Chapter 21

CONFIDENTIALITY

Our unwavering commitment to client's well-being, our responsibility to being trustworthy, and our duty to protect their private information is at the heart of the work that we do as clinicians. In therapy, clients trust us to guard their confidences. They trust that the digital records of their diagnosis, treatment plan, home address, and billing information will not spill out onto the internet, finding their way to social media, curious eyes, and identity thieves. They trust that we will lock up paper charts. They trust us not to discuss their treatment with colleagues as we walk down hospital halls, eat in the clinic cafeteria, or chat on a cell phone at the train station.

Leaks of all kinds can cause many problems. A rushed response to a subpoena may allow a law firm to get documents they have no right to. A phone message asking a client to return a call may allow the perpetrator of domestic violence to discover that despite his warnings his partner has reached out to a therapist.

The consequences of seemingly confidential information being passed along without the client's awareness can hit clients without warning and cause serious consequences. According to a Canadian Broadcasting Corporation (CBC) News report

> more than a dozen Canadians have told the Psychiatric Patient Advocate Office in Toronto within the past year that they were blocked from entering the United States (U.S.) after their records of mental illness were shared with the U.S. Department of Homeland Security .... According to diplomatic cables released earlier this year by WikiLeaks, any information entered into the national Canadian Police Information Centre (CPIC) database is accessible to American authorities. Local police officers take notes whenever they apprehend an individual or respond to a 911 call, and some of this information

> is then entered into the CPIC database, says Stylianos .... [RCMP Insp. Denis St. Pierre says the CPIC] "also can contain individuals' history of mental illness, including suicide attempts" (Bridge, 2011, paras. 1, 14, 17; see also "Canadians' mental-health info routinely shared with FBI, U.S. customs" 2014).

In another instance of sharing clinical information without the individual's knowledge or consent so that the information could be weaponized and used against a vulnerable individual, the U.S. Immigration and Customs Enforcement (ICE) obtained the psychotherapy records of child immigrants and used them against the children in deportation hearings (Canady, 2020; see also Izquierdo, 2020; Nilsen, 2018).

Clinicians may communicate, with the client's consent, confidential clinical information to insurance companies, employee-assistance companies, and other agencies as a condition of coverage. With increasing frequency, these arrays of confidential information are subsequently aggregated into large research databases in ways intended to make it impossible to identify individual clients. But can sophisticated strategies re-identify individuals and put the information into the hands of advertisers, loan officers, employment screeners, law enforcement, credit monitoring agencies, and others willing to pay for the data or extract it on their own?

Latanya Sweeney, Director of Harvard's Data Privacy Lab, reported in a *Scientific American* interview that she had re-identified people with Huntington's disease, although all identifying information had been removed in creating a large database. She described how a banker followed a cross-referencing strategy when looking at publicly available de-identified data "to see if any of his clients had cancer. If they did, he called in their loans" (Walter, 2007, p. 92; see also Benitez & Malin, 2010; El Emam et al., 2011; Gymrek et al., 2013; Loukides et al., 2010; Rothstein, 2010).

Ohm (2010) wrote that

> scientists have demonstrated they can often 'reidentify' or 'deanonymize' individuals hidden in anonymized data with astonishing ease. By understanding this research, we will realize we have made a mistake, labored beneath a fundamental misunderstanding, which has assured us much less privacy than we have assumed. This mistake pervades nearly every information privacy law, regulation, and debate ...." (p. 1701).

The U.S. *President's Council of Advisors on Science and Technology* reported: "Long used in health-care research and other research areas involving human subjects, anonymization (also termed deidentification) applies when the data, standing alone and without an association to a specific person, do not violate

privacy norms .... Unfortunately, it is increasingly easy to defeat" (2014, p. 38; see also Daries et al., 2014).

Rocher et al. (2019) developed an approach to finding the identities of people in heavily anonymized data sets. They found that 99.98% of people in the U.S. could be correctly identified in any anonymized data set that included 15 demographic attributes. The above-mentioned research is troubling as it illustrates the problem when participants are led to believe that their information is protected when it is not.

