

Confidentiality in the treatment of adolescents

Learning Objective: To gain a framework for understanding and applying rules of confidentiality as they apply to the treatment of adolescents.

Q: *I work with adolescents, and am not clear about my ethical obligations concerning confidentiality. When treating young children, the issue rarely arises. With adolescents, though, I sometimes struggle with whether to share information with a parent. The issue seems especially pointed when adolescents talk about activities that, while not necessarily dangerous, are illegal, such as shoplifting, the recreational use of alcohol or experimenting with drugs. What to do when an adolescent becomes sexually active, of course, is often a difficult issue. Does the APA Ethics Code provide guidance?*

A: It is most helpful to consider this question from three perspectives: that of law, of clinical practice and of ethics.

The law. The law is a blunt instrument, as the issue of minors and confidentiality well illustrates. Minors generally cannot consent to treatment; a parent or guardian consents on the minor's behalf. There are exceptions. Certain states allow minors whom the law deems especially mature, such as those who are married or in the armed services, to consent to treatment, and sometimes minors may consent to treatment for substance abuse or sexually transmitted diseases. The exceptions are few, however, and prove the rule that the law deems individuals under a certain age (often 18) not sufficiently mature to make treatment decisions.

A parent who consents on the minor's behalf generally has the right to know the content of the child's treatment. This state of affairs changes when the minor reaches the age of majority. Until that time, the law will normally give the parent access to the child's treatment.

Clinical practice. From a clinical perspective, the situation is more complex. An important aspect of treatment is to foster an individual's autonomy, and a great pleasure of treating adolescents is to watch as they come to enjoy their growing independence. One aspect of independence is privacy. As a child grows into adolescence and adulthood, the surrounding zone of privacy should increase, thus making room for a more defined sense of self and a greater sense of autonomy. A paradox thus arises: Good clinical treatment may require what the law generally refuses, that is, a zone of privacy.

Consider the following vignette (identifying information has been changed):

Michael, age 8, developed headaches and other signs of anxiety around visits to his father, who divorced his mother several years earlier. Michael's mother, to support Michael's relationship with his father, adhered to the visitation plan strictly, but her son's anxiety and physical complaints worried her. At the outset of psychotherapy, Michael's mother and his therapist had frequent telephone and in-person consultations. Michael's mother wanted help in deciding whether Michael should go for each scheduled visit. Telephone contact between mother and therapist continued

while Michael was in middle school, but lessened as Michael began to feel he had more control over the nature and timing of visits. As the therapy progressed, contact between Michael's mother and his therapist occurred only as needed.

Michael wished to continue therapy in high school, but did not want his mother involved and did not want his therapist and mother speaking unless he were included in the conversation. In his junior year, Michael began to experiment with drugs at all-night parties ("raves") attended by his high school classmates, which he was able to attend by telling his mother he was spending the night with a friend. On several occasions he and a friend shoplifted snacks from a local 24-hour convenience store. Michael's first sexual experience occurred when, after a rave, he followed home a girl whom he had recently met and entered her bedroom through a window. They did not use protection. Michael insisted that his mother not hear any of this. Michael's therapist shared her concerns with Michael about these activities and about what she perceived to be his excessive fear that his mother "couldn't know anything about" these activities. Still, she struggled with whether she had an obligation to disclose something to Michael's mother.

Ethics. Can our Ethics Code ease the apparent tension between law and clinical practice?

Standard 4.01, "Structuring the Relationship," states that "Psychologists discuss with clients or patients as early as is feasible in the therapeutic relationship...the nature...of therapy, fees, and confidentiality." Standard 4.02, "Informed Consent to Therapy," states that when an individual cannot provide informed consent (such as a minor), psychologists "consider such person's preferences and best interests." Standard 4.03, "Couple and Family Relationships," states that psychologists "attempt to clarify at the outset (1) which of the individuals are patients or clients and (2) the relationship the psychologist will have to each person."

Three points emerge. First, early in the relationship the psychologist should make clear what relationship she will have to each of the parties. Second, central to that early discussion should be an explanation of how information-sharing will work--what information will be shared, with whom and when, in a manner appropriate to the child's age and understanding. Third, as the child develops, the structure of the therapy may change for clinical reasons. Thus, the changing *clinical* picture will have *ethical* implications. The child's greater sense of self and enhanced capacity for autonomy may require greater respect for the child's need for privacy. The psychologist will thus need to revisit earlier discussions and explain that, for clinical reasons, the structure of the therapy should change. Such boundary renegotiation, while complex with certain adolescents and families, is clinically and ethically indicated.

