Robert Weinstock,[1] *M.D. and Diana Weinstock,*[2] *Ph.D.*

Child Abuse Reporting Trends: An Unprecedented Threat to Confidentiality

REFERENCE: Weinstock, R. and Weinstock, D., **"Child Abuse Reporting Trends: An Unprecedented Threat to Confidentiality,"** *Journal of Forensic Sciences,* JFSCA, Vol. 33, No. 2, March 1988, pp. 418-431.

ABSTRACT: Some recent interpretations of the child abuse laws are creating serious and unprecedented erosions of therapist/patient confidentiality. In contrast to the Tarasoff decisions and laws, the child abuse statutes introduced a new element of mandatory reporting which permits no discretionary alternatives and presents prospects of criminal penalties for failure to report. A recent development suggests a possible requirement for therapists to violate confidentiality for the sole purpose of punishing perpetrators. Overinterpretations of the laws by some child protective services have led to recommendations that long past child abuse must be reported, even when no current child is in danger. The California Attorney General's Office has issued a clarification stating that the child abuse statute refers to children and not to adults molested as children. A survey of forensic psychiatrists and psychologists shows that most perceived an ethical problem in reporting adults molested as children when no child is presently in danger, and the purpose of the report is solely for maximal legal self-protection. The survey indicates that fears induced by rigid and intimidating child abuse laws can influence therapists to act in ways most consider unethical. Recommendations are made for improving the current child abuse laws so that they accomplish their goals more effectively.

KEYWORDS: psychiatry, jurisprudence, child abuse, doctor-patient privilege, confidentiality, Tarasoff, danger to others, forensic psychiatrists and psychologists, therapist

Many therapists have become so accustomed to violating confidentiality for the specific purpose of protecting victims from harm that they have not recognized the dangers of the rising number of unprecedented assaults upon therapeutic confidentiality. In contrast to their past actions, therapists tend to follow overzealous interpretations of the laws too readily because they fear legal liability. The focus of this paper will be on the serious adverse effects of overinterpretations of the child abuse laws. The problem of violating confidentiality for the sole purpose of prosecution will also be addressed.

Even before the Tarasoff decisions, responsible therapists perceived a clinical obligation to take steps necessary to prevent their patients from harming others. By protecting third parties, therapists were also shielding their own patients from the detrimental consequences to themselves of their violent actions. The Tarasoff decisions originally generated tremendous concerns about their potentially negative effects upon patient therapy. However, the

This paper is based on a presentation at the 39th Annual Meeting of the American Academy of Forensic Sciences, San Diego, CA, 16-21 Feb. 1987. Received for publication 26 May 1987; revised manuscript received 13 July 1987; accepted for publication 14 July 1987.

[1]Associate clinical professor of psychiatry, UCLA, and associate clinical professor of medicine, University of California, Irvine.

[2]Psychologist, Counseling Services, California State University, Hayward.

predicted difficulties generally did not occur because clinicians still were permitted to utilize good clinical judgment in treatment just as they had done before the Tarasoff decisions.

The Tarasoff I decision [*1*] did pose a threat to confidentiality under the finding of a "duty to warn" third parties, but Tarasoff II [*2*] changed it to a "duty to protect." This modification recognized that treatment may be more effective when therapists can use their discretion to choose appropriate, more useful alternatives to reporting and warning. For example, methods such as civil commitment could successfully reduce the risk of violence without betraying a patient's trust. Paradoxically, the original rationale that led to the Tarasoff decisions aimed to preserve patient rights. It was considered less restrictive to warn a victim than to hospitalize a patient involuntarily [*3*]. However, in our experience, most patients may object but will eventually understand and accept the need for involuntary hospitalization, but they are likely to interpret warning a potential victim by a therapist as an unacceptable and unforgivable betrayal of trust.

The Tarasoff I and II decisions were often confused by some therapists and even courts who continued to follow Tarasoff I. They thereby overlooked valuable options legally available in Tarasoff II. The Tarasoff rulings *never* placed the therapist at any risk whatsoever of criminal penalties. Failure to protect could result at most, only in possible civil liability, if the clinician were to be proven negligent.

Major professional organizations supported the passage of the new "Tarasoff"-type law in California [*4*] and in a number of other states. These statutes serve a useful purpose by placing limits upon therapists' civil liability. Generally, they have removed the "should have known" requirement of Tarasoff II which implied that practitioners could "read the patient's mind." Under the current California statute, potential liability exists only when the "patient expresses to the therapist a serious threat to an identifiable victim." Psychotherapists can discharge their legal duty under such circumstances by "reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency." Unfortunately, this law does not encourage potentially more useful actions, such as involuntary hospitalization, but it still does permit them. There is no criminal liability for not notifying the police or not warning the victim. There is potential for civil liability, but that should be negated in the overwhelming majority of circumstances if therapists have a good rationale for their actions and if there is no proof of negligence on their part. The "Tarasoff" law unfortunately encourages rote actions of reporting *and* warning, but therapists can nevertheless do what they consider to be professionally and ethically indicated just as they had done previously, still without any threat of criminal liability. Potential civil liability follows ordinary malpractice standards.

