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CONFIDENTIALITY AND DISCLOSURE:
ASSESSMENT AND INTERVENTION ISSUES

By

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Submitted in partial fulfilment of the requirements
for the degree of:

Doctor of Psychology (Clinical)

Deakin University
Australia
October 2002
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CANDIDATE DECLARATION

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ACKNOWLEDGEMENTS

I wish to thank all those whose support and assistance contributed to the completion of this portfolio.

Firstly, and most importantly, I thank my husband Bob. I am indebted to him for the unswerving practical and emotional support he provided throughout this course of study. He has my love and gratitude.

I also wish to acknowledge the people who are the subject of these case studies. The issues they brought to therapy were both challenging and stimulating. I thank them. To preserve their confidentiality, I have not named the clinic in which the therapy was conducted. However, I am most appreciative of the advice and support provided by the staff of the clinic.

Finally, I also wish to thank Dr. David Mellor of Deakin University for his assistance and guidance in the preparation of this portfolio.
ABSTRACT

This portfolio addresses the moral, ethical and legal issues that impact upon decisions to maintain or disclose confidential communications. The tensions and moral dilemmas that are created when a conflict between these aspects arises are considered. Risk assessment procedures that inform decisions to maintain or disclose confidential information are discussed, as are issues related to the practical implementation of planned interventions.

The topic is addressed by firstly reviewing professional codes of conduct and legal requirements to maintain confidentiality. The limits of confidentiality and privileged communication are then reviewed together with legal requirements of “duty to warn” or “duty of care”. These requirements are then related to risk assessment procedures and relevant interventions.

Four case studies that illustrate the practical application of assessment techniques in the decision process and planned interventions are presented. They cover such diverse topics as disclosure and suicidal intent, threat of harm to a third party, risk of transmission of the AIDS virus and “duty to warn” and maintenance of a minor’s confidential communications. The ways in which these issues were addressed and the outcome is presented.

Note

All names and details that have the potential to identify the people whose cases are presented here have been changed to protect their anonymity.
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Chapter 1

Introduction

Professional codes of conduct and legal principles govern the practices of psychologists, requiring them to act in a moral and ethical manner. Ethics are moral principles that provide the basis for codes of behaviour in professional practice. They delineate between right and wrong, good and bad, reward and punishment. According to Cottone and Tarvydas (1998), “Counselling and psychology have largely espoused principle ethics … [which] involve applying ethical rules and principles to determine what is the right or moral decision when an ethical dilemma arises” (p. 135). Tensions and moral dilemmas may be created when ethical requirements conflict and such tensions are most apparent in the competing requirements to maintain confidentiality and those of disclosure. This portfolio examines some of the issues arising from the intersection of confidentiality and disclosure. The moral and ethical issues are discussed, as are the practical issues of issues of assessment and intervention.

Confidentiality

Confidentiality is an ethical standard of professional conduct that forbids disclosure of information without the express consent of the individual. It involves treating as secret information passed from the client, and is based on the assumption of their right to privacy and ownership of their own thoughts, feelings and personal data. “As a basic human right, every individual deserves to be granted full autonomy and discretion over information that is strictly and intrinsically private” (Peterson & Siddle, 1995, p. 187). Pope and Vetter (1992) cited research showing that confidentiality is considered to be, “one of the most fundamental principles … and in some research has been endorsed by psychologists as the most important ethical duty” (p. 400).

Knowles and McMahon (1995) found widespread support for the principle of confidentiality from both the general public and from professionals, however complexities
have been encountered in translating the principle into practical application. Pope and Vetter (1992) reported that after nine years work the APA was unable to agree on a revision of the confidentiality section of its code of conduct and the most frequently encountered ethical dilemma involved issues of confidentiality. Difficulties in the practical application of the principle led Knowles and McMahon (1995) to conclude that confidentiality is a decrepit concept in contemporary psychological practice. They noted that it is circumscribed by an absence of legal protection, by statutory requirements to report certain behaviours, and by a diversity of ethical beliefs and institutional practices that limit its practical application.

Despite concerns about its practical application, confidentiality remains a core ethical principle in psychological practice, enshrined in professional codes of conduct and circumscribed by legal requirements. Psychologists faced with complex decisions about the maintenance or disclosure of confidential information need to be familiar with these requirements.

Confidentiality and Professional Codes of Conduct
The Psychologists’ Registration Board of Victoria and the Australian Psychological Society are the key bodies governing rules of ethical behaviour and providing guidance to practicing psychologists. Both of these bodies endorse the concept of confidentiality in their ethical code or codes of behaviour, although neither code explicates the rationale or reasoning behind the requirement to maintain confidentiality. From a purely pragmatic and utilitarian stance, maintaining confidentiality can be considered to be of benefit to both the client and the profession (Davidson, 1995). Maintaining confidentiality is thought to promote trust and to aid the formation of an effective therapeutic relationship, hence it is of benefit to the client. It can also enhance the status of the profession in that research data that maintains the anonymity of the participant may provide more accurate results and it can engender a positive perception of psychological practice.

The Bulletin of the Psychologists’ Registration Board (1997) states, “The duty of confidentiality owed by the psychologist to his or her client is a fundamental one. Psychologists must respect the confidentiality of information obtained from persons in the course of their work as psychologists” (p. 1). This requirement to maintain confidentiality is further explicated in the Board’s Code of Behaviour for Psychologists which also requires psychologists to take reasonable precautions to respect the confidentiality of their clients.

must respect the confidentiality of information obtained from clients in the course of their work as psychologists. They may reveal such information to others only with the consent of the person or the person’s legal representative” (p. 1).

Confidentiality and Legal Requirements
Psychologists duty to maintain confidentiality arises out of the client/psychologist fiduciary relationship. According to McBride and Tunnecliffe (2001), “The common law has long recognised the legal duties that should be imposed upon a person who is in a special relationship of trust and confidence with another. These are called fiduciary relationships” (p. 30). They considered the traditional duties of fiduciaries to be to act with reasonable skill, care and diligence and not to make improper use of their position or of information. The latter included a duty to keep confidences. All of the above duties are brought into play when deciding whether to maintain or breach confidentiality, as such decisions can be subject to criminal and civil (contract, tort, equity) law. Legal requirements to maintain confidentiality are also evident in recently enacted privacy laws requiring the secure and confidential maintenance of client records. Hence the maintenance of confidentiality is a legally enforceable ethical standard of professional conduct.

Although the maintenance of confidentiality may be legally enforceable there are few current examples of this happening. Milne (1995) reported a somewhat dated application of the law of tort (negligence) to the requirement that health professionals maintain confidentiality. She cited the case of Furniss v Fitchett (1958) in which a New Zealand doctor who released information to his patient’s husband without her consent was successfully sued for damages. Despite the fact that the husband had both arranged and paid for his wife’s treatment, it was held that the doctor had breached his duty of care toward his patient and she had suffered ongoing damage. Although this case is over forty years old it has continuing relevance in that legal determinations are often based upon precedent and it has established a legal precedent requiring health professionals to maintain confidentiality.

Confidentiality and Privilege
The concept of privileged communication, which is the right of the client not to have private communications disclosed during legal proceedings, (Deardoff, Cross & Hupprich, 1984) is different from, but related to, confidentiality. According to Keith-Speigel & Koocher, (1989) “Privilege is granted by law and belongs to the client in the relationship” (p. 58) and
McMahon (1998) endorsed the above point noting that where privilege is at issue, it is the client not the professional, who holds the privilege.

McMahon (1998) claimed that there is considerable confusion amongst psychologists about the right to withhold certain communications or information from disclosure in court. Such confusion may derive from conflicting views about its application. For example, in Victoria, privilege can have a common law or statutory basis and McMahon cited the example of communication between a priest and penitent, stating that this communication has privileged status, and, even in the event of confession of a crime, the court cannot require disclosure. Communications with legal advisers may also be considered privileged, a further example of limited professional privilege is the doctor-patient relationship, which has privilege in civil but not in criminal proceedings. In contrast The Bulletin of the Australian Psychological Society (1999) offered the following view of the status of privilege,

The common law, with one exception, recognises no absolute professional privilege in communications between professionals and their clients or patients. This one exception is certain communications between lawyers and clients, and lawyers and third parties for the purpose of legal proceedings. Thus common law may ultimately require that a member of the clergy disclose a penitent’s confession, or that a journalist, police officer, or doctor disclose communications respectively with an information source, informant or patient.

Psychologists are no different from other professionals who may be required to attend and give evidence in court (p. 15).

If the above views regarding privileged communication are confusing, even further complications derive from changes to Victorian law that came into effect in 1998 and apply to proceedings started on or after the 1 September 1998. Psychologists and others working for the Family Court of Australia can claim privilege conferred by statute for limited purposes.

According to Hands (1999) there are established principles under which information may be kept confidential without being in contempt of court. For example, some degree of privilege may be accorded to information if it was communicated in confidence, by someone who had allegedly been sexually assaulted to a treating counsellor or (in Victoria) medical practitioner, and the evidence would reveal details of the communication.

Other than in the instances cited above privilege may not be extended to psychologist/client communications and it is apparent that the principle of confidentiality
embodied in privilege is afforded only limited legal status. Certainly privilege does not extend to serious crime and the Victorian Court of Appeal, in the case R v Lowe (1997) cited in McMahon (1998) was clear that psychotherapist-client confidentiality is subordinate to public interest. In this case defence lawyers unsuccessfully argued that evidence obtained from therapy sessions should be excluded because it was in the public interest that such communications remain confidential. The defence argued that the threat of disclosure would inhibit openness and trust in client-therapist relationships and it was in the public interest that perpetrators of crimes continue in therapy. These arguments mirrored those cited in opposition to mandatory reporting by Thompson-Cooper, Fugere and Cormier (1996) and were equally unsuccessful. McMahon (1998) reported that the court noted, “In Victoria it is clear that both common law and statute law subordinate private confidence to the wider public interest; at least when it comes to disclosing information in the interest of prosecuting serious crime and/or protecting public safety” (pp. 12-19). McMahon (1998) further reported that following appeal the Court noted, “an emerging view that a duty of disclosure exists” (p. 13).

McSherry (2001) considered the above case to fall within the “disclosure of iniquity” cases and noted there are no other Australian legal cases that deal with breaching confidentiality in the public interest. She claimed that it seems likely that “Australian courts are more likely to set out exceptions to confidentiality rather than develop a legal duty to protect” (p. 18).

Davidson (1995) claimed that dilemmas about maintenance or disclosure of confidential information may derive from the application of differing and competing ethical systems and proposed that application of the confidentiality rule and when it is to be broken would depend upon the system of ethics adopted by the individual psychologist. However, choice of ethical system is not readily available to practicing psychologists in Australia. State registration bodies and professional associations can apply sanctions to psychologists who do not conform to their codes of practice. Further, obtaining professional indemnity insurance can be contingent upon commitment to adhere to professional codes of conduct and, in the extreme, legal sanctions may apply to non-conforming psychologists. The most relevant determinants of whether or not confidential information will be disclosed, in hierarchical order of precedence, are relevant State or Commonwealth laws, the ethical code of practice of the appropriate registration board and that of the professional association, the Australian Psychological Society (APS). Deviation from the requirements of any of these authorities can invoke legal and/or professional sanctions.
Disclosure
Whilst professional codes of conduct and legal precedents for maintaining confidentiality have been established, the other side of the coin is a requirement of disclosure, embodied in the idea of duty of care or duty to warn. The ethical principle of beneficence underlies the notion of a duty to warn. According to Beauchamp and Childress, (1994), this principle obliges health care professionals to attempt to prevent harm to clients and third parties.

Disclosure and Professional Codes of Conduct
Although both the Psychologists’ Registration Board of Victoria and the Australian Psychological Society endorse the general principle of maintaining confidentiality, neither endorse the notion of absolute confidentiality. The requirement to maintain confidentiality is qualified by reference to the requirements of the law, institutional rules and professional relationships. The codes of practice of both of these professional bodies define the circumstances under which unauthorised disclosure of confidential information is condoned.

The Psychologists Registration Board’s Code of Behaviour states that psychologists will make disclosures in specific circumstances. These circumstances include disclosure at the request of the client or in accordance with the requirements of the law. They also include circumstances where non-disclosure would result in a clear danger to the person or others, for professional purposes, and in the case of minors or others unable to give voluntary, informed consent. In contrast, the APS Code of Ethics (1997) states, “In those unusual circumstances where failure to disclose may result in clear risk to the client or to others, the psychologist may disclose minimal information necessary to avert risk” (p. 1). A discrepancy between these codes exists, in that the APS Ethical Code states that psychologists may disclose whilst the Psychologists Registration Board code states that they will make disclosures. It seems reasonable to assume that in event of dispute, the Psychologists Registration Board’s Code of Behaviour would take precedence, and this code appears to imply that disclosure is mandatory.

Despite the benefits of, and sanctions for not conforming to codes of conduct, mandatory disclosure remains a contentious issue. For example, Thompson-Cooper, Fugere and Cormier (1993) and Adler (1995) argued strongly for therapist discretion in deciding whether to disclose if patients are responding appropriately to therapy and cited the incompatibility of punitive and therapeutic goals.
Although codes of conduct afford a measure of reassurance to psychologists deliberating upon how best to deal with complex issues, they have their detractors. For example, Corey, Corey, and Callanan (1993) stated that, “Ethical codes, by their very nature, tend to be reactive, emerging from what has occurred rather than anticipating what may occur” (p. 4). Brown (1994) claimed that, “The American Psychological Association’s code of ethics, together with other dominant ethical standards, privilege those holding the power – that is the therapists” (p. 204). According to Prilleltensky (1997) professionals construct these codes with little input from the public and he concurred with Brown (1994) that codes of conduct maintain the power imbalance between psychologists and clients. He stated, “Although they serve the public by promoting ethical practices, they primarily protect the interests of professionals and offer a narrow and sometimes legalistic interpretation of ethics” (p. 518). It is in the legal arena that codes of conduct afford professionals a degree of protection leading Fox (1984) to describe the aim of ethical decision making as seeking not the “right” but the most defensible answer.

