

Virtual Mentor

American Medical Association Journal of Ethics
October 2013, Volume 15, Number 10: 834-839.

ETHICS CASE

Pedophilia: Is There a Duty to Report?

Commentary by Fabian M. Saleh, MD, and H. Martin Malin, PhD, MA, LMFT

Dr. Gregory is a third-year psychiatry resident at a large academic medical center. Several months ago, Mr. Green was assigned to his care. A taciturn, overweight, 59-year-old janitor, Mr. Green was admitted to the emergency room with acute alcohol poisoning. He arrived at the hospital after having made a scene at a bar. When he sobered up, Mr. Green explained that he wasn't a regular drinker, but had tried getting drunk because he was so miserable.

Dr. Gregory had a particular interest in dynamic psychotherapy and had been hoping for patients open to that approach. Before discharge, Mr. Green agreed to return to Dr. Gregory's outpatient clinic for help.

Mr. Green was a responsive patient. He pledged never to touch alcohol again and readily admitted that he needed help for depression. In addition to prescribing medication, Dr. Gregory began weekly counseling sessions with Mr. Green. As Dr. Gregory began to earn his trust, Mr. Green shared some intimate details of his past. He had grown up with alcoholic, neglectful parents and had been molested by a family friend when he was a young boy. As an adult, he had no friends and had not had an intimate relationship for more than 2 decades. Dr. Gregory encouraged Mr. Green to be open and trusting. "This is a safe space," he assured him.

Several months into treatment, Mr. Green admitted that he was sexually attracted to little girls. He quickly added that he had never acted on these fantasies. Dr. Gregory reminded him that it was illegal to download pornographic images of children from the Internet. They both acknowledged that it would be catastrophic to act on the fantasies.

Dr. Gregory's acceptance seemed to embolden Mr. Green. Week after week, the conversation was dominated by descriptions of his pedophilic fantasies. More disturbing still, the fantasies all began to revolve around a little girl Mr. Green called "A." Though he spoke about her if she were a real girl, he insisted that she was purely a figment of his imagination.

Despite Mr. Green's insistence that this was fantasy, the specificity of the descriptions and explicit nature of his fantasies caused Dr. Gregory concern that "A" was not a fantasy but a real little girl whom Mr. Green had been watching. But if "A" were indeed an actual child, Dr. Gregory had no idea who she was. A relative? A neighbor? A co-worker's daughter?

Dr. Gregory was unsure what to do about Mr. Green. On the one hand, he had encouraged Mr. Green to be open about his feelings and private thoughts. He had assured him that he was safe. And, as far as Dr. Gregory knew, Mr. Green had never hurt a child. Everyone is entitled to a private fantasy life, Dr. Gregory thought. On the other hand, Dr. Gregory worried that Mr. Green might be a current or potential child molester. Mr. Green was starting to seem obsessed with the idea of “A.” If she were a real little girl, she could be in imminent danger.

Commentary

Dr. Gregory finds himself faced with an increasingly common ethical dilemma in psychiatric practice: how to balance the duty to protect the confidentiality promised to patients with the duty to protect children from a patient he increasingly believes may represent a significant threat.

Reporting

Opinion 5.05 of the American Medical Association’s *Code of Medical Ethics*, recognizing that physicians are impeded in providing appropriate treatment if their patients do not feel safe in disclosing personal information, holds that “information disclosed to a physician by a patient should be held in confidence...subject to certain exceptions which are ethically justified because of overriding considerations” [1]. Such exceptions include threats to inflict “serious physical harm” on the self or others with a “reasonable probability that the patient may carry out the threat” [1]. In such instances, the physician should take “reasonable precautions” to protect the intended victim, including notifying law enforcement. Physicians are further admonished to “disclose the minimal information required by law, advocate for the protection of confidential information and, if appropriate, seek a change in the law” when the law is contrary to the best interests of patients [2].

It would be hard to overstate the importance of the *Tarasoff* decisions with respect to medical ethics in general and confidentiality in particular [3]. The essence of the *Tarasoff* decisions is the dictum that, in conflicts between patient-therapist confidentiality and serious danger to reasonably identifiable others, protection trumps privilege. In his alliterative distillation of this dictum, California Supreme Court Justice Mathew O. Tobriner, for the majority, wrote: “The protective privilege ends where the public peril begins” [4]. It is important to note, however, that, while *Tarasoff* triggered a rash of “duty-to-warn” or “duty-to-protect” statutes nationwide, 16 states have adopted a discretionary approach to those duties and four states currently have no duty-to-warn or -protect statutes [5].

There is considerable congruence between the *Tarasoff* mandate to breach confidentiality in instances of serious threat of physical violence to a reasonably identifiable person and the American Medical Association’s *Code of Medical Ethics* opinion on confidentiality. Ken Kipnis has pointed out, however, that it is an error to infer that because some action is legally required, it is ethically required. Additionally, he warns against “the conflation of personal morality and professional ethics” [6].

