Effects of Statutes Requiring Psychiatrists to Report Suspected Sexual Abuse of Children

Fred S. Berlin, M.D., Ph.D., H. Martin Malin, Ph.D., and Sharon Dean

Objective: *Reporting of child sexual abuse is mandatory in all 50 states. Conceptual distinctions between privileged communications and mandatory reporting are reviewed, and the impact of recent changes in Maryland's reporting laws is examined.* *Method:* *Beginning in 1964 Maryland law required reporting if abuse was suspected when a physician examined a child. In 1988 reporting of disclosures by adult patients about child sexual abuse that occurred while they were in treatment was mandated. In 1989 all patient disclosures, even about such abuse that occurred before treatment, became reportable. During the period of statutory changes, the Johns Hopkins Sexual Disorders Clinic had kept track of adult patients who referred themselves for treatment and adult patients' disclosures of child sexual abuse. This allowed analysis of the impact produced by changes in the reporting requirements.* *Results:* *1) Mandatory reporting of disclosures about prior child sexual abuse deterred undetected adult abusers from entering treatment. The rate of self-referrals when such reporting became mandatory in 1989 dropped from approximately seven per year (73 over a 10-year period) to zero. This may have caused some unidentified children to remain at risk. 2) Mandatory reporting deterred patients' disclosures about child sexual abuse that occurred during treatment. In 1988 the disclosure rate during treatment dropped from approximately 21 per year to zero. This deprived clinicians of information important for early intervention. 3) Mandatory reporting failed to increase the number of abused children identified. The number identified secondary to such disclosures was zero.* *Conclusions:* *Optimal protection of children, as well as treatment for adult patients, may be better accomplished by legislation that supports options other than reporting.*

(Am J Psychiatry 1991; 148:449–453)

Two types of statutes determine whether communications between a patient and a psychiatrist must remain confidential. Statutes on privileged communications forbid a psychiatrist to disclose information without a patient's permission. Statutes on mandatory reporting require that information be divulged even if a patient objects. Mandatory reporting takes precedence over privileged communications.

In all 50 states, reporting of suspected sexual abuse of children is mandatory (1). The relevant statues were enacted because of well-intentioned concerns about protecting children, but enactment was not necessarily based on data demonstrating such statutes' effectiveness. Modifications of statutes on mandatory reporting in the state of Maryland have afforded an opportunity to assess effectiveness empirically.

One intent of this paper is to review briefly the differences between privileged communications and mandatory reporting. A second intent is to present data from Maryland that raise questions about whether mandatory reporting of suspected sexual abuse of children (which eliminates confidentiality) invariably serves its intended purpose.

PRIVILEGED COMMUNICATIONS

The Hippocratic oath states, "All that may come to my knowledge in the exercise of my profession . . . which ought not to be spread abroad I will keep secret and will never reveal." The tradition of maintaining patients' confidences is old and time-honored.

However, time-honored traditions are not synonymous with statutory protection. Therefore, historically, patients and their psychiatrists have supported efforts to codify requirements that communications be-

Received June 20, 1990; accepted Oct. 12, 1990. From the Department of Psychiatry and Behavioral Sciences, The Johns Hopkins University School of Medicine. Address reprint requests to Dr. Berlin, Department of Psychiatry and Behavioral Sciences, The Johns Hopkins University School of Medicine, 101 Meyer Bldg., 600 North Wolfe St., Baltimore, MD 21205.

tween them remain confidential. The statutory privilege belongs to the patient.

Various sorts of communications are protected by statute. These include communications between the clergy and penitents and those between attorneys and clients. In some states, even though psychiatrist-patient privilege is recognized, physician-patient privilege is not (2).

An amicus brief presented to the U.S. Supreme Court by the APA emphasized that "an effective psychotherapeutic relationship is premised on confidentiality. It is a fundamental prerequisite to successful diagnosis and treatment" (3). Analogously, the courts defined the rationale underlying attorney-client privilege: "A lawyer can act effectively only when he is fully advised of the facts and the client's knowledge that a lawyer cannot reveal his secrets promotes full disclosure" (4). Mandatory reporting, in superseding confidentiality, may make accurate diagnosis and successful treatment difficult.

Privileged communications notwithstanding, psychiatrists are ordinarily required to intercede if they know about an intended future dangerous act. Patients' disclosures about their previous acts, even those of a criminal nature, however, are ordinarily privileged.

