The Missing Link in Child Abuse and Neglect Reporting: Speech-Language Pathologists

by
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DISSERTATION
submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Social Welfare (Ph.D.)
in the Wurzweiler School of Social Work
Yeshiva University – Wilf Campus
New York

November 30, 2022

Abstract

Previous research has noted that there are a variety of barriers and hesitations associated with being a mandated reporter for suspected child abuse or neglect across healthcare professionals and what role interdisciplinary team members have on reporting behaviors. However, the literature has minimally included speech-language pathologists, specifically those working in a medical setting, in this discussion. This study examined the reporting behaviors of speech-language pathologists working in a medical setting on an interdisciplinary team by specifically looking at individual perceptions and experiences with reporting. In a qualitative, phenomenological research study, 10 speech-language pathologists were interviewed. Participants reported that being on an interdisciplinary team is an overall positive experience, however it does not largely contribute to the decision to report suspected child abuse or neglect; rather it was noted that individual experiences are what truly drive reporting behaviors and habits. Barriers associated with reporting included: fear of retaliation, considering possible alternatives to reporting, having an unsupportive administration, a lack of education on familial dynamics and socioeconomic factors when working with families, the presence of an unspoken hierarchy, a lack of knowledge on reporting, and the time associated with making a report. Building on these findings it is evident that there is a lack of education provided for speech-language pathologists on the reporting of suspected child abuse and neglect and that more stringent policies and procedures need to be put in place for reporting. Finally, this study concludes with a discussion of the implications and contributions of this work for speech-language pathology practice and education.

Keywords: speech-language pathology, mandated reporting, interdisciplinary work, phenomenology

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CHAPTER ONE: DISSERTATION OVERVIEW

This study examined the first-person accounts and descriptions of the experiences of speech-language pathologists towards mandated reporting of suspected child abuse. The study was a qualitative inquiry utilizing Edmund Husserl's (1970) phenomenological approach to grasp the essence of this phenomenon across participants. Data was gathered by conducting semi-structured individual interviews with 10 speech-language pathologists who were recruited via purposive sampling. The following NASW Code of Ethics are relevant to the proposed research: service and social justice.

This specific population was chosen for the current investigation due to limited studies on barriers and perceptions of speech-language pathologists towards reporting suspected abuse and neglect of children in a medical setting. Participants from New York and New Jersey were selected due to the primary investigator's academic institute being based in New York paired with existing relationships with facilities in the tristate region. The literature review outlines barriers and hesitations noted in a variety of health care professions both in isolation as well as at the interprofessional level. Studies that included speech-language pathologists were all in school settings, therefore it is imperative to investigate and highlight hesitations and barriers to reporting suspected abuse and neglect in speech-language pathologists in medical settings.

Laws regarding mandated reporting state that any professional who regularly interacts with children is legally considered a mandated reporter including professionals such as educators, health professionals, law enforcement, and social services personnel (Golomb et al., 2017). Given that speech-language pathologists are responsible for the evaluation and servicing of children throughout the lifespan, including those with developmental disorders and

disabilities, such professionals are ideal candidates for reporting suspected child abuse and neglect.

It has been noted that the use of interdisciplinary collaboration has resulted in improved patient care by reducing anxiety and burden in practitioners and an overall increase in the quality of care (Feng et al., 2010). Despite these findings, it has additionally been noted that oftentimes health care practitioners experience tension regarding who holds the ultimate responsibility for patients as this role is frequently assumed by the physician without input from the remainder of the interdisciplinary team (Gergerich et al., 2019).

Hesitations and barriers noted in health care professionals other than speech-language pathologists include reluctance to report suspected child abuse and neglect secondary to concerns with confidentiality, time restrictions, an absence of clear cut policies on reporting, a fear of negative outcomes both for the professional and the patient, and negative views towards child protective services (Wilcox et al., 2017).

This proposal will cover the barriers and hesitations noted in speech-language pathologists when working on an interprofessional team in a medical setting and faced with the need to serve as mandated reporters for suspected child abuse or neglect. It will also review the methodology utilized to obtain background knowledge, the theoretical lens to appraise and support the findings, expected contributions to the field, and study limitations.

CHAPTER TWO: STUDY PROBLEM

Introduction

Child abuse and neglect is a chronic issue that crosses all socioeconomic and educational levels, religions, and ethnic and cultural groups. More than 3.6 million referrals are made yearly to child protection agencies for child abuse and neglect, with such reports involving more than 6.6 million children, and with the United States having one of the worst records among industrialized nations (U.S. Department of Health and Human Services, 2016). While 3.9 million child maltreatment referral reports were received in 2020, only 3.1 million received prevention and post-response services (U.S. Department of Health and Human Services, 2019).

According to the U.S. Center for Disease Control and Prevention, a history of child abuse has been linked to plethora of long-term health issues including ischemic heart disease (IHD), chronic obstructive pulmonary disease, mental health disorders, addiction, and sexual and reproductive health issues (U.S. Department of Health and Human Services, 2016). Additional consequences include poor mental health, decreased long-term educational and occupational achievements, and involvement in the criminal justice system (Snow, 2009). Short and long-term negative outcomes cover a wide array of behavioral issues, psychological disorders, emotional disturbances, and physical health concerns throughout the lifespan (Golomb et al., 2017).

Given the prevalence and impact of child abuse and neglect, federal and state laws mandate that teachers, social workers, and health care professionals report cases of suspected child abuse and neglect. Mandated reporter laws state that any professional who regularly interacts with children is legally considered a mandated reporter, with a failure to report suspected abuse and neglect resulting in possible serious consequences including loss of professional license or criminal charges (Golomb et al., 2017).

Healthcare is a key site for identifying abuse and neglect because victims of child abuse and neglect often present in the emergency department (ED), thereby making ED personnel the first or possibly only mandated reporter who can recognize and report abuse or neglect. Yet, healthcare professionals often fail to fulfill their duty as mandated reporters. Failure to report is often due to familiarity with families, a misconception of Child Protective Services (CPS), or choosing an alternative strategy such as independently following-up with the family (Tiyyagura et al., 2015).

When healthcare providers fail to report suspected abuse and neglect, the consequences can be dire. Previous studies conducted by King et al. (2016), Jenny et al. (1999), and Carty and Pierce (2002) noted that "there is evidence that 20% to 30% of children who died from child abuse and neglect had been previously evaluated by health care providers, including ED providers, for unrecognized abusive injuries" (Tiyyagura et al., 2015, p. 2).

Speech pathologists have potential to play a crucial leadership role in healthcare settings due to their knowledge of speech-related disability. Recognizing that a child is experiencing maltreatment requires the clinician to have knowledge of the child's typical appearance and behavior and then differentiate their baseline from indicators of maltreatment. Such recognition is particularly difficult for children with disabilities as physical indicators or abuse-related behaviors may be attributed to the child's underlying disability (Johnson, 2012). It has been noted that children with a history of maltreatment are less verbal, frequently present with delays in grammar and vocabulary, have limited expressive and receptive language abilities, and delayed semantic abilities. Furthermore, children with disabilities are three times more likely to experience abuse in comparison to their non-disabled peers (Smith, 2019). Risk factors associated with a high rate of maltreatment include interpersonal isolation and overall social

immaturity, reduced knowledge of what constitutes maltreatment, and reduced vocabulary to convey that maltreatment is occurring. For children who present with a range of communication disorders, poor physical health, social difficulties, cognitive dysfunction, and behavioral concerns all play a role in the recognition of possible abuse and or neglect (Johnson, 2012).

Role of Speech-Language Pathology in Child Abuse Identification and Treatment

Speech-language pathologists are professionals who engage in clinical services, prevention, advocacy, education, administration, and research in communication and swallowing throughout the lifespan from infancy to geriatric care (ASHA, 2007). While speech-language pathology is typically noted as a 1:1 treatment discipline, Snow (2009) notes that "the profession also has a vital, but largely unmined role to play in the public health and policy discourse pertaining to child safety and health and wellbeing" (p. 101). Speech-language pathologists who work with children are in a unique position to assist in detection and prevention of child maltreatment as receptive and expressive language deficits are often co-morbidly associated child abuse and neglect. This is often because children with disabilities are unable to understand and communicate that they are being harmed paired with a lack of sufficient self-advocacy and self-protection abilities to stop the abuse (Smith et al., 2016).

Though the work of Hammond et al. (1989) is not current, their findings portray the importance of including speech-language pathologists as a valuable member of the interdisciplinary team when reporting suspected abuse and neglect. Hammond et al. (1989) noted that "soft-tissue injuries, including burns, are the most common physical form of abuse and are usually the earliest manifestation of physical abuse" (p. 1258). Given that abuse and neglect typically presents itself as a chronic disease, repeated incidents are common when intervention is delayed. Hammond et al. (1989) proposed that investigating the presence of a language disorder

could potentially serve as a tool for the recognition of child abuse. Beginning in September 1984, 39 children meeting one or more of the criteria for suspected child abuse or neglect were evaluated by a speech-language pathologist at the University of Miami, Jackson Memorial Burn Center. Children ranged from eight months to eight years, and the mean injury size was 9% of the total body surface area. The following parameters were investigated: language, speech, cognition, play, and behavioral milestones. All children were evaluated by the same speech-language pathologist utilizing the Zimmerman Preschool Language Scale (Revised) and the Sequenced Inventory of Communication Development (SICD); the clinician was aware that there was a suspicion of abuse or neglect. Behavioral observations were defined by the Diagnostic and Statistical Manual (DSM-III), and organized by inappropriate affect, a shortened attention span, irritability, withdrawn behavior, and combative or aggressive play. Play-related observations were organized by tactile defensiveness and self-stimulation (Hammond et al., 1989).

The outcome of the social service investigation indicated that of the 39 children who met one or more of the criteria for suspected child abuse or neglect, that there were sufficient grounds for intervention by the State Department of Health and Rehabilitation Services (HRS) for 27 of the children (69.2%). The presence of a language deficit was the most common finding, present in 22 of the 27 abuse or neglect cases (81%), but present in only five of the 12 accidental burn cases (42%). Both expressive and receptive language deficits were noted, and sixteen (59%) presented with severe language delays. The second most prevalent discovery was a profound decrease in attention span, which was noted in 78% of abuse/neglect patients, but only in 25% of those who sustained accidental burns. “Comparison of the proportional rates of the abused and non-abused children shows that measured levels of language deficit or other described behavioral

characteristics were statistically significantly different or show a near statistically significant trend" (Hammond et al., 1989, p. 1260).

This study provides evidence that speech-language pathologists are valuable members of an interdisciplinary team when assessing for signs and symptoms consistent with child abuse or neglect. While speech and language deficits may not be overtly apparent to medical staff, nurses, or to other members of the child abuse team, the additional knowledge of the speech-language pathologist may contribute to the identification of child abuse and neglect (Hammond et al., 1989). Knowledge of underlying speech and language deficits and how they contribute to communicating possible abuse, aid in the identification of possible abuse and neglect not only for the speech-language pathologist working in isolation but also for those who are on an interdisciplinary team.

Noguchi et al. (2006) aimed to understand the occurrence of child abuse and neglect of children and adolescents who were being treated by speech-language pathologists. Of the 500 self-administered mail surveys sent to a random sample of professionals living in Rio de Janeiro, 224 completed surveys were mailed back, and 54 clinicians (24.1%) stated that they had treated at least one case of an abused baby, child, or adolescent. The most common type of maltreatment was physical abuse, followed by psychological abuse, neglect and abandonment, and lastly sexual abuse. Speech and language problems in this patient population included deficits in reading and writing, genetic syndromes and neurological problems, fluency disorders, voice disorders, and maxillofacial anomalies.

Many children who receive speech and language therapy have a history of experiencing multiple aversive childhood experiences (ACEs) that may go unrecognized by service providers. A history of experiencing frequent and prolonged adversity, including physical and emotional

abuse or neglect, may result in disrupted brain development, thereby placing the child at an increased risk for stress-related disease and cognitive impairment. Given that “ACEs are so disruptive of broad areas of development, speech-language pathologists are likely to have a number of children on their caseloads who have experienced a number of ACEs” (Westby, 2018, p. 3), but it is probable that there many more children with underlying developmental delays associated with ACEs who are not receiving intervention. While attempts continue to be made to differentiate between social, emotional and inherent underlying causes of language deficits, in clinical practice it is over-simplistic to categorize language disorders according to either social or biological risk factors as the two frequently co-occur. It is therefore the responsibility of the treating speech-language pathologist to be cognizant of the possibility that the children they are serving have experienced ACEs (Westby, 2018).