Confidentiality helps clients talk freely but tends to trip up us therapists from time to time and calls for us to strengthen our ethical awareness. We're all human and none of us can catch and counter all potential threats to confidentiality. Fatigue, stress, and routine dull our awareness, lull us into ethical sleep, put us on automatic when we need to be fully woke to be aware of what we may be missing. Threats to confidentiality can disappear into the demands and distractions of our work.

NOTE TO READERS

Confidentiality has emerged as a major, persistent ethical challenge for psychologists. Over half (62%) of the therapists in one national study reported unintentionally violating their patients' confidences (Pope et al., 1987). Another national study found that the most frequently reported intentional violation of the law or ethical standards by senior, prominent psychologists involved confidentiality (Pope & Bajt, 1988). In 21% of the cases, therapists violated confidentiality in transgression owf law. In another 21% of the cases, therapists refused to breach confidentiality to make legally required reports of child abuse. Therapists may have experienced violations of confidentiality when they themselves were patients. In one national survey, about 10% of the therapists who had been in therapy reported that their own therapist had violated their rights to confidentiality (Pope & Tabachnick, 1994).

As with driving, even a brief lapse of attention can cause a catastrophe. We do the hard work of sorting through the legislation and case law that govern confidentiality and privilege in our local jurisdiction, study the relevant ethics codes and professional guidelines, consult with an attorney, and keep up with the changing standards of care. But somehow our minds wander, our ethical awareness flickers and falters, and we stumble into trouble.

Bemister and Dobson (2011) provide a thoughtful analysis of how "maintaining and protecting the confidentiality of client records has become far more complex in recent years" (p. 302; see also Allan & Allan, 2016; Halovic,

2019; Pope, 2015a). Allen (2009) discusses additional layers of complexity and potential confusion—resulting in additional pitfalls—that variations in the nature of confidential material and the number of people entitled to receive it can cause. She emphasizes that confidential material includes more than facts alone. "Facts, impressions, events, and data of all sorts can be deemed confidential" (p. 127). Similarly, she notes the great range of people to whom the therapist may—or may not—be allowed or obligated to disclose confidential information. "[T]he community authorized to receive confidential information can be smaller than a family or as large as a workforce" (p. 127; see also Jain & Roberts, 2009).

This chapter highlights some of those easy-to-overlook pitfalls that can lead to violations of confidentiality.

REFERRAL SOURCES

As clinicians, we appreciate referrals to keep our practices going. But there are some key questions that we should consider about our referral sources. For instance, should we tell the referral source whether someone scheduled an appointment with us, whether the person showed up for the appointment, or what might have been discussed or decided if the patient has not authorized the disclosure? Unfortunately, therapists may, without thinking, violate confidentiality by sending referral sources a thank-you note mentioning a specific patient and giving a detail or two about what happened without the patient's knowledge or consent.

PUBLIC CONSULTATION

Consultation provides an invaluable resource for meeting the highest ethical, legal, and clinical standards. It gives us easy access to new information, support, informal peer review, and a different perspective. Psychologists in a national study rated "consultation with colleagues" as the most effective source of guidance for practice (Pope et al., 1987). They judged such consultation to be more effective than 14 other resources, such as graduate programs, internships, state licensing boards, and continuing education programs.

As valuable as consultation is, we need to keep in mind that consultation about patients deserves the same confidentiality as the psychotherapy it focuses on. We lead busy lives and want to make the most of our time. Often the fastest way to catch a colleague for a quick consultation is while we are walking through the halls of a clinic, or sitting together at a large table while waiting for the last arrivals so that a meeting can begin, or at a restaurant during a lunch break, or in other public places. The problem with such on-the-run consultations is that confidential information is often discussed

within earshot of people who are not authorized to receive the information. Many of us have probably overheard such talk in clinic hallways or elevators. Perhaps we heard the patient's name, someone we recognized as a friend, neighbor, or colleague. In one case, a therapist consulted a colleague on a crowded elevator about a particularly "difficult" patient, unaware that the patient was standing only a few feet behind her, listening carefully. Guarding confidentiality includes making sure that we keep private consultations private.

