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Child Abuse Reporting in New York State: the Dilemma of the Mental Health Professional

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CHILD ABUSE REPORTING IN NEW YORK STATE: THE DILEMMA OF THE MENTAL HEALTH PROFESSIONAL

*DAVID JOSEPH AGATSTEIN**

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A young mother, who may be suffering from postpartum psychosis, consults a psychotherapist. She relates the apparently obsessional and possibly delusional belief that a neighbor for whom she sometimes babysits once tortured his son by placing the child's hand in boiling water.

How does the therapist's duty of confidentiality apply to this case? What is the therapist's legal exposure if either child (the mother's or the neighbor's) is thereafter seriously harmed? These and related questions are considered in this article.

I. INTRODUCTION

Encouraged by federal grant legislation,[1] all states[2] have enacted laws aimed at curbing the abuse, maltreatment, and sexual exploitation of children.[3] Most of these statutes place a special burden upon specific

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1. The Federal Child Abuse Prevention and Treatment Act of 1974, Pub. L. No. 93-247, 88 Stat. 5 (codified as amended at 42 U.S.C. §§ 5101-5117d (1982 & Supp. IV 1986)). The Act provides for financial assistance to states which, among other things, adopt a child abuse and neglect law that includes provisions for immunity from prosecution for persons who report abuse or neglect, 42 U.S.C. § 5106a-(b)(1) (1982 & Supp. V 1987), and provides for the reporting of known and suspected instances of child abuse and neglect. *Id.* § 5106a-(b)(1)(A). 42 U.S.C. § 5103(b)(2)(B), a predecessor to § 5106a, is interpreted by the regulations as follows:

> (c) *Reporting.* The State *must* provide by statute that specified persons *must* report and must provide by statute or administrative procedure that all other persons are permitted to report known and suspected instances of child abuse and neglect to a child protective agency or other properly constituted authority.

45 C.F.R. § 1340.14(c) (1988) (emphasis added).

For a period of not more than one year, compliance with these requirements may be waived by the Secretary of Health and Human Services if a state makes a good faith effort to comply. Another one-year waiver is available if the state makes substantial progress toward compliance. 42 U.S.C. § 5103(d)(2)(A) (Supp. IV 1986).

2. Myers, *A Survey of Child Abuse and Neglect Reporting Statutes*, 10 J. JUV. L. 1 (1986).

3. Laws prohibiting child abuse have been enacted throughout the world and can be traced to ancient sources. Consider the following:

> the Biblical commandment regarding the stubborn and rebellious son, who is to be denounced at the gates of the city and stoned to death. The rabbinical commentaries provide, however, that in order for the law to operate, the son must be of the age between thirteen years and one day, and thirteen years and three months. Moreover, since the parents are to denounce him by saying, "he will not obey our voice," it was decided that the parents must be indistinguishable from each other in voice, stature, and facial features. Thus: "There never has been a 'stubborn and rebellious son,' and there never will be." Why, then, the rabbis asked, was the law written? And the rabbinical answer was: "That you may study it and receive reward [in the act of studying]"—which may or may not be an adequate reason for incorporating similar sophistries into [modern provisions of law] . . . .

M. FREEDMAN, LAWYERS' ETHICS IN AN ADVERSARY SYSTEM 55 n.** (1975) (citations omitted).

members of the helping professions, requiring these professionals[4] to report abuse or neglect to a central register maintained by a state agency.

New York's mandated child abuse reporting statute was adopted in 1973.[5] Section 413 of the Social Services Law requires certain professionals, including physicians, nurses, and social workers, to issue reports "when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child."[6] Psychologists were added to the list of mandated reporters in 1979.[7]

In 1984 and 1985, New York's reporting statute was significantly expanded.[8] Currently, affected professionals must report not only when they personally observe the victimized child, but also when "the parent, guardian, custodian or other person legally responsible for such child comes before them in their professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child."[9] Failure to report is a misdemeanor[10] and exposes the practi-

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Blackstone wrote:

> The ancient Roman laws gave the father a power of life and death over his children; upon this principle, that he who gave had also the power of taking away. But the rigor of these laws was softened by subsequent constitutions; so that we find a father banished by the emperor Hadrian for killing his son, though he had committed a very heinous crime, upon the maxim that "patria potestas in pietate debet, non in atrocitate, consistere."

1 W. BLACKSTONE, COMMENTARIES OF THE LAWS OF ENGLAND 646-47 (W. Jones ed. 1915) (paternal power should consist in kindness, not in cruelty).

American child abuse prevention laws received an important impetus from Kempe, Silverman, Steele, Droegmuller & Silver's landmark article, *The Battered Child Syndrome*, 181 J. A.M.A. 17 (1962) [hereinafter Kempe & Silverman].

Samuel X. Radbill offers a brief chronology of child abuse in Radbill, *History of Child Abuse and Infanticide*, in R. HELFER & C. KEMPE, THE BATTERED CHILD 3 (R. Helfer & C. Kempe 3d ed. 1980) [hereinafter THE BATTERED CHILD]. A short history of reporting statutes may be found in Page, *The Law, the Lawyer, and the Medical Aspects of Child Abuse*, in CHILD ABUSE 108, 110 n.1 (E. Newberger ed. 1982).

4. *See infra* note 38. Some states have enacted "universal" reporting laws, mandating reporting by anyone with knowledge of abuse. *E.g.*, TEX. FAM. CODE ANN. § 34.01 (Vernon 1986); *see also* SLOAN, CHILD ABUSE: GOVERNING LAW AND LEGISLATION 23-25 (1983) (listing nineteen such jurisdictions).

5. Act of June 23, 1973, ch. 1039, § 1, 1973 N.Y. Laws 1893 (McKinney) (codified as amended at N.Y. SOC. SERV. LAW §§ 413-428 (McKinney Supp. 1989)).

6. N.Y. SOC. SERV. LAW § 413(1) (McKinney Supp. 1989).

7. Act of May 8, 1979, ch. 81, § 1, 1979 N.Y. Laws 318-19 (McKinney) (codified as amended at N.Y. SOC. SERV. LAW § 413(1) (McKinney Supp. 1989)).

8. N.Y. SOC. SERV. LAW § 413 was amended by Act of Aug. 6, 1984, ch. 932, § 1, 1984 N.Y. Laws 3486 (McKinney), and Act of Aug. 1, 1985 ch. 677, § 7, 1985 N.Y. Laws 1702, 1705 (McKinney).

9. N.Y. SOC. SERV. LAW § 413(1) (McKinney Supp. 1989). In turn, the Family Court

tioner to charges of professional misconduct[11] and civil liability for damages.[12]

However well-intentioned the expanded reporting requirement may be, it imposes a serious ethical, practical, and legal dilemma on mental health professionals. This dilemma arises from the unique therapeutic relationship established between the practitioner and the patient,[13] described by Gutheil and Appelbaum under the heading "Trust as the Basis of the Therapeutic Alliance."[14] The authors state:

> The alliance in therapy is based on a collaboration between the therapist and the nonpathologic (or "healthy") aspects of the patient's personality. To attain this collaborative stance, the therapist attempts to "see the world through the patient's eyes," striving for a state of empathic rapport. At the same time, in tension with this collaborative approach, the therapist must inevitably work in opposition to the pathologic (or "sick") aspects of the patient's psyche (e.g., a tendency toward harshly punitive self-appraisal), in effect acting as an advocate for the healthy side of the patient.
>
> The foregoing requires from the patient an openness of self-disclosure and comfort with candor, in respect to which the physician owes the protection of confidentiality.[15]

As noted herein, breach of the duty of confidentiality may have serious adverse consequences for the patient's health.[16] A therapist's

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Act states that:

> "Person legally responsible" [for a child] includes the child's custodian, guardian, [or] any other person responsible for the child's care at the relevant time. Custodian may include any person continually or at regular intervals found in the same household as the child when the conduct of such person causes or contributes to the abuse or neglect of the child.

N.Y. FAM. CT. ACT § 1012(g) (McKinney 1983). *See In re* Theresa C., 121 Misc. 2d 15, 17, 467 N.Y.S.2d 148, 150 (Fam. Ct. 1983) (holding that " 'person legally responsible' includes an unrelated person who is 'continually . . . found in the same household as the child' at the 'relevant time.' ").

10. N.Y. SOC. SERV. LAW § 420(1) (McKinney 1983) (specifically, a class A misdemeanor).

11. *See* N.Y. EDUC. LAW § 6509(5)(a)(i) (McKinney 1985) ("Each of the following is professional misconduct: . . . Being convicted of committing an act constituting a crime under New York State law").

12. N.Y. SOC. SERV. LAW § 420(2) (McKinney 1983).

13. The term "patient," as used in this article, includes the clients of social workers and psychologists.

14. T. GUTHEIL & P. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 13 (1982).

15. *Id.* at 13-14.

16. *See infra* text accompanying notes 61-82.

breach of confidence may be a tort,[17] professional misconduct,[18] and in some cases, a criminal offense.[19]

The reporting requirement of section 413 of the Social Services Law gives rise to a potential conflict with the duty of confidentiality. Although the statute purports to shield good faith reporting from civil and criminal liability and sets up a presumption of good faith in favor of those who file a report without "willful misconduct or gross negligence, . . . in the discharge of their duties and within the scope of their employment,"[20] mental health professionals may still encounter situations that implicate contradictory principles of good professional practice and lawful behavior. Not surprisingly, some practitioners feel they are damned if they do and damned if they don't.[21]

II. THE THESIS

One need only examine the photographs in Helfer and Kempe's book, *The Battered Child*,[22] or read the various accounts of children

17. MacDonald v. Clinger, 84 A.D.2d 482, 482, 446 N.Y.S.2d 801, 802 (App. Div. 1982) ("such wrongful disclosure is a breach of fiduciary duty of confidentiality and gives rise to a cause of action sounding in tort.").

18. N.Y. COMP. CODES R. & REGS. tit. 8, § 29.1(b)(9) (1977), adopted pursuant to N.Y. EDUC. LAW §§ 207, 6505, 6509 (McKinney 1985 & Supp. 1989), and applicable to all professions licensed by the Department of Education, provides that the revelation of personally identifiable facts or information obtained in a professional capacity without the patient's consent is misconduct and grounds for disciplinary action.

19. *See, e.g.*, N.Y. SOC. SERV. LAW § 422(12) (McKinney Supp. 1989) (unauthorized disclosure of information contained in the state register of child abuse and maltreatment is a class A misdemeanor).

20. N.Y. SOC. SERV. LAW § 419 (McKinney Supp. 1989); *see also* Kempster v. Child Protective Serv., 130 A.D.2d 623, 515 N.Y.S.2d 807 (App. Div. 1987) (civil complaint against defendant hospital dismissed for filing good faith report of suspected child abuse); Viscaino v. City of New York, 541 N.Y.S.2d 809 (App. Div. 1989) (hospitals that are required to make formal reports of suspected sexual abuse of minors are given statutory immunity from any civil liability arising from the report).

21. In a recent survey of clinicians engaged in the treatment of sex offenders, Miller and Weinstock found that "respondents range from those who follow their attorney's advice to warn patients of limitations of confidentiality and to report them, even against clinical judgment, to those who refuse to report patient confidences under any circumstance, despite statutory requirements." Miller & Weinstock, *Conflict of Interest Between Therapist-Patient Confidentiality and the Duty to Report Sexual Abuse of Children*, 5 BEHAV. SCI. & THE LAW 161, 166 (1987) [hereinafter Miller & Weinstock]; *see also* Note, *Duties in Conflict: Must Psychotherapists Report Child Abuse Inflicted by Clients and Confided in Therapy?*, 22 SAN DIEGO L. REV. 645 (1985) [hereinafter Note, *Duties in Conflict*] (need to protect children outweighs problems caused by compliance with reporting statutes), and Note, *Reporting Child Abuse: When Moral Obligations Fail*, 15 PAC. L.J. 189 (1983) (existence of a "special relationship" with a battered child imposes a duty to report abuse); *see also* N.Y. PENAL LAW § 240.40 (McKinney Supp. 1989) (it is a misdemeanor to intentionally file a false report).

22. THE BATTERED CHILD, *supra* note 3.

who have been mutilated, starved, tortured, and killed, to understand the impetus behind mandatory reporting laws. These laws exist because child victims often are unable to protect themselves or denounce their abusers.[23] The statute's praiseworthy goal is the prevention of child abuse. This article will suggest, however, that section 413 is overbroad and misdirected and thereby impinges upon other important societal goals, legal rights, and humane values. In the final analysis, the section's expansive reporting requirement is counterproductive.

After a brief survey of the New York reporting statute, the article will present the therapeutic arguments in favor of confidentiality in psychotherapy, the social work arguments that militate against the present scheme of mandatory reporting, and several legal arguments touching upon these issues. The article will then suggest that mental health professionals may narrow the scope of the dilemma through precise application of the present law to facts as they arise in the course of therapeutic practice. After examining the laws of several other states, the article will conclude by proposing a modification of New York's law, with the hope that such modification will further reduce the therapist's dilemma, and enhance the ability of affected professionals to promote the health and safety of all parties concerned.

III. THE STATUTORY SCHEME

Despite various efforts at government-financed publicity,[24] studies indicate that some affected professionals remain unaware of the report-

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> [E]ven the child's most trusted confidante may be unaware that something has happened. Very young children may simply lack the verbal capacity to report or the knowledge that an incident is inappropriate or criminal. Older children may be embarrassed. Many child victims are threatened into silence. When they do confide in trusted adults, their reports may be dismissed as fantasy or outright lies.
>
> Even if a child's report is believed by a parent or trusted adult, it may never come to the attention of the authorities . . . . These responses probably reflect that most of the nonreported cases had involved perpetrators within the family . . . .

D. WHITCOMB, E. SHAPIRO & L. STELLWAGEN, WHEN THE VICTIM IS A CHILD: ISSUES FOR JUDGES AND PROSECUTORS 4 (National Institute of Justice, U.S. Dep't of Justice, 1985) [hereinafter WHITCOMB].

24. *See, e.g.*, N.Y. STATE SENATE SUBCOMM. ON CHILD ABUSE, PROTECTION OF CHILDREN IN RESIDENTIAL CARE: A STUDY OF ABUSE AND NEGLECT IN CHILD CARE INSTITUTIONS IN NEW YORK STATE 44 (1983) [hereinafter PISANI REPORT]; N.Y. STATE CHILD PROTECTIVE SERVICES PROGRAM MANUAL (N.Y. State Dep't of Social Services, Division of Family & Children Services, looseleaf, updated periodically, 1985) [hereinafter CPS MANUAL]; N.Y. STATE CHILD PROTECTIVE SERVICES, MANDATED REPORTER MANUAL (undated) [hereinafter MANDATED REPORTER MANUAL]; N.Y. STATE ASSEMBLY SUBCOMM. ON CHILD ABUSE, A GUIDE TO NEW YORK'S CHILD PROTECTIVE SERVICES SYSTEM (1986) [hereinafter HOYT REPORT].

ing requirements of New York's reporting statute.[25] Accordingly, before analyzing the particular dilemma of mental health professionals, it may be helpful to provide an overview of the statutory provisions.

A. *Who is an Abused or Maltreated Child?*

Generally, an "abused or maltreated child" under New York's reporting statute is a person under the age of eighteen who is defined as abused or neglected in the Family Court Act or has had serious physical injury inflicted upon him by "other than accidental means."[26] The Family Court Act, in turn, defines abuse or neglect to include such actions as the deprivation of food, clothing, or shelter,[27] the imposition of excessive corporal punishment,[28] and the commission of any sex offense against the child,[29] including incest[30] or prostitution of the child.[31] The failure to provide necessities, including education,[32] medical care,[33] and proper supervision,[34] may also constitute neglect.

The degree of harm suffered by the child, or with which the child is threatened,[35] varies under the statutory provisions from horribly egregious to less serious. Section 413 distinguishes abuse, which under the Family Court Act involves actual or potential "death, or serious protracted disfigurement, or protracted impairment of physical or emo-

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25. *See* Miller & Weinstock, *supra* note 21, at 165 (four out of 51 respondents said they did not know the requirements and many more were confused as to specifics such as time limits and statutes of limitation).

As of January 1, 1989, mandated reporters must provide employees with written information explaining the reporting requirements of the law. N.Y. Soc. Serv. Law § 413(2) (McKinney Supp. 1989). Government agencies must provide similar information to operators of family day care or group family day care homes. N.Y. Soc. Serv. Law § 413(3) (McKinney Supp. 1990). While the statute is silent as to the remedy for noncompliance, failure to supply such information will, at the least, expose the employer or agency to additional theories of tort liability.

26. The definitions are set out in N.Y. Soc. Serv. Law § 412 (McKinney 1982 & Supp. 1989). The statute covers children in residential care. *Id.* §§ 412(1)(b)-(c), (2)(c), (8), (9). *See also* N.Y. Comp. Codes R. & Regs. tit. 18, § 432.1 (1978); Mandated Reporter Manual, *supra* note 24, at v.

27. N.Y. Fam. Ct. Act § 1012(f)(i)(A) (McKinney 1983).

28. *Id.* § 1012(f)(i)(B).

29. *Id.* § 1012(e)(iii) (McKinney Supp. 1989).

30. *Id.* For the definition of incest, see N.Y. Penal Law § 255.25 (McKinney Supp. 1989).

