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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

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A young mother, who may be suffering from post-partem 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 the following article.

Introduction

Encouraged by federal grant legislation, all states have enacted laws aimed at curbing the abuse, maltreatment and sexual exploitation of children. The state laws place a special burden upon members of the helping professions: most laws require specified professionals to report abuse or neglect to a central register maintained by a state agency.

New York's reporting statute (Social Services Law Section 413) was adopted in 1973. From that date until the present it has required certain professionals, including physicians, nurses and social workers, to issue a report "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." Psychologists were added to the list of mandated reporters in 1979.

1/ Editor-in-Chief, Journal of the National Association of Administrative Law Judges. This excerpt is taken from an article appearing in the Fall 1989 issue of the New York Law School Law Review and is reprinted here by permission. Footnotes have been omitted.

In 1984 and 1985 New York's reporting statute was significantly expanded. Affected professionals must now report, not only when they personally observe the victimized child, but when "the parent, guardian, custodian or other person legally responsible for the child comes before them in their professional capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child" abused or maltreated. Failure to report, as required by the statute, is a misdemeanor, and exposes the practitioner to charges of professional misconduct and civil liability for damages.

However well-intentioned the expanded reporting requirement may be, it poses a serious ethical, practical and legal dilemma for mental health professionals. The dilemma arises from the unique relationship established between the practitioner and the patient as a means of improving the patient's condition. The relationship is described by Gutheil and Appelbaum under the heading "Trust as the Basis of the Therapeutic Alliance." 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 obtain 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.

As noted in the New York Law School Law Review article from which this excerpt is taken, breach of the duty of confidentiality may have seriously adverse consequences for the patient's health. A therapist's breach of confidence may be a tort, professional misconduct, and even, in some cases, a crime.

The reporting requirement of Section 413 potentially conflicts 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 "wilful misconduct or gross negligence," "in the discharge of their duties and within the scope of their employment," the mental health professions

may still encounter situations which appear to implicate contradictory principles of good professional practice and lawful behavior. Accordingly, it is not surprising that some practitioners feel they are "damned if they do, and damned if they don't."

The Thesis

One need only examine the photographs in Helfer and Kempe's book, The Battered Child, or read the various accounts of children who have been mutilated, starved, tortured and killed, to understand the impetus behind mandatory reporting laws. These laws exist because child victims are often unable to protect themselves or to denounce their abusers. However, while the statute's praiseworthy goal is the prevention of child abuse, this article will suggest that Section 413, in its present form, is overbroad and misdirected, thereby impinging upon other important societal goals, legal rights, and humane values, and that, in the final analysis, the Section's expansive reporting requirement is counterproductive.

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The Need for Confidentiality in Psychotherapy: Therapeutic Arguments

Sigmund Freud expressed the need for confidentiality in absolute terms. "The whole enterprise becomes lost," he wrote, "if a single concession is made to secrecy." Hippocrates might not have disagreed. His famous oath contains the pledge: "Whatever, 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."

The basic therapeutic rationale for requiring confidentiality in psychotherapy is succinctly 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, stated above, is that the patient must disclose to the therapist all (emph. in orig.) 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 patient alone holds the key to disclosure of matters revealed in therapy.

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

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 confirmed, tentatively, in a number of empirical studies. Moreover, there is evidence developed in other, actionable cases of trust betrayal between therapist and patient. The evidence available to present-day psychotherapists thus suggests the following reasons for upholding the principle of confidentiality in psychotherapy.

The first reason for confidentiality relates to the availability of treatment. It has been observed that abusive parents may withhold medical treatment from battered children because the parents are ashamed, or because they fear the legal consequences of disclosure. In the case of psychotherapy, abusive parents may not only withhold treatment from the child, but may themselves avoid obtaining the treatment they need to overcome their abusive behavior. Psychotherapists have expressed the opinion that abusive parents may be emotionally disturbed, or character disordered, and would benefit from psychotherapy. Accordingly, in the case of psychotherapists, mandatory reporting is especially self-defeating.

