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A THERAPEUTIC JURISPRUDENCE ANALYSIS OF MANDATED REPORTING OF CHILD MALTREATMENT BY PSYCHOTHERAPISTS

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I. Introduction

In addition to focusing on the rights, duties, and fairness of procedures in mental health law, therapeutic jurisprudence directs our attention to whether rules of law facilitate or impede therapeutic aims.[1] Rules of law implemented in complex social contexts may have unintended or unanticipated consequences; therapeutic jurisprudence directs us to attend to a specific consequence, namely a therapeutic effect. The deductions of therapeutic consequences from an analysis of the legal rule become hypotheses subject to empirical testing as illustrated in studies grounded in a general psychological jurisprudence.[2]

Therapeutic jurisprudence points us in a direction. However, because we are dealing with a law's therapeutic effects, the law is

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[1] David B. Wexler, *An Introduction to Therapeutic Jurisprudence, in* THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT 3, 3-5 (David B. Wexler, ed., 1990); Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of* Zinermon v. Birch, *in* ESSAYS IN THERAPEUTIC JURISPRUDENCE 83, 83 (David B. Wexler & Bruce J. Winick eds., 1991).

[2] *See* David W. Shuman, *Overview*, 46 SMU L. REV. 323, 324-25 (1992) (overview of Symposium, *Psychological Jurisprudence: Another Perspective*). *See also* David B. Wexler, *Therapeutic Jurisprudence and Changing Conceptions of Legal Scholarship*, 11 BEHAVIORAL SCI. & L. 17, 21 (1993) ("Therapeutic jurisprudence will lead us to raise questions, the answers to which are empirical and normative.")

necessarily implemented in an organized social context. Our social system incorporates patients or clients, therapists and service providers, and parents and relatives of patients or clients, among others. When formal legal activity is involved, the functionaries of the law are also involved. Each functionary performs and interacts within a social organization. Each person performing a role has interests which he or she strives to fulfill. We must assume the actors are not passive but are actively pursuing their interests. They adapt their behavior to available resources, to barriers to obtaining resources, or to threats to their current adaptation.[3]

The system of interest I will focus upon is child protection in New York State. Child protective service (CPS) agencies, the successors to the private Societies for the Prevention of Cruelty to Children that developed in the 1870s,[4] now embedded within public social services departments, receive so many reports of suspected child maltreatment that the National Advisory Body for the National Center on Child Abuse and Neglect released a report asserting that the system was in crisis and in need of drastic reform.[5] One element subject to reform is the mandate to designated professionals working with children and families to report suspected child maltreatment.[6]

In what follows, I will define the law's therapeutic aim, examine the child protection system as it operates, and examine some of the rules of law that may promote or impede therapeutic aims. In

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[3] *See generally* MURRAY LEVINE & DAVID PERKINS, PRINCIPLES OF COMMUNITY PSYCHOLOGY 100-125 (1987) (discussing psychological adaptation to environments).

[4] MURRAY LEVINE & ADELINE LEVINE, HELPING CHILDREN: A SOCIAL HISTORY 208-210 (1992).

[5] U.S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT, OFFICE OF HUMAN DEVELOPMENT SERVICES, CRITICAL FIRST STEPS IN A NATIONAL EMERGENCY 2, 92 (1990).

[6] *See* Margaret H. Meriwether, *Child Abuse Reporting Laws: Time for a Change*, 20 FAM. L. Q. 141, 145-46, 164 (1986) (discussing the need for all professionals who work with children to report abuse); *see also* Douglas Besharov, *Gaining Control Over Child Abuse Reports*, 48 PUB. WELFARE 34, 34 (1990) (stating that all states now require a broader category of professionals to report abuse); Elizabeth D. Hutchison, *Mandatory Reporting Laws: Child Protective Case Finding Gone Awry?* 38 SOC. WORK 56, 57 (1993) (the definition of those who are required to report suspected child abuse has been expanded). *But see* David Finkelhor, *Is Child Abuse Overreported?*, 48 PUB. WELFARE 23, 28-9 (1990) (Finkelhor believes that the reporting system is not out of kilter, but that a certain amount of inefficiency is inevitable).

particular, I will concentrate on the impact of the mandate to report suspected child maltreatment on the psychotherapy relationship. I will illustrate the complexities that are introduced when we view a system through a broader therapeutic jurisprudence lens that takes into account the characteristics of the roles played by actors in the system.

Child protection legislation has an impact on the confidential psychotherapy relationship. The law requiring the breach of confidentiality has a clear therapeutic purpose, but so also do provisions for confidential and privileged communications. Professors Shuman and Weiner have argued that the absence of a legal privilege has little or no effect on whether clients choose to enter psychiatric or psychological treatment and that once having entered, their treatment is unaffected by the lack of privilege.[7] In pre-therapeutic jurisprudence days, they were saying that the law of privilege had neither therapeutic nor antitherapeutic effects. That proposition may be true on the very general level at which they examined it. However, Shuman and Weiner did not examine the effects on a psychotherapeutic relationship when a privilege did not exist. Under child protection statutes, privilege is limited for the purpose of making a report to state authorities to protect a child. Will that limitation of privilege have an effect on an ongoing confidential relationship?

II. Note on Method

To illustrate the issues, I will present excerpts from open ended, semi-structured interviews conducted with thirty psychotherapists who had made one or more reports within the previous year on clients they had in therapy, and with twenty-five CPS workers who had investigated reports coming from mental health sources.[8] The therapists were asked to think of a case they had

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[7] Daniel W. Shuman & Myron F. Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C.L. REV. 893, 894 (1982).

[8] Murray Levine et al., Mandated Reporting and the Therapeutic Alliance in the Context of the Child Protection System (Baldy Center for Law & Social Policy, SUNY Buffalo, Working Paper Series CL91.02).

reported within the past year, and the CPS workers were asked to think of a recent case in which they had received a report from a mental health source. The interviewees were all volunteers who responded to an announcement offering to pay $20 for an interview on this general subject. The psychotherapists came from six agencies in two counties, and the CPS workers from two counties.

