Countertransference And Failure To Report Child Abuse And Neglect

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Abstract
Though every state has laws requiring the report of suspected child abuse and neglect, failure to report remains a significant problem. Review of previous research on failure to report suggests that the reporters’ anxieties about disrupting their relationship with the child’s family as well as the reporters’ gender, experience, and training affect willingness to report. Countertransference fear, guilt, shame, and sympathy are discussed as a basis for understanding the reporter’s anxieties. We suggest that countertransference issues should be addressed in the training and ongoing practice of mandated reporters. The following mechanisms are offered to deal with this issue in training and practice: (1) teaching professionals about how countertransference reactions may arise during the reporting process (this training may include the use of risk management groups for private practitioners); (2) identification of a community child abuse expert for consultation; and (3) educating child protection workers about psychodynamics aspects of case management.

Introduction
FAILURE OF MANDATED reporters to report suspected child abuse and neglect cases continues to be a national problem (Zellman, 1988). This problem persists in spite of the considerable effort made over the last 20 years to educate professionals about the problem and legally require them to report. While there has been some empirical investigation of the attitudes of professionals about their failure to report (Attias & Goodwin, 1985; Bavolek, 1983; James, Womack, & Strauss, 1978; Morris, Johnson, & Clasen, 1985; Salsbury & Campbell, 1985; Winefield & Castell-McGregor, 1985; Zellman, 1988), there has been no in-depth discussion of psychodynamic factors, namely countertransference, as important influences on this process. Countertransference is an integral part of clinical work with children and their families (Marcus, 1980; Marshal, 1979; Schowalter, 1985) and is an especially prominent dynamic factor in the evaluation and treatment of abuse and neglect cases (Jones, 1986; Krell & Okin, 1984; Tuohy, 1987). There have been multiple definitions of this concept in the psychodynamic literature (Marcus, 1980). For the purpose of this paper, countertransference is defined broadly and refers to the totality of the emotional reactions, both unconscious and conscious, of the reporter of the child, family, and abuse situation. This includes the unconscious and preconscious impact of the mandated reporter’s needs, conflicts, and life experiences on his/her perceptions, understanding, and reactions. These often occur in response to the transferences of the child and family to the reporter. It also includes conscious or largely conscious responses that may be evoked by the behaviour of the child and family, and/or the unique features of the clinical situation. The purpose of this paper is to clarify a range of countertransferential reactions, namely fear, guilt, shame, anger, and sympathy, that can arise in the process of mandated reporting and ways they may serve to compromise effective and timely reporting. Suggestions will be made as to how to better recognise and manage troublesome countertransference reactions to help enhance compliance with existing statutes. The empirical research on failure to report will first be reviewed to better clarify the extent of resistance to mandated reporting and the reasons offered for this by professionals. Psychodynamic influences, namely, countertransference, will then be discussed in light of these empirical findings.

Review Of Empirical Literature On Failure To Report
Research on failure to report has been dependent upon the conscious awareness of respondents of their reactions to the child and family and how these reactions have entered into the decision to report. Several of these studies have been designed to assess the degree of failure to report among mandated professionals (Attias & Goodwin, 1985; Bavolek, 1983; Finkelhor, Gomes-Schwartz, & Horowitz, 1984; James et al., 1978; Landson, Johnson, & Doty, 1987; Morris et al., 1985; Nightengale & Walker, 1986; Salsbury & Campbell, 1985; Silver, Barton, & Dublin, 1967; Winefield & Castell-McGregor, 1986; Zellman, 1988). An early study by Silver and his
Diploma in Child Protection Studies

co-workers found that over 20% of physicians would not report a suspected child abuse case. Later studies found even higher failure-to-report rates. A survey of paediatricians and family physicians indicated that although 93% of the respondents had seen an intrafamilial sexual abuse case in which the child had been seriously traumatised, only 32% of the physicians had urged a member of the family to report, and only 42% stated they themselves would report (James et al., 1978). In a study of mandated reporters, Finkelhor and his colleagues (1984) found that reporting of suspected cases ranged from 43% for criminal justice personnel to 76% for school personnel. Thus an average of 36% of the cases should have been reported but were not. Another study (Ladson, Johnson, & Doty, 1987) indicated that, except for gonorrhoea and syphilis, less than two-thirds of physicians would report suspected sexual abuse even if they believed that the positive serologic culture in a prepubescent girl indicated it.

In the most recent national survey of 1,200 mandated reporters, Zellman (1988) found that almost 40% of all the respondents admitted that at some time in their career they had suspected child abuse or neglect but did not report it. Insufficient evidence was given as a primary reason for not reporting. Other prevalent reasons given included the following: (1) the cases were not serious enough; (2) the case had already been reported; (3) it would disrupt treatment; (4) the belief that the reporters could help the children better themselves; (5) the poor quality of child protective services; and (6) the abuse situation had resolved itself.