Patient privilege is not absolute. Exceptions may occur, for example, when information must be divulged in order to place a patient in a medical facility (5). Such exceptions permit information to be divulged but do not mandate it. Communicable diseases may have to be reported, but this does not ordinarily create a conflict of interest between the patient and society.

MANDATORY REPORTING

In a free society, neither private citizens nor physicians are ordinarily compelled to act as informants for the state. It is not a crime if one exercises the prerogative not to report his or her neighbor for public intoxication. Psychiatrists are, however, required by statute to report suspected child abuse. Legislative changes were made in the requirements for reporting child abuse in Maryland in 1964, 1988, and 1989.

The first such law to be proposed in Maryland came before the legislature in 1963. Because of fears of possible civil suits against reporting psychiatrists, it was not enacted until the following year. The 1964 statute mandated reporting when suspicions of abuse emerged during clinical examination of a child. It did not mandate reporting the disclosures made by adult patients in psychotherapy (6).

In 1987 the state legislature enacted a new statute (7), which required reporting of child sexual abuse disclosed by adult patients seeking treatment or in treatment. However, the new statute allowed a three-part exclusion. Reporting was not required if 1) the suspected abuse occurred before the adult patient initially sought treatment, 2) knowledge about the abuse was derived solely from the patient's disclosures, and 3) the patient was seeking professional assistance from a program specializing in the treatment of pedophilia. The intent of the exclusion was to encourage adults whose sexual involvements with children had gone undetected to come forward so that the abuse would end. The law became effective on July 1, 1988.

This exclusion generated intense political emotion. Lay opponents labeled it the "Pedophile Protection Bill," while professional organizations such as the Maryland Psychiatric Society took no stance. There was much opinion and few data. Within a year the state legislature removed the exclusion. As of July 1, 1989, all disclosures suggesting sexual abuse of children by adult patients seeking treatment or already in treatment had to be reported. The only remaining exception was if such reporting violated aspects of attorney-client privilege.

Maryland law had been modified, then, in at least three significant ways. 1) From 1964 until 1988, sexual abuse of children disclosed by adult patients did not have to be reported. 2) As of July 1, 1988, reporting of such disclosures became mandatory, but generally only if the abuse had occurred after the adult had entered treatment. 3) As of July 1, 1989, 1 year later, disclosure of abusive behavior that occurred before the adult patient entered treatment also had to be reported.

Because of these statutory changes, it became possible to look at several issues. 1) Had these changes affected the frequency of patients' disclosures of child sexual abuse that occurred while the patients were in treatment? 2) Had the changes affected the frequency of disclosures by prospective patients about abuse that occurred before treatment? 3) Had the changes had an impact on the frequency with which adults were coming forward to report previously undetected abuse? 4) Had the changes had a positive impact on the number of child victims identified through adult patients' disclosures?

DISCLOSURE DURING TREATMENT

The Johns Hopkins Sexual Disorders Clinic, as currently constituted, has specialized in the evaluation and treatment of paraphilic disorders since 1979. Patients can receive treatment in prison, as hospital inpatients, or as outpatients in the community. Over the past several years, the number of individuals in treatment in the community at any given time has remained relatively constant, varying from approximately 180 to 220, 98% of whom are male. About 55% have diagnoses of pedophilia.

In treating patients with paraphilia and related disorders, it is crucial to document treatment outcome. Therefore, the clinic has developed a systematic method for tracking both criminal recidivism (behavior resulting in arrest) and clinical relapse (8). An initial step in that process involves recording relevant information on a standardized relapse report form. The form is divided into several sections. One section documents the initial source

of the relapse report, such as a patient's disclosure during therapy. The form also documents type of abuse during the relapse (e.g., exposing, touching, intimate sexual contact, or penetration).

These data were available for much of the time during which the changes in Maryland law were taking place. Therefore, it was possible to determine what effects, if any, these changes had produced on patients' disclosures about child abuse while they were in treatment.

