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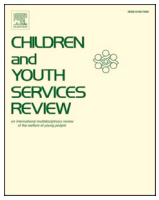

Mandatory reporting and the retaliation factor

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ABSTRACT

Despite state and federal immunity protections, mandated reporters (MRs) of child maltreatment often experience retaliation from alleged perpetrators, employers, or other entities. Existing research demonstrates a correlation between experiencing retaliation and failing to report incidents of future maltreatment. Retaliation may include adverse employment actions, releasing the MRs' identity, civil lawsuits, board complaints, and harassment. This study examines the impact of experienced/witnessed retaliation, fear of retaliation, and professional training on MRs' willingness to report maltreatment, accept maltreatment cases, and testify in court. A self-administered survey sampled 619 MRs from varying professions throughout the United States and found (27.1%) experienced retaliation, though (14.9%) of those did not indicate retaliation type experienced. The most common forms included harassment (73.8%) and releasing the MRs' identity (30.4%). Experienced retaliation resulted in MRs being less willing to report maltreatment and testify in court. Witnessed retaliation resulted in MRs being less likely to report abuse and accept certain maltreatment cases.

1. Introduction

In the United States, each state requires certain individuals (i.e., Mandatory Reporters or MRs) to report suspected child maltreatment. In approximately 18 states and Puerto Rico, all adults are mandated to report suspected child abuse, while the other states designate certain professionals as MRs, such as teachers, social workers, medical and mental health professionals, and childcare workers. MRs must report to CPS or law enforcement and most states have a toll-free number for anonymous reports (U.S. Department of Health & Human Services [DHHS], 2019). In some states, employers may require the MR to report to their direct supervisor or another employer representative. Each state determines whether MR education or training is required as well as the content (Hughes, 2018).

In 2010, Congress passed the Child Abuse Prevention and Treatment Reauthorization Act (CAPTA; 2010 (P.L. 111–320) which required states receiving federal funding to create statutes providing immunity from civil and criminal liability for MRs who make good-faith reports or provide information or assistance, including medical evaluations or consultations related to a report, investigation, or legal intervention. This law also created federal immunity protections. MRs who make a good faith report cannot be sued or criminally prosecuted under federal law for making the report, and there is a presumption of good faith (Victims of Child Abuse Reauthorization Act, Federal Immunity Clause, 34 U.S.C. §20342). The following is a typical state immunity law:

> Any person or party participating in good faith in the making of a report or the submitting of copies of medical examination, treatment, or hospitalization records pursuant to §§ 26-8A-3 to 26-8A-8, inclusive, or pursuant to any other provisions of this chapter, is immune from any liability, civil or criminal, that might otherwise be incurred or imposed, and has the same immunity for participation in any judicial proceeding resulting from the report (Immunity from Liability, S.D. Codified Law §26-A-14, 1991).

After the United States legislated mandatory reporting, many other countries also established reporting requirements by a variety of professionals who work with children. Though Brazil, Denmark, Finland, France, Hungary, Israel, Malaysia, Mexico, Norway, South Africa, and Sweden established reporting requirements, Australia, Canada and the United States enacted the most comprehensive laws. The United States

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and other countries have many variations in their mandatory reporting requirements (St. John, 2013).

Retaliation against mandated reporters (MRs) after reporting child maltreatment is a legitimate threat to their personal and professional well-being. Retaliation, fear of retaliation, and lack of training were addressed in the required 2013 Report to Congress by the U.S. Children's Bureau (USCB). The report examined federal and state immunity laws to determine how immunity from prosecution impacts MRs' willingness to cooperate, consult, or assist in making good faith child maltreatment reports.

Recommendations from respondents to increase the likelihood of their future participation in child maltreatment cases included: Strengthening immunity provisions for reporting, expanding protections for other types of case involvement, addressing suits that circumvent state immunity statutes by filing under federal civil rights law and/or malpractice, ensuring physician anonymity when reporting, and creating consistent laws across states (p. 7).

The study utilized a convenience sample of 544 medical practitioners, primarily pediatricians and measured one type of retaliation: civil lawsuits initiated by the alleged perpetrators against the MR (U.S. Children's Bureau, 2013). Eleven percent of medical practitioners faced lawsuits after filing an abuse report or providing professional consultation on a child maltreatment case (U.S. Children's Bureau, 2013). After the U.S. Children's Bureau (2013) completed their review of existing federal and state statutes, they concluded that current laws do provide MRs with sufficient immunity for good faith reporting and associated actions.

Since the 2013 study, more states enacted laws which: provide consequences for employers who prevent reporting or retaliate against reporting MR employees; provide clarification about which MR activities are covered by immunity; require MR training; protect the MR's identity; and provide the MR with immunity from liability for acting in good faith. However, very few states enacted laws enforcing MR protections, such as allowing MRs who have experienced retaliation for reporting to sue their employer for damages (Hughes, 2018).

Though most states eliminated institutional reporting, certain states still allow it in hospitals, schools, and organizations. Many of these states have enacted laws providing more administrative accountability, such as requiring the MR to be present when their superior makes a report (Hughes, 2018).

Current mandated reporting laws remain highly varied, confusing, and sometimes even have internal contradictions (Hughes, 2018). No two states even define "MR" the same way (Mathews & Kenny, 2008). Further, MR immunity protection is focused primarily on protecting MRs from criminal and civil liability, ignoring other types of retaliation (Hughes, 2018).