31. N.Y. Fam. Ct. Act § 1012(e)(iii) (McKinney Supp. 1989). For definitions of the promotion of prostitution, see N.Y. Penal Law §§ 230.25, 230.30, 230.32 (McKinney 1980).

32. N.Y. Fam. Ct. Act § 1012(f)(i)(A) (McKinney 1983).

33. *Id.*

34. *Id.* § 1012(f)(i)(B).

35. *See* Matter of Sarah K., 142 Misc. 2d 275, 536 N.Y.S.2d 958 (Fam. Ct. 1989) (exposure of children to dangerous or harmful conditions rendered child abused).

tional health or protracted loss or impairment of the function of any bodily organ,"[36] from maltreatment, a term that implies less permanent, aggravated, or extensive injury to the child's physical or emotional health. In all cases, the actual or potential harm must be of sufficient gravity to warrant legal intervention.[37] In the case of a psychotherapist who has not seen the child, the difficulty of making this assessment constitutes one aspect of the therapist's dilemma.

B. Who Must Report?

Section 413 specifically identifies the persons and officials required to report.[38] It is significant that attorneys, other than prosecuting attorneys, are not included in the list of mandatory reporters. Nor are parents, guardians, siblings, neighbors, or other persons who may have actual knowledge of abuse or neglect.[39]

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36. N.Y. FAM. CT. ACT § 1012(e)(i) (McKinney 1983).

37. Augustine v. Berger, 88 Misc. 2d 487, 388 N.Y.S.2d 537 (Fam. Ct. 1976) (leaving infants alone for half hour is not "maltreatment"); *see also* CPS MANUAL, *supra* note 24, at vi.

38.

> The following persons and officials are required to report or cause a report to be made . . . :any physician; surgeon; medical examiner; coroner; dentist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; hospital personnel engaged in the admission, examination, care or treatment of persons; a Christian Science practitioner; school official; social services worker; day care center worker; provider of family or group family day care; employee or volunteer in a residential care facility . . . or any other child or foster care worker; mental health professional; peace officer; police officer; district attorney or assistant district attorney; investigator employed in the office of a district attorney; or other law enforcement official.

N.Y. SOC. SERV. LAW § 413(1) (McKinney Supp. 1989).

The statute creates a clear conflict for Christian Scientist practitioners. Article VIII, Section 22 of the By-Laws of the First Church of Christ, Scientist, states: "Members of this Church shall hold in sacred confidence all private communications made to them by their patients; also such information as may come to them by reason of their relation of practitioner to patient. A failure to do this shall subject the offender to Church discipline." M.B. EDDY, CHURCH MANUAL OF THE FIRST CHURCH OF CHRIST, SCIENTIST, IN BOSTON, MASSACHUSETTS 46 (89th ed. 1936).

Employees in residential care facilities and providers of family or group family day care were added to the list of mandated reporters in New York. Act of Aug. 11, 1988, ch. 544, § 1, 1988 N.Y. Laws 1007 (McKinney) (codified at N.Y. SOC. SERV. LAW § 413(1) (McKinney Supp. 1989)).

The mandated reporters in other states as of August 1982 are collected in PROTECTION OF ABUSED VICTIMS: STATE LAW AND DECISIONS, Booklet 6 - Statutes: Reporting Laws 169 (I. Sloan ed. 1982).

39. *See* Page, *supra* note 3, at 111-12 ("The American Medical Association objected to having physicians singled out as reporters and voiced concern that mandating only physicians would deter parents and other custodians from bringing children in for medical treatment and would fail to address comprehensively the issue of child abuse." (citing McCoid, *The Battered Child and Other Assaults upon the Family: Part I*, 50 MINN. L.

C. When and How Must a Report Be Made?

Section 415 of the Social Services Law requires practitioners and officials to report immediately, by telephone or telephone facsimile machine, to the state-wide central register of child abuse or to a local child protective service.[40] Oral reports must be followed, within forty-eight hours, by a written report.[41] Practitioners working in hospitals, schools, or other public or private institutions must also notify the person in charge of the facility or his designated agent, "who then also shall become responsible to report or cause reports to be made."[42] Section 29.29 of the Mental Hygiene Law, as amended by the New York Child Abuse Prevention Act of 1985 ("Act"),[43] details the required incident reporting procedures for in-patient psychiatric facilities.[44] Other sections of the Act contain similar provisions relating to non-psychiatric facilities in which children are housed, treated, educated, or detained.[45]

D. What Must the Report Contain?

Social Services Law section 415 sets forth the contents of the required reports.[46] Reports must contain:

- the names and addresses of the child and his parents or other person responsible for his or her care;
- the child's age, sex, and race;
- the nature and extent of the child's injuries, abuse or mal-

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REV. 1 (1965))). Another commentator stated, "The first generation of reporting statutes singled out the physician as the sole mandated reporter . . . . Today, the focal point is individuals who have constant access to young children and who can identify the inflicted injuries before they become severe." Fraser, *Child Abuse in America: A DeFacto Legislative System*, in 1 THE ABUSED CHILD IN THE FAMILY AND IN THE COMMUNITY: SELECTED PAPERS FROM THE SECOND INTERNATIONAL CONGRESS ON CHILD ABUSE AND NEGLECT 35, 38 (C. Kempe, A.W. Franklin & C. Cooper eds. 1980) [hereinafter THE ABUSED CHILD IN THE FAMILY].

40. N.Y. SOC. SERV. LAW § 415 (McKinney Supp. 1989); *see also* MANDATED REPORTER MANUAL, *supra* note 24, at 1.

41. *Id.*

42. N.Y. SOC. SERV. LAW § 413(1) (McKinney Supp. 1989).

43. N.Y. MENTAL HYG. LAW § 29.29 (McKinney 1988) (amended by Act of Aug. 1, 1985, ch. 676, § 12, 1985 N.Y. Laws 1688, 1697 (McKinney); Act of Aug. 1, 1985, ch. 677, § 20, 1985 N.Y. Laws 1702, 1721 (McKinney)).

44. N.Y. MENTAL HYG. LAW § 29.29 (McKinney 1988).

45. Act of Aug. 1, 1985, ch. 677, §§ 21-32, 1985 N.Y. Laws 1702, 1722-31 (McKinney) (codified as amended at N.Y. EXEC. LAW §§ 501, 510-a (McKinney Supp. 1989); N.Y. EDUC. LAW §§ 4212, 4314, 4358, 4403 (McKinney Supp. 1989); N.Y. CRIM. PROC. LAW 190.25(4)(a) (McKinney Supp. 1989); N.Y. FAM. CT. ACT 1024(a)(1) (McKinney Supp. 1989)).

46. N.Y. SOC. SERV. LAW § 415 (McKinney Supp. 1989).

treatment, including any evidence of prior injuries, abuse, or maltreatment to the child *or, as the case may be, his or her siblings*;
- *the name of the person or persons alleged to be responsible for causing the injury, abuse, or maltreatment*, if known;
- family composition, where appropriate;
- the source of the report;
- the person making the report and where he or she can be reached;
- *the actions taken by the reporting source, including the taking of photographs or x-rays, removal or keeping of the child or notifying the medical examiner or coroner*; and
- any other information which the commissioner may, by regulation, require, or the person making the report believes might be helpful.[47]

Moreover, one court has held that a reporting hospital must, upon request from the Department of Social Services, furnish the victim's entire hospital record, notwithstanding the hospital's claim of patient confidentiality.[48]

E. What Happens to the Report after it Is Filed?

Once made, the incident report is transmitted to the appropriate local child protective service (CPS), which must initiate an investigation.[49] If CPS determines that there is substance to the report, it may commence a Child Protective Proceeding under Article 10 of the Family Court Act[50] or, where indicated, seek emergency removal of the child into protective custody.[51] The statute and regulations implement-

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47. *See id.* (emphasis supplied); *see also* MANDATED REPORTER MANUAL, *supra* note 24, at 1-2.

48. Schuyler County Dep't of Social Serv. v. Schuyler Hosp., 543 N.Y.S.2d 872 (Sup. Ct. 1989).

49. N.Y. SOC. SERV. LAW § 415 (McKinney Supp. 1989); N.Y. COMP. CODES R. & REGS. tit. 18, § 432.2(b)(3) (1984); *see also* MANDATED REPORTER MANUAL, *supra* note 24, at 21.

50. N.Y. FAM. CT. ACT § 1031(d) (McKinney 1983). The provisions governing who may originate proceedings can be found in *id.* § 1032.

51. N.Y. FAM. CT. ACT §§ 1024, 1026 (McKinney 1983 & Supp. 1989); N.Y. SOC. SERV. LAW § 417 (McKinney Supp. 1989).

The treating physician's responsibility is now limited to reporting. N.Y. SOC. SERV. LAW § 417(1)(b) (McKinney Supp. 1989). Hospitals must take all necessary measures to protect abused children, including retaining custody of the child pending family court action. *Id.* § 417(2). For a summary of CPS' responsibilities, see CPS MANUAL, *supra* note 24, at ch. IV, § J.

The procedural obstacles faced by alleged abusers are summarized by Buono:

> Upon application of the parent or other person legally responsible, a probable cause type hearing will be conducted within three days to determine whether

ing this provision make a distinction relevant to the therapist's dilemma. CPS is authorized to take custody of a child treated by a reporting physician when the report indicates the need for such intervention.[52] Apparently, the law does not authorize such extraordinary interference with usual custodial rights unless the physician has actually examined the child.

Apropos of the issue of confidentiality, the regulations require that "the subject and other persons named in the report, except children under the age of eighteen" be notified of the existence of the report and their rights concerning its amendment or expungement.[53] These rights include a fair hearing under the Social Services Law.[54]

Section 422 of the Social Services Law sets forth a general requirement of confidentiality for reports and information provided to the state central register, followed by no fewer than twenty enumerated exceptions.[55]

IV. CONFRONTING THE DILEMMA

Problems of confidentiality under section 413 may arise in one of three ways. First, the patient may be the alleged child victim. Second, the patient may be a guardian or custodial parent other than the abuser. Finally, the patient may be the person suspected of child abuse.[56] To understand the therapist's dilemma, which differs some-

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> the child should be returned. At preliminary hearings, incompetent evidence is admissible, including unsworn testimony and hearsay evidence. The evidentiary weight requirement for a finding of child abuse is a mere preponderance of the evidence. Although the proceedings are styled as civil proceedings, discovery depositions are unheard of. While the state draws expert prosecution witnesses from the professional community and from agents of the state and the child care agencies, the appearance of expert witnesses on behalf of indigent parents is rare, perhaps because the expert fee is $300 per case per expert. The indigent parent defense allocation is nominal at $800 per case per 18B [i.e., assigned] counsel. The payment schedule discourages out of court case preparation. The proceedings are not designed to return a child to an alleged abuser under any circumstances. Statute and policy mostly leave the return decision in the discretionary hand of the Family Court judge.

Buono, *Sex, Science and Law Clash at New York Family Court Hearings*, 40 BROOKLYN BARRISTER 196, 198-99 (May 1989).

52. N.Y. COMP. CODES R. & REGS. tit. 18, § 432.2(e)(3)(xxiv) (1976); *see also* N.Y. SOC. SERV. LAW § 417(1)(b) (McKinney Supp. 1989).

53. N.Y. COMP. CODES R. & REGS. tit. 18, § 432.2(3)(ii)(f) (1985); *see also* N.Y. SOC. SERV. LAW § 424(6) (McKinney Supp. 1989).

For a discussion of the role of a psychiatrist under British law, see Brandon, *The Psychiatrist in Child Abuse - Ethical and Role Conflicts*, in THE ABUSED CHILD IN THE FAMILY, *supra* note 39, at 401, 402.

54. N.Y. SOC. SERV. LAW § 422(8)(a)(i) (McKinney Supp. 1989).

55. *Id.* § 422(4)(A).

56. *See* Coleman, *Creating Therapist-Incest Offender Exception to Mandatory*

what in each of these cases, it is necessary to examine the role of professional silence in the practice of psychotherapy.

A. *The Need for Confidentiality in Psychotherapy: Therapeutic Arguments*

Sigmund Freud expressed the need for confidentiality in absolute terms: "[t]he whole undertaking becomes lost labor," he wrote, "if a single concession is made to secrecy."[57] Hippocrates might not have disagreed. His famous oath contains the pledge: "[w]hatever, in connection with my profession, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge as reckoning that all should be kept secret."[58]

The therapeutic rationale for requiring confidentiality in psychotherapy is explained by Shuman and Weiner:

> Although there are many types of psychotherapy, the model upon which privilege arguments primarily rest is psychoanalysis, originated by Sigmund Freud.
>
> Based on his experience in treating emotional disorders, Freud theorized that certain types of emotional problems result from the rekindling of repressed emotional conflicts from early childhood. Those conflicts are repressed into the unconscious portions of the mind because they are unacceptable to the conscious self. The treatment brings these conflicts to consciousness so that the patient can more adequately deal with or resolve them. Free association is the technique by which the psychoanalyst and patient gain access to the patient's unconscious mind. Hence, Freud's fundamental rule for a patient in psychoanalysis . . . is that the patient must disclose to the therapist *all* of his thoughts or feelings. Freud concluded that withholding material of any sort from the therapist served the purpose of resistance, an automatic attempt by the patient's mind to block the emergence of material from the unconscious. The work of psychoanalysis is removing the patient's resistance to discovery of what has been repressed. Unless the patient is assured that the therapist has no authority over him—for example, through disclosure of their communications in court—the built-in resistance to full disclosure cannot be overcome. The patient must trust the therapist; this can occur only if the pa-

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Child Abuse Reporting Statutes-When Psychiatrist Knows Best, 54 U. CIN. L. REV. 1113, 1116-20 (1986).

57. 2 S. FREUD, COLLECTED PAPERS 356 n.1 (1959 ed.).

58. *Quoted in* Everstine, Everstine, Heymann, True, Frey, Johnson & Seiden, *Privacy and Confidentiality in Psychotherapy*, 35 AM. PSYCHOLOGIST 828, 829 (1980).

> tient alone holds the key to disclosure of matters revealed in therapy.[59]

The same rationale applies, with only slightly diminished force, to other forms of psychotherapy.[60]

Both generally accepted medical theory and repeated clinical observations tend to show that a therapist's breach of silence may have deleterious effects upon a patient. These observations have been tentatively confirmed in a number of empirical studies.[61] Moreover, evidence

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59. Shuman & Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C.L. REV. 893, 896-97 (1982). The authors are not discussing confidentiality, but the related concept of privilege. The quoted material, however, is equally applicable to both concepts.

60. There is reason to believe that, in response to mandatory reporting laws, some therapists discourage their patients from discussing child abuse or neglect. Sixteen percent of the psychiatrists in one study reacted to the threat of personal liability by being more reluctant to probe dangerousness. Miller & Weinstock, *supra* note 21, at 168. The diminished effectiveness of psychotherapy when the "key to disclosure" is held by prosecuting attorneys, malpractice insurance carriers, and members of the negligence bar, instead of patients, must be considered.

Freud was no stranger to patient accounts of child abuse. *See* S. FREUD, DORA: AN ANALYSIS OF A CASE OF HYSTERIA (Collier ed. 1963), and U.S. DEP'T OF HEALTH, EDUC. & WELFARE, NAT'L INST. OF PUBLIC HEALTH, ABSTRACTS OF THE STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD, *A Child is Being Beaten* § 1919E, 17/175, 17/179, 17/186. Freud eventually concluded, apparently upon good evidence, that the incident described in the latter case never occurred. R. SLOVENKO, PSYCHOTHERAPY, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATIONS 51 n.10 (1966). Modern therapists are also familiar with the highly vivid but entirely delusional accounts of violence characteristically rendered by some classes of patients. The significance of this phenomenon should be noted in connection with the present criteria for mandatory reporting.

61. For a summary of some of these studies, see Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH. L. REV. 1, 25 n.163 (1980). The summarized studies include Meyer & Smith, *A Crisis in Group Therapy*, 32 AM. PSYCHOLOGIST 638, 638-40 (1977); Note, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine*, 71 YALE L.J. 1226, 1262 (1962) (the majority of those surveyed would be less likely to make a free and complete disclosure if they knew the psychologist had a legal obligation to disclose confidential information); Willage & Meyer, *The Effects of Varying Levels of Confidentiality on Self Disclosure*, 2 GROUP 88, 94-96 (1978); Project, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165, 183 (1978) [hereinafter Project] (24.5% of therapists surveyed noticed a reluctance of patients to disclose violent tendencies once told that the patient's case may be discussed with others). For more recent studies see Shuman & Weiner, *supra* note 59, at 919-20 (the likelihood of disclosure of information decreased markedly among those surveyed when told psychologist might be forced to reveal information in court); Miller & Weinstock, *supra* note 21.

This writer is unaware of any empirical studies of the specific harm that may result from a therapist's act of reporting child abuse. For reasons that will be supported by arguments advanced later in this article, *see infra* text accompanying notes 63-82, it is assumed that reporting child abuse, with or without a prior warning, constitutes a breach of confidentiality in the psychotherapeutic sense of the term.

supporting these observations has been developed in actionable cases of trust betrayal between therapist and patient.[62] The evidence suggests the following reasons for upholding the principle of confidentiality in psychotherapy.