OUTCOME

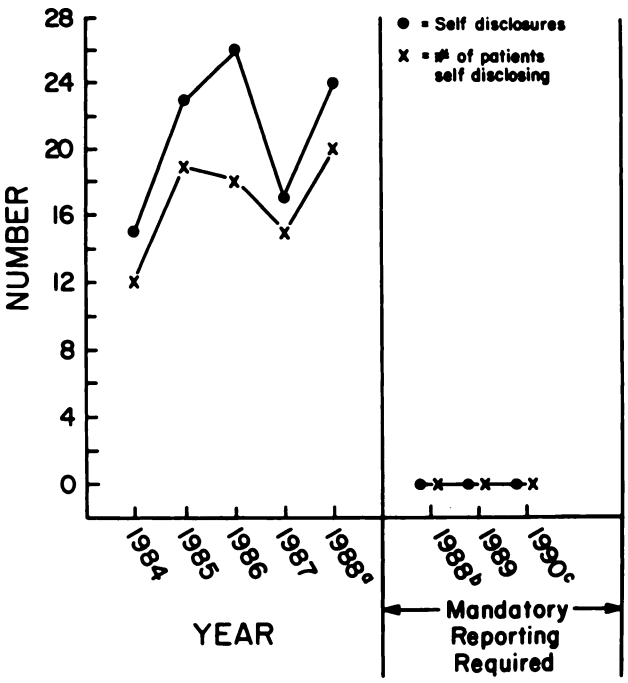
Figure 1 shows both the total number of patients who made disclosures about child abuse and the total number of these disclosures. The data are restricted to disclosures about sexual involvements with children that occurred while the adult patients were in treatment at the clinic (i.e., relapses) between 1984 and 1990. The number of disclosures exceeds the number of patients because some patients made more than one disclosure. None of the patients had been accused by others of criminal wrongdoing at the time the disclosure was made. The way in which the disclosures were dealt with clinically is discussed later in this paper.

The clinic had begun formally tracking disclosures in 1984. Between Jan. 1, 1984, and July 1, 1988, patients' disclosures regarding relapse during treatment did not have to be reported. During that time, the rate of disclosures was a little less than two per month (or about 21 per year). After July 1, 1988, when the Maryland law changed and required that such disclosures be reported, the number dropped to zero, where it has remained since. Because patients made no disclosures of relapse during treatment after the law changed, no children at risk could be identified. The rate of disclosures about offenses that did not have to be reported (e.g., those not involving children, such as voyeurism or exhibitionism) did not drop off during this time.

Analysis of the types of relapses disclosed by patients before July 1, 1988, revealed that 72% (67 of 93 disclosures) were about actions in which there was no adult-child genital contact, for example, unsuccessful propositioning of child prostitutes, voyeurism involving a child while masturbating, or touching a youngster on the thigh and being privately aware of experiencing sexual excitement. Of the 26 disclosures of genital contact, the majority (N=17) were related to fee-for-sex interactions with male adolescents. Patients making a sincere effort to succeed in treatment would be unlikely to fail initially in an extreme fashion (e.g., by engaging in intercourse with a sexually naive youngster). In this sense, the types of relapses disclosed by the patients were generally compatible with what might be expected from persons trying to succeed in treatment but struggling.

Prior to July 1, 1988, when a patient made a disclosure, a variety of clinical actions were quickly initiated. These included immediate hospitalization, voluntary removal from the home when indicated, or voluntary initiation of pharmacotherapy to suppress sexual appetite. In no instances were patients knowingly permitted to continue improper sexual activity. The availability of this type of clinical information allowed early intervention—intervention that is no longer possible in the absence of such disclosure.

FIGURE 1. Disclosures of Relapse Into Sexual Abuse of Children by Adults in Treatment at a Maryland Clinic



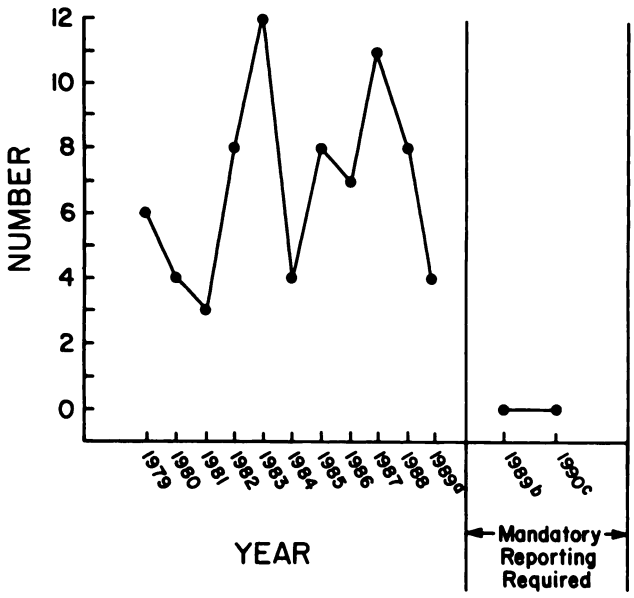
[a]Before July 1. The number for the first 6 months of 1988 was projected to a yearly rate by doubling it (projected disclosures=24, actual disclosures=12).
[b]After July 1.
[c]Before July 1.