There has been no research which has focused on the decision-making process itself, that is, the weight of various factors which entered into a decision to report or not to report in a specific case with which a reporter was currently involved. However, clinical vignettes have been used in a few studies (Attias & Goodwin, 1985; Morris et al., 1985; Nightengale & Walker, 1986). In one study (Attias & Goodwin, 1985), a group of psychologists, psychiatrists, paediatricians, and family counsellors were given a vignette about a child who had first made, and then retracted, an incest allegation. More than half of the psychiatrists and less than one-third of the other three disciplines chose not to report the case. Although reasons for not reporting were not elicited, a series of related questions suggested that the belief that children who report incest are recounting fantasies played a role in failure to report. In addition, the authors found that more men than women overestimated false accusations and underestimated father-daughter incest. The study concluded that the data provided some support for the position that minimisation of the problem of incest is a self-protective manoeuvre on the part of male reporters. This self-protective manoeuvre may be largely unconscious and thus may relect elements of countertransference reaction. Morris and his co-workers (1985) interviewed a group of physicians about what factors influenced their reporting of child abuse. They were shown a series of photographs depicting injured children and also asked their attitudes about various forms of discipline. Physicians with a high tolerance for discipline were less likely to report in these cases. When asked why some abuse is not reported, the most common reasons given were the following: (1) abused children seldom appear in private offices; (2) fear of losing patients; (3) lack of certainly about abuse before reporting; and (4) fear of losing rapport with the family.

In a study of HeadStart personnel, the training and experience of the workers, as well as whether they had children of their own, affected whether they would report in a situation in which a 4-year-old boy sustained injuries due to parental abuse (Nightengale & Walker, 1986). The research indicates that several factors, besides whether the abuse may actually have occurred, enter into the decision to report. Clearly, gender, experience, and nature of professional training are of importance. However, it is also clear that certain fears and anxieties play a significant role. For example, the fear of losing patients, losing rapport and confronting the family (Morris et al., 1985) suggests that fear of rejection and retaliation as well as guilt feelings may impact on the decision to report. This research also suggests that there may be other affects and conflicts, often outside the awareness of mandated reporters, which enter into the decision-making process. However, this is a hypothesis that still needs to be tested. Future research on failure to report would need to take these issues into account. What may be useful for such investigations is a conceptual framework that could address how the personality dynamics and life experience of the reporter interact with the individual personalities of child and family members as well as the family system as a whole to impede effective and timely reporting. We feel that a framework based upon a better understanding and appreciation of countertransference reactions would not only be appropriate for such research but also useful for the training of mandated reporters. The following is such a framework based on four categories of countertransference responses. These are not meant to constitute the entire range of possible reactions but ones suggested by research and commonly encountered in clinical practice.

Countertransference Fear
Countertransference fear has been defined as fear of verbal and/or physical assault by the client and is a common response of the clinician in work with highly volatile and disturbed clients (Haldipur, Dewan, & Beal, 1982). Mandated reporting can evoke great concern on the part of the reporter of reprisal or revenge of some
kind from a family member or acquaintance of the family. Some will fear actual physical reprisal while others may fear possible legal or social harassment.

While countertransference fear may be stimulated largely by a realistic perception of the behaviour of the family, psychodynamic issues of the mandated reporter may be a significant contributory factor. This would include one or more of the following: (1) a defensive constellation involving projection of unacceptable and poorly recognised anger and resentment (affects often stimulated in child abuse and neglect cases) resulting in fear of one’s anger in the form of anxiety about reprisal; (2) situations where mandated reporting is unconsciously equated with an aggressive act to be met in kind by aggression and/or justified punishment; and (3) individuals with low self-esteem with respect to their competence or with more general concerns about the adequacy of their judgement, who faced with the obligation to file, fear the ridicule of family and/or colleagues should there be no substantiation. Previous experience where reprisal or judgement in some form did or was felt to occur in response to similar actions, especially where the situation re-eroves some significant childhood events, e.g., the reporter as a child “telling” on a sibling to parents, can serve to augment the potential to provoke troublesome countertransference fear and anxiety.

**Countertransference Guilt and Shame**

Reactions of guilt and shame, often accompanied by feelings of helplessness and depression, are likely to occur in cases where mandated reporting is experienced in one or more of the following terms: (1) as an unacceptable violation of confidentiality and betrayal of trust; (2) as a punitive act perpetuated against the needy and disempowered; (3) as treatment impasse or failure; and (4) as representing a “test” of professional or personal adequacy.