In contrast to the "Tarasoff" laws and decisions, child abuse statutes present new and very serious threats to therapeutic confidentiality. The differences between these laws are not being appreciated adequately. The child abuse acts generally mandate that mental health professionals report all known or suspected instances of child abuse. Serious criminal penalties as well as potential civil liability are imposed upon clinicians for failure to report. Not reporting in and of itself is a misdemeanor that can bring criminal penalties. Since there were so few negative repercussions from the Tarasoff decisions, many therapists have become complacent about routinely violating confidentiality in situations of potential harm to others. They need to realize that the child abuse laws pose much more serious threats to therapy than the "Tarasoff" laws.

Until recently, there was little legal reinforcement of penalties for nonreporting. However, law enforcement of penalties for failure to report under the child abuse acts is beginning to escalate. The result is an increase in fears of liability as well as confusions about implementing the laws. It is, therefore, more essential than ever that therapists guard against any unnecessary attacks upon confidentiality that can have negative impacts upon therapy. Legislators also need to appreciate the values to victims and to society of permitting clinicians greater flexibility in dealing with child abuse problems.

California's child abuse law [5] is similar to those of most other states. It specifically demands a telephone call to designated agencies upon learning of the child abuse, followed by a written report within 36 h. No flexibility is allowed even if there are good clinical reasons for postponing a report. Practitioners are given too little time to work on the problem with patients who have been abused and can feel "abused" again when therapists betray their confidences. Unless the abuse may be ongoing, there is no justification for inflexibility in the time allotted before a report is made.

The legislative intent of the child abuse act is "to protect children from abuse. In any investigation of suspected child abuse, all persons participating in the investigation of the case shall consider the needs of the child victim and shall do whatever is necessary to prevent psychological harm to the child victim" [6]. However, many children today need protection from those who are ostensibly "helping" them under the laudable umbrella of child protection. "The child may be as traumatized by . . . intervention as by the initial abuse or neglect" [7]. In addition, some agencies become so involved in bringing perpetrators to justice that these attempts may take priority over the welfare of child victims. Understandable emotional reactions must not be permitted to divert attention from children who need immediate and appropriate help.

The soaring volume of child abuse cases and the sometimes almost hysterical reactions to child sexual molestation have generated overinterpretations and confusions about the laws. Some child protective services and local branches of the California Attorney General's Office have expanded the scope of the law beyond its original intent of child protection. In doing so, they are overlooking many frequent negative ramifications for victims. An example involves their recommendations to report all cases of *past* abuse even if many years have elapsed since the cessation of the abuse, no child is currently at risk, and the victim does not wish it reported. There is no comparable stipulation in any law other than perhaps the new progeny of the child abuse laws, such as elder abuse or dependent adult abuse laws. In these statutes, similar problems may arise because of the analogous language in the three laws. In almost all other situations, therapists are required to attempt to prevent current and future dangerousness, but not to report past crimes [8]. Obvious exceptions are those which suggest a recent past crime and probable continuing danger without intervention. Examples of such special circumstances are battered children and gunshot wounds. Mandated reporting in such circumstances is consistent with therapists' usual acceptance of violations of confidentiality when necessary to prevent injury to others.

Problems arise, however, when distant past abuse is confused with recent past abuse. An example of *recent* past abuse, as used in this paper, is the discovery of signs of abuse that occurred a relatively short time ago. The environment remains similar and therefore it is likely that the recent past abuse will continue into the future and that such a child is in dire need of immediate intervention. *Distant* or long past abuse, on the other hand, as used in this paper, refers to a situation that occurred some time ago in the past and there is no current child in danger. The formerly abused child may now be an adult who does not want the abuse reported, or the victim may still be a child. However, significant time has elapsed, important changes in circumstances have occurred, and there is no current or future danger of abuse to any child.

Butz, an attorney [9], states that "actual abusive behavior that has occurred in the past" must be distinguished from abuse that is ongoing. "Only the latter need be reported." A parent who has been abusing a child is likely to continue if there is no change in circumstances and environment. However, such recent past abuse has a totally different connotation from abuse that has occurred in the distant past and there is no current child in need of immediate protection by the law. There are also differences in treatment approaches for each of the following sets of situations: abuse on just one occasion and a pattern of abuse, successful or unsuccessful intervention by the clinician, and discovery of the abuse by a therapist or by another professional such as a teacher who may not have the expertise for evalua-

tion or the same dilemma with breaching confidences as a treating therapist would have Each problem is approached best through laws that permit appropriate flexibility for therapists [*10*]. Reports could still be made if treatment is unsuccessful or if the patient leaves therapy prematurely.

Most states do not have a clear requirement to report past abuse, yet some child protective services have overinterpreted the laws and have been advising such reports. However, great caution is necessary because whether the patient is a victim or an abuser, an informer can catapult a family into an even greater injurious and painful experience. Therapists are placed into the disquieting position of masquerading as empathic clinicians who become undercover police agents by betraying patient confidences. Reports can interfere with a patient's need for professional help by undermining trust in therapy. Even warning a patient at the initiation of treatment is inadequate because few patients recall the details of a consent form. This is also true for medical patients who tend to exhibit trust in their doctors [*11*].