To further assess the U.S. Children's Bureau (2013) conclusion that current MR immunity laws are sufficient, we used a nationwide convenience sample of MRs in various professions, explored several types of retaliation, and measured whether experienced retaliation, witnessed retaliation, fear of retaliation, or formal immunity training impacts reporting behavior, acceptance of child maltreatment cases, and court testimony.

2. Retaliation

Previous studies found MRs may face retaliation by the alleged perpetrator, an employer, or other entity after reporting child maltreatment. In one study, 13 % of pediatricians were threatened with lawsuits, while 3 % were sued (Gunn et al., 2005). In a study of 284 licensed psychologists, 71.5 % reported they knew a colleague who had a state licensure board complaint filed against them, 41 % reported being threatened with a complaint, and 39 % of those reported the threat resulted in a complaint. Out of the sample that had complaints filed against them (N = 31), 9.7 % were due to retaliation by the complainant. The study also found that 38.7 % knew a colleague who was sued for malpractice, and 6 % had been sued themselves for malpractice (Montgomery et al., 1999).

Retaliation in the form of civil lawsuits initiated by the alleged perpetrator must be litigated by the MR to receive a dismissal due to immunity. The alleged perpetrator claims defamation of character by the MR in most of these lawsuits (., p. 1). Also common are licensure board complaints (Montgomery et al., 1999, p. 404), adverse employment actions, releasing the MRs' identity to the alleged perpetrator(s) and/or public, harassment or threats by the alleged perpetrator, and licensure revocation or suspension (Baumgarten, 2017; Gunn et al., 2005, p. 98; McKenna, 2011, p. 100; Sippel, 2016; Jones v. Wang, 2015).

Some MRs may be particularly vulnerable to retaliation. Chances of retaliation are higher when a MR is required to report up the chain of command at their employing agency, when the MR lacks formal training in mandated reporting laws, or when a third party is involved in a client's therapy, such as a parent attending their child's therapy session(s). MRs have faced lawsuits from third parties participating in therapy, who claimed they were owed a standard of care from the therapist, even though they were not the identified client. Other MRs have been sued for ordinary torts by alleged perpetrators such as intentional infliction of emotional distress (See Applebaum & Zoltek-Jick, 1996; Piro v. McKeever, 2016; Ramona v. Isabella, 1994).

2.1. Fear of retaliation

Fear of retaliation (i.e., without experiencing prior retaliation) also decreases MRs' reporting behavior in the United States, Australia, and the United Kingdom (Falkiner et al., 2017; Farmer, 2013; Flaherty et al., 2006; Gunn et al., 2005; Lazenbatt & Freeman, 2006; Kitchens & Gray, 2017; Kruppa et al., 2018; Mathews et al., 2009; McKenna, 2011; Walsh & Jones, 2015; Zellman & Fair, 2002). Common types of feared retaliation reported by MRs are lawsuits of all types, a ruined reputation, licensing board/ethics complaints, and retaliation for unsubstantiated reports (Flaherty et al., 2006; Gunn et al., 2005; Lazenbatt & Freeman, 2006; Kitchens & Gray, 2017; McKenna, 2011; Sippel, 2016; Zellman & Fair, 2002; Walsh and Jones, 2015). Kitchens and Gray (2018) found fear of retaliation especially high for MRs reporting sexual abuse, where 49 % of respondents were worried about a lawsuit and 36 % feared a ruined reputation.

Fear of retaliation for reporting child maltreatment may result in MRs choosing not to report suspected child maltreatment (Kitchens & Gray, 2017). MRs in the mental health profession who fear retaliation may be less likely to treat children in individual therapy or consult on child maltreatment cases where the likelihood of having to report suspected abuse and testify in court is higher. Further, some mental health professionals may no longer accept complex cases they may have accepted in the past (Flaherty et al., 2006; Gunn et al., 2005; Lazenbatt & Freeman, 2006; Kitchens & Gray, 2017; McKenna, 2011; Walsh & Jones, 2015; Zellman & Fair, 2002).

2.2. Lack of training

In addition to fear of retaliation, several studies indicate MRs feel uncertain regarding how to report abuse and lack formal training on child abuse reporting (Gunn et al., 2005; Walsh & Jones, 2015). Gunn et al. (2005) found eight percent of pediatricians felt unsure how and when to report abuse and therefore were significantly less likely to report suspected abuse (Gunn et al., 2005, p. 99). Walsh and Jones (2015, p. 6) reported 35 % of respondents felt state statutes were unclear concerning reporting. Thirty-one percent reported that a lack of knowledge about identifying abuse hindered their decision to report child maltreatment (Walsh & Jones, 2015, p. 6). This study also found that MRs with formal training were more likely to report maltreatment and less likely to face retaliation (Walsh & Jones, 2015, p. 6). However, we will demonstrate that the USCB report did not accurately capture the prevalence and chilling effect of retaliation against MRs, and our study

will re-measure these phenomena. We used a varied nationwide sample of MRs, explored several types of retaliation, and measured whether experienced retaliation, witnessed retaliation, fear of retaliation, or formal immunity training impacts reporting behavior, acceptance of child maltreatment cases, and court testimony.

We began our study with three hypotheses:

1. MRs who experience retaliation, witness retaliation or fear retaliation will be less likely to report child maltreatment, accept child maltreatment cases and testify in court.
2. MRs who report alleged sexual abuse will more likely experience retaliation.
3. MRs who receive training will be more likely to report child maltreatment.

