REPORTING CASES OF CHILD MALTREATMENT: DECISION-MAKING PROCESSES OF FAMILY THERAPISTS IN ILLINOIS

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ABSTRACT: This study advances the research on decision-making concerning child maltreatment by providing descriptions of both the process and outcome of therapist decision-making. Results indicated that decision-making about child maltreatment involves therapist-specific factors such as worldview assumptions, ethical principles, and prior clinical and life experience; situational factors including the type and severity of abuse, the amount of evidence presented, and client characteristics such as age and personal history; and interactional factors including cooperation and willingness on the part of adult clients to comply with the therapist. A contextual framework for decision-making that explicitly involves consideration of therapist-specific, situational, and interactional factors is proposed to enhance therapist decision-making.

KEY WORDS: ethics; decision-making; child maltreatment; therapists; marital and family therapy.

A significant gap in the literature exists for descriptive studies of clinical processes (Jankowski & Ivey, 2001; Pinsof & Wynne, 1995). Moreover, research concerning the clinical process of decision-making seems particularly lacking (Burkemper, 2002; Jankowski & Ivey, 2001). This study is a preliminary attempt to address the gap in the literature by

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offering descriptions of the decision-making processes of therapists regarding the reporting of suspected cases of child maltreatment.

Although some research on decision-making in child maltreatment reporting has been done using family therapists (e.g., Burkemper, 2002; Green & Hansen, 1989), the existing literature is filled with studies that have focused on psychologists, clergy, physicians, or social workers. One hypothesis for the lack of research in general on clinical decision-making within marital and family therapy (MFT), let alone studies that focus on child maltreatment reporting, is that there is a paradigmatic difference between the systemic orientation of MFT and the extant literature which for the most part considers decision-making as a linear, sequential processing of external information within the therapist and neglects the role of context and interactional factors in shaping the decision-making process (Ivey, Scheel, & Jankowski, 1999; Jankowski & Ivey, 2001). This study fits within the overall effort to consider more contextually oriented models of clinical decision-making (e.g., Holt, 1986, 1988; Ivey et al., 1999; Jankowski & Ivey, 2001; Sarbin, 1986), thereby hopefully increasing the compatibility of decision-making research with MFT.

Following the lead of the extant literature on decision-making, this study examined the likelihood that family therapists would report five different types of cases: physical abuse, neglect, latchkey situations, sexual abuse, and emotional abuse. In addition, this study investigated the factors that influenced the therapists' decision to file a report. The study diverges from the extant literature, not only by utilizing a sample of family therapists, but also by offering descriptions of the processes and outcomes of therapists' decision-making, and utilizing a mixed quantitative and qualitative methods research design.

LITERATURE REVIEW

The law has required the reporting of child maltreatment by helping professionals to state authorities since the 1960's, with all 50 states having developed reporting laws by 1970 (Warner & Hansen, 1994). By 1978, Washington, DC, Puerto Rico, the Virgin Islands, Guam, and American Samoa had enacted reporting laws (Besharov, 1985; Fraser, 1978) and by 1984 the Northern Marianas Islands had done so (Besharov, 1985). Similar mandatory reporting laws exist in Canada, Denmark, Sweden, and Finland (Gilbert, 1997), which makes cross-cultural comparisons and applications of research findings possible (Beck &
Ogloff, 1995) and moves the study of child maltreatment to larger levels of analysis (Gilbert, 1997).

Consideration of larger levels of analysis frames child maltreatment as a product of structural inequalities and social injustice (Gil, 1975). Children are seen as victims of a larger system that denies them "equal intrinsic worth" (Gil, 1975, p. 347). In addition, child maltreatment stems from and simultaneously reinforces the fact that children are denied basic civil rights, such as protection and an opportunity to achieve optimal development. Any structural condition that perpetuates injustice and contributes to the lack of opportunity for optimal development has been referred to as structural violence (Galtung, 1969), and direct forms of violence such as child maltreatment flow out of structural violence (Winter & Leighton, 2001). Within this framework, reporting laws are an effort to alleviate direct and structural violence. Furthermore, when child maltreatment is framed as a public health problem (Donnelly, 1997; Gil, 1971), it further clarifies the role of reporting laws as strategies to alleviate child maltreatment on multiple layers of analysis. As a primary prevention strategy alleviating structural violence, mandatory reporting laws address issues of social injustice and extend basic civil rights to children (Jimenez, 1990). As such, reporting laws initiated and continue to promote the kind of change needed at the societal level, challenging and changing how people view children and the rights they possess (Gil, 1975; Helfer, 1982). As a tertiary prevention strategy (Helfer, 1982), reporting laws require investigation and intervention into suspected cases of child maltreatment (Besharov, 1985), thereby providing effective after-the-fact healing and prevention of further incidences of maltreatment. In sum, reporting laws seek to address child maltreatment on multiple levels of analysis, and frame child maltreatment as a matter of social justice to be addressed on each level of the social context.