Not only is reporting of distant past abuse an unwarranted abrogation of rights to confidentiality, it is also an unrealistic and futile exercise because many agencies cannot even reach all of the current abused children who are in urgent need of immediate help. They could not possibly cope with the vast number of distant child abuse cases. It seems, therefore, that unless the victim wishes it or the therapist sees a specific need for it, such as suspected ongoing abuse, these reports can drain limited resources unnecessarily, and can be more harmful than beneficial.

Therapists who routinely and indiscriminately report all cases of long past child abuse should be alert to possible future court rulings that conceivably could bring some unpleasant legal consequences to those who report thoughtlessly. It seems prudent to evaluate each situation responsibly before making a report that serves no useful purpose and may prove harmful. Hopefully, common sense and good clinical judgment will be allowed to prevail over routine and unwarranted reporting.

In California, as elsewhere, there has been widespread confusion between mandated reporting of recent past abuse and the reporting of long past abuse which is not clearly mandated. Because California decisions often have been setting trends across the country, it is especially relevant that direct questioning on this issue before the 1987 AAFS Meeting led to the California Attorney General's Office, in February 1987, issuing an informal opinion that states that under present law a therapist could be found liable for failure to report only if the victim is still a child. The Opinion states further that any ambiguity in the statute must be construed as favorably to a defendant (in this case, the therapist) "as its language and the circumstances of its application may reasonably permit."[3] Hopefully, this recent announcement will allay the fears of liability and the many overreactions current in California. Examples of some of the problems resulting from confused implementation of the law will be described in the cases presented in this paper.

However, the problem of past abuse may not have been put to rest in California because the Attorney General's Office Informal Opinion also encourages the legislature to clarify its intent. The directions that new laws and modifications may take are unpredictable. For example, legislators could include a requirement to report solely for prosecution of past offenders if the statute of limitations for it has not passed.

The California Supreme Court has already included possible prosecution of perpetrators as one intent of the child abuse act. Judge Klaus [*12*], in his concurring opinion stated, "The law presumably has three objectives: to punish the abuser, to identify and protect victims, and to cure (the abuser) in order to protect future potential victims." This opinion still does not suggest reporting long past abuse because, according to the Informal Opinion,[3] none of

[3]K. Ziskind, Adult Abuse Victim, Informal Opinion by the California Attorney General's Office, Feb. 1987.

the three objectives would be met. The ruling is very unusual, however, if it suggests the legitimacy of violating confidentiality solely for the unprecedented purpose of punishment. Hopefully, the intent was merely to include prosecution as one purpose of the child abuse law, but does not imply that confidentiality should be violated for punishment alone. Since Judge Klaus stated that one purpose of the law is to "cure (the abuser)," he indicates an encouraging appreciation of the value of therapy in alleviating child abuse problems. This aspect, rather than punishment, belongs within the therapeutic community.

Overinterpretations, however, conceivably could require violations of confidentiality solely for punishment of abusers. This potentially dangerous possibility has brought an astonishing silence from therapists who seem unaware of this unprecedented threat to confidentiality. It would be encouraging and reassuring if the California Supreme Court and government agencies would demonstrate their appreciation of the value of maintaining therapeutic confidentiality by keeping prosecution of offenders within the legal system where it belongs. Because the law is presently ambiguous, it would be highly unlikely that a therapist would be prosecuted for not reporting distant past abuse even if the victim of the past abuse is still a child. Statutory ambiguity "must be construed in favor of . . . the mandated reporter."[3]

Previously, the psychotherapist-patient privilege in California applied to criminal as well as civil matters. The California Supreme Court's objective of punishing abusers raises additional questions for legislators to clarify in the area of maintaining confidentiality. For example, what are the implications when the victim of distant past abuse is now an adult, there is no evidence of ongoing abuse, the statute of limitations for prosecuting the offender has not run out but the therapist has failed to report? There is also the problem of the victim of distant past abuse who is still a child but there is no ongoing abuse. Hopefully, the legislators and courts will consider it counterproductive to require violations of confidentiality solely for prosecution when no current child is at risk. It may be fully appropriate for the legal system to attempt to punish offenders, but punishment is not a function of therapists and should not be a reason to violate confidentiality.

It is especially unclear why some child protective services recommend reporting of distant past abuse when such violations of confidentiality are not required in other instances of past criminal behavior. Even in cases of past robbery, rape, or murder, confidentiality is respected unless a present danger to another is likely to exist [*8*]. Judges Mosk and Clark showed strong appreciation of the value of maintaining confidentiality in their Tarasoff dissents [*13*].

The legal and justice systems have been unsuccessful in halting the rising tide of child abuse, yet they interfere with practitioners who wish to address these problems. Under the child abuse statutes in most states, therapists are allowed little control, input, or influence over what happens to the patient both prior or after a report. They have no recourse in the entire process but to hope that some modicum of trust still could be salvaged after a report.

Child abuse has long been present, but the enormity of this phenomenon was first revealed in Kempe's nationwide survey in 1962 [*14*]. Legislators reacted rapidly by passing laws aimed at protecting children. By 1965, all states had enacted statutes which provided for the formation of child protective services. Their function was to try to meet the needs of the family rather than to institute criminal proceedings as the law enforcement agencies were likely to do. This original purpose of the Child Protective Services was clearly therapeutic and presented no ethical problems for therapists.