It has been noted that approximately fifty percent of children who experience either child abuse or neglect are estimated to demonstrate delays in communication abilities, and oftentimes a history of maltreatment is overlooked once a child is diagnosed with a speech or language disorder or developmental delay. While universal screening for children with communication deficits could potentially aid in identifying risk factors for abuse, such a system is yet to be implemented. Therefore, as potential reporters of abuse, speech-language pathologists must have a working knowledge of federal and state laws, develop workplace guidelines regarding suspicious case intakes, partake in visual scanning of patients, and regularly review and revise reporting procedures. In addition to making note of pertinent details during the case history intake, the speech-language pathologist should make a conscious effort to be aware of signs of abuse and neglect during assessments such as evaluations of gross motor skills and oral-facial examinations, making note of seasonally inappropriate clothing that may be hiding markings,

multiple bruises, lacerations, and burns. Signs of psychological or emotional abuse that could be noted by the evaluating or treating clinician may include: observable behavioral extremes, bullying of other children, variations in behaviors when parents are present and absent, and a history of running away from home. Indicators of probable sexual abuse that should be noted by the clinician may be spontaneous statements regarding advanced sexual knowledge, sexually explicit drawings, and excessive masturbation (Radford, 1998).

Strategies to better prepare speech-language pathologists to deal with mandated reporting include: networking with other professionals who deal with maltreatment, being familiar with law enforcement professionals, being aware of local organizations that provide services to families about preventing abuse, and understanding that there may be the need to implement interventions that involve parent training (Radford, 1998). Additionally, clinicians should be aware that while physically abused children will perform similarly to their non-abused peers in the areas of vocabulary and grammar, there will be prominent differences in pragmatic skills as "physically abused children, by the nature of their experiences, are socialized to reject conversational partners and to respond impulsively and negatively" (Radford, 1998, p. 3). In contrast, Radford (1998) noted that children with a history of neglect will typically demonstrate delays across a variety of language areas, and unlike those with a history of physical abuse, will be generally more social with adult clinicians eager to receive attention.

Regardless of the pattern of abuse or neglect, children who have a history of maltreatment require the need to heal emotionally. As their knowledge of speech and language expands, the ability to express concerns and fears will present through speech and play behaviors. Incorporating play therapy focusing on emotional concerns may indirectly promote language growth, and "speech-language pathologists can help children who are abused and

neglected with accompanying delays in speech and language by structuring therapy to teach the children the words they need most to express themselves and to label their own emotions" (Radford, 1998, p. 301). To create effective intervention programs that take into consideration both environmental and emotional needs of children with a history of abuse and neglect, the treating clinician should: avoid therapy with closed doors, allow children to reject typical affection including hugs, observe and label expression of positive and negative emotions, creating comforting and predictable routines, and utilize activities that are reasonable and feasible for the child (Radford, 1998).

History of Child Abuse and Mandated Reporting

In the 1870s, child abuse captured the nation's attention when an eight-year-old orphan was sustaining daily beatings at her foster home. At the time, there was no organization to protect abused children. Her case went before a judge who convicted the foster mother of assault and battery, and the case generated enough outrage that in 1874 the New York Society for the Prevention of Cruelty to Children was formed. The concept of child abuse captured the country's attention yet again in 1962 following an article published in the *Journal of the American Medical Association* which outlined symptoms of child abuse and deemed it diagnosable. Within ten years, every state in the nation had mandatory reporting laws, and in 1974, a federal law, the Child Abuse Prevention and Treatment Act (CAPTA) reinforced efforts to eliminate child abuse by funding programs to help individuals both identify and report child abuse (Brown & Gallagher, 2014).

Mandatory reporting laws differ by state however each identify individuals as mandatory reporters to report suspected physical abuse, sexual abuse, emotional abuse and neglect. In some states, mandatory reporters are required to report the abuse or neglect to a proper authority such

as a law enforcement agency or child protective services, while in other states the mandatory reporting laws indicate that any person who suspects child abuse or neglect should report such instances. Per CAPTA there is no federal mandatory reporting provision, however each state must pass their own mandatory reporting provisions to receive federal grants. “All states require at least some professions to report suspected abuse. The most comprehensive statutes require all persons who have reasonable cause to suspect abuse to report, while the least comprehensive statutes require only a small list of named professional groups to report” (Brown & Gallagher, 2014, p. 38). The most comprehensive systems are in the nineteen states that have universal mandatory reporting, while states such as New Jersey and Wyoming still follow the original model for universal mandatory reporting which places the duty for reporting on all individuals without itemizing certain professions (Brown & Gallagher, 2014).

Role of Professional Values

It is the responsibility of the speech-language pathologist to act in the best interest of the patient while upholding the practice values set forth by the American Speech-Language-Hearing Association (ASHA). Values that are specifically pertinent to medical ethics in clinical care include: autonomy, beneficence, nonmaleficence, justice, dignity, truthfulness and honesty. Autonomy refers to a patient or guardian to be actively involved in decisions surrounding their clinical care. In cases involving suspected child abuse and neglect the treating clinician must make an active decision of whether to report concerns therefore potentially disrupting the autonomy of parents or caregivers. The core value of beneficence indicates that it is the ethical responsibility of the treating clinician to always act in the best interest of their patient (Kummer & Turner, 2011). Therefore, reporting cases of suspected child abuse or neglect are the ethical and legal responsibility of the therapist.

Nonmaleficence is the concept of doing no harm. It is thereby the responsibility of the clinician to ensure that any recommendations are based on knowledge and evidence to avoid causing possible harm to the patient or their family (Kummer & Turner, 2011). For cases of suspected abuse or neglect it is imperative to have reasonable suspicion prior to making a report. Justice refers to the rights of all individuals to have equal access to health care. This includes children of any race, gender, class, or citizen status, who may present with communication disorders or developmental disabilities. Given that children presenting with developmental disabilities and cognitive impairments are more susceptible to child abuse and neglect it is the responsibility of the speech-language pathologist to not only provide care but ensure that the child is residing in a safe environment. Children with disabilities are more likely to be abused than children without disabilities (Sullivan & Knutson, 2000), and children with a history of abuse and neglect are more likely to develop disabilities which affect their cognition and language skills (Osofsky, 1995). Dignity is associated with the basic rights of the patient and family, which must be considered while being serviced. No child is deserving of abuse or neglect therefore by serving as a mandated reporter the speech-language pathologist upholds the dignity of their patients. Lastly, truthfulness and honesty are necessary in the ongoing communication between the clinician, and the patient and/or family so that they have all the information necessary to make decisions about their care (Kummer & Turner, 2011).

Role of Professional Training

During undergraduate, graduate, and post-graduate coursework, speech-language pathologists are taught that teamwork is essential for patient-centered care. This is because speech-language pathologists are often members of multidisciplinary teams across a variety of settings. However, there are limited opportunities to take coursework in effective

interprofessional interaction that may play a role in implementing successful interdisciplinary decisions (Gurevich et al., 2019). The American Speech-Language-Hearing Association (ASHA) advocates for interprofessional collaborative practice, and highlights the need for partnerships particularly when working with children who have a history of adverse childhood experiences. There is a symbiotic relationship between speech-language pathologists and mental health professionals as speech-language pathologists must have an understanding about the social and emotional effects of trauma, and mental health professionals need to be able to recognize how communication disorders may disrupt mental health management, as children with a history of trauma are at an increased risk for developmental delays and language disorders (Westby, 2018).

Relevant Policies and Judicial Decisions

Negative outcomes of neglect and abuse require a formal system for ensuring accountability for the protection and welfare of children. The Child Abuse Prevention and Treatment Act (CAPTA), first passed in 1974, has been influential in the determination to advocate for children who are victims of abuse and neglect. CAPTA defines various types of maltreatment which encompass a variety of behaviors that may potentially cause harm. Most states recognize four categories of child maltreatment: physical abuse, sexual abuse, emotional abuse, and neglect (Glynn, 2006). Neglect is then subdivided into the four subtypes of physical, medical, education, and emotional neglect (Vaughn & Boothe, 2014). CAPTA also mandates states to have provisions requiring certain professionals to report suspected child abuse and neglect. While requirements differ from state to state, mandated reporters often include educators, health professionals, law enforcement, and social services personnel" (Golomb et al.,

2017, p. 3). Additionally, failure to report suspected abuse may result in consequences, including the loss of licensure or criminal charges (Glynn, 2006).

According to the US Department of Health and Human Services (2016), approximately 48 States designate professions whose members are required by law to report maltreatment. Speech-language pathologists have the opportunity to gain experience from a variety of clinical interactions, or through choosing to engage in coursework for continuing education licensing requirements. At the pre-licensure stage, graduate students gain knowledge from their clinical fieldwork where they are guided by speech-language pathologists who are licensed and have completed a predetermined amount of coursework on clinical supervision. While graduate students may be introduced to the topic of child maltreatment in their coursework, there are no specific outlined mandates by ASHA regarding this area, though individual states may have requirements for clinicians who work either for public or private schools. Additionally, while the American Speech and Hearing Association's Code of Ethics informs the practice as it relates to child maltreatment, it does not specifically mandate how or when to report (Smith et al., 2016).

Conclusion

Child abuse is a significant problem in the United States with 4.1 million child abuse cases currently affecting 7.5 million children. Consequences and risk factors of child neglect and maltreatment include but are not limited to an increased likelihood of teen pregnancy, increased probability to engage in sexual risk taking behaviors, and the presence of at least one psychological disorder (American Society for the Positive Care of Children, 2020). It has been noted that approximately 30% of abused and neglected children will later abuse their own children therefore continuing and perpetuating the cycle of abuse (American Society for the Positive Care of Children, 2020). Healthcare is a key site for identifying child abuse and neglect

because rehabilitation professionals have the opportunity to consistently work with children and their families. Given their training in typical child development and identification of communication disorders, speech pathologists are in a position to lead interprofessional healthcare teams on early detection, identification, and prevention of abuse and neglect. It is within the scope of practice of speech-language pathologists to utilize their relationships with children and their families to educate team members and ensure abuse is reported. In order for speech pathologists to play a leadership role on child abuse reporting in healthcare settings, more understanding is needed on the barriers to reporting they face. The next chapter will summarize literature on reporting behavior of speech pathologists and other health professions.

CHAPTER THREE: LITERATURE REVIEW

Introduction

The literature demonstrates that multiple barriers exist to reporting behavior among mandated reporters. Though legally required to report suspected abuse and neglect across various settings, studies have noted that health care professionals as a whole are often reluctant to report child abuse and neglect due to concerns of confidentiality, time restrictions within the workplace, a lack of clear policies regarding reporting, a generalized fear of negative consequences both for the patient and the professional, and negative views towards child protective services, (Wilcox et al., 2017). Further, research investigating reporting hesitation has only been conducted within school settings. No research to this author's knowledge has been conducted on hesitancy among speech-language pathologists working in a medical setting when part of an interdisciplinary team.

Interprofessional collaborative practice is becoming increasingly widespread as there is the need to improve health care processes, patient outcomes, and overall costs. While studies such as Mitchell et al. (2002) have shown positive effects of working on an interdisciplinary team, including improvement of patient behaviors and patient satisfaction, Rawlinson et al. (2021) noted barriers including a lack of time and training, a lack boundaries, insufficient knowledge of professional roles, poor communication, and the presence of an unspoken hierarchy. Therefore, there continues to be a need to investigate the perceptions of speech-language pathologists working on an interdisciplinary team in a medical setting to address these barriers and advance collaborative practices.

This literature review presents studies that identify responsibilities of the mandated reporter, discuss hesitations and barriers in reporting child abuse in medical health professionals,

and examine the role that interdisciplinary care plays in improving patient outcomes. The proposed research seeks to address the gaps in the current literature.

Literature Review Methodology

To accurately capture and validate the need to investigate barriers to reporting suspected abuse and neglect in speech-language pathologists working in a medical setting on an interdisciplinary team, the search for relevant literature included searching for articles about hesitations in a variety of medical professionals, reluctance in speech-language pathologists in a range of settings, and interprofessional practice. Search terms included but were not limited to: speech pathology AND mandated reporting, speech pathology AND reporting hesitations, speech therapy AND child abuse, speech therapy AND mandated reporting, interprofessional collaboration AND mandated reporting, interprofessional education AND reporting hesitations. Relevant articles were obtained predominantly from Google Scholar, YU Find, The American Speech-Language-Hearing Association, and the *Journal of Interprofessional Care.* Articles included in the literature review range from 2008-2021.