The first reason for confidentiality relates to the availability of treatment. Under a scheme of mandatory reporting, abusive parents may withhold medical treatment from battered children because they are ashamed, or because they fear the legal consequences of disclosure. In the case of psychotherapy, abusive parents not only may withhold treatment from the child, but may themselves avoid obtaining the treatment they need.[63] Psychotherapists have observed that abusive parents may be emotionally disturbed[64] or character disordered,[65] and would benefit from psychotherapy. Accordingly, in the case of psychotherapists, mandatory reporting is especially self-defeating.

The next reason for confidentiality relates to diagnosis. The information necessary to make a proper diagnosis almost always must come from the patient. As Coleman has observed, a proper psychotherapeutic diagnosis requires full disclosure, in a safe environment, of the pa-

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62. *See* MacDonald v. Clinger, 84 A.D.2d 482, 446 N.Y.S.2d 801 (App. Div. 1982) (patient sued psychiatrist for disclosing confidential information to patient's spouse; court held plaintiff has an action for breach of fiduciary duty and that both contract and tort damages may be recovered); Doe v. Roe, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (Sup. Ct. 1977) (psychiatrist's publishing of book anonymously revealing patient's disclosures during psychoanalysis violated patient's right to confidentiality and therefore patient can recover for damage to well-being and emotional health as well as loss of income).

Interestingly, psychiatrists frequently discuss sexual relations between patients and therapists in terms of trust betrayal. For a further discussion, see T. GUTHEIL & P. APPELBAUM, *supra* note 14, at 152-53; A. STONE, LAW PSYCHIATRY AND MORALITY 191-216 (1984).

It has been observed that "[j]udges and juries are becoming increasingly willing to label such behavior as medical malpractice and to award huge sums of money to the victims of what Dr. [Nanette] Gartrell refers to as 'psychiatric sexual abuse'." *Sex with Patient Prohibited Even After Treatment Over*, 14 CLINICAL PSYCHIATRY NEWS, Apr. 1986, at 2, *cited in* R. Kammerman, On Medical Ethics in General with Specific Examination of the Ethical Issues in Psychiatrist-Patient Sexual Involvement 29-30 (1987) (unpublished manuscript) (on file at *New York Law School Law Review*).

63. "[M]andated reporters who participated in the community meetings articulated the following frustrations: . . . Professional relationships, i.e., between a doctor and a patient or between a caseworker and a client, often are strained or severed when the mandated reporter calls the Hotline." N.Y. STATE ASSEMBLY SUBCOMM. ON CHILD ABUSE, STATEWIDE COMMUNITY MEETINGS ON CHILD ABUSE: JANUARY - FEBRUARY 1988, 10 (June 1988).

64. *See* Coleman, *supra* note 56, at 1132; Brandon, *supra* note 53, at 403 ("[t]he conflict between treatment and management need is one of the commonest tensions experienced by the psychiatrist in cases of non-accidental injury, for the patients are often vulnerable, immature individuals seriously in need of professional help").

65. HANDBOOK OF CLINICAL INTERVENTION IN CHILD SEXUAL ABUSE 256-58 (S. Sgroi ed. 1982) [hereinafter HANDBOOK OF CLINICAL INTERVENTION].

tient's innermost feelings, fantasies, terrors, and shame.[66] A patient who does not expect confidentiality from the therapist may not make the necessary disclosures. If the diagnosis is not accurate, the patient consequently may not be correctly treated.[67] If the untreated illness is related to the alleged child abuse, the absence of confidentiality in connection with the diagnosis may defeat the very purpose of the reporting laws.

Reduced to its essence, the third reason for confidentiality is that the patient, having learned of the therapist's act of reporting, may discontinue treatment entirely or (in the case of an involuntarily committed patient) merely withhold, deliberately or subconsciously, the frank disclosure necessary for effective psychotherapy.[68] In either case, the patient's recovery may be impeded or reversed.

The fourth reason for confidentiality is that disclosure may be devastating to those patients whose mental illness affects their ability to establish relationships of trust. Coleman notes that a pathological inability to trust is a common symptom among incest offenders.[69] Janssen expressed the opinion that, for some patients, the development of a trusting relationship is the essence of treatment itself.[70] A number of therapists have hypothesized that the experience of growing up within an abusive family inhibits the formation of basic trust necessary to relate to others outside of the family.[71]

A patient's actual knowledge of mandatory reporting laws or even prior warning by the therapist may be insufficient to overcome the decompensation that may result from reporting in, for example, the case of a patient with a borderline personality disorder. If the patient is suicidal or has other violent tendencies, the risks attendant upon a breach of confidence are especially great.

Writing about incest as a form of reportable abuse, Coleman, cit-

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66. Coleman, *supra* note 56, at 1122-23.

67. *See* T. GUTHEIL & P. APPELBAUM, *supra* note 14, at 150-51.

68. *See* Shuman & Weiner, *supra* note 59, at 922 (significant number of patients refused further treatment after warning); Project, *supra* note 61 (one-quarter of therapists surveyed noticed a reluctance of patients to disclose violent tendencies once told that the patient's case may be discussed with others).

To the same effect, see R. Kammerman, *supra* note 62, at 16 ("the goal of psychotherapy could be conceived of as the learning of trust itself").

69. *See* Coleman, *supra* note 56, at 1125-26; HANDBOOK OF CLINICAL INTERVENTION, *supra* note 65, at 195-96.

70. Janssen, *Disclosure of Psychiatric Records (Part II): A Psychiatric Perspective*, 50 KAN. J. ST. B.A. 27, 30-31 (1981), *cited in* Coleman, *supra* note 56, at 1120 n.41, 1126 n.60.

71. *See, e.g.*, J. JACOBSEN, PSYCHIATRIC SEQUELAE OF CHILD ABUSE 175 (1986) (citing Humphrey, Ackerman & Stickler, *Child Abuse: Psychological Antecedents & Sequelae*, 8 PA. MED. 8, 10-12 (1978); Green, *Psychopathology of Abused Children*, 17 J. AM. ACAD. OF CHILD PSYCHIATRY, 92-103 (1978); E. ERICKSON, CHILDHOOD AND SOCIETY (1950).

ing Meiselman,[72] states:

> Psychosis would also seem to be a factor in incest because of the breakdown in ego controls that accompany a psychotic condition. Nevertheless, despite its reasonableness, the presumption that many incestuous fathers must have been psychotic when the incest began has not been confirmed. However, it is interesting to note that a father often becomes psychotic after the offense has been exposed, sometimes while serving his prison sentence. This is particularly important in the context of the psychiatrist's duty to report. It would seem extremely unrealistic to expect a psychiatrist to report his or her patient if the psychiatrist believes the report and possible subsequent incarceration would cause a psychotic break.[73]

Other diagnostic categories may be imagined in which the therapist's breach of trust might adversely affect the patient's recovery.[74]

The fifth reason for confidentiality is that when the patient is the suspected abuser and is subject to criminal prosecution, reporting contravenes the therapist's duty to promote healing. This duty has been recognized by the American Psychological Association, the American Medical Association, and the American Psychiatric Association.[75]

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72. K. MEISELMAN, INCEST 100-02 (1981).

73. *See* Coleman, *supra* note 56, at 1132 n.81 (citations omitted).

74.

> [T]he psychiatrist may be apprehensive about the effects of disclosure or removal of the child upon his patient, fearing perhaps suicide or serious decompensation and the patient may be bewildered if 'his' doctor reveals to a health visitor [in England] or social worker events from the past unknown to anyone else or 'takes sides against him' in court. In these circumstances the engagement with the psychiatrist had been a voluntary one initiated by the patient whereas the agency involvement was unsought and a consequence of its social controlling practice.

Brandon, *supra* note 53, at 402.

75. *See* AMERICAN PSYCHIATRIC ASSOCIATION, THE PRINCIPLES OF MEDICAL ETHICS: WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY (1984) [hereinafter PRINCIPLES OF MEDICAL ETHICS], which provides:

> *SECTION 3*
>
> *A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patients. Id.* at 5 (emphasis supplied).
>
> *SECTION 4*
>
> *A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law. Id.* at 5 (emphasis supplied).
>
> 1. [C]onfidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. . . . Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must

Finally, Dubey argued that a therapist should not disclose a patient's confidences, *even with the patient's consent*, if the use of the information will have legal consequences for the patient.[76] Observing that "what may be in a person's best legal interests—maintenance of dramatic symptoms in order to present a sound case for disability or liability—may be directly contrary to his therapeutic interests—relinquishing of symptoms,"[77] Dubey wrote: "[T]he psychiatrist's problem with the waiver of privilege is that it can force the therapist to cooperate with the patient's strategies to acquire secondary gain."[78] Dubey agreed with Hollander that: "If the psychiatrist speaks in court in the patient's behalf, he becomes an ally against an outside adversary; if he speaks against his patient, he becomes an enemy. In either case he abrogates his therapeutic role and takes another, and potentially incompatible, role."[79] Thus, wrote Dubey: "in order to discourage secondary gain, confidentiality is necessary so that disclosures will have

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be circumspect in the information that he/she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration. *Id.*

2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privileges of privacy. This may become an issue when the patient is being investigated by a government agency, . . . or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies . . . . *Id.* at 6.

. . . .

5. Ethically the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact. *Id.*

. . . .

7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parent or guardian in the treatment of a minor. At the same time the psychiatrist must assure the minor proper confidentiality. *Id.*

. . . .

9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients he/she may comply or he/she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand. *Id.*

The Principles of Medical Ethics of the American Medical Association from which the APA provisions were adopted, was annotated by the American Psychiatric Association. *Id.* at 1 & n.3.

76. Dubey, *Confidentiality as a Requirement of the Therapist: Technical Necessities for Absolute Privilege in Psychotherapy*, 131 AM. J. PSYCHIATRY 1093, 1093 (1974).

77. *Id.*

78. *Id.* at 1095.

79. *Id.* at 1094 (quoting Hollander, *Privileged Communication and Confidentiality*, 26 DISEASES OF THE NERVOUS SYSTEM 169, 173 (1965)).

no power or influence of any kind, harmful or helpful, over the patient's extra-therapeutic life."[80] It follows that confidentiality, which is "needed to protect the practice of psychotherapy,"[81] cannot be waived, even before a therapeutic relationship is established. "When the therapist is asked, 'Doctor, is what I tell you confidential?' he must be able to answer, 'What you tell me I will keep confidential, even if you decide that you don't want me to.' "[82]

Based upon the foregoing, the therapeutic argument concludes with the observation that something of great value, if not the "whole undertaking," may be lost if the therapist divulges that "which ought not be spoken abroad."

B. The Social Work Arguments

"Social work arguments" take into consideration not only the immediate interests of the patient and the child, but the interests of other family members and society as a whole. While some professional social workers would disagree with some arguments advanced in this article,[83] or with the ultimate conclusion, the arguments attempt to reflect the serious concerns of the profession. In social work, as in law, there is often truth on both sides of an issue.

The first social work argument is that, for largely unavoidable rea-

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80. *Id.*

81. *Id.* (quoting Hollander, *supra* note 79, at 175).

82. *Id.* at 1093. The argument that a therapist can remain silent in the face of a waiver of privilege by the patient was rejected by the California court in *In Re* Lifschultz, 2 Cal. 3d 415, 423-24, 467 P.2d 557, 561-62, 85 Cal. Rptr. 829, 833-34 (1970), and is contrary to the law in New York. *See* E. FISCH, FISCH ON NEW YORK EVIDENCE § 542 (2d ed. 1977).

83. For a contrasting view, see Graves & Sgroi, *Law Enforcement and Child Sexual Abuse*, in HANDBOOK OF CLINICAL INTERVENTION, *supra* note 65. *Compare* Weisberg & Wald, *Confidentiality Laws and State Efforts to Protect Abused or Neglected Children: The Need for Statutory Reform*, 18 FAM. L.Q. 143 (1984).

.On the other hand, some educators resist required reporting because they:

— operate from the premise that all communications between themselves and their students as clients are confidential and if they learn of the abuse or neglect during a private conference, it is unethical or illegal to divulge it;

— fear they will alienate the parents if the child's injury turns out to be accidental;

— fear that the student who is moderately or severely abused will be placed in further jeopardy if the parents learn of the referral;

— believe they alone can handle the situation and affect reasonable change in the behavior of the abusing party without additional professional assistance; or

— believe that child protective services are not effective in intervening on behalf of the child.

ERICKSON, MCEVOY & COLUCCI, CHILD ABUSE & NEGLECT: A GUIDEBOOK FOR EDUCATORS & COMMUNITY LEADERS 106 (2d ed. 1986).

sons, the act of reporting child abuse often leads nowhere.[84] This is illustrated by the 1983 Family Court opinion in *In re Marcario*.[85]

Marcario involved the application of a CPS caseworker for a search warrant to determine if an abused or neglected child was present in the family home.[86] Some three months earlier, the case worker received a telephone call from a person identifying herself as a "Mrs. Ocario" who stated that her angry, intoxicated husband, had on an occasion not further identified, punched his six-year-old son in the stomach several times and threw a coffee table at him.[87] On further investigation, both Mr. and Mrs. Marcario denied the alleged abuse, and Mrs.

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84. *See* J. GOLDSTEIN, A. FREUD & A.J. SOLNIT, BEFORE THE BEST INTERESTS OF THE CHILD 71 (1979) [hereinafter J. GOLDSTEIN]: "Laws requiring physicians, nurses, social workers, and educators to report suspected cases have contributed little to protecting children." This sentence is explained in a footnote:

> Mandatory reporting has swelled the number of complaints for neglect and abuse that must be investigated by the state. In most states a third or more of these complaints are for alleged neglect that does not involve imminent risk of serious bodily injury. Investigations in such cases frequently constitute an unwarranted intrusion into family privacy, weakening the integrity of the family involved. Two-thirds of the mandated reports are for alleged physical or sexual abuse or for children at imminent risk of serious bodily injury. Coercive inquiries follow even when the state does not have adequate homemakers, social workers, psychiatric, emergency, foster, medical care, or other backup services. The overbroad and vague base for mandatory reporting and inquiry has led to overreporting, to unnecessary demands on services that are inadequate even for those children at greatest risk, and damaging coercive intrusion is encouraged into families of children whose needs, if real, can best be served—and perhaps can only be served—by a range of voluntary services that would be available, accessible, and attractive to families who are or tend to be disorganized.

Id.

In support of the same arguments based upon more recent data, see Besharov, *Doing Something About Child Abuse: The Need to Narrow the Grounds for State Intervention*, 8 HARV. J.L. & PUB. POL'Y 539 (1985) [hereinafter Besharov 1985] (suggesting that policy makers use criminal law as model to develop realistic legal standards for intervention). *See also* LAUER, LOURIE, SALUS & BROADHURST, THE ROLE OF THE MENTAL HEALTH PROFESSIONAL IN THE PREVENTION AND TREATMENT OF CHILD ABUSE AND NEGLECT (1979) [hereinafter LAUER]:

> Mental health practitioners who have had an unfortunate experience when reporting suspected child abuse and neglect may be reluctant to become involved a second time. Such practitioners may have been discouraged from reporting, or may have developed a distrust of CPS (or another agency) or its staff, feeling that a previous case was not handled to their satisfaction. These concerns are real, and often valid . . . .

Id. at 31.

85. *In re* Marcario, 119 Misc. 2d 404, 462 N.Y.S.2d 1000 (Fam. Ct. 1983). The case arose prior to the 1984 amendments to Social Services Law Section 413, *see supra* note 8 and accompanying text. The amendment mandated reporting by the specified persons even if they had not personally observed the victim.

86. *Marcario*, 119 Misc. 2d at 405, 462 N.Y.S.2d at 1001.

87. *Id.*

Marcario denied she had made the initial call to the CPS caseworker.[88]

The Family Court declined to issue a search warrant, holding that the *Aguilar* test, pertaining to the adequacy of an informant's knowledge to support an application for a search warrant, had not been met.[89] The court, in response to the caseworker's argument that she was a mandatory reporter, noted that the child himself had not come before the CPS caseworker, as then required by Social Services Law section 413.[90] Of course, section 413 pertained to mandatory reporting, and not to the granting of a search warrant. The court's point was that the caseworker in *Marcario* did not have any information about the alleged abuse derived from the child himself.

The 1984 and 1985 amendments to section 413 which provide for mandatory reporting, even if the professional did not personally examine the child, did not resolve this problem. A therapist who provides all the information required by section 415[91] might, in some cases, enhance the ability of a CPS caseworker to secure judicial process to aid her investigation. But when the therapist does not examine the child, her report to a caseworker who also has not examined the child may be insufficient under *Marcario* to support the application for a search warrant.[92] Moreover, it is unlikely that a patient will provide the thera-

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88. *Id.*

89. *Id.* at 407, 462 N.Y.S.2d at 1003. The test is derived from Aguilar v. Texas, 378 U.S. 108 (1964). The two prongs of the test are that the informant have an adequate "basis of knowledge" and that he be either generally "reliable" or "credible" in the particular case (the so-called "veracity" prong).

90. *Marcario*, 119 Misc. 2d at 408, 462 N.Y.S.2d at 1003.

91. N.Y. Soc. Serv. Law § 415 (McKinney Supp. 1989).

92. *Compare* People v. Smith, 545 N.Y.S.2d 616 (App. Div. 1989) (expert testimony of a psychotherapist with regard to behavior of children who are victims of sexual abuse, was properly admitted even though witness had not interviewed victim).