The survey was conducted by a group associated with the State University of New York at Buffalo. Three of us have extensive experience as line CPS workers, and the graduate students are advanced trainees in clinical psychology with clinical experience. We reviewed the examples and tested our interpretations against the experience of team members as a means of identifying idiosyncratic and typical examples. We used something like a process of cross-checking to guide our presentation and our conclusions. Our aim is to produce representations that "ring true."[9]

We do not have a systematic sample. Our interest is not in specifying the frequency of occurrence of different events, but rather in identifying essential issues that will be encountered inevitably by those working in similar situations. We assume an organized social world with regularities that occur because social settings tend to be coercive of the behavior they elicit.[10] In the absence of evidence to the contrary, experiences in a given setting are more likely to be typical than atypical. We asked our respondents to tell us whether the events they related were typical of their experiences. Usually, more than one respondent described similar occurrences. Often, we were able to identify complementary phenomena in the transcripts of interviews with therapists and with CPS workers. We also used members of our research group as a social control.

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[9] *See generally* Murray Levine et al., *Learning from Seymour Sarason*, 18 AM. J. COMMUNITY PSYCHOL. 343 (1990) (explaining the value of research work which is insightful, challenging, and makes a "positive contribution" to knowledge).

[10] LEVINE & PERKINS, *supra* note 3, at 107.

III. The Child Protection System

A. History

The child protection system developed when mid-nineteenth century "child savers"[11] became concerned about the plight of impoverished immigrant families who sometimes abandoned their children, who sometimes exploited them, and who sometimes treated them with great harshness.[12] Child protective services were authorized under the state's *parens patriae* and police powers.[13] The intent was to protect children, often by removing them from their parents and placing them in institutions.[14]

One early catalyst in the child protection movement was the well publicized case of Mary Ellen, a child placed by a charitable organization with a foster family who was cruelly abused by that family. A missionary learned of the case, but found that neither she nor any other agency had authority to intervene in an intact family where the child had not been abandoned. Eventually, the American Society for the Prevention of Cruelty to Animals acted.[15] Her case resulted in a criminal trial and the conviction of her caretaker for assault.[16] The trial received a great deal of publicity.[17] In 1875, the attorney Elbridge Gerry organized the New York Society for the Prevention of Cruelty to Children.[18]

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[11] ANTHONY M. PLATT, THE CHILD SAVERS: THE INVENTION OF DELINQUENCY (1969).

[12] LINDA GORDON, HEROES OF THEIR OWN LIVES: THE POLITICS AND HISTORY OF FAMILY VIOLENCE 32-37 (1988).

[13] *See* New York *ex rel.* State Board of Charities v. New York Soc'y Prevention of Cruelty to Children, 55 N.E. 1063, 1065 (1900).

[14] *In re* Knowack, 53 N.E. 676, 677 (1899).

[15] The legal basis for intervention was not that the child was entitled the legal protection afforded animals; rather it was initiated by a writ *de homine replegiando*, an English writ of law that removes one person from the custody of another. Mason P. Thomas, Jr., *Child Abuse and Neglect, Part I: Historical Overview, Legal Matrix, and Social Perspectives*, 50 N.C.L. REV. 293, 307 (1972).

[16] *Id.* at 310.

[17] Stephen Lazoritz, *Whatever Happened to Mary Ellen?* 14 CHILD ABUSE AND NEGLECT 143, 145-147 (1990).

[18] Thomas, *supra* note 15, at 307-08.

Child maltreatment was never high on the public agenda although the child protection movement spread throughout the United States very quickly.[19] In the early twentieth century, child protection became caught up in the struggle to remove welfare functions from the private sector and place them in public agencies. The Social Security Act of 1935 provided the decisive element in reform by conditioning federal reimbursement upon the creation of centralized state welfare authorities and the delivery of services in local communities.[20]

Child abuse was rediscovered after World War II.[21] Pediatric roentgenologists reported unexplained cases of multiple healed fractures in infants and children.[22] The Children's Bureau had been collecting information on child maltreatment and supported some research on the topic.[23] C. Henry Kempe and his co-workers' study of the frequency of serious injury and deaths in emergency rooms, accompanied by an editorial in the Journal of the American Medical Association, and a well publicized symposium at the American Medical Association meetings, pushed the issue to the front burner.[24] A great deal of publicity, and professional acceptance followed.[25] Not long after, almost all states developed reporting laws, and reports of child maltreatment skyrocketed.[26]

Reporting laws were adopted in order to allow physicians to report without concern about breaching confidentiality.[27] Legislators believed that a reporting law and a state hotline were inexpensive

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[19] R. C. MCCREA, THE HUMANE MOVEMENT: A DESCRIPTIVE SURVEY 389-431 (1910).

[20] LEVINE & LEVINE, *supra* note 4, ch. 12.

[21] BARBARA J. NELSON, MAKING AN ISSUE OF CHILD ABUSE 11-12 (1984).

[22] *Id.*

[23] *Id.* at 45.

[24] *Id.* at 13, 16. *See* C. Henry Kempe et al., *The Battered Child Syndrome*, 181 J. AM. MED. ASS'N 17 (1962).

[25] Stephen J. Pfohl, *The "Discovery" of Child Abuse*, 24 SOC. PROBS. 310, 310 (1977).

[26] NELSON, *supra* note 21, at 13, 16. Abuse was emphasized rather than the far more frequent case of neglect in order to insulate legislation to protect children from association with the then politically unpopular War on Poverty. *Id.* at 14-15.

[27] *See* Monrad Paulsen et al., *Child Abuse Reporting Laws: Some Legislative History*, 34 GEO. WASH. L. REV. 482, 483 (1966); *Cf.* Pfohl, *supra* note 25, at 316, 320.

means of expressing concern about children.[28] They badly underestimated the frequency of child maltreatment in the United States.[29] Reports grew from 669,000 in 1976 to 2,086,000 in 1986.[30] The list of those mandated to report grew as well,[31] without regard to the fact that the first laws were really directed to emergency room physicians who generally do not have continuing relationships with patients.[32] The frequency of sex abuse cases has also grown from 3.2% of reports in 1976 to 15.7% in 1986.[33] These figures continue to grow. The number of reports in 1992 will be about 2.7 million, placing the entire system under strain.[34]

B. Therapeutic Aim

The therapeutic purpose of the child protection statutes and the reporting law may be stated simply—to protect children from maltreatment that threatens them physically and psychologically.[35] The intent of the law is to prevent children "from suffering further injury and impairment."[36] The state intends this intervention to "protect children from injury or mistreatment and to help safeguard their physical, mental and emotional well-being."[37] At its best, the law requires the Social Service Department to assist a family in distress by eliminating the maltreatment and to restore family competence. Even if a child is removed from a family, it is considered a temporary action.[38] Social Services has a duty to work

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[28] NELSON, *supra* note 21, at 76-77.

