

Although many studies have examined issues relevant to reporting child maltreatment to state authorities, empirical evaluation of intervention programs to assist professionals in reporting child abuse is lacking. In the present study, a medical student was taught to perform a standardized behavioral method of reporting child abuse that incorporates nonperpetrating caregivers of child abuse victims in the reporting process. A controlled multiple baseline across behaviors (i.e., initiating child abuse report, responding to upset) experimental design was utilized to evaluate skills acquisition. Improvements in interpersonal skills related to reporting child abuse were demonstrated consequent to intervention. Future directions are discussed in light of these results.

A Standardized Method of Diplomatically and Effectively Reporting Child Abuse to State Authorities

A Controlled Evaluation

BRAD DONOHUE

University of Nevada, Department of Psychology

KIM CARPIN

University of Nevada, School of Medicine

KRISANN M. ALVAREZ

University of Nevada, Department of Psychology

AMY ELLWOOD

University of Nevada, School of Medicine

RICHARD W. JONES

Aetna U.S. Healthcare

Nearly 3 million children were reported to Child Protective Services in the United States during 1998 (U.S. Department of Health and

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Human Services, Administration on Children, Youth and Families, 2000). Although the number of reported victims of child abuse may appear strikingly high, it is a gross underestimate of the total number of children who are abused each year. Indeed, up to 40% of mental health and medical professionals have failed to report child abuse to state authorities at least once, despite their knowledge of the mandate to report child maltreatment when suspected (see Zellman & Coulborn-Faller, 1996). Decisions of professionals not to report child abuse when warranted, include their inability to report child abuse in a timely manner (e.g., Van Haeringen, Dadds, & Armstrong, 1998; Wright, Wright, Farnan, & Isaac, 1999), their discomfort with the victim's family in making the report (Zellman, 1990), being unfamiliar (Sandberg, Petretic-Jackson, & Jackson, 1986) or confused (Felzen-Johnson, 1993; Kalichman & Brosig, 1992) with state reporting laws, and being unfamiliar with the specific steps involved in initiating the report (Kim, 1986; Reiniger, Robison, & McHugh, 1995; Sandberg et al., 1986).

Examination of each of the preceding difficulties supports the contention that professionals lack training in responding to child abuse (e.g., Massey, 1999). Indeed, most professionals who are mandated to report suspected child abuse have not received training in identifying and reporting child maltreatment during their formal education (King, Reece, Bendel, & Patel, 1998), and lack of training and experience in child abuse has been found to be a major obstacle in reporting child abuse (Wright et al., 1999). Although the lack of training in child abuse reporting practices has been recognized in the literature for over 25 years (e.g., Helfer, 1975; Kim, 1986; Reiniger et al., 1995; Warner-Rogers, Hansen, & Spieth, 1996), there is an absence of studies examining the efficacy of training programs designed to assist professionals in reporting suspected incidents of child abuse. For instance, we reviewed over a thousand abstracts that were identified in a psychology database (i.e., PsycInfo) using keyword searches that were relevant to child abuse reporting practices and found no empirical evaluations of such training programs.

Non-empirically derived training programs have been developed to assist professionals in responding to child maltreatment. These programs have primarily focused on reviewing state child abuse laws, teaching professionals to identify child abuse, and teaching profes-

sionals to refer suspected child abuse to Child Protective Service agencies (Pagel & Pagel, 1993; Reiniger et al., 1995). In addition, investigators have recommended that skills training programs be developed to assist professionals in conveying distressful information to caregivers of victims using simulated child abuse scenarios (Alexander, 1990). The latter recommendation is noteworthy inasmuch as most professionals believe it is best to notify and/or involve caregivers in the reporting process (Berliner, 1993; Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2000), and caregivers who are not responsible for the suspected abusive incident are often present when abuse is first identified by the professional. The purpose of the present study was twofold: (a) to develop a training program to assist professionals in the initiation of state-mandated reports of suspected child abuse and (b) examine the efficacy of this program utilizing a controlled experimental design.

METHOD

PARTICIPANT

The participant was a 25-year-old, Caucasian female who was enrolled in her 3rd year of medical school at a state university. She had no prior training, or experience, in reporting child abuse to state authorities (i.e., Child Protective Services, police).