The Supreme Court's abandonment of the *Aguilar* test does not enhance the ability of New York CPS caseworkers to obtain search warrants. For example, it is unlikely the facts in *Marcario* would satisfy the "totality of circumstances" test enunciated by the Court in Illinois v. Gates, 462 U.S. 213 (1983). In any event, in a case involving a warrantless arrest, the New York Court of Appeals declined to follow *Gates* as a matter of state constitutional law. People v. Johnson, 66 N.Y.2d 398, 406-07, 488 N.E.2d 439, 445, 497 N.Y.S.2d 618, 624 (1985). In the companion case of People v. Bigelow, 66 N.Y.2d 417, 488 N.E.2d 451, 497 N.Y.S.2d 630 (1985), the court observed, "New York's present law applies the *Aguilar/Spinelli* rule . . . ." *Id.* at 423, 488 N.E.2d at 455, 497 N.Y.S.2d at 634; *see also* People v. P.J. Video, 65 N.Y.2d 566, 483 N.E.2d 1120, 493 N.Y.S.2d 988, *rev'd sub nom.* New York v. P.J. Video, 475 U.S. 868, *on remand*, 68 N.Y.2d 296, 501 N.E.2d 556, 508 N.Y.S.2d 907 (1986), *cert. denied*, 479 U.S. 1091 (1987). Later, citing *Johnson*, the New York Court of Appeals found that the minimum showing necessary to establish probable cause for the issuance of a search warrant was not made when the supporting affidavit did not set forth the requisite "basis of knowledge" for the hearsay upon which the application was predicated and the allegedly corroborating facts were as consistent with innocence as with guilt. People v. Vernon Edwards, 69 N.Y.2d 814, 815, 506 N.E.2d 530, 531, 513 N.Y.S.2d 960, 961 (1987). In 1985, the Monroe County Court

pist with all of the required details unless the therapist encourages the patient to do so. This involves the therapist in the further ethical dilemma of determining the extent to which the patient should be questioned for the purpose of filing a child abuse report.[93] If the patient is the suspected abuser and is subject to criminal prosecution, the question arises whether, and under what circumstances, the therapist becomes a custodial agent of the government who must provide the patient with *Miranda* warnings.[94] One might also ask whether the therapist, consistent with her professional duty to the patient, should participate at all in a process that might lead to her patient's incarceration. In any event, the additional cases now subject to mandatory reporting by reason of the 1984 and 1985 amendments are precisely those cases least likely to result in successful judicial intervention.

In sum, the first social work argument is that since caseworkers frequently are unable to secure the evidence necessary to initiate child protective proceedings, the filing of a child abuse report is often futile.[95]

Secondly, even if caseworkers possess sufficient prima facie evi-

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observed: "Apparently *Aguilar* is still the law in New York." People v. Windrum, 128 Misc. 2d 1043, 1044 n.2, 492 N.Y.S.2d 328, 329 n.2. In light of *Vernon Edwards*, the same conclusion can be made with even greater assurance today.

93. *Compare* Estelle v. Smith, 451 U.S. 454, 467 (1981) (doctor's testimony at penalty phase violated fifth amendment protection against self-incrimination when patient was not advised of right to remain silent before examination and information was used) *with* Allen v. Illinois, 478 U.S. 364, 375 (1986) (doctor's testimony not violation of fifth amendment protection against self-incrimination when examination is compelled by statute in proceeding deemed not criminal). An investigating CPS caseworker is not a custodial agent of the government under the circumstances described in People v. Gwaltney, 140 Misc. 2d 74, 530 N.Y.S.2d 437 (Sup. Ct. 1988) (in dicta, no privilege between father of abused child and caseworker since the latter is not a custodial agent of the state).

94. Miranda v. Arizona, 384 U.S. 436, 444-45 (1966) (once in custody and before questioning, defendant must be informed that he has the right to remain silent, that any statement made can be used against him, and that he has a right to an attorney either retained or appointed, and that no questions can be asked if he indicates he wants an attorney present).

95. Recognizing child abuse is not as easy as it may seem. Because abuse usually occurs in the privacy of the home without witnesses, recognition is often based on deductions; often there is no hard first-hand evidence. That is why the law requires the reporting of *suspected* abuse or maltreatment.

> In grappling with the problem of recognition, professionals depend upon a series of clues, which, based on their experience, they look for in diagnosing abuse or maltreatment. These clues are not conclusive proof. They are nothing more than circumstantial evidence tending to show that a child has been abused or maltreated. . . . It should be noted that *these indicators can exist in situations where a child is not abused.*

HOYT REPORT, *supra* note 24, at 11 (emphasis in original). For statistics on the number of child abuse or neglect cases reported between 1963 and 1982, see Besharov 1985, *supra* note 84, at 545.

dence, successful prosecution, particularly in criminal cases, is far from assured. Child witnesses and other family members may be reluctant to testify, or may recant their allegations, or the accused may offer credible evidence in rebuttal.[96]

Next, the investigation of a child abuse report may do more harm than good. The investigation can result in an intrusion by government agents (CPS caseworkers) into intimate family matters, it disrupts family unity, and it involves a breach of family privacy which, at best, is unsettling to the child, the suspected adult, and other family members.[97] In cases where one member of the household already is speaking

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96. In *Pennsylvania v. Ritchie*, the Supreme Court stated: "Child abuse is one of the most difficult crimes to detect and prosecute, in large part because there are often no witnesses except the victim. A child's feelings of vulnerability and guilt, and his or her unwillingness to come forward are particularly acute when the abuser is a parent." 480 U.S. 39, 60 (1987).

As Justice Duffy observed in People v. Bass, 140 Misc. 2d 57, 529 N.Y.S.2d 961 (Sup. Ct. 1988), cases involving sexual abuse are particularly difficult to prove because of their heavy dependence upon the credibility of the victim's testimony; because scientific evidence of the kind often obtained in forcible rape cases can rarely be offered; by reason of the passage of time between the act of sexual abuse and its discovery by the authorities; because young children are particularly vulnerable to pressure from family members to recant their testimony; and because young children often lack the vocabulary and fortitude to withstand cross-examination in the hostile courtroom environment. *Id.* at 62-63, 529 N.Y.S.2d at 964.

Efforts to ease the child victim's courtroom trauma have met the obstacle of the confrontation clause. *See* Coy v. Iowa, 108 S. Ct. 2798 (1988) (the use of a back-lit screen around the child-witness denied defendant's constitutional right to a face-to-face confrontation). *But see* People v. Logan, 141 Misc. 2d 790, 793, 535 N.Y.S.2d 322, 324 (Sup. Ct. 1988) (New York's procedure of simultaneous transmission between witness and defendant did not violate the sixth amendment because the prosecution had to prove the witness would be harmed by testifying in the presence of the defendant, and because image of jury, defendant, and examiner would be seen by the witness).

For further discussion of the difficulties involved in securing criminal convictions in child abuse cases, see Capra, *Hearsay Exceptions in Child-Abuse Prosecutions*, N.Y.L.J., Oct. 13, 1989, at 3, col. 1; Capra, *Innovations in Prosecuting Child Sexual Abuse*, N.Y.L.J., Nov. 9, 1989, at 3, col. 1.

97.

> [T]he level of child protective intervention into private family matters has reached unprecedented levels . . . . Unfortunately . . . the determination that a report is "unfounded" can only be made after an unavoidably traumatic investigation which is, inherently, a breach of parental and family privacy. To determine whether a particular child is in danger, workers *must* inquire into the most intimate of personal and family matters. The parents and children almost always must be questioned about the report. And it is often necessary to interview friends, relatives, and neighbors, as well as school teachers, day care personnel, doctors, clergymen, and others who know the family. Whether or not the allegations of the report are true, their disclosure can violate the sensibilities of all those involved and can be deeply stigmatizing.

Besharov 1985, *supra* note 84, at 556-57 (emphasis in original); *see also* Besharov, *Legal Aspects of Reporting Known and Suspected Child Abuse and Neglect*, 23 VILL. L. REV.

to a psychotherapist, the therapist, rather than a government caseworker, may be in a better position to address the underlying problem.[98]

If the investigation is harmful, litigation is worse. The feelings engendered by court proceedings, especially criminal proceedings, are totally inconsistent with family stability.[99]

As the Institute of Judicial Administration-American Bar Association Joint Commission on Juvenile Justice Standards observed:

> We believe . . . that the general principle that all persons must give basic respect to parents' control over their children is most consistent with our social traditions and with the psychological tenet that an intense bonding between parent and child should be fostered in all ways possible. . . . A legal rule which authorized—and, in effect, invited—any professional to disregard the traditional norms of confidentiality in dealing with children would unduly denigrate the principle of parental control.[100]

One frequently encountered goal of psychotherapy—a goal expressly recognized in New York's Consolidated Services Plan[101]—is preservation and unification of the family unit. In cases of incest, the indicated course of treatment may include family counseling. Coleman has suggested that the efficacy of such treatment may be undermined

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458, 461 (1978) [hereinafter Besharov 1978] ("Coercive intervention into family life should not be authorized unless there is sufficient reason to believe that child abuse and neglect exist. Moreover, these terms should be carefully defined in state law to minimize their improper application to situations where societal intervention is not justified.") (footnotes omitted); J. GOLDSTEIN, *supra* note 84, at 64 ("When suspicion is aroused, the harm caused by inquiry may be more than that caused by not intruding.").

The extent to which allegations of child abuse are used as a tactic in divorce litigation is a matter of concern and debate. Thoennes concludes that such allegations are raised in an attempt to gain custody in a small but growing number of cases. Thoennes, *Child Sexual Abuse: Whom Should a Judge Believe? What Should a Judge Believe?*, 27 JUDGE'S J. 14, 16 (Summer 1988). Interestingly, Thoennes finds support for "the view expressed by many mental health professionals interviewed in the study that abuse is often first disclosed by children or acknowledged by a caretaker only after a divorce is final." *Id.* at 17. "[I]t is desirable for such parents on their own initiative to seek psychological assistance for themselves and their child. The state should provide such opportunities for those who want help." J. GOLDSTEIN, *supra* note 84, at 64.

98. "Studies have . . . found that child-serving professionals, such as doctors and social workers, often fail to file official reports when they suspect child abuse. Such professionals often prefer to enroll troubled families in counseling, substance abuse treatment or other social services." WHITCOMB, *supra* note 23, at 4 (footnotes omitted).

99. *See* Coleman, *supra* note 56, at 1134-35.

100. JUVENILE JUSTICE STANDARDS PROJECT, INSTITUTE OF JUDICIAL ADMINISTRATION—AMERICAN BAR ASSOCIATION STANDARDS RELATING TO ABUSE AND NEGLECT Standard 5.1(A)(1) comment (1981) [hereinafter STANDARDS RELATING TO ABUSE AND NEGLECT].

101. CPS MANUAL, *supra* note 24, at ch. I, § B.

or lost by reporting and the investigation and legal proceedings that may then ensue.[102] Certainly, the problem of confidentiality, which is difficult enough in the context of family counseling, is compounded by the requirement of reporting confidences to an outside agency.[103]

The incarceration of an abusive parent puts a further strain on family stability because it removes a member who, to some extent, may support the family emotionally or financially.[104] Removal of the child to a foster home, which may result from criminal or protective proceedings, is also highly inimical to family cohesiveness.[105] Moreover, while the judgment in successful child protective proceedings frequently provides for mandatory therapy of the abuser, the social work argument suggests this result may be achieved earlier, more effectively, and at less cost to the state through skillful intervention by the family's own therapist.[106]

Indeed, the process leading to compulsory treatment is inherently self-defeating because the basic trust necessary for effective psychotherapy cannot be mandated.[107]

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102. Coleman, *supra* note 56, at 1134-35 n.44.

103. *See* Brandon, *supra* note 53, at 402-03.

104. Coleman, *supra* note 56, at 1134 & n.87.

105. *See* Besharov 1985, *supra* note 84, at 560 ("Long term foster care can leave lasting psychological scars. It is an emotionally jarring experience which confuses young children and unsettles older ones. Over a long period, it can do irreparable damage to the bond of affection and commitment between parent and child.") (footnotes omitted); Solnit, *Too Much Reporting, Too Little Service: Roots and Prevention of Child Abuse*, in G. GERBNER, CHILD ABUSE: AN AGENDA FOR ACTION 146 (1980) ("Neglect that does not seriously threaten to do bodily injury should not be a basis for coercive intrusion into the privacy of the family or for the removal of children from their family homes to state-supervised shelters, foster homes, or other institutions.").

106. "Certainly within the context of child abuse there is no scope for passive treatment; without the active cooperation of the patient no therapy is possible . . . ." Brandon, *supra* note 53, at 404.

107. It is extremely doubtful that a patient who has been put through the ordeal of civil or criminal prosecution will be persuaded to open his heart to a court-appointed therapist by promises of legal immunity or explanations of the double jeopardy clause. In any event, the process of psychotherapy takes place at a subconscious level, where knowledge of the legal probabilities may have little impact. *See* JACOBSEN, *supra* note 71, at 6. Of course, involuntary treatment may have some beneficial effect through mechanisms other than pure psychotherapy: the instillation of guilt, shame, and so forth. In this respect, however, the process is penal, not therapeutic. An evaluation of the efficacy of involuntary treatment is beyond the scope of this article. In short, it has been observed that:

> [i]nitiating a therapeutic relationship can actually trigger a violent episode due to the predictable anxieties that accompany seeing a therapist for the first time. This is especially true if the client is participating in therapy "involuntarily," due to coercion from a partner or a court's mandate. Involuntary clients may be more resistant to therapy, more distrustful of therapists, and more susceptible to the anxiety that discussing problems with a therapist-stranger can sometimes induce.

By discouraging frank disclosure, the present system tends to perpetuate abusive parenting. Children learn inappropriate patterns of behavior from unrehabilitated family members.[108] Abused children tend to become abusive parents.[109]

In addition, the reporting statute encourages professionals to overreport, thereby diluting the ability of CPS caseworkers to respond aggressively to genuine emergencies.[110] The serious consequences of an abuse investigation are brought to bear in many situations where no abuse has occurred.[111]

Finally, government intervention may breed resentment, hostility, and retaliation by the alleged abuser. The incidence of family violence may actually increase.[112]

McNeill, *Domestic Violence: The Skeleton in Tarasoff's Closet*, in D.J. SONKIN, DOMESTIC VIOLENCE ON TRIAL 210 (1987).

Involuntary treatment, however, need not always be futile. "Although in some instances involuntary treatment may not be effective there are approaches mental health professionals can use that can encourage cooperation on the part of clients and increase their potential to change." LAUER, *supra* note 84, at 50.

108.

> Contrast the benefits of effective treatment with the results if the psychiatrist is compelled to report the abuse and the offender is incarcerated. The offender probably receives no help, or aid is postponed while he is in jail. The child feels guilty and the family may be destroyed. No one obtains counseling and the cycle continues. Even if the offender is not jailed as a result of the report of his psychiatrist, the essential trust relationship between doctor and patient will have been destroyed. This rift may create an insurmountable barrier to the patient receiving help from the doctor, and possibly from any other therapist as well.

Coleman, *supra* note 56, at 1134-35 (footnote omitted).

109. *Id.* at 1117; STANDARDS RELATING TO ABUSE AND NEGLECT, *supra* note 100, standard 1.5 comment.

110. "The system is so overburdened with cases of unsubstantial or unproven risk to children that it does not respond forcefully to situations where children are in real danger." Besharov 1985, *supra* note 84, at 540. The experience in New York illustrates the harmfulness of present trends. Between 1979 and 1983, as the number of reports increased by nearly 50% (from 51,836 to 74,120), the percentage of substantiated reports fell by almost 20% (from 42.8% to 35.8%). In fact, the absolute number of substantiated cases actually declined by 100. Although more than 20,000 additional families were investigated, fewer children were aided. *See also* N.Y. SOC. SERV. LAW § 421-a (McKinney Supp. 1989), added by Act of Sept. 2, 1988, ch. 707, § 8, 1988 N.Y. Laws 1446, 1452 (McKinney) (requires the Department of Social Services to promulgate regulations to enhance performance standards for the delivery of child protective services).

111.

> Even after the extensive screening of reports performed by child protective agencies, these agencies still place over 400,000 American families under home supervision. Facing the threat of court action, these families are compelled to accept treatment services. However, a recent study conducted for the United States National Health Center on Child Abuse and Neglect found that in about half of these cases, the parents never actually maltreated their children.

Besharov 1985, *supra* note 84, at 558 (footnotes omitted).

112.

For these reasons, the social work argument concludes that the present system of mandatory reporting is not in the best interests of the child, the patient, the family, or the community. At best, the benefits of the system are outweighed by its emotional and social costs. At worst, the effects of the law are in direct opposition to the goals of both the social work profession and the statute itself.

C. Some Legal Arguments

Stone remarks that lawyers assume the need for confidentiality in their own profession while demanding justification for its recognition in psychotherapy.[113] Whether or not this is entirely true, there are legal arguments for confidentiality in therapy that cannot be swept away by mandatory reporting laws. Four such arguments are herein presented.

