

**DUBLIN BUSINESS SCHOOL**

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**THESIS TITLE:**

*Psychotherapists Perceptions and Experiences of Mandatory  
Reporting within the Therapeutic Relationship*

This thesis is submitted as partial fulfilment of the requirements of BA (Hons)  
In Counselling and Psychotherapy.

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<b>CONTENTS</b>	<b>I – II</b>
<b>ACKNOWLEDGEMENTS</b>	<b>III</b>
<b>ABSTRACT</b>	<b>IV</b>
<b>CHAPTER 1 : INTRODUCTION</b>	<b>1</b>
1.1 Outline	1
1.2 Aims and Objectives	1-2
<b>CHAPTER 2 : LITERATURE REVIEW</b>	<b>3</b>
2.1 Introduction	3
2.2 Historical Overview	4
2.3 The Present Day	5
2.4 Mandatory Reporting Worldwide	6
2.5 Advantages and Disadvantages	7-8
2.6 The Therapeutic Relationship	8-16
<b>CHAPTER 3 : METHODOLOGY</b>	<b>17</b>
3.1 Introduction	17
3.2 Research Design	17-18
3.3 Sampling	18
3.4 Data Collection Method	19-20
3.5 Data Analysis Method	21
3.6 Limitations	21
3.7 Ethical Concerns	22
<b>CHAPTER 4 : DATA ANALYSIS</b>	<b>23</b>
4.1 Introduction	23
4.2 How therapists feel about mandatory reporting	24
4.3 Disruption to Treatment Process due to Mandatory Reporting	25
4.3.1 The Therapeutic Contract and Confidentiality	26
4.4 The Need for Protection of Adult Clients making Retrospective Disclosures	26-27
4.4.1 Therapists Role as Container	28
4.5 Ineffectiveness in the Process of Mandatory Reporting	28

<b>CHAPTER 5 : DISCUSSION</b>	<b>29</b>
5.1 Introduction	29
5.2 How therapists feel about mandatory reporting	29
5.3 Disruption to Treatment Process due to Mandatory Reporting	30-31
5.3.1 The Therapeutic Contract and Confidentiality	31-32
5.4 The Need for Protection of Adult Clients making Retrospective Disclosures	32-33
5.4.1 Therapists Role as Container	33-34
5.5 Ineffectiveness in the Process of Mandatory Reporting	34-35
5.6 Further Research	35
5.7 Strengths and Limitations	36
<b>CHAPTER 6 : CONCLUSION</b>	<b>37</b>
<b>REFERENCES</b>	<b>38-44</b>
<b>APPENDIX 1 : CONSENT FORM</b>	<b>45</b>
<b>APPENDIX 2 : INTERVIEW QUESTIONS</b>	<b>46-47</b>

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This study is dedicated to all of the survivors of child abuse around the world.

## **Abstract**

*Mandatory reporting of child abuse has been introduced in Ireland as a way of identifying cases of child maltreatment on the basis that otherwise they would remain hidden. The current study seeks to explore how mandatory reporting is viewed by therapists and mandatory reporting within the therapeutic relationship.*

*Aim: The aim of this research was to explore psychotherapists' experiences and challenges in relation to mandatory reporting and whether or not it impacts on clinical practice. Method: A qualitative approach was used and semi-structured interviews were conducted with four experienced and accredited psychotherapists. These participants were chosen due to their knowledge and experience working with survivors of child abuse. The data that emerged was analysed using thematic analysis. Findings: Four main themes emerged from the analysis: how therapists feel about mandatory reporting, disruption to treatment process due to mandatory reporting, the need for protection of adult clients making retrospective disclosures and the ineffectiveness of the process of mandatory reporting. Conclusion: The needs of all survivors must to be taken into account when dealing with abuse. A more holistic approach needs to be implemented to ensure their needs are met. The strengthening of support systems is required. The literature lacked in the area of psychotherapist's views and feelings around mandatory reporting. Further research was suggested in the area of mandatory reporting in Ireland as a whole and in particular into the impact of mandatory reporting on adult survivors of child abuse needs to be addressed so that Irish society does not continue to fail these individuals.*

Key Words: Mandatory reporting, psychotherapy, therapeutic relationship.

## **CHAPTER 1.0**

### **INTRODUCTION**

#### **1.1 Outline**

Modern history in Ireland is saturated with high profile cases involving physical, emotional and sexual abuse of children. National inquiries have highlighted children's stories of abuse and neglect. Although each inquiry had various terms of reference, scope and status, collectively they address a wide range of issues significant to the issue of child protection. Focus was placed on how child protection can be improved. The recommendations range from general (to review policies on child protection) to the specific (introduction of mandatory reporting of child abuse) to the practical (protocols which improve communication between agencies) to the symbolic (creation of a monument to the victims of abuse). This study seeks to acquire an insight into and offer an alternative lens in which to view the attitudes of psychotherapists in relation to mandatory reporting of child abuse in Ireland.

#### **1.2 Aims and Objectives**

This study sought to acquire an understanding of therapist's attitudes and beliefs in relation to mandatory reporting. The aim of this study is firstly to explore, broaden and deepen the researchers understanding of; how therapists view mandatory reporting? Secondly, it seeks to uncover how psychotherapists experience mandatory reporting? And finally, it seeks to ascertain if there is any impact on the therapeutic alliance following the introduction of mandatory reporting.

The objectives of the research are to:

1. Explore how therapists personally feel about mandatory reporting (taking out the legal and ethical elements).
2. To establish any challenges and difficulties that may be present when working with disclosures of child abuse.
3. To investigate if mandatory reporting impacts on the therapeutic relationship.
4. To contribute to counselling and psychotherapy as a whole by gaining new insights.

## CHAPTER 2.0

### LITERATURE REVIEW

#### 2.1 Introduction

For the purpose of this research mandatory reporting refers to the mandatory reporting of child abuse. On the 10<sup>th</sup> of November 2012 a referendum was held in Ireland. The results of the referendum were an amendment to the Children First: National Guidance for the Protection and Welfare of Children (2011)<sup>1</sup>, to include mandatory reporting. This piece of legislation is paramount in a move towards the protection of children at risk of abuse. Following on from this the Government is in the process of introducing Children First Act 2015 and Withholding Information on Offences against Children and Vulnerable Persons Act 2012. These two separate and distinct Acts are to recognise the very separate and distinct roles of the Garda Síochána and TUSLA (The Child and Family Agency) with regard to the protection of children and vulnerable persons. Under the Children First Act 2015 – mandated persons (which includes accredited psychotherapists and counsellors) must report where he or she knows, believes or has reasonable grounds to suspect that a child has been or is being harmed or may be at risk of being harmed.