BEHAVIORAL SKILLS TRAINING

Structure of training sessions. Six training sessions were performed with the participant within 4 weeks. Instruction was conducted by a trained senior undergraduate student enrolled in a state university. All training sessions lasted approximately 45 minutes.

Review of child abuse laws. During the first two training sessions, the trainer reviewed all laws pertinent to child abuse in the state of Nevada (The Protection of Children from Abuse and Neglect, 1999) and discussed issues relevant to child abuse. The trainer answered the participant's queries and provided feedback to the participant when

misinterpretations of the law were evidenced. After the state child abuse laws were reviewed with the undergraduate trainer, the participant was provided a copy of the laws to read at her leisure.

Skills relevant to initiating child abuse reports. The first skills component was taught sequentially and cumulatively utilizing role-playing methods during training Sessions 3, 4, 5, and 6.¹ This skills component includes 29 actions that are relevant to initiating a state-mandated child abuse report to Child Protective Services with a nonperpetrating caregiver of the suspected victim (see Appendix A for a sequential list of these 29 actions).

Skills relevant to resolving upset in the reporting process. The second skills component was taught sequentially and cumulatively utilizing role-playing methods during training Sessions 5 and 6. This skills component includes nine actions that are relevant to resolving upset (e.g., yelling, crying, swearing) in nonperpetrating caregivers during the mandated child abuse reporting process (see Appendix B for a sequential list of these nine actions).

Protocol adherence. To facilitate the integrity of training, prompting checklists were utilized by the trainer during each training session that included requisite tasks to be accomplished, and the trainer received ongoing supervision relevant to protocol adherence. A validity estimate of adherence to protocol during training sessions was based upon prompting checklists completed by an independent rater's assessment of audiotapes of the training sessions and was calculated by dividing the total number of tasks completed by the total number of tasks assigned and multiplying the dividend by 100. For training in the initiation of child abuse reports with nonperpetrating caregivers, the validity estimate was 94.0%. The validity estimate for skills training in resolving upset of nonperpetrating caregivers in the child abuse reporting process was 100%.

Reliability of protocol adherence was obtained. As mentioned above, an independent rater was instructed to indicate on her prompting lists whether each task during training was performed. Another independent rater, blind to the nature of this study, reviewed audiotapes of each training session and indicated on a separate prompting

list whether each assigned task had been completed by the trainer. The lists were compared, and a reliability estimate was computed for each of the two skills components. Reliability was calculated for each skills component by dividing the total number of agreements between the raters by the total number of agreements plus disagreements and multiplying the resulting dividend by 100. The reliability estimate for training in initiating the child abuse report was 94.0%, and the reliability estimate for resolving the caregiver's upset in the reporting process was 100%. These results suggest that the trainer adhered closely to protocol and that protocol adherence was corroborated by an objective rater.

ROLE-PLAY ASSESSMENT

Format of assessment probe sessions. A probe session involving role-play assessment was performed with the participant after each training session, and 45 days after the termination of the last training session, to evaluate the participant's utilization of the two skill components across time. Role-play interactions during all assessment probe sessions were initiated by a trained research assistant. The following instructions were read to the participant at the start of each probe session by the research assistant:

I'm going to read you a scenario depicting a child abuse situation. In this assessment, we will pretend that you suspect abuse and that you are a licensed medical practitioner who is not required to consult a supervisor or staff administrator prior to reporting child maltreatment to the authorities. I will read the situation twice. While I read the scenario, think of yourself in that situation, including what you might say or do if the situation were really happening to you. After I read the scenario, I want you to say or do whatever you feel is best.

After the preceding instructions were administered to the participant, the following scenario was read:

A mother brings her 7-year-old to your medical office for an examination. The child presents with burns on both feet. When asking the child about the injury, he is quiet. However, upon further questioning, he discloses to you that his father placed his feet in scalding water as punish-

ment. The boy tells you that his mother was not home that day but that he overheard his mother yelling at his father about the incident. You have asked the mother to join you in the office. She and the boy are now in the office with you. The mother looks at you and says, "So you wanted to speak with me??"

To assess the participant's skill in initiating a child abuse report in this situation, the research assistant was trained to portray the role of the mother in the role-play scenario (confederate) and to initially respond to all statements made by the participant in a nonconfrontational manner. The confederate was trained to provide information only when specifically asked to do so by the participant and to maintain flat affect (e.g., "that's fine," "I can't think of anything," "I think that'll be o.k.").