3. Method

3.1. Participants

After obtaining Institutional Review Board (IRB) approval in November of 2017, (2017–10-27A), the recruitment phase obtained a U. S. sample of MRs using various list serv groups as well as members of professional organizations. Dissemination of the survey was achieved via Survey Monkey whereby a link was provided to participants via the following organizations: National Education Association (NEA) listserv, American Professional Society on the Abuse of Children (APSAC), National Association of Social Workers (NASW), Academy of Certified Social Workers (ACSW, part of NASW), and American Counseling Association (ACA) listserv. Requests for survey participation were also sent via CSNET (a listserv for counselors and counselor educators) and via social media with a brief description of the research and contact information for the primary authors. Targeted attempts (direct emails to physicians/pediatricians, psychologists and psychiatrists the authors know personally requesting they post the survey to the American Psychiatric Association, American Medical Association, and American Psychological Association listservs) were made to obtain responses with limited results.

This study utilized a national convenience sample of interested MRs from various professions and the results were not intended to be representative of any particular group. Valid returned responses included 619 mandated reporters: physicians (8.9 %), teachers (1.1 %), daycare providers (0.49 %), licensed mental health counselors (7.6 %), licensed social workers (37.4 %), licensed psychologists (5.1 %), and "other (37.5 %). The "other" category included numerous demographic populations with very small sample sizes such as law enforcement agents, law clerks, and emergency management technicians/paramedics. Demographics for survey-completion were largely female (n = 536), Caucasian (n = 519), were an average age of 46.69 (*sd* 12.75) with twenty plus years of experience in their field. Data shows that more women work in helping professions than men and most mental health providers in the United States are white (Zippia, 2021). All states but Delaware were represented in the sample. See Table 1.

4. Research materials

This study utilized a modified version of the Children's Bureau survey (2013) which was originally developed and pretested by the American Academy of Pediatrics and was in the public domain. The seminal survey question was "Please indicate which of the following factors influenced your decision *not* to report to Child Protective Services." Respondents could choose a variety of answers such as concern of legal retaliation, fear of getting fired, fear of getting reported to the licensing board, or they could write in an "Other" response (see Appendix B). Some questions were in Likert format with one being "Very Uncertain" and four being "Very Certain.".

4.1. Data analysis

Though added questions were not formally validated, the survey achieved face validity.

Face validity is apparent given the interface between desired information, the questions utilized to acquire data, and the collected data (Johnson, 2013). Statistical conclusion validity determines whether there is a relationship between cause-and-effect variables, affirming any data-based conclusions are believable (Garcia-Perez, 2012). Statistical conclusion validity was supported by utilizing bootstrapping, a method of resampling a single dataset and creating random multiple simulated sample sets (Tambling & Anderson, 2014. P. 413). Bootstrapping enhances face validity by giving more accurate standard errors and confidence intervals of the estimate (Tambling & Anderson, 2014, p. 413). This method assures appropriate data analysis is conducted to show any existing linkages between dependent and independent variables (Cook & Campbell, 1979).

Based on (n = 168) reporting MRs who experienced retaliation, with 25 not specifying retaliation type, data were analyzed using SPSS version 25, and Real-Statistics Excel add-on utilizing a combination of measures of central tendency, correlation, Welch's *t*-test of unequal variance, Analysis of Variance (ANOVA), Multiple Analyses of Variance (MANOVA), Chi-Square, and Binary Logistic Regression. In addition, true significant differences were assessed using Tukey's Honestly Significant Difference Test (Tukey's HSD). These statistical measures were chosen to give the best possible fit to how MRs responded to their reported experiences with retaliation due to multiple types of data requiring analysis (categorical, binary, two independent variables, and two or more dependent variables), how retaliation impacted MRs' future behaviors, and what types of abuse are associated with retaliation. Measures of central tendency examined the mean, standard deviations, frequency of the responses, and the data ranges within the demographic section to give an overall view of the responses received. The mean is also the primary basis of the remaining statistical models utilized.

Both ANOVA and Chi-square were used to analyze data related to hypothesis one. ANOVA was utilized to determine specific retaliation outcomes for MRs who experienced retaliation and measured the variance between all responses for part of hypothesis one. In addition, Chi-square was used to measure categorical data related to type of retaliation outcome and type of abuse associated with that retaliation. Chi-square was also used to measure categorical variables within fear of retaliation, fear of retaliation's impact on reporting behavior, and to calculate differences in retaliation by specific abuse types.

Pearson's correlation was used to determine hypothesis two: MRs who report alleged sexual abuse will more likely experience retaliation. The correlation between reporting sexual abuse and retaliation was necessary to determine if the relationship between sexual abuse and retaliation needs additional study in the future.

Table 1
Demographics.

Sex	N	Average Age	Caucasian/ White	Asian/ Asian Am.	African/ African Am.	Native Am./ Am. Indian	Latino/ Hispanic	Middle Eastern	Multiracial
Female	541	46.05	452	9	26	11	28	1	13
Male	77	46.72	65	0	4	4	3	0	0
Total	618	46.69 (*sd* 12.75)	517 (83.98 %)	9 (1.46 %)	30 (4.85 %)	15 (2.42 %)	31 (5.02 %)	1 (0.16 %)	13 (2.10 %)

MANOVA was used to address hypothesis three, which states MRs who receive training will be more likely to report child maltreatment. The MANOVA examined whether there were differences between MRs with training and MRs without training related to child abuse on several dependent variables: suspected abuse, reported abuse, and retaliation outcome experiences.

