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Clinical Management of Confidentiality: A Survey of Professional Psychologists in Seven States

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CLINICAL MANAGEMENT OF CONFIDENTIALITY: A SURVEY OF PROFESSIONAL PSYCHOLOGISTS IN SEVEN STATES

by

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VITA

The author, Keith Alan Baird, is the son of Douglas Paige Baird and Martha (Schwardt) Baird. He was born on October 9, 1957 in Schenectady, New York.

His elementary education was obtained in the public schools of Wappingers Falls, New York, and secondary education at the Roy C. Ketcham High School where he graduated in 1975.

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CHAPTER I

INTRODUCTION

The concept of confidentiality has always been of importance to any psychologist who provides direct clinical services to patients or clients. It is also one area of the mental health field which is undergoing some transformations and will continue to do so for some time in the future. Probably for most psychologists most of the time, confidentiality is a rather banal concept which, when incorporated into therapy, is pretty much forgotten about and taken for granted. When the maintenance of confidentiality is called into question, however, it soon becomes a complex issue for which there are no easy solutions.

Max Siegel, a recent president of the APA, highlighted a common ethical dilemma in the following story told in a recent interview:

> "'Max, this boy is dangerous,'" Siegel remembers the psychiatrist telling him. "'He has many, many homocidal tendencies in his dreams, his talks ...He threatens to get a gun as soon as he's old enough.'" His father had left home and he was transferring (onto) other men, to other authorities. "My reaction was that my colleague had the makings of a good treatment case," Siegel recalls. "Work with this kid, help him, become his friend," I told him. "But the psychiatrist said that his ethical standards required him to tell his mother, and he called them both in and told her of her son's behavior. The mother slapped her son in front of the psychiatrist and told him not to say such things. Of course they never returned to therapy, and we never knew what happened to

him." He paused, then added, "The boy was Lee Harvey Oswald" (Mervis, 1983, p.24).

The zeitgeist which affects confidentiality is formed by a number of interrelated forces and elements. Within our society there seem to be opposing forces, some of which push for more erosion of privacy, others which pull for the protection of the privacy of the individual. The trend is for more laws to be passed requiring that confidentiality be breached and privacy invaded, while at the same time more laws are passed mandating that confidentiality and privacy be preserved (Everstine, Everstine, Heyman, True, Frey, Johnson & Seiden, 1980). One of the primary factors in recent years which has created a push for more privacy of the individual has been the Watergate break-in. Many feel (Grossman, 1978; Payson, 1978; Siegel, 1979; Simon, 1978) that the break-in was a critical incident which spurred a curtailment of the invasion of privacy on the part of the government. It displayed graphically the "...outrageous intrusions upon the privacy of Americans in all walks of life.... The nation became aroused (by) the fundamental danger ...to the vital right of every American (i.e., rights to personal privacy)" (Siegel, 1979,p. 252). Shortly after Watergate, the Privacy Act of 1974 was passed which in turn spawned the creation of the Privacy Protection Study Commission, and task forces on privacy and confidentiality on the part of the American Psychological Association, the American Psychiatric Association, and the Orthopsychiatric Psychiatric Association. Siegel (1979) feels

that the very creation of these task forces and commissions was evidence of the:

> mounting concern across the country about the apparent collision course being travelled by those helping professions which adhere to the Hippocratic Oath (maintaining absolute confidentiality) and those who are caught up in the public's need and perhaps right to know (p. 252)

There are other, opposing societal forces that push for the decrease in the privacy of information. There has been an increased interest in demanding accountability on the part of professionals. The public's disillusionment and loss of faith in many professions is felt to be a primary cause for this increased interest in accountability (Michels, 1976; Naisbitt, 1982; Roston, 1975). Such disillusionment may be a result of the public's disappointment with the limitations of science and reasoning in answering the problems of mankind (Michels, 1976) which Stone (1983) feels was exacerbated by several decades of the mental health professions promising more than they could deliver. Siegel (1979) fears that the pressure for more accountability on the part of psychotherapists is much more likely to threaten confidentiality than it is to enhance it. Peer review programs and insurance company reviews mean that more confidential information will be shared not only with more professionals, but also with a wider range of supporting staff as well. In an impassioned, if not one-sided view of the impact of these societal trends on confidentiality and psychotherapy, Everstine et al. (1980) write that we:

> live in a nation in which and at a time when a)information processing technology has escaped from ethical restraints,

> b)governmental agencies have become too inquisitive about personal characteristics, thoughts, and actions; and c)radical means are being sought to identify and deter those who would commit violent acts against others. Buffeted by these winds of change, the psychotherapist trudges along, a lonely pilgrim (p. 831).

The push for accountability could be a positive trend in that it may promote the increased quality of care and thus prove to be ultimately beneficial to the psychotherapy recipient. Regardless of the position that one might take on this issue, however, the zeitgeist illuminates an inescapable burden or challenge which each individual therapist must face; it is the very conflict between the right to privacy of the individual receiving psychotherapy and the rights of others to know certain things about that individual in order to protect society, to assure quality of care, or to warrant further treatment. No psychotherapist can ever escape from this fundamental dual responsibility. Many consider this dual responsibilty to be one of the most difficult of the ethical dilemmas for the mental health professional (Karasu, 1980; Lane & Spruill, 1980; Noll, 1974). The potential for conflict, confusion, and uncertainty is high. It is therefore important to gather data from psychologists on how they think through these difficult issues in order to make their clinical decisions.

The purpose of this research was to collect descriptive data and to test the effects of specific variables on how psychologists manage confidentiality during the course of psychotherapy. This was done through a survey of psychologists in seven states who provide psychotherapy services. The survey asked the respondents about their

various experiences and opinions about confidentiality, their knowledge of various statutes and ethical guidelines, as well as how they thought through hypothetical situations in which the management of confidentiality could be a problem.

CHAPTER II

HISTORY, THEORY, AND RESEARCH ON CONFIDENTIALITY

Definition of Terms

Before proceeding with a brief history of confidentiality in psychotherapy, it is important to define a number of terms which are critical in this research. The first term is privacy. The right to privacy is a constitutional guarantee and it refers to the freedom of individuals to choose for themselves which of their beliefs, behaviors, and opinions are to be shared or withheld from others (Siegel, 1979, p.251).

Confidentiality is a concept originating in professional ethics which is an explicit or implicit promise to reveal nothing about an individual except under certain conditions agreed to by that individual. More recently, confidentiality has become a legal term as well carrying with it a legally binding contract to not reveal private information under the threat of civil (Spiegel, 1979) or even criminal (Slovenko,1966) liability. Whenever the phrase "breach of confidentiality" is used in this paper, it refers to a therapist sharing confidential, identifying information about a patient to a third party without the patient's consent.

Privileged communication is a legal term which guarantees that confidential information is protected from disclosure in a legal proceeding. In almost all states the privilege is granted solely to the individual (or recipient of services) not to the professional (DeKraai & Sales, 1982). Privilege is not a constitutional right, but a specific grant made to "individuals at risk" (Payson, 1978, p.134). Throughout this dissertation, the term "privilege status" will be used to refer to whether or not a psychologist has privileged communication. The way in which confidentiality and privileged communication are written into specific laws is determined solely at the state level. The privilege statutes vary widely from state to state and are modified by "exceptions" which have been written into the statutes (DeKraai & Sales, 1982). Some of the more common exceptions encountered include:

Future crime exception: generally this means that either a confidential or privileged relationship can be made non-confidential whenever it appears that the client is likely to commit a crime. Within mental health, this is frequently referred to as a "dangerous patient exception."

Judicial discretion exception: If a client is involved in a legal proceeding, a judge can decide that in the interest of justice, the need to know outweighs the need to maintain confidentiality, and the relationship then ceases to remain confidential. For all practi-

cal purposes, the inclusion of such an exception negates any existing privilege statute (Nye, 1983). This exception is in place in the mental health laws of five states (DeKraai & Sales, 1982).

Patient-litigant exception: this is a general exception which says that a confidential relationship may cease to be confidential whenever a client is involved in a legal proceeding. It is more general than the judicial discretion exception because anyone in the legal proceeding (lawyers, etc.) can request that confidential information be revealed.

History

Virtually every historian of professional ethics traces the start of confidentiality to the Hippocratic Oath (Schuchman, 1980; Slovenko, 1966). which states:

> Whatsoever I shall see or hear in the course of my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be secrets.

The original Hippocratic oath spoke to the need for absolute confidentiality. As a result of many social currents and forces, particularly during the past 100 years, this code has undergone a modern translation which has been included in the AMA code of ethics (American Psychiatric Association, 1968). The translation reads:

> A physician may not reveal the confidence entrusted to him in the course of his medical attendance, or the deficiencies he may observe in the character of his patients, unless he is required to do so by law, or unless it becomes necessary in order to protect the welfare of the community.

A shift from absolute confidentiality to a position of "relative confidentiality" is made evident by this modern translation. Some of the historical markers which may have played a role in such a shift will be reviewed.

The first legislation to protect the confidentiality of a helping profession (outside the legal profession) was passed in New York State in 1828 granting privilege to physicians. There were no exceptions to the privilege (Dubey, 1974). The purpose of the privilege was to encourage patients to seek medical treatment particularly when they might have a contagious disease with a social stigma attached to it. It was reasoned that if the patient's privacy could be maintained, thereby sparing him shame and embarrassment, he then would be more willing to seek treatment. During the years that followed the passage of this New York statute, other states adopted similar statutes, adding modifications or exceptions. Soon, the conditions under which privilege applied and when it did not became a complex matter (Slovenko, 1966).

Wigmore's (1940) classic treatise, Evidence, has been a major influence on the legal profession's view of privileged relationships. He outlined four conditions which should be satisfied in order to warrant the establishment of a privileged relationship. These conditions have been recognized as the standard by which decisions are made about the privileged status of professional relationships. They are:

1. Does the communication in the given professional relationship originate in a confidence that it will not be disclosed?
2. Is the inviolabilty of that confidence essential to the achievement of the purpose of the relationship?
3. Is the relationship one that should be fostered?
4. Is the expected injury to the relationship, through the fear of later disclosure, greater than the expected benefit to justice in obtaining the testimony?

The justification for a physician-patient privilege came under heavy criticism based on Wigmore's four criteria. Wigmore himself attacked the medical privilege on the basis that the medical condition of most patients could not only be disclosed without shame, but was frequently known by the public anyway. Wigmore argued that the guarantee of privileged communication is usually not necessary in order to pursuade persons to seek medical help. He further stated that the injury to the physician- patient relationship by disclosure is not greater than the social benefit to be gained by having physician's testimony at litigation where it seems appropriate.

The development of medical privilege has served as the precedent upon which decisions have been made about the worthiness of a privilege for psychotherapists. This precedent had been in place for a number of years because as Slovenko (1966) points out, law is conservative; it attempts to regulate behavior by general principles and does so by referring to knowledge developed in other fields. Thus, if history serves as a precedent, as mental health professionals become successful in achieving privilege status, then undoubtedly there will be attempts to limit the scope of that privilege.

In 1952, a case was heard in Illinois in which the need to establish unique privileged communication for the practice of psychiatry was tested (Slawson, 1969). A husband was bringing a claim against his wife and trying to use the fact that she was receiving psychiatric treatment as evidence against her. The treating psychiatrist who was subpoenaed in this case refused to testify on the grounds that such communications should be protected. The psychiatrist was taking a calculated risk since there was no statute granting such a privilege. The judge agreed with the psychiatrist. The ruling was not appealed, and in 1959 Illinois passed a privileged communication statute for psychiatrists. In 1960, model legislation known as the GAP (Group for the Advancement of Psychiatry) Proposal recommended that Connecticut establish a psychiatrist-patient privilege (Goldstein & Katz, 1962). The thrust of their argument was that the psychiatrist urges the client to discuss problems, such as the possibility of some future dangerous behavior..."on the assumption that less harm will insue if (feelings are) ventilated than if (they are) suppressed" (p. 736). such a privilege was granted in Connecticut based on Wigmore's four points. Georgia also passed a similar statute at this time.