Despite the existence of mandatory reporting laws, the recognition that effective prevention must occur at every level of analysis (Gil, 1975; Kostelny & Garbarino, 2001), and that mandatory reporting is understood to be an effective aspect of prevention (Finkelhor, 1993; Warner & Hansen, 1994), research on reporting behavior has consistently shown that professionals do not report every case (e.g., Beck & Ogloff, 1995; Finkelhor, 1993; Kalichman, Craig, & Follinstad, 1989; Kalichman & Brosig, 1992; Swoboda, Elwork, Sales, & Levine, 1978; Watson & Levine, 1989). In fact, Finkelhor (1993) argued that underreporting remains a serious problem in need of attention. Common therapist-specific reasons for failure to report have included fear of poor
CONTEMPORARY FAMILY THERAPY

handling by the child protection agency (Beck & Ogloff, 1995); not enough evidence (Beck & Ogloff, 1995; Watson & Levine, 1989); perceived potential for negative consequences on the child, family, and professional (Badger, 1989); previous negative interactions with child protective services (Badger, 1989; Saulsbury & Campbell, 1985); and fear of losing the therapeutic alliance with clients (Harper & Irvin, 1985; Watson & Levine, 1989).

Perhaps because the assumed negative effect of reporting on the therapeutic relationship is the most frequently cited reason for not reporting (Harper & Irvin, 1985), a significant amount of research attention to this reason has occurred. For example, Steinberg, Levine, and Doueck (1997) found that 27% of the clinicians studied had clients leave therapy after making a report. The clinicians believed that the filing of the report was the cause for leaving therapy (Steinberg et al., 1997). However, they also found that the presence of a strong therapeutic relationship and explicit therapy consent form mediated against clients dropping out of therapy following the making of a report. In earlier studies, as much as 76% of cases examined showed that reporting had virtually no effect or positive effects on the therapeutic relationship (Watson & Levine, 1989), while Harper and Irvin (1985) found that negative effects on the relationship occurred in only two of 49 cases. Harper and Irvin (1985) also found that a strong therapeutic relationship mediated against any negative effects of reporting and that reporting could function as a clinical intervention that was beneficial to therapy. Thus, it would seem that while it is a common reason cited for not reporting, clinician concerns about negative effects on the therapeutic relationship are overestimated, particularly since there appear to be ways to lessen the potential for any negative effects.

Apart from reasons for not reporting, the extant research has also focused on identifying therapist-specific factors that influence the reporting of maltreatment. Reasons for reporting include the legal obligation to report, the need to protect the child, certainty that abuse had occurred (Beck & Ogloff, 1995), the therapist’s expectation that reporting would have a positive effect on treatment (Kalichman et al., 1989), fear of malpractice (Hansen et al., 1997), and the clinician’s personal history of abuse (Hansen et al., 1997). One additional therapist-specific factor found to affect the decision-making of clinicians concerning child maltreatment consists of perceptions of perpetrator behavior. However, two studies produced somewhat conflicting results in that one study indicated that when the father admitted to abusing the child, a report was more likely to be made (Kalichman et al., 1989), while the other
study found that noncompliance in treatment was a more important factor in making a report (Kalichman & Craig, 1991).

Another avenue of research stemming from the focus on factors affecting the filing of a report includes the consideration of client factors when making a decision to report. Kalichman and associates (1989) confirmed the results of earlier research when they found that situational factors associated with the occurrence of abuse were more important than client factors, such as the child's age or sex. Situational factors associated with the occurrence of abuse included the kind and severity of abuse, as well as the child's behavior in sessions (Kalichman et al., 1989). However, in other studies age was found as a significant factor that positively affected the decision to file a report, with the younger child associated with a higher likelihood of reporting (Hansen et al., 1997; Kalichman & Craig, 1991; Kennel & Agresti, 1995). Last, there is also some evidence that socioeconomic status and race are related to rates of reporting. For example, Hansen and colleagues (1997) found that lower socioeconomic status and being Caucasian were related to a greater likelihood of reporting by the therapist. Interestingly, the Hansen and associates finding contradicts earlier research that found that a report was more likely to be made if persons were African-American or Hispanic (Hampton & Newberger, 1985).