The next reason relates to diagnosis. In almost every instance, the information necessary to make such diagnosis must

come from the patient. As Coleman has observed, a proper psychotherapeautic diagnosis requires full disclosure, in a safe environment, of the patient's innermost feelings, fantasies, terrors and shame. A patient who does not expect confidentiality from the therapist may not make the necessary disclosures. If, in consequence, the patient's diagnosis is not accurate, he or she may not be correctly treated. The therapist will have failed in the duty to advance the patient's cure. Here again, 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 simply withdraw from treatment. The patient may discontinue treatment entirely or (as in the case of an involuntarily committed patient) merely withhold, deliberately or subconsciously, that high degree of frank disclosure necessary for effective psychotherapy. In either case, the patient's recovery may be impeded or reversed.

Next, disclosure by the therapist 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. Janssen expressed the opinion that, for some patients, development of a trusting relationship is the essence of treatment itself. In an observation particularly relevant to the problem under discussion, a number of therapists have hypothesized that the experience of growing up within an abusive family inhibits the formation of basic trust, which is necessary to relate to others outside of the family.

Even actual knowledge of mandatory reporting laws, or prior warning by the therapist, may be insufficient to overcome the decompensation which may result from reporting in (for example) a patient with 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, citing Meiselman, states:

> Psychosis would also seem to be a factor 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.

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

The fifth reason is that, where 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.

Finally, Dubey has argued that a therapist should not disclose a patient's confidences, <u>even with the patient's consent</u>, if the information is to be used in a manner which will have legal consequences for the patient. Observing that "what may be in a person's best interests, i.e., maintenance of dramatic symptoms in order to present a sound case for disability or liability, may be directly contrary to his therapeutic interests, i.e., relinquishing of symptoms," Dubey writes:

> . . . the 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. Halleuk (cit. om.) discussed at length the problems encountered in psychiatric excuse giving.

Quoting Hollender, Dubey states:

> 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.

Thus writes Dubey:

> In order to discourage secondary gain, confidentiality is necessary, so that disclosures will have no power or influence of any kind, harmful or helpful, over the patient's extra-therapeutic life.

It follows from Dubey's argument that confidentiality, which is "needed to protect the practice of psychotherapy" 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."

Upon the basis of the foregoing, the therapeutic argument may conclude with the observation that something of great value, if not the "whole enterprise" may be lost if the therapist divulges that "which ought not to be spoken abroad."

The Social Work Arguments

As used in this article, "social work arguments" are those which 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 not every professional social worker would agree with every argument advanced in this article, nor with the ultimate conclusion, the arguments reflect, or attempt to reflect, serious concerns of the profession. In social work, as in law, there is often truth on both sides of an issue.

Thus, the first social work argument is that, for largely unavoidable reasons, the act of reporting child abuse often leads nowhere. This is illustrated by the 1983 Family Court opinion, Matter of Marcario.

Marcario arose prior to the 1984 amendments to Social Services Law Section 413. It involved the application of a Child Protective Service case worker for a search warrant to determine if an abused or neglected child was present in the family home. Some three months earlier the case worker had received a telephone call from a person identifying herself as a "Mrs. Ocario" (sic) who stated that her angry husband, while under the influence of alcohol, on an occasion not further identified, punched his six-year-old son in the stomach several times and threw a coffee table at him. On further investigation, both Mr. & Mrs. Marcario denied the alleged abuse, and Mrs. Marcario denied that it was she who made the initial call to the CPS case worker.

The Family Court declined to issue a search warrant, holding that the Aguilar test, pertaining to the adequacy of the informant's knowledge, had not been met. In so doing, the Court

noted, among other things, that the child himself had not come before the Protective Service worker, as then required by Social Services Law Section 413. Of course, Section 413 pertained to mandatory reporting, not to the granting of a search warrant. The Court's point was that the case worker in Marcario did not have any information about the alleged abuse derived from the child himself.

