

1) Given the above information, my clinical impression is that there is: (please check one)

_____ a) no reason to suspect child abuse
_____ b) little reason to suspect child abuse
_____ c) moderate reason to suspect child abuse
_____ d) substantial reason to suspect child abuse

2) Given the above information, I feel _____% certain that child abuse is occurring in this case.

(place an X on the continuum)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3) Given the above information, I would: (please check one)

_____ a) definitely not report this case to the authorities
_____ b) be unlikely to report this case to the authorities
_____ c) be likely to report this case to the authorities
_____ d) definitely report this case to the authorities

4) If Tracy's mother refused to schedule another appointment, stating that she had decided to handle Tracy's problems within the family, I would: (please check one)

_____ a) definitely not report this case to the authorities
_____ b) be unlikely to report this case to the authorities
_____ c) be likely to report this case to the authorities
_____ d) definitely report this case to the authorities

**If your answer on question 3 was a or b, please answer question 5.
**If your answer on question 3 was c or d, please answer question 6.

5. Rate the impact that each of the following factors had on your decision not to report this case to the authorities.

0 = no impact on decision
I = little impact on decision
2 = moderate impact on decision
3 = strong impact on decision

a) Little or no clinical suspicion of child abuse in this case _____

b) Evidence does not warrant the breaking of client/therapist confidentiality _____

c) Lack confidence in the ability of the authorities to adequately evaluate and/or protect in cases of child abuse _____

d) Concern that premature reporting of child abuse may interrupt the uncovering or disclosure additional details of the abuse _____

e) Concern that premature reporting of child abuse may cause the family to flee from the evaluation _____

f) Other (please describe)_____ _____

g) Other (please describe)_____ _____

6. Rate the impact that each of the following factors had on your decision to report this case to the authorities:

0 = no impact on decision
I = little impact on decision
2 = moderate impact on decision
3 = strong impact on decision

a) Clinical suspicion of child abuse in this case _____

b) Confidence in the ability of the authorities to adequately evaluate and/or protect in cases of child abuse _____

c) Ethical/moral obligation to report _____

d) Concern that the child is at risk for further abuse _____

e) Fear of prosecution for failure to report _____

f) Other (please describe) _____ _____

g) Other (please describe) _____ _____

The Case of Jean

Jean (age 7) was referred for psychological evaluation by school officials. Jean's mother reports that Jean has had a sudden change in behavior over the past month. She notes that Jean has become unusually whiny, clingy, and fearful. In addition, she now wets her bed every night. Jean's teacher has also reported a sudden deterioration in Jean's school performance.

Jean lives with her sister (age 4), mother, and step-father. Her mother denies any traumatic events or significant life changes in the past year. She reports that Jean's behavior began to change several months after she started her part-time evening job. She admits that she has less time to spend with Jean but feels comforted that her husband cares for the children while she works.

During the child interview, Jean exhibits significant problems separating from her mother. She insists that the door to the office remain open during the interview. Jean appears frightened and does not interact freely with you. She is reticent about playing or talking with you and asks frequently to return to her mother. Her drawings are disorganized and infantile. You ask Jean to tell you about her drawing and she states, "It's a picture of the bad man". You inquire further about the "bad man" and Jean responds, "The bad man is dead". You ask Jean about her worries and fears but she insists on returning to her mother.

1) Given the above information, my clinical impression is that there is: (please check one)

_____ a) no reason to suspect child abuse
_____ b) little reason to suspect child abuse
_____ c) moderate reason to suspect child abuse
_____ d) substantial reason to suspect child abuse

2) Given the above information, I feel _____% certain that child abuse is occurring in this case.

(place an X on the continuum)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3) Given the above information, I would: (please check one)

_____ a) definitely not report this case to the authorities
_____ b) be unlikely to report this case to the authorities
_____ c) be likely to report this case to the authorities
_____ d) definitely report this case to the authorities

4) If Jean's mother refused to schedule another appointment, stating that she had decided to handle Jean's problems within the family, I would: (please check one)

_____ a) definitely not report this case to the authorities
_____ b) be unlikely to report this case to the authorities
_____ c) be likely to report this case to the authorities
_____ d) definitely report this case to the authorities

**If your answer on question 3 was a or b, please answer question 5.
**If your answer on question 3 was c or d, please answer question 6.

5. Rate the impact that each of the following factors had on your decision not to report this case to the authorities.

0 = no impact on decision
1 = little impact on decision
2 = moderate impact on decision
3 = strong impact on decision

a) Little or no clinical suspicion of child abuse in this case _____

b) Evidence does not warrant the breaking of client/therapist confidentiality _____

c) Lack confidence in the ability of the authorities to adequately evaluate and/or protect in cases of child abuse _____

d) Concern that premature reporting of child abuse may interrupt the uncovering or disclosure additional details of the abuse _____

e) Concern that premature reporting of child abuse may cause the family to flee from the evaluation _____

f) Other (please describe)_____ _____

g) Other (please describe)_____ _____

6. Rate the impact that each of the following factors had on your decision to report this case to the authorities:

0 = no impact on decision
1 = little impact on decision
2 = moderate impact on decision
3 = strong impact on decision

