

Professionals' Attitudes and Accuracy on Child Abuse Reporting Decisions in New Zealand

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Abstract:

Without mandatory child abuse reporting laws in New Zealand, professionals' decisions to contact child protective services must often reflect subjective and situational factors. This study examined abuse reporting decisions of 255 New Zealand health, education, and mental health professionals on 12 abuse scenarios. Certainty ratings on reporting decisions and eight attitudes about reporting were also obtained. Accuracy of professionals' decisions was compared to judgments by child protective services. Mental health professionals were less accurate in reporting decisions than were teachers or doctors. Across occupations, those opposed to mandatory reporting were least accurate but most certain in their reporting decisions. Accuracy was lowest for child neglect and highest for sexual abuse cases. Continued efforts to clarify influences on reporting behavior will enable a review of public policy initiatives and the efficacy of mandatory reporting laws.

Article:

Adoption of legal mandates for abuse reporting has been slow in many countries globally, particularly for child maltreatment occurring within the home (Doek, 1991). Many countries prefer voluntary reporting. Despite laws in countries requiring consultation with child protective services, numerous factors influence the abuse reporting behavior of professionals. In the absence of specified mandatory child abuse reporting laws or guidelines, professionals in industrialized countries, such as New Zealand, must rely entirely on subjective and situational factors when deciding whether to contact protective services. Minimal research on child maltreatment reporting has been conducted in New Zealand (Kotch, Chalmers, Fanslow, Marshall, & Langley, 1993). Because New Zealand is an industrialized nation endorsing voluntary abuse reporting, the actual influence of situational and personal factors on abuse reporting decisions can be studied more purely, without the confound of the perceived constraint of legal consequences. Such studies of professionals in the United States must factor in the legal pressure to report child abuse. Investigating such characteristics in an industrialized country such as New Zealand thus presents a unique opportunity to evaluate how reporting decisions are made in the absence of laws. The present study evaluated how various factors relate to the accuracy of reporting decisions as well as to professionals' attitudes and beliefs about abuse reporting policies.

With regard to the legal background relevant to child abuse in the United States, child maltreatment first gained widespread popular and scholarly attention following the seminal article by Kempe, Silverman, Steele, Droegemueller, and Silver in 1962 identifying nonaccidental injury to children. In 1963, the first mandatory reporting laws were drafted in the United States, "based on the belief that professionals, particularly physicians, would not voluntarily report suspected cases of child abuse" (Thompson-Cooper, Fugere, & Cormier, 1993, p. 558). All states had a statute governing child abuse reporting by 1966, and after the Child Abuse Prevention and Treatment Act of 1974, procedures for the definition, investigation, and intervention of child abuse were clarified (Lindsey, 1994).

Mandatory child abuse reporting laws require professionals to advise child protective services whenever they have reasonable grounds to suspect child abuse or neglect. Confusion and resistance occurs in the gray area of what constitutes reasonable grounds, thereby enabling professionals to exercise judgment on whether a particular situation necessitates compliance with the statutes. Introduction of such laws to a region typically prompts a precipitous climb in the number of cases reported to social services. For instance, in 1962, when

Kempe et al. first pronounced the existence of a “battered child syndrome,” there were about 10,000 reports of child abuse in the United States (Lindsey, 1994), compared to the nearly 3 million reports in 1999 (U.S. Department of Health and Human Services, 2001). This exponential rise is understandably accompanied by concerns about large numbers of unfounded reports (Besharov, 1990). However, concerns about the extensive financial and emotional costs of unsubstantiated claims must be weighed against the value of protecting the lives of countless children in danger (see Lindsey, 1994, for discussion).

Despite legal requirements in countries with mandatory reporting, professionals still express reluctance to report. One early study of mental health professionals found that 85% of psychologists, 63% of psychiatrists, and 50% of social workers failed to report a physical abuse case to child protective services (Swoboda, Elwork, Sales, & Levine, 1978, cited in Crenshaw, Bartell, & Lichtenberg, 1994). A study of doctors in Australia found that 43% chose not to report a case of suspected child abuse in spite of their legal reporting obligations (Van Haeringen, Dadds, & Armstrong, 1998). Other studies have implied selective compliance with mandatory reporting laws even among highly experienced psychologists, with a substantial percentage (21%) failing to report because they believed reporting would endanger therapeutic relationships and client welfare (Pope & Bajt, 1988). The justification for such resistance to complying with statutes has been heatedly debated (Ansell & Ross, 1990; Kalichman, 1990; Van Eenwyk, 1990), with some recommending more flexible reporting approaches as alternatives to existing legal mandates (Crenshaw et al., 1994; Finkelhor & Zellman, 1991). Clearly, professionals sometimes elect to disregard the law for a variety of reasons. Hence, identifying those factors that influence a professional’s decision to report would serve as a framework to consider the ramifications of any potential revisions in public policy and mandatory reporting laws.

Factors Influencing Abuse Reporting Decisions

Abuse reporting behavior is generally regarded as a function of three broad areas, including qualities of the reporter, specifics of the case in question, and the legal technicalities (Brosig & Kalichman, 1992b). Those factors considered in the current study are reviewed below. Various characteristics of potential reporters appear to play a significant role in their decision to contact social services. For example, different occupational groups can vary in their perception of their reporting responsibilities and in their reporting behavior. One study compared dentists, nurses, physicians, psychologists, and social workers and found considerable variability in their chosen intervention for cases of suspected abuse in their actual practice (Tilden et al., 1994). Only physicians and social workers selected reporting to child protective services or police as their most frequent decision in suspected abuse cases (and then only 39% and 59% of the time for those two professions respectively) (Tilden et al., 1994). Comparisons on knowledge of reporting obligations across professional groups has found psychologists were the most informed of their legal responsibilities, followed by nurses and physicians, with the least knowledge demonstrated by chiropractors, optometrists, podiatrists, and teachers (Reiniger, Robison, & McHugh, 1995).