Consider also three standards under "Privacy and Confidentiality." Standard 5.01 states that psychologists discuss with their patients "the relevant limitations on confidentiality," 5.02 that psychologists recognize "confidentiality may be established by law," and 5.05 that psychologists disclose confidential information without consent "(1) to provide needed professional services...(3) to protect the patient or others from harm." These ethical standards again recommend several points. First, while it is clinically and ethically indicated to make clear how the relationship is structured and how information will be shared, a psychologist *cannot promise* a minor that information will be kept from a parent who has legal custody. A parent

with the legal right to treatment information may choose--however counterproductive in the psychologist's eyes--to exercise that right.

Second, clinical judgment will indicate to what extent maintaining an adolescent's privacy is central to the treatment. It may be, for example, that an adolescent has conflicting wishes about keeping information private. A psychologist may conclude that an adolescent's wish not to have information shared reflects an appropriate separation and so should be honored. Or, a psychologist may conclude that sharing certain information would be helpful; if so, the ethical standards from the section on "Privacy and Confidentiality" give the psychologist permission to do so.

Third, few things carry such potential to disrupt a treatment as an adolescent's feeling that information was shared without his or her knowledge. Regardless of whether an adolescent assents to have information disclosed to a parent, it makes both clinical and ethical sense to tell the adolescent--beforehand, if possible--what information will be shared, and when. Ideally, the adolescent would be part of such conversations.

Fourth, at times a psychologist will be mandated to disclose information. Serious threats of harm must be disclosed in many states. Neglect or abuse falls under mandatory reporting laws. The extent to which the psychologist explains the limitations on confidentiality will depend on the child's age and maturity. Certainly, however, adolescents should be told that serious threats of harm to self or others will not be kept confidential.

Fifth, many of the activities adolescents engage in do not rise to the level of reportable behavior. Nevertheless, some are on the edge and require judgment calls. For this reason, psychologists who treat adolescents will want to have a good working knowledge of mandatory reporting requirements and to be liberal in their use of consultation.

Finally, a psychologist may feel strongly that revealing information to a parent could harm the patient or be destructive to the treatment. A refusal to disclose in such a case, even in the face of a parent's request, may be legally supportable. A psychologist in this position should seek both legal counsel and consultation from colleagues.

Michael's therapist used these points as a guide. When Michael reached high school and expressed a wish that the therapist not speak with his mother, the therapist revisited the issue of confidentiality. A compromise was reached whereby the therapist would speak to Michael's mother only with Michael present. The issue of confidentiality became more complicated during Michael's junior year, when the therapist felt that certain information should be shared and Michael refused. The therapist gently explored with Michael the reasons behind this refusal. During some sessions, the therapist was direct with Michael about her discomfort with his behavior, especially the illegal activities, and pointed out the kinds of risks he was taking. Over time, Michael and his therapist agreed that Michael himself would begin to speak to his mother about these issues, and that the therapist could follow up with a phone call. At this juncture in Michael's development, it was important to discuss each and every contact between therapist and mother thoroughly with Michael, as well as to support his independent use of psychotherapy.

Ethics Rounds

Release of test data and the new ethics code

Learning Objective: To understand the ethical underpinnings of the Ethics Code's standard on release of test data.

The Ethics Code Task Force balanced competing values in revising an ethical standard.

Print version: page 90

A good ethics code serves as an arbiter when primary values conflict. Primary values are those values that are inherently good. Examples of primary values in psychology are safety, confidentiality, advancing science and fairness. As psychologists, we unequivocally endorse each of these values. The "General Principles" section of APA's Ethics Code sets out and describes our primary values.

An ethical dilemma arises when two primary values conflict. When a patient poses a threat of danger to himself or to another, for example, an ethical dilemma arises because the psychologist may have to break confidentiality in order to protect safety. The psychologist cannot give priority to both confidentiality and safety; one value must yield to the other. When a social psychologist engages in deception research, an ethical dilemma arises between the values of truthfulness and advancing science; truthfulness yields to the advancement of science in this very circumscribed context and under the very specific conditions set out in the code.

In writing the new code, the Ethics Code Task Force addressed an ethical dilemma posed by the release of test data. The dilemma, like all ethical dilemmas, arose by virtue of a conflict between values. While this dilemma is complex and implicates various values, a clear conflict arises between Beneficence (doing good; General Principle A), on one hand, and Respect for People's Rights and Dignity (General Principle E), on the other.

Beneficence is implicated by virtue of how the term "test data" is defined. Note how the definition will sometimes include what otherwise would be defined as test materials, such as test questions or test items. When, for example, an individual's responses are placed on a scoring sheet, then that scoring sheet, which was formerly "test materials," now becomes test data, which psychologists provide "pursuant to a client/patient release." The release of test materials may, at times, compromise a test's validity and render the test less useful to individuals who are then inappropriately exposed to the test items. To the extent that the integrity of the test is compromised, a psychologist's ability to do good may be compromised as well.