In 1974, the federal government enacted the Child Abuse Prevention and Treatment Act [*15*] which was revised in 1978 [*16*]. The federal law was not binding on the states but it did allocate sums of money for states who met prescribed conditions [*17*]. At present, all 50 states as well as the District of Columbia, the Virgin Islands, Samoa, Puerto Rico, and Guam have similar but not uniform child abuse laws. Generally, they all mandate mental health professionals to report known or suspected cases of abuse and they identify agencies

who receive the reports. They provide criminal and civil immunity for those who report, and most states impose serious penalties for failure to report.

The child abuse laws may differ in detail from state to state. In California, for example, the most recent law [5] requires reporting "where one acquires knowledge of or observes facts which give rise to a reasonable suspicion." Reasonable suspicion occurs when "it is objectively reasonable for a person to entertain such a suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse." Failure to report is a misdemeanor [*18*], punishable by a term in jail not to exceed six months or a fine not to exceed $1000 or both. In California, the definition of child abuse [*19*] is, physical injury, sexual abuse, willful cruelty, or unjustifiable punishment or injury, severe and general neglect, and abuse in out-of-home care. Reporting of emotional abuse is not mandated but it may be reported.

Child Protective Services can perform a vital function by attempting to rehabilitate the family or to determine other appropriate actions in each case. However, these agencies are currently underfunded and understaffed, and it is unrealistic to expect that funding will increase sufficiently in the foreseeable future to improve the situation substantially. Frazer [*20*] points out that the laws assume that "treatment services are available . . . but the assumption is "erroneous in most cases." Goldstein et al. [*21*] found that intervention by the state can sometimes do more harm than good. There is also an understandable but detrimental inclination by some people to overreport in order to be certain of avoiding liability. Schultz [*22*] describes "a case worker who tried to get state custody for all suspected abused children" in order to achieve maximal legal self-protection, regardless of the consequences to the children. Lack of funds has also contributed to a tendency to prosecute offenders as opposed to providing treatment for those involved in a case of abuse. These trends towards punishment exacerbate the ethical problems of therapists who are mandated to report.

Another dangerous trend in some states is the requirement by courts that therapists testify against patients in criminal child abuse cases [*10*]. A similar problem occurs in cases of child neglect where parental rights are terminated. In one author's experience, little effort is made to discover alternative ways of supplying information to the courts. Instead, to save the costs of court ordered evaluations, therapists are asked routinely to violate confidentiality without consideration of potential resultant damage to anyone involved in the case.

The child abuse laws are having a strong impact upon clinicians. The positive effect is an increased sensitivity to the prevalence of child abuse. However, the negative side includes: the detrimental effects of strong fears of liability upon therapy, overreporting and misinterpretations such as the suggestion to report long past abuse when the victim is now an adult, a deterioration of patient-therapist confidentiality and trust, an increasing disregard for the effects of reporting upon victims and families, and requirements for therapists to act in ways many consider unethical. Most striking is that these developments have occurred almost unchallenged by professionals whose skills are being restricted by unprecedented assaults upon confidentiality. Instead of encouraging therapeutic treatment of the problem, the law is undermining such approaches even for victims of child abuse.

We are witnessing a growing insensitivity to the values of preserving confidentiality whenever possible. A patient may trust a therapist sufficiently to divulge information that probably would not be forthcoming in any other circumstances. However, when patients become sophisticated about the insidious changes in the status of confidentiality, whereby the confidante becomes an informer, they will be less likely to reveal sensitive information. If therapists become cavalier about violations of confidentiality, there is a danger that reporting mandates could be extended gradually to many other situations such as speeding in traffic, drug use, and so forth. We are already seeing such extensions in the new elder abuse and dependent adult abuse laws.

The understandable emotionality generated by the crime of sexual abuse of children has contributed to a loss of perspective in this area. An example is evident in the McMartin child

molestation case in Los Angeles in which many teachers and administrators were indicted on hundreds of counts of child sexual abuse. It now appears that "leading suggestive questions" may have been asked of the children and there are serious doubts about the guilt of most of the teachers [*23*]. This much publicized and sensationalized case is one example of overzealous attempts to gain public acclaim by punishing alleged perpetrators. When accusations are made, guilt tends to be automatically assumed in cases of sexual abuse. The current climate is described in a recent *Los Angeles Times* report [*24*] that a "witch hunt for molesters is under way, clogging the system with unsubstantiated cases and draining the resources away from the real cases." The article points out that accusations of child abuse are being contrived to obtain divorces, child custody, and revenge, or they may result from erroneous interpretations of marks on a child's body.

Instead of balancing the necessity to safeguard patient information with the needs of society, recent interpretations of the child abuse laws are leading to some unnecessary and serious violations of confidentiality whenever there is a competing duty to society. Some therapists mistakenly believe that they must accept all interpretations to report. It would be very unfortunate if passivity or overwhelming fears of liability lead to the destruction of confidentiality to an extent unanticipated nor mandated by the legislators.

This paper will present some case illustrations of problems caused by the child abuse laws and their interpretations. It also will present and discuss a survey of forensic psychiatrists and psychologists. The study investigates their views regarding the ethics of reporting distant past child abuse when no child is currently at risk and the past victim is now an adult.