Literature Review Themes

The subsequent literature review provides an overview of mandated reporting as a whole, mandated reporting across healthcare professionals and speech-language pathologists, a summary on interprofessional teamwork, the education required for effective interprofessional collaboration and mandated reporting, and an inspection of power dynamics on interprofessional teams.

Mandated Reporting

Much of the known literature on reporting behavior focuses on the social work profession, educators, and medical professionals while disregarding health care workers who

have consistent contact with children who may be at risk for abuse and neglect. Looking at a wide array of professions, McTavish et al. (2017) conducted a systematic review of research regarding the effectiveness of mandatory reporting of child maltreatment and synthesized the experiences of mandated reporters. The meta-synthesis included 42 studies representing the viewpoints of 1088 mandated reporters including, "231 physicians, 224 nurses, 168 CPS professionals, 156 teachers, 114 psychologists and therapists, 85 social workers, 19 dentists, 16 domestic violence workers and 16 police officers" (p. 4). Of the articles analyzed, 91% noted the construct of reporters being undecided on when to report as they questioned the available evidence, perceived impact, and context of the family. Other factors noted by mandated reporters included their level of trust and collaboration with other professionals throughout the reporting processes, a general burden felt as a response to reporting, and feelings of ineffectiveness regarding the process, limited support, negative feelings regarding filing a report, conflicting values regarding child rights and well-being, and overall perceived responsibility. Of the 42 studies, only six articles made mention of mandated reporters noting training on how to recognize and respond to child maltreatment (McTavish et al., 2017).

Using qualitative methods and individual interviews Feng et al. (2012) sought to understand the ethical and legal challenges faced by professionals when deciding when to report child abuse impacting challenging child abuse cases. The sample consisted of 18 professionals including social workers, physicians, nurses, and teachers. Thirteen disclosed that they had reported suspected child abuse, while 5 indicated that they had failed to report at least one case of suspected child abuse. A structured interview guide was used to obtain a description of the experiences of reporting child abuse and the ethical and legal barriers to reporting. Interviews lasted 60-100 minutes and were transcribed verbatim. Following transcription and coding, three

categorical themes emerged: conflicts, time, and law as refuge. Conflicts were further categorized as: ethical conflicts, sympathy versus responsibility, and cultural norms versus responsibility. It was consistently noted that all professionals desired to do no harm, and therefore sought evidence to accurately portray cases of suspected abuse. It was noted that a professionals' sympathy for family hardships exacerbated the difficulty of having to report suspected abuse, and when there is a cultural emphasis on parental rights and familial privacy, the choice to report abuse often contradicts the norms and values of a given society.

Time constraints paired with an uncertain future were noted by participants who reported caring about the child's future and wanting to do no harm. Though the law states that professionals have the right and responsibility to intervene in cases of abuse it is evident that professionals continue to require support when working through individual cases. While professionals seek to advocate for children based on a code of ethical conduct, they often question if their actions will do more harm than good (Feng et al., 2012).

Schols et al. (2013) aimed to investigate patterns of Dutch frontline workers' child abuse detection and reporting behaviors. The study was conducted at two Dutch health service organizations and three primary schools in The Netherlands. Participants were healthcare nurses, public child healthcare physicians, primary school teachers, and a school principal. Focus group interviews were completed according to the participants' profession with the hope of creating a homogenous environment to explore the opinions and experiences of the subgroups. The researchers used a set of interview topics to guide discussions based on three main topics: signs of child abuse, the value of having a child abuse detection tool, and dealing with signs of child abuse. Data analysis included thematic analysis to identify key issues. The primary investigator

developed a codebook according to the themes and issues noted across interviews (Schols et al., 2013).

It was noted by Schols et al. (2013) that teachers consistently reported that their awareness of the baseline rates of child abuse is lacking, and that they do not always want to acknowledge the gravity a child's situation, therefore making excuses both for themselves as well as for the parents. It was reported by some teachers that they had concerns that a child's situation may become exacerbated as a result of reporting, with parents choosing to move the child to a different region. Barriers experienced by teachers included feelings of guilt towards the child when reporting suspected abuse and neglect, fears of how parents would react, and fears of false positives. Teachers directly reported "their need for practice in communication skills" (Schols et al., 2013, p. 8) and "indicated that they have difficulty finding the right words in their dialogue with parents" (Schols et al., 2013, p. 8). Such findings support the need for speech-language pathologists to have greater involvement in child abuse and neglect reporting as their expertise lies in communication skills.

In the Schols et al. (2013) study public child healthcare workers "expressed their dissatisfaction with regard to the quality, speed, and continuity of care started at the request of public child health" (p. 11). They noted not always being taken seriously by child abuse reporting agencies, and mentioned a lack of support from higher management. Barriers to reporting noted by healthcare professionals included losing contact with parents, and overall safety risks of retaliation. Of the 33 frontline professionals interviewed by Schols et al. (2013), teachers appeared to have less knowledge of the signs of abuse in comparison to public child healthcare workers, stating that "public child healthcare workers might be better at detecting child abuse risk factors and child abuse than teachers" (p. 13), therefore providing support

for speech-language pathologists working in a healthcare settings as ideal reporters for suspected child abuse and neglect should it be encountered.

Forsner et al. (2021) sought to explore professionals' experiences and deliberations in situations where child abuse or neglect was suspected. The researchers utilized a mixed method approach to investigate the experiences of school professionals to further understand how they think, reason, and act. The study was completed within the primary school system in Sweden and included six primary schools representing both public and private institutions. School team members and staff included principals, nurses, teachers, auxiliary staff, counselors and psychologists. Interviews were completed utilizing two interview techniques, the narrative interview and the think-aloud method. While the narrative interview allowed the researcher to gain knowledge of participants' experiences of concrete situations of suspected abuse and neglect, the think-aloud technique was utilized to generate new perspectives which responded to the following three questionnaires: *The Moral Sensitivity Questionnaire (MSQ), Work Related Moral Stress Questionnaire (WRMS),* and *The Ethical Climate Survey (ECS).* Qualitative data analysis included narrative transcription which was divided into meaning units and the units were then coded and analyzed according to similarities and differences and then placed into categories; quantitative data analysis was completed utilizing SPSS software, version 24 (Forsner et al., 2021).

In Forsner et al.'s (2021) study participants described scenarios when they had to decide whether to report suspected abuse and/or neglect. When faced with the possibility of child maltreatment three phases were identified: awareness, deliberation, and aftermath. Experiences during the three phases were further described as: feeling concerned about the child, deciding whether to report, identifying what is best for the child, maintaining a relationship with the child

and the family, considering possible negative consequences from reporting, and overall long-standing concerns. Awareness presented as feeling concerned about the child, and deliberation included consideration of whether to report, and what is best for the child while considering future relationships with the child and family. It was noted from the interviews that negative consequences from previous action influenced the participants' experience and affected participants morally and emotionally (Forsner et al., 2021). "The participants, in this study, expressed a sense of personal vulnerability; being exposed to threats and being questioned by colleagues and social service as to their observations of suspected child abuse" (Forsner et al., 2021, p. 605). The findings from Forsner et al. (2021) shed light on the moral complexity involved in the decision-making process of whether to report child abuse and neglect. Though the interview professionals were able to identify the signs of maltreatment, and understood their legal responsibilities, the most notable barrier to reporting was fear of adverse consequences for the child.

Mandated Reporting Across Healthcare Professionals

The objective of Herendeen et al. (2014) was to examine the experiences of pediatric nurse practitioners (PNPs) in identifying and managing cases of child abuse, to determine how frequently they report child abuse, and to describe the effects, attitudes and overall confidence in reporting. A survey adapted from one previously utilized with members of the American Academy of Pediatrics was sent to 5,764 members of the National Association of Pediatric Nurse Practitioners. Six hundred and forty-three respondents started or completed the survey with a total response rate of 11%; 604 were utilized in the final analysis. The responding PNPs were surveyed on their attitudes and experiences with Child Protective Services (CPS), and their attitudes and confidence regarding their ability to recognize and manage cases of child abuse.

Respondents were additionally presented with two case studies; one which clearly contained a case of child abuse, with the second case being ambiguous. Following review of the case study the PNPs were asked to indicate the probability that abuse had occurred, their recommendations for referral, and whether they would take further action to report the case to CPS (Herendeen et al., 2014).

Of the PNPs surveyed by Herendeen et al. (2014), 89% reported that they had seen a case of suspected child abuse, and 46% had seen at least one case in the past year. Twenty percent indicated that they had not reported every child with suspicious injuries either due to a previous referral to CPS, referral to another professional, working one-on-one with the family, disagreement with the collaborating physician on the assessment, or request of the physician to not pursue reporting. The most common negative consequence to reporting was losing a family as patients, and "additionally 19% reported that the child experienced further abuse because the agency did not act or did not act quickly enough" (Herendeen et al., 2014, p. e4). Over half of the respondents either disagreed or strongly disagreed that CPS kept them informed regarding the findings of the investigation, and 21% reported that CPS services were inadequate. Seventy percent expressed confidence in identifying children at risk for abuse, and nearly 60% expressed confidence in managing cases of maltreatment.

PNPs identified continuing education in child abuse as a confidence enhancing factor to reporting suspected abuse. It is concerning that cases of a physician suggesting that the PNP not report possible child abuse as there is the belief that teamwork and interdisciplinary teams provide the most effective patient care. This study further supports the need for ongoing child abuse education to practicing PNPs (Herendeen et al., 2014). The findings of Herendeen et al. (2014) are consistent with the hesitations towards reported noted in both Schols et al. (2013) and

Feng et al. (2012), however only include PNPs in their sample. As PNPs are often on the same interdisciplinary team with speech-language pathologists working in a medical setting, and frequently have the opportunity to make referrals for pediatric speech and language evaluations, examining if barriers are consistent between professions would allow for future training on team approaches to reporting suspected child abuse and neglect.

Jones et al. (2008) evaluated study data: "(1) to identify the factors that clinicians weighed when deciding whether to report injuries they suspected might have been caused by child abuse; (2) to describe clinicians' management strategies for children with injuries from suspected child abuse that were no reported; and (3) to describe how clinicians explained not reporting high-suspicion injuries" (p. 259). Of the 434 pediatric primary care clinicians who participated in the Child Abuse Reporting Experience Study (CARES) and who noted that they had previously provided care for a child with a suspicious injury, a subsample of 75 clinicians completed a telephone interview. The interviewees included 36 clinicians who suspected child abuse, however did not report the injury, and 39 clinicians who reported a suspicious injury. Interview data was analyzed utilizing ethnographic techniques and coded. Themes identified were grouped into four main categories with a focus on: (1) the clinicians' acquaintance with either the child or their family; (2) reference to components from the case history intake; (3) use of available resources; and (4) perceptions of the outcomes of CPS intervention. It was noted that when pediatric primary care clinicians chose not to report, they planned alternative management strategies including case follow-up. "When interviewed, some clinicians modified their original opinion that an injury was likely or very likely caused by abuse, to explain why they did not report to child protective services" (Jones et al., 2008, p. 259). It is evident through Jones et al. (2008) that decisions regarding reporting to CPS are guided by individual circumstances,

experiences with the family, consultation with other professionals, and previous experiences with CPS. Given the consistent contact that speech-language pathologists have with children on their caseloads as well as with families, it is vital to further investigate patterns and hesitations associated with reporting when the speech-language pathologist is practicing in a medical setting.

Other studies have noted that healthcare professionals are reluctant to report child abuse due to decreased confidentiality, time restrictions, a lack of protocols and policies for reporting, a lack of formalized training on how to recognize and report child abuse and neglect, a fear of negative consequence and for the patient, negative views towards CPS, ethical conflicts, and cultural issues (Wilcox et al., 2017). Given the noted themes regarding hesitations and barriers to mandated reporting it is imperative to investigate if such themes are consistent in other health care professions, including speech-language pathology, to remediate and focus efforts on how to be effective reporters of suspected abuse and neglect.

Mandated Reporting Among Speech-Language Pathologists

To date studies investigating hesitations in reporting suspected child abuse and neglect have only been completed with speech-language pathologists working in school-based settings. Deterrents to reporting include: a lack of knowledge regarding the indicators of abuse and questions on how to report suspicions, anxiety regarding incorrectly reporting abuse resulting in negative consequences; and a lack of confidence in child protective services to investigate the report (Smith, 2019).