Initially, privilege was extended only to physician-patient or psychiatrist-patient relationships. The psychology profession, still "new-comers" to the field of psychotherapy, was relatively less organized regarding privilege in psychotherapy. In time, however, others began to argue that Wigmore's four criteria are met in the case of the

psychotherapist- patient relationship (Diamond & Weihofen, 1953; Louisell, 1956; Rappaport, 1963; Zenoff, 1962). Slovenko (1966) argues that the general public assumes that communications to a psychiatrist (psychotherapist) are confidential, and that the very essence of psychotherapy is to discuss confidential personal matters which the patient is normally reluctant to discuss. Out of the 41 states and Canadian provinces granting privilege for the treatment of psychiatic patients (as of 1967), 32 granted the privilege with specific reference to the psychologist-client relationship, and used the attorney-client model (APA, 1967). By 1969, 41 of the 50 states offered some type of privilege (Slawson, 1969).

Throughout the time that these statutes were being created and discussed in the state legislatures, there were numerous attempts by different groups to thwart the successful passage of privilege statutes. The legal profession has had a long and vigorous opposition to the creation of any privilege statutes other than those granted to lawyers (Chafee, 1943). Before the U.S. Code of Evidence (proposed by the U.S. supreme court in 1969) was sent to congress for approval, the psychotherapist-patient privilege (Rule 504) was added because there seemed to be a constitutional basis for it. However, the AMA and the ABA (American Bar Association) recommended action to eliminate Rule 504 from the code. It was largely due to this protest that the bill was never passed and the congress left the matter for the state legislatures to discuss (Grossman, 1978). More recently, the ABA

opposed the psychotherapist-patient privilege bill proposed in New York State and this was felt to undoubtedly have influenced the decision of Govenor Carey to veto the bill in 1975 (Grossman, 1978, p.145). To this day New York has a judicial discretion exception in their statute which all but effectively eliminates the privilege. Grossman (1978) attributes this state of affairs to the strong lobbying by the ABA in that state. At the present time six states including New York have this judicial discretion exception (DeKraai & Sales, 1982).

The legal profession's argument against a privilege for psychotherapists is that no substantial evidence exists suggesting that the treatment of patients is actually hindered in states without privileged communication. They suggest that this might be so because the patients probably do not know that they do not have privileged communication (Yale Law Journal, 1962). One might wonder, however, whether a psychologist's knowledge of whether of not he/she has privileged communication is reflected in the treatment process thereby affecting the patient. It is clear that the effects of the presence or absence of privilege have not been studied very thoroughly; therefore, it would be of importance to investigate what effect the presence or absence or prvileged communication has on patients or therapists. It would first be important to find out if psychologists know what the term "privileged communication" means, and whether or not they know if they have privilege in their respective states of practice.

The Tarasoff Decision

Probably no event has had more of an impact on the management of confidentiality in psychotherapy than the Tarasoff case in California. Because it was such a landmark case, it will be explored more fully here in the hope that some of the effects of this decision can be evaluated in the proposed research. Although the actual account of what happened in the Tarasoff case has been reported in numerous articles (Bersoff, 1976; Fleming & Maximov, 1974; Gurevitz, 1977; Karasu, 1980; Lane & Spruill, 1980; Oldham, 1978; Paul, 1977; Roth & Meisel, 1977; Siegel, 1979; Stone, 1984) as well as in the original court recordings (Tarasoff vs. the Regents of the University of California, 1974), the best summary of the case is found in an article by Grossman (1978) and will be presented here:

> The story as it unfolds in the introduction of the California Supreme Court's first decision of December 23, 1974, begins with a patient, Prosenjit Poddar, (who was) receiving outpatient psychotherapy at the Cowell Memorial Hospital of the University of California at Berkeley. The date on which he began therapy was not available to the court. On August 20, 1969, Poddar's therapist determined that Poddar, in his threats to kill Tatiana Tarasoff, had become a great enough risk to warrant starting proceedings for involuntary hospitalization and did so. At the time, Tatiana was visiting Brazil for the summer and did not return for approximately two months. In accordance with L.P.S.[1] procedure,

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[1] L.P.S. or the Lanterman-Petris Short Act is a civil commitment statute in California which outlines treatment of the mentally ill and protection of their individual liberties while also protecting society. This act made civil commitment more difficult to initiate and to prolong. Indeed under this act the psychiatrists at the student health facility did not have the authority to confine Poddar on the basis of their judgement that he was dangerous and

the therapist, Dr. Moore, applied to the campus police to take Poddar into custody pending the issuance of a 72-hour hold for observation, also in accordance with L.P.S....L.P.S. dictates that the party to whom application is made must determine independently that the patient presents evidence of being dangerous. The police did take Poddar into custody, decided he was not dangerous, and freed him with a warning to stay away from Tatiana. A complication, clouding the issue further, was the absence of the director of the clinic at the time; on his return days later he demanded that all records of the attempt to secure involuntary hospitalization be destroyed. (Not in the record are two factors that may be involved. First, the University had previously been sued for imprisonment following a successful attempt for commitment. Second, openly known and widely reported in local newspapers was an ongoing feud between the director and the therapy staff.) As might have been expected, Poddar thereafter refused to return for further therapy.

Nowhere in the court's decision is there any linkage between these factors although all are taken up individually. Even Judge Mosk in his forceful criticism of the majority's reasoning, in his concurrence of ordering the case to trial, bases his concurrence on the "fact" that Poddar was planning to kill...Tatiana." And he concurred in the majority's major determination that there is a duty to warn under Tarasoff conditions.

Tatiana did not return home until October 1969. In the two-month interval Poddar was free, (he) caused no problems, showed no evidence of violence, and in fact became a roommate of Tatiana's brother. We must assume he voiced no threat against Tatiana during this time, otherwise it would have constituted a warning. On October 27, 1969, shortly after Tatiana's return, Poddar killed her. Apparently the plaintiff's statements seeking damages went into inflammatory detail of the violence, giving the multiple number of stabbings and shooting.

Tatiana's parents sued the psychologist treating Poddar, Dr. Moore, the physicians with whom the latter consulted for seeking the involuntary hospitalization, the police who failed to carry through with the custody proceedings, the director of the clinic, and primarily the Regents of the University of California who employed all the others. The suit was on four grounds of causing or contributing to the wrongful death of their daughter. The

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mentally ill (Stone, 1984)

lower courts dimissed the action outright on the basis of immunity for the multiple defendants and the psychotherapist's need to preserve confidentiality.

On appeal, The California Supreme Court agreed with the lower courts on all counts except one entered by the plaintiffs as the second of the four causes of action: failure to warn Tatiana's family of the danger since they (the staff) knew that Poddar was at large and dangerous. In dismissing the need for confidentiality, the summmation of the court's argument rests in one sentence: "The protective privilege ends where the public peril begins." It is interesting to note that this sentence in the original December 23, 1974 decision is repeated verbatim in the July 1, 1976 post-rehearing decision, and has proven a catchphrase used as a precedent in country-wide hearings after the original order was made to return the case to the lower court for trial (p156-158).

The initial Tarasoff decision established that psychotherapists or the police have a duty to warn, not a duty to commit (Stone, 1984). During the appeal, the court abandoned its position on the liability of the police stating that the police did not have a special relationship to the defendant and thus did not have a duty to warn. This illogical decision (Donelly, 1978; Stone, 1984) is ironic because as Stone (1984) points out, if anyone "...behaved improperly it was the police who made an independent judgment about the likelihood of Poddar's violence and his sanity and rejected the judgment of the clinic" (p.162) that he was dangerous and mentally ill. Stone asks: "Can courts claim to be protecting the public when they assign police duties to psychotherapists and absolve the police of those same duties?" (1984, p.174).

Before the final ruling was made on appeal, the Tarasoff family settled their claim out of court, thus it remains uncertain whether or not a judge or jury would have found the defendants negligent (Stone, 1984). The events during both Tarasoff hearings, however, lead one to speculate that any ruling would have been in the Tarasoffs' favor. Reviewers of the Tarasoff decision(s) (Grossman, 1978; Stone, 1984) point out that an article by Fleming and Maximov (1974) which appeared in a law journal heavily influenced the courts. The article contained many references to Thomas Szasz who has maintained a decidedly anti-commitment position in psychiatry. From this influence, Fleming and Maximov tried to solve the therapist's dilemma of responsibility towards both society and the individual patient by saying that the therapist should protect society in a way which is least harmful to the patient (which from the Szasz influence means least restrictive and avoiding containment). Fleming and Maximov reasoned then that the duty to protect society should take the form of a duty to warn potential victims, not a duty to commit. As Stone (1984) points out, Fleming and Maximov in no way considered that such a warning does not protect society as much as would confining the patient. They made the judgement that the breach of confidentiality by warning a third party is far preferable, less abusive and harmful to the patient than confining him. This, however, is only one of many ways of managing the dangerous patient (Roth & Miesel, 1977).

Psychiatry or psychology as an organized body were not officially involved before a settlement was made. It was felt to be "too messy a controversy" to become involved in (Gurevitz, 1978) because it was coupled with an embroiled internal controversy among the personnel of the Student Health Center. After the settlement was made which found the defendants liable, however, the Northern California Psychiatric Society prepared an amicus curiae brief. They criticized the Tarasoff decision on many points, one of which is that dangerousness is difficult to predict and therefore the defendants should be absolved of any liability in this case. While it is true that dangerousness is difficult to predict, there is a difference of opinion about the importance of this fact in the case. A major counter-point was that the prediction issue was a moot point since the clinical decision was made that Poddar was dangerous; therefore, the issue was then one of how the case was managed once the dangerousness was established (Oldham, 1978; Paul, 1977). Thus, it was not the breach in confidentiality per se whch was problematic, but rather it was the "bungled" attempt at restraint by Dr. Moore and the police combined with the inconsistent attitude on the part of the Student Health Center (as shown in the director's decision to destroy the records) which caused Poddar to terminate treatment (Gurevitz, 1977). The court however did not consider this to be an issue. The court stated that there is a duty to break confidentiality where danger to society demands it in order to prevent a dangerous act from occurring. Influ-

enced by Fleming and Maximov's article, the courts made a questionable inference leap (Grossman, 1978) by equating "protection of society" with "warning a supposed victim." Furthermore, the courts did not differentiate bewteen a "viable, uncontestably present danger" (Grossman, 1978,p. 161) such as a washed out bridge or an uncovered manhole on a busy sidewalk, and a possible threat which might become a danger and thus is not truly forseeable (Grossman, 1978, p. 161). The courts overlooked the fact that the possible (as opposed to uncontestably present) danger could have been decreased by not disclosing and simply pursuing further treatment (amicus curiae brief).

Stone (1984) points out the increased conflict which occurred when Tarasoff established the distinction between a duty to warn and a duty to commit:

> In essence, originally asked to choose between a duty to warn and a duty to confine, the court opted for a third and more ambiguous choice, a duty to protect. Thus they avoided taking a position that would seem to favor civil commitment. But as a result, Tarasoff II set a much more ambiguous precedent than did Tarasoff I - an ambiguity that would allow ingenious lawyers to claim negligence whenever a patient who has seen a psychotherapist subsequently harms a third party. The central ambiguity of Tarasoff II is that it tells the psychotherapist that he or she must protect third parties, but does not specify what steps are legally necessary and sufficient to meet this obligation to protect the public.

Gurevitz (1977) fears that the decision reinforces a social control function for psychiatry. Stone (1984) feels that the effect on psychotherapists of the Tarasoff decisions is to leave therapists with a high degree of confusion about what the actual duty is and what the

limits are of that duty. This could create any number of possible consequences. It could mean a lower level of safety for society as psychotherapists avoid dangerous patients in order to avoid liability. Another possibility is that in an attempt to carry out this duty to warn, there will be many futile warnings (Bersoff, 1976; Roth, 1983) and "increased revolving-door civil commitments" (Stone, 1984, p. 175). This in turn may also have the effect of patients leaving treatment precipitously thereby potentially increasing the risk of a future dangerous act.