ADULTS ENTERING TREATMENT FOR PREVIOUSLY UNDETECTED ABUSE

For approximately the past 11 years, the Johns Hopkins clinic has maintained a record of patients who have sought treatment although no criminal allegations have been made. Prior to July 1, 1989, patients whose sexual involvements with children had previously gone undetected could seek treatment without fear of criminal jeopardy. Even so, such self-referrals could be difficult. Some prospective patients probably worried that they would be reported even if the law did not require it. Indeed, this had occurred at other treatment facilities. Stigma and shame could also act as deterrents. Prospective patients may not have known where to go to find help, and denial and rationalization regarding the need for help are common.

Figure 2 shows that in spite of such difficulties, a

FIGURE 2. Self-Referred Adults Entering Treatment at a Maryland Clinic After Previously Unreported Sexual Abuse of Children (projected N=75, actual N=73)



[a]Before July 1. The number for the first 6 months of 1989 was projected to a yearly rate by doubling it.
[b]After July 1.
[c]Before July 1.

total of 73 self-referred patients who had previously engaged in some type of sexual activity involving children entered treatment at the clinic between Jan. 1, 1979, and July 1, 1989. They were not facing criminal allegations at the time they entered treatment, and none of their disclosures, to the best of our knowledge, subsequently came to the attention of criminal justice authorities. The rate of self-referrals of this sort between Jan. 1, 1979, and July 1, 1989, was approximately seven per year, or one every 2 months. A year after the law changed on July 1, 1989, not a single self-referred patient not facing criminal charges who had a previously undetected history of sexual activity with children had entered treatment.

During the first several months following implementation of the 1989 statute, clinic lawyers were of the opinion that reporting was not required if a patient was referred by an attorney for evaluation (as opposed to treatment). Prospective patients who contacted the clinic were told this. During that time period, five patients, all of whom were unknown to the criminal justice system, inquired about evaluation under attorney-client privilege. None of them, however (including four following the advice of their attorneys), was willing to enter treatment if doing so required reporting to criminal justice authorities. It is not surprising that attorneys had advised against such self-incrimination. A review of our clinical records revealed that four patients, seen previously after having disclosed their child sexual abuse elsewhere and having been reported, eventually had been sentenced to a total of 110 years in prison.

On Feb. 8, 1990, the Attorney General of Maryland gave the opinion that individuals seeking psychiatric evaluation who have not been criminally charged, even if they are referred by a lawyer, are not protected by attorney-client privilege (9). No patients with histories of previously undetected sexual involvement with children have pursued evaluation at the clinic since that time.

Persons who had referred themselves before July 1, 1989, had a variety of vocations. There was a priest who had begun nongenitally fondling boys after having been prescribed testosterone for a medical condition, an attorney fearful of disbarment if incest with his daughter were disclosed, and a schoolteacher who had nongenitally fondled students. There was also a father of several adopted children who feared that he and his wife would lose them, an adolescent counselor employed at a boys' home, a social worker who had fondled his grandchild, and a security guard who had had sexual contacts with children while employed at an art gallery. Neither they, nor in some cases their families, had been willing to identify themselves and to enter treatment before being assured that reporting to the criminal justice system was not required.

In response to clinical intervention, a number of the 73 patients who had sought treatment of their own accord gave up previous employment involving access to children. All participated in therapy, including couples therapy when indicated. A number moved out of their homes to prevent access to children. Some began treatment with medication to suppress sexual appetite.

Since the 1989 law mandating the reporting of behavior that occurred before (as well as after) seeking assistance went into effect, not a single child has been identified as a consequence of an adult's entering treatment and disclosing abuse. Much clinical information has been lost, and clinical interventions of the type just noted are no longer possible. One cannot intervene clinically if individuals who need help refrain from identifying themselves in the first place.

DISCUSSION AND CONCLUSIONS

Privileged communication statutes protect the privacy of therapy. Mandatory reporting, by superseding privilege, significantly alters the psychiatrist-patient relationship (10). Psychiatrists become informants for the state when patients incriminate themselves. Arguably, this may be necessary if a useful societal purpose is served. The data presented here suggest that this is not so.

Mandatory reporting, at least insofar as its effects on a large sexual disorders clinic are concerned, has not led to identification of even a single child at risk. At the same time, it appears to have deterred honest disclosure by patients in treatment and to have deterred unidentified potential patients from entering treatment.

This deprives clinicians of the opportunity to try to intercede constructively, and some children may therefore remain unnecessarily at risk.

