Therapists’ Obligations to Report Their Patients’ Criminal Acts

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The law governing the obligation of therapists to report their patients’ previous criminal acts was reviewed. Most often, discussions of this subject fall under the general category of “misprision of a felony,” that is, the presumed general obligation of all citizens to report felonies that come to their attention. Review of federal law revealed that the courts have consistently interpreted the federal misprision statute as requiring active concealment of a crime, not a mere failure to report, in order to convict for the offense. State law is more diverse. Only one state has a general misprision statute labeled as such, and several states have recently repealed such statutes. The strong trend in states without statutes is to reject misprision as a common law crime, because of its incompatibility with modern notions of justice. Most states, however, have limited reporting statutes, such as for child abuse or gunshot wounds, that impose similar obligations. Therapists’ reporting of past crimes may be affected by clinical and ethical concerns, as well as by obligations to protect future victims. In almost all jurisdictions, however, the fear of prosecution for failure to report a past crime should not be a factor in deciding on a course of action.

Is a psychotherapist required to report crimes committed by patients that are brought to light in the course of therapy? Are there special considerations when the crimes involve acts of treason or threats to the safety of the President of the United States? We have been asked these questions dozens of times; they are asked repeatedly at continuing education sessions and raised in the psychiatric literature. Most frequently the answers given are that the failure to report patients’ past crimes—when they constitute felonies, and particularly when they involve threats on the President or other federal officials—may itself be criminal.

Our review of the relevant law leads us to conclude that careful analysis does not support this common response. This conclusion must be distinguished from the conclusion to the closely related, and probably more familiar, issue of whether or not psychotherapists must report patients’ threats of committing crimes in the future, the issue thrust into the limelight by the Tarasoff case a decade ago. While an increasing number of states require psychotherapists to issue a warning about a patients’ intended dangerous conduct (or to take other kinds of steps to prevent it from materializing), there is no similar general requirement as to

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completed criminal conduct, “dangerous” or not, of which the psychotherapist becomes aware. Finally, the issue under consideration here is not whether a therapist may disclose a patient’s confessions of crime, but whether there must be such a disclosure lest the therapist also run afoul of the criminal law. However, if our conclusion that there is no duty to report patients’ confessions of crimes is correct, then the issue arises of whether it is permissible to do so without incurring liability for breach of confidentiality.

The Clinical Setting

The following case example, from the senior author’s consultative experience, demonstrates the situations in which the question of reporting can arise and the complexities often associated with the issue.

Case Example A middle-aged, chronic schizophrenic patient with a fluid delusional system and a preoccupation with publicized acts of violence had been in treatment with the same psychiatric resident for two years. During that time, he had confessed to the doctor his responsibility for numerous crimes, including several murders, that had occurred around the country. As these confessions seemed highly improbable and consistent with the patient’s grandiose delusional structure, the resident disregarded them.

At their most recent therapy session, the patient told his doctor about a murder he had allegedly committed at a rooming house for transients in another part of the city. He provided an unusually detailed description of the crime scene and of the victim. The police, he claimed, were unaware that the murder had occurred. Although the resident had previously shrugged off many similar confessions, this one disturbed her. The patient’s tone was different, the alleged site of the crime was nearby, and he seemed to know too many details of the murder to have simply invented them. Concerned about her obligation to report the patient’s confession, as well as about her responsibility to protect the confidentiality of the therapeutic setting, she sought advice about the appropriate nature of her response.

The particular criminal charges for which psychotherapists are often thought to be at risk when they fail to report their patients’ confessions of criminal activity belong to a class of offenses referred to as “inchoate” crimes and include the crimes known as misprision of a felony and accessory after the fact, as well as the closely related offense of obstruction of justice. These inchoate offenses originated in English common law, were often adopted by American courts and thereby incorporated into American common law, and have sometimes found their way into contemporary American criminal statutes. Because the legal issues raised about therapists’ reporting obligations differ under federal and state law, these bodies of law will be considered separately.