Fleming and Maximov (1974) feel that as a result of Tarasoff, therapists will have a duty to advise patients from the outset of therapy about the obligation to warn potential victims under Tarasoff conditions. The literature, however, suggests that there is disagreement about how therapists feel about the Tarasoff decision. Wexler (1981) found that many therapists believe that the exclusive one-to-one therapy model is outdated and ignores the reality of the backdrop against which therapy takes place (i.e., with auxiliary office staff and insurance companies having access to the content of the therapy). Some therapists embrace the duty to warn because it gives them a policy of what to do in a difficult clinical situation and makes it easier for them to bring up difficult issues with a patient when it is required of them to do so (Wexler, 1981). But there is a difference of opinion about whether or not to inform from the outset of treatment about the limits to confidentiality under Tarasoff conditions (Beck, 1982).

The idea that there might be something positive or therapeutic to a breach of confidentiality is shared by other clinicians who work with potentially violent patients:

> The general public, prosepctive patients, and patients in therapy will not lose faith in the psychiatrist as a keeper of secrets when, in case of emergency, he acts contrary to strict and absolute confidentiality. Sooner or later, the patient usually realizes that the psychiatrist has acted in his (the patient's) best interest (Slovenko, 1966, p.56).

Roth and Miesel (1977) address the issue of the therapist's dual responsibility to protect the individual and society. They recognize that when faced with a potentially violent or self destructive patient, a clinician has typically had several conventional options at his disposal, each of which place a different weight upon the "competing values of confidentiality and the protection of social order" (p.508). Those options include: voluntary or involuntary hospitalization, notification of potential victims, calling the police, or continued therapeutic management of the patient without taking any of these other measures. Roth and Meisel have modified these options and made recommended guidelines for the management of dangerous patients which aim to help protect the rights of both the individual and society. They suggest the following: 1) since actual violence is relatively rare, especially among those with no history of previous violence, it is better to rely on the odds and not warn. They add that therapists must not be "stampeded" into providing frequent warnings to third parties because of Tarasoff, particularly when in most cases, it

is just not warranted 2) even when danger seems imminent, the either/or dichotomy of protecting the individual or society can be softened by making the patient an active participant in helping to avert a violent or self destructive episode. The patient might be encouraged to phone the intended victim himself with the therapist's help and explain briefly what circumstance he is in. Family members can be used as sources of support or brought into therapy themselves to diffuse the "identified patient" type of pressure. Their assistance can also be used to help rid the patient's residence of lethal weapons.

Siegel demonstrated a similar kind of modified technique (or balancing act) in the following case from his private practice:

> A teenager set a bomb in the automobile of a dean, at whom he was angry. When I could not convince this youngster to dismantle the bomb voluntarily, I left my office, went a mile up the road, phoned the police from a public phone, (and) phoned the school from a public phone. I in no way incriminated the boy.
>
> The police dismantled it, nobody was hurt, and the boy trusted me. And he came back. There were good results later on: we were able to deal with his anger (Mervis, 1983, p.24).

Here, both the individual therapy relationship and the safety of society were preserved. Roth and Meisel reiterate Siegel's guiding principle in that a therapist's action should always be assessed in terms of how likely the therapeutic manuever is to prevent the violent act, but also what its effect might be on the future of the treatment relationship.

A final guideline suggested by Roth and Meisel is that of informed consent. They recommend that a therapist should inform his patient of the confidential nature of the therapy relationship, being sure to warn of the limits of confidentiality. Yet they also acknowledge that despite the virtues of informed consent, such a detailed explanation of the limits of confidentiality may deter some patients from seeking psychotherapy. They seem to be suggesting that sometimes it is recommended that the limits of confidentiality not be mentioned in advance, but only stated when a patient begins to "speak convincingly of potential violence" (p.510). What they seem to be saying is that if it seems reasonable, inform your clients of the limits of confidentiality from the outset. If, however, you have a feeling that such a detailed explanation would deter them, then do not offer one until it really becomes necessary.

This stance is decidedly different from that taken by others (Nye, 1983; Bersoff, 1976) who firmly believe that all patients should be told everything up front from the start. They feel it is better to have some patients deterred from seeking help rather than have some patients in treatment without being fully informed of the parameters of the relationship.

Wise (1978) conducted a survey of mental health professionals in California in order to assess the effects of the Tarasoff decision on their clinical practices. Primarily psychiatrists of a psychoanalytic

orientation responded to the survey. When asked to speculate about their clients' responses to confidentiality, 86.3% of the respondents thought that their patients assumed that what was said in therapy was absolutely confidential. In addition, 79% of the clinicians felt that patients would be less likely to divulge certain information once the patient becomes aware that the therapist may have to divulge it to someone else. When asked about the importance of confidentiality, 69.7% of the therapists thought that confidentiality was important but could be breached under certain circumstances, while 26% thought that confidentiality was essential and should never be breached under any circumstances. Twenty-five percent of the respondents said that they have had patients who have terminated prematurely because they feared a breach of confidentiality. It is not known if these were the same respondents who felt that confidentiality should never be breached under any circumstance. Sixty three percent would discuss confidentiality only as it occurred naturally during the course of therapy. Only 14.5% indicated that they would discuss the issue from the outset of therapy. Since these data are based largely on a survey of psychiatrists, it would be interesting to see if psychologists handle confidentiality in a similar fashion. If so, this would certainly be at odds with the recommendations in the specialty guidelines to mention confidentiality and its limits from the outset of therapy, and to comply with all local, state, and federal laws.

Wise (1978) obtained the following results in response to direct questions about the impact of the Tarasoff decision on their clinical behavior: twenty percent reported discussing confidentiality more frequently with their clients since Tarasoff while 32.9% reported that they consulted with colleagues with greater frequency when treating potentially dangerous clients. Respondents noted changes in the way in which they felt when clients brought up the issue of their potentially dangerous behavior. Fifty-four percent of the clinicians felt increased anxiety when the topic came up, and 55.7% reported an increased fear of law suits when clients mentioned their dangerous behavior. The author noted that:

> If the therapists' apparent preference for not discussing the issue of confidentiality with their patients reflects a clinical principle that patients make more complete disclosures of information crucial to successful treatment when the patients remain ignorant of possible breaches of confidentiality, then Tarasoff may harm therapy by removing the illusion of absolute confidentiality (Wise, 1978, p.184).

The Tarasoff case appears to have left clinicians with much confusion about how to handle confidentiality when a patient is threatening harm. This confusion is also reflected in the various ethical guidelines of the American Psychological Association. In 1981, specialty guidelines for a number of psychological specialities were drafted and published by the APA (1981a). The specialty guidelines for both clinical and counseling psychologists have a quasi-legal, contractual tone . They were designed to clarify and reconfirm many of the aspects of the generic "Standards for Providers of Psychological

Services." Some of the recommended behaviors in these guidelines include:

> All providers within a psychological service unit support the legal and civil rights of the users.... All providers within a psychological service unit are familiar with and adhere to all of the APA official policy statements (e.g., the Ethical Principles, the Specialty Guidelines, etc.).... All providers within a clinical (counseling) psychological service unit conform to relevant statutes established by federal, state, and local governments (p.645).

Among some of the additional, specific behaviors recommended in the specialty guidelines are: encouraging psychologists to be prepared to provide a statement of procedural guidelines, statement of current methods, forms, procedures, and techniques to be used, and to devolop a written treatment plan. In addition, the guidelines recommend that users be informed in advance of any limits in the setting for maintenance of confidentiality of clinical information.

By contrast, the guidelines in the Ethical Principles of Psychologists (APA, 1981b) are less specific in the behaviors which are recommended. Principle 5: Confidentiality of the 1981 edition of the Ethical Principles states: "Where appropriate, psychologists inform their clients of the limits of confidentiality" (p.636). Clearly this latter guideline leaves the psychologist with more freedom and responsibility than the specialty guidelines to decide when it is prudent to inform a client in advance of any limits of confidentiality.

The specialty guidelines emphasize that psychologists support the legal and civil rights of the users. When examined more care-

fully, this is a confusing guideline. "Users" have already been defined as "direct recipients of psychological services, family members, and third party payers such as insurance carriers. What does a psychologist do when these "users" are in conflict? To whom does he owe his primary allegiance? What is the most effective way to support the rights of a client? Might some clients be more willing to disclose and thus better treated when not informed of the limits of confidentiality from the outset of therapy? While these guidelines are in a state of "flux," the individual practitioner must decide how to handle these ethical dilemmas. Many factors, of course, may influence the individual practitioner's decisions in this regard. Factors related to dangerousness of the client and the Tarasoff decision have already been discussed. Other factors such as the practitioner's knowledge and experience, and theoretical orientation have received little attention in the literature. There are, however, theoretical writings which offer some insight into the possible impact that theoretical orientation may have on the practitioner's approach to confidentiality.

Theoretical Views on Confidentiality

Theoreticians on confidentiality in psychotherapy tend to maintain one of two positions: those who advocate the need for complete, absolute confidentiality, and those who feel that relative confidentiality is more appropriate, allowing for confidentiality to be

breached under certain circumstances. Nowhere in the literature were there writers who felt that confidentiality was unimportant in psychotherapy.

Slawson (1969) advocated absolute confidentiality except for those who raise the issues of mental illness as a defense in court. Of those who advocate a position of absolute confidentiality, many are psychodynamic clinicians (Donnelly, 1978). Robert Langs (1976) places a heavy emphasis on the establishment and maintenance of a therapeutic frame which is the structure in which psychotherapy takes place. It consists of a set of conditions which help the patient to feel safe enough to take the necessary risks to explore his psychic life. Langs maintains that the "...exclusive one-to-one relationship with total confidentiality is the core of the therapeutic alliance and as basic as the analyst' objectivity" (p.303). He equates any non-confidential aspect of the therapy as fostering a misalliance which tends to influence all aspects of the therapeutic work. He refers to any deviation from total confidentiality as a "basic impairment in the therapeutic quality of the (bipersonal) field" (p.277). Langs argues that patients are exquistively sensitive to the least modification in the therapeutic frame. Any modification is experienced by the patient as aggression which then fosters mistrust and is a reflection on the therapist's poor control and incompetence.

Many of the psychodynamic writers who believe in absolute confidentiality base their positions on the theoretical concept of the holding environment (Winnicott, 1965) in which the therapist fosters a feeling of safety by serving as the container of a patient's impulses, fantasies, hostilities, etc. Kubie (1950) described therapy as a process in which a patient slowly allows his "secret self" to emerge. He made the analogy that the therapist is a "safe deposit box to which the patient alone has the key." Playing the role of this safe repository is part and parcel of maintaining the therapeutic framework and holding environment. Only when the therapist succeeds in maintaining the safe repository can this final "secret self" emerge. Kubie seems to be saying that a therapist must provide "air-tight" containment because any confidentiality "leaks" will seriously compromise the therapy.

Greenacre (1954) who is also a psychoanalyst, feels that both the maintenance of confidentiality and the limitation of the relationship to a professional one are the key ingredients to therapeutic work. While acknowledging the difficulty in maintaining confidentiality, Greenacre recommended that it is best to give out information only with the patient's consent and knowledge. Neither Langs nor Greenacre discuss the handling of emergency situations.

Otto Kernberg, a well-known psychodynamic theoretician, suggested a modified stance on confidentiality when working with border-

line inpatients (1975). Citing a bordeline's tendency to pit one staff member against another (which he refers to as "splitting" staff members), he recommended that clinicians broaden the therapeutic frame in order to include other staff members so that the splitting can be prevented. While this does not constitute a breach of confidentiality, it does represent a modification of the absolute stance that information never leave the therapist-patient dyad. Karasu (1980) made a much stronger statement when he said that

> (psycho)dynamic psychotherapists so strongly believe in utmost confidentiality and individual privacy of the dyadic relationship that they fail to divulge certain confidences or share information with family members that may prove vital to the welfare of the patient. (p 1507).

Little is known about how theorists from other theoretical orientations view confidentiality. Might other orientations also favor such absolute confidentiality? Appelbaum (1978) criticizes those who take an absolute stance about the maintenance of confidentiality. In a cogent, succinct argument he says "little can be said about psychotherapeutic techniques the opposite of which is also not true under some circumstances" (p.220). While Appelbaum agrees that in most cases it would be better to maintain confidentiality, he does not believe that the therapeutic relationship is irreparrably harmed when confidentiality is breached. In fact, he, like Roth and Miesel(1977), feels that something positive can come out of learning to cope with the imperfections in a treatment relationship.