Method

A questionnaire on controversial ethical issues was distributed to forensic psychiatrists and psychologists who are members of the Psychiatry and Behavioral Science Section of the American Academy of Forensic Sciences. Most members are psychiatrists. One-hundred-and-two questionnaires were sent out. Sixty-two were returned for a response percentage of 60.7% [*25*].

One of the questions addressed the reporting of distant past child abuse. It asked, "Do you see an *ethical* problem if a forensic psychiatrist or psychologist reports an instance of past child abuse with no evidence of ongoing abuse, the abused child is now an adult, the patient does not wish it reported, yet the therapist reports it solely for the purpose of his own maximal legal protection?"

Another related question was directed to the issue of making rote reports to the police and also warning the victim in situations where a violent threat has been voiced. The question asked, "Do you see an *ethical* problem if a forensic psychiatrist or psychologist reports to police, and a potential victim, a patient who initially expressed a serious threat of physical violence to an identifiable victim, even though he evaluated the threat as a mere expression of anger with no imminent danger, yet he reported the case, violating confidentiality, solely to provide himself maximal legal protection?"

Results

The results of these two issues in the survey showed how the following respondents saw ethical problems:

1. Past child abuse reporting

Definitely Yes or Qualified Yes	Definitely No or Qualified No	No Opinion
67.8%	10.2%	22.0%

2. Rote reporting to police and warning a victim for maximal legal self-protection

Definitely Yes or Qualified Yes	Definitely No or Qualified No	No Opinion
66.1%	28.7%	5.0%

Case Examples

In the following cases there are minor changes in facts to preserve confidentiality of therapists and patients.

Case 1

A 21-year-old graduate student disclosed to her therapist that her father had sexually molested her on numerous occasions between the ages of 12 to 16. It occurred at a time when her father's mother had died and her parents were also experiencing marital difficulties. When she was 16, her parents entered couple therapy and the abuse stopped. The patient emphasized that her mother was unaware of the incest and she did not want her mother to know. Currently, a 17-year-old sister and a 16-year-old brother were living at home. The patient convinced the clinician that there was no sexual molestation of her siblings.

The therapist's supervisor contacted the local child abuse agency as well as their malpractice carrier. Both advised that the case must be reported because there was no statute of limitations for reporting. The social worker at the child abuse agency mentioned that it was highly unlikely that they would have the time to investigate the situation but insisted that a report must be made. Moreover, she stated that despite the therapist's opinion, it was conceivable that the younger children could be at risk. The supervisor feared that they could jeopardize their license and also be subject to possible penalties. The clinician, against her better judgment, reported the case.

When the patient learned about the report she was outraged. Her father had just applied for a new position with a correctional agency which was doing a security check on him. She was overwrought because the report could interfere with his obtaining the job. She threatened to sue the clinician who reminded her that she had signed a consent form which stated that child abuse must be reported. The patient declared that she had forgotten about the form, but that it was not relevant because she was no longer a child. The therapist explained that she was legally required to report all instances of child abuse. The patient cried that she had long felt the need to talk to someone about the incest, but she had never anticipated that it would be made public and would bring so much shame to her and to her family. She could not understand why she was being punished for asking for help and that the clinician made her feel worse than her father had ever done.

Case 2

This case involved a 22-year-old woman who had been sexually abused by her father on various occasions from age 9 to 17. She was an only child and believed that her father had never abused anyone else. His work did not involve children and they did not have any relatives with young children. She insisted that the information must be kept confidential because she was so intensely embarrassed by it. However, she felt the need to discuss the incest with someone. The therapist checked anonymously with a child protective service who informed him that all cases of child abuse must be reported. Then he contacted his malpractice carrier who recommended that in California it was considered necessary to report such a case to avoid liability. He then consulted several experts on child abuse. Their opinion was that reporting of past abuse was required only to protect children from danger. After care-

fully checking the family situation, the therapist was convinced that no child was in danger of abuse. He decided that the most responsible action would be to maintain confidentiality and he did not file a report.

Case 3

A badly disabled 19-year-old male confided to his therapist that at the age of 17 he had moved in with a 23-year-old man who had been very helpful to him. They were intellectually compatible and enjoyed each other's company. Eventually they began a sexual relationship. His parents discovered it several months later and forced him to move out. The younger man became very depressed, feeling that he had lost the only person who had ever accepted him as a fellow human being without pitying him. He had not been coerced to engage in sex but he enjoyed and wanted it as part of the relationship that had evolved between them.

The patient was appalled to learn that because he had been below the age of consent at the time of the relationship, the therapist had reported his older companion for sexual abuse. Additionally, the therapist had been concerned that dependent adult abuse laws might apply. The patient felt betrayed by the therapist whom he accused of not even checking to find if the former friend was abusing others at present. He was certain that there was no other abuse. The patient was so disturbed and embittered that the therapist had betrayed his confidences that he stopped therapy, more depressed than ever. He stated that he would never again trust professional therapeutic help.