Respect for people's rights and dignity is implicated because Principle E calls for psychologists to "respect...the rights of individuals to...self-determination." Respecting the right to self-determination entails promoting an individual's right to exercise autonomy. Promoting autonomy entails providing the individual with information related to their mental health, such as test data, that the individual desires and requests.

The Ethics Code Task Force exercised its responsibility to arbitrate between these conflicting values in order to resolve the dilemma: The task force gave priority to self-determination. This decision--to give priority to the exercise of client autonomy over beneficence--is consistent with trends in the law and ethics over approximately the past quarter-century, a trend seen on the federal level, in HIPAA, and on the state level, in state statutes and court rulings. Put another way, the movement in both law and ethics over the past two decades has been toward an expansion of client autonomy, notwithstanding what may be in the patient's best clinical interest. The work of the APA Ethics Code Task Force in revising the code is consistent with, and firmly in the context of, this trend, which can be seen in laws that give greater client access to records.

Assigning priority to one value--self-determination in this case--does not completely resolve an ethical dilemma, however. Because a dilemma arises when inherently good values conflict, resolving the dilemma entails preserving as much as we reasonably can of the value that did not receive priority. In the context of test data, preserving beneficence entails taking steps to limit the distribution of test items or questions. In this manner, psychologists who release test data pursuant to a client release (and thus promote client self-determination) preserve their ability to do good (beneficence) by taking steps to ensure that individuals are not inappropriately given access to the test, so that the integrity of the test is not compromised any further than is necessary.

Concrete steps available to psychologists seeking to protect test integrity include asking a court to issue a protective order (when the court orders that certain material not be disclosed to parties not involved in a legal matter) and requesting a letter of agreement (that the individual to whom the test data is released not further distribute the data). Psychologists may also consider asking the client to discuss the reasons for the request to release test data (often such a discussion will allay the need to provide the data) and offering to send the test data to a psychologist of the client's choosing, so that another professional will have control over the data. Note that these steps, taken in the context of our obligation to provide test data pursuant to a client's release, are intended to promote client self-determination and at the same time, by protecting the integrity of psychological tests, preserve as much of our ability to do good (beneficence) as we reasonably can.

While the psychologist cannot make the client agreeing to any of the steps above a condition of release, it is important to remember that Standard 9.04, "Release of Test Data," contains two discretionary exceptions, the first of which involves substantial harm to the client. By virtue of this exception, the standard serves both to promote client self-determination and protect a client from harm. In the language of ethical dilemmas, the task force determined that protecting a client from substantial harm is more important than promoting client self-determination. Ethical standard 9.04 thus negotiates between competing values by first giving priority to self-determination over beneficence and then, through an exception, giving priority to nonmaleficence over self-determination.

Psychologists, especially those whose work involves psychological testing, are highly concerned about protecting the integrity of our instruments and tests, a concern that has clear ethical aspects. The APA Ethics Committee and Office are therefore very interested in helping psychologists protect test integrity as psychologists adhere to the new release of test data standard.

Future "Ethics Rounds" columns will offer practical suggestions for psychologists who release test data pursuant to Standard 9.04, and we hope to work collaboratively with test publishers in this regard, whose strong interest lies in protecting the integrity of tests as well.

9.04 RELEASE OF TEST DATA

(a) The term test data refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of test data. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

ETHICS ROUNDS

Diagnoses, record reviews and the new Ethics Code

Learning Objective: To examine ethical aspects of diagnoses, including diagnoses rendered on the basis of record reviews.

Ethical Standard 9.01 guides psychologists in rendering diagnostic opinions.

Print version: page 80

The November 2004 "Ethics Rounds" column commented upon ethical Standard 9.01, Bases for Assessments. In response, a reader has asked whether it is acceptable for psychologists to diagnose an individual solely on the basis of a record review, without an examination. Heartened to know I have a reader, I devote this entire column in reply.

Considering values

A good starting point is to reflect upon our values as psychologists and to consider the significance of rendering a diagnosis. The Preamble to the Ethical Principles of Psychologists and Code of Conduct--our Ethics Code--states that the code has as a goal "the welfare and protection of the individuals and groups with whom psychologists work." Principle A, Beneficence and Nonmaleficence, exhorts psychologists "to benefit those with whom they work and take care to do no harm." Promoting welfare and safeguarding from harm are thus values central to our profession. Rendering a diagnosis has direct relevance to each.

Rendering diagnoses

The word "diagnosis" comes from the Greek word "to know." A diagnosis reveals something about an individual that a psychologist has special expertise in knowing. In few areas of practice does a psychologist exercise greater authority and influence than to render a diagnosis, for in so doing the psychologist comes to know and convey information that may profoundly affect that individual's life.