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<sup>1</sup> *Children First: National Guidance for the Protection and Welfare of Children (2011)*. The Guidance states what organisations need to do to keep children safe, and what different bodies, and the general public should do if they are concerned about a child's safety and welfare. It sets out specific protocols for HSE social workers, Gardaí and other front line staff in dealing with suspected abuse and neglect. The scope of the guidance extends beyond the reporting to statutory bodies. It emphasizes the importance of multi-disciplinary, inter-agency working in the management of concerns about children's safety and welfare. Key to this is the sharing of information between agencies and disciplines in the best interests of children and the need for full co-operation ensure better outcomes.

## 2.2 Historical Overview

Looking back in history, prior to the recent past, few references of child sexual abuse exist in Ireland. Child sexual abuse entered the public domain in Ireland in the last twenty years due to a number of high profile cases. Inquiries have played a significant role in bringing the stories of those children who were neglected and abused in Ireland within family settings, as well as those who suffered clerical and institutional abuse.

Seeing such profile cases as the X case (Holden, 1994), the Kelly Fitzgerald case (Keenan, 1996), the Kilkenny Incest Case (McGuinness, 1993), the Brendan Smyth Affair (Moore, 1995) and the Madonna House Affair (Department of Health, 1996) become public in the 1990s has led to child sexual abuse becoming a topical issue publicly, professionally and politically in Ireland.

The cases mentioned above serve not only to vindicate the rights of those children affected but to go further and identify the failings of the authorities to protect children from harm. Prior to this the first reference to child sexual abuse in the Department of Health Guidelines was in 1983 (Department of Health, 1983). However, it is in the Penitentials<sup>2</sup>, which originated in Ireland in the 6<sup>th</sup> century, that the first evidence of sexual abuse in our country are to be found. These were confessional manuals that were used by the clergy. These manuals not only contained exhaustive lists of proscribed behaviours but also gave recommendations for what the appropriate penance for the “misuse” of children should be for such offenders (Beiler 1963).

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<sup>2</sup> Bieler, L. (1963). *The Irish Penitentials. Dublin: The Dublin Institute for Advanced Studies.*

Penitentials were handbooks listing many sins a confessor could be expected to encounter during private confession and the appropriate penances he should assign for each act (or the appropriate moneys the penitent should pay to commit a penance).

## 2.3 The Present Day

Unfortunately to think of this as being something historical only would be a grave error. The World Health Organisation (2014) reported that 20% of women and 5-10% of men have experienced childhood sexual abuse in countries around the world. In Ireland reports by the government concerning child abuse focuses on the organisational structure and failings in specific cases. These reports suggest changes in the management structure and service delivery. However, the abuse continues to take place. They are failing to keep children safe<sup>3</sup>. Recent reports by the Health Service Executive, Garda Síochána<sup>4</sup> and Catholic Church show inconsistency within the Social Care system in Ireland. Take the Ferns Report (2005) and the Murphy Report (2009) as examples. These reports found that the sexual abuse of children was perceived by the Church as being a moral issue, and no effort was made to lessen offending priests contact with children so as to minimise risk. It was also found that the Gardaí in fact colluded with the Church due to the idolisation of the organisation, following complaints they protected priests and failed to fully assess allegations as they saw no risk. The Monageer Report (2009) found a failure within the HSE (Health Service Executive) to acknowledge how vulnerable Adrian Dunne's family were and a correct assessment was not made to assess the risk he posed to himself and his family. The Roscommon Child Care Case FF(2010) found the constant change of social workers to be problematic. The Cloyne Report (2011) acknowledged the fact that Ireland's institutions were resistant to change and had changed very little.

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<sup>3</sup> A HIQA Inspection of the HSE Dunlin North West Local Health Area Fostering Service in the HSE Dublin North East Region, published in February 2013 the findings were that Outcome 4 of the report "Safeguarding and Protection of Children," including the implementation of "Children First: National Guidance for the Welfare and Protection of Children, 1999 Standard" was not met; Outcome 5, Assessment of Children and Young People Standard", was not met. Aras Attracta (2013)

<sup>4</sup> Ferns Report (2005), Ryan Report (2009), Murphy Report (2009), Roscommon Child Care Case (2010), Cloyne Report (2011).

## **2.4 Mandatory Reporting Worldwide**

Following the aftermath of worldwide revelations of both clerical and institutional abuse, there has been a reactive explosion of moralising outrage. This has led to a reaction that society be redeemed by the introduction of legislation. Societies worldwide continue to engage in the question of how best to identify and respond to cases of child maltreatment.

Despite this being a hot new topic in Ireland, mandatory reporting has been widely accepted in many jurisdictions such as the United States of America, Canada, Australia and New Zealand. Whilst mandatory reporting has been introduced and accepted in many jurisdictions worldwide, it has also been the subject of much criticism (Mathews & Kenny, 2008). Abuse and neglect of children are significant problems throughout the world. The issue of mandatory reporting presents great challenges to governments globally, in the areas of both detection and in prevention. Research has indicated that since the implementation of laws regarding reporting there has been a rise in the reported cases of abuse (Kalichman, 1999).

Legislation in relation to mandatory reporting was first developed in the United States in the 1960s. It was developed as a result of the influential work of Kempe and his colleagues in relation to the 'battered child syndrome' (Kempe, 1962). In 1972 mandatory reporting was first introduced in South Australia, since then reporting requirements have been enacted in all other jurisdictions in Australia (Matthews and Kenny, 2008).

## **2.5 Advantages and Disadvantages of Mandatory Reporting**

Research has indicated that the enactment of reporting laws has led to significant increases in reporting, as a result more substantiated cases have come to light (Kalichman, 1999). Mandatory reporting does play an important role in bringing cases of abuse to the attention of the relevant authorities so as to safeguard children and vulnerable adults from being subjected to such neglect and cruelty. It serves as an important symbolic function. It sends a clear message to society that child abuse and/or neglect will not be tolerated. Matthews and Bross (2008, p.511) put forward the argument that ‘without a system where people outside these children’s families bring the children’s circumstances to the attention of authorities, many and perhaps most cases will remain hidden.’ Hence, the most important function of mandatory reporting is that highlighted above and it also plays a vital role in bringing these cases to the attention of the authorities. There are three key assumptions which must be looked at: firstly, children are unable to protect themselves and require someone to act on their behalf, secondly, generally abusive parents will not voluntarily seek or request assistance and thirdly, those who work with children are best placed to detect instances of abuse or neglect (Hutchinson, 1993).