1. Mandatory Reporting May Violate the Therapist's Contractual Obligation and Ethical Duty to Use Her Best Professional Judgment on Behalf of Her Patients

In a case involving publication by a psychiatrist of a patient's disclosures during psychoanalysis, Justice Stecher wrote:

> [A] physician, who enters into an agreement with a patient to provide medical attention, impliedly covenants to keep in confidence all disclosures made by the patient concerning the patient's physical or mental condition as well as all matters discovered by the physician in the course of examination or treatment. This is particularly and necessarily true of the psychiatric relationship . . . .[114]

> [B]eing reported to the authorities does not assure a child's safety. Studies in several states have shown that about twenty-five percent of all child fatalities attributed to abuse or neglect involve children already reported to a child protective agency. Tens of thousands of other children receive serious injuries short of death while under child protective supervision.

Id. at 551 (footnote omitted).

> [R]eporting, while demonstrably beneficial to some abused children, may actually lead to additional problems for others by leading to premature removal from homes and by interfering with the ability of abusing parents to deal with their problems and reintegrate their families.

Miller & Weinstock, *supra* note 21, at 162 (citation omitted).

113. A. STONE, *supra* note 62, at 180. More precisely, Stone said, "[I]t is also true to my knowledge that no one has shown in any empirical study that confidentiality between lawyer and client is essential to good legal services. Nonetheless, lawyers are convinced of its necessity on the basis of their professional tradition and their own clinical experience." *Id.*

114. Doe v. Roe, 93 Misc. 2d 201, 210, 400 N.Y.S.2d 668, 674-75 (Sup. Ct. 1977). The quotation continues:

> [I]n the dynamics of psychotherapy "(t)he patient is called upon to discuss in a

It may be argued that statutory reporting requirements are also implied in every contract for therapeutic services; everyone is presumed to know the law; and, in any event, a therapist may expressly include the duty to report in the contract for professional services by raising the issue at an appropriate time. These arguments do not withstand analysis.

First, it is apparent that the patient may lack the mental capacity to execute a legally binding contract or to understand the reporting requirements of the law when he first seeks out, voluntarily or otherwise, psychiatric examination and treatment. Although possessing that minimal level of competence necessary for voluntary admission to treatment,[115] he may be in turmoil and suffering from a condition which, in the therapist's judgment, would be exacerbated by warnings about disclosure; the patient may even be suicidal. The therapist might find it necessary to enter into an immediate relationship of trust and confidence with the patient, to establish the therapeutic alliance, and to shield the patient, at least temporarily, from certain aspects of unpleasant reality. In short, it may be therapeutically necessary for the therapist and the patient to enter into an agreement, express or implied, providing that the therapist will *not* divulge the patient's confidences—certainly not those which might result in the patient's incarceration. At the very least, the therapist might find it therapeutically inadvisable to force an agreement providing that disclosure will be made "immediately," as required by Social Services Law section 413. In these circumstances, an "implied-in-law" agreement to disclose is a fiction and conflicts with the therapist's duty and agreement to help the patient.

Even in less acute circumstances, where the patient understands the disclosure requirement, immediate reporting may be contraindicated. The therapist may find that the patient's condition will be best treated by helping the patient to recognize and address an unhealthy situation, such as inappropriate sexual contact between the patient's

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candid and frank manner personal material of the most intimate and disturbing nature. . . . He is expected to bring up all manner of socially unacceptable instincts and urges, immature wishes, perverse sexual thoughts—in short the unspeakable, the unthinkable, the repressed. To speak of such things to another human requires an atmosphere of unusual trust, confidence and tolerance. Patients will be helped only if they can form a trusting relationship with the psychiatrist."

Id. at 674-75 (quoting Heller, *Some Comments to Lawyers on the Practice of Psychotherapy*, 30 TEMP. L.Q. 401, 405-06 (1957)).

115. *See* T. GUTHEIL & P. APPELBAUM, *supra* note 14, at 50 (some sacrifice of the patient's autonomy interest in relation to competency may be warranted in the best interests of the patient as an individual in need of care). *Compare* Everstine, *supra* note 58, at 831 (even incompetent clients should be made aware of their rights and informed consent obtained at earliest possible time).

spouse and child. If confrontation does not resolve the problem, the therapist may encourage the patient to report the maltreatment himself.[116] This conduct by the therapist would violate the statute (which requires the therapist, not the patient, to report, and to do so at once), while compliance with the statute would violate the therapist's duty to exercise her professional judgment on the patient's behalf.

Finally, for therapists who follow Dubey, no disclosure agreement made with any patient could be reconciled with the therapist's obligation to advance the patient's therapeutic interests.[117] It follows that mandatory reporting is irreducibly opposed to the principle of patient care and the independence of the therapist's professional judgment.

2. Mandatory Reporting is Inconsistent with the Statutory Grant of Testimonial Privilege

Testimonial privilege is a term of art used in the law of evidence. Unlike the rules of confidentiality—which generally require professionals not only to raise the issue of confidence when questioned before a court, but also to maintain confidentiality outside the courthouse[118]—the rules of privilege encompass the admission or exclusion of evidence in trials, examinations before trials, judicial inquiries, and grand jury and legislative proceedings.[119] To exclude evidence as privileged in New York, the mental health professional must establish that a therapist-patient relationship existed, that the information was acquired during professional treatment, and that the information was necessary to the therapist's treatment.[120]

Questions of privilege relevant to the present topic arise most frequently when a therapist is called to testify about facts—the allegedly privileged communications—acquired in confidence from a patient or to produce records of treatment.[121] With respect to such evidence, the

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116. *See* LAUER, *supra* note 84, at 30 ("In addition, mental health professionals should encourage self-reporting whenever possible."); Brandon, *supra* note 53, at 403 ("Where such a risk [to others] is great the patient should be persuaded to inform the police [in England] himself, and only if he refuses to do so should he be informed that the physician proposes to take the initiative in contacting the police.").

117. *See supra* notes 76-82 and accompanying text.

118. *See* PRINCIPLES OF MEDICAL ETHICS, *supra* note 75, § 4, comments 2, 4 & 9.

119. *See* E. FISCH, *supra* note 82, § 542; *see also* People v. Saaratu, 541 N.Y.S.2d 889 (Sup. Ct. 1989) (physician/patient privlege is not abrogated in narcotics cases when the physician has aquired her knowledge of the patient through her relationship to a hospital).

120. E. FISCH, *supra* note 82, § 542.

121. While a discussion of the rules and exceptions governing the production and admissibility of medical and other treatment records is beyond the scope of this article, it must be noted that written reports from persons or officials required to report are admissible as evidence in any proceeding related to child abuse or maltreatment. N.Y. SOC. SERV. LAW § 415 (McKinney Supp. 1989); People v. Gwaltney, 140 Misc. 2d 74, 530

following general rules apply:

A privilege, like a confidence, may exist without a contract and moreover, without the patient's consent,[122] as in the case of involuntary commitment. The patient, not the therapist, owns the privilege and thus, the therapist may not use the privilege to prevent the patient from obtaining information about himself.[123] Even if the patient is not a party to the proceeding, the privilege may be invoked by the therapist or by any party to the action on the patient's behalf[124] by raising the appropriate objection.[125] Questions of privilege are decided by the court.[126]

New York, which pioneered the physician-patient privilege in 1828,[127] has expanded its list of privileges to include psychologists[128] and social workers.[129] These privileges are not identical.

Section 4504(a) of the Civil Practice Laws & Rules (CPLR) provides that a physician may not disclose "any information which he ac-

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N.Y.S.2d 437 (Sup. Ct. 1988). For examples of the rules and exceptions governing privileged treatment of medical records, see Grand Jury v. Kuriansky, 69 N.Y.2d 232, 505 N.E.2d 925, 513 N.Y.S.2d 359 (1987) (trial court should do in camera investigation to see if government needs documents that may be privileged in a Medicaid fraud case); *In re* Application to Quash, 56 N.Y.2d 348, 437 N.E.2d 1118, 452 N.Y.S.2d 361 (1982) (hospital under Medicaid fraud indictment cannot assert physician-patient or social worker-client privilege, or patient's right to privacy in attempt to quash subpoena for hospital records); Henry v. Lewis, 102 A.D.2d 430, 478 N.Y.S.2d 263 (App. Div. 1984) (only information obtained in doctor's professional capacity and which is needed to diagnose and treat is privileged); Villano v. State, 127 Misc. 2d 761, 487 N.Y.S.2d 276 (Ct. Cl. 1985) (non-medical records not privileged and court determines what medical data is to be disclosed after in camera inspection); E. FISCH, *supra* note 82, § 547 (some courts find privilege inapplicable to or waived by state institutions).

122. E. FISCH, *supra* note 82, § 543.

123. *Id.* § 542.

124. *Id.* § 551.

125. *Id.* §§ 542, 551. As previously noted, the therapist is ethically bound to invoke the privilege in this situation. *See* PRINCIPLES OF MEDICAL ETHICS, *supra* note 75.

126. E. FISCH, *supra* note 82, § 542.

127. *See* Coleman, *supra* note 56, at 1137; *see also* Camperlengo v. Blum, 56 N.Y.2d 251, 254, 436 N.E.2d 1299, 1300, 451 N.Y.S.2d 697, 698 (1982), where Chief Judge Cooke wrote: "[T]he privilege is designed 'to protect those who are required to consult physicians from the disclosure of secrets imparted to them; to protect the relationship of patient and physician and to prevent physicians from disclosing information which might result in humiliation, embarrassment or disgrace to patients.'" (quoting Steinberg v. New York Life Ins. Co., 263 N.Y. 45, 48-49, 188 N.E. 152, 153 (1933)).

This provision of confidentiality encourages the patient to seek medical treatment and to be frank in describing his or her symptoms to the physician so that the most effective treatment can be obtained.

128. N.Y. CIV. PRAC. L. & R. § 4507 (McKinney 1983).

129. N.Y. CIV. PRAC. L. & R. § 4508(a) (McKinney 1983 & Supp. 1989); *see also* People v. Bass, 140 Misc. 2d 57, 529 N.Y.S.2d 961 (Sup. Ct. 1988) (holding that section 4508 is broad enough to allow an accused child-abuser to invoke a psychiatrist-patient privilege in child abuse cases).

quired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity,"[130] unless the patient waives the privilege. Section 4504(a) includes doctors, nurses, and dentists.[131] Conversely, if a patient is less than sixteen years old and is a crime victim, section 4504(b) *requires* the physician to disclose the information.[132]

With respect to psychologists, CPLR section 4507 equates the communications between a psychologist and a client/patient with those between an attorney and a client, and provides that "nothing [in the professional registration statute] shall be construed to require any such privileged communication to be disclosed."[133]

The privilege pertaining to social workers, contained in CPLR section 4508, provides that a certified social worker is not required to disclose privileged information obtained in the course of professional employment.[134] The social worker is not required to treat as confidential, information from a client that would reveal "the contemplation of a crime or harmful act."[135] Where the client is under sixteen years old and is a crime victim, the social worker "may be required to testify" as to the privileged information.[136]

None of the foregoing privileges apply to child protective proceedings under Article 10 of the Family Court Act.[137] This limitation is presumably based upon the overriding importance of protecting the child. Restriction of the privilege, however, diminishes professional confidence. As Guttmacher and Weihofen have said:

> The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams,

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130. N.Y. CIV. PRAC. L. & R. § 4504(a) (McKinney 1983 & Supp. 1989). Apart from the mandate of specific statutes, private citizens, therapists among them, are not obligated to report crimes to the authorities; the common law misdemeanor of "misprision of felony" is not recognized in New York. *See infra* text accompanying notes 166-67.

131. N.Y. CIV. PRAC. L. & R. § 4504(a) (McKinney 1983 & Supp. 1989).

132. *Id.* § 4504(b).

133. *Id.* § 4507. As a general rule, a party waives the physician-patient privilege by putting his medical condition at issue (for example, by undertaking a lawsuit claiming bodily injuries). *See* E. FISCH, *supra* note 82, § 553. Psychologists are granted a broader, attorney-client type privilege when the patient's mental condition is at issue. Accordingly, psychiatrists, who are physicians, ordinarily rely upon the broader privilege granted to psychologists.

134. Section 4508 states in relevant part: "A person duly registered as a certified social worker . . . shall not be required to disclose a communication made by his client to him, or his advice given thereon, in the course of his professional employment." N.Y. CIV. PRAC. L. & R. § 4508(a) (McKinney 1983 & Supp. 1989).

135. *Id.* § 4508(a)(2).

136. *Id.* § 4508(a)(3).

137. N.Y. FAM. CT. ACT § 1046(a)(vii) (McKinney 1983).

> his fantasies, his sins and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition . . . . It would be too much to expect them to do so if they knew that all they say—and all that the psychiatrist learns from what they say—may be revealed to the whole world from a witness stand.[138]

A detailed discussion of the inconsistencies among the various testimonial privileges, pertinent as it may be, is beyond the scope of this article. The point is that *all* of the cited privileges, to one degree or another, are in potential conflict with the child abuse reporting law, which applies to children under eighteen years of age (not sixteen) and applies whether or not the child is the patient or client. With respect to the psychologist-patient privilege, which is equated with the attorney-client privilege, it will be recalled that psychologists are required to report child abuse; attorneys, except for prosecuting attorneys, are not. Accordingly, situations may arise in which the professional's report of suspected child abuse may trigger a legal proceeding, which ultimately will fail for want of the professional's crucial but privileged testimony. The unhappy consequences of this imbroglio have already been noted.[139]

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138. M. GUTTMACHER & H. WEIHOFEN, PSYCHIATRY AND THE LAW 272 (1952). An analogy may be drawn between the dilemma that is experienced by a psychotherapist and that experienced by a clergyman to whom a penitent confesses a crime or civil wrong.

> Religious confidentiality fulfills vital utilitarian functions. It fosters the clergy-communicant relationship from which many individuals draw psychological and spiritual sustenance. The well-being of these individuals contributes to the collective health of society. Without the promise of confidentiality, the clergy-communicant relationship would be impaired and those benefits jeopardized. That danger was clear even in the fifth century when Pope Leo I demanded an end to the practice of reading confessions in public. He wrote: "[I]t is necessary to desist from this custom . . . lest many be put off from availing themselves of the remedies of penance, either through shame or through fear of seeing revealed to their enemies deeds for which they may be subject to the action of the law . . . . Only then will many allow themselves to be summoned to penance, if the conscience of him who is confessing is not to be revealed to the ears of the people."

Note, *Religious Confidentiality and the Reporting of Child Abuse: A Statutory and Constitutional Analysis*, 21 COLUM. J.L. & SOC. PROBS. 1, 15 (1987) (citations omitted); *see also* N.Y. CIV. PRAC. L. & R. § 4505 (McKinney Supp. 1989) (New York recognizes a clergyman-penitent privilege); *see, e.g.*, Kruglikov v. Kruglikov, 29 Misc. 2d 17, 217 N.Y.S.2d 845 (Sup. Ct. 1961); E. FISCH *supra* note 82, § 745. In our constitutionally secular society in which troubled individuals may seek help from a therapist rather than a clergyman, the policy considerations that accord privilege to a devotee's confessions may be applied by analogy and used to foster the relationship between some patients and their therapists.

139. *See supra* notes 95-99 and accompanying text; *see also* Smith, *supra* note 61; Cooper, *The Physician's Dilemma: Protection of the Patient's Right to Privacy*, 22 ST.

3. Mandatory Reporting is Irreconcilable with Patients' Legitimate Interest in Privacy

This argument suggests that a right of confidentiality is implicit in the United States Constitution, and is reflected in statutory provisions which uphold the autonomy, dignity, and privacy of the individual.[140]

Cases in California,[141] Pennsylvania,[142] and the United States Court of Appeals for the Ninth Circuit[143] have referred to a constitutional basis for a psychotherapist-patient privilege. In an extended analysis relying upon the substantive due process constructs of *Griswold v. Connecticut*[144] and *Roe v. Wade*,[145] and other lines of reason-

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LOUIS U.L.J. 397, 399-400 (1978).

140. The statutory right of privacy set forth in N.Y. CIV. RIGHTS LAW § 50 (McKinney 1976) (prohibiting the commercial use of person's picture or likeness) and N.Y. CIV. RIGHTS LAW § 50-b (McKinney 1989) (prohibiting the commercial or non-commercial dissemination of the identity of the victim of a sex crime who was under the age of 18 years at the time of the act) is inapplicable to other breaches of psychotherapeutic confidence. *See also* MacDonald v. Clinger, 84 A.D.2d 482, 446 N.Y.S.2d 801 (App. Div. 1982) (a patient can bring an action for breach of fiduciary duty of confidentiality against a psychiatrist who disclosed to the patient's wife personal information learned through the course of treatment); Anderson v. Strong Memorial Hosp., 140 Misc. 2d 770, 531 N.Y.S.2d 735 (Sup. Ct. 1988) (publication of a photograph, taken of the patient with his consent, in silhouette form and intended to conceal the patient's identity, held to be breach of the physician/patient privilege when patient was recognized despite attempts to disguise). *But see* Smith v. Long Island Jewish Hillside Medical Center, 118 A.D.2d 553, 499 N.Y.S.2d 167 (App. Div. 1986) (disclosure of photograph and medical information but not the identity of terminally ill child for advertising purposes constituted an invasion of the infant's right to privacy). However, the Restatement of Bill of Rights for Mental Health Patients, 42 U.S.C. § 10841 (Supp. V 1987) establishes:

> (1)(G) The right to a humane treatment environment that affords reasonable protection from harm and *appropriate privacy* to such person with regard to personal needs. (H) The right to *confidentiality of such person's records.*

Id. (emphasis added). The American Hospital Association's Statement on a Patient's Bill of Rights (1977), *reprinted* in R. REISER, A. DYCK & W. CURRAN, ETHICS IN MEDICINE 148-49 (1977), states:

> 5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly in his care must have the permission of the patient to be present.
> 6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

In *Anderson*, the person's identity and the fact the person has received treatment were said to be as privileged as the nature of the treatment itself. *Anderson*, 140 Misc. 2d at 775-76, 531 N.Y.S.2d at 740.