Due to unequal responses in each category, the overall variance was unequal, meaning Welch's *t*-test was the best fit to assure statistically significant results. Tukey's HSD was utilized to assure the best fit of the data for each test. Tukey's also allowed the authors to determine if the results are truly significant given the unequal variances.

Binary logistic regression was used to investigate variables contributing to the presence or absence of a retaliation outcome. This is beneficial for potential further research and for risk management and child maltreatment training considerations.

5. Results

Reliability testing was conducted arriving at an internal consistency of $\alpha = 0.71$ for the overall instrument. A bootstrapping analysis (a resampling method drawing 10,000 random samples) found a confidence interval of 3.26 (lower bound) to 3.71 (upper bound) for the true mean master score of the instrument. The overall mean master dataset score (3.48) fell within this confidence interval, supporting statistical conclusion validity of the results (See Table 2). Descriptive statistics were derived using measures of central tendency on each MR type and their reporting experiences in the past year.

The results indicated physicians reported suspected abuse more often than any other profession with a mean of 59.11 ($sd = 123.71$). One physician reported 600 cases; three reported 500 cases; nine others reported 100 – 250 cases, with the remaining reporting < 75 cases of suspected abuse in the past year. Those in the "other" category reported second most frequently with a mean of 15.62 ($sd = 73.75$) reports. Two people in the "other" category reported between 800 and 1000 cases, with fifteen others reporting between 100 and 300 suspected cases of abuse.

Licensed social workers were a close third ($\mu = 10.62$, $sd = 28.32$), with licensed mental health counselors fourth ($\mu = 7.35$, $sd = 15.18$). Licensed psychologists reported 6.49 ($sd = 16.90$) cases; teachers and unknown MRs reported 1.29 ($sd = 1.13$) cases, and daycare providers reported less than one case per year ($\mu = 0.33$, $sd = 0.58$). See Table 3.

Reported abuse-type frequencies were also aggregated using measures of central tendency: sexual abuse (4903 total) was most frequently reported with a mean of 7.92 ($sd = 32.75$) reports per MR, followed by physical abuse (3968, $\mu = 6.41$, $sd = 20.001$), neglect (3130, $\mu = 5.06$, $sd = 29.41$), and emotional abuse (1158, $\mu = 1.87$, $sd = 17.30$). There were 13,159 ($\mu = 3935.75$, $sd = 1595.04$) total reports.

Of the 168 participants reporting retaliation, 249 retaliation episodes were experienced. There were 52 MRs who reported multiple forms of retaliation (8 % of the overall responses, 31 % of those who experienced retaliation). Being confronted, harassed, or threatened by the person they reported was the most frequent form of retaliation: 73.8 % ($n =$ confrontation events, N = total retaliation events). Additionally, 30.4 % ($n = 63$) experienced having their identity released to the perpetrator, nearly 11 % ($n = 27$) were harassed by another entity, 7 % ($n = 18$) were civilly sued, 3 % ($n = 8$) were reported to their professional ethics board, 3 % ($n = 7$) were reported to their licensing board, 3 % ($n = 7$) were fired or demoted, and one MR had their licensed revoked. No MRs in this study were criminally charged.

Table 2
Bootstrapping bounds and confidence intervals.

	Mean	SD	95 % Confidence Interval		*p*-value
			Lower	Upper	
Sample Master Mean	3.48	0.11	3.26	3.71	0
Boostrapping Assumption Mean	0	0			

Table 3
Mean and standard deviation of professions' average reporting behavior.

Profession	*N*	*μ*	*sd*
Licensed social worker	232	10.62	28.320
Licensed mental health counselor	46	7.35	15.179
Physician	53	59.11	123.714
Counselor	7	3.57	2.637
Licensed psychologist	35	6.49	16.900
Day care provider	3	0.33	0.577
Unknown	7	1.29	1.113
Other	229	15.62	73.754
Total	612	15.97	62.106

A Chi-square found significant results supporting being confronted, harassed, or threatened by the person they reported as the most common type of retaliation: $(X^2\ (9, N = 239) = 557.7, p < 0.01)$. Two hundred thirty-nine individual retaliation incidences, with 25 not specifying retaliation type, were analyzed. (See Table 4).

5.1. Experiencing retaliation and reporting behavior

The impact of retaliation on MR reporting behavior was investigated. Just over 27 % of MRs expressed they had been retaliated against for reporting child abuse ($n = 168$). Results showed experiencing retaliation significantly ($p < 0.01$) decreased reporting by MRs, using a MANOVA with MRs' experiences with retaliation or no retaliation as the independent variables (IVs) and reported abuse, suspected abuse, and factors that influenced non-reporting behavior as dependent variables (DVs). In addition, MRs who experienced retaliation were significantly less likely to testify in court ($p = < 0.02$). There was also a significant result between number of reports filed and retaliation ($F(14, N = 1222) = 36.57$, $p = 0$; See Table 5), meaning the more reports an MR filed, the more likely they were to experience retaliation. Further, a ten (possible outcomes of retaliation) by four (types of abuse) Chi-square (X^2 (4, 26) = 78.24, p <.001) was significant (See Table 6). It is believed this significance is due to the category of refusing to accept certain types of child abuse cases as an outcome of retaliation since that category had up to six times more positive responses than any of the other four options.

5.2. Witnessing retaliation and reporting behavior

A one-factor ANOVA was utilized to determine whether witnessing retaliation towards another MR (IV) affects reporting behavior (DV). Results yielded a significant difference ($F(5, 1851) = 29.98$, p <.001), indicating that MRs who witnessed retaliation were significantly less likely to report suspected abuse than those who did not witness retaliation. In addition, they were less likely to accept some types of child abuse cases (p <.001). (See Table 7).