Milnc (1995) made the point that, whilst a breach of the codes of behaviour or ethics can result in disciplinary procedures from these professional bodies, such codes of behaviour and ethics do not have the force of law. They do however, provide a basis for decisions about the application of reasonable professional standards in the event of legal proceedings. For example, in the event of complaint or legal action against a psychologist, they would form the basis of inquiry into how a competent professional should act. McMahon and Knowles (1995) pragmatically claimed the benefit that such approach offers is that of a legally and professionally defensible way of dealing with clients. In similar vein, Borum (1996) further explicated the benefits of this approach, stating that clinicians are not held legally responsible for the accuracy of their decisions but rather they are judged on whether the decision was reasonably made. Questions of whether they gathered relevant risk assessment information and whether most clinicians would have reached a similar decision form the basis of legal judgements.

Disclosure and Duty to Warn/ Duty of Care
According to McMahon (1999) it is unclear if a legal duty to warn pertains in Australia, however this is not the case in America and the most frequently cited instance is that of the case of Tarasoff v Regents of the University of California (1976). This case involved the murder of a young woman, and the court was asked to determine whether a therapist, who was aware of threats to her life, had a legal responsibility to act to protect the victim. The
Supreme Court of California concluded that a “duty to warn” intended victims of a client’s dangerous behaviour does exist when a psychotherapist reasonably determines that a patient presents a serious danger of violence to another. The duty to protect the intended victim may require apprising the victim of the danger, notifying the police, or taking whatever steps are reasonably necessary under the circumstances (p. 334).

The case was reopened when the American Psychological Society, supported by other professional associations, argued that to impose a duty to warn would be detrimental to the profession because of the difficulties inherent in accurately predicting dangerousness and the undesirable effects of disclosure upon the client-therapist relationship. However, the Court disagreed and held that confidentiality “ends where the public peril begins” (Tarasoff v Regents of the University of California, 1976 p. 27 cited in McMahon, 1992). Further, this second hearing produced a broader requirement of care than merely a duty to warn, the Court now held that a psychotherapist has a “duty to protect” an intended victim.

America is a more litigious society than Australia and, as the precedent set by the Tarasoff case has not, to date, been tested in Australian courts of law, there is a lack of consensus about whether an Australian court would uphold these findings. However, McMahon (1999), in a lecture delivered to members of the APS College of Forensic Psychologists, reported a recent Australian case with Tarasoff implications. The case concerned a University counselling service client who threatened harm to one of her lecturers. After assessing the feasibility of the threat being acted upon the counselling service warned the lecturer but refused to divulge the identity of their client, presumably intending to meet duty to warn responsibilities whilst maintaining client confidentiality. The strategy was not successful in that the lecturer resigned her position, attributing her resignation to stress derived from the University’s failure of duty of care. She claimed that, without knowledge of the identity of the student, she was unable to take adequate measures to ensure her safety and suffered additional stress from the inadequacy of the warning. As the case was settled out of court, no Australian precedent for a Tarasoff type case was created.

The foregoing has established that professional codes of conduct and legal precedents define the parameters of the maintenance and disclosure of confidential communications. Risk assessment procedures determine whether or not an issue falls within those parameters.

**Risk Assessment**

Decisions about whether or not to disclose confidential information cannot be divorced from adequate risk assessment procedures. Rose (1998) wrote, “It is the individual professional
who has to make the assessment and management of risk their central professional
obligation" (p. 184). As the law and professional codes of conduct may endorse disclosure
under specific circumstances, the ability to accurately assess what constitutes "a clear risk" or
"clear danger" becomes apparent and raises the issue of the adequacy of risk assessment
procedures.

Judgements of dangerousness are, in effect, predictions about the likelihood of an
individual doing serious harm to self or another (Prins, 1986). However, risk assessment is a
difficult and often imprecise task posing difficulties that can only be addressed on a case by
case basis. Decisions are often required in the absence of certainty about whether or not a
"clear risk" or "clear danger" exists.

Confidence in the ability to accurately predict dangerousness has varied over the
years. According to Rose (1998), "There is no doubt that, from the 1960s to the present,
widespread doubts have been cast upon the powers of mental health professionals to make
accurate assessment and predictions about the future conduct of their patients and clients"
(p. 187). Thomas-Peter and Howells (1996a) identified three distinct phases in the
development of risk assessment that they termed naïve optimism, disillusion and informed
hopefulness. The first phase, naïve optimism was characterised by an unsupported belief
that future behaviour could be accurately predicted. According to these authors this phase
ended with Monahan’s (1981) review of risk assessment procedures and conclusion that there
was a very high frequency of "false positives" in risk assessment. Disillusion followed this
phase and Thomas-Peter and Howells have now made a cautious case for commencement of
the third phase, informed hopefulness, based upon improved research targeting specific
groups.

Practical issues such as imprecision in definition of the term dangerous and debate
about which behaviours should be included have led to a shift away from notions of
dangerousness to the assessment, prediction and management of risk. For example, Greig
(1997) claimed the notion of risk, "seems to herald a more respectable field of academic
endeavour" (P.235). According to Rose (1998) risk profiling and new statistical techniques
for making risk quantifiable are being developed in America across a number of different
professions. For example, developments in the medical field include computer aided medical
history taking and diagnosis that eliminates confirmatory bias, that is the selective collection
of data supporting initial hypotheses (Grossman, Barnett & McGuire, 1971).

Although risk profiling can alert psychologists to the possibility of clients engaging in
dangerous or self-harming behaviours it has limited applicability in that it is not predictive of
future behaviour. More than twenty years ago, Shah (1978) made the point that such procedures may not provide easy answers: “In the final analysis, the decision maker will still have to exercise his or her judgment in light of other social values and objectives and keeping in mind considerations of public policy” (p. 167). Indeed risk profiling has been criticised by Rose (1998) who proposed that this type of assessment devalues the unique assessment skills of the psychiatrist or clinical psychologist because it can be conducted by a variety of staff.

Both Greig (1997) and Rose (1998) raised the ethical issue of whether mental health disciplines are being coopted to assist in the governmental task of identifying and containing risky persons and situations. For example, Greig wrote, “This mode of conceptualising and managing social problems has encouraged a reliance on the skills of psychiatrists and psychologists, who are regarded as possessing the technologies required to achieve political goals of self-responsibility and self-management” (p. 231). The issues considered in assigning patients to levels of risk may include medication compliance, prior incidents of violence, substance use or abuse, age, gender, relationships, social isolation and self neglect, without ever mentioning diagnosis or treatment. Rosc and Greig argued clinical interventions, such as anger management programs, behaviour modification programs and parenting programs have moral implications in that they may all be oriented to the management of risk rather than cure.

Harrison (1997) added an additional dimension to the issue of risk assessment. He claimed that in an increasingly litigious society “mental health professionals are beginning to add an additional factor to their risk calculations when managing difficult patients: the assessment of risk (of a civil action) to themselves in the event of an untoward incident” (p. 37). Thus the factors driving a decision to maintain or disclose confidential information can include degree of risk and the need for societal protection, client welfare or even therapist protection. In some cases all of these aspects may coalesce but the potential for an ethical conflict of interest in deciding whose welfare takes precedence can arise. Despite the complexity of the issues involved, psychologists appear to be legally and professionally mandated to manage risk.

**Risk Intervention**

Assuming that an adequate level of risk assessment can be achieved, the issue then becomes one of planning and implementing practical interventions to minimise or obviate risk. Such interventions may require disclosure of confidential information to other health professionals or crisis services, reporting dangerous behaviours to family members or the police, or directly
informing potential victims of possible risk. The disclosure of confidential information may lead to involuntary detention in a psychiatric in-patient unit in accordance with Section 4(2)(b) of the Mental Health Act 1986 (Vic).

The planning and implementation of risk management interventions requires a case by case consideration of what can be achieved. Implementing risk management strategies can be more problematic with an out-patient population that may be unwilling to cooperate, and practitioners in private practice need to be aware of the availability of community resources and to access the support and input of professional associations and peers. Whilst peer support and consultation with professional associations are desirable adjuncts to deliberations about disclosure some decisions require immediate responses and community support is not always available. Crises requiring on the spot decisions often occur outside of office hours and can be difficult to plan for.

Practical concerns about the availability of crisis support services can include the difficulty in accessing services with limited hours of service delivery. For example, co-treating medical practitioners may not offer after-hours services and simply provide referral to a locum service or general hospital. Staff shortages can, and often do, limit the availability of CAT team services to defined cases of crisis. Similarly, hospital bed shortages can limit the provision of services to those most in need of immediate treatment. As Howells (1996) stated succinctly, "Clearly, we are all involved in ways of working that fall short of what we believe to be good practice. More often than not, the constraints of the real world are such that we have to ‘make do’ in organising services and interventions” (p. 76).

Summary
It is apparent that the decision to maintain or disclose confidential information requires careful consideration of the professional and legal requirements. However, a lack of clarity about the legal requirements of disclosure and between the Psychologists Registration Board and the Australian Psychological Society codes of conduct exists, creating a tension between conflicting requirements. The imprecision of risk assessment procedures and the feasibility of implementing practical interventions contribute to that tension.

The following chapters present four different cases requiring a decision of whether or not to maintain confidentiality. The cases were chosen for their utility in demonstrating the diverse and challenging issues inherent in the decision making process. They highlight issues related to the adequacy of ethical guidelines, the reliability of assessment techniques and the practicality of translating the results of assessment into appropriate therapeutic interventions.
The privacy and anonymity of the clients whose cases are presented here has been protected by allocating each a pseudonym and altering some identifying features and circumstances related to the case. In accordance with established professional practice, and in compliance with the ethical guidelines of the Australian Psychological Society, all clients whose cases are presented here were provided with written information about the limits of confidentiality when initially presenting. All consented to these conditions of treatment, and where appropriate, they were verbally reminded of these limits during the course of treatment. McConaghy (1997) reported that Adler (1995) raised concerns about the effect of such warnings and asked whether patients who were asked to sign a consent form that advised them of the limits of confidentiality would be able to accept treatment or feel able to disclose even vaguely incriminating information. No inhibition of communication was noted as a result of provision of this information and all of those whose cases are presented elected to remain in treatment.

The first case presented is concerned with assessing the risk of a young man committing suicide and determining if disclosure was warranted. In this case, risk assessment was complicated by the client’s denial of suicidal ideation despite engaging in potentially self-harming behaviours. The adequacy of suicide risk assessment techniques is discussed in the light of such ambiguity of intent.

In the event of clearly assessed risk of suicide, professional ethical guidelines require disclosure of confidential information sufficient to ensure safety of the client. However, lack of “clear” indicators of intention to self-harm does not corral the psychologist from the decision-making process. This case raised issues about the difficulty of determining clarity of risk in the face of inadequate means of assessment. Self-report measures of suicidal intent are known to provide both false positives and false negatives. The recommended means of assessment, is concerned with statistical likelihood rather than individual cases.

A further issue affecting the decision to maintain or disclose confidential communications is whether the feasibility of implementing a planned intervention should affect the decision to disclose. If the purpose of disclosure is to ensure the safety of the client, disclosure without likelihood of successful implementation of the intervention may be neither useful nor ethical.

Both the second and third case presented are concerned with duty to warn issues and the complexities of determining when such a duty pertains. According to Thomas-Peter and Howells (1996b), “An increasing number of clinical psychologists are involved in that
segment of professional activity where the world of clinical psychology/mental health intersects with that of the courts, the judicial system and criminal offending” (p. 63).

The second case presented is concerned with deciding whether a “duty to warn” pertains following threats of harm to a third party that are later retracted. The case presented concerns a young woman who threatened to take revenge upon the perpetrator of sexual assault, and involved assessment of whether her disclosures of intent to commit serious assault constituted a threat or whether they were cathartic fantasies related to complicated post-traumatic stress syndrome. Assessing the likelihood of these threats being acted upon was complicated by the involvement of a third person, and a lack of clarity in the literature concerned with acts of violence initiated by victims of post-traumatic stress. The effectiveness of strategies to contain the violence and the possibility of risk to the therapist are discussed.

The third case is also concerned with duty to warn issues. This case concerns a married man engaging in unprotected homosexual intercourse whilst concurrently maintaining his marital sexual relationship. The possibility of the wife becoming infected with the AIDS virus is at issue and the decision about whether a duty to warn exists is complicated by uncertainty about the client’s HIV status. Assessment and intervention issues are discussed in light of professional, moral and legal requirements. The conflict between ethical and legal requirements to maintain confidentiality and the psychologist’s moral assessment of “the right thing to do” is also discussed.