Mandatory reporting upholds that a child’s right to safety and protection is not subjectively determined by an individual adult. Mandatory reporting is a system which is designed to safeguard the rights of children. This topic is very new for Irish psychotherapists who previously had no regulation. This legislation is integral to the safeguarding and protection of the child. Through the work in the therapeutic space the emergence of such traumas as abuse may very well be disclosed.

One of the key disadvantages of mandatory reporting is that child protection agencies are flooded with unsubstantiated claims, which puts a strain on resources and due to this, legitimate claims are detracted from. Mandatory reporting has been debated and strongly criticised, regarding its cost and benefits. It has been noted by Kalichman (1999) that few clinical issues are the source of as much emotionally charged debate as mandated child abuse reporting.

## **2.6 The Therapeutic Relationship**

The therapeutic relationship is a factor that must be considered when it comes to Mandatory Reporting. The therapist's role around managing such disclosures and ability to hold and contain will be paramount.

Brazelton and Cramer (1991) in infant psychological research portray how genetic predispositions in the mother and infant relationship may be selectively attuned to allow for the development of a containing relationship between the infant and its main attachment figure. If the parental object fails to meet an infant's innate expectations the infant will suffer primary disappointment (Emanuel, 1984). Bion (1962) refers to the infant's expectation of a containing object which involves the parent or container being in a place that they can receive the infant's primitive communications. The parent or container must think about the infant, to give them meaning. This process is referred to as alpha functioning by Bion, and moreover the parent/container has the ability to respond accordingly. Through repetition of this experience the infant will identify with the care givers function and reflect on its own experience. A container then exists in the infants mind. In essence, the container acts upon the contained through the process of reverie or alpha function, which in turn allows for the development of a mental apparatus for thinking.

In the past researchers have focused on the intrapsychic effects of childhood abuse as opposed to the interpersonal effects, and for this reason intrapsychic effects have been well documented. Intrapsychic effects may include such symptoms as post-traumatic stress disorder, disassociation, emotional dysregulation, negative body image and suicidal ideation (Briere, 1992). It is only in the last decade that researchers have become more interested in the interpersonal effects. These may include, but are not limited to, such issues as insecure attachment, abandonment issues, sexualisation of relationships, re victimisation and viewing themselves as being undeserving of loving relationships (Classen, Field, Koopman, Neville-Manning & Spiegel, 2001).

The case with many abused children is the self-perception that they are bad and this may serve as an attempt to master their anxiety. Through repeating the trauma, making active something which was previously experienced passively, this can allow the child to maintain an illusion of control (Tuohy, 1987). Re-traumatisation is a real concern as clients can become overwhelmed if they are flooded with bodily based and non-verbal aspects of their past experiences. This negative holding experience is not something that they wish to escape, to the contrary, they are often fighting to hold on to it. A need can arise to re-experience the old, familiar environment and will often be re abused in other settings, due to an unconscious fear of loss of the object if they do not experience these feelings.

In the therapeutic space early dynamics are at play and the client often wants the therapist to meet their desire. The undercurrent which is present in this dynamic is often where the original failure lies. This structure is often put in place due to the environment and inability to be with the Other. There is for this very reason often a great fear in letting this go. Winnicott (1958) stated that within the psychotherapeutic space, the holding environment has been viewed as being both a positive and healthy environment which facilitates growth. It is a safe space created to allow a client to explore and understand what they have experienced and

move towards change. The negative holding environment is one which restricts this growth facilitation. Similarities can be drawn between intergenerational cycles of abuse and negative holding.

Nolan (2012) discusses the importance of threading carefully and building trust so as to ensure that therapy does not end prematurely as a result of the client feeling betrayed. Rokop (2003) in the United States examined the client's perspective of how the therapeutic relationship changes after mandated reporting. Clients who had positive experiences in therapy after mandated reporting typically reported having a strong therapeutic relationship before the report was made, and reported that the therapist was direct and apologetic about having to make the report. On the other hand, clients who had negative experiences in therapy after mandated reporting generally reported having a poor therapeutic alliance prior to reporting, and expressed that they experienced the therapist as inexperienced, indirect about making the report, and lacking in empathy (Rokop 2003).

Looking back to Freud and borrowing his idea of 'ego strength' and using it as a measure of psychotherapeutic health, the ego is said to arise from the frustration of the id's drives and wishes. The id operates through the primary process. It seeks to satisfy the pleasure principle aimlessly, its survival is dependent on the development of secondary process which is operated through the ego to bring it into the external world. Davies and Frawley (1994) feel that it is not until the different ego states have been welcomed and explored on their own terms that the adult ego state will begin to relinquish and mourn the loss of the reified abused child. If a client has the ability to satisfy their needs and maturely deal with adversity, think logically about their problems and solve them and relate with more mature ego defence mechanisms, they would be assessed as having good ego strength and would be likely to

respond favourably to psychotherapy. Malan (1995)<sup>5</sup> talks about how in practical terms a therapist must assess.

The clinical issue of trauma and how it effects mental functioning in a disorganised manner brings us back to attachment theory and the inner world. From their earliest attachments individuals form a secure or insecure attachment base. Many theorists such as Bowlby, Klein and Winnicott use their own terms, such as secure attachment, towards independence and depressive position for something which is essentially quite similar in nature. They all see the early part of an infant's life as the foundation as to how they relate in their adult lives. Awareness of the past and how we experience it informs us very much of our present and can, in many cases, be the reason why one thinks and acts the way they do. When a child experiences security in the attachment relationship they will explore their environment from this secure base and in turn, move towards autonomy. Moreover, if a child is responded to in an inconstant manner or suffers rejection, this can lead to the formation of insecure attachments; this can impair their emotional development and ability to explore the world (Bowlby 1973). The consequences of the attachment received have profound and long lasting impacts on the individual's development and way of being in the world.

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- 1) <sup>5</sup>The maximum severity of any past disturbances.
  - 2) A client's inner strength and how they manage to access their inner resources, their capacity to deal with stress and unpleasant feelings which are stirred up in them.
  - 3) The support they have outside of the therapy room.
  - 4) How the potential therapist may deal with any disturbance which may occur.

Child sexual abuse is a developmental trauma and as such, differs from other traumas such as accidents and natural disasters in a number of significant ways:

1. It is as a result of another premeditated action.
2. In many cases it is committed by an individual who is attached to the child in some way.
3. Sexual abuse often occurs alongside other abuse (for example by force or threats if the child tells).
4. It is often misrepresented to the child.
5. The act is often chronic and cumulative.