The clinical literature suggests that there is considerable variability among individual practitioners and theorists regarding how confidentiality should be managed. A recent president of the APA (Siegel, 1979) as well as many other psychologists (particularly those with psychodynamic orientations) believe that confidentiality be absolute even when a client threatens harm to others (Goldstein & Katz, 1962; Kubie, 1950; Langs, 1976; Mariner, 1967; Uchill, 1978). Others, while also arguing for the importance of confidentiality, believe that confidentiality should be relative, allowing for exceptions to be made particularly in emergency situations (Appelbaum, 1978; Fromm-Reichman, 1950; Greenacre, 1954; Karasu, 1980; Kernberg, 1975; Menninger, 1958). There is at least the suggestion from the clinical writings that theoretical orientation may play a role in how confidentiality is managed in psychotherapy, with psychodynamic clinicians opting for a position closer to absolute confidentiality than those clinicians of other orientations.

Empirical Research on Confidentiality

The majority of empirical studies on confidentiality have involved surveys of mental health professionals which fall roughly into three categories: (1)surveys which seek to determine how aware psychotherapists are of their various legal statutes and ethical guidelines, (2)surveys which examine the attitudes and behaviors of therapists in their management of clinical issues as they relate to

confidentiality and privileged communication, and (3) surveys involving the study of mental health professionals' practice of sharing confidential information with other institutions or colleagues.

The two published surveys of the first type, those seeking to test how aware therapists are of their ethical guidelines and legal statutes, provide evidence for mental health professionals' confusion and lack of information about state laws. Suarez and Balcanoff (1966) found that nearly one fourth of the psychiatrists they surveyed in Massachusetts were unaware that there was no privileged communication statute in their state of practice. Swoboda, Elwork, Sales, and Levine (1978) found that nearly one third of the psychologists and one fourth of the respondents overall were not familiar with their privileged communication statutes in the state of Nebraska.

Suarez and Balcanoff (1966) also gathered data about psychiatrists' opinion of desirable exceptions to privilege. Only 5% of the respondents felt that a privilege statute was not necessary. The majority of psychiatrists felt that there should be exceptions to privilege in only 3 conditions: when the patient waives privilege, when the patient is being given a court ordered examination and is informed in advance of the lack of privileged communication, and when the psychiatrist is being sued for malpractice. Seventy-three percent of psychiatrists favored privileged communication when patients were involved in civil actions, whereas 63% favored such a statute when

clients were involved in criminal actions. Finally, 28% of the psychiatrists reported at least one case within the last five years in which they felt that privileged communication had been a "significant factor." The role of privileged communication in these cases is not known. The authors noted that based on some of the psychiatrists' comments, it seemed that many of them had confused the term "confidentiality" with "privileged communication."

Studies of the second type which examined psychologists' attitudes and behaviors in the clinical management of confidentiality, have generally revealed that psychologists willfully violate laws which they feel are not in their clients' best interest. This position changes to some degree, however, when the psychologists' legal liabilities are called into question.

In one such survey, Swoboda et al. (1978) provided a vignette of a family therapy case in which child abuse was disclosed. Although two thirds of all of the respondents were aware of the mandatory child abuse reporting law, 87% of the psychologists, 63% of the psychiatrists, and 50% of the social workers said that they would not report the child abuse, choosing instead to proceed with clinical management of the case. Lack of familiarity with the law did not seem to be a primary reason why a professional would break the law. The authors speculate that the reason mental health professionals would choose to break the law is because the laws appear to be punitively oriented while the helping professional is therapeutically oriented.

Jagim, Wittman, & Noll (1978) surveyed psychotherapists in North Dakota and found that virtually all of the therapists felt that confidentiaity was essential to maintaining a positive therapeutic relationship and believed that clients expected that their communications would remain confidential. When forced with a hypothetical choice between disclosing confidential information or accepting a contempt of court citation, 59% of those surveyed indicated that they would prefer the latter. However, when choosing between maintaining confidentiality or breaking it when a third party was in danger, 71% of the subjects chose disclosure to that third party. The authors postulated several possible reasons for the results:

> The respondents' endorsement of disclosure of information may reflect their concern for third party or societal interests (e.g., insure third party safety). On the other hand, their endorsement may reflect merely their feeling that they ought to comply with laws requiring disclosure (Jagim et al., 1978, p.463).

Unfortunately, insufficient data were collected to know exactly why the psychologists responded in the way that they did. Was it out of ethical or legal considerations, or both? Did Tarasoff sensitize them to be more legally conservative? It would be interesting to see if confidentiality were managed differently when faced with the clinical situation of a patient threatening harm towards others as opposed to threatening harm towards himself.

Kahle and Sales (1978) surveyed members of division 12 (clinical psychology) of the APA concerning their attitudes toward involuntary commitment. Clinical psychologists were asked to respond to question-

naire items by rating them on a 7 point Likert scale. While no statistical analyses were performed on the data, it is striking to compare the means of some of the items. Psychologists rated the criterion: "dangerous to others and mentally ill" (M=6.18) as a more suitable criterion for involuntary commitment than "dangerous to self and mentally ill" (M=5.57). Obviously at least some of the respondents made the value judgment that a patient threatening to hurt himself is less of a reason to take evasive action than when the patient is threatening to hurt someone else. One cannot help but think that Tarasoff had some role in producing this discrepancy in values.

Although the Tarasoff decision seems to have had some impact on the mental health professions, the actual effects are difficult to measure. Wise's (1978) survey asked for psychiatrists' subjective impressions of the impact of the Tarasoff decision on their work. It is hard to know if the Tarasoff ruling actually caused a change in therapeutic behavior since no pre-Tarasoff measures were given. Other studies support the idea that professionals are sensitized to the issue. Therapists seem to be more willing to take action (such as hospitalization) when a patient is dangerous to others as compared to dangerous to self (Kahle & Sales, 1978). Furthermore, Jagim et al. (1978) found that while 59% of therapists felt strongly enough about the importance of confidentiality to the point that they would rather face contempt than break confidentiality, 71% would break confidentiality in order to warn a third party whom a patient had threatened harm.

The surveys of the third type, those which have examined the practices of mental health professionals in their reporting of client information to various institutions, have revealed a state of confusion and misunderstanding as to what is acceptable practice. Noll and Hanlon (1976) surveyed all 50 state mental health department directors as well as 210 community mental health center directors across all 50 states regarding policies and actual practice in reporting confidential patient information (name, address, and social security number). One or more of these pieces of personal information were given to state mental health departments by 30% of the local community mental health centers. Of these, 36% did so without informing their patients of such a practice. The confusion regarding what and how confidential information should be disclosed to state officials was displayed when in some cases, mental heath center directors reported that they were granted no discretion in what had to be reported when their own state mental health departments indicated that this was not the case. Only one of the 50 states (Connecticut) had enacted legislation which prohibited revealing this kind of private information. Noll and Hanlon emphasized the fact that the individual's right to privacy is being violated by mental health officials on a large scale through such reporting practices. It would have been interesting to know if the therapists who were working with these patients were aware that this personal information was being reported, and if so, how they felt that such practices affected their clinical work.

Although the limited research to date suggests that much confusion and uncertainty exists regarding confidentiality and the Tarasoff decision, conclusions beyond this are difficult to draw. None of the studies surveyed a large number of psychologists, and usually surveyed practitioners within a small geographic region. The studies have generally been limited to a survey of mental health professionals' knowledge or opinion regarding existing child abuse, privilege, or civil commitment statutes. Nowhere were psychologists' daily management of confidentiality explored. There also has been no empirical research which has examined what factors influence psychologists' management of confidentiality.

Summary and Research Questions

The literature does suggests that there is considerable variation among psychologists as to their attitudes and actual behaviors in clinical situations where confidentiality or privileged communication becomes an issue. The literature also suggests that the following variables may affect the management of confidentiality: theoretical orientation, presence or absence of privileged communication, effects from the Tarasoff decision, and prior experience with breaches of confidentiality. An additional variable, the level of the client's functioning, although not explored in the literature, seems to be an important variable which may affect how confidentiality gets managed. All of these variables were studied singly and in combination in this research.

The present study surveyed practicing psychologists in seven states regarding their knowledge and management of confidentiality. The questionnaire used in the survey, which is described in detail in the Method section, employed a number of question formats from open-ended questions to Likert scale items. These items were explored both qualitatively and quantitatively to provide descriptive data about what psychologists know about confidentiality, and how they routinely manage confidentiality during the course of their day-to-day clinical work. In addition, specific therapist variables such as orientation, privilege status, and previous breaches of confidentiality were examined for their influence on the psychologists' knowledge of laws and statutes, as well as how it influences their routine management of confidentiality. These variables were further analyzed for their effects on how a psychologist handles confidentiality in specific situations such as when a client is harmful to self or others. Finally, the psychologists' opinions about different statutes, ethical guidelines, and the Tarasoff decision were examined.

The specific questions investigated fall into five general areas. In many cases, questions in those areas were aimed at gathering descriptive data and hypothses were not advanced. In some cases where hypotheses were being tested, the specific predictions are given following the investigative question.

Knowledge of Confidentiality. This category was included for a number of reasons. Previous research has suggested that psychiatrists may be confused about the terms "confidentiality" and "privileged communication" Suarez and Balcanoff (1966), and that many mental health professionals may be unaware of their privilege status (Jagim et al, 1978; Suarez and Balcanoff, 1966). However, knowledge in this area has not been systematically examined on a large scale. Additionally, whether or not a psychologist knows what these concepts means is important in terms of understanding the implications of other questions which use these concepts. Thus, the first question in this category was:

1. Do psychologists know what the terms the terms "confidentiality" and "privileged communication" mean?

2. Do psychologists know whether or not they have privileged communication in their state of practice?

3. How familiar are psychologists with the confidentiality and privilege laws in their state of practice?

Routine Management of Confidentiality. This area was important to include, because nowhere in the literature is there a good, comprehensive description of how psychologists manage confidentiality in their day-to-day work. The specific questions in this area were:

4. Under what type of conditions (i.e., with a patient's knowledge only, with a patient's consent and knowledge, or with neither) would a psychologist divulge confidential information to: the patient's family? the patient's employer? an insurance carrier? with a colleague? with a collection agency? Are there significant differences in how willing psychologists might be to share such information with these different people?

5. What percentage of psychologists say something about confidentiality from the outset of therapy?

6. What do most psychologists tell their patients about confidentiality from the outset of therapy?

7. How many of the psychologists have felt that their position on confidentiality has changed? In what way and why has it changed?

Factors Influencing Knowledge and Routine Management of Confidentiality. The influence of the specific factors such as: theoretical orientation, privilege status, and previous breaches of confidentiality on the management of confidentiality is a new feature in the research in this area. The first two questions in this category dealt with analyzing what factors may affect a psychologist's knowledge of various definitions and statutes.

8. Does the accuracy of psychologists' definitions of "confidentiality" and "privileged communication" vary according to previous breaches of confidentiality or privilege status?

9. Is a psychologist's knowledge about whether or not he/she has privilege commmunication affected by privilege status? It was predicted that the psychologists in states which do not have privileged communication should have more accurate definitions of privileged communication than psychologists in states which have privileged communication. It was also predicted that those psychologists with a history of previous breaches of confidentiality should have more accurate definitions of both confidentiality and privileged communication. Based on this reasoning then, it was further predicted that psychologists who have had to break confidentiality before and who also do not have privileged communication would have the most accurate definitions.

In addition to the role of these variables as they affect psychologists' knowledge about confidentiality, is the influence of these variables on psychologists' routine management of confidentiality.

10. Does the presence or absence of privileged communucation affect how a psychologist routinely manages confidentiality and its limits in therapy? It was predicted that psychologists in states without privileged communication will be more likely to inform their clients about confidentiality from the outset of therapy; it was also predicted that they would be more explicit about what the limits are since they (theoretically) have an additional limit placed on them.