A diagnosis has clinical, personal and social significance. In the clinical context, a diagnosis reveals the nature of an illness. A correct diagnosis provides a basis for effective treatment. An incorrect diagnosis may delay or impede effective treatment or even exacerbate a situation by inviting inappropriate treatment. A diagnosis has personal significance insofar as it can become central to how a person experiences him- or herself. While a correct diagnosis of a severe disorder can be enormously difficult to integrate into one's sense of self, an incorrect diagnosis can be crippling. A diagnosis is also a label to which others respond and thus has profound social implications. Social judgments are made in response to a diagnosis of mental illness, and diagnoses can play an important role in awarding entitlements and determining placements. A diagnosis asserts itself on multiple levels of experience.

Rendering a diagnosis can be a complex process. Consider, for example, that psychotic experiences are part of multiple diagnoses. The treatment for an affective disorder with psychotic features, a schizophrenic disorder, a post-traumatic stress

reaction, a severe personality disorder and a substance abuse disorder can vary dramatically; yet, psychotic processes may be present in each. Making the correct diagnosis will depend on the psychologist engaging in a thoughtful and competent process and often requires having sufficient time and opportunity to interact with an individual in order to differentiate among various possibilities.

Record reviews and the code

In the new APA Ethics Code, Section 9, Assessments, begins with standard 9.01, Bases for Assessments, which speaks directly to the foundation for diagnostic statements:

9.01 BASES FOR ASSESSMENTS

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

Consider three points about diagnostic statements made solely on the basis of a record review. First, a good record will almost certainly contain considerable information directly relevant to diagnosis. Psychologists may review the record and offer statements such as "This record is consistent with the diagnosis" or "Aspects of the record do not support this diagnosis." Given that psychologists render diagnoses on the basis of multiple sources of data, using the record as one data source is highly appropriate.

Second, in using multiple sources of data to render a diagnosis, psychologists inevitably make judgments concerning the quality of their data. In certain settings, psychologists can assess the reliability of the data source, for example, when the source is a supervisee or other members of a treatment team. In these instances, the psychologist can interact with other mental health professionals and, by extension, with the individual being diagnosed. Rendering a diagnosis thus becomes an interactive process, whereby the psychologist is able to assess directly the extent to which information relevant to the diagnosis can be relied upon and gather additional information if necessary.

Using a record as the sole basis for a diagnosis is a more static process. There may be limited ability to assess the quality of the data in the record and no opportunity to explore aspects of the record that are ambiguous or incomplete. If psychological testing is part of the record, there may be little evidence concerning whether the testing was done under standardized conditions and can be relied upon in making the diagnosis. A diagnostic process based solely on a record review thus potentially presents significant limitations.

While each clause in Standard 9.01 offers concrete guidance to psychologists making diagnoses from whatever source, clause (b), which addresses situations "in which an examination is not practical," speaks directly to the limitations inherent in record reviews. Under clause (b), psychologists clarify the probable impact of their limited information and appropriately limit their conclusions. Psychologists rendering diagnostic opinions solely on the basis of a record review therefore think through and make explicit how the absence of an examination affects their conclusions--and limit their diagnostic statements accordingly. Note how, through its limiting language, clause (b) emphasizes the centrality of an examination in the diagnostic process.

Under clause (c), psychologists make a preliminary determination that an examination is not warranted or necessary. In the case of a record review, it is helpful to read this phrase in clause (c) in conjunction with clause (a), which says that psychologists base their opinions on "information and techniques sufficient to substantiate their findings." Thus, to make a diagnostic statement solely on the basis of a record review, psychologists must first determine that the information they have, and the techniques used to gather that information, are adequate to support their findings. Only when this determination has been made could the psychologist conclude that an examination is not warranted or necessary for the opinion.

The Ethics Code exhorts psychologists to use their influence to do good and to avoid harm. Standard 9.01, Bases for Assessments, gives specific guidance for psychologists rendering diagnostic opinions, an area of practice where our profession's influence is most keenly felt. Offering a diagnosis based solely on a record review raises special considerations and unique challenges with great ethical significance. The spirit of the Code, embodied in the language of Standard 9.01, focuses on the quality of the data and processes we use to render judgments that affect the lives of others.

Ethics Rounds

Record-keeping under the new Ethics Code

Print version: page 72

Learning Objective: To understand how the Ethics Code addresses record-keeping.

The following question comes to the APA Ethics Office: The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule creates a category of records, "psychotherapy notes," that it defines as notes "documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record." Given that HIPAA affords psychotherapy notes heightened protection from disclosure to third parties, such as insurance companies, do psychologists have an ethical obligation to keep psychotherapy notes?

This interesting and thoughtful question raises the broader issue of how the Ethics Code addresses record keeping. The first ethical standard in section six, "Record Keeping and Fees," provides one of the few instances in which the code explicitly states its reasons for a rule:

6.01 DOCUMENTATION OF PROFESSIONAL AND SCIENTIFIC WORK AND MAINTENANCE OF RECORDS

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law.