Therapists’ Obligations under Federal Law

Misprision of a felony has been a statutory offense under federal law since 1790. The current statute, which differs little from the original one, defines the crime in these terms:

Whoever, having knowledge of the actual commission of a felony cognizable by a court of the United States, conceals and does not as soon as possible make known the same to some judge or other person in civil or military authority under the United States, shall be fined not more than $500.00 or imprisoned not more than three years, or both.
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The statute was apparently little used for 150 years after its passage. A federal court concluded in the 1930s that only two previous cases had ever reached the appellate level.\(^6\) More recently there has been a flurry of cases decided on misprision, as prosecutors have engaged in some creative uses of the statute.

The rule enunciated in *U.S. v. Farrar*, however, the first case in this century to address the misprison statute, has been accepted in all subsequent cases.\(^4\) Examining the language of the statute, and particularly the portion reading “conceals and does not as soon as possible make known,” the court concluded that the law “requires both concealment and failure to disclose. Under it some affirmative act toward the concealment of the felony is necessary. Mere silence after knowledge of the commission of the crime is not sufficient.” This rule was elaborated in *Neal v. U.S.* into a four-part test for establishing that the crime of misprision had occurred: (1) the principal committed and completed the felony alleged, (2) the defendant had full knowledge of that fact, (3) the defendant failed to notify authorities, and (4) the defendant took an affirmative step to conceal the crime.\(^7\) It seems clear that the therapist's mere failure to report the commission of a federal crime under the Farrar-Neal test would not, in itself, expose the therapist to legal jeopardy.\(^8\)-\(^14\) This would appear to be true regardless of the crime involved, including threats to federal officials and even treason. “Misprision of treason” is addressed by a separate statute, but the wording of the key section “conceals and . . . does not disclose” is the same as in the general misprision statute.\(^15\) We have not been able to find a case in which this latter statute was interpreted by a federal court.

Are there actions of the therapist that might be construed as “concealment” sufficient to bring the therapist within the scope of the federal misprision statutes? First, it is important to note that federal criminal law, as a general matter, has a very limited scope of applicability and is unlikely to apply to most therapeutic situations. In other words, most conduct that is criminal is a violation of state law, not federal law. However, it is conceivable that the actions of a therapist could implicate federal criminal statutes, such as when the patient has committed either a crime against a federal official or treason.

Assuming that there is federal jurisdiction, other questions remain to be answered. Among the actions that have been recognized by the courts as “concealment” are “suppression of evidence, harboring of the criminal, intimidation of witnesses,”\(^6\) aiding in the recovery of stolen money,\(^13\) and holding money that is being used for a bribe.\(^14\) In general, these behaviors lie outside the scope of the therapeutic relationship. Could a psychiatrist who hospitalizes a patient, however, knowing that the patient is fleeing from the law after committing a federal offense, be deemed to be “harboring” a criminal, and thus come within the ambit of the misprision statute? Does the patient's need for hospitalization affect this determination? The cases are silent on this question, but it
may be that a psychiatrist who admitted a patient specifically to aid him or her in escaping detection would in fact come within the ambit of concealment.

Of greater relevance to most psychotherapists is the issue of how to respond to questions posed by law enforcement personnel. At least two federal cases have held that, "Although 'mere silence' is insufficient (i.e., there is no obligation to notify civil authorities) the giving of an untruthful statement to authorities is a sufficient act of concealment to sustain a conviction for misprision of a felony."10,12 Thus, it appears that when therapists respond to investigators' questions, they have an obligation to do so truthfully. There does not appear to be an obligation, however, to say anything at all, and a therapist could respond to an investigating officer without incurring criminal liability by stating that he or she is unable to provide any information because of the confidential nature of the therapist-patient relationship. In the unlikely event that a therapist and a patient had jointly participated in a crime, the therapist would be further relieved from making any statements to investigating authorities on the basis of the therapist's own Fifth Amendment privilege against self-incrimination.9