141. *In re* Lifschultz, 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1977).

142. *In re* "B", 482 Pa. 471, 394 A.2d 419 (1978).

143. Caesar v. Mountanos, 542 F.2d 1064 (9th Cir. 1976), *cert. denied*, 430 U.S. 954 (1977).

144. 381 U.S. 479 (1965).

145. 410 U.S. 113 (1973).

ing, Smith advanced the argument for further recognition of this constitutional right.[146] While a constitutional basis for psychotherapeutic confidentiality has not been identified by any New York court, appropriate recognition of fundamental values, as expressed in the United States Constitution, militates in favor of modifying the New York reporting law by assigning greater importance to the privacy interests of psychotherapeutic patients.[147]

4. Mandatory Reporting Involves the Therapist in a Personal Conflict of Interest and the Prospect of Serious Economic Harm

It is a cardinal rule of good professional practice that the needs of the patient, rather than those of the therapist, should determine the course of treatment.[148] This principle cannot withstand the distorting influence of the reporting law.

In most instances, mandatory and voluntary child abuse reporters are immune from tort liability.[149] On the other hand, the statute expressly creates a civil cause of action against therapists who fail to report when required to do so.[150] The pressure to report all instances of suspected child abuse and the desire to avoid personal liability may skew the therapist's professional judgment, forcing her to weigh her own legal interests against the therapeutic needs of her patients. The introduction of the therapist's own interest as a factor in the therapeutic equation is contrary to the ethical ideals that distinguish a learned and helping profession from a mere trade or business.[151]

That failure to report as required by the statute may result in civil liability—and an award of substantial damages[152]—is no longer open to

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146. *See generally* Smith, *supra* note 61; Cooper, *supra* note 139, 399-400 (1978).

147. At least one state court has disagreed. The privacy argument and other constitutional claims were rejected by the Michigan Court of Appeals in People v. Cavaiani, 172 Mich. App. 706, 432 N.W.2d 409 (Ct. App. 1988).

148.

> This fundamental feature of the professional relationship was well stated by Edmund D. Pelligrino, M.D., a physician with a national reputation in Bioethics, in an interview when he stated, "The thing that distinguishes professions is this: . . . you can depend on the one who is in a true profession to efface his own self-interest. In a profession you promise fidelity to the good of another person as your *primary* aim. It is a voluntary act of commitment that a physician makes when he takes his oath of profession."

Kammerman, *supra* note 62, at 5-6 (emphasis added) (citing *Knowledge of Bioethics Even More Essential in Future*, AMERICAN MEDICAL NEWS, Jan. 2, 1987, at 20). Kammerman traces the principle of self-effacement to the Hippocratic Oath: "In every house where I come I will enter only for the good of my patients." *Id.* at 11.

149. N.Y. Soc. SERV. LAW § 419 (McKinney Supp. 1989).

150. N.Y. Soc. SERV. LAW § 420(2) (McKinney Supp. 1989).

151. *See supra* note 148.

152. *See* 27 ATLA L. REP. 392 (1984) (discussing O'Keefe v. Osorio, No. 70-L-14884

doubt. The leading precedent is the California case *Landeros v. Flood.*[153] *Landeros* involved none of the more difficult ethical issues: the patient was the child victim and, accordingly, the physician's responsibility was not divided. The case dealt not with the confidences of psychotherapy, but with the observable evidence of physical abuse. The California Supreme Court decided the key question of professional standards by holding that "battered child syndrome" was a legally qualified medical diagnosis which the defendant physician had negligently failed to make, and therefore failed to report.[154]

The famous *Tarasoff* case,[155] also decided in California, is more difficult to reconcile with principles of confidentiality and the primacy of patient care. *Tarasoff* was a civil action by the family of a homicide victim against a therapist who failed to disclose to the victim his patient's lethal ideations. The case imposes upon psychotherapists an obligation to protect identifiable victims of future harm when a patient makes a credible threat of violence.[156] The duty usually takes the form of warning the intended victim.[157] The *Tarasoff* court derived the therapist's obligation to the victim from the "special relationship"[158] said to exist between therapist and patient.

The *Tarasoff* rule has been followed elsewhere[159] and cited with

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(Ill. App. Ct. 1984), which resulted in a verdict of $186,851).

153. 17 Cal. 3d 399, 551 P.2d 389, 131 Cal. Rptr. 69 (1976), *vacating* 50 Cal. App. 3d 189, 123 Cal. Rptr. 713 (Ct. App. 1975).

154. *Id.* at 409, 551 P.2d at 393, 131 Cal. Rptr. at 73.

155. Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). For a further discussion of the *Tarasoff* case and its progeny, see A. STONE, *supra* note 62, at 161-90.

156. 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

157. *See* A. STONE, *supra* note 62, at 164. Stone observes that involuntary commitment, which would incapacitate the potentially violent patient, was not a favored solution in California. Stone also reminds us that, absent a "special" relationship, there is no general duty on the part of therapists or anyone else to rescue bystanders or warn potential victims. *Id.* at 165, 175.

158. 17 Cal. 3d at 435, 551 P.2d at 343, 131 Cal. Rptr. at 22-23 (1976).

159. It might be more accurate to say that *Tarasoff* is frequently discussed by academic writers, usually cited by courts when the issue arises, and sometimes followed. *See, e.g.*, A. STONE, *supra* note 62, at 171 n.26, 172-85; *see also* S.E. PEGALIS & H.F. WACHSMAN, AMERICAN LAW OF MEDICAL MALPRACTICE § 18:4 n.37 (1982) (citing *Tarasoff* to support "foreseeability" as the root concept of the duty to prevent injury to a third party); F. HARPER, F. JAMES & O. GRAY, THE LAW OF TORTS § 16.12 n.14 (Dec. Supp. 1988) (citing *Tarasoff* as an extreme case of liability for failure to guard against foreseeable harm caused by another, and citing several cases that discuss the *Tarasoff* decision); Cain v. Rijken, 300 Or. 706, 716-17, 717 P.2d 140, 146-47 (1986).

The *Tarasoff* rule has been expansively applied in more recent cases. *See* McNeill, *supra* note 107. The California legislature responded by the addition of Civil Code § 43.92, which states in relevant part:

> (a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist . . . in failing to

approval in New York.[160] The rule expands the therapist's legal duty to include the interests of certain non-patients as well as her patient. These interests may be in conflict. Where, as in *Tarasoff*, a threat of deadly violence has been made by a patient capable of effectuating such a threat, the court understandably may place the safety of the intended victim over the therapeutic needs of the intended perpetrator. The therapist also may make that choice and should be legally free to do so. A rule that requires the therapist to report, however, serves only to substitute the coercion of the law for the professional judgment of the therapist and introduces extraneous legal considerations into the therapist's deliberation. While it is extremely difficult to predict dangerousness,[161] the therapist is presumably in the best position to assess the credibility of threats made in his presence by his patients.

Moreover, the New York child abuse reporting statute is not limited to the emergency situation contemplated by *Tarasoff*. The New York law makes no express reference to the nature or degree of the patient's therapeutic needs, the quality or extent of the suspected abuse or maltreatment, nor most significantly, whether there exists any possibility that abuse or maltreatment will occur in the future. If the

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warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient's violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

(b) If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psycotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

CAL. CIV. CODE § 43.92 (West Supp. 1989).

The Arizona Supreme Court has held that the *Tarasoff* duty to warn is not limited to "specific threats to specific victims" but includes others within "an obvious zone of danger." Hamman v. Maricopa County, 161 Ariz. 58, 775 P.2d 1122, 1128 (1989).

In DeShaney v. Winnebago County DSS, 109 S. Ct. 998 (1989), the Supreme Court held that a state's failure to provide protective services does not give rise to a cause of action under 42 U.S.C. § 1983 for unconstitutional deprivation of liberty where a non-institutionalized child is abused by a non-governmental actor. The Court rejected the contention that states have an affirmative constitutional duty to protect reported children, and left such children to remedies under state tort law. The Court noted, however, that "several Courts of Appeals have held . . . that the State may be held liable under the Due Process Clause for failing to protect children in foster homes from mistreatment at the hands of their foster parents." *Id.* at 1009 n.9. It cited Doe v. New York City DSS, 649 F.2d 134 (2d Cir. 1981), *after remand*, 709 F.2d 782, *cert. denied sub nom* Catholic Home Bureau v. Doe, 464 U.S. 864 (1983), but expressed no view on the merits of that holding. *Id.* The Court also declined to consider other theories of constitutional liability arising from a due process "entitlement" claim under Board of Regents v. Roth, 408 U.S. 564 (1972). *Id.* at 1002 n.2.

160. MacDonald v. Clinger, 84 A.D.2d 482, 487, 446 N.Y.S.2d 801, 805 (App. Div. 1982).

161. A. STONE, *supra* note 62, at 167-68, 184.

statute's conditions are met,[162] the New York therapist has no discretion to withhold reporting.

Under New York law, the decision to report is not vested in the therapist's professional judgment. It is mandated by a statute that is both civilly and criminally enforceable against the therapist. As previous arguments have tried to demonstrate, the statute requires reporting in circumstances that may compromise the interests of patients and children alike. Conscientious psychotherapists must choose between obeying the law to protect their own interests, or defying the law to promote the interests of their patients. It is a choice that the law should not require.

V. NARROWING THE DILEMMA: RESPONSES UNDER THE PRESENT LAW

The structure of the reporting statute invites overreporting—the principal focus of this article—and underreporting,[163] particularly on the part of those who are unaware of the law, or whose concern for confidentiality is misdirected.[164] Reporting laws have been criticized for vagueness; they are certainly not self-explanatory. Accordingly, a first step toward narrowing the therapist's dilemma is to examine closely the precise requirements of the statute.

A. What Quality of Evidence Gives Rise to a Duty to Report?

The statute contains both an objective and a subjective standard.[165] The objective standard, applies when the patient is not the victim. The statute requires reporting when a parent, guardian, custodian, or other legally responsible patient "states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child."[166] The subjective standard requires that the therapist have "reasonable cause to suspect" that the child before her is abused or maltreated.[167]

Viewed literally, the "if correct" clause seems to require reporting even when the most delusional or intoxicated patient gives a seemingly fanciful account of abuse. This literal interpretation is mitigated by the "reasonable cause to suspect" provision, which should be interpreted

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162. *See supra* notes 26-55 and accompanying text.

163. *See* Besharov 1985, *supra* note 84, at 571 (imprecise definitions in reporting statutes make caseworkers uncertain about whether to intervene in a given situation); *see also* N.Y. PENAL LAW § 240.40 (McKinney Supp. 1989).

164. *See supra* note 25 and accompanying text.

165. In this sense, New York's statute is more explicit than others, in which the dual standard is implicit. *See* Note, *Duties in Conflict*, *supra* note 21, at 667.

166. N.Y. SOC. SERV. LAW § 413(1) (McKinney Supp. 1989).

167. *Id.; cf.* People v. Cavaioni, 172 Mich. App. 706, 432 N.W.2d 409 (Ct. App.1988) (subjective test based on suspicion not unconstitutionally vague).

as requiring that the therapist believe that the patient's account is plausible, or at least possible, before a report is mandated in any situation. The therapist acts at his peril, however, in failing to report. If the objective test is met, the therapist will be hard pressed to articulate an adequate basis for his lack of suspicion, particularly if the child is abused thereafter. A contemporaneous notation in the patient's record as to why the patient's disclosure was not credited will, at best, cut both ways. By far the safer course, in these circumstances, is to report.

Similarly, the "personal knowledge" test probably includes hearsay, inference, and even the patient's speculation, particularly if the speculation proves to be accurate. If the patient has reason to know or says he knows of the abuse, the cautious therapist, in the interest of avoiding personal liability, will believe him.

On the other hand, the immunity granted to reporters may be broader than the statute implies. The "good faith" test of Social Services Law section 419[168] probably protects those who believe a child abuse report should be filed, however foolish that belief may be, if there is no affirmative evidence of improper motive.[169] Any inference of malice derived from the filing of a wholly groundless report is offset, in the case of mandatory reporters, by the presumption of good faith that attaches to those who report "in the discharge of their duties and within the scope of their employment."[170] To overcome this presumption, it is necessary to show either "willful misconduct or gross negligence" on the part of the reporter.[171] Accordingly, the remedy of a person wrongfully reported as an abuser is amending or expunging the record of the report.[172]

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168. N.Y. Soc. Serv. Law § 419 (McKinney Supp. 1989).

169. *See* Miller v. Beck, 82 A.D.2d 912, 440 N.Y.S.2d 691 (App. Div. 1981), in which the court stated:

> Section 419 provides immunity from civil liability when the report is made in good faith, which, under the statute, is presumed. Where, as here, a defendant's statements are presumptively privileged, either by statutory mandate or at common law, they are actionable only if the plaintiff can prove their falsehood and that the defendant was motivated by actual malice or ill-will.

Id. at 913, 440 N.Y.S.2d at 691-92; *see also* Besharov 1985, *supra* note 84, at 571 ("Because professionals and private citizens do not have a clear idea about the meaning of the terms 'child abuse' and 'child neglect', they report many minor situations that do not amount to child maltreatment."); N.Y. Penal Law § 240.40 (McKinney Supp. 1989) (it is a misdemeanor to intentionally file a false report).

170. N.Y. Soc. Serv. Law § 419 (McKinney Supp. 1989).

171. *Id.*

172. The statute provides in pertinent part:

> the subject [of the report] may request the commissioner to amend or expunge the record of the [investigatory] report. If the commissioner does not amend or expunge the report in accordance with such request within ninety days of receiving the request, the subject shall have the right to a fair hearing . . . to determine whether the record of the report . . . should be amended or expunged on the

B. *What Children Are Included in the Mandatory Reporting Statute?*

As previously noted, children who come before the therapist in the therapist's "professional or official capacity" are within the class protected by the mandatory reporting law.[173] With respect to other children, the statute requires reporting when "the parent, guardian, custodian or other person legally responsible for such child" gives the therapist reason to suspect that "such child" is abused or maltreated.[174] Thus, if a patient discloses that his neighbor's child is abused, the therapist is not required to report that fact, even if the therapist believes the neighbor is likely to cause the child serious harm. Under *Tarasoff*, the therapist may be obliged to warn the child if the therapist believes the patient is likely to harm the neighbor's child, even though the patient is not the parent, guardian, custodian, or person legally responsible for the child. If warning the child would be futile, a court might conclude that the therapist should call CPS, but this conclusion goes beyond both *Tarasoff* and the language of the reporting statute. Similarly, if a child in therapy discloses that a minor sibling is sexually abused by a common, custodial parent, the therapist is not required to report under section 413, nor under *Tarasoff*, which applies only to cases in which the *patient* threatens to do harm.

Consistent with his professional responsibility, the therapist will take appropriate steps to avert anticipated harm to any individual, even if the person threatened is not individually identifiable. In the examples given, this may consist of persuading the patient to report the neighbor, or bringing the abused sibling and parent into therapy (an act that may lead to mandatory reporting). The point is that the therapist would be free to exercise sound professional judgment without the inflexible constraints of the mandatory reporting law.

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grounds that it is inaccurate or it is being maintained in a manner inconsistent with this title.

Id. § 422(8)(a)(i). If the hearing produces no credible evidence that the subject committed an act of child abuse or maltreatment, the department must expunge the record and notify the subject of such a result. *Id.* § 422(8)(a)(iii). *See* Ebanks v. Perales, 111 A.D.2d 331, 332, 489 N.Y.S.2d 313, 315 (App. Div. 1985) (report will not be expunged from register if sufficient evidence of maltreatment exists to sustain decision); Maroney v. Perales, 102 A.D.2d 487, 478 N.Y.S.2d 123 (App. Div. 1984) (proof of excessive punishment imposed by parent which resulted in injuries to child supported determination that record of report of suspected child abuse should not be expunged).

173. N.Y. Soc. Serv. Law § 413(1) (McKinney Supp. 1989).

174. *Id.*

C. *Of What Relevance Is the Age of the Child, the Recency of the Incident, or the Probability of Future Harm?*

If the victim is eighteen years of age or older at the time disclosure is made to the therapist, the mandatory reporting requirement is inapplicable. Accordingly, the therapist is free to act in conformity with other principles of lawful professional behavior.