One conclusion evident from the research cited above is that the decision-making process of reporting maltreatment is a complex matter comprised of therapist, client, and situational factors. The complexity is also evident in the multiple layers of decision-making that occur when a decision to make a report of child maltreatment is considered. For example, the issue of determining the severity of abuse involves a clinical judgment within the larger decision-making process of reporting. The research indicates that the more severe the abuse, the more likely the therapist is to report the abuse (Kalichman et al., 1989). As a sub-process within the larger process, determining severity is affected by similar factors to that of the decision to report. For example, Howe, Herzberger, and Tennen (1988) found that therapists who had a personal history of abuse tended to rate hypothetical scenarios about abuse as more severe. Similar complexity can be seen in other clinician judgments such as problem definition (Jankowski & Ivey, 2001), and suggests that the nature of clinical decision-making is multi-dimensional.

While the extant research reveals the complex nature of decision-making processes concerning child maltreatment, knowledge gaps are also evident. The research literature lacks an explicit MFT focus, consists largely of quantitative studies, and neglects descriptions of the
decision-making processes of clinicians, particularly in connection with outcomes or therapists' actual decisions.

**Child Maltreatment Research Within Marriage and Family Therapy**

The scant MFT research on decision-making regarding child maltreatment that does exist can be categorized into (1) survey approaches that provide descriptive statistics or summaries of clinician responses, and (2) approaches that utilized an existing typology for conceptualizing the decision-making process of clinicians. One apparent limitation of the existing MFT literature is that the study of decision-making concerning child maltreatment was not an explicit focus of the research. The study of decision-making concerning child maltreatment usually occurred within the context of a much broader focus on ethical decision-making in general. Thus, detailed attention was not given to the unique issues involved in decision-making about the reporting of child maltreatment. In contrast, an obvious strength of the MFT research consists of attempts to conceptualize the decision-making process. This study seeks to address the limitation by focusing explicitly on decision-making concerning child maltreatment and further strengthens the emerging conceptualizations of clinician decision-making.

Perhaps, the first effort to study decision-making concerning child maltreatment within MFT was Ratliff's (1988) survey of members of the Texas Association for Marriage and Family Therapy. Ratliff posed numerous ethical dilemmas to respondents, including two dilemmas on reporting child abuse, and then summarized their responses. For example, in one dilemma a 16-year-old female indicated that her stepfather had sexually abused her from the ages of 8–13. In Ratliff's study, "65% of therapists said they would be unlikely to report this case to protective services, 6% were undecided and 29% said they would be likely to report the abuse" (p. 32). Ratliff also found that female therapists were more likely to file a report for this situation than males.

In another study, Brock and Coufal (1994) utilized the Ethical Behavior Index for Marriage and Family Therapists that included one item asking, "Would you? Break confidentiality to report child abuse." Only 54% of clinicians responded that they would always report the case, leading the authors to conclude that failing to report child abuse was an issue in need of attention within MFT. Their finding confirmed earlier research. In response to an ethical dilemma posed to therapists rather than a survey item, Green and Hansen (1989) found that roughly
half of the participants hesitated “to report child abuse right away” (p. 156).

More recent research within MFT reflects a trend away from simply reporting summaries of participants’ responses to efforts at conceptualizing the decision-making process that therapists used when making their judgments. Newfield, Newfield, Sperry, and Smith (2000) utilized a dilemma concerning child abuse and found that both marriage and family therapists’ and individual oriented therapists’ responses were consistent with an ethic of care, as described by Gilligan (1977, 1982) and Gilligan and Attanucci (1988). An ethic of care involves decision-making based on a concern for client needs and maintaining the therapist-client relationship. The authors did not report whether the respondents in the study would file an abuse report for the dilemma provided.

Rather than drawing upon the moral judgment literature to conceptualize clinician decision-making, Burkemper (2002) utilized Kitcener’s (1984) model of ethical decision-making. In Kitcener’s (1984) model, decision-making processes can be categorized into intuitive level decisions, critical-evaluative decisions, and the level of meta-ethical principles. The results of Burkemper’s (2002) study indicated that therapists were more likely to utilize legal considerations, that is, a critical-evaluative decision-making process, when making a report of child abuse as compared to a dilemma involving duty to warn.

The MFT research is an improvement over much of the extant literature because it focuses on the process of decision-making rather than merely the outcome. This study advances the MFT research on decision-making concerning child maltreatment by providing descriptions of both the outcome of clinician decision-making and the processes utilized in arriving at the particular outcome. In an effort to describe both outcome and process, this study utilized a mixed methods research design.