[29] *Id.*

[30] BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACTS OF THE UNITED STATES 186 (1992).

[31] Mark A. Small, *Policy Review of Child Abuse and Neglect Reporting Statutes*, 14 LAW & POL'Y 129, 131 (1992).

[32] *See* Pfohl, *supra* note 25, at 317, 319.

[33] BUREAU OF THE CENSUS, *supra* note 30.

[34] U.S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT, *supra* note 5, at 15.

[35] *See* NELSON, *supra* note 21, at 13-14.

[36] N.Y. SOC. SERV. LAW § 411 (McKinney 1992).

[37] N.Y. FAM. CT. ACT § 1011 (McKinney 1983 & Supp. 1993).

[38] N.Y. FAM. CT. ACT § 1055(b)(i) (McKinney Supp. 1993) (initially placements are one year long).

to restore the child to a renewed family.[39] Often families will be referred for counseling or psychotherapy as a consequence of a child protection investigation or an adjudication of abuse or neglect.

C. Due Process Considerations

The therapeutic purpose of protecting the child is so greatly valued that society is willing to intrude on the constitutionally protected privacy of the family in order to protect a child. Society accords a low standard of due process protections to the parent when the state does intrude.[40] An investigation is triggered by a "reasonable cause to suspect,"[41] a relatively low standard of evidence for maltreatment. An investigator has the authority to enter a home in an emergency and to remove a child temporarily.[42] An administrative determination, made by the investigator, requires only "some credible evidence" of maltreatment.[43] The determination is subject to appeal.[44] Moreover, the investigating agency and the investigative worker are granted immunity from prosecution for most errors that might be made in the course of an investigation.[45]

An adjudication in cases that reach a family or juvenile court in a dependency and neglect hearing[46] requires only a "preponderance" of the evidence.[47] The respondent to a neglect or abuse petition has no right to a jury trial, a reduced right to confront

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[39] *See, e.g.*, N.Y. SOC. SERV. LAW § 384-1(a)(iii) (McKinney 1992) ("The state's first obligation is to help the family with services to prevent its break-up or to reunite it if the child has already left home.").

[40] *See generally* Santosky v. Kramer, 455 U.S. 745, 769 (1982) (holding clear and convincing evidence as the standard of proof).

[41] N.Y. SOC. SERV. LAW § 413.1 (McKinney 1992).

[42] N.Y. SOC. SERV. LAW § 417 (McKinney 1992).

[43] N.Y. SOC. SERV. LAW § 412.12 (McKinney 1992).

[44] N.Y. SOC. SERV. LAW § 422.8 (McKinney 1992).

[45] *See* Cheryl A. Nohejl et al., *Risk Assessment Implementation and Legal Liability in CPS Practice*, 14 LAW & POL'Y 185, 189-190 (1992).

[46] Such hearings constitute about 15% of "indicated" cases. Douglas J. Besharov, *The Need to Narrow the Grounds for State Intervention*, *in* PROTECTING CHILDREN FROM ABUSE AND NEGLECT: POLICY AND PRACTICE 47, 57 (D. J. Besharov ed. 1988).

[47] N.Y. FAM. CT. ACT § 1046(b)(i) (McKinney 1983).

witnesses, and a limited Fifth Amendment right against self incrimination.[48] In contrast to a criminal trial, the silence of a respondent in this type of civil proceeding may be used as evidence against the respondent.[49] Moreover, child protection statutes limit privilege so that it is not available in a child protection proceeding.[50] A therapist's records may be subpoenaed and the therapist required to testify. The standard for introducing evidence is not very high. The judge may follow civil law procedure, but has discretion to modify those procedures.[51] In some circumstances, hearsay may be used to corroborate hearsay.[52] The adjudication may result in the exercise of the coercive power of the court to implement a treatment plan.[53]

Given the limitations on other rights and the level of due process afforded respondents, we should examine the costs and benefits of reporting legislation carefully.

IV. How the Law Affects Therapists and Therapy

The standards in all states for mandated reporting of suspected child maltreatment include some variant of "reasonable suspicion."[54] This vague standard reflects a policy decision to cast a broad net to identify all cases of maltreatment. The policy insures that there will be a large number of false positives (cases of suspected maltreatment that prove to be unfounded) and assumes that the cost of investigating

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[48] Murray Levine & Eric Doherty, *Professional Issues: The Fifth Amendment and Therapeutic Requirements to Admit Abuse*, 18 CRIM. JUST. & BEHAV. 98, 99 (1991).

[49] *In re* Commissioner of Soc. Servs. v. Philip De G., 450 N.E.2d 681, 683 (1983).

[50] N.Y. FAM. CT. ACT § 1046(a)(vii) (McKinney 1983).

[51] *See* N.Y. FAM. CT. ACT § 165(a) (McKinney 1983) ("The provisions of the civil practice law and rules shall apply to the extent that they are appropriate to the proceedings involved.").

[52] Murray Levine & Lori Battistoni, *The Corroboration Requirement in Child Sex Abuse Cases*, 9 BEHAVIORAL SCI. & L. 3, 7 (1991).

[53] *See* N.Y. FAM. CT. ACT § 1057 (McKinney 1983) ("Rules of court shall define permissible terms and conditions of supervision under this section."); N.Y. FAM. CT. ACT § 1072(b) (McKinney 1983) (failure to comply with terms and conditions of supervision is punishable by up to six months in jail).

[54] Meriwether, *supra* note 6, at 146.

false positives is less important than the potential for protecting children. The policy also assumes, if not a helpful system, at least a benign one. That assumption is open to question.