Smith (2019) aimed to examine the relationship between school speech-language pathologists' reporting practices and their attitudes toward maltreatment while controlling for the demographic variables of gender and ethnicity. The study utilized a convenience sample of 117

licensed school-based speech-language pathologists across the United States. The sample was comprised of males (n=3) and females (n=114), which is consistent with the current gender ratio within the field. All participants completed an online survey consisting of demographic questions, the Teacher Reporting Attitude Scale (TRAS), ten short vignettes, and ten images of possible child maltreatment. The TRAS was used to measure the predictor variables of commitment, confidence, and concern. The ten vignettes and images were judged using a seven-point Likert-type scale ranging from one to seven with one indicating, *definitely would not report*, and seven, *definitely would report*. Descriptive statistics included a hierarchical multiple regression while controlling for demographic variables.

Concern was noted to be the strongest predictor of reporting practices among participants. Attributes associated with concern are intrinsic to the profession of speech-language pathology. Male speech-language pathologists appeared to be more interested in solving the central problem of child abuse and neglect in the United States, whereas females were noted to focus on the impact that maltreatment has on individual children. Overall all "practicing professionals appear concerned about the problem and interested in facilitating improved reporting practices" (Smith, 2019, p. 5). Given that Smith (2019) only focused on speech-language pathologists working in school settings, future studies are necessary to investigate the attitudes and reporting practices of speech-language pathologists in a variety of healthcare settings.

Interprofessional Teamwork

According to the World Health Organization interprofessional collaboration is defined as, "multiple health workers from different professional backgrounds working together with patients, families, carers (caregivers), and communities to deliver the highest quality of care"

(World Health Organization, 2010). Hallmarks of interprofessional practice include a focus on integrated care, teamwork, communication and respect, and when assessment and intervention conclusions are made by a team as opposed to an individual health care provider, the care becomes more effective and patient-centered (Wilcox et al., 2017).

In response to the need for interprofessional learning (IPL), the Interprofessional Education Collaborate (IPEC) was formed and 38 competencies for interprofessional practice were created across the following four domains: Values and Ethics, Roles and Responsibilities, Interprofessional Communication, and Teams and Teamwork (Almendingen et al., 2021). Anyone who is involved in health care can engage in interprofessional collaboration including doctors, nurses, hospital staff, public health professionals, and social workers. Benefits may include improved quality of patient care, increased patient satisfaction, and a reduction in costs secondary to reducing redundancy and improving efficiency.

Flood et al. (2019) explored professionals' experiences of engaging in interprofessional collaboration to uncover what truly matters and lies at the heart of interprofessional practice. The philosophy and methodology of hermeneutic phenomenology was utilized for this investigation as the researchers sought to explore the phenomenon of interprofessional practice through stories to uncover how professionals understand their role in such partnerships. The study took place in Aotearoa, New Zealand, and participants were recruited across the professions of nursing, physiotherapy, occupational therapy, speech-language pathology, medicine, social work, and midwifery. In-depth semi-structured interviews were completed by the lead researcher between December 2014 and July 2015 to capture participants' experiences and perspectives regarding interprofessional practice. Interviews of 45-65 minutes in length were recorded and transcribed verbatim. When engaging with the data it was noted that there were three main ways in which

participants described their experiences; “those things which called them to interprofessional practice, things that were occurring in the midst of the being and doing interprofessional practice, and things that safeguarded and preserved the way of working” (Flood et al., 2019, p. 746).

During their analysis Flood et al. (2019) noted that across professions, participants’ stories revealed that there was a sense of calling from beyond to engage in collaborative work with other professionals. It was additionally noted that each professional’s past experiences, beliefs, and individual interpretations play a role in how and when they will choose to partake and initiate interprofessional practice. When interpreting all the narratives, it was noted that being compassionate and patient-focused united members within the interprofessional team. Interprofessional practice therefore thrives when each member feels valued and respected by other team members (Flood et al, 2019). Though each interprofessional interaction is influenced by a variety of human and contextual factors, allowing for open dialogue and respect, while placing the patient at the center of care, allows for effective interprofessional care and decision making to take place.

Given that shared leadership in healthcare involves shared responsibilities between interprofessional team members, Ong et al. (2020) examined the influence of team characteristics and team conditions on leadership roles during interprofessional team meetings (IPTMs). A cross-sectional study of healthcare professionals who attended IPTMs at subacute and palliative care wards at a hospital in Singapore was completed. Such meetings are imperative as they allow team members to meet and discuss complex care needs of mutual patients to formulate a plan of care while utilizing the expertise of each profession, and are comprised of physicians, nurses, pharmacists, physiotherapists, occupational therapists, speech therapists, dieticians, care coordinators, and social workers. The study utilized the 14-item Clinical Leadership Scale

(CSLS) and measured internal team environment (ITE) and transactive memory systems (TMS). All statistical analyses were conducted using STATA 12, and a total of 133 healthcare professionals completed the survey (Ong et al., 2020).

The findings of Ong et al. (2020) revealed several vital considerations when creating an interprofessional team responsible for shared decision-making for patient care. It was noted that when teams are more mature and have a positive working relationship, team leaders have the opportunity to maximize on the internal team environment (ITE) to support shared leadership, however when teams are less mature, leadership can best be utilized to build upon existing transactive memory systems (TMS) by sharing and exchanging experience and expertise. When engaging in decision-making, individual team members depend on previous experiences and memories, therefore in order for leadership responsibilities to be shared, a certain level of knowledge must be present. In addition, for a team environment to contain fluid leadership, there must be a sense of acceptance between members (Ong et al., 2020). If a positive working environment stimulates a perception of shared leadership, then a focus nurturing such interactions may eliminate stressors associated with the presence of a hierarchy among interprofessional teams.

While interprofessional collaboration has the potential to improve population health and enhance patient care, deficiencies in interprofessional communication and teamwork may weaken patient care and patient outcomes (Ulrich et al., 2019). Ulrich et al. (2019) sought to evaluate and compare the interprofessional attitudes of young healthcare professionals including pediatric nursing graduates, physical therapists, and speech and language therapists utilizing the German version of the University of Western England Interprofessional Questionnaire (UWE-IP). Ulrich et al. (2019) identified positive and neutral attitudes toward interprofessional

collaboration and learning in the overall UWE-IP scores. Additionally, all three professions noted similar attitudes towards interprofessional collaboration despite their different scope of practice. Unlike the findings of Ulrich et al. (2019), Reeves et al., (2016) suggested that health professionals do not always work together effectively, and Gilbert (2005) observed that students in various healthcare professions are not effectively prepared to collaborate with other professionals during their future careers due to minimal time spent on common learning activities.

Interprofessional Education as Foundation for Effective Interprofessional Teams

For interprofessional collaboration to be successful, interprofessional education (IPE) must take place. Such activities have been noted to be more relevant and successful when the participants engage in small groups rather than partaking in larger lectures. To investigate interprofessional education practices Mills et al. (2020) utilized a mixed-methods study design to evaluate a novel simulation-based IPE activity for students from occupational therapy, speech pathology and dietetics. All participants completed a three-hour IPE workshop; prior to the workshop all students received a patient case study and medical chart for review. Upon arrival to the workshop students were randomized into interprofessional teams of eight to nine students with at least one person representing each discipline. All participants were undergraduate students in occupational therapy or speech therapy, and postgraduate dietetic students. Prior to and following the IPE experience, all participants were presented with the Readiness for Interprofessional Learning Scale (RIPLS) which is designed to evaluate the thoughts and perceptions of students and professionals to the importance of interprofessional practice. The four subscales on the RIPLS include: “(1) teamwork and collaboration, (2) negative professional identity, (3) positive professional identity, and (4) roles and responsibilities” (Mills et al., 2020,

p. 474). Additionally, the Simulation Design Scale (SDS) was utilized to assess perceptions of the objectives outlined, information, support, problem solving skills, and feedback and fidelity of simulation. At the close of the workshop, students were invited to partake in focus groups to discuss the IPE event. A semi-structured interview guide was utilized to ensure consistency, and included a set of topic points for the facilitator. Focus group discussions were transcribed verbatim and significant statements and quotes were coded by two coders who reviewed the data to arrive at a final consensus on codes and themes (Mills et al., 2020).

Of the 69 students who participated in Mills et al. (2020), there was a 100% response rate in both pre- and post-workshop data. When comparing the total of the Readiness for Interprofessional Learning Scale pre- versus post-simulation, a paired samples t-test indicated that attitudes towards interprofessional practice improved. Additionally, there were statistically significant improvements in attitudes across the factors of teamwork, and negative and positive professional identity. All discussion sections were well received by students who noted that having small group discussions allowed for the sharing of thoughts, and that such discussions allowed for the improvement of an underlying knowledge base about how other disciplines operated. It was reported that students increased their confidence following participation in the workshop (Mills et al., 2020), providing evidence that early exposure to interdisciplinary practice is important for future clinicians to work together to produce improved patient outcomes. Noted barriers such as reduced time and resources paired with scheduling conflicts were noted by pre-licensure level students who were aware of future limitations thereby reinforcing interprofessional education prior to licensure. Though Mills et al. (2020) targeted occupational therapists, speech therapists, and dietetics students, these three professions typically work together in the acute adult setting, rather than with the pediatric patient population.

Interprofessional Teamwork and Mandated Reporting Behavior

Given the complexity of child abuse, research shows that the utilization of multidisciplinary collaboration allows for better patient care. By engaging in collaborative care to protect children, there is a reduction in anxiety, a reduced burden of caring, reduced risk of being targeted by family members, and overall improved quality of care and communication among care providers (Feng et al., 2010).

Successful models have been developed to improve reporting behavior through interprofessional teamwork. Victor-Chmil and Foote (2016) utilized the Child Abuse Reporting Interprofessional Simulation-Based Learning Experience (CAR-ISBE) to provide nursing and pharmacy students the opportunity to work together to problem solve and collaborate and communicate in a representative yet safe environment in which child abuse and neglect must be reported. Following the simulation, participants indicated interest in wanting to participate in more interprofessional activities, stating that they felt a sense of teamwork with the other participants, and reporting that they felt better prepared to collaborate in an interprofessional setting (Victor-Chmil & Foote, 2016).

Wilcox et al. (2017) sought to examine the attitudes of students working in interprofessional healthcare teams and their readiness to work in such teams. For this study, students from nursing, social work, and medicine served as participants. Faculty members from the respective departments developed complex scenarios related to child abuse and domestic violence, utilizing best practices in the creation of simulation scenarios. Overall it was noted that simulated scenarios are a step towards improving barriers between interprofessional collaboration as well as individual reluctance to report child abuse (Wilcox et al., 2017). This is consistent with Vaughn and Boothe (2014) who noted that, “mandated reporters need to have

someone with whom they can discuss fears and hesitations, can help support them in thinking through decisions such as disclosing the report and how to do so. It is best if this supporting relationship can be determined in advance of a suspected abuse or neglect situation so that mandated reporters are clear about whom they can contact" (p. 15).

Power Dynamics on Interprofessional Teams

When poor communication exists among health care professionals, there becomes an increasing possibility of adverse patient outcomes. Though health care systems have been historically hierarchical, the existence of a tiered structure may result in conflict. Gergerich et al. (2019) sought to analyze qualitative data from a four-day interdisciplinary training which "included seven students in a counseling psychology doctoral program, nine students in a nurse practitioner program, eight pharmacy students, and seven family medicine residents" (Gergerich et al., 2019, p. 530). Students were placed into teams with each team having representatives from each profession. Faculty used the core objectives from the national Interprofessional Education Collaborative (IPEC) competencies focusing on the values and ethics of various professions, effective communication, and efficient teamwork.

Following the immersion all participants joined a focus group consisting solely of individuals from their profession. "The results reflect that the participants experienced tension during the training about who holds ultimate responsibility for patients, who is important on the team, and how their roles fit together" (Gergerich et al., 2019, p. 530). Members from all disciplines noted their understanding that the physician is frequently the leader of the team, however feelings of uneasiness towards hierarchy and marginalization were still unresolved following the interdisciplinary training. When such frustrations arise, and hierarchy is left undiscussed, professional training becomes weakened which may result in an overall reduction

of professionals wanting to partake in interdisciplinary work. To avoid such consequences Gergerich et al. (2019) suggest that interprofessional education should consider presenting various leadership models and discussions surrounding typical hierarchical structures within health care with the opportunity to consider alternative models.