Note how Standard 6.01 gives different categories of reasons. From the moment a psychologist begins to practice, he or she will develop an approach toward record-keeping. The code invites psychologists to think through their approach in an explicit and organized manner.

In the treatment (as opposed to research) context, the reasons for keeping records set forth in Standard 6.01 could be framed as clinical, organizational, legal, risk management and reimbursement. From a *clinical* perspective, keeping a record provides a history that a treating psychologist can review to further the treatment and help meet the client's clinical needs. Psychologists vary widely in their clinical use of a record; some take detailed notes, others are sparse in their approach. Also, from a clinical perspective, a record may significantly facilitate the work of a subsequent treating psychologist when the opportunity or necessity of another treatment arises.

From an *organizational* perspective, keeping a record may facilitate the efficient and effective administrative provision of services, for example, in a setting where the

organization, rather than a specific treater, is considered the provider or is responsible for ensuring that clients receive the services to which they are entitled.

From the perspective of *reimbursement*, an accurate record allows the party responsible for payment to confirm the nature and dates of services. The specific payment context--managed care, Medicaid, or private insurance, for example--may have its own record-keeping requirements.

From a *legal* perspective, state or federal law may require that a record be kept. What the law requires varies according to jurisdiction. Some states are nearly silent on the issue, while others are specific in what a record must contain (see Kansas regulation 102-1-20 at www.ksbsrb.org/psychologists.html, for an example of greater specificity). Other states explicitly allow a psychologist not to keep a record under certain circumstances (see for example Washington state regulation 246-924-354(g), at www.leg.wa.gov/wac). It is interesting to note that often the actual requirements of statutes and regulations are minimal, and it can be very useful for psychologists to acquaint themselves with their jurisdiction's record-keeping requirements.

From a *risk management* perspective, keeping a record may be the standard of care. Also, documenting one's thoughtful and reasonable work may protect the psychologist in an ethics committee, licensing board, or court proceeding, should an action against the psychologist arise. Some courts have held that for the purposes of litigation, a fact finder may assume that the record reflects the totality of service provided; from this perspective, what is not documented did not occur. Thus, keeping a record may help minimize the psychologist's exposure to legal or ethical liability.

At the beginning of a career and periodically along the way, it can be very useful for psychologists to think through and refine their own philosophy of record-keeping. Psychologists may want to examine each of the perspectives above in turn, insofar as each consideration will become part of that philosophy. As part of this process, each psychologist must determine how these perspectives are best integrated with one another and into the psychologist's practice, and how they are weighted in the context of jurisdictions, practice settings, and payment contexts that have considerable variability in what record keeping they require. Some psychologists, for example, may write with risk management primarily in mind, others with clinical considerations primarily in mind, still others with meeting their jurisdiction's record-keeping requirements as a primary motivation. However a psychologist assigns priority to these considerations, the point is for the psychologist to think through what works best for his or her particular practice.

It is important to recognize and acknowledge time as a significant limitation on record-keeping. Many psychologists simply do not have the time to create the records they would like, and a lack of time may result in a minimalist approach. In addition, assigning priority to one consideration may mean less emphasis on another. For example, writing primarily from a risk-management orientation may mean that the record is less valuable from a clinical perspective. Again, over time each psychologist will develop and refine a record-keeping philosophy that makes sense given the psychologist's personal preferences, setting and practice.

HIPAA defines psychotherapy notes as notes kept separate from the medical record that document or analyze the contents of conversation and that do not contain "medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date" (see HIPAA section 164.501; www.cms.hhs.gov/hipaa). Using the Ethics Code as a guide, the psychologist who posed the question for this *Ethics Rounds* might consider whether, given his record-keeping philosophy, he will keep notes that document and analyze conversations from his sessions--sometimes referred to as process notes--and if he chooses to do so, whether he will keep the notes separate from the medical record so as to afford them the greater HIPAA psychotherapy-notes protection. (The psychologist will remain mindful of what record-keeping requirements the particular jurisdiction and organizational setting may have.) Because HIPAA does not require that psychologists keep psychotherapy notes, the focus of our ethical analysis now turns to Ethical Standard 4.02, according to which psychologists discuss with their clients the limits of confidentiality:

4.02 DISCUSSING THE LIMITS OF CONFIDENTIALITY

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality...

The Ethics Code makes clear that record-keeping is not an end in itself. Rather, keeping a record serves multiple goals. The more a psychologist has examined the reasons behind keeping a record and has considered how those reasons fit together when applied to his or her own practice, the more likely it is that the record will convey a coherent, useful history of the treatment--a history that will serve both the psychologist and the patient well.

Ethics Rounds

Must a psychologist report past child abuse?

Learning Objective: To gain a framework for analyzing the relationship between law and the APA Ethics Code in the context of mandatory child abuse reporting.