The fourth and final case presented involves the difficult decision of whether or not to disclose confidential information obtained in therapy to the parents of a mature minor. This case considers the psychologist’s responsibilities to both the client and the parents and discusses the legal and professional requirements of working with adolescents. The case presented concerns evaluation of whether information about a young adolescent’s potentially self-harming behaviour and experimentation with alcohol and illegal drugs should be disclosed. Issues of defining the limits of confidentiality when working with minors are raised and discussed in the light of some confusion about boundaries between adolescence and adulthood. The difficulties encountered in assessing if a minor is sufficiently mature to decide against disclosure are also discussed and possible benefits of disclosure are weighed against the negative effects upon the therapeutic relationship.
Chapter 2

Suicide, Duty of Care and Disclosure

The most clinical psychologists will encounter suicidal clients at some stage of their professional practice. American data reported by Chemtob, Hamada, Bauer, Torigoe, and Kinney, (1988) suggested that the average American psychologist has a one in five chance of having a client suicide. These clients can create difficult practical issues and moral dilemmas for treating clinicians that are only partially answered by codes of conduct and ethical guidelines of professional associations.

Schneidman, cited in Hankoff and Einsidler (1979) defined suicide as a human act of self-inflicted, self-intentioned cessation. This definition implies that the act of committing suicide is consciously and deliberately intended and initiated with knowledge of the fatal outcome, 'a conceptualisation of death' (p. 144). However each case of suicide is different and no universally accepted understanding of suicide exists. Consequently, Hankoff (1979) suggested the need to classify all deaths according to the role of the individual in his or her own demise. Such classification would include intentioned, sub-intentioned (an individual has partially or unconsciously been involved in the act of suicide) or even un-intentioned deaths. However, broadening the definition of suicide can raise difficulties. According to Allen (2000) who claimed that the element of intentional self-harm is the crux of the matter in the definitional debate. If intention is not the essential ingredient, the definition could be broadened to include self-injurious lifestyles, such as high alcohol consumption, dangerous driving or self-starvation.

Despite the lack of consensus on the definition of suicide, in 1997 a total of 2,723 deaths (approximately 14 per 100,000) were attributed to suicide in Australia and the majority of these were males (2,146). The Victorian Suicide Prevention Task Force (1997) reported a large increase in the number of deaths by suicide in the young and relatively high rates for older men. Since 1991 suicide deaths have outstripped deaths from motor vehicle accidents, although it has been acknowledged that a number of motor vehicle deaths may also be attributed to suicide (Baume, 1995).

Interventions aimed at obviating suicide may require the disclosure of confidential information and such disclosure is contentious. According to Hands (1999),
There is a tendency to abandon the structures of confidentiality and client self-determination when faced with the risk of self-harm. Yet any breach of confidentiality needs to be justified under the various exceptions, as in any other case of disclosure without consent (p. 62).

This author continued,

"If disclosure is permitted, on what grounds? Does some public interest in preserving life outweigh the duty of confidentiality? Does suicidal ideation constitute mental incapacity, so that the client is no longer in a position to take responsibility for their own decisions? Does the duty of care owed to the client include intervening to prevent self-harm, breaching confidentiality if necessary? Does the client give implied consent to such intervention? (They sometimes expressly refuse that consent.) There are no clear answers to these questions in Australia (p. 62).

The following case highlights some of the ethical and practical issues inherent in dealing with potential suicide in an outpatient setting. These issues include ambiguities in professional codes of conduct and guidelines for dealing with suicidal clients and difficulties in accurately assessing suicidal intent, raising considerations about the ethics of disclosure of confidential information without "clear" intent of purpose. The case also raises issues regarding the practicality of implementing appropriate intervention strategies.

Case Summary

Martin, a 32 year-old computer analyst, recently separated from his wife, presented to his medical practitioner requesting "something to help me sleep". He was prescribed antidepressant medication and referred for concurrent therapy. Martin's stated reason for attending was "to show her [wife] that I'm doing something about changing, so we can get back together as a family."

History

Martin was born in the north of England, came to Australia on a working holiday and decided to stay, reporting he had nothing to go back to. His father died some months prior to his departure and his mother continued to reside in England. He had no family or relatives in Australia other than his estranged wife and four-year-old son.
Martin described his marriage as difficult and reported arguments and bickering, culminating in his wife asking him to leave the marital home. Despite the arguments, Martin wished to resume the relationship for his son’s sake, stating, “He’s all I’ve got”. He claimed that he had few, if any, friends in Australia and described himself as “a bit of a loner”. At the time of interview he was living alone in rented accommodation.

Martin reported one previous episode of untreated depression following his father’s death and no further medical history relevant to his current condition was obtained. His legal history included loss of his driving licence two years prior for driving whilst intoxicated and he reported having attended a court-mandated program for alcohol abuse. His wife had obtained an intervention order after Martin made abusive and threatening phone calls whilst intoxicated.

**Initial Assessment**

Martin presented with clinically significant symptoms of depression. He reported dysphoric mood, sleep disturbance and significant weight loss. His score on the CES-Depression scale was in the upper range for moderate depression and he commenced a program of cognitive-behavioural therapy in combination with prescribed medication. Although he denied suicidal ideation he was provided with the phone number of a crisis centre for after-hours contact, if required.

At initial presentation Martin was also assessed for risk of suicide in accordance with the APS Guidelines Relating to Suicidal Clients (1998). These guidelines state that, “Failure to conduct an adequate and appropriate assessment and response may constitute professional negligence” (p. 2) and require the treating psychologist to,

(i) take a thorough and specific assessment of suicidal risk, and
(ii) arrange appropriate psychological, medical, psychiatric and/or social care, and community response (p. 27-28)

The Bulletin of the Australian Psychological Society (August, 1999) noted the existence of various models of suicide risk assessment and recommended that the following aspects should be included in such assessment,

**Enquiry about current suicide ideation:**

Does the client have a well thought-out plan?

**Assess person’s previous history of response to stress and or loss:**

(with particular emphasis on previous suicide attempts or self-harm injuries.

**Assess current psychological state:** According to some theories a suicidal
state of mind can be characterised by a sense of unbearable psychological pain, hopelessness, anxiety, constricting of the mind or narrowing of perceptual focus, ambivalence in attitude to suicide, intensity of disturbing effect, aloneness and special meaning of death (i.e. rebirth, reunion, riddance, revenge, self-punishment.

Assess factors, which may increase risk or protect against risk:
e.g. alcohol or substance abuse. How resourceful is the client?
Assess interpersonal environment: External resources and supports.
Assess for violence as well as suicide: Has the person displayed previous violent behaviour or been exposed to violence?
Assess the need for follow-up treatment: (p. 27).

Martin was assessed using the above protocol, and factors indicative of suicidal risk were noted. These included his previous depression at loss of the relationship with his father, his limited social supports and abuse of alcohol. On the other hand, he adamantly denied suicidal intent and expressed the hope of effecting reconciliation with his wife in the future. Although unhappy about his marital situation, he did not express hopelessness. No history of prior suicidal attempt or self-harm injuries was reported and previous violent behaviour was limited to abusive phone calls to his wife.

Protective factors included his resourcefulness in obtaining accommodation and maintaining employment and his care and concern for his son. He had sought medical and cognitive-behavioural treatment for his depression and did not initially appear to be at immediate risk of suicide. However, subsequent events necessitated revision of this assessment.

Approximately four weeks after commencing therapy, on the Saturday morning, Martin left the following ambiguous and slurred message on the clinic’s answering machine: “So you’re not there either. [Sarcastically] Great! Well, I just want to say, I’ve had enough of this ... And [I’m?] ... not f***** sticking around for any more of this shit ... no point trying ... [unclear] ... might as well be dead ... Don’t bother asking what happened to me”.
A return phone call was unanswered and it was unclear whether Martin was simply not at home or was in urgent need of assistance, and further assessment of suicide risk appeared warranted.

A variety of factors have been proposed as indicative of suicide risk, and the World Health Organisation’s Treatment Protocol Project for the Management of Mental Disorders
(1997) suggested that using the acronym SUICIDAL provides a simple way of remembering some of the factors associated with risk:

**S**  **SEX:** Women attempt suicide more often than men but men complete suicide more often than women.

**SIGNIFICANT OTHERS:** Single, divorced or widowed people are more likely to attempt suicide than those who are married. Living alone also increases the risk of suicide. Caring for a child has been found to be a protective factor.

**STRESSFUL LIFE EVENTS:** such as loss of a loved one, financial problems, and job loss may make suicide attempts more common.

**U**  **UNSUCCESSFUL** attempts in the past make it more likely that a future attempt will be successful.

**UNEMPLOYMENT** or being retired is associated with increased suicide risk.

**UNEXPLAINED IMPROVEMENT** in clinical features (often the result of deciding on a suicide plan) may indicate suicidal thoughts.

**I**  **IDENTIFICATION** with other family members who have committed suicide may make suicide a more acceptable option to some individuals

**C**  **CHRONIC ILLNESS,** or severe illness of recent onset, whether psychological or medical, increases the risk of successful suicide.

**D**  **DEPRESSION,** bipolar disorder, and acute schizophrenic episodes are associated with high risk.

DEPRESSION, hopelessness, frustration and hostility are associated with suicide risk.

**DECISION** that suicide in the future remains a possibility.

**A**  **AGE.** Generally, the older the individual, the greater the risk of suicide, (although this is not necessarily true for older women).

**ALCOHOL** or other substance abuse is often associated with completed suicide.

**AVAILABILITY** of weapons, especially guns, is associated with high risk.

**L**  **Lethality** of previous attempts. Guns, hanging, and jumping from high places are generally more lethal than drug overdoses or wrist slashing.

Using the above protocol, additional risk factors emerged and these included his gender, combined with his depression, frustration, and hostility. His abuse of alcohol, and environmental factors such as living alone and the lack of close and supportive relationships also placed him at risk. Recent stressful life events that included marital breakdown, and alienation and separation from his family were further risk factors in Martin’s life. It was unknown if weapons were readily available, however, taking into account the implied threat in Martin’s phone call “I might as well be dead”, it was decided to err on the side of caution and the issue became one of intervention.

**Intervention**

Having decided that intervention was warranted and finding return phone calls to Martin’s home unanswered, the question became one of what could be done in this situation. The APS Ethical Guidelines Relating to Suicidal Clients (1999) provided the following suggestions:

- The appropriateness of alerting professional or social supports (eg.
- Mental health professionals, community psychiatric assessment team, relatives, friends or others) to the client’s suicidal risk or intention must be evaluated making due consideration to the client’s current situation.
- In addition, the psychologist must take into account the quality of these relationships and the capacity of those involved in providing support to deal appropriately with the responsibility implied (p. 28).

In Martin’s case there were no geographically close relatives or friends who could be alerted and his treating general practitioner was not available. The crisis assessment and treatment team (CAT team) appeared to be the most appropriate mental health professionals to alert.

The World Health Organisation’s Treatment Protocol states, “If the individual satisfies the criteria for ‘mental illness’ or ‘mental disorder’ under most mental health acts hospitalisation (voluntary if possible, involuntary if not) will be the intervention of choice” (p. 534). The example given in that protocol was most pertinent to Martin’s case:

- For example, a person may suffer a traumatic crisis in a close personal relationship, get drunk, and, overwhelmed by emotional turmoil, become unable to control his or her emotions, thus becoming seriously out of control. This individual would be classified as mentally disordered under the Mental Health Act (p. 534).
Accordingly, the local CAT team was contacted and requested to attempt to contact Martin to evaluate his need for further assistance. The duty worker was provided with a brief history of Martin's issues, the possibility that he was intoxicated or had taken an overdose and his name and address. This request was refused on the basis of the ambiguity of the threat and the fact that he was already receiving private treatment.

In lieu of response, the duty worker suggested that the psychologist could visit Martin's home and, if still concerned, report the matter to the Police. This visit accomplished little as there was no response to his door bell, his neighbours knew nothing of his whereabouts and there was no motor vehicle in his car port, suggesting that he was not at home.

The absence of a motor vehicle raised a further consideration. At times, disclosure to obviate suicidal risk may also include a duty to warn. According to the APS Guidelines Relating to Suicidal Clients,

In situations where there is a high risk that suicide might be attempted by means that place others at direct risk (e.g., arson, motor accident, or family homicide), the psychologist has a duty to report in order to protect relevant others. Only information pertinent to the risk and its prevention needs to be divulged (1998, p. 3).

In Martin's case, reporting the matter to the Police was considered, and dismissed because of the sheer impracticality of them being able to do anything about the situation. It appeared unlikely they would intervene on the basis of a report that there may be an inebriated and possibly suicidal male, driving somewhere in the State. Beyond continuing to attempt telephone contact over the weekend no further practical intervention could be implemented.

Outcome

The following Monday afternoon, a shamefaced Martin appeared at the clinic without an appointment. He explained that on the previous Saturday morning, during an access visit with his son, he had learnt that his wife now had a new partner and had no intention of resuming the marriage. He had commenced drinking, made the phone call whilst inebriated and had driven interstate, stopping overnight in a motel where he continued drinking. He was unable to say what his goals or intentions had been.

Martin appeared to be unconcerned about the ineffectual disclosure of confidential information to the CAT team, and seemed both surprised and pleased that the psychologist had been concerned about his welfare. He elected to continue in therapy and a revised
management plan was negotiated. It transpired that he had ceased taking his medication because he felt better and his management plan included follow up with his general practitioner to enhance compliance. A referral to a specialist agency for substance abuse was offered and refused. However, some months later Martin voluntarily elected to join Alcoholics Anonymous and his participation in this group served the dual purpose of providing both a means of containing his drinking, which was more problematic than originally reported, and a supportive social network.

A mobile phone number was obtained as a means of establishing emergency contact if required and Martin elected to investigate the feasibility of installing a device to immobilise the car in the event of inebriation. To date, the effectiveness of this strategy has not been tested and Martin continues to deny that he was ever suicidal.