School principals were considerably more likely to report abuse than social workers or clinical psychologists, whereas child psychiatrists were the group most likely to fail to report suspected abuse, followed by social workers and clinical psychologists (Zellman, 1990b). Teachers tend to report suspected abuse to other school personnel (Abrahams, Casey, & Daro, 1992). Several factors appear to affect reporting decisions for health professionals, who are also likely to encounter abuse cases (see review of Warner & Hansen, 1994). For example, nurses appear to be primarily influenced by characteristics of the case but also, to some extent, by personal characteristics (O’Toole, O’Toole, Webster, & Lucal, 1993; Pillitteri, Seidl, Smith, & Stanton, 1992).

Yet, most of the research on child abuse reporting behavior has focused on mental health professionals, with comparatively less information on educational and health professionals. In particular, this line of research has included how psychologists are affected by statutory wording and requirements (Brosig & Kalichman, 1992a; Kalichman & Brosig, 1992), as well as the impact of individual qualities of the mental health practitioner (Hansen et al., 1997; Kalichman & Brosig, 1993; Kalichman & Craig, 1991; Nicolai & Scott, 1994). Concerns about the impact of reporting on the therapeutic relationship appear to play a pivotal role for mental health professionals (Kalichman & Craig, 1991; Smith-Bell & Winslade, 1994; Steinberg, Levine, & Doueck, 1997).

As a whole, psychologists appear relatively well-informed of their legal obligations, but they may be one of the most resistant occupational groups when confronted with reporting suspected abuse.

Across professions, several characteristics of the reporter affect decision making, including both professional and demographic factors. One of these potential variables involves their amount of professional experience. However, an examination of health professionals' identification of a drowning as neglectful did not find any differences based on years of professional experience (Feldman, Monastersky, & Feldman, 1993). For educational personnel, child care workers with more experience with preschoolers were more likely to report suspicious incidents (Nightingale & Walker, 1986). With regard to mental health professionals, those psychologists with less experience appeared more likely to report (Brosig & Kalichman, 1992b). Moreover, those psychologists with more educational training (doctorate versus master's degree) were less likely to report suspected abuse in scenarios (Beck & Ogloff, 1995). Ascertaining the impact of this variable is complicated because more recently trained professionals could have educational experiences reflecting an increased appreciation of child abuse issues, whereas some professionals with additional years of experience may feel more confident to report their suspicions (Brosig & Kalichman, 1992b).

Related to years of professional experience is the age of the reporter. Brosig and Kalichman (1992b) suggest that age does not affect the reporting decisions of mental health professionals. Based on child abuse vignettes, age was unrelated to the assessment of the abuse severity for social workers (Kean & Dukes, 1991) or the hypothetical reporting decisions of nurses (O'Toole et al., 1993). However, findings for doctors are mixed, with younger physicians considered more likely to report abuse (Warner & Hansen, 1994). Results pertaining to the influence of age on reporting behavior are often confounded by its relationship with years of professional experience.

In contrast, gender more clearly influences child abuse reporting behavior. Women across professional groups tend to be more likely than men to consult others and to report suspicions to child protective services (Tilden et al., 1994). In a study of mental health professionals, women were also more likely to indicate they would report suspected abuse in hypothetical scenarios (Crenshaw, Lichtenberg, & Bartell, 1993). Female psychologists suspect more abuse, and female psychologists and social workers report more frequently than men (Hansen et al., 1997). A study of pediatric psychologists found that women were more likely to suspect and to report child abuse (Finlayson & Koocher, 1991). A study of medical students found no effect of gender on their reporting intentions (Warner-Rogers, Hansen, & Spieth, 1996). One study focusing on sexual abuse found that female psychologists actually failed to report proportionately more cases of suspected sexual abuse (Kennel & Agresti, 1995). Thus, women may ordinarily be more likely to suspect and report child abuse although differences may occur depending on the type of child abuse in question.

Two additional personal characteristics of the individual reporter may be relevant to reporting behavior, but they are infrequently investigated. Some have speculated that being a parent (Warner & Hansen, 1994) or having a personal history of maltreatment (Brawer, 1994) may bias professionals in their reporting decisions. With regard to parental status, those preschool workers with children of their own indicated they were less likely to report in hypothetical abusive situations than those workers without children (Nightingale & Walker, 1986). Similarly, nurses with more children evidenced greater reluctance to recognize or report child abuse in abuse vignettes (O'Toole et al., 1993). For psychologists, parenting status was unrelated to their suspicions or reporting decisions in hypothetical abuse scenarios (Brawer, 1994).

Very few have studied the respondent's perceived history of maltreatment in research on reporting behavior. A study of social service personnel found that those reporting a history of maltreatment (primarily emotional abuse) were more likely to rate vignettes as more abusive (Howe, Herzberger, & Tennen, 1988). Although a history of physical abuse influenced social workers' suspicions and reporting behavior on child abuse vignettes, childhood history of abuse did not appear to influence psychologists (Hansen et al., 1997). Psychologists do not appear to be influenced in their reporting behavior by self-reported abuse history (Brawer, 1994).