Even if Dr. Gregory practices in a state with a Tarasoff-like duty-to-protect statute, it is arguable that not much of Tarasoff applies in Mr. Green's case. There is no reasonably identifiable victim and no serious threat of physical violence as anticipated by the Tarasoff criteria.

While Mr. Green's case currently does not appear to trigger the duty to protect mandated by Tarasoff, Dr. Gregory may have a duty or an ethical obligation to report Mr. Green to a state child welfare or law enforcement agency. In most states, he must make a report if he has a "reasonable suspicion" of child abuse. But what exactly will he report and to whom? He will be unable to identify a child who he believes has been or will be abused by Mr. Green. And while in most jurisdictions reporting in good faith carries with it immunity from suit for breach of confidentiality, Dr. Gregory will want to be certain that he is operating from a standard of practice embraced by his peers.

It seems, therefore, that Dr. Gregory cannot ethically report his fears about Mr. Green to law enforcement. This does not mean, however, that he should simply put his concerns aside. It is important for Dr. Gregory to discuss Mr. Green's case with his direct supervisor, who might suggest consulting with the medical center's risk managers and corporate counsel. It is likely that Dr. Gregory will have signed a document attesting to his awareness of his responsibilities as a mandated reporter as part of his employment agreement with the institution. Furthermore, licensing boards may have required similar attestations. The risk to Dr. Gregory is significant if he fails to honor those agreements.

There is much Dr. Gregory can do to ensure that his professional interactions with Mr. Green remain ethical and responsible.

Clarifying Confidentiality and Privilege

By promising Mr. Green that "this is a safe place," Dr. Gregory has inadvertently misled him. Dr. Gregory must make clear the limits of confidentiality in a psychotherapeutic relationship, including his obligations to protect Mr. Green and others in the event of a credible threat of harm and his special mandate to report suspected child abuse. Ethical practice requires that properly informed consent includes a clear disclosure of the limitations on confidentiality that might apply in Dr. Gregory's state. Mr. Green is entitled to be informed about the risks he incurs should he disclose reportable behavior even though Dr. Gregory assures him that it is safe to tell his story.

Treatment

Once clear boundaries around reporting have been established, it will be important for Dr. Gregory to explore his concern that "A" is an actual child and not just a figment of Mr. Green's imagination as the patient insists. It is not uncommon for clinicians to be so concerned with the legal requirements of mandated reporting that they neglect to question the patient carefully in therapy. Mr. Green's presentation strongly suggests a diagnosis of pedophilia, and denying illegal behaviors is not atypical patient behavior, at least early in therapy. Dr. Gregory will want to continue

scrutinizing the patient's story in the face of his clinical experience and other content in his patient's presentation, such as his detailed description of "A," that suggest that Mr. Green may not be disclosing completely. It will be important for Dr. Gregory to sharpen his interviewing focus and continue to explore discrepancies even if Mr. Green's initial responses are "no."

Dr. Gregory might also consult with or refer the patient to a colleague who specializes in the treatment of paraphilic disorders. Deciding not to report Mr. Green is not equivalent to deciding not to address his sexual fantasies and behavior in treatment; that requires training and a particular skill set that many excellent general therapists do not possess. Mr. Green may, indeed, have been an accurate reporter of his feelings and behaviors in therapy. But even patients who acknowledge sexual arousal towards children may be less willing to acknowledge sexual behavior with children. As a general rule, cognitive-behavioral therapies and relapse prevention strategies, including group therapies aimed at confronting and supporting patients as they struggle with denial, cognitive distortions, and social skills deficits, are helpful for patients like Mr. Green [7]. As an expert in dynamic psychotherapy, Dr. Gregory may not have significant experience with these modalities or the "containment" model for working with paraphilic patients who have abused children or are at risk for doing so.

Protection

Dr. Gregory will want to think about appropriate behavioral restrictions with Mr. Green as a condition of continuing to work with him in therapy. Dr. Gregory has made a start by warning Mr. Green of the illegality of viewing and downloading child pornography and obtaining Mr. Green's agreement that the results of doing so would be "catastrophic" [8]. There are other potential dangers that must be addressed in terms of an overall "safety plan" for Mr. Green. For example, if Mr. Green's job as a janitor involves working in schools or other places where children congregate, Dr. Gregory will want to help Mr. Green understand why he should consider changing jobs. If Mr. Green's job involves such ready access to children and if his symptoms were to become even more intense, an argument can possibly be made that he may be endangering children, thus triggering reporting requirements.

Finally, in view of the disclosures Mr. Green has been making about his pedophilic interests, Dr. Gregory should explore with Mr. Green the possibility of adjusting or modifying his medication regimen with the idea of diminishing his symptoms with the use of a serotonergic or testosterone-lowering agent. Informed consent would need to be obtained prior to treatment with either medication.

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Further Reading

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