**METHOD**

A validity concern exists with qualitative studies and consists of whether the data are conformed to fit into a pre-existing framework or whether the construction of conceptualizations is allowed to emerge from the data (Jankowski, Clark, & Ivey, 2000). This study addresses the validity concern through a methodological solution involving the use of a grounded theory method of data analysis (Charmaz, 1983; Glaser & Strauss, 1967) and a process of self-reflexivity in which new
understandings were consistently juxtaposed with pre-existing ideas (Chenail & Maione, 1997). Another reason for selecting a grounded theory approach as a part of the mixed methods design was the goal of generating descriptions of clinical processes (Raufus & Moon, 1996).

**Sample**

Participants were obtained from a directory of clinical members of the Illinois Association for Marriage and Family Therapy. One hundred family therapists were contacted with a cover letter, consent form, questionnaire, and stamped return envelope. Thirty therapists (30%) responded with completed questionnaires. The mean age of respondents was 50.9 years, and 70% were female. Sixty-six and seven-tenths percent (66.7%) were married, and 13.3% were divorced. Fifty-five and six-tenths percent (55.6%) reported past experience with the Department of Children and Family Services (DCFS), the state maltreatment agency, as positive. More than 44 percent (44.4%) reported that their experience was negative. A quarter (25.9%) indicated that they had previously failed to report maltreatment cases to DCFS. More than a third (36.7%) of the therapists indicated that they had been victims of some form of child abuse in their own childhood.

**Data Collection**

A questionnaire was developed that consisted of 10 scenarios, the Organicism-Mechanism Paradigm Inventory (OMPI) (Johnson, Germer, Efran, & Overton, 1988), and some demographic items. The 10 scenarios included three latchkey/neglect, three physical abuse, three sexual abuse vignettes, and one emotional abuse vignette. The vignettes described a form of maltreatment and therapists were asked to indicate how likely they would be to file a report on a case like the one described. Likelihood of report was measured on a four point Likert type scale from highly unlikely to highly likely. In addition, for each scenario, the therapists were asked to write a narrative about the rationale for their decision. Table 1 is an example of one of the physical abuse vignettes. The OMPI is a 26 item self-report instrument designed to assess a person's philosophical assumptions about him or herself, others, and the world. Scores above the mean of 16.07 indicate a philosophical orientation toward organicism, while scores below the mean reflect adherence to a mechanistic worldview. The OMPI has "good internal consistency, with a Guttman split-half coefficient of .86 and a Cronbach
TABLE 1
Physical Abuse Scenario

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<td>Highly</td>
<td>Likely</td>
<td>Unlikely</td>
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4. A couple comes to therapy saying they have had marital problems for 6 years. The couple has a 5 year old child, but does not consider the child as relevant to their marital problems. However, during one of the sessions in which the couple has brought their child, you notice a handprint sized bruise on the child’s arm. If you were the therapist working with this family, how likely would you be to make a report to DCFS?

Why or why not?

alpha coefficient of .76. A 3-week retest showed a stability coefficient of .77" (Johnson et al., 1988, p. 825). Information was also collected on the characteristics of the therapist. This demographic information included age, gender, type of degree, training in ethics, marital status, amount of clinical experience, theoretical orientation, personal child abuse history, history of failure to report previous cases of child maltreatment, and satisfaction with past experiences with DCFS. A survey design was used to gather information from participants.

Data Analysis

Likert-type items and the demographic data on the questionnaire were analyzed using ANOVAs (Analysis of Variance) and Pearson correlations. The written responses were analyzed using Charmaz’s (1983) interpretation and application of Glaser and Strauss’ (1967) method of data analysis. Sentence by sentence coding of the written responses occurred as the analysis moved from concrete descriptions of the narratives to more conceptual levels of categorization. For example, the code
"factual focus" was later re-coded as "evidential decision-making" which was broadened to fit under the code of "categorical decision-making." Other initial codes were subsumed under the larger conceptual category of "categorical decision-making" including "letter of the law" and "matter of fact" approaches. Throughout the coding process, a self-reflexive process of juxtaposing new codes and understandings with pre-existing ideas about what was expected and known occurred (Chenail & Maione, 1997). The process of self-reflexivity was monitored through note taking in the margins of the transcripts of participants' written responses.