GOSSIP

Few would argue that therapy is easy work. Sometimes it involves considerable stress, and we need to blow off steam. Talking about our work with others—at lunch, in the staff lounge, on the racquetball court, at parties—may make us feel better. Those settings make it easy to let slip the identity of one of our patients or betray what a patient has told us in confidence.

Some patients may be in the news or tell us fascinating information. The urge to tell others that we know them can be powerful. Many of us may know through the grapevine who is in treatment with whom and even what led them to seek therapy. As interesting as this kind of insider trading of confidences may be, it is also unethical and fails to respect the dignity of the patient and the legal rights that belong to the patient.

CASE NOTES AND PATIENT FILES

Protecting client's personal information extends beyond verbal sharing—it also includes documented, written, and virtual notes and files. Have you ever seen a patient's chart, either printed out or on a computer screen, that you were not authorized to see? It is likely that at least some—if not most—of you have happened to see unsecured documents containing patient names and other confidential information. Some clinics and individuals may have difficulty meeting their responsibility to keep confidential records confidential. During a visit to a prestigious university-affiliated teaching hospital, one of the authors noticed, while walking down a public hallway, that the mental health clinic's patient charts were stacked along the walls. The hallway was unattended. The names of the patients were clearly visible, and had the author—or anyone else—opened any of the charts, a wealth of confidential information would have been instantly available. When they asked later about charts being left in the hall, they were assured that this was temporary. Due to insufficient funds, additional storage space was not yet available, and this manner of "filing" was the most convenient for the business office personnel. While on hold for a family member's telehealth appointment, another author of this

text witnessed a provider talking about their previous patient's diagnosis with their staff before turning their attention to the patient waiting (see also Chapter 24: Therapists in a Virtual World). What message is this giving to the patient about the clinician's trustworthiness?

PHONES, FAXES, AND MESSAGES

Some of this book's readers may have visited clinics in which phone messages mentioning a patient's name, telephone number, and reason for calling were left out where they could be seen by those who should not see it. Some may have visited a colleague's office just as a fax about a patient was coming in or the computer was printing out a bill or other document, and ... well, just could not help seeing who it was from and what it was about. Some readers may have overheard a therapist take a phone call from a patient and heard both sides of the conversation (and may have been surprised to recognize the patient's voice).

Answering machines and voice mails with speaker phones create special pitfalls for confidentiality. It is tempting, if our time for lunch is limited, to play back accumulated messages—some from patients—while a friend is waiting to accompany us to the nearest restaurant. If our answering machine is at home, we need to make sure that our family, friends, and others do not overhear messages as they are recorded or played back. Again, the Golden Rule can provide a useful guide to anticipating potential problems and recognizing the need to remain constantly mindful, aware, and alert.

HOME OFFICE

As discussed in prior editions of this book and in *How to Survive and Thrive as a Therapist* (Vasquez, 2005), home offices pose special challenges to confidentiality and privacy. Is it likely that patients—some of whom may not want anyone else to know that they are in psychotherapy—will encounter family members or friends when arriving, waiting for the appointment, or leaving? Any chance that kids will interrupt therapy sessions? Will files, appointment books, message slips, and other documents stay out of sight when family members enter the office? Will family members be able to overhear phone, Zoom, FaceTime, Skype, or other video conferencing sessions with patients? Is confidential information about patients stored on a computer that other family members use? If so, how is it secured against accidental discovery? Is the telephone answering machine that receives calls from or about patients shared with other family members? If so, how can those calls be protected against accidental playback for other family members? Are answering machine messages from or about clients ever played back in the presence of family

members? And are answering machines protected so that children cannot accidentally play back the messages?