Q: I am a psychologist who works mainly with adolescents and young adults. This fall I began treating a 20-year-old woman who came to therapy because of difficulties she was experiencing in an intimate relationship. My patient disclosed that when she was 12, an uncle who had come to stay with the family for several weeks sexually molested her on a number of occasions. My patient reports that I am the first person she has told that her uncle "messed with" her and that were anyone in the family to learn what happened a major and perhaps irreparable rift would inevitably result. The uncle has since moved to a distant part of the state and for the last several years my patient has been able to make plans to be away when he visits.

I have attended workshops in ethics and law in which mandatory reporting requirements have been discussed. But I am uncertain--do mandatory reporting laws apply when a patient reports abuse that occurred many years ago and when there is no further contact between the alleged perpetrator and the victim? What is my ethical obligation? Is there a difference between my legal duty and my ethical duty?

A: Ethics means thinking about reasons in terms of values. The values of our profession are set forth most clearly in the Ethical Principles of Psychologists and Code of Conduct (APA, 1992)--our ethics code. As Ethical Standard 5.02 states, "Psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work...." At times, the value of confidentiality will conflict with other important values. Such a conflict may arise when a psychologist receives information concerning child abuse--information that may be helpful or necessary to stop the abuse and protect the child.

Society has made a value choice. The value of protecting a child, who may be dependent and vulnerable, and so not able to protect him- or herself, outweighs the value of confidentiality. Thus, confidentiality yields to the value of protecting society's most innocent, vulnerable and dependent members. This value choice is expressed through mandatory reporting laws for child abuse. These laws require that when a psychologist receives information concerning child abuse, the psychologist must disclose the information to a state agency. Mandatory reporting laws are thus the mechanism by which society's value choice is put into practice.

The law often paints with broad brush strokes. As a consequence, the exact contours of a legal mandate are not always entirely clear. Mandatory reporting laws illustrate this feature of law well.

Mandatory reporting laws often state that a psychologist must report when there is "reasonable cause to suspect" that a child is the victim of abuse or neglect. While many laws define what constitutes "abuse" and "neglect," few indicate in their

language how far into the past the mandate to report extends. The language of the law and common sense establish certain boundaries: Current physical or sexual abuse falls under the law and requires a report; abuse that occurred 25 years ago at the hands of an individual who's long since passed away does not. Between those boundaries lies a good deal of gray.

Five points may be helpful for practitioners who find themselves in a gray area:

First, review your state's mandatory reporting statute, which is probably available online, to see whether it contains time limits. Minnesota's statute, for example, states that a psychologist must report abuse when the psychologist "knows or has reason to believe a child...has been neglected or physically or sexually abused within the preceding three years." Washington's statute states that the mandate "does not apply to the discovery of abuse or neglect that occurred during childhood if it is discovered after the child has become an adult." The statute adds that the psychologist must nevertheless make a report, regardless of whether the child has become an adult, "if there is reasonable cause to believe other children are or may be at risk of abuse or neglect by the accused." Knowing the language of your state's law can be very helpful in assessing whether you have a duty to report.

Second, many state child protective agencies will provide consultation concerning whether a report is required. It may be possible to call child protective agencies, without providing your name, to present your particular situation, ideally to a supervisor, and ask for an opinion concerning whether the situation mandates a report. The person you speak with should be aware of any agency regulations that are relevant to your question. Be sure to document the call and the name of the individual with whom you speak.

Third, share your anxiety. Pick up the phone and call a trusted colleague or someone with expertise in law and ethics. Many state licensing boards are very helpful in this regard. Many local and state psychological associations provide ethics consultation, as does the APA Office of Ethics. Your malpractice carrier may prove an excellent resource. Although you may feel very alone, you are not. Use the resources available to you and document that you have reached out for professional advice.

Fourth, be mindful that mandatory reporting laws protect psychologists who make reports in good faith. If you are inclined to make a report, your state statute will almost certainly shield you from liability, including a claim for breach of confidentiality, for doing so. The reason has to do with values: When it comes to child abuse, society is more concerned with protecting the innocent and vulnerable than preserving confidentiality. Mandatory reporting laws reflect this value choice by containing protections for psychologists who act in good faith to safeguard a child who may be at risk.

Fifth, don't be harsh on yourself for not knowing the answer. We like the law to draw clear lines, and sometimes it does. Speed limits are a good example. But many times the law speaks less distinctly. When the law does not provide clear guidance, it's important to recognize that the problem lies not with what a psychologist knows or does not know, but rather with how the law is written. The trick is to find resources and have a thoughtful process for determining what to do.

The five points above will help as you decide whether your situation falls under the mandatory reporting law. If yes, the appropriate next step is to file a report. While a client may object to the disclosure of information, a psychologist can explain that the law leaves no room for discretion in this instance.