Sanderson (2006) speaks about the importance of the therapeutic space being a safe place for survivors of CSA (Child Sexual Abuse) to explore their experience so that they can speak their truth as opposed to being like a court room. Emphasis is put on validating the survivors' narrative truth to enable an exploration of the impact it has had on their life. CSA survivors require clear, consistent boundaries given the boundary violations they experienced in the past. This will facilitate them rebuilding trust. Herman (1992a) notes that trust is the developmental achievement of earlier life. It may be useful to look to Freud and psychoanalysis and an ethical dilemma which may be present with the introduction of mandatory reporting.<sup>6</sup>

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<sup>6</sup> Psychoanalysts work with the transference, the fundamental rule, fantasy and drives. Breuer and Freud (1895), in the case of Anna O, the patient of Josef Breuer, we see an example of transference and the drive of sexuality. Breuer becomes the object of her affections as she transfers her feelings from a significant other onto him and falls deeply in love with him. So much so that she experiences a phantom pregnancy including nausea and other pregnancy symptoms. Psychoanalysts may see it that to quote from a session as quoting from the Other. The material shared is meant to be interpreted by the analyst and analysed, and is not something which is put out there to be judged by the Superego.

It is worth noting the following to quote Alvarez (1992) when it comes to retrospective disclosure of child abuse:

*“Whereas the more mildly traumatised patient, whose disorder is affecting his personality on the neurotic level, may need to remember the trauma in order to forget, the more damaged children whose trauma is more severe and more chronic may need to forget the trauma in order to be able to remember.” (1992, p. 151).*

Studies have shown that many mental health practitioners oppose mandatory reporting as they believe it breaches confidentiality (Kalichman, 1999). Professionals’ non-reporting of concerns about child abuse is a significant issue. It is also believed that a third of psychologists hold the view that reporting of abuse interrupts the treatment process (Kalichman and Craig, 1991). Zellman (1990) conducted a national survey which found that one in five clinicians cited a disruption to the treatment process as influencing their reporting behaviour.

Research in the UK conducted by Lazenbatt and Freeman (2006) suggests that there is a wish among health professions for a more multidisciplinary approach to educational workshops, training and teaching aids. This corresponds with research conducted by Fagan (1998) and Jesse and Martin (1998) which both confirmed how the effective management of individual cases of abuse can develop when each individual profession has an understanding of the functions and goals of the other professionals involved in the case through the uses of interdisciplinary training and educational programmes.

Whilst mandatory reporting in Ireland is non-mandatory at present in a legal sense, this is expected to change in the near future. The Irish Association of Counselling and Psychotherapy (IACP) and Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) recommend that members would be wise to ensure that their contracts with clients refer to their obligations under the Children First Guidelines.

Professional's own beliefs and attitudes about the nature and prevalence of abuse and childhood experiences may also play a role in determining how they define abuse (Dickens, 2001; Tite, 1993), whilst their interpretations of legal reporting thresholds can vary significantly (Levi and Brown, 2006).

There seems to be reluctance within Irish society to deal with disclosures of abuse by children and adult survivors. Such disclosures have often been dismissed as being fantasy due to the struggle by society to accept that these experiences actually took place (Wyatt and Powell, 1998). It may be viewed that society has a role to play in how abuse is dealt with and the way in which it is viewed and, in fact, understood. A major issue which arises according to Kremer and Gresten (1998) is how the client views the therapeutic relationship and how, in a great number of cases, absolute confidentiality is expected by the client. This raises the researcher's question of how it is dealt with by therapists when it comes to disclosures of abuse. As appealing as absolute confidentiality may sound, room must be made for mandatory reporting, the importance of which is to protect society's children from harm. Clarkson (2003) talks about the implications of mandatory reporting and how serious and devastating it can be for the client.

Alternatively, the act of reporting sends an important message to the client. It shows the client that they have been heard by the therapist and that it is going to be dealt with not only in a professional but also an appropriate manner (Kalichman, 1999). Another significant point is that the therapist must also take into account that there are others outside of the therapy room that may be at risk. The therapists' duty of care lies with any child at risk and this supersedes their duty of care to their client. The therapist must take into consideration the legal and ethical concerns surrounding the need to breach confidentiality and this should be discussed in detail with the client (Bromley & Riolo, 1988, Crenshaw & Lichtenberg, 1993; Nicolai & Scott, 1994). Watson and Levine (1989) conclude that informing the client of the mandated reporting responsibility before therapy begins helps to maintain the relationship when it became necessary to make a report. However, studies suggest that there tends to be inconsistency among therapists in relation to procedures for informing clients of confidentiality limits, including the mandate to report (Nicolui & Scott, 1994). It is also paramount that the therapist assesses the type of help the client may require and whether they can provide this or not.

The 2002 SAVI report in Ireland, in discussing incidences of historical sexual abuse among psychiatric patients, it was noted that questions in relation to sexual history were not routinely asked. It was speculated that this may have been due to the requirement within certain organisations to mandatory report these incidents. It also referred to 'professional discomfort' with the topic. This report also found that 42 per cent of Irish women and 28 per cent of Irish men had experienced some form of sexual abuse or assault in their lifetime. Approximately 7 per cent of those abused had reported it to the Gardaí. Only 10 per cent of reports result in prosecution, and between 5 per cent and 10 per cent of prosecutions result in convictions.

Look to the recent case of Fiona Doyle, whose father Patrick O'Brien was convicted of raping her over a period of years and was subsequently jailed. This was seen as being a rare 'victory' for a sexual abuse victim in the Irish criminal justice system. O'Brien was only sent to jail after the trial judge reversed his decision to release him on bail pending an appeal. The decision to grant bail triggered a public outcry.

This is evidence that there are a lot of Fiona Doyles who have not seen justice done.

## **CHAPTER 3.0**

### **METHODOLOGY**

#### **3.1 Introduction**

This chapter will outline the methods that were employed in carrying out this research. It will explore the reasons for using qualitative analysis, opting for semi-structured interviews, the participants that were selected, how the data was collected, the procedure adopted and finally the ethical considerations that informed the study.

#### **3.2 Research Design**

In keeping with the explorative nature of the paper, the researcher chose the realist and experiential method of qualitative analysis over any other method. Qualitative data is said to focus on the “description of the qualities (or characteristics) of data” (Howitt and Cramer, 2008, p.285). McLeod (2001) in qualitative research the sample is purposely selected and consists of a small number of participants who have experience relevant to the research topic. It is designed to reveal the behaviours and perceptions of a target audience with reference to specific issues or topics. Their experience allowed them to give a more in-depth account of their knowledge in the area. The qualitative method was flexible in nature and allowed for subjective thinking. The results of qualitative research are more descriptive than predictive. In recent years, qualitative research has been very influential in the area of healthcare and social sciences. Qualitative research is particularly useful for those conducting research on real life and sensitive topics; it is flexible and can give new meaning to areas which may not have previously been understood. Furthermore, it is essentially a journey of discovery giving new insights and meaning to the issues the participants are dealing with.