Discussion

Martin's case illustrates some of the difficulties encountered in assessing suicidal intent and in implementing a practical intervention strategy. Both prior to, and following the incident, Martin denied that he was contemplating suicide and it remains unclear if his behaviour should be considered to be sub-intentionally suicidal as suggested by Hankoff (1979) or his explanation accepted at face value. Regardless of whether he was or was not actually suicidal, it was apparent that his behaviour: driving under the influence of alcohol whilst emotionally distraught, placed him and others at risk of harm.

Conducting an adequate and appropriate assessment of Martin's risk of committing suicide posed difficulties. According to Allen (2000) suicide risk cannot be accurately predicted and is therefore assessed on the basis of probability, raising concerns for clinical assessment. For example, the Australian Psychological Society's (1999) Discussion Paper on Suicide, as well as a paper by Graham, Reser, Scuderi, Smith, Turley, & Zubrick, (2000) noted that a great deal of risk factor research is about suicide rates for a population, whereas clinical assessment is about suicide risk for an individual. The APS paper further noted that research is usually concerned with the prediction of suicide over a period of years, or even a lifetime, whilst clinical assessment is concerned with risk over the next few hours, days or weeks. Immediacy was clearly a factor in Martin's case.

One difficulty with assessments based upon factors predictive of suicide risk is the lack of a percentage increase of risk for the number or type of factors endorsed. This method of risk assessment does not provide a hierarchy of risk factors in which certain factors are accorded more weight than others. For example, is the presence of severe depression a more
important predictive factor than living alone? Intuitively, it would appear so. Is any combination of factors, such as depression, prior suicide attempt, and access to weapons, a better predictor of risk than other combinations? Beyond alerting the clinician to the need to consider risk of suicide, such assessment measures may have limited application.

Additional to the indicators provided in the World Health Organisation's Protocol and in the APS Guidelines further risk indicators encountered in clinical practice could be considered. For example, disposing of valued possessions may be indicative of suicidal intent as some clients have been known to offer gifts of personal effects prior to suicide attempt. Ambiguous client communications can also be indicative of suicidal intent as the following anecdote illustrates. Clinic reception staff became concerned when a client had difficulty confirming his next appointment, stating "I may not be here". Unable to ascertain what this statement meant, the treating clinician was alerted and suicidal intent confirmed.

The assessment of suicidal intent based upon risk factors will continue to present difficulties. Such assessment will always present both false negatives and false positives and psychologists working with suicidal clients may have to decide on which side to err. Given the ambiguity of many situations, the gravity of the issue, the finality of suicide and its far reaching effects, erring on the side of false positive judgements may be the moral imperative.

It is unclear whether continuation in therapy following advice of the limits of confidentiality constitutes consent to disclosure. At initial consultation, Martin was routinely advised of the clinic's attitude to suicide, and the limits of confidentiality in accordance with APS ethical requirements and that information was provided in writing:

Most people who consider suicide have some ambivalence about their decision. We are of the belief that life is precious and that most crises can be resolved. To this end, we will work to help you address those issues causing you to feel suicidal and to promote your safety and well-being. This may mean that we will divulge confidential information if we believe that you are likely to harm yourself. We believe that we have a duty of care to ensure your safety. Only the minimum amount of information necessary to protect you will be divulged.

The decision to continue in treatment after receiving such advice may constitute informed consent to intervention. However, many clients present in a state of crisis and such information or warning may be neither comprehended nor attended to. Further, McBride and Tunnecliffe (2001) make the point that client consent to disclose can be overturned at any time.
Rather than divulging the psychologist's attitude to suicidal intent, it appears more relevant to divulge how suicidal intent will be treated, and this treatment will most likely be in line with the requirements of the law and the licensing body. At issue was some ambiguity in APS Guidelines Relating to Suicidal Clients requiring that psychologists acknowledge client autonomy and implying that psychologists have a choice of response according to their attitude toward suicide: "Where the psychologist's attitudes are inconsistent with help the client is seeking, alternative options should be provided" (p. 1). From these guidelines it is unclear whether a client's autonomous decision to commit suicide or to refuse treatment should be respected or merely acknowledged, as the guidelines then go on to suggest interventions that would override client autonomy. There also appears to be a discrepancy between The Victorian Psychologists' Code of Conduct and the APS Guidelines Relating to Suicidal Clients (1998), the former requiring that psychologists will make disclosures in circumstances where failure to disclose would result in a clear danger to the person or others. As these guidelines could be referred to in the event of legal challenge there is a need to clarify what is intended by "acknowledging client autonomy". If the client autonomously forbids disclosure, should their wishes be overridden?

Devising and implementing practical interventions also posed difficulties. From perusal of the literature, it appears that difficulties in obtaining CAT team intervention are not uncommon. For example, The Victorian Task Force Report on Suicide Prevention (1997) highlighted some of the difficulties encountered in obtaining adequate care and treatment:

Police cannot 'force' a suicide attempter to seek professional help. For these reasons, they are increasingly required to rely on the services of Crisis Assessment and Treatment teams. Unfortunately, in many cases, the CAT team is not prepared to intervene because it has assessed the person in crisis as not suffering from a serious mental illness (p. 98).

Noting the limitations of after-hours services, the report further claimed that the limitations of CAT team services elicited some of the most passionate criticism of mental health services. According to one medical doctor interviewed, "As a general practitioner, I deal with crisis intervention; the support services are simply not available. The (local psychiatric centre) has a crisis assessment team but the response time can be up to 24 hours" (p. 106). Auerbach (1998) who drew attention to a "schism" between the private and public sector also noted similar problems. She wrote, "Because they are so overworked, I find the attitude of emergency care teams is that - If you're being managed by a private psychiatrist or
psychologist, you should be seeing your private psychologist or psychiatrist, not the Acute Team" (p. 16). Auerbach reported resorting to implied threat to obtain services:

If one of my patients needs emergency care, I find it sometimes necessary to raise medico-legal issues first to get them seen. You know, 'I have a suicidal patient here, if they kill themselves tonight, my notes will indicate calls for your emergency service were ignored' (pp. 16-17).

As far as the practical application of planned interventions is concerned, the poet Robert Burns succinctly summed up the situation, "The best laid plans of mice and men gang aft agley". Devising an intervention strategy is relatively easy; implementing it is the hard part, as overworked and under-funded crisis services cannot be relied upon consistently to provide the care needed. Clearly the police have limited powers in the case of suicidal intent and their involvement may not always be appropriate. Despite limitations on their ability to respond to cases of suicidal risk, these services may be all that is available.

It appears that there are no easy answers for clinicians dealing with potential suicide in the community. They are required to make professional judgements and devise adequate interventions in the absence of accurate predictive assessment instruments and despite severe limitations upon the availability of supportive emergency services.
Chapter 3

Confidentiality, Risk of Violence and Duty to Warn

According to Otto (2000), "Perhaps no issue raises as much concern among clinicians as cases in which they suspect a client may be at risk for harming others" (p. 1239). However, such cases are not uncommon and McMahon and Knowles (1997) found that 87% of psychiatrists and 54% of clinical or counselling psychologists reported having to deal with a "dangerous" client. Psychologists are routinely required to assess and manage the risk of violence in clinical practice despite the difficulties of doing this. Applebaum (1985) wrote,

The requirement that therapists protect victims not only when they know of potential dangerousness but when, according to professional standards, they should know of it is probably too stringent, given the limits of current abilities to predict dangerousness and the absence of professional standards for this task (p. 429).

Borum (1996) echoed concerns about the ability to "make these judgements in accord with applicable professional standards, despite the fact that no explicit national standards exist" (p. 952).

Given the complexity and variety of issues encountered, Appelbaum (1992) suggested that guidelines, rather than standards may be more applicable:

- Standards define procedures that must be followed in all cases; they can be formulated only when indications for evaluation or treatment are unambiguous. Guidelines, used when greater flexibility is needed, allow modification to meet the needs of individual patients (p. 341).

The APS supplementary Guidelines on Confidentiality (1999) recognised the need for flexibility and acknowledged the difficulties associated with the definition of risk or harm and determining who ought to be protected as well as the basic dilemma between the need to maintain confidentiality and the duty to warn or to protect others.

The accurate assessment of dangerousness is difficult. Monahan (1981) drew attention to the high rate of false positives, that is people who are incorrectly predicted to be dangerous, and McMahon (1992) noted the lack of research applicable to psychologists
working with outpatients. Most of the research in predicting dangerousness has been carried out with in-patient or criminal populations with a history of violence and the findings of such studies are not easily transferred to outpatient and voluntary client populations. Despite such concerns, McMahon cited an American study showing that less than five percent of clinical psychologists interviewed believed they could not predict dangerousness, and 52% believed they could make the prediction with certainty or near certainty. Such confidence in the accuracy of their predictions is not supported by research findings.

The following case examines assessment and intervention issues related to duty to warn.

Case Summary
Julie, a 22 year-old pale and slightly built young woman sought therapy under the provisions of the Victims of Crime assistance Scheme. At interview she reported a history of childhood sexual and physical abuse that commenced when she was approximately 10 years old and ended when she was about 15 years of age.

When Julie disclosed her father’s abuse to her mother, he denied the accusation and she was forced to leave home. To maintain herself, she left school without completing her education and drifted in and out of low-paid employment and temporary accommodation. She reported multiple short-term relationships with a variety of partners, some of whom were physically abusive.

Throughout, Julie maintained intermittent contact with her younger sister who revealed that the father had also sexually abused her. Despite their mother’s opposition they complained to the police and, at interview the father made limited admissions, was charged, found guilty, and received a non-custodial sentence. The leniency of his sentence infuriated Julie.

Julie presented with symptoms congruent with a diagnosis of Post Traumatic Stress Disorder. Her symptoms included persistent re-experiencing of the trauma of abuse in the form of intrusive recurrent memories, particularly during intercourse; dreams and flashbacks, emotional numbing and hyper-arousal. Julie also reported recurrent depression and anxiety, with panic attacks and concurrent substance abuse. She stated that she regularly used marijuana to help her relax, intermittently binged on alcohol and occasionally used other recreational and mood altering drugs.

Julie was preoccupied with fantasies of revenge and expressed a desire to harm or kill her father. She fantasised about purchasing heroin, hiding it in his car and informing the
police that he was a dealer. The purpose of this elaborate plot was to ensure he received the jail sentence she believed he deserved. During the course of therapy she became romantically involved with Jason, a young man with a history of violence. Julie related a detailed plan of how, together, they intended to give her father "the beating of his life".

The Issues
Julie's case raised a number of ethical and legal issues in deciding whether or not a duty to warn her father pertained. Her initial threat to implicate her father in dealing heroin required assessment of the feasibility of implementation. Determination of whether this threat should be considered to be a cathartic fantasy of revenge, not uncommon in cases of complex post-traumatic stress (Herman, 1992), or likely to be acted upon was required.

Assessment of Julie's second threat to physically assault her father in concert with her partner raised further assessment issues. The involvement of a third party added to the complexity of determining if this was a further revenge fantasy or required an appropriate intervention strategy.

Post-Traumatic Stress Disorder and Potential Violence
Post-Traumatic Stress Disorder (PTSD) is classified in DSM IV under Anxiety Disorders and according to Creamer (1996) PTSD may be relatively common in the general community, with lifetime prevalence rates for females twice those reported for males (approximately ten percent for women and five percent for men). The condition of psychological trauma has been noted under a variety of different names throughout history. Following two world wars when large numbers of military personnel developed stress related symptoms after combat or wartime trauma, the condition gained wider interest. Gradually the concept was extended to include stress experienced by civilians (Trimble, 1985).

According to Yehuda (1999) PTSD was categorised as a clinical entity when Vietnam veterans and their clinicians claimed that existing diagnostic categories did not adequately describe their symptoms. Although anger and aggression are acknowledged features of the disorder (Herman, 1992) they were never included in the original diagnostic criteria. Yehuda (1999) hypothesised that they were omitted because the concept of PTSD developed in the political milieu of the 1980s and was sensitive to the needs of veterans. Inclusion of anger and aggression in the criteria could have been seen as denoting criticism of the victim. Diagnostic criteria have since been updated, revised and refined and the concept, although evolving, still does not include anger or aggression.
Although case studies of the violent and aggressive behaviours of war veterans with PTSD have been reported (Beckham, Feldman, Kirby, Herzberg and Moore, 1997), the relevance of these studies to the present case is questionable because they were concerned with random and spontaneous acts of violence perpetrated by males. The targets of these acts of violence were frequently members of the immediate family whose proximity at times of rage rendered them vulnerable to attack.

A link between PTSD and female violence was reported by Stone (1993) who cited legal evidence from cases involving the defence of battered wife syndrome which he described as, “a clinically recognised sub-type of PTSD” (p. 26). The cases reported involved serious assaults or homicides, however the examples cited differed from the current case in that the perpetrators were still located in the abusive relationship and their actions were often a response to continuing violence rather than planned revenge.

Herman (1992) proposed the notion of complex post-traumatic stress response, a condition that derived from prolonged and complicated exposure to trauma and included anger and fantasies of revenge:

The revenge fantasy is often a mirror image of the traumatic memory, in which the roles of the perpetrator and victim are reversed. It often has the same grotesque, frozen, and wordless quality as the traumatic memory itself. The revenge fantasy is one form of the wish for catharsis (p. 189).

Although some individuals do harbour resentment toward the perpetrators of their suffering, the extent to which revenge fantasies are acted upon is unclear.