Case 4

A 20-year-old woman came to therapy for help with her depression. When she was 12 her parents were divorced and her father was given full custody because her mother was an alcoholic. Her father began an incestuous relationship with the patient that lasted until she was 15 when he stopped at her insistence. The patient hoped that therapy would help her deal with many feelings she had about her father. The therapist reported the incest and notified the patient who became very frightened and angry about it. Her father would no longer speak to her, and she felt very guilty about betraying him to others because, except for the molestation, she had been very happy living with her father. He had always been very kind to her and had complimented her a great deal. She feared her father would never forgive her and she would never forgive herself for telling anyone about the abuse. Her father had a history of heart problems and if this killed him she was sure that she was the cause. She was terrified that he might be sent to prison. Her father was living in a brother's home. Her uncle was so shocked at the revelation of the incest that she was worried that he would put her father out. The patient asserted that she had come to therapy for relief from her depression but now she felt worse than ever before. She declared that she would commit suicide before she would ever again turn to a therapist for "help."

Case 5

A 28-year-old man returned to college after dropping out of school for several years. When he entered therapy, he was suicidally depressed and felt trapped in his relationship with an older woman. He was insecure and felt inferior to his older sisters who were all professionals, one of whom was a psychiatrist. He had vegetative signs of depression and improved with antidepressants.

During therapy, he revealed that when he was 18, on one occasion, he had tried to have sex with a 12-year-old cousin. The incident truly embarrassed him and it never recurred. Moreover, he disclosed that one of his sisters had been sexually abused as a child by their father. At present, there were no other children at home and no reason to suspect any ongoing

abuse. The therapist checked with the local branch of the Attorney General's Office and with his malpractice carrier. At that time, both advised that *all* abuse must be reported no matter how long ago it occurred. His malpractice carrier added that California law was being interpreted in this direction even though there was no case law to support this interpretation. After reading the law carefully, the therapist did not agree with his legal advisors' interpretations and he decided not to report the abuse. He hoped that future courts would affirm that he had made a sound and responsible clinical decision. He saw no clearcut requirement to report and he decided that, in this particular case, reporting would do more harm than good. Nevertheless, he was disturbed and annoyed at being placed in such an untenable position by what he believed to be an incorrect and destructive interpretation of the law. He felt he should not be at risk for exercising his best professional judgment as opposed to making a counterproductive report that could have driven the patient to suicide.

Discussion

As the survey and case examples indicate, the current child abuse laws can present difficult ethical dilemmas for therapists as well as serious problems for patients and society. Not only do the statutes demand rigid reporting actions that practitioners may find clinically and ethically contraindicated, but serious criminal and civil penalties are imposed for failure to obey the laws. The current child abuse acts require reports of known or suspected child abuse. However, there is no clear mandate to report distant or long past abuse when no child is currently at risk. Since the original intent of the law is to protect children, it appears counterproductive to report when there is no child in need of protection by the law. Our survey shows that most clinicians consider it unethical to report long past child abuse when the formerly abused child is now an adult, there is no ongoing abuse, and the sole purpose of the report is for maximal legal self-protection. Fears of legal liability appear to influence some clinicians to act in ways many consider unethical. Similar dilemmas are not likely to occur in states such as Maryland [*26*] where therapists are granted the discretion to choose actions they consider more appropriate than reporting.

A positive clarifying note has been introduced by the California Attorney General's Informal Opinion of February 1987, which states that reporting of past abuse is required only if the victim is still a child. It is not mandated for adults molested as children if there is no child currently at risk. However, there are still some unanswered questions. Is a report necessary when the circumstances under which the past abuse occurred have changed considerably, there is no ongoing abuse, the former victim is still below the legal adult age, and the victim as well as the family are strongly opposed to a report? What are the considerations in past abuse cases where no child is currently being abused, and there is ongoing therapy which has the potential to prevent a recurrence? In such situations, reporting over the victim's objections does not appear to serve any useful purpose and, in addition, may undermine any therapeutic alliance. Of course, nothing said in this paper should prevent a therapist from assisting a patient to report past or present child abuse if the patient wishes it reported and wishes to have the perpetrator punished. However, hopefully, the law will be interpreted to exclude all past abuse from the reporting process when the circumstances have changed so that there is no longer any danger to a child and all involved do not want it reported.

Future problems are foreshadowed by indications from the Attorney General's Office that their Opinion is subject to modifications of the statute. California's Supreme Court has already stated that one purpose of the child abuse act [*12*] is punishment of abusers. Hopefully, therapists will not be required to provide information for the sole purpose of punishment when no child is at risk, but the statute of limitations for prosecuting the offender has not passed. This would constitute a dangerous and destructive precedent. Heretofore, violations of confidentiality were restricted to protecting victims from harm. It would be unfortunate if the Supreme Court ruling is overinterpreted, as others have been, and the therapeutic

community is compelled to betray patient confidences solely for punitive purposes. Punishment and prosecution are functions of the law while treatment and prevention are components of therapy. Practitioners have a professional responsibility to bring the problems to the attention of legislators so that they become aware of the negative consequences, to patients and society, of unwarranted invasions of confidentiality. Hopefully, therapists will not violate confidentiality blindly when the law does not clearly and unambiguously demand it and no beneficial purpose would be served by doing so.

When one unnecessary attack upon confidentiality is accepted, then others are likely to follow. This trend is already materializing in the new elder abuse and dependent adult abuse laws in which the language is analogous to the child abuse statutes and it is likely that similar problems will develop in implementation. Instead of recognizing and addressing the problems generated by the child abuse laws, the latter regretfully were used as a "model" for other situations of possible abuse.