Conclusion

While there is a plethora of research available regarding hesitations associated with mandated reporting, the majority of studies involve nurses, pharmacists, social workers, psychologists, and physician assistants. Though a couple of studies have investigated hesitations of speech-language pathologists regarding reporting, the current literature only includes speech-language pathologists working in school-based settings. No research to date has investigated concerns specifically in speech-language pathologists working in medical settings, nor has the current research addressed the role of interdisciplinary teamwork between healthcare professionals, including speech-language pathologists, occupational therapists, physical therapists, and medical professionals on mandated reporting.

The current investigation seeks to explore if hesitancy to report suspected child abuse and neglect noted in other healthcare professions is consistent with speech-language pathologists working in medical settings, how mandated reporting is approached when working on a team, and if interdisciplinary work reduced hesitations. Further, it is important to investigate this phenomenon as speech-language pathologists in a medical setting are consistently interacting with pediatric patients, and are integral members of the interdisciplinary team.

CHAPTER FOUR: THEORETICAL FRAMEWORK

This section will cover three comprehensive theoretical frameworks that inform the study content and methodology of the current investigation. The three presented frameworks are intrinsically connected to the proposed research, spanning the underlying motivation to report suspected abuse and neglect, describing the processes that result in possible reluctances and obstacles, and providing support for interdisciplinary collaboration.

Theory of Reasoned Action

The theory of reasoned action (TRA) is grounded in the notion that an individual's goals and behaviors are comprised of their attitudes and subjective norms. In addition, an individual's attitude towards a subject is directed by their emotions and feelings, whereas subjective norms are frequently dictated by mentors, family, friends, and societal expectations. A person's behaviors and actions are therefore frequently shaped by their life experiences (Smith, 2019).

In the past, the theory of reasoned action has been utilized to explain the relationship between behaviors, social norms and individual attitudes in various contexts including healthcare and marketing. This theory can also be applied to predicting behavioral patterns in violent social situations, as the theory utilizes an individual attitude variable paired with a social norm variable to then predict behavioral intentions. Observable and reported behavioral intentions have been noted to be predictive of future behavior executions, therefore if an individual has an intention to perform a behavior there is a greater likelihood that the behavior will be executed (Sulak et al., 2014). "Behavioral intentions allow this model to be applicable in a wide variety of situations because a participant does not actually have to execute the behavior, only express the intention to act" (Sulak et al., 2014, p. 166).

Sulak et al. (2014) sought to examine the relationship between domestic violence and hypothetical outcomes utilizing the theory of reasoned action as their underlying framework to answer the following research questions: “(1) Does the theory of reasoned action explain the relationship between behavior, behavioral intentions, social norms and attitudes about domestic violence in a sample of youth and young adults? and, (2) Do the relationships differ by victimization and sex?” (p. 167). All models proposed by the investigators fit the data suggesting that both beliefs and attitudes towards domestic violence may influence the goals and behaviors during violent situations.

These findings provide support for the portion of the theory of reasoned action which explains the relationship between beliefs and attitudes to intentions and behaviors; per the theory the intention to engage in a behavior predicts engagement in the behavior. Sulak et al. (2014) additionally identified that social norms were more predictive of intention to report in comparison to attitudes. Such findings have imperative clinical implications as many interventions seek to change attitudes related to the justification of the use of violence.

Utilizing this framework, “from the perspective of child maltreatment, one might posit that a school- based speech-language pathologist’s attitudes and subjective norms directly influence their decision (e.g., action) to report alleged maltreatment” (Smith, 2019, p. 2). For the current investigation application of the theory of reasoned action relates to understanding how attitudes and social norms affect the reporting of suspected child abuse and neglect and could be helpful for clinicians who are serving affected children. Given that the theory of reasoned action can be utilized for predicting an individual’s behavior as it states that the best predictor for a behavior is their intention to perform that particular behavior, it can be postulated that the intention of a speech-language pathologist to partake in mandated reporting is influenced by their

attitudes towards suspected child abuse and neglect. Individual intentions are additionally influenced by the attitudes of the people who are important to the clinician including interdisciplinary team members. Given that individuals typically choose to perform behaviors that they feel positively about, and that they are less likely to perform a behavior that is unpopular with others, the importance of disseminating information regarding suspected child and abuse is necessary to all team members within a given interdisciplinary team. While the theory of reasoned action has been noted to predict behavior more successfully than models that only consider attitudes, this theory is only applicable to deliberate behaviors, therefore when there are scenarios when there are barriers to a particular behavior, an extension of the theory of reasoned action, the theory of planned behavior (TPB) can be applied.

Theory of Planned Behavior

The theory of planned behavior, an extension of the theory of reasoned action, notes that "intention is the best predictor of behavior, and it is a function of the persons' attitude toward performing the behavior and general subjective norms concerning the performance of the behavior" (Feng & Wu, 2005, p. 338). According to the theory of planned behavior, any behavior produced is determined by an intention to follow through with the behavior with intention being determined by one's attitude toward the behavior, subjective norms, and perceived behavioral control. Generally, the more favorable the attitude and the norms associated with a task, the stronger the intention to perform the behavior that is in question (Feng & Wu, 2005). Therefore, according to this model, for the current investigation, it is postulated that in order for a speech-language pathologist to engage in mandated reporting of possible abuse or neglect they must feel that the reporting would have a positive outcome for the child and their

family, that those who they professionally respect are expecting the clinician to partake in mandated reporting when appropriate, and that they have control over the reporting.

The theory of planned behavior has been utilized in predicting and explaining human behavior via a level of beliefs. Investigation into the level of beliefs allows researchers to understand why some individuals choose to partake in a particular behavior, while others choose a different course of action. The three constructs of attitude, subjective norms, and perceived behavioral control (PBC) represent three types of beliefs that are useful in understanding elements of behavior. Subjective norms refer to social pressures or expectations to either perform or not perform a behavior and include an individual's level of motivation to comply or not comply with expectations (Abdullah et al., 2020). By applying the theory of planned behavior Abdullah et al. (2020) examined the relationship between attitude, subjective norms, and perceived behavioral control and how they apply to the intent of reporting child abuse by formulating the following three hypotheses: "H1: There is a significant relationship between attitude and intention to report suspected child abuse; H2: There is a significant relationships between subjective norms and intention to report suspected child abuse; H3: There is a significant relationship between perceived behavioral control and intention to report suspected child abuse" (Abdullah et al., 2020, p. 230).

Abdullah et al. (2020) identified that while the relationship between subjective norms and society's intention for child abuse reporting and the relationship between perceived behavioral control and society's intention for child abuse reporting is significant, the relationship between attitudes towards child abuse and society's intention for child abuse reporting is not significant. It was noted that subjective norms emerge as the greatest factor for influencing the reporting of suspected child abuse thereby indicating that deciding not to report is influenced by both social

pressures as well as the motivation to conform to societal expectations (Abdullah et al., 2020). Utilizing these findings, it is imperative to instill within the individual, team, and culture a collective responsibility to report suspected child abuse and neglect.

Christodoulou et al. (2019) used both the theory of reasoned action and the theory of planned behavior to predict teachers' intentions to report child maltreatment. While both theories view behavior as the outcome of purposeful deliberation, the theory of reasoned action proposes that behaviors result from intentions to perform them as a function of one's attitude paired with pertinent norms, whereas the theory of planned behavior adds perceived behavioral control in addition to attitude and subjective norms. Utilizing the theory of reasoned action, the researchers hypothesized that teachers' intentions to report child maltreatment would be predicted according to their attitudes paired with subjective norms towards reporting suspected child abuse regardless of the type of abuse and severity. Based on the theory of planned behavior it was hypothesized that teacher's intentions to report child maltreatment would be predicted by attitudes, subjective norms, and the teachers' perceived behavioral control regardless of the type and severity of maltreatment (Christodoulou et al., 2019).

The findings of Christodoulou et al. (2019) indicate that while the theory of reasoned action is better for predicting the intention to report lower severity cases, the theory of planned behavior is better suited for high severity cases; "the difference as concerns the predictive power of these theories is related to the additional variance explained by perceived behavioral control" (p. 522). Utilizing these findings, it can be concluded that to report high severity cases one must have not only both favorable attitudes and subjective norms, but also a sense of having control over the reporting. Such discoveries are concerning as incidents that one would expect to be the most urgent to report would be the scenarios that pose the greatest barriers to reporting

(Christodoulou et al., 2019). For the current investigation, it is therefore important to explore what factors affect clinicians' beliefs and thereby hinder or enable the speech-language pathologist to report suspected child abuse and neglect.

Zielinska-Tomczak et al. (2021) utilized the theory of planned behavior to understand the intentions of pharmacists and physicians regarding interprofessional collaboration by "evaluating their attitudes, subjective norms, and perceived behavioral control variables to identify factors crucial to developing their behavioral intention towards it" (Zielinska-Tomczak et al., 2021, p. 2). Semi-structured interviews were conducted, with sixteen pharmacists and eleven physicians, and content analysis identified the following six main themes: "the relationship between previous experiences and attitudes towards collaboration, pharmacist's role in collaboration, mutual reluctance toward collaboration, the role of decision- and policy-makers, knowledge and qualifications gaps in collaboration, and lack of organizational paths" (Zielinska-Tomczak et al., 2021, p. 4). It was noted that previous experience of collaboration between the two professions affected their future views towards establishing a partnership and that the majority of participants held positive beliefs towards the effectiveness of interprofessional work. It was additionally noted that participants described a voluntary isolation between the two professions resulting in coinciding reluctance to contact the other, paired with the predisposed stereotype of both professions indicating subjective norms. A lack of knowledge regarding mutual competencies, the opportunity to partake in collaboration, and overarching perceived behavioral control may therefore limit the possibility to cooperatively engage. Lastly it was concluded that providing opportunities to collaborate may facilitate contact between the two professions, whereas an absence of such may serve as a barrier to interprofessional collaboration indicating perceived behavioral control (Zielinska-Tomczak et al., 2021).

The findings of Zielinska-Tomczak et al. (2021) noted that subjective norms and perceived behavioral control may impede the overall opportunity and willingness to partake in interprofessional collaboration. Pharmacy participants consistently noted physician's limited awareness of their competencies and therefore mistrusted physician intentions. Both groups demonstrated "low self-confidence in establishing the partnership resulting from insufficient interprofessional competencies," and "barriers such as the lack of time, medical staff, or previous negative experience were also observed" (Zielinska-Tomczak et al., 2021, p. 11). Utilizing the theory of planned behavior in the current investigation, the findings of Zielinska-Tomczak et al. (2021) provide further support as themes noted may be consistent with speech-language pathologists working on interprofessional teams in a medical setting. Similar to Renzi and Klobas (2008), the current investigation will use qualitative data coding and interpretation to explore factors of reporting hesitancies to highlight differences in attitudes, subjective norms and perceived control of speech-language pathologists in medical settings working on interprofessional teams.

Transactive Memory Systems Theory

Transactive memory systems theory focuses on the mechanisms by which individuals within a group discover which members are responsible for a certain set of information within the group, and how that knowledge affects team performance. Important aspects of transactive memory include the degree of specialization of knowledge within the team, the coordination of knowledge between members of a team, and the beliefs about the reliability of one another's knowledge. The development of transactive memory systems is constructed over time, and commences when group members interact and learn about the expertise that other members may possess (Tan et al., 2014). "Transactive memory is the shared division of cognitive labor with

respect to the encoding, storage, retrieval, and communication of information from different knowledge domains" (Brandon & Hollingshead, 2004, p. 633).

Though initially hypothesized as a theory to explain the implied division of gendered labor in intimate couples, transactive memory systems theory “has expanded to explain the cognitive processes in groups, the factors that affect those processes, and the group performance outcomes that result” (Lewis & Herndon, 2011, p. 1254). Given that transactive memory often occurs in work groups, as individuals become increasingly aware of the expertise of others in their group, holding expertise within the group is often either implicitly or explicitly assigned to the most expert member. This is consistent with the notion that there is an unspoken hierarchy when working on an interprofessional team, with the physician being identified as either the leader or the quarterback of the interdisciplinary team.