Pincus (2001), a neurologist with extensive experience of assessing criminals with a record of serious violence makes an interesting connection between PTSD and propensity for violence. He claims that “Abused children and adults are more likely to develop post-traumatic stress disorder (PTSD) if they are neurologically impaired” (p.68) and theorises that individuals who have experienced abuse and whose frontal lobes are damaged are less able to contain their rage. It appeared unlikely that Julie would agree to undertake or fund neurological testing to determine if she had suffered frontal lobe damage, however the possible connection warranted consideration.

Risk Assessment Issues
Beck (1987) cited in The World Health Organisation’s Treatment Protocol Project (1999) noted, “It is impossible to assess with 100 percent accuracy the likelihood of rare events such
as serious violence” (p. 532). In this case, the starting point for assessing whether a duty to warn pertained was consideration of the feasibility of implementing the threat. Julie initially proposed an elaborate scheme to ensure her father was charged as a drug dealer. Inquiry into how she proposed to implement this scheme revealed she had no prior experience of purchasing heroin, no knowledge of how much heroin would be required to ensure a charge of dealing, and no experience of breaking into motor vehicles to place the evidence. This scheme was considered to be a revenge fantasy with little likelihood of implementation and with no necessity to warn her father. In this instance Julie was simply reminded of the limits of confidentiality and the psychologist’s responsibility to protect her and others. Her second threat was more serious in that she reported a detailed plan, the implementation of which appeared feasible and the issue now became how should this threat be assessed and what should be included.

According to Otto (2000) there are five different approaches to violence risk assessment, each of which has advantages and disadvantages. They include clinical assessment, anamnestic assessment, guided or structured clinical assessment, actuarial assessment and adjusted actuarial assessment.

Clinical assessment involves taking a history, gathering test data and interview information and making a professional judgement. It is the method traditionally used by mental health professionals and has the advantage of familiarity in that many clinicians have been trained in this approach. However, because there can be considerable variation in professional judgements, its validity has been questioned (Ziskin, 1995). Anamnestic assessment utilises all of the clinical assessment methods and supplements them with past histories of violence and with third party information such as police, hospital or significant others’ reports. This approach attempts to identify themes or commonalities in previous violence episodes that would assist in predicting risk in the current situation. In common with clinical assessment, this method also suffers from a lack of consistency in professional judgements. It is also dependent upon availability of past histories. Guided or structured clinical assessment tends to be more accurate than clinical assessment (Borum & Otto, 2000) and involves obtaining information and data that has been shown to be related to violence risk: “Thus, although clinical judgement is still involved, the data on which the judgements are based (1) have some predictive value and (2) should be uniform across examiners using this structured approach” (Otto, 2000, p. 1241). Actuarial assessment approaches minimise or even exclude the involvement of mental health professionals judgements in determining violence risk. Information obtained is evaluated against a pre-existing formula and can be
administered and scored independent of professional input. Although this approach has been demonstrated to perform as well, or better than clinical assessments (Groove & Meehl, 1996), it has been criticised on a number of counts that include the omission of case specific information, and use of the formula on a population that differs from that on which it was normed. Moreover, Otto (2000) reported that there are relatively few actuarial formulae available for assessing violence risk and those available are most appropriately used with institutional populations with criminal histories. Adjusted actuarial assessment attempts to address these criticisms and combines actuarial assessment with expert examiners’ adjustments after taking into account case-specific factors. In common with other violence risk assessment procedures, accuracy is a problem and Quinsey, Harris, Rice and Cormier (1998) reported that this approach is less accurate or no more accurate than simple actuarial assessment.

As interview data and reasonably reliable data related to Julie’s propensity for violence was available a guided or structured clinical approach was adopted in this case. Such information about her partner’s propensity for violence was less readily available. It was evident that Julie lacked the physical strength to implement the plan without his involvement and some evaluation of his propensity for violence appeared warranted.

The Treatment Protocol Project of the World Health Organisation (1999) listed eleven variables associated with potential violence and these were gender (i.e. being male), low intelligence, drug or alcohol abuse, having poor impulse control and the availability of victims and weapons. They also included being unemployed, moving house frequently, coming from a violent family or violent subculture and, most importantly, a history of violence. The single strongest predictor in the above list was a prior history of violence, and, according to Rose (1998) some professionals would argue that it is the only reliable predictor of future violence. The World Health Organisation Treatment Protocol also considered motive to be an important predictive clinical variable. In assessing the potential for violence, they suggested consideration of the following factors,

- The individual’s history of violence (fights, hurting others, trouble with the police).
- Factors that may weaken self-control (e.g. psychotic illness, paranoid thinking, organic personality disorder such as a frontal lobe epilepsy syndrome, drug or alcohol abuse).
• History of impulsive behaviour. In addition to violence, drug abuse, or alcohol abuse, also consider stealing, shoplifting, sexual indiscretions, binge eating, suicide attempts or threats.

• Lastly, assess the level of intent (as you would with the assessment of suicidal thoughts). For example, specific intent, stated in the active voice, is more serious than a general threat in the passive voice (p. 532-533).

Taking into account the above factors, Julie had no prior history of violence, although she had reported a history of impulsive behaviour that included sexual indiscretions and drug and alcohol abuse. Although she considered that her regular use of marijuana decreased rather than increased her feelings of anger this was not the case with alcohol abuse and she reported a history of increased argumentativeness when inebriated. The single outstanding factor was that of intent. Julie voiced specific intent in the active voice and stated that together with Jason she intended to lure her father into the lane beside his home and assault him. Added to these factors are those concomitants of violence proposed by Pincus (2001).

Knowledge of Jason’s propensity for violence was derived from Julie’s reports of his behaviour and history, and observation of their interaction when he came to pick her up following therapy appointments. Julie described him as having a “short fuse” and told of him drinking heavily and occasionally hitting her. She reported that he had a conviction for assault, arising from his employment as a part-time security officer (bouncer) at a nightclub. She claimed that his motive for assaulting her father was his intention to prove his love and devotion. Julie regarded Jason’s potential for violence to be one of his most appealing qualities, denoting an ability to “defend” her. From her description of Jason’s history it appeared that they both had the potential to commit the proposed assault.

McSherry (2001) reported a recent Canadian Supreme Court case with relevance to the current case in that it led to the court providing guidance in the assessment of whether or not to breach confidentiality. The presiding Justice offered a test comprised of three factors to guide health professionals in deciding whether or not to disclose in the public interest: “First, is there a clear risk to an identifiable person, or group of persons? Second, is there a risk of serious bodily harm or death? Third, is the danger imminent?” (McSherry, 2001, p. 19). It was suggested that different weight be given to each factor in any particular case. These factors were then expanded upon to include warning a large but identifiable threatened group, e.g. school children, and to include serious psychological harm, as well as serious bodily harm and the necessity of imposing a particular time limit on the risk was qualified. In
Julie’s case, there was a clear risk of serious bodily harm to an identifiable person and the danger appeared to be imminent.

**Intervention**

Munson (1991) offered intervention guidelines to aid practitioners, whilst stressing they should not be considered rules for a specific situation or setting, warning that the practitioner will confront many situations that are ambiguous and may react to threats in different ways given the circumstances. As a general guide, he proposed, “Duty to warn includes reasonable and timely efforts to (a) seek commitment of the client, or (b) take treatment action designed to eliminate the carrying out of the threat, or (c) inform the police and the identified victim” (p. 3). He further proposed, “The warning given the identified victim should include (a) a description of the threat, (b) identification of the person making the threat, (c) identification of the intended victim or victims” (p. 3).

In accordance with Munson’s (1991) recommendation, treatment action designed to eliminate the carrying out of the threat was initiated. Julie was counselled to abandon her plan to seek revenge and advised of the legal implications of engaging in violence. Cognitive-behavioural anger management strategies were discussed and rehearsed.

When Julie reiterated her intention to proceed with her plan, she was again reminded of the limits of confidentiality that had been provided in written format at the commencement of therapy and which she now claimed to have never read. She was also again advised of the psychologist’s ethical obligation to ensure her safety as well as the safety of others. The decision to warn her father was framed in terms of ensuring her protection from possible legal action if her father reported the assault to the police.

Adoption of this procedure was intended to address the issue of potential damage to the therapeutic relationship in the event of a decision to disclose. The Treatment Protocol of the World Health Organisation (1999) suggested that discussing concerns and intended actions with the potentially violent individual may contain damage to the relationship. This protocol suggests that the relationship is rarely damaged if the intention to warn a third party is discussed: “It was usually when such a discussion with the individual did not take place that the case often ended badly” (p. 533). The suggested exception to this course of action was when such discussion placed the therapist at risk and as Julie was considered unlikely to pose such a risk the intention to warn her father and the possible consequences of such warning were discussed.
Outcome

Julie's initial reaction to the discussion of intended disclosure was one of anger and distress. She argued against the decision, stating, "He's only getting was he deserves" and several times asked: "How can you take his side like this?" Julie then claimed that she had never really intended to carry out her threat. Reluctantly she accepted the argument that this course of action was designed to protect her as much or more than her father and then became concerned about conveying this information to Jason, stating, "You'd better tell him, I'm not".

When Jason was informed of the decision to warn Julie's father he was far less acceptant than Julie and became enraged and intimidating. At one stage he threatened, "You're for it if any of this gets out!" What he meant by this threat was not clarified. He accused Julie of having a big mouth and not knowing when to keep it shut and pushed her out of the consulting room. She insisted that she was fine and required no assistance in coping with his behaviour. Less than an hour later she rang to say that she no longer intended carrying out her threat and requesting that no further action be taken before her next appointment.

When next seen Julie advised that her relationship with Jason had ended as their argument had escalated when they arrived home. Jason had assaulted her and disappeared when the neighbours called the police, returning the following day whilst she was at work to collect his goods. Although unhappy with this outcome, she nevertheless decided to continue in therapy, addressing her original concerns and the additional issue of abandonment. As there was little likelihood of the assault being committed without Jason's involvement, there no longer appeared to be any need to warn her father.

Approximately six weeks later Julie presented with a new boyfriend who gave every appearance of being a replica of the previous model, however, no further threats of violence to her father were made.

Discussion

The above case highlighted some of the difficulties that can arise in assessing the individual's potential for violence. The risk factors that were considered in assessing Julie's potential for violence gave no clear indication of degree of risk. With no previous history of violence, no access to weapons, and mixed effects of substance abuse, no clear picture emerged. The most salient factors were stated intent, identifiable victim and the ability to carry out the threat. In this case, the issues were clouded by the involvement of a third party whose
potential for engagement in violent behaviour could only be assessed from second-hand report.

An important factor considered in deciding whether a duty to warn existed was the feasibility of implementing the threat. This factor is not discussed in any of the discussions of risk assessment that give consideration to the existence of a plan but not to capacity to carry out the threat. Julie’s initial plan to implicate her father in drug dealing activities was fanciful and considered a cathartic revenge fantasy. It appeared most unlikely that she would be able to implement such plan and warning her father was judged unwarranted. However, there is a dearth of published information about the likelihood of people acting upon revenge fantasies on which to base such judgements.

Examination of the literature relating PTSD or battered wife syndrome to acts of violence didn’t contribute knowledge directly applicable to this case. The violence reported in the literature appeared to be either random, unplanned and related to substance abuse, as in the case of war veterans, or enacted by battered wives whilst in a dissociative state, neither of which applied to Julie’s case. However, recently published work (Pincus, 2001) suggests a link between PTSD and violence that requires consideration.

The second threat could less easily be dismissed as a revenge fantasy and her partner’s involvement in the scheme now lent it feasibility. His role in assisting Julie to effect revenge was analogous to use of a weapon in that he supplied the physical strength needed to implement the plan. Although his potential for violence was only assessed through Julie’s second hand reports of his prior behaviours, he never denied his intention to harm her father and his involvement underpinned the decision to warn.

The effect of disclosure on the therapeutic relationship was considered before discussing this issue with Julie and framing the decision in terms of benefit to her appeared to aid her acceptance and maintenance of the relationship. However, it was a mistake to assume that Jason, with whom the psychologist had no relationship, would be equally acceptant, or that his reaction could be reliably predicted. Although he made no specific threat of what he would do if disclosure were effected, he was sufficiently intimidating to cause discomfort. Julie’s reluctance to advise him of the decision was an indicator of his potential anger and the possible need to protect her. How this could have been effected without her co-operation is unclear but warrants consideration.

Davison and Neale (1990) raised a further issue, related to the effects of disclosure upon the therapeutic relationship. They argued that duty to warn requirements can erode confidentiality and increase the risk to potential victims in that clients who are aware of
disclosure provisions will avoid being truthful about their intentions. Such avoidance could ensure that the issues are not dealt with in therapy. Julie’s retraction of her threat and avoidance of attempts to further discuss her prior plan could well indicate a decision to avoid discussing any future intention of revenge rather than abandonment of such plans. Although this could may be the case, it is impossible to assess if her father remains at risk.
Chapter 4

Acquired Immune Deficiency Syndrome (AIDS) and Duty to Warn

According to Morrison (1989) psychologists are likely to confront the AIDS epidemic at some stage: "There exists a strong likelihood that difficult ethical decisions will be demanded of practitioners as they respond to the AIDS epidemic" (p. 300).

AIDS (acquired immune deficiency syndrome) is a frightening disease, transmittable through the exchange of bodily fluids, inevitably fatal, and is the last stage of the illness caused by the HIV (human immunodeficiency virus). The Australian HIV Surveillance Report (1999) states that there are 19,225 Australians infected with the HIV virus; the majority (17,850) of whom are males. Plummer, Kovacs and Westmore (1995) concluded that in Western countries transmission of the infection is predominantly a problem for gay men and unprotected homosexual intercourse with multiple partners is considered to be a major factor in transmission of the virus.