Countertransference guilt is likely to be intensified in cases where the family evokes guilt or the professional is especially vulnerable to guilt and shame responses. The latter would include (1) individuals whose exacting standards do not allow for any exception to the principle of confidentiality; (2) individuals with poorly resolved conflicts with respect to the expression of aggression, including (a) individuals with salient defences of repression and reaction formation against hostile feelings and impulses, (b) individuals with self-esteem and professional identities organised around insuring they are seen as caring, supportive, and nonintrusive, and/or (c) individuals with prominent passive-dependant and passive aggressive styles; (3) individuals with low self-esteem coupled with excessive narcissistic vulnerability where having to file constitutes a sense of personal failure to better manage the case or an indictment of the adequacy of their judgement in the event of no finding; (4) individuals already experiencing guilt for unacceptable though commonly stimulated feelings and impulses with this client population, i.e., anger, disgust, and or abandonment; and (5) individuals with strong needs for certainty and predictability, i.e., with a low tolerance for ambiguity, who may be vulnerable to guilt and shame responses when confronted by clinical decision making often based on incomplete, even scant data.

**Countertransference Anger**

Considerable anger and resentment, often unfortunately displaced onto the family, can occur when mandated reporting is experienced in one or more of the following terms: (1) as unnecessary bureaucratic intrusion on the professional’s autonomy, and (2) as an indictment of competence.

Individuals with strong counterdependent needs and/or control and authority difficulties are prone to reactions of this general kind when they feel they are being forced to engage the assistance and expertise of often anonymous others who will henceforth play a key role in important aspects of case management or decision making. Individuals with less than well integrated and poorly worked through grandiosity and excessive need for control may view the obligation of mandated reporting as a personal assault on their sense of perfection and capacity to successfully exert the necessary control over what will and should happen with their cases. This may lead to passive-aggressive behaviour where reporting is delayed or does not occur.

**Countertransference Sympathy**

Reactions of sympathy and support can be easily evoked, as many families from this population will present a picture of emotional deprivation, victimisation, ostracism, and economic need often coupled with ostensibly genuine caring and desire to change things for the better (Krell & Okin, 1984). The result can be a stance in which the reporter may wind up making excuses for the family and fail to attempt to set necessary limits on destructive patterns by, for example, timely mandated reporting. In such cases the act of reporting can unfortunately be seen as an unusually stern and extreme measure foisted on an already burdened, well intentioned family, trying desperately to mend their ways. Individuals who consciously or unconsciously overidentify with such families, based, for example, on their own childhood experience and/or current family
situation or with some unworked through guilt about their own relatively more advantageous background or situation, are especially vulnerable to this kind of reaction.

Case Example

An experienced child clinical psychologist working for a school system within a highly educated and affluent suburban community filed a report with the division of social service on a family with a question of verbal, physical, and sexual abuse of a teenage daughter by father. Prior to filing, the clinician had met with the daughter, mother, and father for individual interviews (though the family was noncompliant with conjoint interviews) and had been in contact with concerned parents and teachers in the community regarding the family. Father was reportedly a volatile man who allegedly had been engaging in abusive behaviour at home for many years, and school personnel readily admitted feeling mistrustful as well as intimidated by him. However, no action had ever been taken against the family. The clinician informed the daughter directly of her intention to file and followed up with a letter to the parents notifying them that she had completed a mandated report. The clinician, though fairly seasoned with respect to various aspects of clinical work with children and families, had very limited direct experience with mandated reporting. Once notified, the family response was quite negative. The daughter angrily accused the clinician of trying to break up her family, stormed out of the office and informed her teachers that she would under no circumstances return for further interviews. Several days later the clinician was informed by school authorities of the first of several phone calls as well as letters written by father, with copies to his attorney, and addressed to the superintendent of schools impugning the clinician’s reputation and professionalism, alleging emotional harm to his daughter as the result of her contacts with the clinician, and demanding release of the clinician’s records pertaining to work with the family. Prior to filing, the clinician had experienced considerable reservations.

The family was minimally compliant with respect to gathering relevant information and, increasingly, reliance had to be placed on concerned third party reports. The clinician began to worry about the child’s safety and the safety of others in the family and that, by virtue of reporting, she could in some way be causing serious harm. At times she wondered if the motivation for filing stemmed more from wishes to punish the family for their non-compliance and general manipulative and elusive style and specifically to get back at father for his evasive behaviour with her, than from a true suspicion of mistreatment within the family. She began to worry about hurting the reputation of father, a high-powered professional in the community, as well as her own reputation in the event of lack of substantiation. She knew all about the legal safeguards to protect reporters but continued to ruminate about possible legal and personal harassment, especially from father. As a result she actually delayed reporting until several weeks after the initial contacts with the family. She ultimately filed when she learned that additional allegations were being made from independent sources. With the filing, feelings of guilt and fears about reprisal grew to the point that the clinician sought consultation with social work and psychologist colleagues as well as with the school attorney to attempt to ease her anxiety and reach a better understanding of her feelings. Once the threatening phone calls and letters began to appear, she found herself increasingly preoccupied with the case. Despite her belief that this was indeed a family in trouble and that she had acted in a correct and responsible manner, she continued to worry that she had overreacted and provoked an unnecessary upset and controversy within the school system and possibly even victimised an innocent family. Anxiety was intermingled with intense anger in response to father’s efforts to intimidate and discredit her. Several weeks later she learned that most of the allegations were substantiated and that the division of social service would remain closely involved in the case. The working through of her troublesome reactions, already underway with ongoing self-analysis and supportive consultation, was then furthered by this knowledge regarding outcome.