It is a rare occurrence for team leadership to be exercised by one appointed individual, rather it is often shared by a variety of team members in accordance with various needs and situations that the team may encounter. Though hierarchical models are common in health care settings, non-hierarchical leadership is growing increasingly popular given the awareness of the importance of distributing, creating, and organizing knowledge throughout the team to improve overall performance. Therefore, by retrieving specialized knowledge from individual team members, shared leadership is highlighted by the transactive memory systems theory, which additionally allows for heightened specialization and coordination among team members (He & Hu, 2021).

Transactive memory systems are believed to improve performance in interprofessional settings as they accelerate swift and organized access to a variety of experts, resulting in an increased amount of knowledge on collective tasks (Lewis & Herndon, 2011). For the current

investigation, transactive memory systems theory supports the need for interprofessional teams to work together cooperatively towards the single goal of identifying and accurately reporting suspected abuse and neglect, while simultaneously highlighting their individual areas of specialization, therefore the investigation seeks to gain understanding of team goal unity on interprofessional teams.

Summary of Theoretical Framework

The decision to include three theoretical frameworks in this study reflects the intricacy of hesitations associated with reporting suspected child abuse and neglect. To reduce barriers to mandated reporting speech-language pathologists on interprofessional teams in a medical setting must consider underlying attitudes and subjective norms which may surface either at the individual or team level and reflect on the intentions driving behaviors. Using the theory of planned behavior questions will be developed utilizing elements of the model including behaviors of interest, attitudes, subjective norms, perceived behavioral control and actual behaviors. To uncover attitudes speech-language pathologists will be asked about the phenomenon of reporting hesitancies and what they consider to be both positive and negative outcomes of reporting suspected child abuse. Subjective norms will be identified by asking questions about the influence of individuals on interprofessional team members including physical therapists, occupational therapists, social workers, doctors, and nurses. Perceived control factors will come from understandings of the benefits versus perceived hesitancies including the possible negative consequences that may arise from reporting suspected abuse, and lack of interprofessional team support. Lastly, actual behavioral control will be investigated through inquiry regarding the degree of autonomy and flexibility the speech-language pathologist perceives including organizational factors and what support is available.

CHAPTER FIVE: RESEARCH QUESTION

This section will outline the research questions which this study sought to answer as well as reviewing the significance behind the selected questions. Discussion of how each question is grounded in the literature and theoretical framework will be presented. This investigation sought to gain a deep understanding of how speech-language pathologists working in a medical setting on an interdisciplinary team view mandated reporting of suspected child abuse and neglect. Though there has been extensive research on barriers and hesitations with reporting in a variety of healthcare professions, such research has not been completed with speech-language pathologists outside of investigations in a school setting, therefore the underrepresentation of medical speech-language pathologists indicates a gap in the current literature. Additionally, the current literature introduces a discussion on the role of interdisciplinary work on mandated reporting, however to date speech-language pathologists have not been included in this discussion.

Research Questions:

What are the perceptions and experiences of speech-language pathologists, working in a health care setting, towards mandated reporting?

Understanding the attitudes and experiences of speech-language pathologists towards mandated reporting will allow for future training and policies to be put into place to support clinicians who are faced with cases of suspected child abuse and neglect. The proposed project is a qualitative study utilizing a phenomenological approach. Phenomenological designs allow the researcher to "discern the essence of life experiences and tend towards a small sample size because of the richness and quantity of data that is collected" (Konrad, 2008, p. 42). Such studies are not meant to be generalized to other populations but rather to provide insight on those who

are experiencing the same phenomenon (Konrad, 2008). The proposed study is supported by the theory of reasoned action which is grounded in the notion that an individual's goals and behaviors are controlled by attitudes and subjective norms, with attitudes being directed by both emotions and feelings, and norms being dictated by mentors, family, friends, and societal beliefs (Smith, 2019). Furthermore, the theory of reasoned action will be utilized to explain how the beliefs of speech-language pathologists influence their intentions to engage in mandatory reporting.

How does working on an interdisciplinary team create or remediate barriers to reporting suspected child abuse and/or neglect?

Having the opportunity to hear the individual perceptions of speech-language pathologists working in a medical setting, will allow the primary investigator to obtain firsthand accounts of how professionals perceive and navigate team dynamics when working on an interdisciplinary team. Obtaining such information will contribute to the understanding of speech-language pathologists' hesitations associated with mandated reporting of suspected child abuse and neglect when engaging in interdisciplinary teamwork in a medical setting. Using a qualitative approach will allow for the collection of subjective values and thinking processes of the individual. The proposed study is supported by the transactive memory systems theory which focuses on the mechanism by which individuals with a group identify which members are responsible for certain information within the group, and how that knowledge then effects team performance (Tan et al., 2014).

CHAPTER SIX: RESEARCH METHODOLOGY

The following section will cover the study's research methodology, review qualitative methodology and rationale, and include information on the sample, data collection methods, data analysis, ethical practices associated with the study, credibility, and possible researcher bias. This investigation aimed to provide information regarding how speech-language pathologists working in a medical setting on an interdisciplinary team engage in reporting of suspected child abuse and neglect, and sought to understand the subjective-experiences of speech-language pathologists working in a medical setting. Moreover, the primary investigator sought to gain a greater understanding of how speech pathologists working on interdisciplinary teams navigate barriers to child abuse reporting.

Research Design

Reporting habits in health care professions are vastly studied; however, there are yet to be studies investigating hesitations and barriers in speech-language pathologists, specifically those working in a medical setting. Though there is some consensus on studied health care professions regarding reoccurring obstacles in reporting suspected child abuse and neglect, medical speech-language pathologists working on interdisciplinary teams are yet to be included.

Within the literature studies regarding hesitations with reporting suspected child abuse and neglect are focused on social workers, teachers, nurses, and doctors; the few studies which include speech-language pathologists as participants were completed in a school-setting. To reduce the occurrence of child abuse and neglect, particularly with children who have underlying developmental disabilities, professionals who work closely with this patient population must be studied. More specifically, speech-language pathologists working in a medical setting are a small niche within the profession who have the opportunity to work with medically fragile and

developmentally disabled children, oftentimes several times per week, thereby creating a deep connection with their pediatric patients and their families. This research hopes to bring awareness to areas of hesitation and barriers in reporting suspected child abuse and neglect so that the appropriate training may be provided to medical speech-language pathologists working on interdisciplinary teams.

Phenomenological Approach

Phenomenological studies allow for the description of a given phenomenon or lived experience for several individuals with a focus on describing what the participants have in common. The researcher typically collects data from those who have experienced the phenomenon and then develops an amalgamated description of the spirit of the experience for all participants. The data collection for phenomenological studies typically involve interviewing individuals who have experienced the phenomenon, with the data analysis following systematic procedures which move from narrow units of analysis and move towards broader themes to obtain a rich description of what the individuals experienced and how it was experienced (Creswell & Poth, 2018).

When conducting phenomenological research, there are several procedural steps involved. The researcher must first decide if the research problem or question is best examined utilizing a phenomenological approach, and then specify the assumptions of phenomenology. Next the researcher collects data from individuals who have experienced the identified phenomenon via in-depth interviews. Utilizing the interviews themes are generated from significant statements which are then developed into deeper textural and structural descriptions. Lastly the researcher reports the essence of the phenomenon by using a composite description and then presents their understanding via written form (Creswell & Poth, 2018).

Limitations of the Phenomenological Approach

Limitations of phenomenological research may occur if there is a preexisting relationship between the primary investigator and the participant which could potentially affect honest responses should there be a power differential. It is imperative for the researcher to remain unbiased and non-judgmental of all responses received to fully understand the essence of the phenomenon being investigated. Additionally, should a participant choose not to answer a question, missing data points may become a limitation to the study. Finding individuals who have all experienced the same phenomenon may be difficult. Further, "bracketing personal experiences may be difficult for the researcher to implement because interpretations of the data always incorporate the assumptions that the researcher brings to the topic" (Creswell & Poth, 2018, p. 130). Other limitations to qualitative inquiry include the inability to document prevalence in noted attitudes, experiences or behaviors paired with limited capacity to test for causation between attitudes and behaviors allowing for the generalization of findings.

Data and Subjects

The study procedure was submitted to Western Institutional Review Board, Yeshiva University's Institutional Review Board (IRB) prior to beginning the research and was determined to be exempt on July 11, 2022 (WCG IRB Work Order #1-1565043-1).

Data was collected from speech-language pathologists who work on an interdisciplinary healthcare team. A purposive sample was obtained as participants were chosen based on their knowledge on the topic. Purposive sampling is utilized when a researcher decides what information needs to be obtained and then sets out to find participants who are willing to provide the information based on their knowledge or experience. "It is typically used in qualitative research to identify and select the information-rich cases for the most proper

utilization of available resources" (Etikan et al., 2016, p. 2). Purposive sampling methods place an emphasis on saturation, which encourages the researcher to obtain a comprehensive understanding of the topic by continuing to sample until no new fundamental information is acquired, therefore the sample size is determined by data saturation rather than by statistical power analysis (Etikan et al., 2016). Purposive sampling allows the researcher to make the most out of a small population of interest while still arriving at valuable research outcomes. Creswell and Poth (2018) state that the exploration of the phenomenon with a group of individuals who have all experienced it can vary from three to four or potentially 10 to 15. The sample consisted of licensed speech-language pathologists who held professional licensure in their state of practice as well as a certificate of clinical competence in speech language pathology from the American Speech-Language-Hearing Association (ASHA).

Participants were recruited through contacting various directors of rehabilitation who are responsible for overseeing interdisciplinary healthcare teams. Recruitment was additionally completed through professional contacts made while in the field for the past decade and through clinicians met during the primary investigator's previous education. All data collection took place via Zoom. The study used open-ended interviews to examine the following research questions: (1) What are the perceptions and experiences of speech-language pathologists, working in a health care setting, towards mandated reporting? (2) How does working on an interdisciplinary team create or remediate barriers to reporting suspected child abuse and/or neglect? Each interview was conducted by the primary investigator and was conversational in nature. It was however guided, to ensure that the responses obtained would respond to the research questions and inform the aims of the study.

Limitations of the Sample

While purposive sampling is often utilized in qualitative work, there are limitations as it is often not generalizable to the larger population but rather those who meet the inclusion criteria of the particular study.

Procedures

Data collection included obtaining brief demographic information paired with in-depth one-on-one interviews. Prior to data collection all participants were informed of the purpose of the study and the voluntary nature of their participation. All interviews were offered via Zoom, and were recorded. The audio recordings were transcribed and stored on the primary investigator's laptop in a password-protected file. Participants were informed should they choose to discontinue at any time, they may withdraw from the study and their information will be deleted at their request.

Measurement

Prior to in-depth interviews, demographic information was obtained and included: age, gender, years of experience, years at current position, and licensure. Inclusion criteria for the study consisted of the following: licensed speech-language pathologists working in New York, New Jersey, or Connecticut, having current active licensure in their practicing state, holding a certificate of clinical competence in speech language pathology from the American Speech-Language-Hearing Association (ASHA), current employment in a medical setting (hospital, inpatient, outpatient) with a pediatric patient population, and active participation in an interdisciplinary team. Exclusionary criteria included those who are not actively treating pediatric patients and those who are not on an interdisciplinary team. The following questions were used to answer the research questions:

1. “Tell me about your experience as a pediatric speech-language pathologist working in a medical setting.”
2. “Tell me about your experience working on an interdisciplinary team.”
3. “What type of training or education have you had on mandated reporting of suspected child abuse or neglect?”
4. “Tell me about your experiences, attitudes, and perceptions towards reporting suspected child abuse or neglect.”
5. “How has being on an interdisciplinary team affected the reporting of suspected child abuse or neglect?”
6. “What have you encountered that has prevented or impeded your reporting of suspected child abuse or neglect?”
7. “What level of perceived control do you feel you have towards the outcome of your reporting?”
8. “What type of support would you want to have in place for reporting suspected child abuse or neglect?”

Data Analysis

All interviews were initially transcribed via an audio transcription embedded into Zoom, and were then manually reviewed against the recording by the principal investigator. Each transcript was then read several times to obtain an overall feeling from the interview. Significant phrases were identified and meanings were formulated (Creswell & Poth, 2018). The formulated meanings were then manfully clustered into themes, allowing for the development of common themes between transcripts.

CHAPTER SEVEN: RESULTS

The following chapter provides a description of the sample as well as an explanation of the themes emerging from participant responses relevant to the research questions.