A Commonwealth Department of Community Services and Health (1998) pamphlet stated that the number of women who have been infected with the virus in Australia is quite small, but increasing. It is unclear if this increase is related to unsafe substance abuse practices such as needle sharing or sexual practices. A newspaper article ("The Age", August 20, 1999) reported very low male to female transmission, even when specific high risk behaviours were included. The conclusion was that the only sexual practice increasing the risk of HIV transmission between heterosexual partners was that of anal sex. In contrast, Plummer, Kovacs and Westmore (1995) claimed,

While it is true that HIV can be spread easily through anal intercourse, some people have concluded that vaginal intercourse with someone who may be infected is therefore not a great risk. This is a dangerous example of denial. In fact, either partner has a significant risk during unprotected anal or vaginal intercourse when the other partner is HIV positive (p. 92).
It appears that knowledge about risk factors in HIV transmission is still evolving and psychologists can be faced with difficult decisions about the legal and moral requirements to disclose to third parties at risk of infection.

**Disclosure and Legal Requirements**

Morrison (1989) cited American law that varied across States, both for and against disclosure. For example a Tarasoff type duty to warn pertained in some States, whilst in Maryland psychotherapists may be found guilty of a breach of confidentiality if they attempt to warn a third party. In Australia the legal responsibilities of persons who are aware of their HIV status is relatively clear, however the position with regard to health professionals' duty to warn is less clear and two newspaper articles are illustrative of these issues. For example, the Court found a male who engaged in unsafe sex with his wife subsequent to learning of his HIV-positive status to be guilty of reckless conduct. He was considered to have placed his wife in danger of serious injury and was jailed for the offence. (‘The Age’ August 14, 1999).

The second article concerned a doctor’s responsibility for transmission of the virus:

In a recent court case in NSW, a treating general practitioner was found guilty of negligence for failing to test a hepatitis-B positive man for HIV infection. The man, who denied having homosexual sex or using intravenous drugs, subsequently infected his wife with HIV. The judge contended that he would not have engaged in un-protected sex with his wife had he been aware of his HIV status and a prudent GP would have advised in favour of HIV testing (‘The Sunday Age’, January 16, 2000; p. 20).

It is unclear if the court would have considered that the doctor had a duty to warn the wife had an HIV test been conducted, or simply a duty to advise his patient about the need to take precautions to ensure his wife’s safety. As there is a lack of clear legal guidelines to clarify the situation the position adopted by professional associations requires consideration.

**Aids, Disclosure and Professional Codes of Conduct**

Neither the Australian Psychological Society nor the American Psychological Association has a policy relating to the protection of third parties of clients who are HIV infected or engaging in behaviours with a high risk of HIV infection. However, the American Psychological Association has adopted the following position in the event of legislation requiring disclosure being enacted:
1. A legal duty to protect third parties from HIV infection should not be imposed.

2. If, however, specific legislation is considered, then it should permit disclosure only when (a) the provider knows of an identifiable third party who the provider has compelling reason to believe is at significant risk for infection, (b) the provider has reasonable belief that the third party has no reason to suspect that he or she is at risk; and (c) the client/patient has been urged to inform the third party and has either refused or is considered unreliable in his/her willingness to notify the third party.

3. If such legislation is adopted, it should include immunity from civil and criminal liability for providers who, in good faith, make decisions to disclose or not to disclose information about HIV infection to third parties (American Psychological Association, 1991, p. 1).

In contrast, the American Psychiatric Association’s policy (APA AIDS Policy, 1988) states that it is ethically permissible to notify third parties who may have been exposed to infection by an HIV-positive client. According to Zonana, (1989) this policy was developed in the context of medical tradition of duty to the community and the duty-to-warn precedent set by the Tarasoff decision. The policy recommends that disclosure should only be made after all efforts to induce the client to terminate behaviour placing others at risk have been made, and if the client is cognisant of the limits of confidentiality. In lieu of an endorsed policy on disclosure, each case must be dealt with on a case by case basis. The following case illustrates some of the moral and legal issues pertinent to AIDS and duty to warn.

Case Summary
Clifford J, a 63 year old retired public servant was referred by his solicitor for psychological assessment in relation to a pending court case. The referring solicitor wished to know if there were mitigating circumstances that could be raised in his defence. Clifford had been charged with indecently assaulting a 16 year-old boy in a public toilet, a charge he strenuously denied. According to Clifford, the charges against him arose from a misunderstanding. Whilst using the public toilet he dropped his pen which rolled into the next cubicle and in attempting to retrieve it he inadvertently touched the genitals of the occupant of that cubicle. His explanation was somewhat implausible and the presiding magistrate at his trial reached a
similar conclusion. He was subsequently found guilty, received a community based sentence, and was mandated to continue in therapy until a place became available in a sex offenders' program. As Clifford was considered to be at risk of re-offending, whilst awaiting a place, he was permitted to continue attending the clinic that provided his initial assessment.

Initially Clifford maintained his innocence, claiming to be a happily married man, the father of two adult daughters and an active member of his church with no prior convictions. However, in the course of therapy, he disclosed that he had, over a period of many years, maintained a sexual relationship with his best friend who had died of natural causes in the previous year. Since his friend's death, Clifford had sought intercourse with a variety of partners and most of his sexual encounters occurred in public toilets and involved unprotected sex. Concurrently he continued to have intermittent and unprotected sexual intercourse with his wife who was unaware of his homosexual activities and maintained this lifestyle whilst in therapy.

Clifford's motivation to attend private therapy sessions was related to his desire to conceal his conviction from his wife, family and the wider community. He believed the confidential nature of the sessions would enable this and he threatened to kill himself if the information became known.

**Duty to Warn Assessment**

Clifford's case raised a number of ethical, legal and moral issues in deciding whether a duty to warn existed. According to Melchert and Patterson (1999),

> Complex clinical and legal issues arise for mental health professionals when their HIV-positive clients pose a potential danger to others as a result of engaging in needle sharing or unprotected sex (e.g., clients who became HIV-positive as a result of extra-marital intercourse but continue to have sexual relations with their own spouse) (p. 180).

A factor contributing to the complexity in Clifford's case was a lack of clarity about his current HIV status. He had never been tested for the illness and even if he were tested the knowledge may not have assisted in determining whether a duty to warn his wife existed. As he continued to engage in risky behaviour, even if he currently tested negative he may well subsequently test positive. Although it was clear that Clifford's behaviour placed him at risk and had the potential to harm his wife it was unclear if he posed sufficient risk to warrant disclosure.
An initial step in determination of an appropriate course of action was consideration of possible therapist bias affecting deliberations. Roy and Tsoukas (1986) warned health professionals of the ethical danger of permitting prejudice and panic to influence behaviour toward AIDS victims and the APS Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (2001) caution psychologists of the need to ensure the rights of such clients to ethical treatment. Both Keith-Spiegal and Koocher (1985) and the Australian Psychological Society Code of Ethics (1997) advised psychologists to be aware of their biases and to take responsibility for avoiding the imposition of their own values on clients. For example, the APS code states,

Psychologists must be sensitive to cultural, contextual, gender and role differences and the impact of those on their professional practice on clients. Psychologists must not act in a discriminatory manner nor condone discriminatory practices against clients on the basis of those differences (p. 1).

Such warnings appear warranted as personal bias can affect decisions of whether or not to disclose.

McMahon (1993) cited research by Morgan and Moore, (1991) in which graduate psychology students were presented with a case vignette containing issues similar to those of the current case. When asked to determine whether or not to inform the wife of her husband’s HIV status, a significant variable in this study was mode of infection. Disclosure was significantly more likely to be advocated by respondents when the client had become HIV positive through homosexual activity or sex with a prostitute, than in the event of infection from blood transfusion or heterosexual intercourse. Moral judgements of whether the infection had been contracted “innocently” or in a “guilty” manner affected the decision of whether or not to disclose.

In light of this study, the initial assumption that a duty to warn Clifford’s spouse must exist was re-examined. The question of whether a duty to warn would have been assumed if Clifford had “innocently” contracted the illness or been engaging in unprotected heterosexual intercourse with multiple partners was considered. The salient feature was the degree of risk posed by the behaviour rather than a moral judgement of the behaviour and it was concluded that therapist bias, if present, was not motivating the assumption that disclosure may be necessary.

Two further factors were considered in deciding whether a duty to warn existed, and they included the degree of risk posed by Clifford’s behaviour and the possible legal
consequences of the decision. Consideration was given to the possibility of legal action being instituted against the psychologist following either the decision to maintain confidentiality or to disclose. It was unclear if the therapist could be held legally responsible for Clifford’s pain or suffering in the event of unnecessary disclosure or if failure to warn the wife could result in Tarasoff type proceedings. Yet another consideration was the possible effect of the decision on Clifford who had threatened suicide in the event of disclosure. The Psychologists’ Registration Board’s prerequisite to disclosure is establishment of “clear danger” and assessing the degree of risk of HIV infection being transmitted was a major factor in deciding whether a duty to warn pertained. The question became: Without knowledge of Clifford’s HIV status, how could the degree of risk involved be determined? Zonana (1989) claimed, “In deciding whether disclosures are warranted several factors should be considered. The more likely it appears that the patient will cause harm, the more important it is to take protective action. Another factor is the duration of the risk posed by the patient. The longer the period of risk, the more important it may be to make a disclosure” (p. 164). All of these factors were relevant to Clifford’s case.

According to Melchert and Patterson (1999), if the risk of transmission were sufficiently low, warning a third party, against the stated wishes of the client, would not be warranted. In order to assist in determining degree of risk of transmission, these researchers developed a model of risk assessment and intervention based upon assigning HIV-positive clients to four degrees of risk categories. They designated clients as no risk, negligible risk, high risk or severe risk, and the final category was reserved for those individuals who expressed an intention to harm others by deliberately infecting them with the virus.

Table 1 shows Melchert and Patterson’s (1999) model of risk assessment and proposed interventions. From examination of this table it can be seen that the suggested intervention is linked to HIV status, knowledge of which may not always be available. These authors acknowledge this point:

In practice, however, there are many clients who could have contracted HIV as the result of having engaged in a large amount of high-risk behaviour in the past but whose HIV status is unknown because they have not yet been tested for the virus (Melchert & Patterson, 1999, p. 183).
<table>
<thead>
<tr>
<th>Level of Risk to others</th>
<th>Engaging in high risk behaviour</th>
<th>HIV Testing Results</th>
<th>Partner/s aware of test results</th>
<th>Duty to Warn</th>
<th>Intervention (see below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None or Very low</td>
<td>No (a)</td>
<td>No</td>
<td>No</td>
<td>*1.</td>
<td></td>
</tr>
<tr>
<td>No (a)</td>
<td>Yes</td>
<td>Negative</td>
<td>No</td>
<td>*2.</td>
<td></td>
</tr>
<tr>
<td>No (a)</td>
<td>Yes</td>
<td>Positive</td>
<td>No</td>
<td>*3.</td>
<td></td>
</tr>
<tr>
<td>Negligible (b)</td>
<td>No</td>
<td></td>
<td>No</td>
<td>*4.</td>
<td></td>
</tr>
<tr>
<td>Negligible (b)</td>
<td>Yes</td>
<td>Negative</td>
<td>Yes or No</td>
<td>*5.</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Negligible (b)</td>
<td>Yes</td>
<td>Positive</td>
<td>No</td>
<td>*6.</td>
</tr>
<tr>
<td></td>
<td>Negligible (b)</td>
<td>Yes</td>
<td>Positive</td>
<td>No</td>
<td>*7.</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Yes (c)</td>
<td>No</td>
<td>No</td>
<td>*8.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes (c)</td>
<td>Yes</td>
<td>Negative</td>
<td>No</td>
<td>*9.</td>
</tr>
<tr>
<td></td>
<td>Yes (c)</td>
<td>Yes</td>
<td>Positive</td>
<td>No</td>
<td>*10.</td>
</tr>
<tr>
<td>High Risk</td>
<td>Yes (c)</td>
<td>Yes</td>
<td>Positive</td>
<td>Yes</td>
<td>*11.</td>
</tr>
<tr>
<td></td>
<td>Yes (c)</td>
<td>Yes</td>
<td>Positive</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Severe Risk</td>
<td>Intent to infect</td>
<td>Yes or No</td>
<td>No</td>
<td>Yes</td>
<td>*12.</td>
</tr>
</tbody>
</table>

(a) Persons not engaging in high-risk behaviors refer to those who are not engaging in sexual intercourse, intravenous drug use, or other activities that carry a significant risk of exchanging bodily fluids with another individual. (b) Negligible-risk behaviors refer to safe sex and clean needle-sharing. (c) High-risk behaviors refer to unprotected intercourse and unclean needle sharing.

**Intervention:**

1. If client may have been exposed to HIV in the past, discuss need for testing. Educate about HIV as appropriate.
2. If client may have been exposed to HIV since one half-year before being tested, discuss need for retesting. Educate about HIV as appropriate.
3. Encourage client to get treatments and inform past partners, health care providers, etc., as appropriate. Provide HIV-specific treatment interventions.
4. If client may have been exposed to HIV in the past, discuss need for testing. Support safe practices and educate about HIV as appropriate.
5. If client may have been exposed to HIV since one half-year before being tested, discuss need for retesting. Support safe practices and educate about HIV as needed.
6. In addition to (3) above, support safe practices.
7. In addition to (3) above, discuss need for informing current partner(s) of test results. Support safe practices.
8. Encourage client to cease high-risk behaviours and get HIV testing. Educate about HIV as needed.
9. If client has engaged in high-risk behaviour since being tested with anyone not known to be HIV-negative, encourage client to cease high-risk behaviors and get HIV retesting. Educate about HIV as needed.
10. In addition to (3) above, discuss need to cease high-risk behaviors and educate about HIV as needed.
11. Strongly encourage client to cease high-risk behavior. Encourage client to inform partner(s). If client will not cease behaviours or inform partner(s), therapist or authorities should notify the partner(s). See also (3) above.
12. Assess dangerousness to others and need for hospitalization and informing police and potential victims.
It was apparent that Clifford would fall into the category of unknown HIV-status and in order to deal with this issue, a second factor, test status and results, was introduced into the model. Assessing Clifford, in accordance with this model, would result in him being assigned to the intermediate risk category as he was engaging in high-risk behaviours and his HIV status was untested.