11. Will a previous breach of confidentiality sensitize psychologists in any way to be more familiar with the laws governing confidentiality in their state of practice? It was predicted that psychologists who have had to breach confidentiality in the past will be more familiar with their state confidentiality laws.

12. Will those psychologists who have had to break confidentiality in the past be more likely to report having changed their position on confidentiality at some point in their careers? It was predicted that psychologists who have had to break confidentiality in the past will be more likely to report a change in their position.

13. Do those psychologists who have had to break confidentiality in the past differ from those who have not in terms of what and when they tell their clients about the limits of confidentialty? It was predicted that psychologists who have had to break confidentiality in the past, particularly where it has affected the therapy, will be more likely to inform their clients of the limits of confidentiality, and to do so more often from the outset of therapy.

14. Does a psychologist's theoretical orientation affect what and when he(she) tells a client about confidentiality? The clinical literature suggests that psychodynamic writers may be more likely to take an "absolute confidentiality" position than other clinicians. However, theoretical orientation is another variable that has never been tested empirically for its effect on the management of confi-

dentiality. It was predicted that psychodynamically oriented psychologists would: (a) be less likely to mention anything about confidentiality from the outset of therapy; and (b) mention fewer limits to confidentiality if the issue is raised at the outset of therapy.

Management of Confidentiality in Specific Clinical Situations. The first questions in this area were asked to see if psychologists manage confidentiality differently based on whether a patient was threatening harm towards himself or towards someone else. Three questions were asked using the same independent variables: theoretical orientation, and whether a client was threatening harm towards self or others. The dependent variable was modified slightly in each question, but always examined what might be said to the patient in the first session after the patient has hinted that he might do something harmful. These questions were asked separately because of a problem in establishing an interval scale which would have allowed them to be combined into one variable.

15. Does the degree to which a psychologist informs a client about the limits of confidentiality change as a function of theoretical orientation or whether a client is threatening harm towards himself or threatening harm towards others?

16. Does the frequency with which a psychologist tells a client from the outset of therapy that everything is confidentiality change as

a function of theoretical orientation or whether or not the client was threatening harm towards himself or threatening harm towards others?

17. Does a psychologist's tendency to say nothing at all about confidentiality from the start of therapy change as a function of theoretical orientation or whether a client is threatening harm towards himself or towards others? Theoretical orientation was included in these analyses because previous psychodynamic writers have suggested that they would maintain absolute confidentiality even under Tarasoff conditions. An attempt was made to see if such a management of confidentiality might be used by psychodynamic clinicians in the survey. It was predicted that psychologists will: (a) inform about the limits of confidentiality to a greater extent, (b) be less likely to assure the client that everything is confidential, and (c) be less likely to say nothing at all about confidentiality when a client is threatening harm towards others as compared towards self. It was predicted that the psychodynamic psychologists would maintain more of an absolute confidentiality stance than the other psychologists.

In order to understand qualitatively how psychologists think through confidentiality when a client is threatening harm, the following question was asked:

18. Are there some psychologists who would maintain absolute confidentiality under Tarasoff conditions? If so, what is there rationale?

A second specific clinical situation was created in the questionnaire. This situation dealt specifically with privileged communication and was intended to evaluate if a client's level of functioning affected a therapist's willingness to testify about that client in a child custody suit. The literature suggests that clinicians differ on their view about the maintenance of absolute confidentiality. Some clinicians embrace the duty to warn established by Tarasoff as a welcomed therapeutic lever that they can employ. It would be of interest to know if the situation of being asked to testify in court about a client could constitute a similar kind of therapeutic lever. That is, whether or not there may be some therapeutic advantage to offer such testimony. Thus, the following questions were asked:

19. Would psychologists tell their clients that the law protects them from a subpoena when that client raises the possibility that the therapist might be subpoenaed to testify about thie client's fitness as a parent in a child custody suit? Would this decision be based on the client's level of functioning, or the therapist's privilege status or theoretical orientation? It was predicted that psychologists would be more in favor of testifying if the client is functioning reasonably well than if the client has long-standing emotional problems where her fitness as a parent could legitimately

be called into question. Furthermore, it was predicted that non-psychodynamically oriented psychologists whose clients are functioning well will be the most likely to testify in this type of situation. Related to this is the question:

20. Would psychologists with the low functioning patient be more likely to consult with a lawyer? It was predicted that they will.

Psychologists' opinions about different statutes, court decisions, and ethical guidelines. This area was introduced into the research because the literature had suggested that it was not clear how psychologists felt about various ethical guidelines and court decisions. For example, although reviewers of Tarasoff were very critical about the decision, Wise (1978) discovered in his research that some psychiatrists welcomed a ruling which would tell them what to do when a client was imminently dangerous. The first of the questions in this area was:

21. What impact do psychologists feel their state laws on the presence or absence or privilege communication have on their clinical work? Is their opinion affected by privilege status? It was predicted that the psychologists with privilege will view their state laws as impacting more favorably on their clinical work than those without privilege.

22. What do psychologists think about an ethical guideline which requires that clients be informed in advance of the limits of confidentiality? Is their opinion affected by their theoretical orientation? It was predicted that the psychodynamic psychologists will be less in favor of such a guideline compared to other psychologists.

23. How familiar are psychologists with the Tarasoff decision?

24. If familiar with the Tarasoff case, what kind of impact does it have on their clinical work? The next chapter will explain how the data were collected to answer all of these questions.

CHAPTER III

METHOD

Participants

Psychologists were chosen from the National Register of Health Service Providers in Psychology (1983).[1] All 233 psychologists from the Register were surveyed in the four states which did not have privileged communication at the time of the initial mailing (Iowa, South Carolina, West Virginia, and Vermont).[2] The same number of psychologists were chosen at random from three neighboring states which have very liberal privileged communication laws (Illinois, Georgia, and Pennsylvania). There was a total of 1,956 psychologists listed in the National Register in the four states with privilege from which the 233 psychologists from these states were drawn. This second sample was stratified according to state in order to insure that the sample was representative of the different populations in those states. Subjects within each state (stratum) were chosen on a random basis. Obviously the sample of psychologists in the no-privilege states was not strati-

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1 using the 1981 edition with the 1982-83 supplement.

2 Excerpts from the statutes on confidentiality and privileged communication for each of the seven states are presented in Appendix A.

fied since each member of that population was sent the questionnaire. A total, therefore, of 466 psychologists was mailed questionnaires.

Using an estimate of a 40% return rate, a minimum of 186 completed questionnaires was predicted. The number of surveys mailed, the number returned, and the return rates for each state are presented in Table 1. The mean return rate across all of the states was 41.9%. The lowest return rate was from Vermont (28.3%) while the highest return rate was from West Virginia (69.0%). Table 2 contains demographic data of the sample while Table 3 shows the nature of the clinical activities of the sample. Included in both of these tables are some corresponding data from members of the National Register of Health Service Providers in Psychology as of 1978 (Vandenbos, Stapp, & Kilburg, 1981).

The sample of psychologists in the present study was comprised of predominantly male (76.6%) psychologists. They tended to be APA members (91.0%) holding a Ph.D. (79.3%) whose major field of graduate study was in clinical psychology (71.8%). They had an average of 16.1 years of experience. Their primary treatment modality was individual psychotherapy, averaging 14.8 hours of individual therapy per week. Seventy-one percent of their patient load was adult while 15% were adolescent and 14% child. Many psychologists in the sample (56.5%) indicated that they were eclectic; however, such an "orientation" was broken down into more discrete orientations for the sake of later

TABLE 1

Survey Response Rate by State

State	Number Surveys Mailed(a)	Number Surveys Mailed(b)	Number Returned	Return Rate
IL	106	103	44	42.7
PA	96	92	37	40.2
GA	31	29	10	34.5
IA	76	73	31	42.5
WV	33	29	20	69.0
SC	77	77	33	42.9
VT	47	46	13	28.3
Totals	466	449	188	41.9

(a) reflects number initially mailed

(b) reflects number which reached targeted psychologists

TABLE 2

Sample Demographics

Variable	N	%	Population %
Sex			
Male	144	76.6	71.1
Female	44	23.4	28.9
APA member			
Yes	171	91.0	
No	15	8.0	
Degree			
PhD	149	79.3	83.8
PsyD	1	0.5	
EdD	10	5.3	
MA / MS	28	14.9	
Major Field Grad Study			
Clinical	135	71.8	64.0
Counseling	32	17.0	14.2
Educational Psy.	5	2.7	2.0
School	5	2.7	8.5
Other	10	5.3	

TABLE 3

Professional Practice of Respondents

Variable	Mean	(S.D.)	Population
Years Experience	16.10	(8.44)	11.73
Weekly Clinical Work (hours)			
Individual therapy	14.80	(10.10)	
Group/Family therapy	3.73	(4.72)	
Testing	5.40	(7.99)	
Other	1.00	(2.74)	
Mean % age of clients			
Adult	70.68	(31.25)	
Adolescent	15.34	(18.70)	
Child	13.98	(18.10)	
Theoretical Orientation	N	%	
Psychodynamic	62	33.0	
Cognitive-behavioral	74	39.4	
Behavioral	11	5.9	
Humanistic	40	21.3	
Missing	1	0.5	

analyses. If respondents were eclectic, they were encouraged to rank order the influence of other orientations on their eclecticism. The orientation which a psychologist ranked first was used as his(her) official orientation. The discrete orientations in the questionnaire were collapsed into four categories for the purpose of data analysis. Rational emotive therapy and family systems therapy were combined with cognitive behavioral; person-centered, gestalt, and existential were all combined under "humanistic." Psychodynamic and behavioral fromed their own categories. Based on such a categorization, their predominant theoretical orientations were cognitive behavioral (39.4%), psychodynamic (33.0%) and humanistic (21.3%).

Materials

The questionnaire which was designed for this study was created to gather descriptive data about psychologists' management of privileged communication and confidentiality as well as to test the effects of specific variables which may affect the management of confidentiality. The survey used a wide range of question formats from open-ended, short answer items to specific Likert scale items. Among the 55 items in the survey (see Appendix B), 12 were open-ended requiring that the respondent write a few sentences in order to answer the item. There were also 31 closed-ended (i.e., Likert scale) items, and the remaining 12 items were "semi-open-ended" requiring a fill-in-the-blank type of answer. All three types of questions were used to test the effects of the specific variables in question.

The demographic descriptive items which were used in the questionnaire were derived from a number of sources. Those items dealing with APA division status, degree, and theoretical orientation were modelled after the research conducted by Vandenbos, Stapp, and Kilburg (1981). The theoretical orientation categories were based on research by Garfield and Kurz (1976,1977), Wildman and Wildman (1967), and Ivey (1980). The item which asked about the type of setting that the respondents work in was modelled after a survey by Stapp and Fulcher (1982).

Part of this study was exploratory and descriptive in nature. The descriptive items, which used all three types of question formats, sought to find out what psychologists typically tell their clients about confidentiality, when they tell them, and why. They also sought to describe the situations under which the psychologists would be willing to share private and confidential information about a patient to various third parties (e.g., with the patient's employer, family member, insurance company, or with a professional colleague). The descriptive items asked psychologists to discuss any changes in recent years in their views on confidentiality and to speculate about why they feel these changes have come about. Finally, the respondents were asked to discuss any experiences with breaches of confidentiality and whether they feel that these breaches affected the therapy.

As in the study by Swoboda et al. (1978), vignettes were used in this research in order to have a standard clinical situation in which to evaluate the psychologists' attitudes and behaviors concerning confidentiality. Two types of clinical vignettes were used in the present study. One dealt with confidentiality under a Tarasoff condition, the other more specifically with privileged communication. Each type of vignette contained two forms. In the confidentiality vignette, one form contained a situation where the client was potentially harmful towards himself while in the other form the potential harm was toward others.

The confidentiality vignette:

> An agency has referred a 25 year old man to you for individual psychotherapy. You were told in the referral that this man has had trouble in the past with impulses to harm others (himself). You agree to work this man. In his first session with you, he tries to tell you what is troubling him but stops himself and expresses a fear that if he is more explicit about what these impulses are, then you as the therapist might take some action against him such as hospitalizing him or calling the police.