5.3. Fear of retaliation and reporting behavior

A multinomial logistic regression measured whether fear of retaliation affected MRs' reporting behavior. The dependent variables included: declining to accept certain types of child abuse cases; declining to accept any child abuse cases; no longer testifying in court; reporting less suspected child abuse; and reporting more suspected child abuse (See Table 8). Fear of retaliation significantly decreased MRs accepting certain child abuse cases ($p = 0$), testifying in court (p <.001), and significantly increased (p =.02) and decreased (p <.001) reporting suspected child abuse. Results were also statistically significant for fear of being reported to the licensure board and failing to report suspected abuse (p <.001).

Table 4
Chi-square of type of retaliation by reporting of abuse.

	Civilly sued	Confront	Criminally charged	Fired or demoted	License Susp.	License Rev.	Reported to licensing board	Reported to ethics board	ID release	Other	Total
Obs	14	124	0	5	0	0	13	7	51	25	239
Exp	23.9	23.9	23.9	23.9	23.9	23.9	23.9	23.9	23.9	23.9	239
										X^2	557.70
										df	9
										p-value	0

Table 5
MANOVA of Number of Reports Filed by Experienced Retaliation.

	stat	*F*	*df1*	*df2*	*p-value*	*eta-sq*
Pillai Trace	0.590581	36.57488	14	1222	0	0.295291
Wilk's Lambda	0.409426	49.04687	14	1220	0	0.360136
Hotelling Trace	1.44243	62.7457	14	1218	0	0.419015
Roy's Lg Root	1.442418					

Table 6
Chi-square of possible outcomes of retaliation by types of abuse.

	Emotional	Neglect	Physical	Sexual	Other	Total
Observed	14	35	70	41	5	165
Expected	33	33	33	33	33	165
					X^2	78.24
					df	4
					p-value	0

5.4. MR training and reporting behavior

MRs were asked how comfortable they felt identifying physical abuse, sexual abuse, emotional abuse, and neglect. Ninety-five percent ($n = 588$) answered certain or very certain of their ability to identify physical abuse. Four percent ($n = 27$) felt uncertain or very uncertain in identifying physical abuse. Eighty-five percent ($n = 526$) felt certain, or very certain in their ability to identify sexual abuse. Fourteen percent ($n = 88$) felt uncertain or very uncertain. One percent did not answer the question. When identifying emotional abuse, 90 % percent ($n = 556$) felt certain or very certain in their ability and 10 % ($n = 62$) felt uncertain or very uncertain. Ninety-two percent ($n = 569$) felt certain or very certain in their ability to identify neglect while seven percent ($n = 46$) felt uncertain or very uncertain. Overall, 8.50 % of respondents felt uncertain or very uncertain, on average, of their ability to accurately identify abuse.

The impact of training on MRs' reporting behavior was also measured. A MANOVA comparing the IVs "Implied No Training" and "Training" to the DVs "reported abuse" and "suspected abuse" led to significant results. These results support hypothesis three: MRs who completed training ($p = 0.03$) were more likely to report child maltreatment. These MRs were also less likely to face retaliation. (See Table 9).

5.5. Retaliation by profession, work setting, and type of reported abuse

Additionally, we explored whether retaliation occurs more frequently within certain professions, within certain workplace settings, or by type of abuse reported. A Chi-Square (X^2 (7, 167) = 198.01, $p < 0.01$) found social workers faced the most retaliation by profession (See Table 10). A Chi-Square (X^2 (4, 168) = 28.25, $p < 0.01$ – two-tailed) determined that retaliation is more common in certain workplaces-retaliation occurred more often in agencies and hospitals compared to those who work in private practice or schools (See Table 11). Here N = 168 because there were 168 participants who reported their 'work setting' and reported 'retaliation.' The MRs' sex did not correlate with retaliation.

Out of 249 abuse incidents related to retaliation, 41.5 % were due to physical abuse, 23.5 % to sexual abuse, 22.5 % to neglect, and 12.5 % to emotional abuse. A Phi-coefficient determined the binary variable 'reporting sexual abuse' moderately correlates with the binary variable 'facing retaliation' ($\phi = 0.39$, $p = .01$). One hundred twenty-seven people experienced retaliation unrelated to reporting sexual abuse, 41 people experienced retaliation related to reporting sexual abuse, 450 people did not experience retaliation related to any reporting of abuse, six people reported sexual abuse without retaliation, and one person gave no data. A Chi-square was also significant (X^2 (4, N = 165) = 78.24, $p < .01$), showing that retaliation for reporting sexual abuse is statistically higher than it should be for the expected results with this sample size (See Table 12). This result supports hypothesis two: MRs who report alleged sexual abuse will more likely experience retaliation.

Regarding Chi-square analysis of type of retaliation by type of abuse, several closely related categories were collapsed to honor the rule of thumb that the total number of participants, when divided by the number of cells, should remain greater than five. The categories of confronted/harassed/threatened, identity released to perpetrator, and harassed by other entity were collapsed into a new category called "identified by/confronted by/harassed by reportee or other entity." The categories of license revoked, reported to state licensing board, and reported to professional board were collapsed to a new category called "reported to licensing or ethics board." This gave the authors a six (types of retaliation) by four (types of abuse) Chi-square ($X^2(15, N = 153) = 25.53$, $p = .04$) that was significant. The *N* of 153 differs from the 168 overall cases of retaliation because eight participants indicated a type of retaliation, despite also indicating they were not retaliated against; seven participants indicated they were retaliated against yet did not indicate retaliation type. These 15 cases were omitted from the analysis. (See Table 13).