Another factor in abuse reporting decisions is the professionals' confidence in their suspicion that the situation is indeed abusive (Brosig & Kalichman, 1992b). Among physicians, clinical psychologists, and psychiatrists, concerns about insufficient evidence for abuse was cited as the primary rationale for not reporting suspicions in their actual practice (Zellman, 1990a). Canadian psychologists said limited evidence was their primary reason not to report suspected abuse cases encountered in their work (Beck & Ogloff, 1995). Kalichman and Brosig (1993) found that psychologists who inconsistently report often cite a lack of confidence that abuse occurred, feeling obligated to investigate and gather adequate evidence prior to reporting. Not only does certainty correlate with psychologists' reporting decisions (Kalichman, Craig, & Follingstad, 1990; Nicolai & Scott, 1994) but most of those electing not to report are still strongly suspicious (Nicolai & Scott, 1994). Similar to psychologists, teachers prefer to establish reasonable grounds before contacting protective services to be certain their report would be substantiated (Tite, 1993). For physicians, their "estimate of diagnostic accuracy" that abuse occurred affects their reporting behavior; they prefer to wait until they feel more certain (Warner & Hansen, 1994, p. 19). Consequently, professionals assess their level of certainty prior to arriving at abuse reporting decisions.

In part, a professional's certainty about reporting a given case is a function of characteristics of the abuse situation. Psychologists' ratings of their certainty that abuse was occurring was highest for sexual abuse and neglect cases and lowest for physical abuse and emotional maltreatment (Beck & Ogloff, 1995). A study of physicians, child psychiatrists, psychologists, social workers, and educational professionals found that sexual abuse was rated as more serious than physical abuse (Zellman, 1990c). An evaluation of the National Incidence studies found that sexual abuse was reported proportionately more frequently than physical or emotional abuse, which in turn were more likely to be reported than neglect (Ards & Harrell, 1993). For preschool workers, neglect was significantly less likely to be reported than sexual abuse, but no differences were found between sexual and physical abuse reporting (Nightingale & Walker, 1986). Overall, the type of abuse does appear to affect reporters' willingness to contact child protective services (Brosig & Kalichman, 1992b).

Professionals also hold a number of attitudes that may influence their reporting decisions (Brosig & Kalichman, 1992b), particularly with regard to the perceived negative consequences of reporting (Warner & Hansen, 1994). Across professions, some commonly cited reasons for failing to report suspicions include concerns about disruption of treatment, inferior services provided by protective services, and further harm to the child outweighing the benefits (Hansen et al., 1997; Zellman, 1990a). Mandatory reporting may also deter treatment seeking or self-disclosure by perpetrators of abuse (Berlin, Malin, & Dean, 1991; Crenshaw et al., 1993). Many of the concerns arise from fears that reporting will impede the therapeutic relationship (Brosig & Kalichman, 1992b). Actually, one study of a child guidance clinic found that the therapeutic alliance in 76% of psychotherapy cases either remained the same or improved following a report of suspected child abuse (Watson & Levine, 1989). Another study confirmed that, in reality, the majority (73%) of clients did not drop out of treatment after a report by their therapists and that the quality of the relationship prior to a report significantly affects outcome (Steinberg et al., 1997). However, professionals often consider the costs of reporting too high, with potentially negative sequelae for themselves and the family (Warner & Hansen, 1994).

The current study thus investigated the decision-making patterns of health, educational, and mental health professionals in New Zealand. These three occupational groups were considered the most likely to encounter potential abuse reporting situations. Differences in attitudes and reporting accuracy among these professional groups were examined. Moreover, professionals' attitudes and aspects of the case (e.g., type of abuse) were examined because such factors have been shown to affect abuse reporting decisions (e.g., Brosig & Kalichman, 1992b). Confidence in decisions was also investigated because professionals' sense of certainty of abuse affects their reporting behavior.

METHOD

Participants

Surveys were sent to 659 educational, health, and mental health providers in the Otago region of the South Island in New Zealand. Based on a list provided by the New Zealand Educational Institute, one third of all

schools in Otago ($n = 51$) were randomly selected to participate. These schools received a total of 331 survey packets, which principals were asked to complete themselves and distribute to their teachers. Of those mailed, 40% ($n = 132$) were returned by educators, including teachers ($n = 106$) and principals ($n = 26$). In addition, all 101 psychologists and psychotherapists registered with the New Zealand Psychologists Board and practicing in the Otago region were mailed survey packets, which constitutes all certified mental health professionals in the area. Of these, 44 surveys were completed by mental health professionals (8 returned as undeliverable), yielding a response rate of 47.3%. All 227 general medical practitioners registered in Otago were asked to participate, with 79 completed surveys returned (16 undeliverable), resulting in a response rate of 37.4%. Thus, of all the surveys delivered to the three professional groups, 255 participated, yielding an overall response rate of 38.7%. Based on participants' responses, the overall sample was predominantly female, ranging in age from 22 to 74 and reporting considerable professional experience (Table 1).

TABLE 1: Means and Standard Deviations for Background Questions and Demographics Across Professional Groups

	Professional Group				Statistic ^b
	Overall ^a	Educators	General Practitioners	Mental Health Professionals	
Sex					
Female	148	98	22	28	$\chi^2 = 45.7^{**}$
Male	105	33	57	15	
Age					
M	42.56	41.93	42.52	44.48	$F = 1.33$
SD	8.96	9.62	8.49	7.54	
Experience					
M	16.00	17.00	16.04	13.02	$F = 3.00^c$
SD	9.38	10.37	8.68	6.69	
Parent					
No	44	29	7	8	$\chi^2 = 5.81^c$
Yes	210	103	71	36	
Abuse history					
No	211	111	71	29	$\chi^2 = 8.35^*$
Yes	37	17	8	12	
Facility policy					
No	118	31	56	31	$\chi^2 = 66.22^{**}$
Yes	100	81	12	7	
Don't know	31	18	10	3	
New Zealand policy					
Full	94	65	21	8	$\chi^2 = 36.36^{**}$
None	50	10	22	18	
Partial	92	49	31	12	

a. Given some missing data, not all numbers sum to 255, the total number of respondents.

b. Statistical values reported reflect chi-squares or one-way analyses of variance differences across the three professional groups.

c. Because the significance level was reduced to $\alpha = .01$, these differences were only marginally significantly different at $p \leq .05$.