Two different privileged communication vignettes were created, one in which the client is functioning well, the other where the client is not doing very well. Each subject was randomly given one of the following vignettes:

High functioning vignette:

For three months now you have been treating a 35 year old woman who entered therapy following a recent divorce. It is your impression that she has functioned quite well psychologically throughout much of her life and is presently trying to adjust to her new roles as single woman and single parent since the divorce. She has attended her sessions regularly and seems to be making progress. Her ex-husband has just expressed his intention to take her to court in order to obtain custody of the children on the grounds that your client is an unfit parent. Your client fears that her ex-husband may use the fact that she is in therapy as evidence against her. She is concerned about continuing in therapy out of fear that it will leave the impression in court that she is emotionally unstable. During the course of the session she also mentions that her husband intends to file for a subpoena in order to have you testify about your client's emotional stability.

Low functioning vignette:

For three months now you have been treating a 35 year old woman who entered therapy following a recent divorce. It is your impression that she has not functioned very well psychologically throughout most of her life. She has a history of depression for which she has been hospitalized three times, the most recent of which followed a nearly fatal suicide attempt. Her present attempt to adjust to her new roles as single woman and single parent since the divorce is but one of many "crises" which this woman has experienced. She has attended her sessions regularly and seems to be making a little progress. Her ex-husband has just expressed his intention to take her to court in order to obtain custody of the children on the grounds that your client is an unfit parent. Your client fears that her ex-husband may use the fact that she is in therapy as evidence against her. Your client is concerned about continuing in therapy out of fear that it will leave the impression in court that she is emotionally unstable. During the course of the session she also mentions that her husband intends to file for a subpoena in order to have you testify about your client's emotional stability.

Both the privileged communication and the confidentiality vignettes were based on actual clinical situations. They were also evaluated by ten clinical psychologists for authenticity and believeability

before they were included in the questionnaire. The ten psychologists also provided feedback concerning the clarity of the items and the length of the questionnaire.

Procedure

A variation of the "Total Design Method" (TDM) was used in the preparation and dissemination of the questionnaires (Dillman, 1978). The questionnaire which was used in the present research was not only lengthy, but also contained a large proportion of items which were open-ended. The use of some type of follow-up mailing, therefore, was necessary. Because this survey asked psychologists about their compliance with laws and ethical guidelines, it was desirable not to compromise the anonymity of the questionnaires by coding them.

The questionnaires together with a cover letter were mailed following the recommended guidelines of the TDM. The only variation in the TDM was that the questionnaires were sent anonymously, hence they were not coded. Thank you/reminder post cards (see Appendix C) were mailed five days after the initial mailing of the questionnaires as consistent with the TDM strategy. Seven days after this mailing, a second wave of thank you/reminder post cards was mailed. This second mailing of post cards was in lieu of Dillman's recommendation to mail second questionnaires and reminder letters to those who have not yet sent their questionnaires in. Because the questionnaires were not coded, it was not possible to determine who should receive a second

mailing of the questionnaire. If the Total Design Method were to be carried out completely (including a third mailing of the questionnaires to non-resonders by registered mail), then a return rate in excess of 70% could have been expected (Dillman, 1978). Because some of the steps of the TDM were not used in the present research, however, a return rate of between 40 and 50 percent was predicted.

CHAPTER IV

RESULTS

Knowledge of Confidentiality

Several questions regarding psychologists' general knowledge about confidentiality were explored. The first concerned basic knowledge of terms. In the survey, psychologists were asked to define the terms "confidentiality" and "privileged communication" (item 26 of the questionnaire). Their written definitions of the term "confidentiality" received one of three scores; 6.5% of the psychologists received a score of zero indicating that either they could not provide a definition (this is different from not answering the item) or they provided a definition which was grossly inaccurate; 43.5% of the psychologists defined confidentiality as an agreement to not disclose private information without the client's permission (and received a score of 1), and 50% of the psychologists also added that the term contained exceptions or that it was a legally binding obligation to not disclose (score of 2). On the average the psychologists were familiar with the term ($\underline{M}$ = 1.44, S.D. = 0.62).

The psychologists' privileged communication definitions also received one of three scores; 70.6% of the respondents received a score of zero which meant at least one of the following: (a) they stated that they did not know what the term meant, (b) they equated the term entirely with the term "confidentiality," or they (c) stated that confidentiality is an ethical term and that privileged communication is simply a legal definition of confidentiality. A score of "1" was received by 2.9% of the psychologists by acknowledging that the two terms (confidentiality and privileged communication) were clearly different from one another but did not, like the remaining 26.5% of the respondents, indicate that privileged communication means that a psychologist is protected from having to testify about a client in a court of law (score of 2). Thus, only slightly more than one-fourth of the sample provided accurate definitions of the term "privileged communication."

Apart from whether or not the psychologists knew what the term "privileged communication" meant, an attempt was made to see if they knew whether or not they had privileged communication in their state of practice (Question 2). In order to test this, an error score was created for each psychologist based on his (her) response to item 34 of the questionnaire. If a psychologist had privilege in his state of practice, then his "correct answer" for item 34 was "5-definitely has privilege." If that psychologist were to indicate that he, "4-probably had privilege," then he was assigned an error score of

"1." The mean error score across all psychologists was 0.89 (S.D.=1.24), indicating that as a group, the psychologists were generally aware of whether or not they had privilege in their state of practice. However, there was a significant difference across states in their error scores, F (6,179)=3.39, p,<.005. A Neuman Keuls post hoc pairwise comparison of mean error scores indicated that psychologists from Iowa (M= 1.43) and West Virginia (M=1.40) had significantly higher error scores (at the .01 level) than psychologists from Georgia (M=0.10). Vermont psychologists (M=1.31) had significantly higher error scores than those from Georgia (at the .05 level). Although psychologists from Illinois (M=0.80), Pennsylvania (M=0.62) and South Carolina (M=0.56) had low error scores, they were not significantly different than psychologists from any other states.

The last question in this category was concerned with how familiar psychologists are with the confidentiality laws in their state of practice. Because states varied in accessibility of their confidentiality laws, only psychologists from Illinois were used in the analysis. These psychologists were asked to rate how legal it would be for them to share confidential information about their clients with several different people. Legality was rated on a 5 point Likert scale with a score of 1 indicating "definitely illegal," a score of 3 indicating "not sure," and a score of 5 indicating "definitely legal." For each situation which tested a psychologist's knowledge of a given statute or exception, a "correct" answer for each state was deter-

mined. If a particular clinical behavior as defined by the state law is judged to be legal, then the "correct answer" was (5) - definitely legal. A psychologist from this state who answered (4) "probably legal," in response to this item, received an "error score" of 1 for that item. The error score thus increased the further in magnitude and direction the psychologist's score departed from the "correct answer."

A potential problem with this scoring system is in the assumption that the correct answer is either a 1 or a 5. It was for this reason that only psychologists from Illinois, which has clear-cut, minimally ambiguous and "readily accessible" statues, were included in this analysis. The mean legal ratings and error scores are presented in Table 4. The error score was not calculated for psychologists' knowledge of how legal it would be to contact a collection agency since this situation is not discussed in the Illinois confidentiality statutes.

The Illinois psychologists believed that it was legal to break confidentiality when a client was imminently dangerous or when the psychologist wished to consult with a colleague about certain troubling aspects of the case. They were on the average "not sure" if it was legal to break confidentiality when contacting a collection agency to recover money from an unpaid bill. Although still "not sure," they tended to rate it "illegal" to provide more detailed information about

TABLE 4

Legal Ratings and Error Scores

of Illinois Psychologists on how

Legal it Would be to Break

Confidentiality in Different Situations

Situation:	Legal rating(a) Mean (S.D.)	Error score(b) Mean (S.D.)
Client imminently dangerous	4.69 (0.52)	0.31 (0.52)
Family member wants information	1.78 (0.91)	0.78 (0.91)
Client's employer wants info.	1.45 (0.71)	0.45 (0.71)
You want to consult colleague	3.81 (1.07)	1.19 (1.07)
Insurer wants more information	2.73 (1.39)	1.76 (1.39)
You want to contact coll. agency	3.22 (1.17)	(c)

(a) the higher the rating, the more they felt that it was legal to break confidentiality

(b) the higher the error score, the less accurate were the legal ratings.

(c) not computed since this situation is not discussed in Illinois statutes.

a client to an insurance carrier without the client's knowledge and consent. The psychologists rated it "illegal" to give out information to a client's family or employer without the client's consent. The psychologists as a group seemed to be quite aware of their state confidentiality statutes, having a total mean error score of 0.90.

In order to check for differences in error scores across the five situations, an apriori repeated measures analysis of variance was conducted. The analysis yielded a main effect for "situation" $F(4,232)=9.98$, $p<.001$. A post hoc Newman-Keuls pair-wise comparison of mean error scores was conducted to see where these differences occurred. Eight of the ten pair-wise comparisons were significant (seven at the .01 level). The psychologists were the most accurate in their assessment of whether or not it was legal to break confidentiality when a patient was imminently dangerous ($M=0.31$) or to consult with the client's employer ($M=0.45$) than in any of the other situations. They were the least accurate in rating the legality of breaching confidentiality in order to answer questions from the client's insurance company ($M=1.76$) or to consult with a colleague ($M=1.19$). The other situations, answering questions from a family member or contacting a collection agency, had error scores which fell inbetween the two extremes. The error scores were significantly different from each other and from the other conditions.

In summary, psychologists as a group knew what the term "confidentiality" meant, but only one-fourth provided accurate definitions of "privileged communication." Even though they were not able to provide accurate definitions of the latter term, they generally were aware of whether or not they had privileged communication. The psychologists from three of the states, however, (Iowa, Vermont, and West Virginia) were significantly less aware of their privilege status than the psychologists in Georgia, with psychologists from Illinois, Pennsylvania, and South Carolina falling somewhere in between. On the average, psychologists from Illinois were aware of their state confidentiality statutes. They had the lowest error score in rating the legality of breaching confidentiality when a patient was imminently dangerous, and the highest error score regarding the legality of breaching confidentialty when answering questions from a client's insurance company.

Routine Management of Confidentiality

The first investigative question in this area (Question 4) concerned psychologists' willingness to share confidential information in various situations. Psychologists were presented with six clinical situations and asked to indicate the conditions under which they would share information in each situation. The four conditions, their corresponding scores, and the third party situations are presented in Table 5. The mean score for the condition under which identifying,

confidential information would be shared with a third party when a client was believed to be imminently dangerous to self or others (item 27) was 3.31 (S.D.=0.53). Only one respondent would never breach confidentiality under this situation, while 63.8% would share this information only with the client's knowledge but not necessarily with his consent, and 34.1% would share this information without requiring the client's consent or knowledge.

When a family member of a client contacts a psychologist and wants to know why that client is having so many difficulties (item 28), most of the psychologists would require the client's consent before revealing such information ($\underline{M}$=1.86, S.D.=0.36); 14.6% indicated that they would never share this information with the family member under any circumstance, 84.9% would require the client's consent, and only one psychologist would give this information without the client's knowledge. No one would share this information without the client's knowledge.

Were a client's employer to contact a psychologist for an explanation of why that client has missed so much work (item 29), all but one of the psychologists (99.5%) would atleast require the client's consent and knowledge ($\underline{M}$=1.76, S.D.=0.46), and of these, 24.9% would not share such information with the employer under any circumstance.

Under the situation where the psychologist wanted to share personal, identifying information about a client with a colleague because

TABLE 5

Conditions Under Which Psychologists Share Confidential Information

Score:	Condition:
1.	Would not share such information under any circumstance.
2.	Would share such information only with a client's complete consent and knowledge.
3.	Would share such information with a client's knowledge, but not necessarily with a client's consent.
4.	Neither a client's consent nor knowledge is necessary.

Situation:	Mean Score	S.D.
Dangerous pt	3.31	0.53
Family	1.86	0.36
Employer	1.76	0.46
Colleague	3.28	0.94
Insurer	2.02	0.35
Collection agency	2.39	1.18

of certain troubling aspects of the case, (item 30), a bimodal frequency was observed ($\underline{M}$=3.28, S.D.=0.94); 59.5% would require neither a client's consent nor knowledge in order to share this information, 11.9% would require the client's knowledge alone, 25.9% would require both the client's consent and knowledge, and only 2.7% would not share this information under any circumstance.