A. Participating in the System

Social policy aims, ethical requirements, and legal requirements should be congruent. When they conflict, actors in the system experience stress[55] and tend to feel that aspects of the law are obstructive, irrational, or absurd.[56] Therapists and CPS investigators have different tasks and share overlapping, but different, cultures. Therapists are concerned about their clients and seek to help them through the exercise of particular professional skills. Reporting takes place within a system of investigation and intervention. From the viewpoint of the reporting therapist, the outcomes may be unpredictable. Unpredictability derives, in part, from the application of the vague governing statutory definitions. Also, the investigative process may have emotional effects on the clients who are reported. One of the therapists we interviewed said about reporting:

> It's not pleasant. . . . I feel like I have created a train wreck somewhere. But I know that it's part of the job and I am willing to accept that. . . . It is a yucky feeling. I have done it numerous times and it doesn't get any better. If anything it gets worse because the more I have to do it, the more I appreciate the impact on the family.[57]

Another therapist compared the experience with involuntarily hospitalizing someone. For him, the experience of reporting suspected child maltreatment was very different:

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[55] H. Watson, Child Abuse Reporting: Factors Affecting the Decision Process 47 (1991) (unpublished Ph.D. thesis, SUNY Buffalo) (75% of therapists who made a report experienced it as personally stressful).

[56] Gail L. Zellman & Stephen Antler, *Mandated Reporters and CPS: A Study in Frustration*, 48 PUB. WELFARE 30, 34-35 (1990).

[57] LEVINE ET AL., *supra* note 8, at 11.

> The first time I filed a report, I had that same feeling: this is going to be very painful, but they'll [the clients] recognize . . . how it was necessary and benefitted them. . . . I don't feel that way anymore. I just do it, but I hold my breath while doing it because I don't know what's going to happen. . . . I don't even have the self satisfaction of feeling I prevented something. I don't feel the system works well or benefits clients.[58]

B. Emotional Costs of a Report

In addition to the dollar costs to the state,[59] to say nothing of legal costs to a respondent of an investigation, there are emotional or other costs to the family. Richard Wexler has documented some of the horror stories that have led to adverse publicity and law suits.[60] Our CPS investigators provided us with numerous examples of emotional costs to the subjects of their investigations.[61] CPS investigators are aware that their very appearance raises the specter that children may be removed from the home:

> Oh yeah. They'd go to the door and they were very guarded. They don't want to talk to you because they are afraid you are going to walk out the door with their kids. They are very frightened of child protection. We terrorize people. . . . Just the thought of CPS frightens people.[62]

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[58] *Id.* at 12.

[59] The New York Department of Social Services estimates that a hot line screening call costs $6, while an investigation costs $309. BUREAU OF MANAGEMENT, PLANNING AND EVALUATION, N.Y.S. DEP'T OF SOCIAL SERVICES, UNFOUNDED CPS REP., INTERIM REP., PHASE I 1 (1991).

[60] *See generally* RICHARD WEXLER, WOUNDED INNOCENTS: THE REAL VICTIMS OF THE WAR AGAINST CHILD ABUSE (1990).

[61] Murray Levine, et al., Child Protection Workers' Views of Mandated Reports of Child Maltreatment Made by Psychotherapists 3-5 (Sept. 30, 1992) (unpublished manuscript, on file with the author).

[62] *Id.* at 3.

When the therapist is uncertain or anxious about the therapeutic value of a report, and makes the report just to comply with the law, the therapist is coerced by potential civil and criminal penalties, or by agency policy, to act against his or her professional judgment. Therapists are also concerned about another cost of reporting: the impact on the therapeutic alliance.[63]

C. Informing the Client of the Mandate to Report

The therapeutic alliance develops with the first encounter between therapist and client. Most therapists feel an ethical responsibility to inform a client of the limits of confidentiality. Informing the client is an act that respects a client's autonomy. Enhancing client autonomy is certainly a therapeutic goal, but the reporting mandate complicates the effort to meet the duty to inform. What should the therapist inform the client about?

What constitutes reportable maltreatment? Our therapists had little hesitancy about reporting incidents involving visible signs of injury and disclosures of sexual abuse when the allegation was clear and the perpetrator was named.[64] The criteria for other types of maltreatment were less clear. One therapist summed up the problem with unintended irony: "The reporting criteria are unambiguous. The incidents that come up are ambiguous."[65]

If the standards for reporting are vague to mandated reporters who receive some training in reporting, what must they be like for clients who, upon entering treatment, might be informed of the psychotherapist's duty to report suspected child maltreatment? Psychotherapists appear reluctant to engage clients in any detailed discussion of the limits of confidentiality when clients enter

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[63] *See generally* THE PSYCHOTHERAPEUTIC PROCESS: A RESEARCH HANDBOOK (Leslie S. Greenberg & William Pinsof eds., 1986) (describing a therapeutic alliance as the bond between the therapist and patient that creates a sense that they are in a joint struggle against the patient's problem).

[64] The therapists seemed to adopt criteria for reporting that were similar to those described in the literature based on surveys and vignette studies. *See* Brosig & Kalichman, *Clinicians' Reporting of Suspected Child Abuse: A Review of the Empirical Literature*, 12 CLINICAL PSYCHOL. REV. 155, 163-165 (1992).

[65] LEVINE ET AL., *supra* note 8, at 18.

psychotherapy despite ethical, if not legal, duties to do so.[66] What is a client to understand by the vague terms that are often embedded in an assurance of confidentiality?

We have very little knowledge of common practices in obtaining informed consent for psychotherapy. Only half of the therapists in one survey said they always provided information about confidentiality limits. A little over half provided information orally only.[67] A minority of respondents (36.9%) in another survey said they forewarned their clients of the duty to report suspected maltreatment either orally or by means of a written notice.[68] About 57% gave warnings only when a suspicion was aroused or a disclosure was actually made.[69] In effect, more than half did not give their clients notice before the duty to report crystallized.[70] One of the agencies where some of our therapists worked had a policy of not informing clients in advance because they dealt with high risk clients and were concerned that clients would not disclose maltreatment.

Assuming the desirability, what should be conveyed to a client at the outset to support an autonomous decision? How much can or should the therapist explain what is meant by child maltreatment? How much should a therapist convey about the consequences of a report of child maltreatment? Should the therapist tell about the

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[66] *See* Charles P. Ewing, *Mental Health Clinicians and the Law: An Overview of Current Law Governing Professional Practice, in* PSYCHOLOGY, PSYCHIATRY, AND THE LAW: A CLINICAL AND FORENSIC HANDBOOK 527 (Charles P. Ewing ed., 1985); *See generally* AMERICAN ASSOCIATION OF COUNSELING AND DEVELOPMENT, ETHICAL STANDARDS OF THE AMERICAN ASSOCIATION OF COUNSELING AND DEVELOPMENT (3rd revision), 67 J. COUNSELING & DEV. 4 (1988); AMERICAN ASSOCIATION OF MARRIAGE AND FAMILY THERAPISTS, CODE OF ETHICS, Rule 2.1 (1991); AMERICAN PSYCHIATRIC ASSOCIATION, Principle 5: Confidentiality (amended June 2, 1989); FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK, CODE OF ETHICS (1988).