a) Clinical suspicion of child abuse in this case _____

b) Confidence in the ability of the authorities to adequately evaluate and/or protect in cases of child abuse _____

c) Ethical/moral obligation to report _____

d) Concern that the child is at risk for further abuse _____

e) Fear of prosecution for failure to report _____

f) Other (please describe) _____ _____

g) Other (please describe) _____ _____

The Case of Brenda

Brenda (age 7) was referred for psychological evaluation by school officials. Brenda's mother reports that about two months ago, Brenda's mood and behavior showed a marked change. She notes that Brenda was previously a happy, well-adjusted child. Brenda's mother now observes that she seems worried, preoccupied, has nightmares every night, and has a diminished appetite. She reports that Brenda's teacher has also noticed the recent change in Brenda's behavior.

Brenda lives with her sister (age 4), mother, and step-father. Her mother denies any traumatic events or significant life changes in the past year. She reports that Brenda's behavior began to change several months after she started her part-time evening job. She admits that she has less time to spend with Brenda but feels comforted that her husband cares for the children while she works.

During the child interview, Brenda is nervous and shy. You ask Brenda about what is worrying her, and she tells you, "I can't tell you." You ask her if she can show you in a drawing. She proceeds to draw a picture which appears to be two naked people. You ask Brenda to tell you about the picture and she says, "He's hurting her". You ask her to tell you more and she says, "He's peeing on her". You ask her to identify the characters in the picture and she states, "That's my daddy and that's me, and sometimes my daddy pees on me." She proceeds to cry and is unwilling to talk anymore.

1) Given the above information, my clinical impression is that there is: (please check one)

_____ a) no reason to suspect child abuse
_____ b) little reason to suspect child abuse
_____ c) moderate reason to suspect child abuse
_____ d) substantial reason to suspect child abuse

2) Given the above information, I feel _____% certain that child abuse is occurring in this case.

(place an X on the continuum)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3) Given the above information, I would: (please check one)

_____ a) definitely not report this case to the authorities
_____ b) be unlikely to report this case to the authorities
_____ c) be likely to report this case to the authorities
_____ d) definitely report this case to the authorities

4) If Brenda's mother refused to schedule another appointment, stating that she had decided to handle Brenda's problems within the family, I would: (please check one)

_____ a) definitely not report this case to the authorities
_____ b) be unlikely to report this case to the authorities
_____ c) be likely to report this case to the authorities
_____ d) definitely report this case to the authorities

**If your answer on question 3 was a or b, please answer question 5.
**If your answer on question 3 was c or d, please answer question 6.

5. Rate the impact that each of the following factors had on your decision not to report this case to the authorities.

0 = no impact on decision
1 = little impact on decision
2 = moderate impact on decision
3 = strong impact on decision

a) Little or no clinical suspicion of child abuse in this case _____

b) Evidence does not warrant the breaking of client/therapist confidentiality _____

c) Lack confidence in the ability of the authorities to adequately evaluate and/or protect in cases of child abuse _____

d) Concern that premature reporting of child abuse may interrupt the uncovering or disclosure additional details of the abuse _____

e) Concern that premature reporting of child abuse may cause the family to flee from the evaluation _____

f) Other (please describe)_____ _____

g) Other (please describe)_____ _____

6. Rate the impact that each of the following factors had on your decision to report this case to the authorities:

0 = no impact on decision
1 = little impact on decision
2 = moderate impact on decision
3 = strong impact on decision

a) Clinical suspicion of child abuse in this case _____

b) Confidence in the ability of the authorities to adequately evaluate and/or protect in cases of child abuse _____

c) Ethical/moral obligation to report _____

d) Concern that the child is at risk for further abuse _____

e) Fear of prosecution for failure to report _____

f) Other (please describe) _____ _____

g) Other (please describe) _____ _____

Professional Background Information Sheet

1. _____ SEX 2. _____ AGE

3. _____ In what states are you licensed as a psychologist?

4. _____ Number of years since initial licensure.

5. Number of hours per week spent in direct clinical service or supervision of clinical cases.

   (circle one) 0 1-10 hrs 11-20 hrs 21-30 hrs over 30 hrs

6. Please indicate the type of setting in which the majority of your practice of psychology takes place.

   (check one)
   _____ Medical Hospital
   _____ Psychiatric Hospital
   _____ University Clinic
   _____ Outpatient Clinic
   _____ Private Practice
   _____ Other (specify)_____