Qualitative research focuses on the real world and how it is experienced. Harper and Thompson (2012) stress an important fact that qualitative research enables understanding of experience and this is the overall aim of the researcher in this study.

### **3.3 Sampling**

Therapy centres in the greater Dublin area were contacted by the researcher to recruit participants. Four participants, who are members of the Irish Association of Counselling and Psychotherapy (IACP) or Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) who had at least two years post accreditation experience, were selected. A phone call was made explaining the nature of the study and the requirements for those who wish to participate. Once contact had been made the researcher identified herself and the participants were informed of the nature of the research and the process of being involved in the research. The participants were informed that they would not be identified in the results of the research and the information provided would be used by the researcher only for the purpose of this research project.

Once the participants agreed to partake in the research times and dates were scheduled at the participant's convenience. Each interview lasted from 25 to 40 minutes (and took place in the participant's place of work). All participants had experience working with clients who disclosed child abuse. Participants experience ranged from working 5 to 10 plus years as fully accredited therapists.

### **3.4 Data Collection Method**

Semi-structured, informal face-to-face interviews were conducted in a location selected by the participant due sensitive nature of the subject topic. There were four participants interviewed for the study. This style allowed the interviews to be flexible in nature and did not restrict the interviewer in any way. A series of open ended, non directive questions were asked which allowed for a deeper exploration of the interviewees experiences and allowed a space for participants to elaborate on their views.

One to one semi-structured interviews were conducted with the goal of eliciting participant's experiences and views on the research topic being investigated. The questions were compiled following the information that arose from the literature review. Semi-structured interviews allow for a process which "enables and encourages interviewees to think out their positions on complex issues" which in turn allows "an opportunity to reflect on their values and opinions" (Oliver, 2003, p.56). Hancock (2001) talks about how the open ended nature of semi-structured interviews aids the process of individuality in each interview to take place and for the interviewer to follow an amended line of inquiry if new material comes to light during the interview process.

The overall purpose was to obtain qualitative data regarding participants' perceptions and experiences of mandatory reporting in the area of counselling and psychotherapy. The reason for opting for interviews over questionnaires is that the conversation is likely to be more natural, which will lead to richer, deeper and more realistic data. Semi-structured interviews also allow for the questions to be modified depending on the participant's responses.

All interviews were recorded using a Dictaphone; the interviews were then downloaded to the researcher's personal computer and transcribed verbatim into text for data analysis. All interviewees were informed of the technical details related to tape recording. The interview procedure was explained to each participant and began when the participants felt ready to begin. Following the transcription into text, audio recordings will be kept on the researcher's computer for a period of seven years and password protected in order to maintain anonymity of each of the participants. This is in accordance with The Data Protection Act of 2003, section 2(1) (c) (IV) of the Act states that "the data shall not be kept for longer than is necessary for that purpose or those purposes". No identifying information was written into the research paper and any names given or places referenced were amended in order to protect the anonymity of the participants.

### **3.5 Data Analysis Method**

Following on from this, the data from the interviews was subjected to thematic data analysis process. Thematic analysis extracted the themes and concepts from the interview data. Emergent topics were identified within the data as a means of translating meaning of individual experiences into quantitative data (Boyzatis, 1998). The employment of this method of data analysis will allow for the potential emergence of rich insights and detailed data (Braun and Clarke, 2006). The reason this method will be implemented is that it suits any topic. It is also the most flexible method of analysing qualitative research. For the purpose of clear analysis the researcher will employ the method as outlined by Braun and Clarke (2006) a six step approach to thematic analysis. It begins with becoming familiar with the data, initial coding, beginning to identify themes based on the initial coding, a review of the themes, theme definition and labelling and then finally reporting of the data. The theoretical framework is based on the organisation of key issues within the data into themes reflecting important relations to the research questions which serve to frame key topics that involve specific description rather than provide overall answers (Boyzatis, 1998).

### **3.6 Limitations**

This was a qualitative research study which consisted of a volume of in-depth data and focused on a small sample of participants only. The intention was not to make generalisations from the findings but was rather to gain insight and understand individual experience and see if any commonalities emerged.

### **3.7 Ethical Concerns**

With regard to ethical issues, the author adheres to the Belmont Principles of Ethics (1979). It was explained to participants that they were free to withdraw from the study at any time, their participation was voluntary, and also that their anonymity was assured. They were given a consent form granting permission to be interviewed and for the information collected to be used in the research project (Appendix 1). Due to the sensitive nature of the topic, and the data collection method to be used, participants were advised of the purpose of, and the interview procedure and style in advance. Prior to the interview beginning all participants were given the opportunity to ask any questions they may have about the research or the interview about to be carried out. Anonymity of all participants was guaranteed prior to the commencement of the interviews (Bell, 2005). Interviews will be carried out in a variety of locations where privacy will be guaranteed. During the process of transcription, interviews were coded by number and names and any other identifying data will be obscured. Pseudonyms were also adapted so as to further protect participants' identity and ensure anonymity. Participants were notified of how the transcripts will be stored. They were stored and password protected and only the researcher will know the password. Each participant has given consent for their opinions and views to form part of the thesis with the understanding that they can withdraw consent at any time. In keeping with ethical boundaries all therapists have had experience working with victims of child abuse. An offer will also be made to provide each participant with a copy of the results if requested.

## **CHAPTER 4.0**

### **DATA ANALYSIS**

#### **4.1 Introduction**

This chapter focuses on the results of the analysis of the data collected from the semi-structured interviews that took place. Four participants were interviewed for the study. They were all fully accredited practising psychotherapists with between 5 and 10 plus years experience, they were all working in different capacities within centres and in private practice. The participants had a range of training backgrounds; Gestalt, psychodynamic, humanistic and integrative. The aim of the study was to explore how therapists personally feel towards mandatory reporting (beyond the legal and ethical elements) and establish the challenges and difficulties that may be present when working with disclosures of child abuse. A further aim was to see how mandatory reporting may impact on the therapeutic relationship. Finally it wished to address any fears that may be present for the therapist in relation to this new dynamic of including mandatory reporting within the therapeutic relationship.

The data collected from the interviews were examined and using the method of thematic analysis, themes and sub-themes were extracted so as to report the findings. The transcripts were coded and several themes emerged. The use of pseudonyms was implemented so as to protect the participant's identities. The principle themes were:

1. How therapists feel about mandatory reporting.
2. Disruption to treatment process due to mandatory reporting.
3. The need for protection of adult clients making retrospective disclosures.
4. The ineffectiveness of the process of mandatory reporting.