The suggested interventions proposed by this model are related to the degree of risk that the client poses, as well as their HIV status. They range from educating low risk individuals about the possible effects of the virus to disclosure or seeking police intervention in the case of high risk individuals who have expressed a deliberate intent to infect another person.

Melchert and Patterson (1999) made the point that disclosure needs to be based upon actual risk and cited findings of the Texas Supreme Court that upheld this principle:

Although the past behaviour of some clients would clearly put them at risk of HIV infection, warning their partners is not justified without reasonably clear information that they present an actual (and not simply potential) risk to those partners as the result of being HIV-positive (p. 183).

In Clifford’s case, independent legal advice was sought and this advice confirmed that Australian courts were likely to adopt a similar position to that of American Courts and the psychologist was cautioned against disclosure.

**Intervention**

Melchert and Patterson’s (1999) recommendations formed the basis of the intervention in Clifford’s case. On the assumption that no duty to warn existed without actual risk being established the recommended intervention was aimed as risk reduction and included educating Clifford about HIV, encouraging him to cease high-risk behaviours and to obtain HIV testing.

Initially risk reduction targeted the most dangerous of Clifford’s behaviours which was engaging in unprotected oral and anal sex with multiple partners whose HIV-status was unknown. He was reluctant to talk about this topic and appeared to have limited knowledge about HIV. His reluctance to discuss the topic made it difficult to evaluate how much he knew about HIV/AIDS and he was provided with a copy of Plummer, Kovacs and Westmore’s publication “Sexually Transmitted Diseases” to read and discuss. This educative
publication was selected for its relevance to an Australian population and its readability. He half-heartedly discussed the issues and seemed to be more concerned with placating the psychologist than obtaining useful information.

Clifford was also provided with information about the need for HIV testing and offered referral to a discrete specialist clinic. The referral was never taken up and Clifford continued to discount the possibility that he could have AIDS or be HIV positive. An offer of assistance in making limited disclosure to his wife was firmly declined as he believed, quite possibly correctly, that “coming out” at his age would lead to loss of his marriage, home, assets and community standing.

Intervention was therefore concentrated upon encouraging Clifford to cease engaging in high-risk activities and to adopt safe sex practices that afforded some measure of protection for both his wife and himself. He rejected suggestions that he seek alternative and safer ways of meeting sexual partners preferring the anonymity and excitement of casual encounters. He was also counselled to use condoms when engaging in sexual intercourse with his wife, an idea he initially resisted, expressing concern about how he would explain his reasons for doing so. He eventually claimed that he could think up a satisfactory explanation for using condoms, and would somehow relate their use to a bladder infection.

Despite Clifford’s assurances it was unclear if he genuinely intended to adopt this practice or was again placating the psychologist. Clifford was also highly resistant to the idea of carrying condoms for use outside of the home, despite acknowledging the risk posed by his behaviour. He claimed that the unplanned nature of his sexual encounters often precluded the use of condoms and it became clear that he equated the use of condoms with planned intention to engage in homosexual intercourse and with being “a homosexual”. He found this notion to be completely ego-dystonic, insisting that he was mainly a normal heterosexual male, as evidenced by his marriage and family, who occasionally found himself in “awkward situations”. It appeared that further exploration of Clifford’s understanding of his sexuality was required before his acceptance of the need for behavioural change.

Clifford was invited to explore those issues central to his sense of sexual identity and the psychologist’s attitude to homosexuality as a normal variant of human sexuality was discussed. He recounted the trauma he experienced when, at 16 years of age, his father chanced upon him having sex with a friend, and “all hell broke loose”. He was chastised with a leather belt, and his father arranged introductions to suitable females from their church youth group where he eventually met his wife. They married when he was 19 and she was 21 years of age and the birth of their two daughters provided him with the security of
heterosexual approval in his family. He described a fondness for his wife and acknowledged
the protection from discrimination that his marriage had afforded him. He came to the
conclusion that in different times, or a different society, he may have been openly
homosexual but believed, possibly correctly, that this was not an option in Australian
suburbia 40 years ago. At 60 plus years of age he had no intention of “coming out” and,
despite the dangers inherent in his current practices, he felt the need to continue to seek
clandestine homosexual encounters.

After exploring his sexuality, Clifford now characterised himself as bi-sexual,
however adoption of this sexual identity only translated into marginally safer behaviours. He
claimed that he now used condoms when seeking sexual encounters. He left private therapy
to join a mandated sex offenders program.

Discussion
Clifford’s case posed a dilemma for the treating psychologist. The principal conflict was
between the legal requirements to maintain confidentiality and moral concerns for the welfare
of his wife and other partners. Although legal advice and accepted assessment measures
delivered the verdict that no duty to warn was warranted in the present case, together with the
fact that the therapist would be in breach of fiduciary requirements in disclosing without the
client’s consent, disquiet with the decision remained.

Pope and Vetter (1992) made the point, “Most psychologists are likely to have
encountered dilemmas in which following legal requirements seemed clinically and ethically
wrong, perhaps placing the client or third parties at needless risk for harm or injustice”
(p. 400). Clifford’s case provided a pertinent example of just such a dilemma.

Legal and professional consultation was undertaken to determine the psychologist’s
position regarding disclosure in this case and to determine if the case had ‘Tarasoff’
implications. Consultation with the Australian Psychological Society regarding the ethics of
disclosure in this particular case led to referral to the Melchert and Patterson (1999) model of
risk assessment whilst consultation with an Australian criminal law practice yielded advice
similar to that offered by Melchert and Patterson. The central legal issue was the difference
between actual and potential threat and without knowledge of Clifford’s HIV status, the
threat could only be considered as potential and disclosure without client consent could leave
the psychologist open to legal action. Ultimately the decision against disclosure was based
on this model, and legal advice. Although the decision to maintain confidentiality met legal
and professional requirements it seemed morally wrong.
In therapy, Clifford was provided with information and discussion about the dangers inherent in his current sexual practices and any decision to continue engaging in such practices must be considered to be an informed decision on his part, with recognition of the potential harm deriving from that decision. The reality of the situation was that his wife was not in the position to make such an informed decision and her health and safety remained dependent upon her husband's behaviour.

Clifford entered therapy in denial of the danger that his sexual practices afforded to both himself and his wife. Despite the provision of educative material, discussion of the need for testing and some clarification of his sexual identity, he left still in partial denial. He remained unwilling to countenance the possibility that he could have contracted AIDS or to undertake testing to clarify his status.

Clifford gave assurances that he would now use condoms and possibly seek safer venues for meeting sexual partners. It is unclear if he actually did use condoms and there was no way of establishing the veracity of his assurances. He acknowledged a moral and legal obligation to ensure that his wife was safe from the possibility of infection. He also acknowledged self-interest in ensuring his own freedom from risk of infection and risk of further prosecution if he continued to use public toilets as meeting places. Despite these assurances the likelihood of him implementing such changes was questionable because he found the clandestine nature of his encounters dangerous but exciting, and related that he experienced arousal from fantasising about them.

Although extensive consultation and consideration was given to the ethical and legal recommendations for interventions in such cases, the outcome could only be considered to be mildly satisfactory. At the conclusion of therapy, the psychologist remained disquieted with the outcome and ill at ease in attempting to reconcile the moral and legal aspects of this case. Some consolation was afforded by the fact that Clifford was required to continue therapy in a mandatory sex offenders program, and the hope that this program may have reinforced and extended the changes he commenced in individual therapy.
Chapter 5

Confidentiality and Minors

The decision to maintain or disclose confidential information when working with minors is of considerable complexity. Intuitively, it seems that the treating psychologist takes on considerably more responsibility in treating an adolescent if the parents are unaware of the issues involved. The psychologist providing services to minors needs to be aware of the legal and professional responsibilities accompanying this area of practice. For example, Hands (1999) noted, “Third parties, such as parents, school principals, teachers, supervisors, managers and external consultants may claim a right to, or even ownership of confidential information” (p. 59).

Milne (1995) claims that possible legal and professional repercussions exert considerable force in this arena of professional practice: “A counsellor has a primary obligation to observe a minor’s expressed wish that information remain confidential” (p.174). The exception to this primary obligation is when non-disclosure would be adverse to the child’s welfare or disclosure is directly required by law. The Bulletin of the Psychologists’ Registration Board (September, 1997) states,

The common law treats minors as capable of giving voluntary, informed consent when the minor has sufficient understanding and intelligence to understand a matter. If a minor gives his or her voluntary and informed consent to a matter, any right which a parent may have had over the child in relation to that decision ceases” (p. 2).

Similarly, the APS Guidelines on Working with Minors (1999) recognised that psychological services can be sought and consented to by a minor and that a wish for confidentiality should be respected within the legal requirements and obligations related to maturity. Milne (1995) asserted that if a psychologist provided information to the parents of a mature minor, without that minor’s consent, the psychologist could be successfully sued for negligence. In this regard, she suggested it is reasonable to apply legal principles as they relate to the doctor/patient relationship and considered that, under equity (secrecy law), counselling relationships would be considered to be subject to fiduciary law.
Minors are protected under the amended Family Law Act 1995, and the best interests of the child remain the Court's paramount consideration. In the opinion of the Psychologists' Registration Board, the amended act does not grant rights over minors, which do not otherwise exist at law, "such as the right of a parent to require disclosure of confidential information of a minor where that minor is able to give voluntary and informed consent but withheld it" (p. 2).

The issue of disclosure appears to hinge upon the notion of maturity and the ability of the minor to provide voluntary informed consent to treatment and/or disclosure. Difficulty arises in defining who is a "mature minor" as there is no magic formula in relation to this issue and children of varying ages are considered legally competent to give voluntary informed consent in different situations. For example, Milne (1995) reported that in Britain it was found lawful to provide medical treatment to a 14 year old minor without need for parental consent (Gillick v West Norfolk and Wisbech Areas Health Authority, 1985). In New South Wales, under the Minor's Act, if children from 14 years of age do not consent to their dental and medical treatment, such treatment can be considered to be assault. There is a Common Law presumption (doli incapax), which applies in all Australian States and Territories, that a child between the ages of ten and fourteen is not able to form the necessary criminal intent to commit an offence. The APS Guidelines on Confidentiality, including Working with Minors (1999) suggested, "Maturity is a professional judgement but around fourteen or fifteen years is generally regarded as a good 'rule of thumb'" (p. 3). These guidelines advise that the limits of confidentiality should be explained to minors seeking professional services and the Bulletin of the Psychologists Registration Board (1999) states, "When establishing the clinical relationship, psychologists should determine in consultation with the client, the persons to whom information may be disclosed" (p. 3). These parameters of confidentiality in no way exclude the duty to warn in the case of clear danger to the client or others.

The following case is concerned with assessing the capacity of a minor to determine if confidential information should be disclosed and whether disclosure is in the best interests of the minor. The effects of non-disclosure on the provision of family therapy is also addressed and interventions dealing with these issues are discussed.

**Case Summary**

Elena (Elly) the youngest child of migrant parents was referred, together with her family, for family therapy when her school became concerned about her lack of academic achievement,
defiance of school rules, abuse of staff and occasional unexplained absences from class. She had been unwilling to talk to the school counsellor. Elly referred to her school counsellor as “The Seven Nightly News”, a play on the counsellor’s surname and Elly’s belief that issues discussed with her would be divulged to her teachers and parents. She had accumulated numerous demerit points and the school was considering its options for further action.

Elly’s parents both worked long hours in the family business and her paternal grandmother who lived with the family was responsible for her day to day care. Her two older siblings, a brother and sister, had attended the same private college as Elly and were now completing tertiary studies. Elly described them as “sucks” and “goody-goodies” and referred to her grandmother as “that old bitch”. Her hostile and disobedient behaviour at home alienated her from other family members.

The entire family, with the exception of the grandmother who had limited English, attended family therapy sessions. Elly’s contribution to these sessions was restricted to sullen silence or “don’t know” responses and she was offered limited individual therapy sessions to which she reluctantly agreed.

Elly met DSM IV criteria for a diagnosis of Oppositional Defiant Disorder and concurrent Dysthymic Disorder. A pattern of hostile and defiant behaviour that included temper tantrums, frequent arguments with adults, refusal to comply with family and school rules was reported, and this pattern had been present since early childhood but had become worse in the last two years. She was angry and resentful, easily annoyed by others and deliberately provoked her siblings. At the same time she reported that she had felt sad and unhappy for a lengthy period of time but was unable to say when this started. She claimed that she was unable to live up to her parents’ expectations or compete with her siblings’ academic achievements and had stopped trying. No suicidal ideation, general medical condition or other condition that could account for her symptoms was reported.