As to the recency of the alleged incident and the possibility of future harm, it is noted that the statute speaks in the present tense. The therapist must suspect that the child is abused or maltreated at the time disclosure is made.[175] CPLR section 4504(b) requires physicians and nurses to disclose information indicating that a patient under the age of sixteen has been the victim of a crime.[176] There is no broader obligation for therapists to report a crime disclosed by a patient. As a general rule, the therapist is not required to report past instances of abuse or neglect: the issue is whether the child is currently abused or neglected.[177]

The therapist will, of course, be aware of the frequency of recidivism in child abuse cases in making this assessment. The temporal remoteness of the facts, conditions, or circumstances disclosed by the patient will constitute part of the subjective test: whether the therapist has "reasonable cause" to suspect that the child is abused or neglected at the time of disclosure.[178] The statute's vagueness on this point is a legitimate cause of criticism: it might be preferable to substitute, by statute, regulation, or professional standard, a rule of thumb with respect to remoteness in time.

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175. According to Robert G. Kammerman, M.D., a board-certified psychiatrist with many years of experience in clinical practice, it is rare for abusive parents to disclose ongoing abuse while in therapy. More commonly, the patient either relates instances of past abuse, without giving the therapist reason to believe repetition of such behavior is imminent or likely, or the patient, having no history of abusive conduct, relates the fear that he or she will harm a child in the future. Telephone interview (Nov. 29, 1988).

176. N.Y. CIV. PRAC. L. & R. § 4504(b) (McKinney Supp. 1989).

177. Courts are not inclined to dismiss a claim merely because the complaint focuses on prior neglect. *See, e.g., In re* TC, 128 Misc. 2d 156, 161, 488 N.Y.S.2d 604, 609 (Fam. Ct. 1985) ("[The petition does] state a legitimate cause of action against both Respondent-mother and father. Although couched mainly in terms of past history, there are sufficient allegations of the present inability of either parent to care for the child for these allegations to resist a motion to dismiss.") (*cited with approval in In re* Cruz, 121 A.D.2d 901, 902, 503 N.Y.S.2d 798, 800 (App. Div. 1986)); *cf. In re* Theresa C., 121 Misc. 2d 15, 20-22, 467 N.Y.S.2d 148, 152-53 (Fam. Ct. 1983) where the court distinguished between neglect and sexual abuse cases with respect to the "contemporaneousness" of the prohibited acts in stating a valid cause of action. In neglect cases, the focus is on the current conditions and whether a child is in imminent danger. In sexual abuse cases, the court stated that " 'contemporaneousness' of the alleged sex offense is not an element of this cause of action."

178. N.Y. SOC. SERV. LAW § 413(1) (McKinney Supp. 1989).

On the other hand, if the therapist suspects that the child is abused, reporting is mandatory, even if the child is about to reach the age of eighteen. Moreover, reporting appears to be mandatory even if the therapist has reason to believe that the abusive conduct will not be repeated in the future: it is the child's present condition that triggers the reporting obligation.[179]

D. Must Abuse Disclosed in Group Therapy Be Reported?

Disclosures made by patients in group therapy are confidential. Since each patient becomes the therapeutic agent of the others,[180] confidentiality is "of paramount concern"[181] to the success of the therapy and underpins the spontaneity that is crucial to the effectiveness of group therapy.[182] In addition, the physician-patient testimonial privilege is not dependent upon confidentiality: a physician is usually prohibited from testifying even with respect to communications made in the presence of third parties.[183] Accordingly, insofar as the therapist is concerned, the appropriate testimonial privilege applies to disclosures made by patients in group therapy.[184] Notwithstanding confidentiality

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179. *See* Landeros v. Flood, 17 Cal. 3d 399, 412 n.9, 551 P.2d 389, 395 n.9, 131 Cal. Rptr. 69, 75 n.9 (1976), which provides a list of authorities advocating mandatory reporting of child abuse to prevent probable and further injury to the child. The list includes Kempe & Silverman, *supra* note 3, at 24; Boardman, *A Project to Rescue Children from Inflicted Injuries*, 7 Soc. Work 43, 49 (1962) ("Experiences with the repetitive nature of injuries indicate that an adult who has once injured a child is likely to repeat . . . . [T]he child must be considered to be in grave danger unless his environment can be proved to be safe"); Fontana, *The Maltreatment Syndrome in Children*, 269 New England J. Med. 1389, 1393 (1963) ("over 50 percent of these children are liable to [suffer] secondary injuries or death if appropriate steps are not taken to remove them from their environment"); Friedman, *The Need for Intensive Follow-Up of Abused Children*, in Helping the Battered Child and His Family 79 (R. Kempe & C. Helfer eds. 1972) ("the severe permanent damage associated with 'battered child syndrome' usually does not occur with the initial incident . . . . Identification of abuse at this time thus offers an opportunity for intervention with the goal of preventing subsequent trauma and irreversible injury to the child").

180. Cross, *Privileged Communications Between Participants in Group Psychotherapy*, in 2 Law and the Social Order, Ariz. St. L.J. 191, 196 (1970).

181. *Id.*

182. *Id.*

183. *See* Hobbs v. Hullman, 183 A.D. 743, 171 N.Y.S. 390 (App. Div. 1918) (doctor was not permitted to testify about his "patient's condition and its cause" even though a nurse was present during the doctor's conversation with the patient); *see also* E. Fisch, *supra* note 82, § 546.

184. Although it has been argued that New York law permits non-therapist group members to raise the privilege, Cross, *supra* note 180, at 201, this argument finds little support in the reported cases or the language of the current privilege statutes. Other jurisdictions do not extend the privilege so far. *Id.* In any event, even if a non-therapist group member has standing to raise the privilege, the objection of privilege is likely to be overruled by reason of countervailing arguments in favor of disclosure. The testimonial

and privilege, however, the group therapist is a mandatory child abuse reporter, and other members of the group may report voluntarily, with all of the legal immunity provided in the reporting statute.

E. What Considerations Affect Children or Patients in Institutional Settings, or Children in Foster Care?

A dilemma equally as troubling arises when professional or non-professional employees of a custodial facility have reason to believe that a child within the facility is abused or maltreated.[185] Such employees may perceive a conflict of interest between the statutory duty to report their suspicions to an outside agency and their desire to protect their employer from the consequences of reporting.

Conversely, institutions have a legitimate interest in monitoring employee child abuse reports, whether indicated or unfounded. Thus, the Pisani Report, which proposed the 1985 amendments to the child abuse reporting law, observed that while official New York City Special Services for Children (SSC) policy required that all reports of abuse and neglect be reported directly to the State Central Register and the Central Investigation Unit, public facility directors in reality had no direct access to the State Central Register.[186] Rather, they were required to report all alleged abuse or neglect incidents to SSC administrative offices. SSC's Central Investigation Unit then investigated the allegations and determined whether to notify the state.[187]

These concerns are also addressed in section 29.29 of the New York Mental Hygiene Law,[188] which requires the development of plans and procedures for prevention and remediation with respect to indicated child abuse reports. The reporting statute, however, provides that a residential facility's medical, social work and nursing staff, hospital personnel engaged in admission, examination, care, or treatment of patients, and volunteers in residential care facilities must report abuse.[189] As previously noted, parents, foster parents, and guardians are not mandated reporters.[190]

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privileges granted by statute are not absolute.

185. *See generally* PISANI REPORT, *supra* note 24 (detailing recommendations and findings of legislative subcommittee's three-year examination of state residential care facilities).

186. *Id.* at 28.

187. *Id.*

188. N.Y. MENTAL HYG. LAW § 29.29(6)-(8) (McKinney 1988).

189. N.Y. SOC. SERV. LAW § 413(1) (McKinney Supp. 1989).

190. *See supra* note 39 and accompanying text.

F. *Must a Treating Therapist Warn the Patient That Disclosures of Child Abuse Will Be Reported?*

The New York statute contains no such requirement. Thus, if the patient discloses abuse or neglect, the therapist must report it, even if the therapist did not anticipate the disclosure and did not inform the patient of the statutory reporting requirement.

Once the patient has disclosed reportable abuse or neglect, most therapists would deem it good therapeutic practice to tell the patient that the disclosure will be reported in compliance with the law.[191] Unless therapeutically contraindicated, a "warning" of this nature is perfectly lawful. So long as the therapist reports "immediately," she is free, and no doubt obliged, to assist the patient in working through the resulting problems with trust. The therapist's manner of informing the patient or her decision not to inform the patient, is a therapeutic question to be decided on the basis of therapeutic standards.

In some circumstances, where the therapist anticipates that the patient may disclose a reportable offense, the therapist may choose to warn the patient, either when the therapist believes that disclosure is imminent, or in the form of a blanket warning at the onset of therapy. As previously discussed, this choice is highly problematical. The patient may heed the warning and withdraw from therapy or fail to participate effectively.[192]

The situation is entirely different if the patient is being examined not for the purpose of treatment, but in connection with a criminal prosecution. Because no therapeutic relationship is established or contemplated, the statutory rules of testimonial privilege do not apply, and the requirement of confidentiality is greatly modified.[193] In this

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191. This "warning" would prevent the occurrence of a scenario envisioned by Coleman: "Imagine a patient's shock and dismay when, responding to a knock on his door, he discovers a policeman with a warrant for his arrest or a social worker armed with a complaint prepared to conduct an investigation based upon the patient's confession to his doctor of his incestuous conduct." Coleman, *supra* note 56, at 1125 (footnote omitted).

192. *See supra* note 63 and accompanying text. Some commentators, however, observe that some patients will trust the therapist even more as a result of the warning, and will thereupon make disclosures that will result in their incarceration or loss of child custody. Applebaum, *Confidentiality in the Forensic Evaluation*, 7 INT'L J. L. & PSYCHIATRY 285, 290 (1984). This writer believes conscientious therapists will want to avoid this scenario. In such instances the therapist may be seen as manipulating the patient and gaining his trust under false pretenses: the therapist is, in effect, encouraging the patient's psychological predisposition to confess, knowing that the information so confessed may be used in an extra-therapeutic context where it may be very markedly opposed to the patient's legal interests. The patient who wishes to confess to the authorities can do so directly; the therapist should avoid being used as an instrument of the patient's desire for punishment. A rule permitting discretionary reporting would undercut the rationale for a prior warning and avoid this problem.

193. Generally, the scope of confidentiality is determined by the therapist's legal

case, the fifth amendment to the United States Constitution may act as a bar to admission of some evidence derived from a patient who has not been properly warned.

Thus, as the United States Supreme Court recognized in *Estelle v. Smith*,[194] if the patient has been referred to the therapist by a criminal court, evidence obtained by the therapist may be excluded, unless the patient is informed of the purpose of the examination and the uses to which it will be put.[195] The therapist in such a case would be acting as an agent of the state and should represent himself accordingly.[196] Similarly, a child abuse report, which is otherwise admissible in criminal as well as civil proceedings under Social Services Law section 415,[197] could be subject to exclusion on constitutional grounds.

For evidentiary purposes, warning may be necessary in connection with post-conviction psychological evaluations. The problem of self-incrimination may continue to exist with respect to other crimes of which the defendant has not been convicted.[198]

By contrast, if the psychological examination is conducted in connection with a civil proceeding, evidence derived from the patient is generally admissible, notwithstanding the absence of a warning.[199] In *Allen v. Illinois*,[200] the Supreme Court declined to apply the rule of *Estelle v. Smith* to civil cases. Moreover, as previously noted, the statutory testimonial privileges are expressly abrogated in New York child protective proceedings.[201]

It follows that therapists who examine persons referred by a court must obtain competent legal advice. Whether other therapists need concern themselves with the effects of a warning as to the ultimate use to which a child abuse report may be put in a legal proceeding, is a

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mandate, as disclosed and consented to by the patient. *See* N.Y. CRIM. PROC. LAW § 60.55 (McKinney 1981); *see also* E. FISCH, *supra* note 82 (Supp. 1988), which states that:

> a statement made by defendant to a psychiatrist or licensed psychologist during his examination of defendant in connection with an affirmative defense of lack of criminal responsibility by reason of mental disease or defect is admissible on this issue whether or not it would otherwise be deemed a privileged communication but can be considered only on the issue of such affirmative defense and may not be considered in determining whether defendant committed the act constituting the crime charged.

Id. at 163 n.36 (Supp. 1988).

194. 451 U.S. 454 (1981).

195. *Id.* at 467.

196. *Id.*

197. N.Y. SOC. SERV. LAW § 415 (McKinney Supp. 1989).

198. The general effect of a patient's fear of self-incrimination in the process of psychotherapeutic evaluation and treatment constitutes a principal argument for maintaining the patient's trust.

199. E. FISCH, *supra* note 82, § 550.

200. 478 U.S. 364, 374 (1986); *see supra* note 93.

201. N.Y. FAM. CT. ACT § 1046(vii) (McKinney 1983).

question respectfully submitted to the reader.

Finally, the therapist faces danger in giving an ill-advised warning because while child abuse reports are immune from civil liability, warnings are not. In *Satler v. Larsen*,[202] the defendant physician treated a child who was brought to his office on various occasions by the child's mother and a close family friend.[203] On the day in question the physician stated to the mother in the presence of the friend, "I must report you to the Bureau of Child Welfare for child abuse."[204] The physician later concluded that his suspicion was unfounded and the report was withdrawn.[205] The mother sued for defamation, contending that the remarks were actionable because made in the presence of a third person.

The Appellate Division, First Department, dismissed the complaint, stating: "Viewed fairly, the complained of statement does not purport to accuse the plaintiff of child abuse; it indicates only that a report of child abuse was considered necessary."[206] The court dealt with the issue of publication by stating that since the mother's friend knew that the plaintiff had not abused her child, the plaintiff was not damaged by the allegedly defamatory remark.[207] Thus, while the outcome of the case was favorable to the physician, it is clear that the court was stretching to reach what it considered to be a socially desirable result. A similar outcome cannot be anticipated in all cases of inappropriate warning.[208]

G. By What Standard Will the Therapist's Decision to Report or Not Report Be Judged?

The question is most significant in the context of civil litigation, where a court is likely to apply one of two different standards: negligence or malpractice.[209] Negligence is the standard of the ordinary, reasonable person, as determined by a jury on the basis of its collective experience.[210] Malpractice is the standard of the professional commu-

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202. 131 A.D.2d 125, 520 N.Y.S.2d 378 (App. Div. 1987).

203. *Id.* at 126, 520 N.Y.S.2d at 380.

204. *Id.* at 127, 520 N.Y.S.2d at 380.

205. *Id.*

206. *Id.* at 128, 520 N.Y.S.2d at 381.

207. *Id.* at 129, 520 N.Y.S.2d at 381.

208. Questions of defamation may also arise in connection with *Tarasoff* warnings to potential victims.

209. *See generally* Curran, *Professional Negligence—Some General Comments* and McCoid, *The Care Required of Medical Practitioners*, in PROFESSIONAL NEGLIGENCE 1 and 13 respectively (T. Roady & W. Andersen eds. 1960).

210. "Negligence. The omission to do something which a reasonable man, guided by those ordinary considerations which ordinarily regulate human affairs, would do, or the doing of something which a reasonable and prudent man would not do." BLACK'S LAW

nity, which must be proven through the testimony of expert witnesses.[211]

In *MacDonald v. Clinger*,[212] a patient sued his psychiatrist for breach of confidentiality, claiming that the psychiatrist had made unauthorized disclosures to the patient's wife. The Appellate Division, Fourth Department, implicitly rejected a malpractice standard.[213] It found that the relationship between psychiatrist and patient gave rise to an implied covenant of confidentiality, actionable in contract,[214] but went on to observe that the damages which might be awarded to the plaintiff in a contract action would not include recovery for non-economic loss (i.e., the plaintiff's "mental distress, loss of his employment and the deterioration of his marriage.").[215] The court thereupon held that the psychiatrist's disclosure also constituted an ordinary tort, which the court denominated "breach of the fiduciary duty of confidentiality."[216]

Presiding Justice (now Judge) Simons, in a concurring opinion, sharply criticized the majority's rule, which he said permitted the plaintiff to establish a prima facie case by proving that the breach was unauthorized.[217] The better standard, he argued, is malpractice, which bases liability on an objective standard measured by the general quality of care in the professional community.[218] Because the confidentiality of patient-physician disclosures is an important part of medical treatment, a violation of a confidence would be judged as would any other violation of the general quality of care standard.

Justice Simons asserted that the majority abandoned a standard measured by general quality of care:

> [T]he rule advanced by the majority permits the standard of care in unauthorized disclosure cases to be set by the jury. Thus, in every case of disclosure, the physician is exposed to the danger of a damage verdict resting upon the jury's subjective view of his explanation of his conduct even if it was in accordance with accepted medical practice.[219]

DICTIONARY 930 (5th ed. 1979).

211. "Malpractice. . . . any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct." *Id.* at 864.

212. 84 A.D.2d 482, 446 N.Y.S.2d 801 (App. Div. 1982).

213. *Id.* at 488, 446 N.Y.S.2d at 805 (Simons, J.P., concurring).

214. *Id.* at 486, 446 N.Y.S.2d at 804.

215. *Id.*

216. *Id.* at 487, 446 N.Y.S.2d at 805.

217. *Id.* at 489, 446 N.Y.S.2d at 806.