* $p < .01$. ** $p < .001$.

Materials

Respondents provided basic demographic information followed by several personal background questions. Professionals indicated whether they were parents (henceforth referred to as parent), whether they believed they had been abused as children (abuse history), whether their employer/facility had a mandatory reporting policy (facility policy), and whether they believed New Zealand should adopt full or partial (high-risk professions only) mandatory reporting (NZ policy; see Table 1 for a summary). Respondents then answered eight attitude questions (see Table 2), each on a 5-point Likert-type scale from 1 = *strongly agree* to 5 = *strongly disagree*.

Participants then read 12 potential abuse scenarios. Based on consultation with the Otago Children and Young Persons Service (CYPS), 12 brief scenarios were constructed by modifying actual reported cases. The intake

coordinator, who is responsible for ascertaining the need for CYPS investigation, provided initial details regarding 15 typical cases encountered at CYPS. These cases were then modified to obscure any specific and potentially identifying information (including manipulations of gender and age). Two experienced CYPS investigators then evaluated each scenario to assess its need for further direct investigation. In this fashion, each scenario was classified as an incident that either did or did not actually warrant further CYPS consultation and potential investigation. Once all modifications had been agreed on, the 12 best scenarios with greatest consensus across the three CYPS workers were selected for the survey instrument.

The 12 scenarios were presented in random order, including three types of abuse (sexual, physical, and neglect). The survey consisted of four neglect, four physical abuse, two non-incest sexual abuse, and two incest sexual abuse cases. Half of the scenarios were considered by CYPS to be reportable, and the other half had insufficient cause for investigation. A sample sexual abuse scenario that was considered reportable follows:

Ann reports to you that a friend recently overheard a conversation between their daughters, both age 13. Ann’s daughter, Rachel, reportedly disclosed in that conversation that she is upset about having been sexually interfered with by her 34-year-old male neighbor, although Rachel provided no details. This neighbor lives near Rachel, although Ann is uncertain how regularly Rachel sees him. Rachel’s grades have been recently dropping, and she has appeared preoccupied and moody.

A sample physical abuse scenario deemed not necessary to report follows:

TABLE 2: Mean Attitude Scores for Overall Sample and Analysis of Variance for Differences Across Professional Groups

	Overall	Mental Health Professionals (MH)	General Practitioners (GP)	Educators (E)	F
Mandatory reporting decreases the likelihood that people will disclose or report suspicions	2.92	2.50	2.71	3.18	8.34** E > GP and MH
The negative impact on my relationship with the family involved affects my decision to report a potential abuse case	3.52	3.49	3.19	3.73	5.53* E > GP
I am less likely to report potential abuse the more familiar I am with a family	3.56	3.79	3.55	3.49	1.30
Preserving family privacy affects my decision to report a potential abuse case	3.89	4.07	3.67	3.95	2.57 (MH > GP ^a)
Preserving family cohesion affects my decision to report a potential abuse case	3.72	3.91	3.41	3.85	4.95* GP < MH and E
Reporting abuse is often more harmful than helpful to the child	3.71	3.24	3.65	3.89	6.21* MH < E (and GP ^a)
Social welfare does not have sufficient resources to handle the number of currently reported cases	1.94	1.71	2.21	1.85	4.42* GP > MH and E
I prefer to make work-related decisions independently	3.34	3.09	2.65	3.82	24.17** E > GP and MH (MH > GP ^a)

NOTE: Respondents were asked: “Circle the degree to which you agree or disagree with these statements.” Replies were made on a scale from 1 = *strongly agree* to 5 = *strongly disagree*.

a. Because the significance level was reduced to alpha = .01, these differences were only marginally significantly different at $p < .05$.

* $p < .01$. ** $p < .001$.

Fiona, age 9, lives with her mother and two younger siblings, ages 2 and 4. Fiona’s grandmother tells you she is worried about her daughter’s discipline of Fiona. Gail, Fiona’s mother, is described as moody and short-tempered. Fiona’s household responsibilities include feeding and changing her younger siblings. Gail often becomes angry with Fiona if one of the younger children misbehaves. The grandmother tells you she has seen Gail “give Fiona a quick spank” with her hand if her siblings are not fed or dressed promptly, although she has never seen a mark on Fiona.

Six of the scenarios involved male potential perpetrators, but the distribution of gender was imbalanced by abuse type (e.g., only males were suspected in the sexual abuse). Gender of the potential victim involved six girls, four boys, and two neutral (i.e., one case with a brother and sister, one with a baby, gender unidentified). Ages of the potential victim varied from infancy to age 14, with only three adolescents. After reading each scenario, participants indicated whether they would need to contact CYPS “because you believe there are sufficient care and protection issues to warrant further investigation.” Following their reporting decision, professionals rated their level of certainty in their decisions on a 5-point Likert-type scale from 1 = *very certain* to 5 = *doubtful*.