[67] Katherine M. Nicolai & Norman A. Scott, Psychotherapy's Miranda Warning: Effects of Informing Clients of Confidentiality Limits on Reporting Child Abuse 4 (March 14, 1992) (unpublished manuscript, on file with the author).

[68] Wesley B. Crenshaw & James W. Lichtenberg, *Child Abuse and the Limits of Confidentiality: Forewarning Practices*, 11 BEHAVIORAL SCI. & L. 181, 189 (1993).

[69] *Id.*

[70] Robert F. Schopp, *The Psychotherapist's Duty to Protect the Public: The Appropriate Standard and the Foundation in Legal Theory and Empirical Premises*, 70 NEB. L. REV. 327, 342 (1991).

limitations of privilege if a report is made[71] and that a child protection investigation could lead to a criminal investigation? [72]

Therapists acknowledge that informing clients in advance is helpful in enhancing the relationship: "It's clear that we respect and acknowledge confidentiality. There's relief on the part of the client because we are clear." [73]

However, in presenting the limitations, our therapists said they emphasize confidentiality and mention limitations:

> It's tricky because you are laying out confidentiality with people and that's important to establish, but there's also the dilemma about whether you emphasize that [reporting mandate] and not get disclosures that . . . need to be disclosed and discussed and treated. So I don't go crazy emphasizing that. . . . I don't know if I am violating people's rights in that. It's an ongoing question that's hard to answer, but I do make clear what confidentiality is, especially when you are working with kids.[74]

Anticipating the effect on therapy, the therapist may not always convey the mandate to report:

> Now . . . in the first few interviews, or one of the first interviews [I try to] say that if anything is ever disclosed to me, I need to do this [report]. There may be times when I may have forgotten to do that. It's not a hundred percent foolproof, but I try to do that.[75]

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[71] N.Y. SOC. SERV. LAW § 415 (McKinney 1992) (permitting disclosure of "any other information which the commissioner may, by regulation, require, or the person making the report believes might be helpful, in the furtherance of the purposes of this title.").

[72] *See* Levine & Doherty, *supra* note 48, at 101.

[73] LEVINE ET AL., *supra* note 8, at 13.

[74] *Id.* at 14-15.

[75] *Id.* at 15.

Note that by emphasizing confidentiality and omitting to tell the clients about the limits, therapists may find themselves in a bind when a client does disclose a reportable episode. A therapist working with an adolescent said: "I felt just horrible, like I had really betrayed her."[76]

Therapists who work with high risk clients may not inform their clients of the mandate to report either because they assume the client knows of the mandate and doesn't need the warning, or because they are concerned about losing the fragile rapport they have with clients who may not be entering treatment entirely of their own free will.[77]

One hazard of mandated reporting is the exposure to criminal prosecution if a client discloses an episode of abuse. What a client learns about the limits of confidentiality through an informed consent formula can result in a severe drop in disclosures of episodes of abuse if the client does enter treatment, and may act as a deterrent to the voluntary entry into treatment of some pedophiles.[78] Thus, the mandate to report under some conditions may have an antitherapeutic effect both in restricting topics that come up for discussion in treatment and in failing to protect children from further episodes of abuse.

What do clients understand even if warned? Assuming a minimal warning, what does the client understand? Views of what constitutes maltreatment may vary widely among CPS investigators, therapists, and clients. For example, a parent who severely punishes a child by using a belt and leaves marks may view himself as a good parent trying to discipline a wayward child. The parent, in discussing his or her frustration or guilt in disciplining a child, may not understand how the therapist or the CPS investigator will look at those well intended actions. Nor will the client appreciate the nature of the investigation until he or she experiences it:

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[76] *Id.* at 16.

[77] Mandated reporters are granted either good faith or absolute immunity for reports made pursuant to the mandate. Besharov, *supra* note 46.

[78] Fred S. Berlin et al., *Effects of Statutes Requiring Psychiatrists to Report Suspected Sexual Abuse of Children*, 148 AM. J. PSYCHIATRY 449, 451 (1991).

> The initial reaction [upon being informed] is very matter of fact: "I understand." After that person [CPS worker] comes out, then it really sinks in. "My God, this is going on. I'm furious," and she gets furious at the guy who made the report. So I really wasn't surprised with her reaction [delayed anger] because I have seen it before. . . . I would like to think they really heard what I was saying and take it in, and I am not sure they really did that. . . . So in hindsight, I can see that talking about being a mandated reporter, it just didn't connect with them.[79]

D. Unfounded Reports

The vague statutory standards and the different standards of evidence used by CPS investigators and therapists lead to unfounded reports. Nationally, sixty percent of reports are unfounded.[80] Most of our therapists told the client when they made a report because they felt an ethical obligation and a therapeutic hope that the communication would help preserve trust and the therapeutic alliance. However, about half of the CPS investigators we interviewed would have preferred an unannounced visit. Thus, differing obligations in the two roles leads to conflict between the actors. Statistically speaking, when a therapist makes a report, the odds are against indication by the CPS investigator. That means that therapists are left to deal with clients who were told by the state, implicitly if not explicitly, that the therapist was "wrong" in making the report.[81] If the report was unfounded, the client was subject to an upsetting

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[79] LEVINE ET AL., *supra* note 8, at 16.

[80] Besharov, *supra* note 6.

[81] *Compare* Wexler and Winick's concept that the criminal plea process may contribute to cognitive distortion or cognitive restructuring with sex offenders. David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence and Criminal Justice Mental Health Issues*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 225, 229 (1992). *See* Jeffrey A. Klotz et al., *Cognitive Restructuring Through Law: A Therapeutic Jurisprudence Approach to Sex Offenders and the Plea Process*, 15 U. PUGET SOUND L. REV. 579 (1992) (discussing the implication of the Alford plea for cognitive restructuring in sex offenders).

experience that would confirm that the system was an adversary not a friend:

> When the mother learned of the report, she threatened to pack up the kids and leave the city. She was convinced her children would be taken from her. She was also fearful that welfare authorities would discover she was living with a man and would stop her public assistance.[82]

The report was unfounded. According to the therapist, the CPS worker said: "This isn't any big deal. We don't even know why you reported this. There's no marks on the child."[83]

E. Stale and Inappropriate Reports

We have identified two classes of reports that are likely to be unfounded—stale reports and inappropriate reports. Reporting statutes contain nothing like a "statute of limitations" or a requirement that the suspected maltreatment be ongoing or imminent. Stale reports are made when the therapist takes a literal view of the law's requirements and reports an episode from the client's past.[84] A CPS worker described a report she had investigated:

> She was upset one day, and she slapped her child across the arm and left . . . supposedly left a red

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[82] LEVINE ET AL., *supra* note 8, at 10.