It is of interest that, as defined by the federal courts, the crime of misprision of a felony becomes almost coterminous with the related crime of being an accessory after the fact. This latter crime has traditionally been defined as the act of "one who, with knowledge of the other's guilt, renders assistance to a felon in the effort to hinder his detection, arrest, trial or punishment."16 One federal court attempted to distinguish the two crimes by noting that an accessory acts with intent to benefit the felon, whereas one who commits misprision technically need not have that intent.17 It is difficult to imagine, however, that a person would be found guilty of misprision in the absence of intent to aid the perpetrator of the crime. However, some state court decisions lend support to the view that both misprision and accessory liability require an intent to aid the perpetrator, thus making them essentially identical crimes.18,19

**Therapists' Obligations under State Law**

Our review of state statutes revealed only one state with a law specifically prohibiting "misprision of a felony." South Dakota, in its misprision statute, departs from the federal example by using a disjunctive rather than a conjunctive test. That is, misprision occurs when a person with nonprivileged knowledge of a crime "conceals the same, or does not immediately disclose such felony."20 Although the wording suggests that mere nondisclosure is sufficient to constitute the crime, we could find no South Dakota cases explicating the statute.

Other states have statutes that are essentially misprision statutes, although not denominated as such. An Ohio statute, for example, entitled "Failure to report a crime or knowledge of a death," states simply, "no person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authori-
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The statute exempts privileged relationships, including “doctor and patient, licensed psychologist or licensed school psychologist and client,” but the Ohio Attorney General has issued an opinion that an evaluator carrying out a court-ordered psychiatric examination does not establish the requisite doctor-patient relationship with the subject of the examination and thus is obligated to report crimes revealed. An Ohio case construing this statute held that a refusal to answer police questions when the police were already aware of a crime having been committed did not constitute misprision; dicta in the decision went so far as to suggest that even “unsworn oral misstatement to the police is not punishable conduct.” Still other jurisdictions may establish what are, in effect, limited misprision statutes by requiring specified professionals, or in some cases the public, to report child abuse, crimes of violence, or treason, under threat of penalty for failure to comply.

It should be noted that the popularity of misprision statutes appears to be decreasing. The Model Penal Code, for example, deletes misprision from its classificatory scheme. Maine repealed its misprision statute in 1975, as did New Jersey in 1978. Interestingly, before the Maine statute was repealed, the state’s supreme court construed its language covering persons who conceal or fail to disclose information of a felony to require that they conceal and fail to disclose. State statutes have generally been construed narrowly. A Louisiana court, for instance, interpreting that state’s now repealed statute, ruled that there was no obligation to report a crime that had occurred in another state. Although under the Model Penal Code there is a crime known as “obstruction of justice,” like misprision it requires the performance of an affirmative act on the part of the therapist before liability can be imposed.

Misprision may be an issue even in states without statutes on the subject because its status as an offense derives from the common law of England. All states have incorporated English common law into their jurisprudence at least to some extent. Although the trend is clearly away from the imposition of liability on the basis of common law crimes, states still recognizing them may include misprision among them. The Rhode Island Supreme Court, for example, has recognized misprision as an indictable offense, though it did not reach the issue of how the crime should be defined, i.e., whether an act of concealment is required. Delaware and Vermont courts accepted the common law crime of misprision earlier in this century, but the current status of those holdings is unclear. The Vermont case limited the scope of the offense by nothing that, “The motive prompting the neglect of a misprision must be in the same form evil as respects the administration of justice”—thus possibly excluding cases in which failure to report is motivated by fear or indifference. Whether a therapist could claim that failure to report was motivated by a desire to keep a patient in treatment, and thus not “evil,” is an interesting but unexplored possibility.
setts Supreme Court later followed Vermont in declaring that if misprision were to be accepted as a common law offense in that state, the crime would require an evil intent. 36