6. Discussion

The purpose of this study was to investigate the impact of experienced retaliation, witnessed retaliation, fear of retaliation, and training on MRs' reporting behavior. Consistent with our hypotheses, this data showed that MRs who experience retaliation are significantly less likely

Table 7
One-factor ANOVA on witnessing retaliation.

Sources	*SS*	*df*	*MS*	*F*	*P value*	*F crit*	*RMSSE*	*Omega Sq*
Between Groups	219,663	2	109831.5	29.9843	1.53E-13	3.000586	0.220269	0.030319
Within Groups	6,780,150	1851	3662.966					
Total	6,999,813	1853	3777.557					

Table 8
Multinomial Logistical Regression of Suspected Abuse Cases (IV) by Actual Reported Abuse (IV) by Behavior Changes Resulting from Fear of Retaliation (DV).

						Confidence Interval	
	coeff	*s.e.*	*Wald*	*p-value*	exp *(b)*	*lower*	*upper*
intercept	−0.57	0.02	1354.71	0	0.57		
I have declined to accept certain child abuse/ neglect cases	0.41	0.08	27.77	1.37E-*	1.51	1.30	1.77
I have declined to accept any child abuse/ neglect cases	−0.14	0.19	0.57	0.45	0.87	0.60	1.26
I no longer testify in court	0.18	0.03	30.07	4.17E-*	1.20	1.12	1.28
I report less child abuse	0.05	0.01	18.68	1.54E-*	1.06	1.03	1.08
I report more child abuse	0.11	0.05	5.36	0.02**	1.11	1.02	1.22
I have not been the victim of retaliation	0.05	0.00	117.18	0	1.05	1.04	1.06

* = Significant at the 0.001 level.
** = Significant at the 0.05 level. Reference values: 0 – During the past year, approximately how often did you suspect a case of child abuse?1 – Of those times, for how many did you file a report?

Table 9
MANOVA of reporting behavior by implied no training vs training.

	stat	*F*	*df1*	*df2*	*p-value*	*eta-sq*
Pillai Trace	0.017018	2.657566	4	614	0.032029*	0.017018
Wilk's Lambda	0.982982	2.657566	4	614	0.032029*	0.017018
Hotelling Trace	0.017313	2.657566	4	614	0.032029*	0.017018
Roy's Lg Root	0.017313					

* = Significant at the 0.05 level.

to later report child abuse and testify in court. They are also less likely to accept (i.e., treat in individual therapy or consult on) certain types of child abuse cases (e.g., sexual abuse cases). This study also found that MRs who report sexual abuse are at greatest risk of experiencing retaliation. Why this is the case warrants further research. MRs who witness retaliation against another professional are significantly less likely to report child abuse and accept certain child abuse cases. MRs who fear retaliation are less likely to accept certain types of child maltreatment cases, less likely to testify in court, and are more and less likely to report suspected abuse. This data demonstrates the chilling effect that some MRs would rather violate the law and sacrifice a child's safety than risk retaliation.

This study found a significant number of MRs experienced retaliation, sometimes more than once, for simply performing their reporting mandate. Out of 619 MRs, (27.1 %) experienced retaliation, though

Table 11
Chi-square of retaliation by workplace setting.

	Agency	Hospital	Private Practice	School	Other
Observed	50	42	32	9	35
Expected	33.6	33.6	33.6	33.6	33.6
				X^2	28.25
				df	4
				p-value	0.00001111

Table 12
Types of abuse by all types of retaliation.

	Emotional	Neglect	Physical	Sexual	Total
Observed	14	35	70	5	165
Expected	33	33	33	33	165
				X^2	78.24
				df	4
				p-value	0
				Yate's X^2	75.43
				p-value	0

(14.9 %) did not indicate retaliation type experienced. The two most common forms of retaliation reported were being harassed/threatened by the person they reported (73.8 %) and having their identity released to the perpetrator or another entity (30.4 %). In some cases, the MR's identity may be surmised, placing them at risk. United States' legislators have recognized the importance of enacting laws to protect reporting MRs from reprisals. Consequently, the MR's identity is protected from disclosure to the alleged perpetrator in 44 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, and Puerto Rico (DHHS, 2019). This protection is maintained even when other information from the report may be disclosed. Protecting the MR's identity encourages reporting whereas the absence of such protection deters MRs from performing their reporting mandate (Abrahms et al., 1992; Mathews et al, 2008). However, there is no current remedy should their identity be released (Hughes, 2018).

It is a significant problem that the most common reported forms of retaliation are not addressed in states' immunity protections. Though all states provide varying forms of immunity from a lawsuit, only 26 states include statutes protecting MRs from other forms of retaliation, such as adverse employment actions. Only 11 states include an enforcement mechanism for retaliation laws (Hughes, 2018). Previous research has largely measured only lawsuits as retaliation (Gunn et al., 2005; Kitchens & Gray, 2017; Zellman & Fair, 2011) which does not reflect the spectrum of retaliation experienced by reporting MRs. Comparatively, the USBC (2013) *Report to Congress* found 11 % of MRs were sued and this study found 8.3 % were sued. While lawsuits appear to be a relatively common experience for reporting MRs, they are less common than other retaliation types.