SHARING WITH LOVED ONES

Some therapists may hold back no secrets from a spouse, partner, or other loved ones. For some, sharing what happened during the day with a loved one may be a crucial act of intimacy. The ethical challenge is to do this while respecting the client's rights by not violating their confidentiality.

POST-DEATH CONFIDENTIALITY

Our responsibility to be trustworthy requires us to discuss with patients the role of confidentiality after the patient dies. We may not want to think about death and dying, but as therapists it is important for us to do so. Post-death confidentiality is important and in particular when we are working with clients who are terminally ill. Generally, the responsibility to maintain confidentially extends beyond the client's death. Werth et al. (2002) provide a useful clarification statement for us to explain to clients and include in our informed consent form. The following exemplar provides a model we can adapt to help clarify the place of confidentiality on what they call "confidentiality beyond the grave:"

> You need to know before you disclose anything to me that, following your death, the executor of your estate may be legally able to obtain information and materials accumulated in the course of this psychotherapy. You and I need to discuss how you would like to proceed regarding highly sensitive material. In addition, you may want to consult with an attorney to request that these materials continue to be confidential following your death (p. 218; see also Chapter 18).

COMMUNICATIONS IN GROUP OR FAMILY THERAPY

When therapy includes more than one individual, as in group and family therapy, patients have a right to know in advance, as part of the informed consent process, any limitations of privacy, confidentiality, or privilege affected by the presence of more than one patient. For example, if a clinician is providing family therapy, will they keep confidential from other family members information conveyed in a telephone call from a minor son that he is using drugs, from a minor daughter that she is pregnant, from the father that he is engaging in an extramarital affair and plans to leave his partner, or from the mother that she has secretly withdrawn the family's savings and is using it to

gamble? What does a psychotherapist need to tell prospective patients about how "secrets" will be handled so that the clients' consent can be informed (see, e.g., Mark & Schuman, 2020; Marks et al., 2019; Turliuc & Candel, 2019)?

Psychotherapy involving more than one patient emphasizes trust, a major theme of this book (see Chapter 5: Trust, Power, Caring, and Healing). The therapist and members of a therapy group may assume that everyone involved is trustworthy. But what if that is wrong? What if a group member is a newspaper or magazine reporter gathering information for an exposé of what the reporter considers bogus therapy groups, or of the therapist, or of what the reporter considers a "culture of dependency"? Or what if a group member later decides to write a memoir to be published in a magazine or book about what the experience of group therapy was like? Or what if some of the group members simply pass along what they learn about other group members to their family and friends and that information ripples outward to those who recognize and know members of the group? What if group members run into each other at a social gathering or a public setting and one of them discloses that they both are/were in therapy together? Group and family therapists must struggle with these issues in a way that respects the patients' legitimate rights to privacy, confidentiality, and privilege and their right to know the limits—both legal and practical—of their privacy, confidentiality, and privilege.

Therapy involving more than one person also presents challenges to documentation. If, for example, the therapist keeps one set of therapy records for "the family" or "the group," what happens if one member of the family or group requests or subpoenas a copy of those records? How can a therapy record that mentions more than one patient by name be turned over without the informed consent or legal waiver of each patient? One approach that some therapists use is to keep a separate chart for each patient in a family or group.

WRITTEN CONSENT

A common problem is failing to obtain written informed consent to release confidential information. As discussed in Chapter 16: Informed Consent and Informed Refusal, both the APA Ethics Code and the CPA Ethics Code address documenting a patient's consent with either a signed consent form or a note in the record about obtaining consent orally.

Obtaining written consent can help promote clarity of communication between therapist and patient in situations when misunderstandings can be disastrous. Both need to understand exactly what information the therapist will release. Is the therapist free to discuss any aspect of the client's history, situation, and treatment? Is the therapist authorized to provide a written

summary or all clinical files? When does the client's authorization end? If the person who is to receive the confidential information contacts the therapist with additional questions next month, next year, or several years from now, does the written consent need to be renewed, or does it explicitly cover such future requests?