Procedure

Professionals targeted for the survey were mailed an initial letter detailing the nature of the study, emphasizing that responses were anonymous. Enclosed was the survey instrument and a self-addressed stamped return envelope. The respondents were given 2 weeks to return their surveys because it was believed that busy professionals would respond to shorter deadlines that they would be less likely to forget. The target group received a reminder card prompting them of the impending due date a week after receipt of the initial letter.

All statistical analyses were conducted using the SPSS for Windows package. Accuracy scores were computed by comparing professionals’ reporting decisions against the determinations made by CYPS. Thus, respondents received total scores reflecting how many “correct” decisions they made across scenarios. Respondents also received total certainty scores summing across scenarios their rated certainty on individual reporting decisions. Given the number of comparisons, the significance level was reduced to an alpha of .01 (with the exception of demographic/background comparisons, which were kept at alpha of .05 to better determine the potential need to covary such variables in subsequent analyses).

RESULTS

Summary of Results on Demographics

Refer to Table 1 for a summary of demographic and background information. With regard to gender differences for the overall sample, males tended to be older, $t(250) = 3.14, p \leq .01$, with more experience professionally, $t(248) = 4.29, p \leq .001$, than women. More women reported that they had a history of child abuse ($\chi^2 = 5.16, p \leq .05$). Chi-squares indicated there were no significant gender differences in parental status or New Zealand abuse reporting policy preference (all $p > .05$).

On average, males reported marginally more certainty in their reporting decisions, $t(230) = 1.89, p \leq .05$, particularly with regard to scenarios dealing with physical abuse, $t(224) = 2.54, p \leq .01$. With regard to attitudes, the only significant gender differences found were that men were significantly more likely to report a preference for working independently, $t(246) = 4.9, p \leq .001$, and women were more likely to consider CYPS underresourced, $t(241) = 2.4, p \leq .01$. Although there were no significant gender differences on total accuracy, $t(225) = 1.72, p = .09$, men tended to be somewhat more accurate on reporting decisions for scenarios involving neglect, $t(229) = 2.43, p \leq .01$.

Age and years of experience were not correlated with attitude, accuracy, or certainty scores (all $p > .05$). However, ANOVAs indicated those who stated that they did not know their facility’s reporting policy were the youngest, $F(2, 245) = 6.53, p \leq .001$, and the most inexperienced, $F(2, 243) = 10.03, p \leq .001$. Those respondents who wanted full mandatory reporting were most likely working in a facility with a mandatory reporting policy, whereas those who did not want mandatory reporting were those most likely working in a facility with no standing policy ($\chi^2 = 50.96, p \leq .001$).

Table 1 also summarizes the comparisons across professional groups on demographic and background questions. Whereas physicians were predominantly male, educational and mental health professionals were more likely female ($\chi^2 = 45.7, p \leq .001$). Consistent with this gender difference in professions and the gender difference in abuse history, physicians were least likely to report a childhood history of abuse ($\chi^2 = 8.35, p \leq .01$).

.01). Physicians and mental health professionals were more likely to work in facilities that did not have specified reporting requirements ($\chi^2 = 66.22, p \leq .001$).

Summary of Results on Attitudes

As seen in Table 2, for the total sample of respondents, the only attitude rated by professionals near the midpoint or neutral range of the scale was the belief that reporting may decrease self-disclosure, one-sample $t(245) = -1.14, p > .05$. All other attitudes were significantly different from the midpoint of the Likert-type scale (all $p \leq .001$). Professionals indicated that their reporting decisions were not strongly influenced by their desire to preserve their relationship with the family, by their desire to maintain the family's cohesion or privacy, or because of their familiarity with the family. Overall, respondents also did not believe that reporting abuse would be more harmful, nor did they indicate a strong preference to make work-related decisions independently. However, the professionals believed that child protective services was ill-equipped to handle their caseloads.

Table 2 also displays differences across professional groups on their attitudes, including the post-hoc comparisons underneath the overall ANOVA statistic. Mental health professionals were most likely to believe that reporting decreases self-disclosure, $F(2, 243) = 8.34, p \leq .001$. Physicians were the most concerned about the negative impact on their relationship with the family, $F(2, 251) = 5.53, p \leq .01$, as well as preserving family cohesion, $F(2, 250) = 4.95, p \leq .01$. Mental health professionals were most likely to consider reporting more harmful to the child than beneficial, $F(2, 249) = 6.21, p \leq .01$. Physicians were the least likely to believe protective services has insufficient resources, $F(2, 242) = 4.42, p \leq .01$. Physicians were the most likely group to indicate they prefer to make work-related decisions independently, $F(2, 247) = 24.17, p \leq .001$. ANCOVAs using sex of the respondent as a covariate indicated that none of the significant differences in attitudes across professional groups were accounted for by gender. Sex of the respondent was a significant covariate only in the attitude involving working independently, and the differences across groups remained significant even after controlling for gender, $F(2, 244) = 18.69, p \leq .001$.

Summary of Results on Accuracy and Certainty Scores

Refer to Table 3 for means and standard deviations on accuracy and certainty scores. For the total sample, total accuracy was not strongly correlated with attitudes (all $p > .01$), with the exception of one mild correlation between total accuracy and the harmfulness of reporting ($r = .18, p \leq .01$). Accuracy scores were also uncorrelated to respondents' certainty scores (all $p > .01$).