FINDINGS

Findings indicated that, in general, the majority of therapists were likely to report, meaning that they indicated either a likely or highly likely response on the Likert items, across all types of maltreatment cases except emotional abuse. However, there was more variability of responses for the three physical abuse vignettes compared to the scenarios involving latchkey/neglect, and sexual abuse. In the three physical abuse vignettes from 40% to 82.8% of therapists were likely to report. In the neglect case vignette 60% of the therapists were likely to report. In the two latchkey vignettes 79% and 65.5% of the therapists were likely to report. In the three sexual abuse vignettes from 96.4% to 100% of the therapists were likely to report. In a departure from other forms of maltreatment only 10.3% of the therapists were likely to report based on the emotional abuse vignette. In contrast to the likelihood of reporting percentages in this study, earlier studies involving family therapists found likelihood ranges of only 35% to 54% (Brock & Coufal, 1994; Green & Hansen, 1989; Ratliff, 1988).

Results of statistical analyses indicated that age, gender, failure to report previous cases, experience in the field, personal child abuse history, and feelings about previous contacts with DCFS were not significantly related to therapists' responses on likelihood of reporting for any of the case vignettes of the study. Of particular interest are the latter two findings which differ from previous studies involving other helping professionals in which personal child abuse history was correlated with the likelihood of reporting (Hansen et al., 1997) and previous negative interactions with child protective agencies was correlated with the likelihood of not reporting (Badger, 1989; Saulsberry & Campbell, 1985). In addition, worldview, theoretical orientation, level of education, degree, approved supervision, and training in ethics showed no
clear pattern of relationship across the vignettes as a whole or categories of abuse vignettes.

Qualitative analyses of the written responses led to the construction of 6 decision-making processes, with slight variation between the different types of abuse. Tables 2 and 3 describe clinicians’ “to report” and “not to report” decision-making processes across vignette types, along with a basic definition of the decision-making process and an excerpt from participants’ written responses. The excerpt illustrates the types of responses that fit within the decision-making category.

The decision-making processes for neglect are described in an attempt to illustrate the types of decision-making processes found across scenarios. While each of the six decision-making processes was found in responses to the neglect scenarios, this was not true for the other scenario types. Decisions to report neglect involved ascertaining the developmental level of the child, a “categorical” approach that focused

| TABLE 2 |
| "To Report" Themes |

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<th>Decision-Making Process</th>
<th>Definition</th>
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<td>(1) developmental level (neglect only)</td>
<td>The younger the child, the more likely the therapist was to report.</td>
<td>Ex.: “Children of this age are in need of responsible adult supervision. These parents would be placing their children at high risk.”</td>
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<td>(2) “categorical” (neglect, physical, sexual abuse)</td>
<td>Focus on the facts, ascertaining the evidence as fitting a legal definition, and/or the reality of being a mandated reporter.</td>
<td>Ex.: The incident is “reportable as defined by the mandated reporters act.”</td>
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<td>(3) “cautious” (neglect, physical, sexual abuse).</td>
<td>Focus on the possibility that abuse was occurring, had occurred or could occur.</td>
<td>Ex.: “If there is any suspicion of abuse I would make a report so an investigation can be made.”</td>
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TABLE 3
"Not to Report" Themes

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<th>Decision-Making Process</th>
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<td>(1) “conditional” (neglect, physical, sexual abuse)</td>
<td>The need for a future condition to be met before a report is made.</td>
<td>Ex.: “If father refused to admit and get therapy immediately, I would report to DCFS immediately.”</td>
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<td>(2) “situational” (neglect, physical, sexual abuse)</td>
<td>Reporting is dependent upon other past or current criteria being present.</td>
<td>Ex.: “It would depend upon the explanation given for how the child received the bruise and/or if other marks were visible.”</td>
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<td>(3) “intervening” (neglect, physical, abuse)</td>
<td>Some type of clinical intervention is determined to be more beneficial than reporting.</td>
<td>Ex.: “Instead I’d work on ways of dealing with her acute stress, identify support services and possible home visits for mother.”</td>
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on the factual evidence presented in the vignette and the reality of being a mandated reporter, and/or a “cautious” approach that reported on suspicion alone. On the other hand, decisions not to report neglect involved “conditional decision-making” that centered on a prior condition needing to be met before a report was made and/or “situational decision-making” that was dependent upon other criteria needing to be present before a report would be made. The difference between “conditional” and “situational” decision-making was that the “conditional” approach involved a “clear cut” decision to report if a condition were met in the future, while “situational” reasoning was left as a “maybe” decision depending upon other conditions being present in the past and the need to find out more information. Finally, some decisions not to report neglect involved a “therapist intervention” approach that
involved the determination that some type of clinical intervention would be more beneficial.