What are your ethical obligations?

A question arises: If you are not *legally* mandated to file a report, what *ethical* obligations might you have? Ethical Standard 5.05 states that "Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose...." One can think of Ethical Standard 5.05 as having three doors, one of which must be open for the psychologist to disclose otherwise confidential information. These three doors are: the client consent door, the legal mandate door and the legal permission door. Before releasing information gathered in a professional context, the psychologist must ask which of these three doors is open so that the information may pass through.

As we review the vignette, the question we ask is, therefore: Which door is open? The patient appears not to have given permission for a disclosure (and Ethical Standard 5.05 assumes that the client consent door is closed). The psychologist may follow the process described in this article to determine whether the legal mandate door is open. If the mandate door is closed, the psychologist will then attempt to determine whether the legal permission door is open. If the legal permission door is closed as well, we will conclude that Ethical Standard 5.05 will not allow the psychologist to disclose confidential information. There is no door open through which the information may pass.

A hard ethical question arises when only the legal permission door is open and the client does not consent to the disclosure. In this instance, the law says to the psychologist, "Even though your client does not consent to your releasing this information, you may nevertheless do so." This situation will call for both ethical and clinical consultation.

In the case example, the state's child protective agency indicated that a report was not mandated. The state's reporting law, however, nevertheless provides legal *permission* for the psychologist to make a report. Because the legal permission door is open, the Ethics Code allows a disclosure. This psychologist is thus faced with a client who appears adamant that the psychologist not disclose information and serious concerns about whether she should nonetheless ensure that some authority is aware of the uncle's behavior and propensities.

Ethics Rounds

Reporting past abuse, Part II

Learning Objective: To explore different perspectives on analyzing the legal and ethical dimensions of reporting child abuse that occurred in the past.

Experts weigh in on the ethical dilemma posed in the *May Monitor*.
page 90

Our previous "Ethics Rounds" posed the following clinical vignette:

I am a psychologist who works mainly with adolescents and young adults. This fall I began treating a 20-year-old woman who came to therapy because of difficulties she was experiencing in an intimate relationship. My patient disclosed that when she was 12, an uncle who had come to stay with the family for several weeks sexually molested her on a number of occasions. My patient reports that I am the first person she has told that her uncle "messed with" her and that were anyone in the family to learn what happened a major and perhaps irreparable rift would inevitably result. The uncle has since moved to a distant part of the state and for the last several years my patient has been able to make plans to be away when he visits.

As discussed in the May "Ethics Rounds," child-abuse reporting laws do not always address how far into the past their mandates extend. The vignette occurred in a state where the law was silent concerning this question. The psychologist sought an official opinion and was informed that no report was legally mandated. The psychologist was also informed that the law provided the discretion to report. The psychologist wondered whether, even in the absence of a legal requirement, there might be an ethical obligation to break confidentiality and tell some authority about the uncle's behavior.

"Ethics Rounds" sought the advice of ethics experts to answer this question: Gerry Koocher, PhD, Mary Brabeck, PhD, and Kalina Brabeck. Gerry Koocher, professor and dean of the School for Health Studies at Simmons College, is co-author (with Patricia Keith-Spiegel, PhD) of "Ethics in Psychology: Professional Standards and Cases" (Oxford University Press, 1998); Mary Brabeck, PhD, professor and dean, counseling, developmental and educational psychology, Boston College, is editor of "Practicing Feminist Ethics in Psychology" (APA, 2000); and Kalina Brabeck is a doctoral student in the counseling psychology program at the University of Texas, Austin.

Gerry Koocher's advice

In planning a response to this scenario, a psychologist should first take stock of the facts and the duties owed the client. Based on the case as presented, we know what the client has told the therapist and we know that the potential reporting obligations depend on state law. But wait; what state's law? Suppose the abuse occurred in Minnesota, the alleged perpetrator lives in Washington and the client disclosed her saga to the therapist in Massachusetts? Let us assume that the therapy takes place in vivo, as opposed to occurring across state lines by electronic means.

Fundamental ethical principles such as fidelity (i.e., trustworthiness), beneficence (i.e., doing good) and nonmaleficence (i.e., doing no harm) now become critically important guideposts. What does the client want and need from the therapist? Most likely, the client wants to process the long-concealed distress and address myriad emotions, including anger, shame, sadness, guilt and a host of other issues commonly experienced by victims of sexual abuse. The client wants and needs to do this in a supportive, safe and reassuring context in order to regain a sense of control and mastery over the frightening events of the past that radiate into her present. Based on experience, the therapist may anticipate these needs, but must be guided by the client's goals, wishes and pace. The therapist must listen carefully, offer encouragement, and ask the client about her needs and goals.