## 4.2 How Therapists feel about Mandatory Reporting

Prior to beginning the interview process each participant was asked to put the legal and ethical considerations to one side and answer the questions based on how they honestly feel in relation to mandatory reporting. The first question that was posed to participants encompassed this. In essence the question was used to gain an understanding of how the participants personally feel about mandatory reporting. All participants reported different opinions when asked this question.

Elaine expressed that: *“I think it’s hugely problematic for therapists and for clients . . . it’s changed the nature of psychotherapy . . . I actually dislike it immensely.”*

Julie commented: *“I wouldn’t force the issue because I know of the impact that it has on the client.”*

Sarah spoke of being in agreement with mandatory reporting, however felt it limited the work: *“I think there’s a place for it, I think it’s important to try . . . and protect people. I guess it’s the scope of what becomes mandatory that can cause concern, it can cause challenges, it can create resistance . . . in essence the notion of mandatory reporting makes sense but the broad scope of it can be an impediment . . . to the client, to the relationship, to lots of things within the therapeutic space . . . I’m in agreement in theory with it but I think it’s quite limiting to the work.”*

Paul expressed feeling conflicted: *“I would feel that I wouldn’t want to report at all, well I would and I wouldn’t, I’d be conflicted.”*

### **4.3 Disruption to Treatment Process Caused by Mandatory Reporting**

The question focused on the treatment process and was posed in an effort to gain an insight into whether or not there is any impact on the therapeutic process due to the issue of mandatory reporting. All four participants presented rich data which illustrated that they felt mandatory reporting causes a disruption to the treatment process and will hinder what takes place within the therapeutic space.

Elaine highlighted the following in relation to clients: *“They [clients] are consciously aware that they mustn’t give that information so the client is not free to just talk; they’re on alert all the time so that’s hugely disruptive.”* Julie echoed this view and added a new dimension: *“It just interferes with the healing process and very often the therapy can be taken up with the reporting rather than what the actual issue is.”* Sarah pointed out the importance of readiness of clients to take this step: *“Certainly in cases of retrospective disclosure, it can create barriers. Clients aren’t always ready to disclose their experiences beyond the safety of the therapeutic space . . . they obviously have to make some decisions around that and I think for a lot of clients who have held these very difficult feelings and very difficult experiences and all the shame and all the different emotional responses that come with these experiences. I think that can block the work GREATLY.”*

Paul made a further point that there will often be reluctance on the client’s behalf to disclose identifying information. He explained: *“Very disrupted, because you have a client who comes in and they are aware now that . . . there might be an obligation to report, that they will talk around the issue, they won’t name somebody, they won’t even give details so you kind of know you are left with this secret lurking in the air . . . that can’t be spoken about or they are unwilling to speak about because they don’t feel free to be able to speak about it.”*

### **4.3.1 The Therapeutic Contract and Confidentiality.**

During the interview process all four participants raised the importance of having a clear contract which sets out the limits around confidentiality. Within each interview conducted, each participant expressed the importance of the therapeutic contract and that the client was explicitly aware of the limits around confidentiality. Sheila reported: *“I’ve now changed my contract with the client when they come in to emphasise . . . clause in there around confidentiality”* Julie expressed: *“I think if it’s laid down in the first session, I don’t necessarily think it’s a breach of confidentiality.”*

### **4.4 The Need for Protection of Adult Clients making Retrospective Disclosures**

Sarah expressed: *“I certainly do think that clients are being lost . . . I think the focus is on the perpetrator and stopping continued criminal behaviours and that’s very, very important but I do think we forget that actually there’s individuals who have been damaged and been hurt and they really should be the priority, what their needs are, I think that should be the key focus.”*

When asked about clients in the case of retrospective disclosure, participants spoke about working with vulnerable and distressed adults who have reached out for help in order to deal with the impact of child sexual abuse on their lives. They highlighted the importance of balancing the clinical needs of individual clients, allowing them the right to access support and a commitment to the protection of children. There was a feeling that premature or hastily reporting was an exercise that involved ticking boxes as opposed to contributing to child protection in a meaningful way. This in turn can lead to client’s being lost and not engaging in therapy.

Sheila mentioned that: *“Now therapists in private practice will be obliged to report or risk being prosecuted themselves for nondisclosure so there is a different energy in the room now with these cases but for sure, the clients, the adult clients who choose not to report are completely abandoned . . . and morally that feels all wrong, and of course I’m not advocating we should not report when there is clearly a child at risk . . . but to say all issues of sexual abuse, childhood sexual abuse, have to be reported . . . it’s a bit like there’s a certain type of fishing that’s banned in Ireland because it destroys too many species along with the aimed target . . . I think it’s a bit like that . . . we’re convincing ourselves, taking this high moral ground that oh it’s for the good of children but we know there are thousands of adults who would be far too fearful to name their perpetrators, so what happens to them?”*

Julie reported: *“that’s where the therapy goes, it’s based on reporting not what the actual person is going through and I know that again from personal experience of working with people who have come in who were forced to report it because of the mandatory [reporting] and didn’t actually get any therapy because it was just on the reporting so they were left, they were lost and again had to re-engage with therapy later in life because of what they didn’t get the first time round.”*

There was a strong recognition that the authorities failed adult survivors of child sexual abuse and cost was a feature that emerged for Sarah in relation to support and she had a very clear view in relation to this. She reported: *“the support that’s available to alleged victims really reverts back to their therapist and that could be a private therapist where there is huge cost involved or any one of the organisations that are out there which is normally time limited to some degree so I certainly think there is a lack of support.”*

#### **4.4.1 Therapists Role as Container**

Sarah made a further point about support and the therapist acting as a container. She explained: *“I often think that clients are just left . . . without guidance, without containment, without support, without nurturing and that then falls down to the therapist”*. Paul felt that the therapist was the person who should take responsibility to act as the container in the process of reporting, saying: *“I don’t think the client will get lost if the therapist is able to act as the container because the therapist has to be the container for that [reporting] process.”*

#### **4.5 The ineffectiveness of the Process of Mandatory Reporting**

Participants shared concerns about the lack of a robust system, lack of staff and the inappropriately high level of caseloads being dealt with by social workers. In essence this theme centred on the lack of efficiency within the HSE (Health Service Executive) and TUSLA (The Child and Family Agency). Sarah mentioned that: *“. . . therapists know that when we do make reports very little action is going to be taken in any sort of timely manner”*. Julie felt quite strongly about this also and commented: *“. . . For what it’s worth, it makes me angry that there’s no actual system in place after making this mandatory and there is no actual real system to support it.”* Sheila reported: *“The reality is the social workers are inundated with reporters, reports and it doesn’t go anywhere . . . it doesn’t go anywhere because the resources aren’t there so there is massive over reporting, there is a massive under resourcing.*

Four main themes emerged from the analysis: how therapists feel about mandatory reporting, disruption to treatment process due to mandatory reporting, the need for protection of adult clients making retrospective disclosures and the ineffectiveness of the process of mandatory reporting.