Discussion And Recommendations

Countertransference as it relates specifically to the mandated reporting process is an almost inevitable part of work with abuse and neglect cases. It can be managed poorly or adaptively depending on the circumstances prevailing in the clinical situation and the personal resources available to the reporter. Up to now the major intent of social service bureau has been to disseminate knowledge as to the legal and procedural aspects of the various statutes to the very wide range of personnel affected. In contrast, there has been little, if any, emphasis on the psychodynamic aspects of the process, including the potentially disruptive impact of the interplay of transference and countertransference. This is significant when one considers that the majority of reporters, though liable under existing laws, remain inexperienced with regard to psychodynamic principles and can be limited in self-understanding in ways that can compromise effective action. However, even the relatively seasoned and well-
trained reporter is vulnerable to potentially disruptive countertransference responses. Recent research suggests that, while over the past decade the number of reports of abuse and neglect has steadily increased, there has been a noteworthy decrease in the rate of substantiation, currently estimated at slightly over 35% (Eckenrode, Powers, Doris, Munsch, & Bolger, 1988). This, together with the reality of large numbers of vague, “borderline” cases and the recent finding of instances of exaggerated and false allegations (Yates & Musty, 1988) and “pseudoabuse” (Kaplan, 1986), may also serve to strengthen countertransference reactions and result in additional compromise with respect to effective reporting.

There are clearly no simple and proven techniques to insure effective action unencumbered by the often negative effects of countertransference. However, an enhanced sensitivity to the often problematical nature of the reporting process and the vulnerable position in which the mandated reporter may find him/herself can serve to facilitate constructive intervention. Constructive intervention would meet the goals of timely reporting and the maintenance of a positive working alliance with family and co-workers while minimising undue stress on the reporter secondary to unexamined countertransference. The following are a list of suggestions to facilitate the meeting of these objectives:

1. Education and training of personnel should include provision for greater understanding of countertransference reactions which can be expected to emerge as part of the mandated reporting process. This can be incorporated into existing didactic programmes on reporting and should be part of any curriculum and training programme aimed at the development of clinical skills for work with abuse and neglect cases. Special efforts should be made to reach personnel who can be expected to have only sporadic involvement with cases of this type and/or have only modest exposure to psychodynamic issues in their work, e.g., school employees and nonpsychiatrically trained medical staff. One format could be the use of risk management groups formed along the line of Balint groups (Scheingold, 1988). Balint groups deal with countertransference issues in the doctor-patient relationship. These would be resources for a wide range of reporters, including private practitioners to present cases in which the individual has some inner conflict or uncomfortable feelings about whether or not to report. These groups should also address aspects of the reality-based risks of the reporting process. Attendance at such groups may be facilitated by offering continuing education credit.

2. An alternative would involve use of a colleague identified as a child abuse expert by the local social service agency who can be made available for phone consultation. For example, a list of designated physicians and allied mental health professionals could be circulated to their peers in the community. Funding for their consultation time might be facilitated by joint efforts between professional societies and the protective service agency. Mandated reporters who are initially reluctant to call protective services about a case in which they are experiencing some conflict, might contact their designated professional colleague to discuss the facts of the case and work through their doubts and concerns.

3. Child protection workers, though well-versed in legal and procedural dimensions of the reporting process, should also receive additional training to better appreciate psychodynamic considerations. This would allow greater insight into the case and increased empathic connection to reporters contacting them for information and direction and in follow-up communications.

Finally, more empirical data are needed on the attitudes and feelings of personnel with direct experience with the reporting process to further clarify the nature of the psychological issues involved. This could include process research focusing on cases in which reporters are currently involved. Such research would necessitate reporters recording their reactions as they decide whether or not to report on cases as they present themselves. Research could also be retrospective in nature, relying upon recent experience with reporting. This type of investigation may be especially useful in establishing the extent to which problematic feelings persist for at least some mandated reporters which may warrant further consultation or supervision.

References