Patients may not understand the type of information that insurance companies require to authorize coverage and the degree to which information will or will not be sufficiently safeguarded by the insurance company. It is helpful to let patients know that you have no control over what happens to information or documents, or how they are used, once they leave your possession.

MANAGED CARE AND OTHER ORGANIZATIONS

How widely do your therapy reports circulate within managed care and other organizations? Many patients feel betrayed when records of their psychotherapy sessions become part of their general medical or health record in a health maintenance organization (HMO), employee assistance program (EAP), or other organization find their way into other hands. One woman was shocked to find her treatment mentioned on the employee relations bulletin board where she worked. Management and the union, eager to cut both sick leave and the costs for their health-care plan, had decided to post all utilizations of the health-care plan by employees. Under the terms of the contract that had been negotiated by labor and management, the date and reason for each utilization was provided by the health-care organization to officials for both union and management.

From the creation of the first managed care organizations, challenges to confidentiality have grown:

> Managed care companies generally ask for much more information than third parties have traditionally requested from clinicians. The ethical explanations given for such requests generally have fallen into two categories. One is based on the known history of some clinicians to distort information on forms .... Then managed care companies began to discover that some clinicians charged for sessions not provided or approved. A more general reason applicable to all clinicians is to make sure that the intended treatment meets criteria of medical necessity as designated in the third-party benefits. In addition to treatment plans, managed care companies will often ask for copies of any notes kept on patients; they sometimes do on-site reviews of charts in hospitals, and on occasion they even talk directly to the patient to try to verify information (Moffic, 1997, p. 97).

Early on, the National Academies of Practice (including dentistry, medicine, nursing, optometry, osteopathic medicine, podiatric medicine, psychology,

social work, veterinary medicine, audiology, occupational therapy, physical therapy and speech and language pathology) adopted Ethical Guidelines for Professional Care and Services in a Managed Care Environment (1996). Confidentiality is one of five guidelines listed as a primary concern. While the National Academies of Practice acknowledges that utilization and quality assurance reviews are appropriate functions in a healthcare system, they emphasize the importance of safeguards to protect the privacy and confidentiality of patient data and the practitioner's clinical materials. They state,

> The rationale for this position is founded on the patient's autonomous right to control sensitive personal information. It is further based upon an historical recognition in the oath of Hippocrates and corroborated throughout the centuries, of the enduring value of preserving confidentiality in order to enhance mutual trust and respect in the patient-provider relationship (p. 5).

Anne Slowther and Irwin Kleinman (Slowther & Kleinman, 2008) wrote:

> The increasing capacity to generate and disseminate information in health care, together with the increasing complexity of healthcare provision, has implications for our understanding of the nature and limits of confidentiality. Development of multidisciplinary healthcare teams raises questions of how much information can be shared within the team, and who is recognized as a team member for this purpose (p. 43).

Healthcare organizations may not always monitor who attends case conferences, and discussions of a patient's condition may be overheard by an inappropriate audience.

Similarly, Anne Ward (2010) discusses "how difficult it can be for teams to keep the psychotherapeutic aspects of confidentiality in mind and how, in the current electronic age, fears can arise that patient records may be circulated more widely than is appropriate" (p. 113).

Electronic medical records (EMRs) post difficult challenges to confidentiality. In "Electronic Medical Records: Confidentiality Issues in the Time of HIPAA," Margaret Richards (2009) wrote:

> For a psychologist in a major academic or medical institution, the EMR provides unique ethical conflicts of which the psychologist may be unaware. By documenting within the EMR, the psychologist is potentially informing all members of that patient's medical team that this patient is involved in psychological care. While most informed consents discuss the limits of confidentiality, patients may not always realize the information that is being shared and with whom. At a minimum, the psychologist using an EMR is providing information regarding the patient's participation in therapy, dates

of appointments, types of services offered, and diagnoses, even if the content of the session is not revealed. Typically, this is the same information that is being provided to insurance companies as a natural part of the billing process since the advent of HIPAA (Freeny (2007). Yet, this may not be information that a client wants his primary care physician to have (p. 553; see also Chapter 24: Therapists in a Virtual World).