## CHAPTER 5.0

### DISCUSSION

#### 5.1 Introduction

This research set out to explore the experiences, attitudes and challenges of psychotherapists in relation to mandatory reporting. This chapter will discuss the findings with reference to the existing relevant literature, with the overall aim of exploring mandatory reporting. The limitations will be addressed with suggested recommendations for the future. As noted in the literature review there is reluctance within our society to deal with and speak about child abuse (Wyatt and Powell, 1998). This is evident from the lack of literature in certain areas.

#### 5.2 How Therapists Feel about Mandatory Reporting

Mandatory reporting is a challenging element of the therapeutic alliance for the therapist and the participants expressed mixed feelings in relation to it. One participant expressed a strongly opinion in relation to this and reported that it changed the essence of what psychotherapy is about: *“It’s changed the nature of psychotherapy.”* Another participant mentioned if it was not mandatory: *“I would feel that I wouldn’t want to report at all, well I would and I wouldn’t, I’d be conflicted.”* The literature does not cover in depth the barriers and challenges present in relation to Mandatory Reporting.

### 5.3 Disruption to Treatment Process Caused by Mandatory Reporting.

The participants in this study had genuine feelings that the act of mandatory reporting was disruptive to the work. One participant reported: *“They [the client] are consciously aware that they mustn’t give that information so the client is not free to just talk; they’re on alert all the time so that’s hugely disruptive”*. Sanderson (2006) the quality of the therapeutic relationship is of upmost importance to survivors of child sexual abuse. This relationship with their therapist will be the foundation of the therapeutic process for survivors, it is the safe space in which traumatic memories and their accompanying affect can be addressed safely. It can be seen to serve two significant functions, to facilitate the survivors’ integration of self and to offer a corrective experience for the interpersonal damage to such things as trust, dependency and intimacy. However, as one participant explained: *“It feels a little bit like that we have to look beyond the client all the time and I guess that, that itself, that looking beyond the client within the therapeutic space creates a distance in the therapeutic space.”*

The thoughts that the participants in this study had in relation to the disruption of the process are similar to the finding of research undertaken by (Kalichman and Craig, 1991). This would echo findings of previous studies conducted (Zellman, 1990). One participant expressed: *“The work . . . becomes supportive work as opposed to maybe exploratory so regardless of the reason why the client has come into the therapeutic space there is a very distinct shift in focus and again is that always in the best interest of the client, I am not sure.”*

This issue of disruption of the treatment process or therapeutic alliance following mandated reporting has not been explored thoroughly in current research. The most recent results come from a study conducted by Rokop (2003). This research indicates that it is not the act of mandated reporting itself that can cause harm to the therapeutic relationship, but it is the manner in which the reporting is handled by the therapist or any other mandated individual that can be harmful. It is critical that this issue be revisited with more up to date data.

### **5.3.1 The Therapeutic Contract and Confidentiality.**

Mental health professionals have both an ethical and legal obligation to protect the confidentiality of their clients. Exceptions to this include reporting cases of suspected child abuse. In this study, all participants took a similar stance in relation to informed consent practices. The importance of effectively managing confidentiality cannot be overstated. Good practice suggests that responsibility of working with clients and explaining why limitations are necessary will be in the best interests of both the client and therapist. One participant emphasised: *“If the contract is done correctly there is no breach of the contract cause it’s outlined in the beginning, that has set out the terms and conditions of the therapeutic relationship and the confidentiality.”* Literature would indicate that a frank discussion around confidentiality and the limits of confidentiality, lead to a process of informed consent and that this is of upmost importance and extremely useful to the therapeutic process (Bromley & Riolo, 1988, Crenshaw & Lichtenherg, 1993; Nicolai & Scott, 1994). This may indicate that informing the client adequately in advance of beginning treatment helps maintain trust when a report is necessary (Watson & Levine, 1989). Another participant discussed similarly that: *“I think if it’s laid down in the first session, I don’t necessarily think it’s a breach of confidentiality”*.

In Watson and Levine's (1989) study, fewer than one fourth of clients terminated treatment following a report by a therapist. The authors concluded that "reporting abuse is not always detrimental to the goals of therapy and under some circumstances may even be helpful" (p. 255)

#### **5.4 The Need for Protection of Adult Clients making Retrospective Disclosures**

The therapeutic alliance is imperative to help survivors feel safe. Childhood sexual abuse survivors often present with symptomatic problems, feelings, and behaviours that result from the abuse, rather than for the sexual abuse itself. Feelings of fear and of being vulnerable can prevent a client from disclosing childhood sexual abuse. The therapeutic relationship is one where the early deficits such as hope, trust and interpersonal connections, that may have been absent during infancy can be (re)built (Classen et al., 2001). Participants in this study reflected on their awareness that adult survivors of abuse were being lost in the process of mandatory reporting. One participant reported: "*I am not sure what the answer is, but I certainly do think that clients are being lost*".

Similarly another participant commented "*that's where the therapy goes, it's based on reporting not what the actual person is going through*". If this is the case the essence of what psychotherapy is about as outlined in the literature is being lost in this process also. The purpose of psychotherapy must not be forgotten following the implantation of mandatory reporting was the underlying tone of participants.

One participant highlighted that in the case of retrospective disclosures, significant damage could follow if a report is made too quickly for a client: *“Clients aren’t always ready to disclose their experiences beyond the safety of the therapeutic space”*. The psychotherapist’s primary function when working with traumatised individuals is to help them to make sense of their emotional experience (Sanderson, 2006). This involves initially receiving and containing the emotions surrounding the trauma and then in turn attending to the fragments presented and the emotions evoked by them in the therapist. The client must learn to name the elements of their emotional experience before thought about the relationships between the elements is possible. Once a client has an experience of containment this will enable them to develop a way of thinking, and reflect on self function, in relation to early trauma. An essential ingredient of this is the involvement of an emotionally responsive therapist who can help contain the emotional experience in the sense described by Bion (1962). This will in turn give rise to hope that an object is present and emotionally available. It is precisely this that was lacking in their early life. The notion of containment is central to understanding why the ‘meaning-creation’ process of a secure attachment is so crucial for a resilient personality and to enable development to proceed. It also limits the necessity to pass the trauma onto the next generation if it can be adequately worked through.