Respondents' overall accuracy was about 80% across abuse scenarios, with the highest accuracy on those situations involving alleged sexual abuse and the lowest accuracy for neglect scenarios. Repeated measures ANOVAs indicated the accuracy scores were significantly different across abuse type, $F(2, 227) = 33.04, p \leq .001$, with post-hoc comparisons showing significantly lower accuracy for neglect, $t(230) = 7.41, p \leq .001$, and physical abuse, $t(233) = 6.25, p \leq .001$, compared to sexual abuse. Similarly, certainty scores were significantly different across abuse type, $F(2, 203) = 11.60, p < .001$, with lower certainty on neglect, $t(209) = 4.71, p \leq .001$, and physical abuse, $t(215) = 4.47, p \leq .001$, compared to sexual abuse scenarios.

Table 3 also presents differences across professions in accuracy and certainty scores. For certainty, no significant ANOVA differences across professional groups were found (all $p > .01$). However, ANOVAs revealed total accuracy scores were significantly different across professions, $F(2, 226) = 4.12, p \leq .01$, with mental health professionals the least accurate across scenarios. This pattern of lower accuracy for mental health professionals was most evident in sexual abuse, $F(2, 236) = 3.88, p = .02$, and neglect scenarios, $F(2, 230) = 2.94, p = .05$, which were marginally significant. Analyses using gender as a covariate revealed that none of the differences across professional groups on accuracy were accounted for by sex of the respondent.

TABLE 3: Certainty and Accuracy Scores by Professional Group and Abuse Type

	<i>Overall</i>		<i>Mental Health Professionals</i>		<i>General Practitioners</i>		<i>Educators</i>		<i>F^a</i>
	<i>M</i>	<i>(SD)</i>	<i>M</i>	<i>(SD)</i>	<i>M</i>	<i>(SD)</i>	<i>M</i>	<i>(SD)</i>	
<i>Certainty</i>									
Total	2.20	(0.56)	2.13	(0.57)	2.10	(0.51)	2.29	(0.58)	2.96 ^b
Sexual abuse	2.05	(0.67)	1.91	(0.62)	1.97	(0.62)	2.14	(0.71)	2.38
Neglect	2.28	(0.65)	2.19	(0.69)	2.16	(0.63)	2.38	(0.64)	2.99 ^b
Physical abuse	2.25	(0.66)	2.25	(0.68)	2.13	(0.57)	2.31	(0.70)	1.73
Significant difference ^c	<i>F</i> = 11.60**		<i>F</i> = 5.85*		<i>F</i> = 2.39		<i>F</i> = 4.82*		
<i>Accuracy</i>									
Total	80.42	(13.25)	75.20	(15.45)	81.60	(13.84)	81.59	(11.55)	4.12*
Sexual abuse	87.76	(17.88)	81.55	(21.43)	87.17	(18.02)	90.29	(15.93)	3.88 ^b
Neglect	75.33	(20.43)	69.64	(23.77)	79.11	(19.55)	75.00	(19.34)	2.94 ^b
Physical abuse	78.36	(19.60)	74.40	(19.51)	79.67	(19.14)	78.93	(19.90)	1.07
<i>F^c</i>	33.04**		3.34 ^b		6.72*		25.70**		

a. ANOVAs differences across the three professional groups.

b. Because the significance level was reduced to alpha = .01, these differences were only marginally significantly different at $p \leq .05$.

c. Repeated measures ANOVAs of certainty or accuracy difference by type of abuse.

* $p < .01$. ** $p < .001$.

Summary of Results on New Zealand Policy

See Table 4 for a summary of the ANOVA results on New Zealand reporting policy differences for the total sample. Several significant differences emerged, particularly for those who indicated they did not want mandatory reporting. Those respondents who wanted no mandatory reporting agreed most that reporting leads to decreased disclosure, $F(2,224) = 21.49, p \leq .001$; that reporting impairs family cohesion, $F(2,232) = 7.59, p \leq .001$; that reporting is more harmful than beneficial, $F(2,231) = 12.21, p \leq .001$; and that they prefer to work independently, $F(2, 229) = 11.77, p \leq .001$.

Furthermore, those professionals who did not want mandatory reporting were the most certain in their reporting decisions across all scenarios, $F(2, 214) = 7.46, p \leq .001$, particularly for physical abuse scenarios, $F(2, 209) = 6.00, p \leq .01$. In contrast, those who did not want mandatory reporting were least accurate across all scenarios, $F(2, 209) = 5.32, p \leq .01$, particularly on sexual abuse scenarios, $F(2, 219) = 6.35, p \leq .01$.

As seen in Table 1, educational professionals were most likely to endorse a full mandatory reporting policy for New Zealand ($\chi^2 = 36.36, p \leq .001$), with physicians more likely to consider partial reporting and mental health professionals more inclined toward no reporting requirement.

Subsample Comparisons: Abuse History and Parental Status

Parental status and abuse history were analyzed with *t* tests to evaluate whether these variables reflect potential biases in abuse reporting. However, a limited number of the total sample of respondents indicated that they were not parents ($n = 44$) or that they had a history of child abuse ($n = 37$). Therefore, to evaluate the impact of these two variables, rather than conduct group comparisons based on heavily imbalanced numbers, matched groups were developed. This process allows these variables to be examined while controlling for background and demographics. Based on the characteristics of the group of nonparents, a sample of parents was extracted matched for gender, ethnicity, professional group membership, age and years of experience (within 5 years), and abuse history. A similar comparison group was created for individuals reporting an abuse history, using the same characteristics and substituting parental status for abuse history.

For parental status, respondents in the matched group of parents versus nonparents did not demonstrate significant differences in attitudes (all $p > .01$). Moreover, the two groups did not differ in accuracy or certainty scores (all $p > .01$). For abuse history, respondents who reported a history of child abuse were not significantly

different from the matched group of professionals who did not report an abuse history (all $p > .01$). Similarly, the abuse history group did not differ from the comparison group on accuracy or certainty scores (all $p > .01$).