Decision-making in response to the vignettes was consistent with participants' responses to actual situations in their practice as therapists. Reliance upon case vignettes to assess decision-making has been recognized as a weakness of previous research (Kalichman & Craig, 1991; Kalichman et al., 1989), with others also acknowledging the strengths of the methodological approach (Hansen et al., 1997). In an effort to address this potential problem, participants were asked to indicate a time when they did not report a case of child maltreatment in the past and to provide a written narrative of their decision-making process. Coding of these written responses resulted in finding parallels in the types of decision-making processes that were found in their responses to the case vignettes. This seems to suggest that the same types of decision-making processes occur between hypothetical and actual clinical situations. While more research is clearly needed to compare actual and hypothetical decision-making processes, the results of this study confirm Kalichman and Craig's (1991) finding that there is a consistency between the way clinicians respond to hypothetical scenarios and their actual or real-life decisions.

The most common reason for likelihood of reporting was that the behavior was assessed as meeting the legal definition of abuse and that reporting such behavior was required by law. The most frequent explanation for failure to report was that DCFS did not investigate cases of emotional abuse and, thus, the report would have no effect. Of particular interest was the finding that even though therapists indicated a likelihood of reporting on the Likert scale, their written responses in some instances indicated that they would in fact not report the case and that their reporting was contingent upon certain other pieces of information being found to be factual, or whether or not clients would meet certain treatment conditions thereby removing the need to report.

**DISCUSSION**

The findings of this study fit within existing conceptual models applied to decision-making within the MFT literature. First, following Burkemper's use of Kitchener's (1984) model, the "to report" themes in this study seem to fall within Kitchener's (1984) critical-evaluative category. Critical-evaluative decision-making utilizes "the rules, pro-
fessional codes and laws that govern therapist behavior (Burkemper, 2002, p. 204). Each of the “to report” decision-making processes identified in this study involved following perceived standards of practice, whether it was the consideration of age in the definition of neglect, the presence of factual evidence that met the definition of physical or sexual abuse, or an understanding of the fact that the law requires the reporting of suspected cases of abuse.

In contrast, the “not to report” decision-making processes seem consistent with Kitchener’s (1984) meta-ethical principles category. The meta-ethical principle that seemed to guide much of the therapists’ decision-making in the “not to report” category was beneficence or the decision that what was best for the client was to gather more information before reporting, or to intervene therapeutically in some way before reporting. Not surprisingly, therapists’ differed in their determination of what was best for the client. It could be argued that those who did report were also basing their decisions on beneficence and making the determination that what was best for the child was to make a report. However, this was not evident in their written responses. Nevertheless, it could be that it was a part of their decision-making process, but they decided not to include it in their written responses because the overriding factor in making the decision was accepted standards of practice. This highlights a methodological limitation of the study in that follow-up questions could not be asked in order to ascertain some of these more subtle aspects of the decision-making process.

Last, it could also be argued that the therapists’ used an intuitive decision-making process for the vignettes involving sexual abuse. Kitchener’s (1984) intuitive decision-making process “involves considering ordinary moral sense in reaction to the facts of the situation resulting in a knee-jerk” decision (Burkemper, 2002, p. 204). According to Hare (1991, cited in Burkemper, 2002) intuitive decision-making is the “joining of prior ethical knowledge and experience in an immediate, prereflexive response” (p. 204). For the sexual abuse scenarios, many of the participants’ written responses when compared to their responses for the other vignettes were much more brief and succinct, for example, simply stating “this is sexual abuse” or “sexual abuse of the child has occurred.” Furthermore, all but one of the participants were likely or highly likely to report the scenarios involving sexual abuse. Thus, it seems that for the sexual abuse scenarios, a more complex decision-making process involving rational thought processes was not required. In other words, it was more obvious to the therapists that these were reportable situations.

Hill, Glaser, and Harden (1995) articulated an adaptation of Kitch-
ener's (1984) conceptual model. In the model, which they have called the Feminist Ethical Decision-making Model, the rational-evaluative decision-making process encompasses Kitchener's (1984) critical-evaluative and meta-ethical principles categories, while their feeling-intuitive category parallels Kitchener's (1984) intuitive level (Hill et al., 1995). Newfield and associates (2000), based on their research, suggested a third category for the Hill and colleagues (1995) model. Newfield and associates, drawing upon the moral development literature, labeled this third category of decision-making as a relationship-caring process. According to Newfield and associates the relationship-caring process focuses "on preventing interpersonal harm and finding solutions that balance the needs of all involved, addressing the relationship complexities" (p. 185).