#### **5.4.1 Therapists Role as Container**

One participant reported that once the therapist can act as the container that clients will not be lost: *“I don’t think the client will get lost if the therapist is able to act as the container because the therapist has to be the container for that [reporting] process.”* The integration of childhood sexual abuse into adult life requires survivors to acknowledge the full painful reality of their childhood experiences and the damage that was done to them. They must learn

to integrate their feelings of fear, rage, desperation and helplessness. The goal in therapy is not to overcome the past; it is to allow for personal integration and growth. When the therapeutic space can provide safety (Sanderson, 2006), holding (Winnicott, 1958) and containment (Bion, 1962) this will allow survivors to move towards change and can regain a sense of empowerment and growth (Winnicott, 1958).

### **5.5 Ineffectiveness of the Process of Mandatory Reporting**

This theme may reflect not only the views of the participants but of many therapists and mandated reporters. Participants had a pervasively negative view of the reporting process in terms of its effectiveness. One participant commented: *“therapists know that when we do make reports very little action is going to be taken in any sort of timely manner”*. Not only were there concerns around the lack of adequate funding to allow for the investigation of child abuse, there was a strong perception that when investigations did occur, they were less than beneficial to the client. One participant expressed: *“Anecdotally in my own clinic I see that all the time with clients, eight months later they get a letter from the HSE and that’s it.”* This echoes findings of previous studies (Zellman, 1990). It was prevalent throughout the interviews that there was disillusion about this process and participants felt that it came into question for who’s benefit was it to report alleged or suspected abuse if nothing is done about it. There was a sense that in principle one could not disagree with mandatory reporting. However, there is no way of guaranteeing that investigations by the relevant authorities will ensure that every alleged case gets pursued to a satisfactory level. Unfortunately, it has been observed that the current system appears to have paradoxical effects. It has had clearly negative side effects, some of which probably adversely affect children’s safety. The Monageer Report (2009) and the Cloyne Report (2011) show evidence of this. There is no

doubt that more specific training is needed which takes account of the barriers and concerns different professional groups experience around reporting. Training, which models itself on a multidisciplinary approach where different groups of health professionals have opportunities to share experiences and learn together, is likely to increase cross-agency collaboration and health service effectiveness (Lazenbatt and Freeman, 2006).

Children First legislation will only be effective if it can be practically implemented. One participant highlighted this point: *“I think that speaks to the law makers not involving people on the ground, i.e therapists thus creating protocols and systems that would attend to all the needs . . . not just about catching perpetrators but also supporting and helping clients, there is a sense that on paper, it makes a lot of sense to do this but behind every report that is sent into the HSE is an individual who is suffering.”*

## **5.6 Strengths and Limitations**

This research was based on qualitative research methods which endorse an exploratory inquiry of human perspectives and interpretations, which gave the researcher a great insight into the participants’ experiences. The main limit was that the literature was based on international investigation due to this being a new topic within Irish society. A further limit of this study was due to the small sample group of four therapists which cannot be seen to represent all therapists. A larger sample size would elicit more information for the research.

The major strength of this research lies with both the extensive experience and knowledge of the participants interviewed, who in turn provided extensive and meaningful data for the research, which both corroborated and conflicted with the literature.

## **5.7 Further Research**

Research in many areas is needed in relation to the topic of mandatory reporting. In particular in a timely manner the effectiveness of the reporting system is an area that needs further investigation. More in-depth research into the impact of mandatory reporting on adult survivors of child abuse needs to be addressed so that Irish society does not continue to fail these individuals. More time and resources needs to be invested in this area to get a true reflection of the struggles and challenges present and how they can in turn be overcome so as to safeguard the protection of the vulnerable members of Irish society.

## **CHAPTER 6.0**

### **CONCLUSION**

Many questions remain unanswered. However, this study set out to examine some of the issues that present, for example the therapist's experience of role conflict as a result of the implication of mandatory reporting and the subsequent effect on the therapeutic relationship.

While mandated reporting continues to cause controversy, it is without a doubt a legal and ethical issue. The very term "mandated" indicates the level of seriousness at which professionals must consider this. Again, research suggests that only a few professionals actually report all suspected cases of maltreatment. Several reasons are given for this phenomenon within the literature, and they include such beliefs as not having enough evidence to make a report, the belief that Social Services will not intervene as needed, cultural differences/competency, and the belief that reporting suspected maltreatment will cause further harm. Certainly, child sexual abuse must be stopped but if it is at a cost to survivors this must be re-examined.

From undertaking this research it is evident that mandatory reporting plays an important role in bringing cases of abuse to the attention of the authorities. However, it is paramount that a holistic approach and reform of existing services is undertaken, this would include but is not limited to: clearer legislation, greater resources, more comprehensive training, raised public awareness and more efficient methods of dealing with reported cases. This would allow for an improvement in efficiency, productivity and effectiveness of the system.

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# Appendix 1

## INFORMATION FORM

My name is Erin Price and I am currently undertaking a BA in Counselling and Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with exploring Mandatory Reporting. I will be exploring the views of people like yourself, all of whom work as psychotherapists

### What is Involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, in having experienced Mandatory reporting. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than 30 minutes to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

### Anonymity

All information obtained from you during the research will be anonymous. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. All data stored will be de-identified. Audio recordings and transcripts will be made of the interview will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

### DECLARATION

**I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.**

**I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.**

**Name of Participant (in block letters)** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date**    /    /

## **Appendix 2**

### **Interview Questions**

1. If it were not for the ethical considerations, how would you feel about mandatory reporting?
2. Do you feel mandatory reporting is a breach of the confidential nature of the therapeutic relationship?
3. To what level if any is the treatment process disrupted due to the issue of Mandatory reporting?
4. Do you feel that the dynamic of a co-created therapeutic relationship shifts to a place where the therapist is holding the power due to legal and ethical implications of mandatory reporting when working with a client who does not wish to proceed to reporting?
5. As mandatory reporting legislation makes the duty to report compulsory, without their discretion in determining whether or not to report. This disregards individual reporters' subjective notions of abuse or neglect, this leads to unsubstantiated notifications and over reporting as reporters are unable to use their own judgment to determine whether their mere suspicions are actual cases of real abuse or neglect. – Do you think this leads to over reporting?
6. Victims of sexual abuse are encouraged to report the crimes against them – but when they do, they can often find themselves isolated from family and friends, with little support from the authorities and the legal system that are supposed to help them. The pressure on victims to report is enormous, yet the support is almost non-existent. Would you agree with this?

7. Do you think clients making retrospective disclosures are being lost in the process of mandatory reporting?