7. Approximately how many books have you read on the evaluation or treatment of child sexual abuse?

   (circle one) 0 1-3 4-6 7-9 10 or more

8. Approximately how many journal articles have you read on the evaluation or treatment of child sexual abuse?

   (circle one) 0 1-5 6-10 11-15 16 or more

9. How many workshops have you attended on the topic of the evaluation or treatment of child sexual abuse?

   (circle one) 0 1-2 3-4 5-6 7 or more

10. How many courses or seminars have you attended or taught that covered in-depth the topic of child sexual abuse?

    (circle one) 0 1 2 3 4 or more

11. How many clinical cases have you seen or supervised in which child sexual abuse was a major treatment issue?

    (circle one) 0 1-3 4-6 7-9 10 or more

12. How many clinical cases have you seen or supervised which involved the evaluation of child sexual abuse?

    (circle one) 0 1-3 4-6 7-9 10 or more

13. How many cases of suspected child sexual abuse have you reported to the authorities?

    (circle one) 0 1-2 3-4 5-6 7 or more

14. How many cases of suspected child abuse or neglect not involving sexual issues have you reported to the authorities?

    (circle one) 0 1-2 3-4 5-6 7 or more

APPENDIX E

Dear Colleague:

We recently sent you a survey regarding clinical decision-making and child abuse. If you have already returned the survey, thank you for your participation. If you have not yet completed the survey, we encourage you to do so. Your help is greatly appreciated.

Sincerely,

Louise M. Finlayson, M.A.
Gerald P. Koocher, Ph.D.

APPENDIX F

Name: _____

Date of Interview: _____

I. Background Information: (get copy of CV)

A. Approximately how many cases of child sexual abuse have you evaluated

in your career? _____

in the past year _____

B. Approximately how many hours a week do you spend in direct clinical contact? _____

C. Approximately what percentage of your clinical time is spent in the treatment of or evaluation of sexual abuse? _____

D. In what sort of setting do you practice?_____

_____

II. Reporting Behavior:

A. Are you a mandated reporter? Yes No Don't Know

B. What does that child abuse reporting law in your state say is the necessary threshold for reporting sexual abuse?_____

_____

_____

C. Approximately how many cases of suspected sexual abuse have you reported to the authorities in the past year?_____

in your career? _____

D. Compared to other clinicians with less experience in sexual abuse do you feel you have a low threshold for reporting (that is you are more likely to report) or a high threshold for reporting (that is you are less likely to report)?_____

_____

_____

E. How do you decide whether to report to protective services for suspicion of sexual abuse? Can you define specific factors that influence your decision?

F. Are there specific symptoms or behaviors that would compel you to report to protective services 100% of the time?

G. In your opinion what constitutes full legal evidence to confirm a diagnosis or finding of sexual abuse?

H. Are there ever times that you report a case of suspected sexual abuse that you do not have full evidence to confirm such a diagnosis?

I. Are there ever times that you report a case of suspected sexual abuse that you have only vague or diffuse evidence?

J. Are there ever times that you clinically suspect sexual abuse but do not report it? Under what conditions might this occur?

K. In your opinion, is there a difference between a legal suspicion of sexual abuse and a clinical suspicion of sexual abuse?

Can you define this?

III. List of Factors

A. How do the following factors influence or impact your decision of whether or not to report a clinical suspicion of sexual abuse?

Y N 1) age of child

Y N 2) sex of child

Y N 3) age of alleged perpetrator

Y N 4) sex of alleged perpetrator _____

_____

_____

Y N 5) whether a perpetrator has been named _____

_____

_____

Y N 6) relationship of child to perpetrator _____

_____

_____

_____

Y N 7) perceived safety of child at time of evaluation

_____

_____

_____

Y N 8) mother's (un)willingness to contemplate possibility of abuse_____

_____

_____

Y N 9) mother's presentation as a (un)protective parent

_____

_____

_____

Y N 10) mother's level of cooperation with evaluation process

_____

_____

_____

_____

Y N 11) concerns about the impact of allegations on the alleged perpetrator _____

_____

_____

Y N 12) belief that you can protect the child without outside intervention _____

_____

_____

Y N 13) previous +/- experience with protective services on a similar case _____

_____

_____

_____

Y N 14) previous +/- experience with a specific protective services office or district _____

_____

_____

_____

Y N 15) concerns about potential harm protective services involvement will have on the child_____

_____

_____

_____

_____

Y N 16) concerns about potential harm of reporting on your your therapeutic relationship with the child _____

_____

_____

_____

Y N 17) concerns about the skills of protective services workers in evaluating sexual abuse _____

_____

_____

_____

Y N 18) concerns about protective services ability to protect the child _____

_____

_____

_____

Y N 19) concerns that premature reporting will lead to a retraction of the allegations by the child. _____

_____

_____

_____

_____

Y N 20) concerns about impact on you of getting involved in legal issues _____

_____

_____

_____

Y N 21) concern that your report will be screened out because of inadequate evidence

_____

_____

_____

_____

IV. Protective Services:

A. In your experience, how effective are child abuse reporting laws in protecting children from sexual abuse once suspicion of abuse has been reported?

0 1 2 3 4 5 6 7 8 9 10
ineffective effective

B. In your experience, how effective is protective services in evaluating sexual abuse?

0 1 2 3 4 5 6 7 8 9 10
ineffective effective

V. Opinions about Child Abuse Reporting Laws

A. What complaints do you have about child abuse reporting laws?

_____

_____

_____

_____

_____

_____

_____

B. Do you have any suggestions for changes in the child abuse reporting laws? _____

_____

_____

_____

_____

_____

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