Applied to the findings in this study, both the "to report" and "not to report" themes could fit within the rational-evaluative category of Hill and associates (1995). The exception might be, once again, that for the sexual abuse vignettes it could be argued that the therapists' decision-making processes in this study fit within the feeling-intuitive category. It could also be argued that the participants in this study were displaying the relationship-caring ethic of Newfield and colleagues (2000). Many of the written responses for not reporting included references to the alleged perpetrators and other family members getting treatment, rather than just the child. The references to other family members getting their needs met may reflect the relationship-caring ethic proposed by Newfield and associates (2000).

Apart from the Feminist Ethical Decision-making Model, Newfield and colleagues (2000) also drew upon Kohlberg's (1969, 1976, 1981, 1984) justice orientation to decision-making and Gilligan's (1977, 1982) and Gilligan and Attanucci's (1988) care orientation to decision-making in order to conceptualize therapists' decision-making. Within this framework, the "to report" findings seem to fit within a justice orientation to decision-making. The basis for this categorization lies in the therapists' appeal to the obligation of being a mandated reporter and the sense of fairness that lay beneath many of their written responses. Their sense of fairness was seen in their notion of the right of the child to be protected and the consequences that needed to be meted out against the perpetrator. In contrast, the "not to report" decisions seem to fit within a caring orientation to decision-making. The reasons for this categorization include the participants' consideration of the needs of other family members and on the specific details of the situations described in the vignettes (Flanagan & Jackson, 1987).

Another means of conceptualizing the findings of this study con-
sists of considering the decision-making processes as fitting within a mechanistic or contextual worldview (Ivey et al., 1999; Jankowski & Ivey, 2001). The inclusion of the OMPI (Johnson et al., 1988) in the questionnaire for this study stemmed from the work of Ivey and associates (1999) and their consideration of decision-making at the level of worldview assumptions. While the participants’ OMPI scores did not show any clear pattern of association with Likert type responses to the vignettes, their written responses were somewhat consistent with the worldview categories. For example, it is possible to consider the “not to report” responses as fitting within a contextual paradigm. A contextual paradigm for decision-making involves considering therapist-specific, interactional, and situational factors that also includes client-factors and the larger social context within which therapy is embedded. The consistencies between the “not to report” themes and the contextual paradigm include the consideration of situational factors such as “network supports,” prior incidents of abuse, “parenting skills,” and medical issues when making the decision to not report. Furthermore, some of the written responses in the “not to report” category revealed a consideration of interactional factors such as the father’s “openness” to getting help, the mother’s willingness to follow through on suggested courses of action, “cooperation” between adult clients and the therapist, and the “therapeutic bond.” The category of interactional factors refers to those qualities or experiences that arise out of the relationship between therapist and client(s) (Jankowski & Ivey, 2001).

The “to report” themes appear to be a bit more difficult to categorize, but can be conceptualized as mechanistic. The primary basis to this characterization of the “to report” themes consists of their lack of reference to situational and/or interactional factors in the participants’ decision-making. In fact, the therapists focused on the concrete facts of the scenario and made objective, clear-cut responses, both of which are consistent with a mechanistic orientation (Jankowski & Ivey, 2001). However, some of the “not to report” responses also revealed an objective, clear-cut course of action on the part of the therapist, making these responses also somewhat characteristic of a mechanistic approach.

One last means of conceptualizing the findings in this study consists of using Jankowski and Ivey’s (2001) internal versus conversational decision-making approaches. In this model, an internal approach involves relying upon one’s own sense-making process as the basis for making decisions while a conversational approach involves making overt one’s internal sense-making and opening up the decision-making process for discussion and analysis.
process to include input from the clients. The methodology of this study limits the application of their model because direct observation and/or interview of the participants would have been necessary to ascertain some of the more implicit processes of decision-making, such as the positioning of the therapist in relation to the client during therapy. Nevertheless, it seems that many of the “not to report” themes are somewhat consistent with a conversational approach in that the participants’ responses revealed an interest in overtly involving the clients in the decision-making process. For example, therapists responded with statements such as “first I’d talk with the child and couple . . .” and “it depends on how they respond to my questioning.” Methodologically, written responses to vignettes simply do not allow for an assessment of decision-making that relies more on an overt interactional or process-oriented approach rather than an approach to decision-making on the basis of presented factual content. In this sense, both the “to report” and “not to report” categories appear as internal judgments. Nevertheless, it seems that there were some participants who desired a more conversational approach to decision-making, and this was evident in their “not to report” responses.