Most of the more recent decisions on the status of the common law crime, however, have rejected misprision as an offense. As early as 1940, the Supreme Court of Michigan determined that, “The old-time common law offense of misprision of felony, short of an accessory after the fact, . . . is not a substantive offense and not adopted by the constitution, because wholly unsuited to American criminal law and procedure as used in this State.” 37

A scholarly opinion in Pope v. State, in which Maryland rejected common law misprision, explored the reasons that the crime does not seem to fit well in American jurisprudence. 18 The court noted misprision’s “undesirable and indiscriminating width,” commenting that knowledge of a crime may be acquired quite involuntarily from close friends whom one would be loath to betray. Further, the actor is required to make subtle and sophisticated judgments to escape liability, such as (1) whether the offense is a felony (and therefore reportable) or a misdemeanor (which need not be reported) and (2) when his or her knowledge reaches a sufficient level of certainty that a report is required. The latter may be a particular problem in the therapeutic context, as in the case example, where, under a common law definition of misprision with no act of concealment required, the therapist must judge when a schizophrenic patient’s confused, delusional ramblings present certain enough evidence of a crime to require reporting. There appears, in addition, to be no common law limitation regarding reporting of crimes that occurred many years ago. Summing up, the Pope court concluded, “We believe that the common law offense is not acceptable by today’s standards.”

Courts in Nevada and Florida have also rejected a common law basis for misprision in the recent past. 19, 38 In the words of the Florida court, “While it may be desirable that we encourage citizens to get involved to help reduce crime, they ought not be adjudicated criminals themselves if they don’t . . . . We cherish the right to mind our own business when our own best interests dictate.”

To summarize the situation under state law, few states have statutes addressing misprision of all felonies, although most states require reporting of child abuse, gunshot wounds, or other specified evidence of crimes. Even states with reporting statutes frequently exempt privileged relationships, such as that between a doctor or psychotherapist and patient. In jurisdictions without statutes, the strong trend has been for courts to reject the common law crime of misprision. Thus, although absolute certainty is impossible, it seems very unlikely that a therapist, particularly if acting for some beneficient end, need worry about facing a charge of misprision or a related criminal offense.

**Discussion**

Misprision of a felony has long been a legal anomaly. Dating back to medie-
val times in England, when the Norman conquerors placed obligations on their captive populace to help deter crimes against the hated rulers, misprision represents a rare exception to Anglo-American law’s reluctance to place affirmative obligations relative to the conduct of others on individual persons. The crime has rarely been invoked even in England. An affirmation of the common law validity of the offense by the House of Lords in 1966 was followed quickly by legislation abolishing it.

Reported cases in this country, especially in the federal courts, suggest that misprision usually has been used in an effort to punish persons who have acted at the margins of a criminal endeavor but who could not be charged as a principal in the crime itself. Whatever independent utility the crime may have in such circumstances has been largely vitiated by the requirement by the federal courts that active concealment have taken place.

It is of interest that misprision is losing much of its residual popularity at a time when a new class of affirmative obligations to control others’ conduct—embodied in the duty to protect, as enunciated in Tarasoff—is being imposed on psychotherapists. This discrepancy relates to the frequently divergent trends in tort law and criminal law, with the former’s increasing emphasis on compensating victims, and the latter’s concern with protecting defendants’ rights.

In any event, the concern of psychiatrists and other therapists about possible legal risk simply for failing to report crimes admitted to them by their patients is, in almost all cases, unwarranted. Although good arguments could be made for exempting psychotherapists from a general obligation to report past felonies, no such general obligation exists. American law at the federal and state levels rejects the imposition of criminal liability for mere failure to report a crime and requires overt assistance rendered to a felon for there to be a criminal offense.