If an insurance carrier were to contact a psychologist and ask for a more detailed description of the client's treatment in order to warrant further treatment (item 31), most psychologists (90.9%) would require the client's knowledge and consent before sharing the information ($\underline{M}$=2.02, S.D.=0.35); 4.3% would not share the information under any circumstance while 1.19% would share the information without the client's knowledge.

The situation in which the psychologist wanted to contact a collection agency in an attempt to recover money from an unpaid bill (item 32) contained the largest variation in responses of any of the third party situations presented to the respondents ($\underline{M}$=2.39, S.D.=1.18). Twenty percent of the psychologists would not require the ex-client's knowledge; 35.6% would require only the client's knowledge, 6.9% would also require the client's consent while 37.4% would not share this information with a collection agency at all.

In order to examine differences in willingness to share information across the six clinical situations, the psychologists' ratings

were subjected to an (a priori) repeated measures analysis of variance. The analysis yielded a significant effect for condition, $F(5,195)=36.27$, $p<.001$. A post hoc Newman-Keuls pairwise comparison of the six means revealed numerous significant differences among the six conditions. Because of the large number of comparisons, they are presented in summary form in Table 6.

Almost all of the six conditions were significantly different from one another at the .01 level, with the following two exceptions. The conditions under which psychologists would share confidential, identifying information about a patient when that patient was dangerous, was not significantly different from the conditions under which information would be shared with a colleague. Moreover, the conditions under which information would be shared with a family member was not significantly different than when giving information to the patient's employer. In their routine management of confidentiality, the psychologists were significantly more willing to share information without a patient's consent when the patient was imminently dangerous, or when the psychologist wished to consult with a colleague than in any of the other four situations. They were significantly more willing to break confidentiality in order to contact a collection agency than to contact the patient's insurer, family member, or employer.

In summary, the majority of psychologists did not feel it necessary to obtain a client's consent when the client was imminently dangerous to self or others or before sharing information with a col-

TABLE 6

Significance Levels from Newman-Keuls Post-hoc Analyses of Differences among the six Clinical Situations in the Conditions under which Information is Shared

	Situations					
	1	2	3	4	5	6
Situations	Employer	Family	Insurer	Collection Agency	Colleague	Patient Dangerous
1	-					
2	n.s.	-				
3	.01	.05	-			
4	.01	.01	.01	-		
5	.01	.01	.01	.01	-	
6	.01	.01	.01	.01	n.s.	-

league for the purpose of consultation. The psychologists tended to be the most guarded about sharing information with a client's employer or family member, more so than with an insurance company or collection agency.

The next group of questions concerned the psychologists' usual and standard practice in the management of confidentiality. The first of those questions (Question 5) asked: what percentage of psychologists say something about confidentiality from the outset of therapy? This was examined in two different ways in the survey. The first way was through an examination of an item which asked psychologists whether or not they routinely mention something about confidentiality from their first contact with a patient (item 12). According to the response frequency of this item, 34.6% of the psychologists always say something about confidentiality from their first contact with a patient, 23.4% almost always say something about it, 17.0% did so "sometimes," 16.0% almost never say anything about confidentiality from the outset, and 5.9% never mention confidentiality from the outset.

The second way this question was answered was according to whether the psychologists responded to item 13 (for those who say something about confidentiality from the outset) or to item 14 (for those who do not say anything about confidentiality from the outset) in the questionnaire. This is essentially a dichotomous version of

item 12. Based on this dichotomy, 61.2% of the psychologists said that they usually inform clients about confidentiality from the outset while 38.8% usually do not.

The next question concerning the routine management of confidentiality asked what is it that is usually said to clients about confidentiality by psychologists who usually raise the issue from the outset of therapy. In item 13 of the survey, the respondents were asked to provide a brief written description of what they usually say if they do indeed say anything about confidentiality from the outset. Their open-ended responses were coded into three categories; 19.1% (or 11.7% of the total sample) usually tell their clients from the outset that <u>everything</u> said in therapy is confidential; 14.8% (or 9.05% of the total) allude to the existence of limits to confidentiality, and 66.1% (40.40% of total sample) usually spell out the limits to confidentiality in a specific manner.

Question 7 investigated how many psychologists have experienced a change in their position on confidentiality and was assessed via a yes/no questionnaire item (item 15). Nearly half the sample (49.7%) indicated a change in their positions. Of those who have changed their position on confidentiality, 78.3% have changed towards a position of favoring more disclosure. A content analysis revealed a number of reasons for making such a change. The Tarasoff decision was the most fequently mentioned reason (N=22). Previous experience with

failure to clarify the limits of confidentiality from the outset with patients "at risk" or to inform their family members when that patient was at risk was cited second most frequently for why psychologists share confidential information more (N=14). Fear of malpractice and change in confidentiality laws (particularly the mandatory child abuse reporting law) were tied for the third most common reason (N=6). Studying law and/or ethics and personal maturation were other commonly mentioned reasons for changing to a position of greater disclosure (N=4). A smaller proportion of psychologists (20.7%) moved toward a position which favors less disclosure Chief among their reasons for doing so was bad experience with breaches of confidentiality in the past (N=6). Moving to a state which has privileged communication (N=2) was cited as the second most common reason.

Factors Influencing Knowledge and Management

Privileged Communication. Question 8 asked whether or not the accuracy of a psychologist's definition of privileged communication is affected by privileged communication status or by a prior breach confidentiality. In this regard, it was hypothesized that psychologists without privilege as well as those who have breached confidentiality will have more accurate definitions of the term "privileged communication." Before addressing this question, however, the privileged communication variable had to be recoded into three levels, thus creating three groups of psychologists. Group 1 (N=91) contained psychologists

in states which have had privilege for a while (Illinois, Pennsylvania, and Georgia). Group 2 (N=53) contained psychologists from states which do not have privilege (West Virginia and South Carolina). Group 3 (N=44) contained psychologists from two states (Iowa and Vermont) which recently acquired privileged communication.[1] The hypothesis was tested using a 3 (privilege status) by 2 (previous breach yes/no) ANOVA of privileged communication definition scores. The main effect for privilege status was not significant, F (2,163) = 0.02, n.s.. However, there was a significant main effect for the breach variable, F (1,163) = 4.00, $p < .05$. Those who did have to breach confidentiality in the past had a significantly more accurate definition (M=0.80) than those who have not had to break confidentiality (M= 0.48). However, even a score of 0.80 meant that the psychologists did not provide very accurate defintions. The interaction was not significant.

The next question (Question 9) concerned whether the accuracy in the knowledge of one's privilege is affected by privilege status itself. There were no predictions. This was examined using a one-way ANOVA. The independent variable was, of course, privilege status (those who have it, those who do not, and those who just recently were granted it). The dependent variable was based on the psychologists' responses to item 34 which asked them to rate on a 5-point Likert scale how sure they were that they had privileged communication in

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[1] The recent changes in the privilege laws of these two states have been included in Appendix A.

their state. The dependent variable was formed by creating an error score for each subject, using the same error score method as in previous analyses.

The results from the one-way ANOVA revealed a significant effect for privileged communication status, F (2,183) = 5.56, $p < .01$. The mean error scores for the psychologists with privileged communication, those without it, and those who recently were granted it were 0.65, 0.88, and 1.40 respectively. A Neuman-Keuls post hoc pair-wise comparison of the means indicated that those who had just received privilege (Iowa and Vermont), were significantly less aware of their privilege status than those psychologists who have had privilege for a while, (Illinois, Pennsylvania, and Georgia), q, (3,183)= 0.75, $p,<.01$, or those who do not have privilege (West Virginia and South Carolina), q, (2,183)= 0.65, $p,<.01$. The difference in accuracy of knowledge of privilege status between the latter two groups was not significant, q, (2,183)= 0.23, $n.s$. As a total sample, however, the psychologists were aware of their privilege status, having a total group mean error score of only 0.89, indicating that they were less than one likert scale point away in the accuracy of their knowledge of their privilege status.

The next issue was whether privilege status affects how a psychologist routinely manages confidentiality (Question 10). Two hypotheses were advanced. First, it was predicted that psychologists

without privilege would be more likely to inform about confidentialty from the outset of therapy. This was tested in a one-way ANOVA based on responses to item 12. The analysis revealed a nearly significant effect for privilege status, F (2,179) = 2.58, p = .079. The psychologists who have had privilege for a while were the most likely to inform of confidentiality from from the outset (M= 3.85), those without privilege were the next likely to (M=3.66), and those were recently granted privilege were the least likely to routinely mention confidentiality from the outset (M=3.32).

The second hypothesis predicted that psychologists who do not have privilege will be more explicit about the limits of confidentiality. This was tested by a one-way ANOVA with privilege status as the independent variable. Their coded responses to an open-ended item (item 13) regarding what they say about confidentiality from the outset of therapy served as the dependent variable. Although the psychologists who have had privilege for a while (M=2.58) as well as those who were recently granted it (M=2.50) were more explicit about the limits of confidentiality than those without privilege (M=2.25), this difference was not significant, F(2,112)=1.79, $n.s$. It should be noted that on the average, all three groups of psychologists at least allude to the existence of limits of confidentiality (which a score of 2.00 would indicate), and tended to be explicit about the limits (score of 3.00).

Previous Breach of Confidentiality. The breach variable was recoded into three levels. The first level contained psychologists who indicated that a previous breach of confidentiality had affected the therapy (N=12 or 6.6%). The second level contained psychologists who reported a previous breach that did not affect the therapy (N=35 or 19.3%), and the third level contained psychologists who had not breached confidentiality in the past (N=134 or 74%).

Question 11 asked if a previous breach of confidentiality sensitized psychologists in any way to be more familiar with their state laws. The dependent variable in this one-way ANOVA was created by adding together the error scores for each of the Illinois psychologists. It was predicted that the psychologists who have had to break confidentiality would be more acquainted with the laws in their respective states and have lower error scores as a result. This hypothesis was not supported, $F(2,38)= 0.19$, n.s. In fact, the psychologists who had to breach confidentiality in the past and found that the breach affected the therapy had the highest mean error scores ($M=1.20$). Those who made a breach and experienced no effect ($M=0.93$) as well as those who never had to breach confidentilaity ($M=1.05$) had lower error scores.

Two questions regarding the relationship between a previous breach of confidentiality and the routine management of confidentiality were explored. The first (Question 12) concerned the relationship

between a breach and a change in position on confidentiality. It was predicted that there would be a relationship between the two. This was examined in a chi-square test where the marginals were breach (breach which affected therapy, breach which had no effect, and no breach) and whether or not their position on confidentiality had changed (yes/no). The results were non-significant, χ^2 (2)=2.94, n.s. and thus did not support the hypothesis.

A further question concerned the relationship between a breach and what or when psychologists tell their clients about confidentiality (Question 13). It was hypothesized that psychologists who have had to breach confidentiality in the past will be more likely to say something about confidentiality from the outset of therapy. The results of the ANOVA were non-significant, F (2,172)=0.18, n.s.

It was predicted that psychologists who had breached confidentiality would be more explicit in informing their clients of the limits of confidentiality. This was tested in a one-way ANOVA of coded responses to item 13. The analysis yielded a significant effect, F (2,108) = 3.90, $p<.05$. Based on a Newman-Keuls post hoc comparison of means, those who breached confidentiality and it affected therapy (M=2.86) were significantly more explicit about the limits of confidentiality than those who never breached confidentiality (M=2.10). Those who breached confidentiality but where it did not affect treatment (M=2.55), were not significantly different from the other two

groups. When the breach did affect therapy, the psychologists who made such a breach were the most explicit about the limits of confidentiality when seeing a client for the first time. Those psychologists who had broken confidentiality in the past but who found that the breach did not affect the treatment were the least likely to specify the limits of confidentiality, while those with no "breach experience" fell somewhere inbetween.