218. *Id.*

219. *Id.*

If the action is based upon the therapist's failure to report child abuse, rather than his breach of confidentiality, the applicable standard in New York is unclear. The New York statute imposes "civil liability" for failure to report, without further explanation.[220] A malpractice standard was adopted by the California court in *Landeros v. Flood*.[221] In *Landeros*, however, the question of a physician's liability for failing to report a case of battered child syndrome turned on whether the syndrome was a medically recognized diagnosis, a formulation of the issue that required proof of prevailing medical opinion.[222]

Stone, disagreeing with Judge Simons, suggests that therapists are better served by an ordinary negligence standard.[223] Stone does not discuss breach of confidentiality or child abuse reporting, but rather, the *Tarasoff* cause of action, which involves a therapist's liability based upon his failure to warn the intended victim of threats made by a patient. Stone argues that holding therapists to a malpractice standard would, in effect, cause them to be potentially liable not only in malpractice for a failure to predict violence, but also in negligence for any error or omission in evaluating the patient.[224]

Stone's observation—that expert witnesses can often be found on both sides of an issue—is entirely valid.[225] Judge Simons' conclusion, however, is more convincing. A jury that considers the conflicting evidence of expert witnesses is likely to arrive at an accurate appraisal of the prevailing standards of the profession, whereas a jury guided by its own conception of reasonable behavior may be less well-informed, less predictable, or unduly influenced *post hoc ergo propter hoc* by the evidence of suffering and damage.

If the therapeutic professions are permitted to develop standards for reporting, then a single malpractice test of liability would be the most logical, fair, and socially beneficial. A malpractice standard would also resolve the issue of reporting: upon the adoption and legal recognition of the malpractice standard, reporting would become a matter of professional therapeutic judgment.

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220. N.Y. Soc. Serv. Law § 419 (McKinney 1983).

221. 17 Cal. 3d 399, 551 P.2d 389, 131 Cal. Rptr. 69 (1976), *vacating* 50 Cal. App. 3d 189, 123 Cal. Rptr. 713 (Ct. App. 1975).

222. *Id.* at 410, 551 P.2d at 394, 131 Cal. Rptr. at 74.

223. A. Stone, *supra* note 62, at 171.

224. *Id.*

225. Stone noted with disapproval Prof. Alan Dershowitz's view that "Since psychiatrists cannot agree on what they are doing, isn't it better that they do it in open court?" *Id.* Query: whether failure to report is covered by policies of malpractice insurance.

H. What Are the Limits of the Therapist's Duty of Confidentiality? What Are the Limits of Testimonial Privilege?

Generally, the duty of confidentiality arises from statute, from standards of professional ethics, and from contracts for therapeutic treatment; testimonial privilege arises from statute or from constitutional requirements. Both confidentiality and privilege attach when the information is communicated from the patient to the therapist[226] and continue to exist during the lifetime of both therapist and patient. Thus, a living patient may assert privilege and confidence against the successor of a deceased therapist, and the personal representative of a deceased patient may invoke the testimonial privilege.[227] After the patient's estate is distributed and the office of personal representative ceases to exist, persons subject to harm from disclosure may claim standing to assert the duty of confidentiality.[228] Full exploration of this issue, however, is beyond the scope of this article.

Dubey's arguments for unwaivable confidentiality in psychotherapy[229] do not reflect the present state of the law. Privilege and confidentiality may each be waived by the patient or by the committee of an incompetent patient during the patient's lifetime and by the personal representative of a deceased patient. Moreover, as a New York

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226. *See* 8 J. WIGMORE, WIGMORE ON EVIDENCE § 2285 (McNaughton rev. 1961).

227. Indeed, prior to the enactment of CPLR § 4504, the privilege could not be waived after the patient's death. E. FISCH, *supra* note 82, § 554; *see also* Smith, *supra* note 61, at 58 (death of a privilege-holder may be an exception because harm to therapist-patient relationship would be minimal). It could not be waived by a living patient prior to trial. *See* N.Y. CIV. PRAC. L. & R. § 4504, practice commentary on statute and related cases (Supp. 1989).

CPLR § 4504 now provides:

(c) Mental or physical condition of deceased patient.

A physician or nurse shall be required to disclose any information as to the mental or physical condition of a deceased patient privileged under subdivision (a), except information which would tend to disgrace the memory of the decedent, either in the absence of an objection by a party to the litigation or when the privilege has been waived:

1. by the personal representative, or the surviving spouse, or the next of kin of the decedent; or

2. in any litigation where the interests of the personal representative are deemed by the trial judge to be adverse to those of the estate of the decedent, by any party in interest; or

3. if the validity of the will of the decedent is in question, by the executor named in the will, or the surviving or any heir-at-law or any of the next of kin or any other party in interest.

While this writer has found no case on point, disclosure of child abuse by the decedent would very likely disgrace the decedent's memory.

228. *See* E. FISCH, *supra* note 82, § 551.

229. *See supra* notes 76-82 and accompanying text.

court observed in *Rea v. Pardo*,[230] a physician's duty of confidentiality is subject to a number of statutory exceptions in addition to child abuse reporting, including information relating to contagion,[231] cancer,[232] gunshot or stab wounds,[233] burns,[234] certain crimes,[235] drug abuse,[236] births, and abortions.[237] Most of these statutes require information which is different in kind from the confidential information necessary for treatment, which is disclosed by a patient in psychotherapy. Some of the information required by these statutes is openly observable rather than confidential. These statutes may discourage some persons from seeking medical treatment, either for themselves or their wards or victims. Accordingly, they should be viewed as limited exceptions to the legislative policy in favor of confidentiality.

VI. Narrowing the Dilemma: The Experience of Three Other States

A. *Maine*

Prior to 1985 Maine had a "treatment exception" to its mandatory child abuse reporting law. The old Maine statute provided that reporting was not required when the information came from the person responsible for the child in the course of treating that person for committing abuse or neglect and where there is little threat of serious harm to the child.[238]

In 1985, Maine repealed the exception and enacted what was no doubt intended as compromise legislation.[239] Under the current law, a mental health professional is required to report whenever he "knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected."[240] When the professional's knowledge or suspicion "comes from treatment of a person responsible for the abuse or neglect,"[241] however, the following procedure is available:

1. The Maine Department of Human Services ("DHS") must consult with the reporting professional and "attempt to reach agreement

230. 132 A.D.2d 442, 446, 522 N.Y.S.2d 393, 396 (App. Div. 1987).
231. N.Y. Pub. Health Law §§ 2101(1), 2300(5) (McKinney 1985).
232. N.Y. Pub. Health Law § 2401(1) (McKinney 1985).
233. N.Y. Penal Law § 265.25(a) (Supp. 1989).
234. N.Y. Penal Law § 265.26(a) (Supp. 1989).
235. N.Y. Civ. Prac. L. & R. § 4504(b) (Supp. 1989).
236. N.Y. Pub. Health Law § 3372 (McKinney 1985).
237. N.Y. Pub. Health Law § 4100(2)(g) (McKinney 1985 & Supp. 1989).
238. 1979 Me. Laws, ch. 733, § 18.
239. 1985 Me. Laws, ch. 495, §§ 19-20. (codified as amended at Me. Rev. Stat. Ann. tit. 22, § 4011 (Supp. 1988)).
240. *Id.* § 4011(1).
241. *Id.* § 4011(1-A).

with the professional as to how the reporting is to be pursued."[242]

2. If agreement is not reached, the professional has a right to meet with a representative of DHS and a mental health professional having expertise in child abuse or neglect. A representative of the District Attorney's office also is required to attend the meeting, unless that office indicates that criminal prosecution is unlikely. The meeting is to be conducted after DHS has completed its investigation and has referred the case to the District Attorney's office, or has obtained a preliminary protection order from the court.[243]

3. The participants in the meeting "shall make recommendations regarding treatment and prosecution of the person responsible for the abuse or neglect," taking into consideration "the nature, extent and severity" of the maltreatment, "the safety of the child and community and needs of the child and other family members for treatment of the effects of abuse or neglect and the willingness of the person responsible for the abuse or neglect to engage in treatment."[244] The stated purpose of this procedure "is to encourage offenders to seek and effectively utilize treatment, at the same time providing any necessary protection and treatment for the child and other family members."[245]

The Maine Psychological Association publicized the statutory change,[246] and DHS "expected that there would be quite a number of professionals asking for meetings."[247] In fact, as of February 10, 1987, only one meeting had been requested.[248]

In its mandated report to the legislature on the effect of the new statute,[249] DHS speculated that the lack of use of the meeting provisions may be attributable to the availability of other advisory resources and to the fact that both DHS and the District Attorney's office can make final case decisions independently of, and contrary to, the recommendations of the treating therapist.[250] This writer suggests a more fundamental reason why mental health professionals have not invoked

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242. *Id.* § 4011(1-A)(A). Note that this section does not appear to apply to a case in which the patient's spouse is responsible for the abuse, for example. Compare the language of the repealed provision. Maine's general mandate to report is now broader than New York's: in New York only the patient's children or wards appear to be covered by mandatory reporting; Maine's statute includes a broader, perhaps unlimited, class of children.

243. *Id.* § 4011(1-A)(B).

244. *Id.* § 4011(1-A)(C).

245. *Id.* § 4011(1-A).

246. MAINE DEP'T OF HUMAN SERV., REPORT TO JUDICIARY COMM. REGARDING REPORTING OF SUSPECTED CHILD ABUSE OF NEGLECT BY MENTAL HEALTH PROFESSIONALS (1987) [hereinafter DHS REPORT].

247. *Id.*

248. *Id.*

249. ME. REV. STAT. ANN. tit. 22, § 4011 (1-A) (Supp. 1988).

250. DHS REPORT, *supra* note 246, at 2.

the consultation provisions.

A therapist who discusses his patient's care with law enforcement officials or child protective workers is compounding the violation of his patient's confidence. Additionally, the therapist is placing himself at substantial risk of divided loyalty. He is no longer solely engaged in promoting the mental health of his patient. He may be seen as, and may tend to become, an advocate or negotiator on behalf of his patient or, worse, an instrument of the state.[251] It is extremely unlikely that effective psychotherapy could take place under these circumstances.

The single case in Maine in which a therapist did invoke the statute is worth discussing.[252] The case involved a pedophiliac homosexual man who sexually molested teenage boys. The therapist recommended deferral of prosecution pending treatment, which was in progress. The District Attorney overruled the recommendation and announced his decision to present the case to a grand jury, thus effectively negating the potential benefit of the statute.

It may be concluded that Maine's attempt to "divide the baby" between child advocates and the mental health professions has not been successful.

B. Maryland

The reporting laws of Maryland developed in a different direction. That state once gave broad discretion to health practitioners in cases of child neglect by providing that reporting is not required either when efforts were being made or would be made which, in the opinion of a professional, would alleviate an abuse or neglect situation or when the professional believed that reporting would deter the child or the adult responsible from seeking help.[253]

In 1984, however, that provision was repealed[254] and replaced by statutes which mandated reporting "notwithstanding any law on privileged communications"[255] by any health practitioner who "contacts, examines, attends, or treats" an abused or neglected child[256] "or who has

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251. *See* A. STONE, *supra* note 62, at 36.

252. The case is noted in DHS REPORT, *supra* note 246. A copy of the district attorney's letter to DHS advising the department of his decision to prosecute is attached to the report.

253. MD. ANN. CODE art. 72, §§ 6-7 (1957). The former Maryland statute had separate sections covering abuse and neglect; the current statute, Family Law § 5-704, covers both in one section.

254. 1984 Md. Laws, ch. 296, § 1.

255. MD. FAM. LAW CODE ANN. §§ 5-704 (1984) (amended 1987) (neglect), and 5-903(a) (1984) (repealed and incorporated into § 5-704 by 1987 Md. Laws, ch. 635, § 2) (abuse).

256. *Id.*

reason to believe that the child" was abused or maltreated.[257] Coleman, relying primarily upon a 1977 opinion by the Attorney General of Maryland,[258] concludes that the 1984 law did not mandate reports by psychiatrists who neither saw nor treated the child: "the question of whether to make disclosures of suspected child abuse [was] left to the psychiatrist's professional and moral judgment."[259]

In 1987, the Maryland statute was amended once again.[260] It now provides that reporting is not required when the sole basis for the report is the admission of the alleged sexual abuser that the individual is being treated for pedophilia and that the abuse occurred prior to the time treatment began.[261]

If Coleman's 1986 interpretation of the Maryland law[262] is correct, it follows that the new statute merely identifies one of a class of cases in which reporting by a therapist is discretionary—namely, the Maine pedophilia case previously described.[263] If, however, the new Maryland statute impliedly limits discretionary reporting to that single case, the scope of discretion is far too narrow. The statute would require reporting in other situations in which the need for confidentiality is of equal or greater exigency, while giving no weight to the nature or degree of the suspected abuse or neglect. So limited an exception does not resolve the problem.

C. *Oregon*

Oregon's law provides that psychiatrists, psychologists, clergymen, and attorneys are not required to report information communicated by any person if the information is privileged under Oregon's testimonial privilege statutes.[264] The privilege statutes are also direct and succinct.[265] So far as this writer is aware, no one has ever argued that children in Portland, Oregon, are at greater risk than those in Portland, Maine.

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257. *Id.*

258. 62 Op. Md. Att'y Gen. 157 (1977) (cited in Coleman, *supra* note 56, at 1151 n.199).

259. *Id.* (quoting 62 Op. Md. Att'y Gen, at 160).

260. 1987 Md. Laws, ch. 635, § 2.

261. MD. FAM. LAW CODE ANN. § 5-704(b) (Supp. 1988)

262. *See supra* notes 258-59 and accompanying text.

263. *See supra* note 252 and accompanying text.

264. Specifically, the Oregon statute provides: "a psychiatrist, psychologist, clergyman or attorney shall not be required to report such information communicated by a person if the communication is privileged under [Oregon's testimonial privilege statutes]." OR. REV. STAT. § 418.750 (1987).

265. *See* OR. REV. STAT. § 40.230 (psychotherapist-patient privilege); OR. REV. STAT. § 40.235 (physician-patient privilege).

VII. Narrowing the Dilemma Through Statutory Change in New York: A Proposal for Guided Discretion

The principal dilemma with which this article is concerned arises from the 1984 amendments to the New York law, which require reporting by psychotherapists who have not seen the child. The Juvenile Justice Standards Project of the IJA-ABA accurately predicted the potential problems with the mandatory reporting laws.

> [M]andatory reporting will not only fail to bring benefits to the child; such reporting will actively hurt the child by interfering with the prospects of successful psychotherapy for the child and his/her family. Discretion to report, when the therapist has reason to believe the child cannot adequately be protected in the processes of therapy, provides a more helpful legal response to this problem.[266]

Other writers have recommended according greater deference to the judgment of the professional psychotherapist. New York should take a step in that direction. If New York is unwilling to allow unfettered discretion on the part of individual psychotherapists, the law should, at least, *authorize the exercise of discretion guided by professional standards, to be adopted and supervised by the therapist's own discipline.*

This approach would involve development of a consensus of the therapeutic community concerning the circumstances under which reports should be filed. The standards would encompass greater detail than any statute can provide—the relevance of temporal remoteness of various acts of abuse or neglect—,greater flexibility, and would make an allowance for the expected incapacity or cure of the alleged abuser. It would allow individual therapists to weigh the professional standards of behavior against the facts of any particular case. Gross departures from professional standards, in either direction, would subject the practitioner to disciplinary action or civil liability based on a malpractice standard. The therapist would be shielded from liability if he displays an appropriate degree of professional competence, either by acting in the best therapeutic interest of his patient or in the overrid-

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266. Standards Relating to Abuse and Neglect, *supra* note 100, § 3.1 (B), comment 3. "The idea that mandatory reporting applies only where the child is the patient is an excellent one and is more likely to achieve the important state interest of the best interests of the child and the reunion of the family as a healthy unit." Coleman, *supra* note 56, at 1152.

"[N]eglect of children not associated with the imminent risk of serious bodily injury should no longer be included in mandatory reporting." Gerbner, *supra* note 105, at 146; *see also* Uviller, *Save Them From Their Saviors: The Constitutional Rights of the Family, cited in* Gerbner, *supra* note 105, at 151-52.

ing interest of some third party or the community as the facts of each case measured against the professional standards might require. The therapist would be required to document and defend the basis for his exercise of judgment. The decision to report or not to report, however, if made in good faith and without malpractice, would result in no legal consequences to the therapist.

This approach, if adopted, would eliminate many of the specific problems that may arise under the present law. It would not resolve the therapist's dilemma, but would go far toward reducing it. It would limit both overreporting and underreporting. It would enhance the therapist's professional ability to deal with issues of confidentiality and trust and thereby increase the likelihood of successful treatment of the emotional problems that may contribute to abuse or neglect. Finally, by bringing professional judgment rather than mere reflex to the abuse reporting decision, the change—as the social work arguments suggest[267]—may actually reduce the overall incidence of unremediated child abuse.

VIII. CONCLUSION

New York's child abuse reporting law, as it relates to the mental health professions, is vague and difficult to apply. The law usurps the therapist's right to exercise professional judgment in important aspects of patient care, undermines the therapeutic process by subjecting the therapist to divided loyalty and eroding patient confidence, and unfairly exposes the therapist to civil damages or criminal prosecution—all without demonstrable benefit to the public or any child. This article does not purport to resolve the therapist's dilemma. It does suggest, however, that the present, inflexible mandate of the law should give way to professional standards of reporting to be developed by consensus of the therapeutic community.

267. *See supra* notes 83-112 and accompanying text.