After 10 seconds of silence in the role-play interaction, the participant's skill in responding to the caregiver's upset during the reporting process was assessed. Specifically, the confederate was trained to spontaneously exclaim, "I'm just upset about this whole thing!" If 5 seconds of silence occurred directly following this prompt, the confederate was trained to exclaim, "This whole thing just makes me sick." The confederate was trained to subsequently listen to the participant while demonstrating affect and actions that reflected upset (e.g., frown face, nodding head sideways). The research assistant was trained to provide information only when specifically asked to do so by the participant. The probe session was concluded after 10 seconds of subsequent silence.

METHOD OF EVALUATING ROLE-PLAY PERFORMANCE

Method of evaluating component skills in role-play assessment. All assessment probe sessions were videotaped. A licensed clinical social worker with 18 years of experience in child abuse, including specialized training in this area, viewed the videotape of each probe session in a random order (follow-up, 2, 1, 4, 5, 3, 6). She utilized a checklist to record if the participant performed each of the 29 actions that were deemed relevant to initiating child abuse reports with nonperpetrating caregivers of suspected victims of child abuse, as well as the nine actions that were deemed relevant to resolving their upset during the reporting process. An estimate of the participant's performance in

each of the two skills domains during each probe session was obtained by dividing the number of actions performed in each skills domain by the total number of actions possible, and multiplying this dividend by 100.

To obtain reliability estimates of the clinical social worker's evaluations, a senior undergraduate student, who was blind to the nature of this study, separately completed a checklist to indicate the presence or absence of each of the aforementioned actions. The lists completed separately by the clinical social worker and student for each probe session were compared, and a reliability estimate was computed for each of the two skills components. Reliability was calculated for each skills component by dividing the total number of agreements between raters by the total number of agreements between raters plus disagreements between raters and multiplying the resulting dividend by 100.

Method of evaluating overall skill in role-play assessment. Videotapes of each probe session were separately viewed by a licensed family physician who was familiar with child abuse state laws, including professional training in procedures involved in reporting child abuse to state authorities. First, the family physician was provided the videotapes in a random order (i.e., 1, 6, 4, 3, 5, follow-up). The physician was told each videotape represented an assessment probe session and that the videotapes did not correspond to the order in which the probe sessions occurred. The physician was instructed to order the participant's performance in each of the probe sessions from least to most "overall skill." Next, the physician was administered another set of randomly ordered tapes (i.e., follow-up, 2, 1, 4, 5, 3, 6), and the physician was instructed to rate each probe session using a 7-point Likert-type scale (1 = *extremely unskilled*, 7 = *extremely skilled*). The method of ordering the tapes in overall skill was performed to assure that each tape was critically examined prior to performing the overall skill ratings. An undergraduate student, who was blind to the nature of this study, was instructed to perform similar procedures in deriving her own overall skill ratings. This student was unfamiliar with child abuse state laws, including reporting practices, and the ratings of this student were included in this study to corroborate ratings obtained by the experienced family physician.

Method of evaluating the participant's satisfaction with the training program. After the follow-up assessment was conducted, a consumer satisfaction questionnaire was read to the participant during a telephone interview. This questionnaire included four statements that were answered utilizing a Likert-type scale (1 = *strongly agree*, 5 = *strongly disagree*). The four statements were as follows: This training program has contributed to my (a) professional development, (b) knowledge in reporting child maltreatment, (c) confidence in reporting child maltreatment, and (d) I would recommend this program to a colleague. The following question was also included: "What changes, if any, would you make to the training program?"

EXPERIMENTAL DESIGN

The results of training on role-play performance during assessment probe sessions are presented in Figure 1. A multiple-baseline design across behaviors was used to examine the extent training had in improving the participant's ability to initiate a child abuse report with the confederate mother, as well as to resolve the confederate mother's upset during the abuse-reporting process. Figure 1 indicates that the participant was taught to initiate child abuse reports with nonperpetrating caregivers between the second and third probe sessions (see top graph) and that she was taught to resolve upset of nonperpetrating caregivers between the fourth and fifth sessions (see middle graph).