The therapist need not investigate or authenticate the client's allegations, but simply work to assist within her own reality. An ethical challenge will appear if the client expresses a wish to confront, or seek a legal remedy from, the alleged perpetrator. In such instances, the therapist may encounter requests to participate as an advocate for the client. Although a therapist can document the client's distress, offer diagnostic opinions, discuss future treatment needs and provide support, caution dictates that the therapist avoid requests to validate the occurrence of abuse or participate as an advocate for the client in court or "therapeutic" confrontations with the alleged perpetrator. The ethical obligations here include maintaining the client's confidence and attempting to help improve her mental health. One should not risk potential harm to the client by abandoning the role of therapist for the potentially incongruent role of advocate. In addition, a psychologist should never participate in defaming or otherwise causing harm to an alleged perpetrator without a sound evaluative basis for doing so.

If the client expresses fear for the safety of other potential victims, the psychologist can help the client evaluate her options. Taking steps to confront an alleged perpetrator by reporting to state authorities or notifying others will require disclosure of the client's status as a prior victim. Such actions may result in unwanted notoriety, criticism from family members and increased personal discomfort. Some clients may be willing to take such steps while others may not be. The choice belongs to the client.

In the final analysis, the psychologist must respect the client's wishes or risk committing yet another betrayal potentially more devastating than the prior abuse. The psychologist should focus attention on the needs and well being of the client, maintain her trust, strive to assist in her recovery and avoid further harm to her.

The Brabecks' advice

Three levels of ethical concerns should inform psychologists' decision-making: the aspirational level (ideal, moral principles), the professional level (standards set by a professional organization, e.g., APA) and the legal level (laws that mandate the standards of behavior that society will tolerate). When a conflict exists (e.g., the aspirational obligation to respect client's autonomy and the legal obligation to report abuse), psychologists face ethical dilemmas. Confidentiality is the bedrock of psychotherapy. If a psychologist breaks confidentiality, he or she violates the obligation to respect the client (the principles of justice and autonomy) and may cause harm (violating the principle of nonmaleficence). At the professional level, psychologists "have a primary obligation" to respect the confidentiality rights

(Standard 5.01). At the legal level, privacy is a right guaranteed by the Fourth, Fifth and Fifteenth amendments of the U.S. Constitution and states have laws that mandate confidentiality.

There are, however, limits to confidentiality. The principles of nonmaleficence (avoid harm) and beneficence (ensure people's well-being) require that psychologists break confidentiality when a client's actions pose potential harm to self or others. At the professional level, "Psychologists disclose confidential information without the consent...to protect the patient or client or others from harm" (Standard 5.05 [a]). Moreover, psychologists must know state mandated limits and inform their clients of the exceptions to confidentiality (Standard 5.02).

If the law neither mandates nor prohibits reporting in a specified time interval, the psychologist must evaluate competing obligations. A psychologist's first duty is to ensure that his or her client is not harmed. In this case, the client is not a minor and not in imminent danger of sexual abuse.

Reporting abuse without consent may communicate a lack of respect for the client and risks harming the therapeutic relationship, which is necessary for the client to safely explore the serious issues she raised. Breaking confidentiality may rob the client of the opportunity to gain insight into the reasons for her silence, to name the wrong done to her and to confront others with the truth, thereby gaining control over her life. Furthermore, the client may conclude that no one is trustworthy and continue her silence regarding the abuse. If trust is broken, the psychologist violates the principle of fidelity and the client may end therapy prematurely. Psychologists have a professional mandate to "not abandon their clients" (Standard 4.08[a]).

Finally, if the psychologist has reason to believe that the client's family will abandon her or will retaliate against her, the psychologist's disclosure might put the client at risk.

To protect others from harm, the psychologist should explore whether the client is aware of any ongoing abuse, or danger of abuse. If the client lacks the answers to these questions, the potential harm from these relatively unknown risks must be weighed against the risks to the client if confidentiality is broken.

On the other hand, by not reporting the abuse, the psychologist may collude with the client in keeping her silence and in letting the abuser maintain power and control over her, which violates her autonomy and may not be in her best welfare. The psychologist's failure to disclose the abuse may make him or her a part of the greater system that fosters silence and fails to condemn abuse of the powerless, which may abet injustice and does not show care for society. If the client perceives the psychologist as a person of authority, his or her participation in this system of silence may exacerbate the client's sense of powerlessness and hopelessness.

The best option is for the psychologist to maintain confidentiality and use the therapeutic relationship as a vehicle to empower the client to report the abuse to appropriate authorities. If this is not an option for her at this time, the psychologist might consider making disclosure a goal of therapy. If other family members have also been abused, breaking the silence may enable others to do the same or prevent additional abuse. Such a resolution might enhance the client's sense of autonomy,

maintain the trust of the therapeutic alliance, end the self-silencing that the abuse fostered and restore the power of the client's voice.