TABLE 4: Means, Standard Deviations, and ANOVAs on Attitude, Certainty, and Accuracy Scores for New Zealand Reporting Policy

	<i>Full Reporting</i>		<i>Partial Reporting</i>		<i>No Reporting</i>		F
	M	(SD)	M	(SD)	M	(SD)	
Attitudes							
Self-disclosure	3.40	(1.05)	2.79	(1.03)	2.24	(0.97)	21.49**
Family impact	3.68	(1.13)	3.45	(1.19)	3.36	(1.22)	1.51
Family familiarity	3.65	(1.12)	3.44	(1.03)	3.58	(1.07)	0.82
Family privacy	4.12	(1.00)	3.81	(0.91)	3.64	(1.32)	3.89 ^a
Family cohesion	4.02	(1.02)	3.66	(1.01)	3.32	(1.19)	7.59**
Harmfulness	4.09	(1.06)	3.57	(0.94)	3.22	(1.22)	12.21**
CYPS	1.92	(0.95)	1.97	(1.10)	2.00	(0.98)	0.096
Independence	3.70	(1.25)	3.30	(1.22)	2.63	(1.30)	11.77**
Certainty							
Total	2.22	(0.53)	2.30	(0.53)	1.93	(0.58)	7.46**
Sexual abuse	2.09	(0.63)	2.14	(0.73)	1.79	(0.64)	4.19 ^a
Neglect	2.31	(0.63)	2.34	(0.60)	2.02	(0.72)	4.05 ^a
Physical abuse	2.24	(0.63)	2.38	(0.65)	1.97	(0.67)	6.00*
Accuracy							
Total	82.14	(11.58)	81.91	(11.55)	75.00	(17.03)	5.32*
Sexual abuse	89.77	(15.92)	90.70	(16.29)	80.21	(21.24)	6.35*
Neglect	76.45	(18.53)	76.51	(20.04)	70.74	(22.91)	1.49
Physical abuse	81.25	(19.05)	78.23	(18.41)	73.44	(20.89)	2.57

NOTE: CYPS = Children and Young Persons Service resources.

a. Because the significance level was reduced to $\alpha = .01$, these differences were only marginally significantly different at $p < .05$.

* $p < .01$. ** $p < .001$.

DISCUSSION

Given that New Zealand does not legally require child abuse reporting, the present study provided a unique opportunity to investigate potential subjective and situational influences on the reporting decisions of 255 health, educational, and mental health professionals who are free of legal restraints.

Across occupations, professionals indicated that their reporting decisions were not strongly influenced by their concern over their relationship with the family or because of their familiarity with the family. Likewise, they indicated that their decisions about abuse reporting were not strongly affected by their desire to ensure the family's privacy or sense of cohesion. As a group, the respondents also did not consider abuse reporting to be more harmful to children, nor did they strongly endorse that they should be able to make work-related decisions independently. Many of the respondents, however, did agree that the child protective services agency is underresourced. Thus, although professionals reported relatively strong attitudes, they did not believe these were influencing their reporting decisions. Although the survey was anonymous, this result may in part suggest a social desirability response, in that professionals did not want to appear influenced in their reporting decisions by such attitudes.

Overall, professionals' accuracy was not significantly correlated to these attitudes (with the one exception of a mild relationship suggesting that the more harmful they considered abuse reporting to the child, the less accurate they were across scenarios). The absence of a relationship between accuracy and attitudes would confirm professionals' aforementioned appraisal that their reporting behavior is not influenced by their attitudes. Interestingly, although certainty was expected to correlate with accuracy, no such relationship was detected. This finding may reflect that professionals experience more certainty in reporting actual cases, such that the hypothetical nature of this research design decreased participant certainty, thereby affecting its correlations with accuracy.

Respondents were most accurate on those situations involving alleged sexual abuse and least accurate for neglect scenarios. Consequently, although child neglect is recognized as the most common form of child maltreatment, this type seems both underreported and underidentified by professionals (cf. Ards & Harrell, 1993). Certainty in reporting decisions followed a similar pattern, with less certainty in reporting decisions involving neglect and physical abuse cases. This finding partly supports conclusions from previous research demonstrating greater certainty for sexual abuse than physical abuse cases (Beck & Ogloff, 1995). Apparently, alleged sexual abuse cases are deemed less ambiguous reporting situations by professionals, prompting more frequent reporting, perhaps because, as suggested by previous researchers (Zellman, 1990c), sexual maltreatment is perceived not only as less ambiguous but also as more serious. This finding indicates that professionals should continue to be alerted to their tendency to overlook and underreport child neglect.

Another interesting set of findings from the current study pertains to professionals' preferences regarding child abuse reporting laws. Those professionals most opposed to any type of mandatory reporting laws were least accurate in their reporting decisions, despite the fact that they were the most certain of their decisions. In particular, those respondents who did not support mandatory abuse reporting were less accurate on their decisions involving sexual abuse cases. This finding is particularly disturbing because those who are the most resistant to reporting laws may be the most resistant to consulting others when they, indeed, should pursue such suspicions. Moreover, those who did not want reporting laws were more likely to believe that reporting leads to decreased self-disclosure, to impaired family cohesion, and to greater harm for the children. Respondents opposed to mandatory abuse reporting also reported a preference to make their work-related decisions independently. Taken together, these results indicate those who are resistant to child abuse reporting appear to underreport and hold attitudes consonant with their bias against reporting.