In the course of therapy Elly slowly developed a rapport with the psychologist and divulged information about her family that was not known to their therapists. She claimed that her parents constantly fought and were on the verge of separating and that her grandmother was the instigator of these family fights. She believed that her grandmother detested her mother and considered her father to have married beneath his social status. She also casually divulged that she regularly drank and “smoked dope all the time”, as did all her friends. She clearly stated that she didn’t want her parents or their therapists to be told any of this information: In relation to family discord she said: “Don’t tell them what I said, they
don’t want anyone to know” and in relation to her drinking and use of marijuana: “You won’t
dob me in, will you?”

Issues
Elly’s case raised numerous ethical, legal and professional issues that included clarifying the
limits of minors rights to confidentiality and their ability to give voluntary informed consent
to treatment and disclosure. Assessment issues included establishing whether Elly could be
considered a “mature minor” based upon her age, IQ and cognitive capacity to make moral
judgements. The question became one of determining if she was sufficiently mature to
decide upon the maintenance of confidential information as well as determining if non-
disclosure was in her best interests and how it may affect her treatment. Did her use of
alcohol and marijuana constitute a “clear danger” that warranted disclosure to her parents or
others? A further issue related to whether the information that Elly provided in individual
therapy sessions should be disclosed to the therapists working with her family.

Peterson and Siddle (1995) raised the possibility of a conflict between the moral duty
to help and the need to protect confidentiality and cited the difficult situation that could arise
in the event that:

A researcher who feels bound by a subject’s trust and/or a promise of
confidentiality to refrain from disclosing to family members a subject’s
alcohol or drug dependence problem discovered during research might
at the same time believe that the only way this subject’s problem will
be overcome is through assistance by the family (p. 190).

The information that Elly provided in individual therapy sessions highlighted just such a
dilemma.

Assessment
Assessment initially focussed upon determining whether Elly was sufficiently intelligent and
mature to understand the issues involved in her decision that information provided in therapy
should not be disclosed to her parents. Although she was 15 years of age, and within the age
level suggested as a rule of thumb criteria for maturity, her academic difficulties, oppositional
behaviour and dysthymia suggested the need for further assessment.

The APS Guidelines on Confidentiality including Working with Minors (1999)
provided no suggestion as to how maturity should be measured, however school reports of
academic performance and details of IQ testing had been provided by the referring School
Counsellor. IQ testing placed Elly in the lower "Normal" range of intelligence but included comments to the effect that her score may have been affected by her oppositional attitude to testing. Her academic performance appeared to have been similarly affected by her attitude and lack of application and her school reports included teachers' comments such as, "Could do better" and "Does not apply herself". No history of developmental disorder or neurological defect that may have affected her results or capacity to make reasoned decisions was obtained from her parents.

Elly's understanding of what behaviour is right and wrong was evaluated in accordance with Kohlberg's (1976) stage theory of moral development. According to this theory, the moral judgement of children under the age of nine is egocentric and the fear of punishment determines judgements of whether any behaviour is good or bad. Between about nine and twenty years of age notions of right and good are equated with the maintenance of social norms and values and affected by a desire to live up to the expectations of others. This is the stage of moral development that Elly's age suggests she should have attained; however her behaviour was not in accordance with this stage. She had stated that she has given up trying to meet her parent's expectations. Kohlberg's third stage of moral development involves the individual applying abstract values to decisions about good and bad and is not reached before twenty years of age. The age at which this stage is achieved is probably related to full mylenisation of the frontal lobes (Pincus 2001) and was not applicable to the current case.

A modified version of a brief series of questions devised by Apler (2000) was used to assess Elly's ability to understand the issues and make moral judgements. The questions concerned her knowledge of the rules of behaviour, her understanding of why there are rules, the consequences of breaking them and the effect on others. Information about her feelings and her behaviour when with others and when alone, was intended to elicit responses of regret, remorse or shame.

Elly clearly indicated that she knew that some of her behaviour was wrong and that she was aware of the effect her behaviour had on others. However, she justified her oppositional stance by referring to the manner in which rules were conveyed: "I might do what they want if they didn't yell at me". She also expressed a keen sense of justice that often led to her arguing with her teachers or disobeying: "It's not fair blaming [school friend] for not having her work done. Her Mum's sick" and "I don't know why everybody should have to stay in when only two did it. I didn't stay". She also appeared to consider that her Grandmother's interference in her parents' marriage justified any rudeness and disobedience:
“She gets what she deserves”. Her appraisal that “everyone does it” was used to justify her use of substances, however she had limited knowledge of their effects. Although there were flaws in her reasoning, Elly appeared to have the capacity to decide whether her confidential communications should or should not be disclosed.

The extent of Elly’s substance abuse was assessed and DSM IV criteria for a diagnosis of substance abuse were not met. Her substance abuse was substantially less than originally intimated, in fact, her experimentation had been limited to a couple of occasions when friends had been able to obtain marijuana or alcohol. Despite bragging about “getting stoned all the time”, she appeared to be an occasional and experimental user, and it was established that she had neither the money to purchase large quantities of alcohol nor did she have access to her parent’s alcohol. A school friend had supplied marijuana, other than this she had no source of supply. Such experimental usage is not unusual among teenagers; the Premier’s Drug Advisory Council (1996) advised that approximately 22% of female Year 7, 9 and 11 students have sampled drugs and this knowledge affected the choice of intervention.

**Intervention**

Prior to Elly commencing individual therapy, her consent and that of her parents was obtained and the limits of confidentiality were discussed. Her parents agreed that any information she provided in therapy would not be disclosed to them, unless there was a serious risk of harm to her or to others. Dadds, Geppert, Kefer and Vaka (2000) recommended “quarantining” the relationship with the adolescent in concurrent family therapy and suggested that this should include discussion of the implications of joint sessions, confidentiality and the sharing of information. Accordingly the way in which information obtained in both concurrent family therapy sessions and individual sessions would be used was negotiated with Elly and her parents. It was agreed that Elly could decide if the content of her individual session communications would be disclosed and she was free to discuss the content of joint sessions if she wished.

The recommendations of the Premier’s Drug Advisory Council (1996) and Spooner, Mattick and Howard’s (1996) review of best practice of treatment for youths aged 11-18 years were adopted. Both of these sources propose that harm minimisation should be the goal of treatment and this has been the guiding principle for the State and National drug strategies for over a decade. This course of action is recommended for a number of reasons:
- It aims to reduce the adverse health, economic and social consequences of drug use for individuals and society and does not necessarily imply the goal of prohibiting or eliminating drug use.
- Harm reduction policy accepts that people use drugs on occasions and aim to minimise the harms associated with misuse. It is about helping people to use drugs as safely as possible (The Premier’s Drug Advisory Council Report 1996, pp. 69-71).

Since young people rarely seek help from specialist drug services (except in cases of severe drug problems) the Report recommended they be provided with information, education and treatment outside of such specialist services. Elly was offered educative literature, discussion about the effects of marijuana and alcohol and encouraged to adopt safe practices. Although she gave no guarantee of refraining from substance use she appeared to understand the need for caution. As her access to both alcohol and marijuana was limited, and as no clear risk of harm was apparent, it was decided to maintain confidentiality about her experimentation with these substances.

The information about family conflict that Elly disclosed was relevant to her family’s participation in therapy and to treatment of her dysphoria, which appeared to be linked to family discord. DSM IV notes that Dysthmic Disorder may be associated with Conduct Disorder and is more common in families where there is serious marital discord. Oppositional Defiant Disorder is a less severe variant of Conduct disorder. Mak and Kinsella (1996) related issues of adolescent drinking and conduct problems to parental bonding, and De Ross, Marrinan, Schattner and Gullone (1999) found that family environments high in control and conflict, but low in cohesion were related to adolescent reports of low self-esteem and high depression. It appeared that raising issues of family discord in joint therapy sessions could be of benefit to Elly and her parents, however she was reluctant to do so. Eventually she decided to make limited disclosures with the support of her psychologist. Following discussion, Elly gave permission for the psychologist to discuss with her parents her need for further treatment of her depression.

Discussion
Although Elly was assessed as being of sufficient maturity and intellectual capacity to decide about the maintenance of confidentiality, this case raised a number of issues about how such maturity should be assessed. The APS Guidelines on Confidentiality including Working with
Minors (1999) suggest that this is a matter of professional judgement, but make no recommendation about what that judgement should be based upon, other than offering an age range as a rule of thumb guide. A starting point may be the assessment of IQ as a relationship between age-normal intelligence and maturity could be argued.

Pincus (2000) considered that neurological assessment may also be warranted when considering the individual’s capacity to make reasoned judgements. However the cost and time required for such assessment is probably not warranted in most instances. It is known that a number of disorders, such as Oppositional Defiant Disorder and Dysthymic Disorder can affect decision making capacity and awareness of the cognitive effects of these disorders requires ongoing evaluation throughout therapy.

It was clear that Elly’s experimentation with alcohol and drugs did not place her in “clear danger” and did not warrant disclosure to her parents. Although the course of action undertaken met best practice recommendations for dealing with adolescent substance abuse, it is unclear if her parents would have arrived at the same conclusion. It is also unclear whether they had a right to know about her experimentation, or how they would have dealt with this issue. The possibility arises that she may, at some later stage, decide to disclose this information to her parents, and this may well affect their continuing participation in therapy.

Elly’s request that information about family conflict not be disclosed raised issues for her therapist, who possessed information not available to the therapists working with the family. Theories of family therapy propose that the maintenance of family secrets has a deleterious effect upon family functioning. An analogous situation now existed between the family therapists and this issue was raised and addressed in peer supervision sessions. In these sessions it was agreed that information obtained in individual therapy sessions with Elly should not be disclosed; however she should be encouraged to raise the issues in joint family sessions. This course of action proved successful and her eventual full participation in joint family sessions contributed to the family addressing previously concealed issues.

According to Milne (1995), “Deciding upon the “best” course of action in many situations can in practice prove very difficult” (p.174). Elly’s case is illustrative of how disclosure issues in family therapy can be complex and can affect all parties.
Chapter 6

Conclusions

The four case studies presented in this portfolio highlighted some of the difficulties encountered when deciding whether to disclose confidential communications. The issues encountered were complex and assessment measures often failed to provide a definitive answer to the question "Should this information be disclosed?"

The first case concerned the accuracy of assessment of suicidal intent and the practicality of intervention. Martin presented with sufficient risk factors to alert to the possibility of suicide; however his intent was never clear and the decision to intervene was made without certainty of intent. The ambiguity of his phone call, the fact that he couldn’t be contacted and the lack of success with attempted intervention made this case stressful. In clinical practice, decisions are sometimes required without certainty of intent. The tale that is told of a gambling man’s response to the question of whether he believed God existed has parallels. He replied that he was betting on it, because, if he was wrong he was no worse off than anyone else, however if he was right he anticipated a good return on his investment. If the decision to intervene was wrong, the therapist would look foolish but no real harm was done; on the other hand if the decision was correct the stakes were high.

It was expected that deciding whether to intervene would be difficult in Martin’s case, what was not anticipated was how difficult it would be to obtain assistance for him. Crises seem to have a propensity for occurring outside of office hours and this case led to some revision of crisis intervention strategies. One simple solution, since instituted, was that of obtaining the mobile phone number of all clients. Obtaining an after-hours contact number from general practitioners referring depressed patients was also considered. The efficacy of these strategies has yet to be assessed.

The second case presented was concerned with assessing whether a "duty to warn" existed. Julie’s initial threats didn’t appear to warrant intervention, however subsequent threats that could feasibly be implemented and the involvement of her partner changed this assessment of the situation. Although advising Julie of an intention to warn was the recommended procedure, in retrospect it was probably not advisable to also advise her partner, who had a reputation for violence and no established relationship with the therapist.
The threat was withdrawn and the necessity of warning her father diminished when her partner, Jason, departed the scene; however, her presentation some weeks later with a new, and similar partner raised some discomforting thoughts. If she was intending to carry out her plan with this new partner, she had clearly decided against letting her therapist know.

The case that caused the most concern was that of Clifford who continued to engage in risky behaviours, despite concerted efforts to educate him about the possibility of contracting the HIV virus. He obviously had no intention of changing his sexual practices and suggestions that he find safer meeting places and use condoms were politely dismissed or received half-hearted acquiescence. He eventually agreed to the use of condoms at home, however it is unknown if he actually intended to do so or merely agreed to appease the therapist; the latter is suspected.

Legal and professional consultation undertaken to determine if Clifford’s wife should be advised resulted in a warning against disclosure without knowledge of his HIV status. However, at the end of the day, the decision not to disclose didn’t sit comfortably because Clifford had made an informed decision to continue to expose himself to risk. His wife was not in the position of being able to make a similarly informed decision.

The final case involved deciding whether a “mature” minor’s confidential communications, particularly those of substance abuse, should be disclosed to her parents. Determining “maturity” required careful consideration, as some of Elly’s behaviours were anything but mature. The decision that disclosure was not warranted was based upon assessment of her intellectual capacity and moral understanding of the issues involved together with consideration of the severity of substance abuse. Elly’s parents may not have reached a similar conclusion and it is possible that, at some later stage, she may tell them herself, because of the shock value inherent in such disclosure and the attention she would receive. How such disclosure would affect their continuation in therapy requires thought. This case also raised issues for family therapists working as a team when information is not available to all team members and no definitive answers were derived from Elly’s case.

A recurring theme, common to all the cases presented, is that of the difficulties inherent in risk assessment and intervention. Beyond the accuracy of assessment measures and a critical analysis of the moral, legal and professional issues involved, is the further need to be able to implement practical and effective interventions. The way in which these issues were addressed does not present a “best practice” model of assessment and intervention, rather it highlights the realities of decision-making and intervention in an imperfect and ambiguous world.
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