Witnessing retaliation against another MR also significantly decreased reporting. This phenomenon is easily understood through Bandura's (1977) Social Learning Theory, which states the tendency to engage in a behavior is less likely to occur after one observes another

Table 10
Chi-square of Profession reporting abuse by retaliation.

	LCSW	LPC	MD	Coun	Psychologist	DC	Teach	Other	Total
Obs.	65	15	21	1	11	1	2	51	167
Exp.	20.87	20.87	20.87	20.87	20.87	20.87	20.87	20.87	167
								X^2	198.03
								df	7
								p-value	0

* LSW = Licensed social workers, LPC = Licensed Professional Counselors, MD = Physicians, Couns. = Non-specified licensure counselors, DC = Daycare providers.

Table 13
Collapsed Chi-square of retaliation by abuse.

	Civilly sued	Confronted/ harassed by family	Fired/ demoted	License revoked	Reported to licensing board	Identity released	Confronted/ harassed by others	Child removed from services	Multiple retaliations	Totals
Emotional	0	3	1	0	0	1	1	1	5	13
Neglect	1	20	0	0	0	3	3	1	6	34
Physical	2	25	2	0	1	1	4	2	30	67
Sexual	4	12	0	0	1	0	1	0	21	39
										153**
									X^2	25.35
									df	15
									p-value	0.04

** n = 168 participants indicated they had been retaliated against, however… retaliation-category × abuse-type cell table tallies equal only n = 153 [15 cases are missing] — here's where they are:
* n = 8 participants said '0′ for 'retaliation type' despite indicating they had been retaliated against.
* n = 7 participants said '0′ for 'type of abuse' despite indicating a type of relation had been exacted against them.
* 8 + 7 = 15 cases; 153 + 15 = 168 - All n = 168 cases can be accounted for.

experiencing negative consequences for engaging in the same behavior. Consequently, when an MR experiences retaliation and suffers emotionally, financially, or has their career compromised or destroyed after reporting suspected child maltreatment, witnessing MRs would be less likely to report. Our research supports the hypothesis that witnessing retaliation decreases MR reporting behavior and acceptance of certain kinds of child maltreatment cases.

Fear of retaliation may influence MRs' reporting behaviors in different ways. Some MRs may be more motivated to be conscientious and report more often, while others may fear that making a good faith report, which may be unsubstantiated and could result in retaliation, report less often. MRs who feared retaliation were also less likely to accept child abuse cases. Eighteen respondents stated they refused to accept certain child maltreatment cases, while five stated they refused to accept any child maltreatment cases. Further research is warranted to determine which specific retaliation fears increase reporting, decrease reporting, and correlate with specific maltreatment cases that are being refused.

Another finding related to fear of retaliation was the surprising number of MRs (n = 81 [44 % of those retaliated against], 13 % of overall N of 619) who believe that reporting child abuse would be fruitless since CPS would not do anything anyway (indifference). Yet despite their belief, most of these MRs (60 %, n = 49, 8 % overall) still reported all suspected child maltreatment cases. Twenty-five percent (n = 20, 3 % overall), however, did not report all suspected cases of abuse. This 25 % who believed CPS would not do anything and did not report all suspected cases of abuse is significantly higher (more than triple) what McKenna (2011) found with 6 % of respondents not reporting suspected abuse due to the indifference of CPS. Additional research is necessary to determine why such differences exist between the two groups.

This study found retaliation is more common in agency and hospital settings, where chain of command reporting is common, as seen in South Dakota's laws for hospital personnel.

> Report of abuse or neglect by hospital personnel–Failure as misdemeanor—Written policy required. Any person who has contact with a child through the performance of services as a member of a staff of a hospital or similar institution shall immediately notify the person in charge of the institution or his designee of suspected abuse or neglect. The person in charge shall report the information in accordance with the provisions of § 26-8A-8 (Report of Abuse or Neglect by Hospital Personnel, S.D. Codified Law §26-8A-6, 1991).

Currently, in several states, rather than report directly to CPS or law enforcement, MRs must report to their superiors, who may or may not comply with mandated reporting. This can place MRs at greater risk for retaliation, such as firing, if they decide to report outside the chain of command. In some states, chain of command reporting is not addressed at all in state statute (Hughes, 2018).

This study found that MRs who had formal training regarding their state reporting laws were more likely to report abuse. The findings showed that 8.5 % of MRs were uncertain, or very uncertain, in identifying abuse. This is consistent with Gunn et al's. (2005) study, which indicated that 8 % of respondents were unsure how to report abuse. MRs in this study were asked about their ability to identify abuse rather than how to report it; however, if one is unable to confidently identify abuse, one is less likely to report. MRs with training were also less likely to experience retaliation. Further research exploring why this is the case is warranted.

Regarding outliers, data results were obtained and downloaded directly from Survey Monkey. There is a possibility the respondents misunderstood the question, keyed in the wrong number, or work in settings where reported abuse is common. For instance, one respondent serves as the administrator of a child advocacy center and another works as a physician at a training hospital. Therefore, it may be plausible for MRs who work in such settings to report hundreds of cases of suspected abuse per year.

Further, according to the Substance Abuse and Mental Health Services Administration, one in seven children experience abuse each year. More than 1,000 children are seen in emergency rooms daily for physical abuse injuries, with many more potentially never coming to the emergency room (SAMHSA, 2022). This number does not account for sexual abuse, neglect, or emotional abuse cases MRs may also encounter. This information led the researchers to conclude the data the outliers provided was still critical to consider in light of the hypotheses.