Sample

Nine of the ten respondents were female, with a range of 2 to 24 years practicing. Three respondents reported working in a facility that only treats pediatric patients, whereas seven noted working in a facility that services both pediatric and adult patients. Four participants noted required annual training on suspected child abuse and neglect. While all ten participants noted working with occupational therapists and physical therapists, additional interdisciplinary team members included: neurologists, primary care physicians, audiologists, dieticians, nurses, respiratory therapists, social workers, case managers, neuropsychologists, child life specialists, nutritionists and registered behavioral technicians. Participants noted working with children from birth to 18 with a range of etiologies including but not limited to: speech and language delays, autism spectrum disorder, Down syndrome, fluency disorders, pediatric feeding and swallowing, craniofacial anomalies, cleft lip and palate, auditory processing disorder, non-verbal communication disorders, cerebral palsy, unspecified genetic disorders, traumatic brain injury, and vent weaning.

Question: Tell me about your experience working on an interdisciplinary team.

One overarching theme was notable when discussing being on an interdisciplinary team.

Communication within the interdisciplinary teams supports meeting a child's needs.

All participants reported that being part of an interdisciplinary team allows for communication between various disciplines to best meet the needs of the child. One participant noted, "it is helpful to have the opportunity to speak with other interdisciplinary team members

to see if there is consistency in opinions," and another participant reported that, "teamwork is necessary and I do not think that my kids could make significant progress without collaborating on an interdisciplinary team because we all have something to bring to the table."

Question: Tell me about your experiences, attitudes, and perception towards reporting suspected child abuse or neglect (general or specific).

When inquiring about both general and specific experiences, attitudes, and perceptions towards reporting, three main themes were noted: deciding to report according to perceived severity, life experiences guiding reporting habits, and limited experiences and exposure due to being a young professional.

Deciding to report according to perceived severity.

It was noted by both novice and seasoned clinicians that it is often difficult to differentiate between neglect and abuse therefore resulting in subjectivity. One participant noted, "I really did not know the levels or like what to expect or even how to really go about it, however if I felt that the child's welfare was in danger I would definitely report." It was reported by several participants that if the behavior noted was truly concerning that steps would be taken towards reporting the case even if the clinicians are not knowledgeable of the specifics of the process.

Life experience guiding reporting habits.

One participant highlighted how her life experiences including being a mother of five as well as having a sibling with a developmental disability have influenced her reporting behaviors. She stated that, "not only am I an advocate, but I push others to advocate." Another participant reported that prior positive experiences with making a report could influence future reporting habits. Lastly a participant highlighted her experiences working with children who are either

currently in foster care or have been through the system. She reported the emotional distress involved with being removed from one's family and how she carries these previous experiences with her.

Limited experience and exposure as a young professional.

Clinicians with less than five years of experience highlighted the seriousness of reporting suspected abuse and neglect. One participant stated, "any situation that involves, like, reporting, I think it's a very serious thing, and you shouldn't just go ahead and report." Another participant noted, "I think just as a young professional, like I would feel like I don't know, or maybe I'm wrong, and feel concerned about reporting something and it's not true, or the opposite where I am concerned about something and I don't report and it is true, so I think like doubting my judgements in that sense."

Question: How has being on an interdisciplinary team affected the reporting of suspected child abuse or neglect?

Two opposing viewpoints were notable when participants were asked about how interdisciplinary work affects reporting behaviors; it was either noted that the team aids in the reporting process or hinders the reporting.

Interdisciplinary work as a barrier to reporting suspected child abuse or neglect.

It was noted that it is not uncommon for one team member to be concerned with the possibility of suspected child abuse or neglect while another member on the interdisciplinary team believes that this is simply an exaggeration of an isolated observation. It is typical for a child to be receiving services initially with one discipline prior to the introduction of additional services, therefore it is possible to encounter an interdisciplinary team member who is protective either of the client or of the pre-existing rapport created and therefore less reluctant to report.

Interdisciplinary team support prior to reporting.

Participants reported that working on an interdisciplinary team aids in reporting when each discipline presents with similar concerns. Though not all interdisciplinary members are required to make the call cooperatively, being able to provide insight and observations may result in clinicians feeling more confident regarding future reporting. One participant noted that interdisciplinary collaboration, "allows for the discussion of observations prior to making a report," and another stated, "we would discuss it together like, this is what I saw, did you find the same, and then bounce ideas off each other before we actually report anything."

Question: What have you encountered that has prevented or impeded your reporting of suspected child abuse or neglect?

When investigating, what clinicians have encountered that has prevented or impeded reporting of suspected child abuse or neglect, there were seven themes identified: fear of retaliation from parents or guardians, considering possible alternatives to making a report, unsupportive administration, lacking specific education, having an unspoken hierarchy within the interdisciplinary team, reduced knowledge on the reporting process, and reporting being time consuming.

Fear of retaliation as a hesitation.

Several clinicians noted that parental or guardian retaliation is a grave concern and therefore, there is extensive consideration required prior to making a report. One participant stated that, "there have been situations where clinicians were threatened and had to be escorted to their cars after work." Oftentimes clinicians build a close relationship with the family and being a trusted provider further prevents reporting.

Alternatives to reporting.

One clinician highlighted the possibility of there being alternatives to reporting immediately, stating that there are other measures that could be taken prior to reporting, particularly considering that several factors are frequently coexisting and that despite the amount of care and empathy that is present, we truly never know what anyone is experiencing. She stated that it is of equal importance to support the family and provide education including instructing parents and guardians on a variety of resources.

Unsupportive administration.

Though some participants noted that their administration is supportive, others stated that administration is sometimes a barrier to engaging in the reporting of suspected abuse and neglect due to the structural nature of some departments. Though one clinician may feel that it is appropriate to report, if administration notes otherwise then the evidence gathered may be deemed as insufficient.

Missing education.

In addition to having a lack of education on mandated reporting as a whole, it was noted that having a lack of baseline knowledge on socioeconomic factors that families may be dealing with, and working with families who may not have community support or resources available may serve as a barrier to deciding to report. An overall lack of underlying education on how to work with families and counsel families may therefore impede reporting even in dire situations.

Unspoken hierarchy as a barrier.

The presence of an unspoken hierarchy within the interdisciplinary team was noted throughout the interviews. One participant stated that they frequently feel as though they are not in the driver's seat as other professionals, particularly social workers, are the ones who do a

majority of the reporting. Another participant states that, “there is an unspoken hierarchy and a feeling of needing to respect seniority at times.”

Lack of knowledge on the reporting process.

A lack of knowledge on the overall reporting process was consistently mentioned throughout a majority of the interviews. Clinicians stated that there needs to be training on the steps involved in making a report so that the confusion and ambiguity are removed from the process of reporting. One participant discussed her empathy and frustration for a coworker who was going through the reporting process and felt that no one else in the department was following-up and that there was no outlined process for her to follow. She stated that, “I feel like there should be some sort of outline so that I don’t have to ask my boss, but rather I know exactly what I need to do.” Another clinician noted that there should be some type of onboarding process for mandated reporting, perhaps even something that is discussed during orientation stating that, “especially since the population that we work with (children with disabilities and limited communication skills), are more susceptible to abuse, I think it is important to inform new therapists and all therapists in general on the signs and symptoms of it.” She additionally noted that, “I just think that maybe people are just afraid of what comes out of reporting because they don't understand what the process even is.” The burden of having to rely on other people when there is a lack of department policy in place serves as a barrier to reporting when a clinician does not feel that they are able to complete the task independently.

Time consuming.

The time required to engage in reporting was noted by participants throughout the individual interviews. One participant noted that though they will do what they need to in order to protect their patients, speech-language pathologists are often pressed for time between running

sessions and completing paperwork and that adding an additional task is daunting. Another participant noted that, “there is a lot of time involved when making a report and sometimes we just don’t have enough time.”

Question: What level of perceived control do you feel you have towards the outcome of your reporting?

When clinicians were asked about their level of perceived control towards the outcome of reporting, participants discussed the role that a supportive administration plays and additionally noted how a possible lack of specific reporting skills can play on the outcome of making a report.

Supportive administration.

Clinicians reported that having a supportive administration aids in the perceived level of control towards the outcome of reporting. It was noted that when speech-language pathologists feel supported by their team and administration, making a report becomes a less stressful process. One participant discussed how during team meetings management is very supportive in giving employees a greenlight for autonomy in reporting, and another participant stated that, “it is usually a team decision to call, usually done by one of the administrators because, like I said, we really keep in close contact as a team. I have to say I’ve never really felt alone.”

Lack of specific skills.

Several participants noted that limited connection with the child paired with a lack of specific skills played a role in the level of perceived control they felt towards the outcome of their reporting. One participant stated, “I don't know that I have any other skills over other professionals; I think whoever spends the most time with the child would probably have an advantage over me because I only spend a half an hour a week with them,” whereas another

participant noted that, “we see such a small part of their life, where I feel like in more of a school-based setting, or something like that, where they are around the child a lot more they understand a lot more of what is going on.” It was also reported that, “not having the child all day, in comparison to an educator, could be a potential barrier as the clinician only gets a snapshot.”

Question: What is it that a speech-language pathologist might pick up that other professions could miss?

Participants reported a variety of field-specific skills that speech-language pathologists have which prepares them to pick up on nuances of both observable behaviors as well as direct reporting. As communication experts they noted that developing a deep developed relationship between the patient and therapist and knowledge of communication and feeding disorders were consistently highlighted as strengths.

Developed relationship.

It was noted that when working with a child on a consistent basis the clinician has the opportunity to build rapport with their patient thereby creating a safe environment where disclosure may occur and where probing for additional details is possible. One participant noted, “I feel that as a speech therapist, my role is not only to be a clinician, but to be a support system, and to be a constant in a child’s life.”

Communication experts.

It is within the scope of practice for speech-language pathologists to target both verbal and non-verbal communication, therefore learning about body language is critical to their craft. When discussing how speech-language pathologists focus on social communication, social interaction, and pragmatics, one participant noted, “with younger kids I think we also pay close

attention to parent and child dyads and their overall interaction, so we could also potentially pick up on certain nuances." It was highlighted that clinicians are taught to be observant not only of the child but also how they react to different environments. Another participant stated that speech-language pathologists, "are trained in active listening, social skills and pragmatics; we are taught to read the room and read the situation at a deeper level, and we are often at the frontlines of many things." It was additionally noted that having the ability to differentiate between the nuances of a disorder and a child reporting possible abuse, is based on knowledge of different styles of communication and nonverbal communication.

Knowledge of feeding disorders.

In addition to working on speech and communication, speech-language pathologists frequently target pediatric feeding and swallowing disorders. For such clinicians, it is possible to encounter children who come in clean and well-dressed for their session, however their nasogastric feeding tubes are either missing or have not been appropriately changed therefore impeding proper nutrition.

Summary

The results section of this dissertation is from the analysis of qualitative data that were generated from voluntary one-on-one guided interviews. The results indicate that though interdisciplinary work frequently aids in the reporting of suspected child abuse and neglect, there are still areas that must be addressed to optimize the relationship between professionals. It was additionally noted that previous experiences, attitudes, and perceptions towards reporting guide future reporting behaviors.

CHAPTER EIGHT: DISCUSSION

This study sought to provide an understanding of the experiences of speech-language pathologists working in a medical setting, and on interdisciplinary teams, towards mandated reporting. While all participants noted that being part of an interdisciplinary team aids in the treatment of pediatric patients with a variety of etiologies, extensive variability was noted in how clinicians are trained and view mandated reporting. Speech-language pathologists working in exclusively pediatric settings reported not only having annual training on mandated reporting, but also noted that there are outlined policies for when reporting must occur. Clinicians employed in settings which treat both pediatric and adult patients discussed that minimal training outside of graduate school on mandated reporting is provided by their facilities and that they were unsure of the specific steps involved in making a report. However, given the qualitative nature of the study no conclusions can be drawn about what role clinical settings have on overall reporting behaviors.

Overall, participants noted that being on an interdisciplinary team is a positive experience which allows for the discussion of mutual patients for their clinical success. Additionally, participants stated that when abuse or neglect is suspected, it is efficacious to have other team members with whom individual cases can be discussed to see if patterns have been noted across clinicians from a variety of disciplines. All participants reported working with both occupational therapists and physical therapists regardless of the setting. One clinician highlighted the role of pediatric feeding and swallowing and how signs and symptoms of abuse or neglect of this patient population may be exclusive to speech-language pathologists who are specifically trained to treat such patients.