Who participates in treatment planning, implementation, and review can be a challenging issue in small towns. In one instance, the chief healthcare administrator proposed a periodic case review of current patients to be conducted by staff psychologists. In this town of fewer than 10,000 people, the psychologists would have known many of the patients in a variety of social and business roles. The patients had not given informed consent for this review. This confidentiality issue is not easily addressed. One solution would be for the administrator to agree to hire a psychologist from another community who did not know the population served by the hospital to visit the hospital once a month to review the cases and make sure that patients understood the review process.

DISCLOSING CONFIDENTIAL INFORMATION FOR MANDATED REPORTS ONLY TO THE EXTENT REQUIRED BY LAW

Evolving legislation and case law in each jurisdiction define the limits of information to reveal in making legally mandated reports. For example, a psychologist was contacted by a mother who wished to arrange appointments for her daughter and her daughter's stepfather to see the therapist regarding allegations that the stepfather engaged in sexual intimacies with his stepdaughter. The psychologist agreed to meet with him and immediately filed a formal report of suspected child abuse.

The next day, a deputy sheriff contacted the psychologist for information. The psychologist provided information about his meeting with the daughter. He would meet with the stepfather later in the day. The deputy called later and asked for information concerning the session with the stepfather and, reading from the Child Abuse Reporting Law, emphasized that the psychologist was obligated to supply additional information, which the psychologist reluctantly provided.

The stepfather claimed in court that the psychologist, after making the initial formal report, should not have disclosed any additional information. The Supreme Court of California agreed with the stepfather:

> The psychologist was under no statutory obligation to make a second report concerning the same activity .... We have recognized the contemporary value of the psychiatric [sic] profession, and its potential for the relief of emotional disturbances and of the inevitable tensions produced in our modern, complex society .... That value is bottomed on a confidential relationship; but the doctor can be of assistance only if the patient may freely relate his thoughts and actions, his fears and fantasies, his strengths and weaknesses, in a completely uninhibited manner (*People* v. *Stritzinger*, 1983, p. 437).

Psychotherapists who disclose confidential information even in court settings may be subject to lawsuits by the client. California, for example, has general legislation protecting individuals from lawsuits for any statements made as part of court proceedings. Nevertheless, a district court of appeals ruled that a psychologist "can be sued for disclosing privileged information in a court proceeding when it violates the patient's constitutional right of privacy" (Chiang, 1986, p. 1).

PUBLISHING CASE STUDIES

Publishing case studies or other confidential information about patients requires exceptional care. Merely changing the patient's name and a few other details may not be enough. Pope et al. (1978) discussed a case in New York in which a therapist was successfully sued for publishing a book in which he described his treatment of a patient. The patient asserted that the therapist had not obtained her consent to write about her treatment and had not adequately disguised the presentation of her history.

APA's Casebook on Ethical Principles of Psychologists (Board of Professional Affairs, Committee of Professional Standards 1988) presents a situation in which a psychologist wished to write a book about an assessment:

> Psychologist G conducted a professional evaluation of the accused murderer in a sensational and well-publicized case in which six teenage girls, who vanished over a period of 18 months, were later found stabbed to death in an abandoned waterfront area of the city. The lurid nature of the crimes attracted nationwide publicity, which only increased as allegations of negligence were pressed against the city administration and the police force. In order to construct a psychological diagnostic profile, Psychologist G spent several days with the accused, conducting interviews and psychometric tests. He presented his findings in court with the full consent of the accused. Six months later, following the sentencing of the now convicted