Disregard for the value of maintaining confidentiality can set precedents for further betrayals of confidences. Conceivably, legislation can include demands for therapists to report past crimes such as drug dealing and abuse, athletes using steroids, dangerous and/or drunk driving, frequent speeding, income tax evasion, and so forth. Reporting such past infractions of the law is but a small step away from the requirement to report long past child abuse when there is no current danger to a child.

If the child abuse statutes are interpreted to include past occurrences, then ethical therapists may face the need to give continuing Miranda warnings to patients so that they remain aware of the possible consequences of divulging incriminating information. Practitioners as well as patients would be placed in the untenable position of keeping one eye on treatment and the other on the law. It is difficult to see how this could lead to productive therapy or how it could be useful to society. There is also a danger that the patient would give the therapist such information before the therapist realizes what is happening and could warn the patient to remain silent.

The following are suggestions for legal modifications that could contribute to more effective implementation of the child abuse laws:

1. A limited exemption for mandated reporting needs to be instituted for treating therapists, but not for other professionals such as teachers who ordinarily do not have the clinical training to evaluate and treat the problem.

2. Treating therapists who wish to address the problem themselves actively must be allowed the flexibility to choose appropriate alternatives to reporting when necessary to intercede effectively in child abuse cases. Since they are familiar with the situation, they are more likely to act productively than an understaffed overworked child protective agency which is new to the case. However, if intervention is not succeeding, if the abuser leaves treatment without other care, or if the therapist does not choose to address the problem of abuse directly, then a report should be filed to enable child protective services to intervene if necessary.

3. All criminal sanctions should be removed for a treating therapist who has good clinical reasons for preferring actions other than reporting. Potential criminal penalties could still be continued for therapists who endanger a child by not addressing the problem in any manner. Civil liability could still be found when the therapist is negligent in his actions and the situation coincides with current malpractice standards.

4. Reporting by a therapist over a victim's objections would be required only if ongoing abuse to a child is not being addressed. The victim's request for confidentiality should be respected if the abuse has clearly stopped or intervention such as family therapy appears to be ameliorating the problem or both.

5. A treating therapist must be permitted more than 36 h, if necessary, to prepare a patient for the very stressful experience of the reporting process. The 36-h limit should be required only if there is a serious danger of ongoing abuse in the interim.

6. Therapists must not be required to violate confidentiality solely to punish perpetrators. Concrete unambiguous provisions must emphasize that punishment is a function of the legal system, not of therapy. Reporting for the sole purpose of punishment should only be done if the patient wishes it reported.

7. Current ambiguities in the laws should be interpreted in the direction of maintaining confidentiality and not for its progressive destruction. Social responsibilities can be met most constructively when patient confidences are protected unless an overriding danger to another exists.

The above suggestions may alleviate many problems that are presently plaguing therapists, patients, perpetrators, families, as well as government agencies. To be effective and fair, statutes must give clear concrete guidance and limitations. Further suggestions for more productive child abuse laws have been discussed elsewhere [*10*].

Above all, mental health professionals must be given the flexibility to exercise their clinical judgment in determining the appropriate course of action in each case of danger to a child. In discussing "Tarasoff," Beck [*27*] also advocates flexibility, stating that "statutes incorporating formulae that require . . . specific action will not serve the public or the professions well. . . ." Legislators and courts who do not trust clinicians ignore the essential fact that treating therapists who are actively involved in addressing their patients' problems are more likely to deal effectively with them than overworked agencies. Only those therapists who choose not to confront the child abuse problem directly should still be required to file a report. More effective protection of children is likely to develop when the government acknowledges that, generally, it has not been able to provide better treatment for troubled families than would a motivated treating therapist.

Currently, most clinicians understand and accept the necessity to balance their duties to society with their duties to their patients. They are aware of the serious negative consequences to a patient who is allowed to engage in antisocial behavior, as well as the need to protect society from danger. The concept of absolute confidentiality in therapy has virtually disappeared. In fact, at the present time, a greater danger is appearing at the opposite end of the spectrum with an increasing tendency for therapists to acquiesce to unnecessary violations of confidentiality because of excessive fears of liability. Another contributing factor may be personal sympathy with the growing trend towards punishment of offenders rather than treatment. The lack of regard for safeguarding patient confidences also may be due, in part, to complacency resulting from so few negative consequences to therapy from "Tarasoff." However, the child abuse reporting laws are qualitatively different and much more serious than Tarasoff decisions and laws. Strong fears of penalties can have a negative effect upon clinical judgments and actions. Future legal modifications need to consider the potentially more effective interpretations of states such as Maryland [*26*] which recognize the values of permitting therapists to use their discretion in treating child abuse cases. Some negative effects of indiscriminate mandated reporting are evident in our case examples which illustrate how intimidated clinicians can cause harm by needlessly reporting patient confidences.

Attacks upon confidentiality are being extended into other family matters such as termination of parental rights in which therapists have been required to testify against their own patients. The required information could have been obtained through a court ordered independent evaluation, but frequently no attempt is even made to seek alternative methods. Patient rights advocates surprisingly have been ignoring these infringements, focusing instead upon less serious problems.