[83] *Id.* at 11.

[84] One might expect the state hot line would screen out reports which are stale or inappropriate. However, the comments of CPS investigators in our interviews suggest that in their view, the hot line does not screen out a sufficient number of what one CPS investigator termed "garbage reports." The state believes that the hot line does screen out a significant number of reports that if investigated would be unfounded. BUREAU OF MGMT., *supra* note 59, at 4. The unexpected comments from CPS investigators, along with the comments of experienced therapists who said they had learned to manipulate the hot line, gave us some insight into the dynamics that affect the process of communication from mandated reporter to hot line and then from hot line to CPS investigator. Levine et al., *supra* note 61, at 19-21.

> mark. The mother had not had her son since three years ago. So basically that was it. This person called in a report because her client told her that she swatted her son on the shoulder and thought she may have left a red mark and felt bad about doing that. . . . The mother pulled out of treatment immediately. She was gone.[85]

Our therapists and CPS workers provided a number of other examples of stale reports. They estimate that anywhere from two to twenty percent of reports coming from mental health sources may be in this category.

The second category, inappropriate reports, reflects both a lack of appreciation of the conditions under which CPS can intervene and vague statutory criteria: "We had lots of reports from therapists treating schizophrenics or personality disorders and I think it is because they're worried that these people could do something to their children."[86]

In discussing another case, the CPS investigator pointed out that she could do nothing in the absence of evidence of maltreatment, or specific threatening conduct by the parent:

> We continually have these disagreements and I find that to be fairly common with most therapists who call in. There's going to be trouble, they'll say . . . there's going to be trouble. We are operating on what's going on right now, this minute, not what may happen next month or next year.[87]

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[85] Levine et al., *supra* note 61, at 5-6.

[86] *Id.* at 12.

[87] Levine et al., *supra* note 61, at 12. *See* David J. Agatstein, *Child Abuse Reporting in New York State: The Dilemma of the Mental Health Profession,* 34 N.Y.L. SCH. L. REV. 115, 154 (1989) (the issue is whether the child is currently abused or neglected). Even though the New York statute does not require injury to the child and permits intervention when some injury threatens, the possibilities for preventive intervention are restricted by due process considerations. N.Y. FAM. CT. ACT § 1012(e)(i) (McKinney 1983 & Supp. 1993) ("[O]r creates a substantial risk of death . . . ."); N.Y. FAM. CT. ACT § 1012(e)(ii) (McKinney 1983 & Supp. 1993) ("[C]reates or allows to be created a substantial risk . . . ."); N.Y. FAM. CT. ACT § 1012 (f)(i)

Another problem arises because the reporting mandate increases the power imbalance between therapist and client.[88] Therapists and CPS investigators stated that reports were made and received when a client dropped out of treatment and the therapist wanted CPS to bring the client back into treatment. Sometimes, the CPS investigators felt the reports were made out of pique that the client had rejected the therapist. We have described how the reporting power was used coercively by therapists to shake up a family, to force a course of action on a client, to attack resistance to treatment or to pursue some other objective such as getting a parent to confront past history of abuse.[89] The therapists' judgments may be correct, and the therapeutic ends may be valid. However, if the report is unfounded, the therapeutic aim may well be frustrated. The CPS investigator cannot indicate a report that does not meet legal standards of maltreatment, and the client receives the message that the therapist was wrong.

This type of disagreement leads to conflicts between therapists and CPS investigators. Therapists, who feel their training is superior to that of CPS investigators, may feel that their views deserve more consideration by CPS workers than they sometimes receive. Unfounded cases are sometimes interpreted by the therapist as an insult to the therapist's competence. On the other hand CPS investigators felt that therapists did not know CPS functions or limits, and the investigator considered the therapist's attitudes to be difficult:

> They [therapists] may think this is not a good atmosphere or a good environment for this child. They will request us to remove the child or make us feel like it's, you know that's our number one priority and it's difficult to let these people [therapists] know what the law requires. . . . They can be very

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(McKinney 1983 & Supp. 1993) ("[O]r is in imminent danger of becoming impaired . . . ."); N.Y. FAM. CT. ACT § 1012 (f)(i)(B) (McKinney 1983 & Supp. 1993) ("[O]r a substantial risk thereof.").

[88] Michael L. Perlin, *Power Imbalances in Therapeutic and Forensic Relationships*, 9 BEHAVIORAL SCI. & L. 111, 115 (1991).

[89] Elizabeth Anderson et al., *Coercive Uses of Mandatory Reporting in Therapeutic Relationships*, 11 BEHAVIORAL SCI. & L. 335 (1993).

> condescending at times. [As] mental health professionals, they know from mind and . . . the family dynamics and what's going on in everybody's head so that can be a problem for us.[90]

Other communication problems arise because of the different roles and tasks that therapists and CPS workers have. We will not address this issue here. Our emphasis on some of the problems should not obscure the fact that good working relationships develop regularly between therapists and CPS investigators, especially among repeat players.

F. Impact on Treatment

What happens to treatment when a report is made? The available data suggests that about twenty-five percent of psychotherapy clients who are subject to a mandated report will drop out of treatment shortly after the report is made.[91] This number does not take into account those who drop out psychologically but are unable to leave therapy physically because they are already enmeshed with child protection, social services or the criminal justice systems.[92] All of our cases came from agencies. Therefore, we do not know what the drop out rate might be in private practice settings.

Our therapists reported numerous examples of clients leaving treatment, and these were confirmed by the observations of CPS investigators. A client on whom a report has been made often feels angered and betrayed. The following quotation is from one of the CPS workers who investigated a report coming from a therapist:

> The mother was very angry that they had called in a report, extremely angry. . . . I think that termination with the therapist who called it in was important at this point even though they [clinic and therapists] are

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[90] Levine et al., *supra* note 61, at 17.