> murderer, Psychologist G determined that he would like to write a book about the murderer and the psychology behind the crimes, which he anticipated would be a lucrative undertaking. Psychologist G wrote to the Ethics Committee to inquire whether it would be ethical for him to do so. The convicted murderer had refused permission to publish in a book the results of the psychological evaluation, despite the fact that the information was now considered part of the public domain because it had been admitted in court as evidence. Opinion: The Ethics Committee responded to Psychologist G that to write the proposed book would be a legal but unethical undertaking. The fact that material has entered the public domain or that there may have been an implied waiver of consent does not free the psychologist from the obligation under Principle 5.b of the Ethical Principles to obtain prior consent before presenting in a public forum personal information acquired through the course of professional work. In this case, the ethics code sets a higher standard than the law would require. Psychologist G thanked the Committee for its advice and dropped the idea of writing the book (p. 72).

DISTRACTION

Major problems related to violations of confidentiality may happen when we are too busy or not paying attention because we are multitasking or trying to get things done quickly. Momentary distractions can cause lasting problems. No matter how senior our status, how extensive our training, or how naturally skilled any of us may be, none of us is perfect. All of us have moments when we are tired, overwhelmed, rushing, or careless. James F. Masterson, a prominent therapist who wrote extensively about borderline personality disorders, showed courage in writing about an instance in which he betrayed a patient's confidence because of something that had happened in his own life:

> One morning I was late and dented my car as I parked in the office garage. A bit frazzled from the experience, I rushed into my office and admitted my first patient who asked me how another patient of mine was doing, calling her by name. I was startled because their appointments were at very different times. I wondered if they had met socially, or if he was dating her. Then I realized what had happened. Worried about my dented fender, I had inadvertently picked her file out of the drawer instead of his, and he had read her name on the folder. My distraction represented a counter-transferential failure to pay proper attention to my patient. I apologized for taking out the wrong chart and told him I was distracted by the accident (Masterson, 1989, p. 26).

FOCUSING ON LEGAL RESPONSIBILITIES TO THE EXCLUSION OF ETHICAL RESPONSIBILITIES

Our ethical commitment to protecting clients' private information goes beyond our legal responsibilities to do so. Unfortunately, as noted by Fisher (2008), confidentiality workshops often focus on laws and risk management while spending relatively little time on our ethical responsibilities. Fisher describes how HIPAA brought forth the growth of attorney-led HIPAA-compliance training that further overshadowed ethics training in confidentiality. Fisher wrote:

> Such legally based training creates several ethical problems for psychologists. First, it fosters the impression that attorneys—not clinicians—have become the only "real" experts about this aspect of practice. Second, it creates a legal language about confidentiality that threatens to usurp psychologists' own clinical or ethical language about it: Laws take center stage, when what is needed is a language for placing them into ethical context. Third, it exacerbates the figure-ground confusion (by substituting legal rules for ethical rules) and often takes a risk-management perspective that raises anxiety: It encourages psychologists to focus on obeying laws in order to avoid risks to themselves, when what they need is a clearer focus on their ethical obligations and the potential risks to clients. Finally, the legal emphasis obscures an important fact about risk management: Understanding and following the relevant ethical principles is an essential ingredient in avoiding a malpractice suit .... (p. 6).

SCENARIOS FOR DISCUSSION

As a new client speaks to you via FaceTime, they describe their intense despair and anger at having had a fever when they were tested before being allowed to enter their workplace. Referred for a more extensive testing, they were diagnosed with the novel coronavirus (COVID-19) two days ago, told to stay home and self-isolate, and not to return to work until cleared by the physician. This means being unable to earn income while sick. Boiling over with rage, they've been going maskless while riding busses and subways, trying to infect as many people as possible. No matter what you say, they refuse to stop expressing their rage in this way.

- How do you feel?
- In your jurisdiction, do you have any legal obligation to breach confidentiality in order to report or protect?
- Do you have any ethical obligation to breach confidentiality in order to report or protect?

(continued)

(continued)

- What are your options?
- What do you think you would do?