**IMPLICATIONS FOR CLINICAL PRACTICE**

One possible implication of this study for clinical practice is the need for supervisors to focus more clearly on supervisees’ clinical decision-making skills and assist them in making decisions that are, as much as is possible, ethical, lawful and clinically effective. The variability of the therapists’ responses could reveal that they lacked a clear model for child maltreatment decision-making. As Ivey and associates (1999) lamented, there is a dearth of practical resources for marriage and family therapists when it comes to clinical decision-making. The findings of this study appear to echo their observation. However, the small sample size in this study prevents any categorical assertion that there is a deficiency in MFT training concerning decision-making. Furthermore, while all of the therapists in this study received some training in ethics, little is known as to how much specific training they received in child maltreatment decision-making. Thus, it is tentatively proposed that therapists’ could benefit from developing a conceptual model for decision-making much the same way they benefit from developing a personal theory of therapy during their training.

More specifically, it is suggested that the development of a model
for decision-making involve a focus on being ethical and lawful in terms of complying with mandatory reporting laws while also acknowledging and making use of the common factors found to promote change in effective therapy (Miller, Duncan, & Hubble, 1997). For example, structuring the therapeutic process and building a strong therapeutic relationship, both found to promote change, could be used to make therapy effective while also allowing for the ethical and lawful reporting of suspected cases of maltreatment. A contextual orientation is offered because it can perhaps best accomplish the aforementioned goal of promoting an ethical, lawful and effective approach to therapy, despite its association with decisions to not report in this study.

A contextual model explicitly involves considering interactional factors such as the therapeutic relationship, and situational factors that can help structure the therapy such as the nature of the referral process and presenting concern and the informed consent process. Since a strong therapeutic relationship and explicit consent form can mediate against negative effects of reporting (Steinberg et al., 1997), and since making a report can be used as a clinical intervention that helps structure the therapy process (Harper & Irvin, 1986; Watson & Levine, 1989), it would seem that a therapist using an approach to decision-making that overtly incorporates interactional and situational factors into his or her therapeutic orientation could make therapy more effective while also meeting the demands expected of mandatory reporting laws.

In addition, a contextual orientation to decision-making is advocated because it enables the therapist to consider the larger levels of analysis within which child maltreatment occurs. It also enables the therapist to conceptualize child maltreatment as a social justice issue. In a discipline that is based on a systemic orientation it is confusing to note that more than two decades of feminist therapists' calls for therapists to be oriented by the value of social justice and to address injustices in the therapy room seems to have been largely neglected by the profession at large and that a recent resurgence of those calls appears to be necessary (e.g., Doherty, 1995; Hardy, 2001; McDowell & Shelton, 2002; Zimmerman & Haddock, 2001). It is also discouraging to note that reporting of suspected cases of child maltreatment as a means to promote greater social justice and bring further equality to the social structure seems to have been a marginalized conceptualization and approach to the problem. It is hoped that advocating for a contextual orientation to decision-making can redress some of these oversights.
FUTURE CONSIDERATIONS

In light of the limitations alluded to earlier, future directions for research include the need (1) for a larger sample size, (2) to more fully describe therapists' decision-making processes, and (3) to link clinical decisions to actual therapeutic outcomes. A larger sample size could allow for more convincing assessments of the current state of decision-making within MFT, and also permit broader application of the findings than was possible in this study. Furthermore, as mentioned throughout the discussion section, a limitation of the study was the use of vignettes. Methods of investigation that involve observation and/or interviews could offer more vivid descriptions of clinical decision-making processes, thereby providing more detailed understanding of the ways in which therapists actually make decisions. Last, another direction for future research consists of determining whether certain decision-making processes are linked to positive clinical outcomes.

CONCLUSION

The findings suggested that “to report” decisions could be conceptualized as consistent with critical-evaluative decision-making, a justice orientation, and mechanistic decision-making. In contrast, “not to report” decisions appeared consistent with meta-ethical principle decision-making, a relationship-caring orientation, and contextual and conversational decision-making models. As such, the conceptualizations are not meant to be representations of how each therapist approaches decision-making, thereby implying that decision-making is solely a function of therapist-specific factors. Nor are the conceptualizations offered as categorical representations of all decisions to either report or not report cases of child maltreatment. Rather, the conceptualizations paint a picture of decision-making about child maltreatment that is multifaceted; a product of the combination of a host of factors. Thus, regardless of the conceptual model used and the categorizations presented, it is apparent that decision-making about child maltreatment is a complex process that involves therapist-specific factors such as worldview assumptions, ethical principles, and previous clinical and life experiences; situational factors including the type and severity of abuse, the amount of evidence presented, and client characteristics such as age and personal history; and interactional factors that include
cooperation and willingness on the part of adult clients to comply with the therapist.

REFERENCES


CONTEMPORARY FAMILY THERAPY