In terms of differences between the three professional groups, mental health professionals were the most opposed to full mandatory reporting, conveying concerns that reporting would lead to decreased self-disclosure and increased harm to the child. In contrast, teachers most favored mandatory reporting requirements and tended to be more likely to work in settings that follow specific reporting guidelines. New Zealand teachers may be most comparable to professionals in countries with mandatory reporting laws; perceiving that reporting is not optional may lead professionals to generate cognitive schemas that justify its need, and this may translate into support for such policies. Mental health professionals were also less accurate in their reporting decisions across abuse scenarios compared to teachers or general medical practitioners. Overall, these findings are consistent with previous research suggesting that mental health professionals may be especially resistant to mandatory reporting laws (Kalichman & Craig, 1991; Smith-Bell & Winslade, 1994; Steinberg et al., 1997). Mental health professionals are likely most resistant because of the strong professional socialization regarding confidentiality, which is not as integral to the professional identity of teachers. Indeed, the fact that physicians represented the middle group, preferring partial abuse reporting laws, may support this interpretation, given that their profession encourages a degree of confidentiality higher than that of teachers but less than that of mental health professions.

Prior researchers have speculated about the potential bias in reporting by individuals who are parents (Warner & Hansen, 1994) or who have a history of child maltreatment (Brawer, 1994). In this study, both of these biases were examined in a well-controlled manner by creating matched comparison groups that would control for other potential explanatory factors. This study thus demonstrated that accuracy in reporting judgments, certainty in those decisions, and attitudes were not affected by the respondents' having children or a reported history of child abuse. Therefore, based on these preliminary findings that neither abuse history nor parental status appears significant, further research would need to ascertain in a similarly controlled fashion that either of these variables could be considered abuse reporting biases. Those who suspect such personal biases in child abuse reporting may illustrate the social psychological phenomenon of the fundamental attribution error, applied in this instance to reporting behavior, wherein we overemphasize the extent of personal characteristics and underestimate the situational components influencing the reporter.

The current study did not find any relationship of age or experience with accuracy, attitudes, or certainty. Given the mixed findings of previous research on these variables (e.g., Brosig & Kalichman, 1992b), our results suggest that such demographic variables may not be significant in reporting behavior. There were also no significant gender differences in overall accuracy of reporting decisions, with the possible exception of males' exhibiting somewhat more accurate reporting on neglect situations. Hence, in contrast with previous findings of female bias (e.g., Crenshaw et al., 1993; Tilden et al. 1994), women in the current sample were not more inclined to report. This inconsistency of the current findings may reflect that women may be more inclined to report actual cases that might not be captured in reporting tendencies on hypothetical situations. In addition, perhaps, in the absence of legal requirements, women are actually not more inclined to report; in other words, in countries where abuse reporting is legally required, women may report because they are socialized to be compliant. This area of gender differences presents an intriguing topic for future research.

Conclusions from this study are somewhat limited by the moderate response rate of 38.7% of the potential respondents, which is comparable with previous research (e.g., Brosig & Kalichman, 1992a; Crenshaw et al., 1993) and reasonable for survey designs involving busy professionals. Ideally, however, the study would have been strengthened by a more complete representation of the professions. Some potential implications of this response rate include that professionals who responded exemplify a more motivated and reporting-compliant sample, who are interested in child abuse issues. Consequently, the current results may actually represent a conservative estimation of abuse reporting behavior and accuracy. For instance, if professionals who did not complete the instrument were those who were most indifferent to mandatory reporting issues, their responses might have strengthened the pattern of reduced accuracy for that group of individuals opposed to reporting.

In addition, the current study examined professionals' anticipated reporting decisions on hypothetical scenarios that may not echo their reporting in actual practice. This limitation is endemic to any study using scenarios. However, the scenarios selected in this study were constructed based on actual cases, and the protective services workers believed that the information provided should be sufficient to render a decision. Nonetheless, professionals usually have richer details available to them when confronted with suspicions of abuse, and this may influence their reporting decisions more saliently than can be adequately depicted in vignettes.

Future research in this area should continue to investigate factors influencing professionals' decisions to report (and not to report) child abuse, because even in the presence of mandatory reporting laws in some countries, adherence to such laws is far from complete. Training strategies for increasing professionals' accuracy should be included in educational programs' discussions of ethical and legal reporting obligations, focusing on how neglect is particularly ignored by professionals. Modifying or addressing the concerns raised by some of their attitudes should also be explored (e.g., encouraging public policy initiatives that would provide greater resources to protective services). Research that continues to address the true effects of reporting child abuse on the relationship between the professional and the family (e.g., Warner & Hansen, 1994; Watson & Levine, 1989) could reduce noncompliance with reporting laws if these findings were conveyed to professionals.

Despite concerns about the impact of mandatory reporting, the vast majority (94%) of psychologists suggest that laws are necessary (Kalichman & Craig, 1991). However, the specific guidelines and nature of the laws remain debatable. Determining how professionals would accurately judge scenarios within the context of some of the proposed alternatives to mandatory reporting (Crenshaw et al., 1994; Finkelhor & Zellman, 1991) would enable us to make more informed decisions about the implications of any revisions to mandatory reporting laws. For instance, modification of reporting laws to rely on professional judgments about the need to report would clearly demand trust in such judgments. Results from this study suggest that those who hold biases against reporting are less accurate. However, continuing to insist on mandatory reporting does not translate into compliance for those with such biases. Researchers must focus on whether more comprehensive training initiatives could improve accuracy and reporting behavior and whether improvements from such training would facilitate policies with more flexible reporting practices.

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