Confidentiality is still sacrosanct within the legal profession. However, it is being severely undermined in the therapeutic community by new rulings and unwarranted interpretations of the laws. Many therapists, because of their fears of liability, have contributed to the problem by violating confidentiality in areas that are not clearly mandated by the law. Often they rely upon child protective services for their information about reporting. However, some

agencies can be so overly zealous that their overinterpretations can lead to misinformation. In addition, they can become so involved with prosecuting offenders, that it restricts their available time to help and protect victims. Their priorities need to be carefully evaluated.

Although child abuse understandably is a very emotional issue, we hope that legislators will develop a perspective that facilitates a return to a better balance between the needs of society and the value of therapeutic confidentiality. In the long run such a balance will benefit all. While the current child abuse laws have had some deterrent effect upon serious abuse of children, most of the problems will not be eliminated by laws that are geared for potential punishment of clinicians who are sincerely and effectively involved in treating their patients. It seems more productive to utilize therapist's expertise than to punish them for performing their function. Therapists may have more time to confront these problems than overworked agencies. Mandated reporting should not be permitted to undermine useful therapeutic endeavors from motivated therapists. Reporting could be left available for therapists who wish not to confront or believe they are ineffective in addressing the problem.

We all agree that a society must protect its children. However, this goal could be achieved best if the negative effects of the current child abuse laws are recognized and confronted. Positive outcomes to the public as well as to individuals are more likely to be generated if respect is shown for maintaining therapeutic confidentiality when no present or future danger is involved.

References

[1] *Tarasoff v. Regents of the University of California,* 529 P.2d 553, 1974.
[2] *Tarasoff v. Regents of the University of California,* 551 P.2d 334, 1976.
[3] Fleming, J. and Maximov, B., "The Patient or His Victim: The Therapist's Dilemma," *California Law Review,* Vol. 62, 1974, pp. 1025-1068.
[4] Calif. Assembly Bill 1133, 1985.
[5] Calif. Penal Code, Sections 11165-11174, 1980.
[6] Calif. Penal Code, Section 11174.5, 1980.
[7] Duquette, D. M., "The Expert Witness in Child Abuse and Neglect; An Interdisciplinary Process," *Child Abuse and Neglect,* Vol. 5, 1981, pp. 325-334.
[8] Appelbaum, P. S. and Meisel, A., "Therapists' Obligations to Report Their Patients' Criminal Acts," *The Bulletin of the American Academy of Psychiatry and the Law,* Vol. 14, No. 3, 1986, pp. 221-230.
[9] Butz, R. A., "Reporting Child Abuse and Confidentiality in Counseling," *Social Casework,* Vol. 66, No. 2, Feb. 1985, pp. 83-91.
[10] Miller, R. D. and Weinstock, R., "Conflict of Interest Between Therapist-Patient Confidentiality and the Duty to Report Sexual Abuse of Children," *Behavioral Science and the Law,* Vol. 5, No. 2, Spring 1987, pp. 161-174.
[11] Robinson, G. and Mercu, A., "Informed Consent: Recall by Patients Tested Postoperatively," *Annals of Thoracic Surgery,* Vol. 22, 1976, pp. 209-212.
[12] *People v. Stritzinger,* 34 Cal. 3d 505, 1983.
[13] Mosk, J., Dissenting in *Tarasoff v. Regents of the University of California,* 551 P.2d 334, 1976.
[14] Kempe, C. H., Silverman, F., Steele, B., Droegenmueller, W., and Silber, H., "The Battered Child Syndrome," *JAMA,* Vol. 181, 1962, pp. 17-24.
[15] Public Law 93-247, 42 U. S. C., Sections 5101-5106, 1974.
[16] Public Law, 42 U. S. C., Sections 5102-5107, 1978.
[17] Public Law, 42 U. S. C., Sections 5103 (b) (1), 1978.
[18] Calif. Penal Code, Section 11172 (e), 1980.
[19] Calif. Penal Code, Section 11165, 1980.
[20] Fraser, B., "Child Abuse in America: A DeFacto Legislative System," *Child Abuse and Neglect,* Vol. 3, No. 1, 1979, pp. 35-43.
[21] Goldstein, J., Freud, A., and Solnit, A. J., *Before the Best Interests of the Child,* The Free Press, New York, 1979.
[22] Schultz, L., *Malpractice and Liability in West Virginia's Child Protective Services: A Social Policy Analysis,* West Virginia University School of Social Work, Morgantown, WV, 1981.
[23] Lacayo, R., "Hollywood Tapes and Testimony," *Time,* 15 Dec. 1986.
[24] Zweig, C., "Parents Get VOCAL About False Child Abuse Accusations," *Los Angeles Times,* Part 5, 16 Jan. 1987, pp. 1-5.

[25] Weinstock, R., "Controversial Ethical Issues in Forensic Psychiatry: A Survey," *Journal of Forensic Sciences,* Vol. 32, No. 1, Jan. 1988, pp. 176-186.
[26] *Shaw v. Glickman,* 415 A 2d 625 (MD. CT. Spec. App.), 1980.
[27] Beck, J. C., "The Psychotherapist's Duty to Protect Third Parties from Harm," *Mental and Physical Disability Law Reporter,* Vol. 11, No. 2, March-April 1987, pp. 141-148.

Address requests for reprints or additional information to
Robert Weinstock, M.D.
UCLA-SPS
Center for Health Sciences, Suite A3-062
Los Angeles, CA 90024