7. Recommendations

MRs in all professional roles need required training on how to recognize child maltreatment, and the who, when, where, and how to report it. MRs should also be taught to explain the limits of confidentiality to clients and guardians, so they are not surprised when a suspicion of child maltreatment must be reported.

Training about multiple types of retaliation and how to proactively respond is critical. MRs should be educated on state and federal immunity laws that offer protection against retaliatory lawsuits and ways to defend against other retaliation (e.g., requesting criminal charges against a harasser, filing suit against an employer for wrongful termination, etc.). University programs that educate MRs should include this in their standard curriculum. Licensure boards could require MR training to pass the licensure exam. In turn, licensure boards should be educated about retaliation, so disciplinary committees can consider that a complaint filed by an alleged perpetrator against the reporting MR may be retaliatory. Our study and others demonstrate that training makes MRs more likely to report child maltreatment and less likely to experience retaliation. (Hogelin, 2013; Mathews et al., 2009; Walsh &

Jones, 2015).

Congress should use CAPTA to create a model statute regarding mandated reporting laws, retaliation, and MR immunity. This could be based upon testimony from leading child maltreatment scholars and organizations, establishing evidence-based best practices and uniformity nationwide. States could be required to pass the model statute to receive CAPTA funding. For instance, a uniform immunity clause which requires the court to make an inquiry regarding the defendant's (e.g., MR's) immunity status, would allow case dismissal without the MR having to appear. Currently, MRs must appear in court and pay costly attorney fees to uphold their immunity.

Additional anti-retaliation measures could include eliminating chain of command reporting in all settings. This practice leads to diluted and miscommunicated maltreatment reports and causes an increase in employer retaliation (Freeh et al., 2012). In Australia, direct reporting was also recommended (Mathews et al., 2008). Prohibiting employers from releasing the MR's identity would further protect the MR from retaliation, including harassment by the alleged perpetrator, licensing board complaints, and civil lawsuits. Penalizing employers who intentionally release the MR's identity could include imposing a hefty fine.

Creating whistleblower protections for MR employees who report their employer for unethical or illegal behavior related to mandated reporting or retaliation is critical. If an employer tries to prevent, discourage, or discipline reporting MRs, whistleblower protections should apply. Creating a special cause of action for MRs who face retaliation in the forms of harassment, defamation of character, or frivolous licensure board complaints is also important. The statute should include special damages for a prevailing MR, such as attorneys' fees and court costs and include an enforcement mechanism. This would ensure that states adopting the model statute are complying with and enforcing the laws protecting MRs.

Finally, it is likely that in any country where mandatory reporting of child abuse is required, some reporting MRs will experience retaliation. A U.S. model law which includes required comprehensive MR training; uniform reporting laws; strengthened MR immunity with enforcement; and whistleblower protection, could serve as an international prototype.

8. Limitations

Future studies could formally validate the modified survey instrument. The self-report survey methodology offered no opportunity to ascertain the responses' validity or explore the reasoning behind individuals' answers (except in the "Other" category). The survey failed to ask "Who" retaliated against the MR and which "certain" types of maltreatment cases would not be accepted. A combination of qualitative and quantitative methods may obtain a more detailed understanding of retaliation experience(s). The quantitative method utilized was deemed the most appropriate for the information sought.

A major limitation of this study was the utilization of a national convenience sample of interested MRs from various professions. A convenience sample may over or under-represent the population and can lead to biased results. Therefore, the results may not be representative of any particular group. A stratified random sample of MRs would have lessened any confounding variables. However, given that some states have enacted universal mandatory reporting, where every adult is an MR, a stratified random sample would be cost prohibitive. Because states define MRs differently, it is challenging to acquire a national stratified random sample from each state. Further, not all MRs are members of a national or state organization from which a sample may be drawn. Finally, it is unclear how the results from this cross-sectional retrospective study might generalize to a representative sample.

Though our data varies from national data in terms of frequency of reported abuse types, the National Child Abuse and Neglect Data System (NCANDS) only includes in their Child Maltreatment report abuse that has been indicated or substantiated (United States Department of Health and Human Services, 2022). In addition to the fact that sexual abuse is difficult to substantiate, the results for this paper are based upon an identified sample of cases where 'incidents are related to retaliation'. This is a 'subset' of the national data that has been uniquely identified and assembled via an original survey instrument designed to make such identification.

Finally, we chose to include several outliers in the data set, reasoning the overall data they provided was still valuable to consider regarding the hypotheses. However, this may have skewed the results.

9. Conclusion

Retaliation against mandated reporters is an ongoing problem that may have devastating implications for MRs as well as the children they serve (Gunn, et al., 2005; Kitchens & Gray, 2017; McKenna, 2011; Zellman & Fair, 2002). Experienced and witnessed retaliation appears to significantly impact child protection: fewer MRs are willing to report child maltreatment. The more an MR reports child maltreatment, especially suspected sexual abuse, the more likely they are to face retaliation. Fear of being reported to the licensure board is positively correlated with a failure to report. Additionally, formally trained MRs are more likely to report maltreatment and less likely to face retaliation.

This study's findings demonstrate that current MR immunity protections are insufficient. Recommendations for change include more and better training for MRs and their licensing boards, and policy change through the creation of a uniform, model statute that all states must adopt to receive federal funding. Further research is warranted to better understand the long-term implications of retaliation on MRs' reporting behaviors.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2022.106747.

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