RESULTS

Role-play assessment of skills components. For the skills component, initiating a child abuse report with nonperpetrating caregivers, the participant improved from approximately 20% of actions performed during baseline (Sessions 1 and 2), to about 85% of actions performed consequent to training (Sessions 3, 4, 5, 6), according to the checklists completed by the clinical social worker and inexperienced undergraduate student (see top graph in Figure 1). These gains were maintained at the 45-day follow-up probe session. The reliability esti-

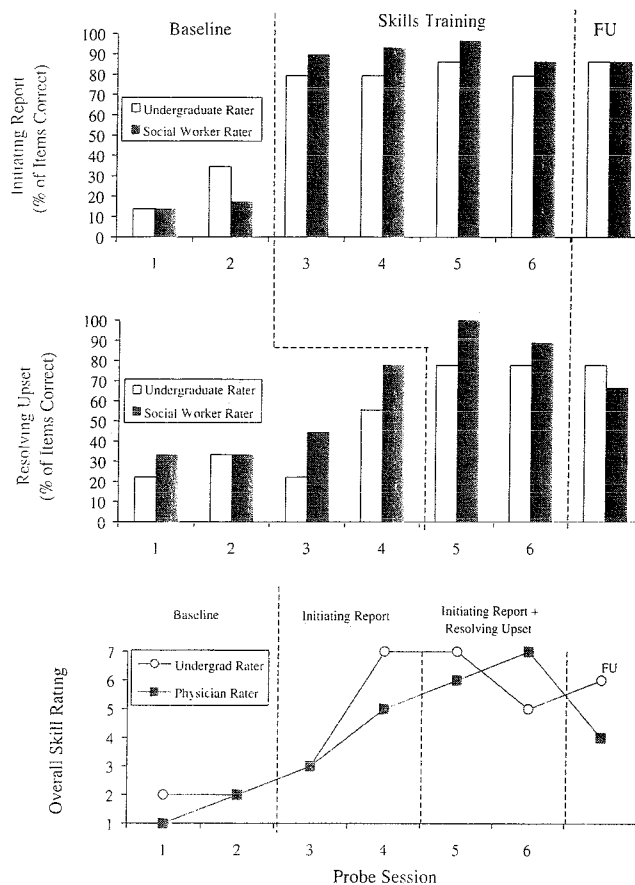


Figure 1. Evaluation of component and overall skills in role-play assessment. Skills relevant to initiating child abuse report were introduced to participant immediately prior to third probe session (see top graph). Skills relevant to resolving caregiver's upset in reporting process were introduced to participant immediately prior to fifth probe session (see middle graph). Overall skill ratings based on 7-point Likert-type scale (1 = *extremely unskilled*, 7 = *extremely skilled*).

NOTE: FU = 45-day follow-up.

mate between the checklists that were completed by the clinical social worker and inexperienced undergraduate student in this skills domain was 86.2%, indicating good reliability.

Regarding the participant's ability to resolve upset of nonperpetrating caregivers during the reporting process, training immediately

resulted in a higher percentage of these actions' being performed (i.e., 90%), according to the checklists completed by the social worker and undergraduate student. However, an ascending baseline confounds interpretation of these findings. That is, the participant was able to perform about 30% of these actions while she reviewed state laws (i.e., baseline Sessions 1 and 2), and 50% of these actions while she learned to initiate child abuse reports (i.e., baseline Sessions 3 and 4). Therefore, her abilities to resolve the caregiver's upset were positively influenced by the training she received in initiating child abuse reports. A slight regression in her ability to resolve upset was evidenced at the 45-day follow-up. The reliability estimate between the checklists that were completed by the clinical social worker and inexperienced undergraduate student in this skills domain was 81.7%, indicating good reliability.

Role-play assessment of overall skills. The graph at the bottom of Figure 1 shows overall skill ratings for each assessment probe session performed by the licensed physician and undergraduate student who was unaware of the nature of this study. Results indicate that these ratings are fairly consistent with one another and that the overall skill ratings are also consistent with the clinical social worker's evaluations of the participant's performance.

Participant's satisfaction with the training program. Not listed in Figure 1 were the results of the consumer satisfaction questionnaire completed by the participant at the conclusion of follow-up. The participant's responses to this questionnaire indicated that she strongly agreed with all four statements. That is, she strongly agreed that the program contributed to her professional development, knowledge in reporting child maltreatment, and confidence in reporting child maltreatment. Furthermore, she strongly agreed that she would recommend the program to a colleague. When asked for suggestions, the participant recommended that the program be shorter in duration of training.² She also recommended the inclusion of a training component relevant to responding to caregivers who are suspected of perpetrating child abuse.