The data we have presented do not address the issue of the numbers of children identified throughout the entire state of Maryland as a result of patients' disclosures of sexual abuse. It is important to do additional research exploring that matter further. The data suggest that imposing mandatory reporting on specialized clinics designed to treat adult offenders is counterproductive.

The Johns Hopkins clinic uses the informed consent procedure for patients and prospective patients. Each is told beforehand that certain types of disclosures will result in reporting. It would probably be possible to identify some children at risk by eliminating the practice of informed consent. However, this would represent a significant departure from societal expectations and a redefinition of the physician-patient relationship. In the absence of a clear declaration of legislative intent to establish such a fundamental alteration in this relationship, the clinic feels that the informed consent procedure must be followed.

Our findings suggest that children at risk were not being identified by the disclosures of adult patients regardless of whether mandatory reporting was in effect. In this sense, mandatory reporting failed to achieve its desired intent of identifying and helping abused children. The problem of identifying children could, perhaps, be resolved in some cases by eliminating mandatory reporting and treating the matter of sexual abuse of children within a mental health, rather than a criminal justice, framework. This might allow some children to be identified through adults' disclosures and to be treated, since the adults' fear of being reported to the criminal justice system would be obviated. Reporting could still be mandated for adult patients in treatment who subsequently become uncooperative.

One could argue that adults should be willing to accept punishment when they disclose child abuse. Moralizing rhetoric notwithstanding, our data suggest that this rarely occurs. Given the extreme penalties that adults who make such disclosures might have to face, it is probably unrealistic and perhaps even unreasonable to expect anything else. Ultimately, society may need to decide in some instances whether it is more important to emphasize a criminal justice approach, giving priority to prosecuting offenders, or to emphasize a public health approach, giving priority to the identification and treatment of abused children.

Some states now have statutes regarding dangerous patients in treatment (11). These statutes generally permit notification of persons at risk and of the authorities as one possible action, but not the only one. Documentation of a clinical plan that adequately addresses the well-being of others as well as the treatment of the patient can be an acceptable alternative. Although these statutes are less than ideal, they may represent a better model for dealing with the problem of child sexual abuse than does mandatory reporting.

Sexual abuse of children is an upsetting and emotional issue. The problem cannot be solved, however, by outrage, polarization, or less than adequate legislation. It is not caused by children but by the adults who pose a risk to them. Many such adults are themselves former victims (*DSM-III-R*, p. 285, and 12). Adequate resolution and prevention of this problem require the provision of effective mental health services to both adults and youngsters. They also require a climate of opinion that does not create a conflict of interest between children and adult patients, that does not see their interests as mutually exclusive but, rather, as complementary, and that accepts the legitimacy of regarding adults who disclose sexual abuse as patients.

REFERENCES

1. US Department of Health and Human Services: State Statutes Related to Child Abuse and Neglect: 1988. Washington, DC, National Center on Child Abuse and Neglect, 1989
2. Malia TR: Validity, construction, and application of statutes limiting physician-patient privilege in judicial proceedings relating to child abuse or neglect. American Law Reports 1990; 44:649–667
3. Brief for the American Psychiatric Association at Doe v United States, 88-2893, filed with US Court of Appeals, 9th Circuit, Feb 9, 1989; declined, US Supreme Court, Oct 10, 1989
4. Pratt v State, 39 Md App 442, 387 A 2d 779 (1978); aff'd State v Pratt, 184 Md 516, 398 A 2d 421 (1979)
5. Knapp S, Vande Creek L: Privileged Communications in the Mental Health Professions. New York, Van Nostrand Reinhold, 1987
6. Maryland Annotated Code, Article 27, Section 35A (1984)
7. Maryland Family Law Code Annotated, Section 5-903 (1988)
8. Berlin FS: Special considerations in the psychiatric evaluation of sexual offenders against minors, in Critical Issues in American Psychiatry and the Law, vol 4: Juvenile Psychiatry and the Law, Victims and Victimizers. Edited by Rosner R, Schwartz HI. New York, Plenum, 1989
9. Opinions of the Attorney General of Maryland, vol 75, number 90-007 (1990)
10. Berlin FS: Laws on mandatory reporting of suspected child sexual abuse (letter). Am J Psychiatry 1988; 145:1039
11. Maryland Courts and Judicial Proceedings Code Annotated, Section 5-316 (1989)
12. Berlin FS, Krout EW: Pedophilia: diagnostic concepts, treatment, and ethical considerations. Am J Forensic Psychiatry 1986; 7:13–30