The 1984 and 1985 amendments to Section 413 do not resolve this problem, while a therapist who provides all of the resolve this problem. While a therapist who provides all of the information required by Section 415 might, in some cases, enhance the ability of CPS to secure judicial process in aid of its investigation, where the therapist does not examine the child, her report to a case worker who has not examined the child may be insufficient, under Aguilar, to support the application for a search warrant. (While the Aguilar test is no longer applied by the Federal courts, it is still the law in New York.) Moreover, it is unlikely that a psychotherapy patient will provide the therapist with all of the specific details required by Section 415, unless the patient is encouraged by the therapist 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. If the patient is the suspected abuser, and is subject to criminal prosecution, it raises the question of whether and under what circumstances the therapist becomes a custodial agent of the government who must provide the patient with Miranda warnings. The question as to whether the therapist, consistently with his professional duty to the patient, should participate at all in a process that might lead to his patient's incarceration is also implicated. In any event, for the purpose of the first social work argument, it may be sufficient to note that the additional cases now subject to mandatory reporting by reason of the 1984 and 1985 amendments to the statute (i.e., cases in which the therapist did not personally examine the child) are precisely those cases least likely to result in successful judicial intervention.

To summarize and continue, the first social work argument is this: since case workers are frequently unable to secure the evidence necessary to initiate child protective proceedings, the filing of a child abuse report is often a futile act.

Secondly, even if case workers possess sufficient prima facia evidence, 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.

Next, the investigation of a child abuse report may do more harm than good. The investigation intrudes government agents (CPS case workers) 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. Where, as in the cases under discussion, one member of the household is already speaking to a psychotherapist, this argument holds that the therapist, rather than a government case worker, may be in the better position to address the underlying problem.

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

One frequently encountered goal of psychotherapy--a goal expressly recognized in New York's Consolidated Services Plan--is preservation and unification of the family unit. In cases of incest, the indicated course of treatment may include family counseling involving all members of the household. Coleman has suggested that the efficacy of such treatment may be undermined or lost by reporting, and the investigation and legal proceedings which may then ensue. 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.

The incarceration of an abusive parent is destructive of family stability, in that it removes a member who, to one extent or another, may support the family emotionally or financially. Removal of the child to a foster home, which may result from criminal or protective proceedings, is also highly inimical to family cohesiveness. Moreover, while the judgment in successful child protective proceedings frequently includes provision for mandatory therapy of the abuser, the social work argument suggests that this result may be achieved more effectively, at an earlier date, and at less cost to the state, through skillful intervention by the family's own therapist.

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

By discouraging frank disclosure, the present system tends to perpetuate abusive parenting. Children learn inappropriate patterns of behavior from unrehabilitated family members.

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

Finally, beyond all this, government intervention may breed resentment, hostility, and retaliation by the alleged abuser. The incidence of family violence may actually increase.

For these reasons, the social work argument concludes, 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 aims of the social work profession and the goals of the statute itself.

Some Legal Arguments

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

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

In Doe v. Roe, Justice Stecher said:

> [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, . . .

It may be argued, however, that statutory reporting equirements are also implied in every contract for therapeutic ervices; that everyone is presumed to know the law; and that, n any event, a therapist may expressly include the duty to eport 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 is first presented, voluntarily or otherwise, for psychiatric examination and treatment. Although possessing that minimal level of competence necessary for voluntary admission to treatment, he may be in a state of turmoil, and suffering from a condition which, in the therapist's professional judgment, would be exacerbated by warnings about disclosure; the patient may even be suicidal. To help such patient, the therapist might find it necessary to enter an immediate relationship of trust and confidence with the patient; to establish the therapeutic alliance; and to shield the patient, at least for a time, from certain aspects of unpleasant reality. In short, it may be therapeutically necessary for the therapist and patient to enter into an agreement, express or implied, that the therapist will not divulge any of 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 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 is at war with the therapist's duty and agreement to help the patient.

Even in less acute circumstances, where the patient understands the disclosure requirement, the therapist may determine that immediate reporting is contraindicated. Thus, in some circumstances, the therapist may find that the patient's condition will be best treated by assisting the patient to recognize and address an unhealthy situation (for example, inappropriate sexual contact between the patient's spouse and child); if confrontation does not resolve the problem, the therapist may, perhaps, encourage the patient to report the maltreatment himself. 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 in the patient's behalf.

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

Mandatory Reporting is Inconsistent With the Statutory Grant of Testimonial Privilege

Testimonial privilege (or, more simply, "privilege") is a term of art used in the law of evidence. Unlike the rules of confidentiality (which generally require professionals to keep silent at all times outside of the courthouse, and to raise the issue of confidence when questioned before the court, the rules of privilege relate specifically to the admission or exclusion of evidence from legal proceedings, including trials and depositions.