DISCUSSION

The present study was the first to empirically examine a training method intended to assist professionals in state-mandated reporting of suspected child abuse. Results indicated that according to ratings of an experienced clinical social worker, the participant was able to effectively initiate a child abuse report with the confederate mother but only after the participant was trained in this skills component. The participant was also able to significantly improve her skills in resolving the confederate mother's upset during the reporting process. However, improvements in this skills component were demonstrated before training was implemented. Indeed, improvements in her ability to resolve upset were first evidenced consequent to her being trained to initiate a child abuse report. The latter finding suggests skills training involved in initiating child abuse reports may assist professionals in resolving upset in their patients. However, given that the participant was able to demonstrate additional improvements in her ability to resolve upset consequent to training in this area, we recommend the implementation of both skills components.

Improvements in the two skill components were associated with improvements in overall skill, according to both a professional who was experienced in child abuse reporting practices, as well as an undergraduate student who had no experience in child abuse. This finding suggests that the component skills evaluated in this study are associated with overall skill in preparing/enlisting nonperpetrating caregivers of child abuse victims in the reporting process.

The present study included administration of a consumer satisfaction questionnaire at the conclusion of the study to establish the training program's social validity. The questionnaire included several items to assess factors that have been shown to increase the likelihood of reporting suspected child abuse when indicated, such as knowledge (Felzen-Johnson, 1993; Kalichman & Brosig, 1992; Kim, 1986; Reiniger et al., 1995; Sandberg et al., 1986) and confidence in reporting child maltreatment (see Zellman, 1990). The participant's responses to the consumer satisfaction questionnaire also indicated that she strongly agreed the program would contribute to her professional development, as well as her intentions to recommend the program to colleagues.

As time constraints have been found to deter professionals from reporting suspected incidents of child abuse to authorities (e.g., Van Haeringen et al., 1998; Wright et al., 1999), it was encouraging to learn that the intervention could be implemented in about 10 or 15 minutes during role-play scenarios. However, it is likely the intervention would require more time to implement *in vivo*. For instance, similar, albeit less structured, interventions that have been implemented by the first author in families afflicted by child abuse have sometimes lasted up to 40 minutes. Therefore, although the intervention is relatively brief, it may be prudent to permanently assign responsibility of its implementation to someone residing in the professional setting with a flexible schedule. For instance, clinical psychologists and social workers are accustomed to conducting 50-minute sessions with their clients, whereas most physicians may need to attend to several patients at once. In terms of the time necessary to implement the intervention, our trained undergraduate student was able to implement all actions involved in the two skills components within 2 hours, including role-playing.

In conclusion, the present study results support long-standing recommendations by others to (a) teach professionals to convey distressful information to caregivers of child abuse victims using simulated child abuse scenarios (Alexander, 1990), (b) improve professionals' comfort with the victim's family in making the report (Zellman, 1990), and (c) improve professionals' familiarity with specific steps involved in initiating the report (Sandberg et al., 1986). However, it should be noted that evaluation of this participant occurred in a contrived child abuse situation with a confederate mother. Therefore, although the participant's skill in initiating the child abuse report was improved with training, it is not possible to determine how the participant would perform in actual abuse scenarios, nor is it possible to determine how this method of reporting would affect families *in vivo*. Indeed, the intervention program that was developed in this study could not be evaluated with caregivers within the context of actual abuse situations because informed consent would be necessary for participant inclusion. However, a more feasible, albeit less desired, research alternative might be to randomly assign parents of nonabused children to receive either the present intervention program or attention control condition in a contrived child abuse scenario and subsequently

assess the parents' satisfaction with each of the two interventions. In any event, the results of this study are encouraging and should provide a research basis for future studies.