[91] Holly Watson & Murray Levine, *Psychotherapy and Mandated Reporting of Child Abuse*, 59 AM. J. ORTHOPSYCHIATRY 246, 252-253 (1989).

[92] *Id.* at 254.

> good treatment providers and there was nothing wrong with the treatment they were providing; mother perceived it as wrong.[93]

A second example from a therapist illustrates the same point:

> She [the client] was angry, denying, frustrated. I am sure she was hurt. You know we had started to develop a rapport in the first session. And here at the second session it was almost like I was beating her over the head with [it]. . . . I didn't feel comfortable at all in reporting this because I truly believed she would not be back. . . . I tried reaching the family, tried reaching the mother to ask her if she would like to come in and talk . . . but I could never reach her. There was never any answer.[94]

Reports made about third parties not in treatment[95] have less of a negative impact on the therapy relationship.[96] Improvement is more likely to occur when the report is made about a third party not in treatment.[97] A CPS investigator observed, "Mom [who was in treatment] was very receptive, cordial, open, glad I came. . . . Dad, [not in treatment] who really the allegations were against . . . Dad, well, he wasn't so receptive. He was really defensive, more guarded."[98]

The end result of a report may be an investigation and an adjudication in which the client is ordered back into treatment. For example, a client who voluntarily sought treatment disclosed episodes of intrafamilial sexual abuse, which was reported. The client was

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[93] Levine et al., *supra* note 61, at 14.

[94] LEVINE ET AL., *supra* note 8, at 36.

[95] A sophisticated client may use the system to make a report about a third party as a tactic in a custody dispute or as a weapon in a relationship. *See* Roe v. Superior Court, 280 Cal. Rptr. 380, 385-386 (Cal. Ct. App. 1991)

[96] Watson & Levine, *supra* note 91.

[97] *Id.*

[98] Murray Levine, Reporting Clients Already in Treatment 9 (July 8, 1992) (unpublished manuscript, on file with the author).

ordered by the family court judge to leave the home and to remain in therapy until the therapist and the social services department felt he could return.[99] However, the client was also prosecuted criminally.[100] The CPS investigator commented, "they bargained down and he was put on probation and ordered into therapy which he was already in."[101]

Perhaps there was merit in prosecuting; perhaps the victim felt more secure or empowered. However what was the effect on the subsequent treatment? We have no information in this case whether therapy was now so spoiled for the client that he was unable to make use of it.

G. Resistance Following a Report

If the client remained in treatment, often the damage to the therapeutic alliance was reflected in guardedness, and related to a loss of trust on the part of the client. A therapist noted:

> I felt that she became more superficial with me after the report even though she continued to share with me the incidents of concern. . . . I felt that she learned to set limits with the sharing of too much information. I felt that she was less open, less spontaneous. . . . We had a very good relationship for a long time, at least a year and a half. And I felt that our relationship was damaged.[102]

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[99] Clients ordered into treatment may still protest their innocence, but therapists insist that no improvement can be made until the client admits the abuse. Under some conditions, the therapeutic requirement may raise Fifth Amendment issues. Levine & Doherty, *supra* note 48 at 98-99; *see* Montana v. Imlay, 113 S. Ct. 444 (1992) (White, J., dissenting from the dismissal of the writ of certiorari).

[100] The district attorney's office is entitled to request all reports for review for consideration of criminal prosecution. N.Y. SOC. SERV. LAW § 424.4 (McKinney 1993).

[101] Levine, *supra* note 98, at 5.

[102] LEVINE ET AL., *supra* note 8, at 38.

Children may be subject to pressure after a report is made either to recant, or to refuse to give further information. A therapist working with a child noted:

> What my hunch is that the family, the parents sat each one of them down and asked them if they told anybody anything and read them the riot act, that they better not tell anybody anything. . . . So I don't think it is going to encourage these kids to open up. That [threats to the child] is one of the risks of doing this kind of reporting.[103]

H. Working Through the Resistance

Our therapists reported that it was sometimes possible to work through resistance and reestablish the therapeutic alliance. Many therapists felt that if the alliance was strong to begin with, the relationship could survive the report. However, some therapists said that it took several weeks of working on the resistance before it dissipated:

> The short term effect is that they withdraw, because the anger is so up front, and the relationship is really broken. You spend a lot of time the next few weeks and months and try to rejoin and reengage. . . . So short term the relationship is cut off, it's disrupted, and long term it's maybe rejoined.[104]

In this day and age of managed care and limited insurance payments for psychotherapy, we can ask how fair it is to the client to use limited insurance time to work through resistance that was stimulated by the mandated report.

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[103] Elizabeth Anderson, et al., *Consequences and Dilemmas in Therapeutic Relationships with Families Resulting from Mandatory Reporting Legislation*, 14 LAW & POL'Y 241, 249 (1992).

[104] LEVINE ET AL., *supra* note 8, at 38.

I. Some Positive Effects on Treatment

Not all reports produce negative results. Watson and Levine found that forty percent of cases that were reported by psychotherapists showed improvement after the report.[105] Harper and Irvin, working in an inpatient pediatric setting with allegations of medical neglect, found that reports improved parent cooperation with medical treatment, and the patients' parents did not flee after a report was made.[106] Some of our therapists also used the reporting power to impress upon reluctant or denying clients the effect of their behavior on their children:

> Reporting is a way to acknowledge to parents that your behavior has a very serious impact on how your kids will behave, and there are some things that you have to start taking in a responsible way right now. . . . They are going to have to acknowledge a problem and deal with it instead of denying it.[107]

Some therapists found the report strengthened the therapeutic alliance, or helped the client to focus on abuse issues that had been avoided before:

> We finally got down to some real work that needed to be done. When I think about it, that was sort of the last crisis. Actually, we have been able to deal a lot around her own sexual abuse when she was a child and that [report] was sort of a turning point.[108]

Therapists reported that some children felt relieved that the report was made, and that someone was concerned enough to take action. Some therapists believed the child clients may have learned

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[105] Watson & Levine, *supra* note 91.

[106] Gordon Harper & Elizabeth Irvin, *Alliance Formation with Parents: Limit-setting and the Effect of Mandated Reporting*, 55 AM. J. ORTHOPSYCHIATRY 550, 553 (1985).

[107] LEVINE ET AL., *supra* note 8, at 41.

[108] *Id.* at 40.

trust, or that they did not have to put up with abuse, or that they could safely reveal their plight to another and be protected.