■ ■ ■

You have been working for two years with a patient who has multiple problems and has disclosed extremely sensitive information to you. The insurance company sends you a letter requesting the entire file, including all of your chart notes and all raw data from the psychological assessment, in order to determine whether further therapy is warranted and, if so, in what form. When you call the insurance company to discuss the matter, the head of claims review (not a mental health professional and whose previous job was quality control officer in a paper clip company) tells you that they must have all these materials within five business days or else therapy will be discontinued.

- How do you feel?
- What options do you consider?
- If the patient refuses to provide consent for you to send the materials, even though it means there are no longer resources to pay for the therapy, and decides to terminate therapy rather than allow the information to go to third parties, what do you do?

■ ■ ■

You have been working with a 14 year-old patient for several months. During one session, the patient suddenly discloses having sex with a parent for the past four years. The patient, who has been chronically depressed, threatens, "If you tell anyone about this, I will find a way to kill myself." You believe that this is not an idle threat.

- How do you feel?
- Under what circumstances, if any, do you believe you might disclose information about the client's claim of having been sexually involved with a parent to any of the following: (a) child protective services or other governmental agency authorized to receive reports of suspected child abuse; (b) your clinical supervisor; (c) any family member; or (d) anyone else?

(continued)

(continued)

- What objectives or priorities would shape your interventions?
- To what extent, if at all, would your own potential legal liability affect your emotional responses to this situation and your course of action?

You are working with a patient who engages in unprotected sex with a variety of partners. Two months ago, the client became infected with HIV. Recent sessions have focused on many topics, one of which is the patient's decision not to begin using protection during sex and not to disclose the HIV status to any partners. The client shows no likelihood of changing this decision.

- How do you feel?
- Does the patient's decision affect your ability to empathize in any way?
- Under what conditions, if any, would you act against the patient's wishes and communicate information about the client's HIV status and sexual activity to third parties? What information would you disclose, to whom would you disclose it, and what are the likely or possible outcomes?

You work for an employee assistance program, spending 4 hours a day, three days a week, providing outpatient therapy at its facility. Four other clinicians provide therapy in the same office. According to program policy, all patient charts of all clinicians using that room must remain locked in a single filing cabinet in the corner of the room. Each clinician has a key to the filing cabinet. You become aware that several of your patients have social relationships with the other therapists. You are also aware that their charts contain extremely sensitive information about them. You also notice the names of two of your friends on the charts of the other clinicians. The employee assistance program refuses to change this policy.

- How do you feel?
- What courses of action do you consider?

(continued)

(continued)

- Are the clients entitled to know about this arrangement? If so, at what point should they be made aware of it?
- If you were the client in such a situation, do you believe that you would be entitled to know about this arrangement?

You have reached a therapeutic impasse with a patient. For weeks, therapy has seemed stalled, but you have not understood why. During the past few supervision sessions, you discovered that this client has stirred up some intense emotions in you. You've mentioned to your supervisor some painful events in your own history about which you have felt ashamed and confused. You have yet to discuss these events with anyone else, even your own therapist. One afternoon you head to the staff lounge but pause just before entering the room. Through the door, you hear your supervisor talking with others about the painful events you had discussed in supervision.

- How do you feel?
- Which of the following do you think you'd do and why: (a) leave immediately, hoping no one saw you; (b) linger at the door, hoping to hear more; (c) enter the room, pretending that you hadn't heard anything; (d) enter the room and indicate that you had heard what they had said; or (e) something else?
- Under what circumstances, if any, do you believe that clinical supervisors should discuss what their supervisees tell them? In your experience, have these boundaries of confidentiality been explicit and well understood by supervisees and supervisors? In your experience, have supervisors respected these boundaries?
- Have the clinical supervisors you have known or known of kept notes or otherwise documented the supervision sessions? What ethical, legal, or other considerations affect the privacy and confidentiality of supervision notes (for example, are they legally privileged communications)?