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. With respect to such evidence, the following general rules apply:

A privilege, like a confidence, may exist without a contract, and even without the patient's consent--for example, in the case of involuntary commitment. The patient, and not the therapist, owns the privilege: if the patient waives the privilege, the therapist may not withhold evidence on these grounds. If the patient is not a party to the proceeding, and has not waived the privilege, the therapist must invoke the privilege on the patient's behalf, by raising the appropriate objection. Questions of privilege are decided by the court.

New York, which pioneered the physician-patient privilege in 1828, has expanded its list of privileges to include psychologists and Social Workers. These privileges are not identical.

* * *

The critical point is that <u>all</u> 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, the maximum age of required disclosure under the physician-patient privilege statute), 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 will ultimately fail for want of the professional's crucial, but privileged

testimony. The unhappy consequences of this imbroglio have already been noted.

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: confidentiality is, for example, complementary to the right of informed consent.

Cases in California, Pennsylvania, and the United States Court of Appeals for the Ninth Circuit 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 and Roe v. Wade (which was subsequently overruled by the Supreme Court), and other lines of reasoning, Smith has advanced the argument for further recognition of this constitutional right. While a constitutional basis for psychotherapeutic confidentiality has not been identified by any New York court, the present argument holds that appropriate recognition of fundamental values, as expressed in the Constitution, militates in favor of modifying the New York reporting law, by assigning greater importance to the privacy interests of psychotherapeutic patients.

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. 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. On the other hand, the statute expressly creates a civil cause of action against therapists who fail to report when required to do so. The pressure thus placed upon a therapist to report all instances of suspected child abuse, in order to avoid personal liability, may skew his professional judgment, to the detriment of his patients. The therapist must weigh his own legal interests against the therapeutic needs of his patients. The introduction of the therapist's own interest as a factor in the therapeutic equation

is contrary to the ethical ideals which distinguish a learned and helping profession from a mere trade or business.

That failure to report as required by the statute may result in civil liability (and an award of substantial damages) is no longer open to doubt. The leading precedent is the California case of Landeros v. Flood, which case, however, involved none of the more difficult ethical issues with which this article is concerned. In Landeros, 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 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.

The famous Tarasoff case, also decided in California, is more difficult to reconcile with the principles of confidentiality and the primacy of patient care. Tarasoff was a civil action by the family of a homicide victim against a therapist to whom the killer had disclosed his lethal ideations. The case imposes upon psychotherapists an obligation to protect identifiable victims of future harm, when a credible threat of violence is made by a patient in therapy. Usually, the duty takes the form of warning the intended victim. (As Stone observes, involuntary commitment, which would incapacitate the potentially violent patient, was not a favored solution in California.) The Tarasoff court derived the therapist's obligation to the victim from the "special relationship" said to exist between therapist and patient.

The Tarasoff rule, which has been followed elsewhere, and cited with approval in New York, expands the therapist's legal duty to include, not only the therapeutic interests of his patients, but the interests of certain non-patients as well. 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 threat, the court may understandably place the safety of the intended victim over the therapeutic needs of the intended perpetrator. The therapist may also make that choice, and should be legally free to do so. However, a rule which requires the therapist to report, upon pain of personal liability, merely substitutes 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, 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 abuse or maltreatment which may be suspected; nor even, most significantly, whether there exists any possibility that abuse or maltreatment will occur in the future. If the conditions of the statute are met, 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 set forth in a statute which is both civilly and criminally enforceable against the therapist. As previous arguments have tried to demonstrate, the statute requires reporting in circumstances which may compromise the interests of patients and children alike. Conscientious psychotherapists are thus torn between obeying the law to protect their own interests, or defying the law to promote the interests of their patients. It is a choice which the law should not require.

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[The balance of the New York Law School Law Review article is devoted to narrowing the dilemma: responses under the present law; the experience of three other states; and a proposal for statutory change in New York. The New York statute is discussed in greater detail, and the questions with which this excerpt began are analyzed.]