APPENDIX A

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

1. Excuse everyone but caregiver.
2. Indicate that it is important to talk to caregiver privately about [suspected abuse].^a
3. Inform abuse is suspected (Bernet, 1995; Spencer, 1996).
4. Inform why abuse is suspected (Spencer, 1996).
5. State that it is law to report suspected child abuse (Bernet, 1995; Spencer, 1996).
6. Indicate that report must be submitted within 24 hours to Child Protective Services (CPS).
7. State that your position is not to determine whether or not abuse has occurred.
8. State that CPS may conduct an investigation to determine whether or not abuse occurred (Mackinnon & James, 1992).
9. State that report may not be accepted if there is incomplete information or failure of incident to meet abuse criteria.
10. State that CPS may accept report but not investigate (see Berliner, 1993; Mackinnon & James, 1992).
11. State that if report is accepted, CPS may conduct an investigation of abuse with other involved persons (Berliner, 1993; Mackinnon & James, 1992).
12. State that CPS may go to the child's school or home for interview.
13. Advise caregiver to be cooperative and respectful with CPS investigator.
14. State that caregiver may be present during call to CPS (Levine et al., 1995; Stadler, 1989).
15. State that caregiver may speak privately with CPS after you make the report.
16. State that caregiver may speak with CPS after you make the report, in your presence (Levine et al., 1995).
17. State that the caregiver has an option not to be involved in the report (Stadler, 1989).
18. Ask how caregiver would like to be involved in the report, if at all.

19. Tell caregiver to call CPS if any questions or concerns arise.
20. Ask if additional information should be included in the report.
21. Ask how report will be disclosed to perpetrator, if at all.
22. Ask how the perpetrator will respond to report and possibly investigation.
23. Ask how each person in home will respond to report and possibly investigation.
24. Assess safety of each person living in the home (Massey, 1999).
25. Confirm caregiver's statement that each person will be safe and/or initiate safety precautions (Massey, 1999).
26. State that a follow-up call will be made by physician.
27. Establish safety codes^b *with patient to be used at time of follow-up call*.
28. Ask the caregiver if there is anything else that can be done.
29. State that call to CPS will be initiated.

a. Discuss evidence of abuse.

b. Safety codes are words that may be used during telephone contact to discretely communicate that caregiver is safe/needs help. For example, in response to professional's query, "How are ya?" the caregiver might utilize a coding system in which "OK" indicates the caregiver needs help and "GOOD" indicates she is safe.

APPENDIX B

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

1. Do not attribute blame throughout the interaction.
 2. Make an empathetic statement.
 3. Assess concerns of caregiver (e.g., "What are you concerned about?").
 4. Solicit potential solutions from caregiver (e.g., "What can I do to help?").
 5. State concern for at least one of the family members (other than the child).
 6. State concern for the child suspected of abuse.
 7. Acknowledge caregiver cares about child (Levine et al., 1995) (e.g., "You want what's best for your child").
 8. State that the report may not be accepted.
 9. State that the caregiver may be present during the report (Levine et al., 1995; Stadler, 1989).
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NOTES

1. Role-playing involved sequential modeling of each target skill (action) while the participant enacted the role of a nonperpetrating caregiver. After each skill was modeled, the participant attempted the skill while the trainer portrayed the role of the nonperpetrating caregiver. Feedback from the trainer (i.e., descriptive praise, instructions to improve performance) was provided to the participant after each role-play interaction.

2. The assessment probe sessions were utilized only to evaluate the training program and would not typically be implemented as they were in this study.

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Brad Donohue, Ph.D., is the director of the Achievement Center and an assistant professor in the Department of Psychology at the University of Nevada, Las Vegas. His areas of research interest are child maltreatment, adolescent substance abuse, child conduct disorders, and sports psychology.

Kim Carpin is a medical student at the University of Nevada, Las Vegas, School of Medicine. Her research interests are pediatric medicine.

Krisann M. Alvarez is a graduate student enrolled in the clinical psychology doctoral program at the University of Nevada, Las Vegas. Her areas of research interest are childhood anxiety disorders.

Amy Ellwood, MSW, LCSW is an associate professor of family medicine and psychiatry at the University of Nevada School of Medicine in Las Vegas, Nevada. She is presently on the Violence Education Committee of the Society of Teachers of Family Medicine. She has published in the field of violence education. She has been in clinical practice for 20 years and has served on a Child Protection Team.

Richard W. Jones, M.D., graduated from University of Nevada School of Medicine in 1993. He completed residency with the Las Vegas Family Practice Residency Program in 1996. He was with the clinical practice and teaching faculty at the University of Nevada School of Medicine from 1996-2001. He is currently working as a medical director for Aetna in Las Vegas.