While specific to each participant, it was notable that individual experiences, both inside and outside of the clinical realm, drive reporting habits of speech-language pathologists. These included being a parent, previous experiences with reporting, and having family members with developmental disabilities. Individual driving forces are deeply rooted in personal experiences and determine reporting behaviors on both a conscious and subconscious level.

A variety of barriers were noted across participants including fear of retaliation by family members and guardians of their patients, unsupportive administration, and a lack of knowledge on socioeconomic factors and how to work with families as a whole. Some participants noted that the presence of an unspoken, and sometimes clearly delineated hierarchy, impede clinicians from making a report, and that the time involved with making a report and follow-up is often tedious and time consuming.

Participants noted that speech-language pathologists are often at the frontlines of reporting and therefore it is imperative that proper training be provided in order to best serve patients. Training in both verbal and non-verbal communication allows clinicians to have insight into observations that may be missed by other professionals, and though the time spent with pediatric patients may only occur one to two times a week, the consistent meetings paired with the ability to observe behaviors over time allows for even slight changes to be noted by speech-language pathologists.

Connecting Findings to Theory

According to the theory of reasoned action, the goals and behaviors of a given individual are comprised of their attitudes and subjective norms. Ones' attitude towards a particular subject is driven by their emotions and feelings, whereas subjective norms are commonly dictated by mentors, family, friends, and societal expectations. A person's behaviors and actions are

therefore frequently shaped by their life experiences (Smith, 2019). Observable and reported behavioral intentions have been noted to be predictive of future behaviors, therefore if an individual has an intention to perform a behavior there is a greater likelihood that the behavior will be executed (Sulak et al., 2014).

In the current investigation, it was noted that participants who reported concern regarding the possible negative implications for the child, additionally spoke of potential alternatives to reporting. These clinicians stated that to report, they would need to feel as though the child is in significant danger. For a clinician who has a patient currently in the foster care system, and who shares the hardships of being moved from one home to another, this theory postulates that future reporting opportunities for that clinician will be dictated by previous experiences, including earlier discussions with patients. The theory of reasoned action provides insight as to how individual life experiences guide future decision making for clinicians who serve as mandated reporters. For the participant who stated that they would have no hesitation reporting despite severity, specifically citing that she is a mother of five, who additionally has a brother with a developmental disability, the theory of reasoned action serves as an explanation for how individual attitudes and previous life experience guide future behaviors.

The theory of planned behavior, which is an extension of the theory of reasoned action, notes that “intention is the best predictor of behavior, and it is a function of the persons’ attitude toward performing the behavior and general subjective norms concerning the performance of the behavior” (Feng & Wu, 2005, p. 338). Per this theory, any behavior produced is determined by an intention to follow through with the behavior with intention being determined by one's attitude toward the behavior, subjective norms, and perceived behavioral control.

For participants who work in a setting which serves exclusively pediatric patients, it was noted that there are clearly outlined policies regarding mandated reporting, and that the interviewed participants from such facilities have minimal hesitations making a report of suspected child abuse or neglect. Given that this theory postulates that intention is the ideal predictor of behavior paired with the individuals' attitudes to engage in the behavior, clinicians who feel knowledgeable about the process, and supported by their administration, are therefore more likely to engage in reporting. Such clinicians additionally feel as though there are less barriers to reporting and that the outcomes of reporting will be favorable for the child.

Transactive memory systems theory places focus on the mechanisms by which individuals within a group discover which members are responsible for a certain set of information within the group, and how that knowledge affects overall team performance. Important aspects of transactive memory include the degree of specialization of knowledge within the team, the coordination of knowledge between members of a team, and the beliefs about the reliability of one another's knowledge (Tan et al., 2014).

All participants noted that being part of an interdisciplinary team is a positive experience that allows for optimal patient care as each member on the team has their own set of knowledge and specialization that they can share with other team members. Several participants noted that when child abuse or neglect is suspected it is efficacious to create discussion to investigate if patterns noted by one clinician are consistent with other team members who work with the child. Though it was noted that actual reporting is done by one team member, and that in exclusively pediatric settings this individual is designated, the experience of being on an interdisciplinary team is generally constructive.

Limitations

Several limitations were noted from the current investigation. As a result of the primary investigator being a member of the profession being studied, and a mother, therefore having a deeply rooted connection to the research, particular attention was given to diminish researcher bias. While multiple people could not be used to code the data and triangulation did not take place, the primary investigator memoed themes as they were noted and had the opportunity to discuss them with both a colleague who was not used as a participant as well as another PhD candidate, as the theme of external experiences guiding decision-making were not previously considered. Given that the study utilized a small sample comprised of participants from New York, New Jersey, and Connecticut, the findings are not generalizable. However, given the consistency in themes noted across respondents, the findings of the current investigation are transferable to speech-language pathologists working in a variety of medical settings. Given the qualitative design, it was expected that open-ended questions would yield discrepancies between participants. While some participants felt that their administration was supportive in the reporting of suspected abuse or neglect, others noted that administration is frequently a barrier to reporting behaviors. Additionally, though themes were identified, and variability existed in the training and reporting habits, particularly according to the setting, specific causation cannot be determined. Given the voluntary nature of the study, there is the susceptibility to voluntary sample bias as participants voluntarily participated in the research. To account for voluntary sample bias the primary investigator recruited from a variety of hospitals both in urban and suburban areas. Lastly given the thematic sensitivity of the current investigation it is feasible that participants were hesitant to provide a thorough account of their experiences with reporting suspected child abuse or neglect should they have been less than diligent in the past.

Contributions

As noted prior, research investigating hesitations and barriers regarding mandated reporting of suspected child abuse and neglect has been explored in a variety of health care professionals including speech-language pathologists in the school setting, however exploration of the voices of speech-language pathologists working in a medical setting on an interdisciplinary team has yet to be investigated. In trying to understand and provide a comprehensive picture of hesitations experienced, this study sought to identify areas requiring remediation including but not limited to interdisciplinary training and mandated reporting.

By utilizing a phenomenological approach this research intended to capture the essence of the phenomenon by investigating the voices and experiences of speech-language pathologists working in medical settings. The findings of this investigation noted that hesitations and barriers reported by medical speech-language pathologists are consistent with those reported by other clinical and medical disciplines. Both previous research and the current investigation noted that much of reporting behaviors are dictated by administration, that there are often fears of retaliation, and that the reporting process is often time consuming and not clearly outlined in the facility policies. Prior to the current investigation no research included speech-language pathologists working in medical facilities nor were individual life experiences discussed in previous literature. This research highlights the need for speech-language pathologists to be included in the discussion of their role in mandated reporting in medical settings in the hopes of decreasing child mortality rates.

Future Research

Given the qualitative nature of this study no broad conclusions can be drawn about what role clinical settings have on overall reporting behaviors, however this allows for future research

to be conducted to further investigate and address the possible gaps in policy and procedures according to the setting. The findings of this investigation raise the question if inpatient and outpatient settings that service both the pediatric and adult populations are equally vigilant in their policies in comparison to solely pediatric clinics. There is still much to learn about the reporting patterns of medical speech-language pathologists, the role of interdisciplinary support, and the determining factors of various clinical settings which either support or deter reporting. For the current investigation is was noted that the experience of being on an interdisciplinary team was generally constructive, however future studies may include groups that are not part of an interdisciplinary team to see if differences exist. Additionally, given the narrow demographic of the participants, investigation outside of the states included is necessary to explore how differences in reporting laws in every state may affect the responses of respondents.

To follow-up on the findings of the current study, it would be efficacious to investigate what role life experiences have on reporting habits across speech-language pathologists working in a variety of settings. Previous experiences with reporting, being a parent, and having family members with developmental disabilities heavily influenced reporting behaviors given the personal connection to children on both the conscious and subconscious level. Given this feature, future studies may consider inclusion criteria of having previously engaged in mandated reporting to see if such factors are truly significant in reporting practices.

The barriers noted across participants included a fear of retaliation, unsupportive administration, and a possible lack of knowledge of socioeconomic factors when working with families. Such barriers have been noted across disciplines and therefore future investigations in healthcare should include speech-language pathologists in the participant pool rather than excluding this clinical discipline. In contrast, clinicians who felt knowledgeable about the

reporting process, and felt supported by their administration reported that they would be more likely to engage in mandated reporting, therefore future research should additionally include administrators to investigate what support systems they have in place to aid in positive reporting experiences.

Implications for Speech-Language Pathology Practice

This study highlighted both individual and organizational factors that contributed to hesitations associated with reporting suspected child abuse and neglect which included a gap in training for speech-language pathologists, the role that administration plays in reporting behaviors, and lack of clearly outlined policies in many facilities. The implications and findings of this investigation could influence how speech-language pathologists are trained on mandated reporting and how interdisciplinary team training is applied in speech-language pathology practice. Specifically, participants reiterated that when there is suspected child abuse or neglect, it is efficacious to discuss observations with other team members to see if such patterns have been noted across disciplines. It is therefore imperative for administrators to encourage open communication between disciplines allowing for the sharing of both clinical and behavioral observations.

Previous studies have indicated that ethical dilemmas are inherent in child abuse reporting particularly those that involve conflicts between the child's and parent's perceptions and truths, however all investigations to date including speech-language pathologists have been completed in a school setting and have not considered interdisciplinary interactions. This is concerning as it may result in cases of child and abuse going unaddressed and speech-language pathology practice would benefit from having a deeper understanding of how speech-language pathologists address suspected cases, specifically when working on interdisciplinary teams, and

will allow the profession to understand what possible hierarchies and communication patterns exist between professions.

For such barriers to be reduced there needs to be the inclusion and encouragement of open communication between clinicians and their administrators when abuse or neglect is suspected. Rather than being fearful of engaging in reporting due to the presence of a possible hierarchy, or assuming that reporting will be completed by another professional, speech-language pathologists must feel that their expertise in treating the pediatric population, particularly those with developmental disabilities, places them in the forefront of engaging in reporting when necessary. Additionally, when having the opportunity to be on an interdisciplinary team, open discussion should not only be encouraged but required between professionals who are working with the same patients. Such discussion, particularly in an outpatient setting when patients are seen on a reoccurring basis is imperative. Though generalizations are not possible given the qualitative design paired with the small sample size, such discussions and openness in communication between interdisciplinary teams is particularly imperative for newer clinicians for the practice of discussion to become engrained early in ones' career.

Speech-Language Pathology Education

This study sought to utilize previous literature paired with study findings to provide recommendations on setting the foundation for speech-language pathology programs to better integrate curriculum focusing on mandated reporting, particularly outside of the school setting, and to prepare future clinicians working on interdisciplinary teams.

It was noted that outside of taking one or two required courses for speech-language pathologists working in New York, minimal education is provided at the graduate level in

mandated reporting. Given these findings it is imperative that the American-Speech-Language-Hearing Association, which dictates what coursework is minimally required at the graduate level, make it mandatory for licensure that all graduating students are appropriately educated in mandated reporting of suspected child abuse and neglect, how to properly communicate with family members and guardians, how to provide resources to families, and to highlight the responsibilities that are associated with being a mandated reporter and the consequences that could arise should this obligation be taken lightly.

The findings of this investigation additionally highlight the need for interdisciplinary education at the graduate level to properly train future clinicians how to successfully work and collaborate when on an interdisciplinary team. Such training would allow for future speech-language pathologists to improve teamwork and their overall ability to communicate with other professionals when presented with the need to identify and report possible cases of child abuse or neglect.

Policy Implications

While policies vary, and will continue to vary, for individual facilities, the findings of this investigation noted that policies and procedures for engaging in mandated reporting are clearly delineated in facilities working exclusively with pediatric patients. Though it is plausible that similar policies exist in organizations servicing the adult and pediatric population, education possibly in the form of in-services for all employees upon hiring is strongly encouraged. Clearly outlined steps for engaging in reporting would allow for a streamline process across disciplines, and allow for resources for individual practitioners to use should they be hesitant to inquire with administration.

In addition, federal funding provided in the Affordable Care Act (ACA) to support interprofessional teamwork in healthcare settings should be continued. Activities funded by the ACA include, the coordinating center for interprofessional education and collaborative practice (CC-IPECP), which provides the framework for leadership, expertise, and support for creating interprofessional education and collaborative practice for health professionals in the United States. It is imperative that funding for the CC-IPECP continue in order to ensure that health profession students nationwide have access to best practice models for interprofessional education.

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