What are the appropriate parameters of a therapist’s behavior when a patient reveals that a serious crime has been committed? Although reporting a patient’s crime is probably not required, that conclusion does not respond to the related question of whether reporting of such a crime is permissible. Physicians, including psychiatrists, have at times been subject to pleas to reveal patients’ illegal behavior for the sake of the general welfare. It must be kept in mind that reporting a patient’s confession of a crime is a breach of confidentiality. If reporting were mandatory, this would clearly serve as a defense to any potential civil liability to the patient arising from the breach of confidence. However, when reporting is not mandatory, the possibility of a civil suit cannot be discounted.

As a practical matter, permissive reporting of a patient’s past criminal activity is unlikely to result in liability for breach of confidentiality if the patient has in fact committed the crime and is convicted of it or pleads guilty to it. This is not to say that “truth” is a legally recognized defense to a lawsuit for breach of confidentiality, but only that
a jury is likely to be far less sympathetic to a convicted criminal. If, as was true in the case example, the patient has not in fact committed the crime, but there are reasonable grounds to believe that he or she has, the therapist who reports is on weaker, but probably still firm, ground. Thus, before reporting, the psychotherapist is well advised to be as diligent as possible in determining the validity of the patient’s confession.

From an ethical perspective, there might be circumstances in which the therapist may feel an obligation to notify the authorities. If the commission of a past crime provides reason to believe that the patient may commit a future violent act, therapists may feel an obligation to take measures to protect future victims. In states that have adopted a Tarasoff-like duty, the failure to fulfill this ethical obligation can leave therapists liable for harms suffered at their patients’ hands. It should be noted, however, that protection can be afforded potential victims (e.g., by hospitalizing a psychotic patient) without necessarily reporting the previous crime or breaching confidentiality in some way.

If the patient confesses to a crime for which someone else has been convicted and sentenced, the clinician may also feel compelled to reveal his patient’s guilt. This obligation might be analogized to the duty to protect potential victims of violence, as in this case an actual victim is suffering significant harm as a result of the patient’s failure to admit his crime. Whether the courts would support such an analogy in a civil suit by a prisoner against a psychiatrist who failed to reveal that his or her patient had actually committed the crime for which he was serving time is a speculative, but intriguing, possibility.

Reporting of a patient’s confession in both these cases would appear to be sanctioned by the Principles of Medical Ethics. Annotation 8 to Section 4 of the Principles permits the release of confidential data “in order to protect . . . the community from imminent danger.” On the other hand, revelation of a crime merely because the psychotherapist is repelled by the type or magnitude of the act (e.g., rape, murder), when future dangerousness is not at issue, would not appear to be sanctioned by the Principles, which permit release of “confidential information only with the authorization of the patient or under proper legal compulsion.”

The use of the information once the therapist reveals it may also be complicated by other issues. In some states with very stringent psychotherapist-patient (or physician-patient) privilege statutes, a patient’s confession to the therapist may be rendered inadmissible in a criminal prosecution. Further, if the statute of limitations on prosecution of the patient’s crime has expired, the patient may escape any sanctions for his act.

Clinically, the ideal way of handling any case in which the therapist believes that the patient’s past behavior should be revealed involves the therapist raising this as an issue in the therapy, explaining the basis for his feelings and encouraging the patient to report the crime himself (preferably after obtaining legal repre-
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servation) or to grant the therapist permission to report the crime, much as might be done if the patient were threatening to commit a crime rather than confessing one already committed. If the patient refuses both options, the therapist may decide to breach confidentiality unilaterally, to preserve confidentiality and continue with treatment, or to terminate treatment because he or she feels unable to continue working with a patient who is concealing a major crime.

In the case example described above, the therapist, who had no legal obligation to report her patient's confession, was sufficiently concerned that, after consultation, she persuaded the patient to contact the police. They confirmed that they now knew of the murder and brought the patient in for questioning, but ultimately concluded that he had not been involved.

In conclusion, factors other than concern about prosecution for misprision should ordinarily determine the behavior of therapists whose patients have revealed the commission of a serious crime.

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