V. Implications for the Concept of Therapeutic Jurisprudence

The major therapeutic purpose of mandated reporting and child protection legislation is to protect children. In keeping with the therapeutic jurisprudence inquiry, we can ask if the law fulfills its purpose. Sometimes the appropriate criteria are less than obvious.[109] Has the reporting law met its purpose of identifying children at-risk and preventing harm to them?[110] Shuman summarizes studies to the effect that the law has failed to meet its therapeutic objectives.[111] Given present knowledge, and the likelihood of obtaining adequate resources to serve children and families, Shuman argues that the state should not assume a duty to protect children, although he does not call for the abolition of child protection efforts.[112]

Protecting children depends on the availability of resources to serve children and families adequately after a case is identified. Protecting children by removing them from the home is problematic. Critics claim children may be at higher risk of maltreatment if they enter foster homes than if they remain in their own homes.[113] Certainly the foster care system is overloaded.[114] That we cannot consider the impact of the law without considering the treatment

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[109] David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Policy Analysis and Research*, 45 U. MIAMI L. REV. 979, 985 (1991) ("[T]he conflicting therapeutic consequences . . . must be identified and defined in ways that can be measured.").

[110] One criterion may be whether fatalities are prevented. The claim that child fatalities have decreased since reporting laws have been in effect is in dispute. Some argue the rate of child fatalities has not changed over the years. Hutchison, *supra* note 6, at 61.

[111] Daniel W. Shuman, *The Duty of the Stateto Rescue the Vulnerable in the United States, in* THE DUTY TO RESCUE: THE JURISPRUDENCE OF AID 131 (Michael A. Menlowe & Alexander McCall Smith, eds., 1993).

[112] *Id.*

[113] WEXLER, *supra* note 60, at 167-68.

[114] *See* U.S. ADVISORY BD. ON CHILD ABUSE AND NEGLECT, OFFICE OF HUMAN DEV. SERV., *supra* note 5, at xiv ("[D]espite the heroic efforts of many foster parents, the foster care system is in crisis.").

resources shows that therapeutic jurisprudence analysis must be extended to consider much more of the context within which the particular law operates, especially if "the law should be designed to serve more effectively as a therapeutic agent."[115]

On the assumption that reporting and investigation has a low cost compared to preventing injury to a child, the law guarantees a high proportion of false positives or unfounded reports. These reports have an emotional cost, a dollar cost, and affect therapeutic process and outcomes. Given the low standard triggering reports ("reasonable cause to suspect"),[116] and the level of due process afforded the subjects of investigations and adjudications,[117] some erroneous determinations are made. These determinations may be leading to some backlash among those who claim they have been falsely accused.[118] Additional costs are the impacts on the confidential psychotherapy relationship, on the therapist and on the client. The therapeutic jurisprudence inquiry centering on the client or defendant without considering the social system may be too narrow.

A great many resources go into investigation. Does the investigation fulfill a therapeutic purpose? In addition to the 60% or more of unfounded cases, a substantial number of cases are indicated and closed on the same day.[119] In some cases services are offered to the family even if the case is closed. The subject of the report may have refused services, and the social services department may not believe that the evidence is strong enough, or the danger to the child is not severe enough, to warrant taking the case to court. In some cases the process of investigation itself, even if the report is

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[115] Klotz et al., *supra* note 81, at 580.

[116] *See* N.Y. SOC. SERV. LAW § 413.1 (McKinney 1992).

[117] *See* Santosky v. Kramer, 455 U.S. 745, 769 (1982) (holding clear and convincing evidence as the standard of proof).

[118] *See* DAVID HECHLER, THE BATTLE AND THE BACKLASH 111-129 (1988).

[119] *See* MURRAY LEVINE & HOWARD J. DOUECK, RESEARCH CENTER FOR CHILDREN AND YOUTH, SUNY BUFFALO, FINAL REPORT, CHILD AT RISK FIELD SYSTEM: FINDINGS FROM ONTARIO COUNTY 29 (finding 70.9% of indicated cases were closed the same day they were indicated); *see also* PERFORMANCE MONITORING AND ANALYSIS UNIT, N.Y.S. DEP'T OF SOC. SERV., MONITORING AND ANALYSIS PROFILES WITH SELECTED DATA: 1987-1991, at 4, 13 (1992) (stating that in New York City, 44.3% of cases are closed at indication, and in the rest of the state the figure is 67.1%).

unfounded, may have some salutary effect on a family, or it may result in some services to the family, although there are many barriers to delivering services to families in need during investigations.[120] The negative impact of investigations have been documented, but we don't have systematic follow up research on how much protection an investigation provides. Research in this field is difficult because under New York State law unfounded cases are expunged.[121] We have very little idea of the rate of re-report in that population. A rule of law designed for one purpose, to protect privacy, acts as a barrier to finding out whether another law is actually accomplishing its purpose.

Whatever the impact of the investigation itself, we are developing evidence that the mandated reporting requirement has both negative and positive consequences for the psychotherapy relationship. Moreover, the mandate to report interacts with other important ethical, if not legal, requirements such as providing information sufficient for the client to make an autonomous decision. Once again, the therapeutic jurisprudence inquiry may be too narrow. We need a broader lens to help identify variables in the social context that interact and help to determine the eventual therapeutic impact of the law in question. The concept of therapeutic jurisprudence carries us a certain distance, but its tenets need expansion if it is to guide research.

The theoretical approaches that have so far characterized much of the therapeutic jurisprudence literature have been very helpful in alerting us to a way of thinking. However, as the example of child protection and mandated reporting illustrates, the consequences of a law may be far reaching indeed. Those who are affected by it have a myriad of concerns and interests that will influence how a rule of law may affect a therapeutic purpose. If we are to attempt to design laws which have therapeutic purposes, we will have to be alert to the maxim that it is always more complicated than it seems. The law on the books is not the same as the law in action. The law in action is shaped by an elaborate social context

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[120] *See* Barbara J. Meddin & Ingrid Hansen, *The Services Provided During a Child Abuse and/or Neglect Case Investigation and the Barriers that Exist to Service Provision*, 9 CHILD ABUSE & NEGLECT 175, 176 (1985).

[121] *See* N.Y. SOC. SERV. LAW § 424 (McKinney 1992).

and therapeutic jurisprudential analysis needs to take the context into account.