Theoretical Orientation. Question 14 concerned the relationship between a psychologist's theoretical orientation and what or when a client is told about confidentiality. It was predicted that the psychodynamic psychologists would be less likely to mention anything about confidentiality from the outset of therapy, and less likely to be explicit about the limits of confidentiality if they did bring the issue up. This was tested in a one-way ANOVA of scores to item 12 (in the first analysis for when confidentiality was mentioned), and to coded reponses to item 13 (for what was said regarding confidentiality). Both analyses contained contrasts which allowed for the comparison of the psychodynamic psychologists with the other three orientations since specific predictions were made based on such a distinction. The results from both analyses were non-significant. In the first analysis which produced a non-significant planned comparison, $F(1,177)= 0.24$, n.s., the cognitive behaviorists were the most likely to mention something about confidentiality from the outset ($M=3.86$) followed by the psychodynamic clinicians ($M=3.64$). The beha-

viorists ($\underline{M}$=3.50) and the humanists ($\underline{M}$=3.40) were the least likely to mention confidentiality from the outset. Because this analysis was not significant, however, these differences may be due to chance alone.

The second analysis, which also produced a non-significant planned comparison, $\underline{F}$ (1, 177) = 0.25, $\underline{n.s.}$, indicated that the psychodynamic clinicians did not differ from the other psychologists in terms of what they say about confidentiality when it is mentioned at the beginning of therapy. The humanists were the least explicit about the limits of confidentiality ($\underline{M}$=2.14) and the behaviorists were the most explicit ($\underline{M}$=2.60). Again, because the analysis was not significant, these results may be due to chance alone.

To summarize this section, while privilege status did not affect the accuracy of psychologists' knowledge of the term "privileged communication," it did affect their knowledge of whether or not they had privileged communication in their state of practice. Psychologists from states which were recently granted privilege were significantly less aware of their privilege status than the other psychologists. There was a trend for privilege status to affect when confidentiality was mentioned. Those who have had privilege for a while were more likely to mention something about confidentiality from the outset. Although a previous breach of confidentiality did not affect psychologists' knowledge of state confidentiality statutes, it did affect the

accuracy with which they could define the term "privileged communication." In addition, although a previous breach was not related to when confidentiality was brought up, it was related to how explicit psychologists were about the limits of confidentiality. A previous breach was not significantly related to a change in position on confidentiality. Those who reported breaches confidentiality which affected the therapy were more explicit than those who never breached confidentiality in the past. Theoretical orientation did not seem to affect either when confidentiality is brought up, or how explicit a psychologist might be about the limits of confidentiality.

Factors Influencing Specific Management

Psychologists' handling of confidentiality was further explored by presenting the respondents with two vignettes of clinical situations in which confidentiality was a particularly salient issue: dangerousness, and potential court testimony. For each vignette, respondents were asked to describe in an open-ended manner how they would handle each situation. They were also presented with a number of potential responses to the two situations and asked to rate the likelihood that they would use such a response on a scale of 1 (definitely would not) to 5 (definitely would). The first vignette described a client who was potentially harmful towards self or others. Respondents' ratings to three items regarding the handling of confidentiality in this situation were analyzed in order to examine the

relationship between theoretical orientation, target of threat (i.e., self or others) and their responses. The psychologists' responses to the items were examined in three separate analyses. In each analysis, a 2 (harmful to self/others) by 4 (psychodynamic, cognitive-behavioral, behavioral, and humanistic) ANOVA was conducted.

The first of the three analyses concerned whether psychologists' tendency to inform about the limits of confidentiality (item 2) changes as a function of theoretical orientation or whether or not a client is threatening harm towards self as opposed to others (Question 15). It was predicted that the psychodynamic psychologists would be less inclined to inform of limits; in addition, it was predicted that all of the psychologists would be more likely to inform of limits when the patient was threatening harm towards others. The ANOVA yielded non-significant results for both main effects ($F(3,176)=0.99$, n.s. for theoretical orientation, and $F(1,176)=0.99$, n.s. for the other/self variable) and for the interaction $F(3,176)=0.525$, n.s.. Thus contrary to prediction, the psychologists' tendency to inform of the limits of confidentiality was not affected by theoretical orientation or whether or not the client was threatening harm towards self or towards others.

The second analysis examined whether psychologists' tendency to say that everything was confidential (item 3) was affected by whether or not the client was threatening harm towards self or others, or according to theoretical orientation (Question 16). Asking the ques-

tion in this slightly different manner yielded a different result. Although there were still no significant main effects for orientation, $F(3,168)=0.27$, n.s., or the other versus self variable, $F(1,168)=0.76$, n.s., there was a significant interaction F $(3,168) = 3.86$, $p=.01$. The psychodynamic clinicians were more likely to say that everything was confidential when the client was threatening harm towards others ($M=2.96$) but were less likely to say everything was confidential when the client was threatening harm towards self ($M=2.12$). The clinicians of the other three orientations (cognitive-behavioral, behavioral, and humanistic), however, were less likely to say that everything was confidential when the client was threatening harm towards others ($M=1.94$, 2.00, and 2.27 respectively) than when threatening harm towards self ($M=2.75$, 2.33, and 2.78 respectively). In each case, a mean less than 3.00 indicated that the psychologist tended to disagree with the idea that the client should be told that everything is confidential. The lower the mean, the more strongly they disagreed with the idea.

The third analysis (Question 17) examined the role of these same two variables on psychologists' tendency to say nothing at all about confidentiality at first in the hope that the client would say more about what it is that is troubling him (item 4). The main effect for orientation was not significant, $F(3,170)=1.48$, n.s.. There was a main effect for other versus self, F $(1,170) = 10.92$, $p<.001$ with the psychologists more likely to say nothing about confidentiality when the harm was threatened towards self ($M=2.28$) than when the harm was

threatened towards others (M=1.67). The interaction was not significant, F(3,17)=1.11, n.s. A mean score of 2.00 indicated that a psychologist disagreed with the idea of saying nothing at all about confidentiality to the client. A mean score of 1.00 indicated strong disagreement, and a score of 3.00 indicated neither agreement nor disagreement. Thus in the previous analysis, psychologists did not think it was a good idea to say nothing about confidentiality to a dangerous patient, but felt stronger in their conviction when the client threatened harm towards someone else than when he threatened to hurt himself.

There were five psychologists who took a position of absolute confidentiality in their responses to the vignette in which the man was threatening harm towards others. The responses of these psychologists were examined qualitatively to provide some insight into their rationale for such an extreme position (Question 18). All five were psychodynamic in orientation. One psychologist wrote in his response to this vignette that "confidentiality is an insignificant issue here." He felt that the client's presentation in this first session was a "transferential issue and one of resistance." He felt that this needed to be interpreted as such and that he as the therapist should not be "seduced" into making confidentiality an issue. Another psychologist felt that the client should be encouraged to speek freely about his impulses both present and past, and would not mention anything at all about confidentiality in this first session out of fear

that doing so would curb the client's willingness to discuss his impulses. Still yet another psychologist would focus on the difficulty in trusting a stranger. This psychologist would also take the stance that if the client could not explore his feelings, then he as the therapist would refuse to work with him. In each case, the psychologist interpreted the client's potential dangerousness as symbolic of some other issue (e.g., transference, resistance, or trust). The issue of confidentiality and how it was to be managed was not mentioned with the client apparently because it was thought not to be the "real" issue.

In summary, the management of confidentiality in the clinical situation in which a patient was potentially harmful was influenced both by the target of the threat and by the psychologists' theoretical orientations. Although the psychologists would tend to say something about confidentiality regardless of the target of the threat, they were more likely to say something when the patient was potentially harmful towards others. Although the majority of psychologists would not maintain absolute confidentiality, the psychodynamic psychologists were "not sure" whether or not they would maintain absolute confidentiality when the patient was potentially harmful towards others. All of the five psychologists who would "definitely" tell the patient who was potentially harmful towards others that everything was confidential, were psychodynamic in orientation. They did not view the danger threat as the "real issue," but rather as one of transference.

The other clinical vignette presented a situation in which a psychologist might be asked to testify about a patient in court. Question 19 concerned whether the handling of confidentiality in this situation was influenced by the client's level of functioning, the psychologist's theoretical orientation, or privilege status. A 2 (high/low functioning) by 4 (psychodynamic, cognitive-behavioral, behavioral, or humanistic) by 3 (privilege status) ANOVA was conducted on the likelihood that the respondents would assure their client (in the vignette) that the law protects them from a subpoena. The analysis yielded a significant main effect for privilege status, $F(2,165)= 14.19$, $p<.001$. As predicted, those psychologists who have had privilege for a while ($M=2.62$) as well those who were just granted it ($M=2.50$) were more likely to assure the client that the law protects from a subpoena than would those psychologists who do not have privilege ($M=1.37$). In each case, however, the psychologists tended not give the assurance that the law would protect from a subpoena. Contrary to what was predicted, however, there was no significant effect for either the client's level of functioning, $F(1,54)=0.80$, n.s., or the psychologist's theoretical orientation, $F(3,54)=0.08$, n.s.. The interactions were not tested because of empty cells.

The second question pertaining to privileged communication and the client's level of functioning (Question 20) was whether psychologists with the low functioning patient would be more likely to consult with a lawyer (item 25), and whether such a decision would be based on

privilege status. A 2 (high/low functioning) by 3 (privilege status) ANOVA was conducted. The analysis yielded no significant effects for level of functioning, $F(1,167)=0.39$, n.s., privilege $F(2,167)=2.27$, n.s., or for the interactions. Regardless of the level of functioning of the client, most of the psychologists (73.7%) would consult with a lawyer in such a clinical situation, while only 14.6% would not.

In summary, privilege status seemed to be a factor which influenced the management of the privileged communiction, child custody vignette. Those psychologists with privilege were more likely to tell their client that the law protects them from a subpoena. The decision to so inform the client was not affected by the client's level of functioning or the psychologist's theoretical orientation.

Psychologists Opinions of Guidelines and Statutes

Question 22 asked if psychologists would have differing views about how positively their state privilege laws affect their clinical work as a function of privilege status. It was predicted that psychologists with privilege would view their state laws as having a more positive impact. This hypothesis was tested using a one-way ANOVA of responses to an item (item 41) asking respondents to rate the impact of presence or absence of privilege on their clinical work on a scale of 1 (very negative impact) to 5 (very positive impact) with 3 indicating "no impact." The analysis yielded a significant main effect for privilege status, $F\ (2,167) = 18.77$, $p<.001$. As predicted, those

who have had privilege for a while (M=3.87) as well as those who were just granted it (M=3.45) had more positive views of the impact of their state privilege laws on their clinical work than those without privilege (M=2.87). Moreover, those psychologists with privilege saw their privilege status as having a positive impact on their work while those without privilege felt that their "no privilege" status had a negative impact on their clinical work.

Because so few of the psychologists (26.5%) could provide accurate definitions of the term "privileged communication," the above analysis was redone to include only those psychologists who were familiar with the term. The analysis was still significant F (2,53) =6.79, p <.01.

Question 22 asked about the degree to which psychologists would approve of an ethical guideline which recommends that clients be informed in advance of the limits of confidentiality. Based on a five-point Likert scale (where a score of "1" indicated strong disapproval and a score of "5" indicated strong approval) the psychologists as a group had a mean rating of 4.03, indicating their approval of the guideline. The majority of psychologists (70.8%) indicated either approval or strong approval, while only 10.8% indicated disapproval or strong disapproval. Contrary to prediction, theoretical orientation did not significantly affect the psychologists' opinions, F(3,180)=0.35, $n.s.$

The next question under this heading was designed to examine psychologists' opinions about the Tarasoff decision. Before doing so, however, it was important to find out if psychologists were familiar with the decision (Question 23). This was answered in item 54 in the survey; 48.6% of the psychologists reported being familiar or very familiar with the decision, while 12.4% were "not sure" if they had heard of the decision, and 38.9% were not familiar with the decision. The question only sought to determine if they were familiar enough with the decision to recognize it by name. Many respondents indicated that they might be familiar with the decision but could not recognize it by name alone. Question 24 concerned the impact of this decision on their clinical work. Psychologists familiar with the decision were asked to rate its impact on a scale of 1 (very negative impact) to 5 (very positive impact) with a score of 3 signifying "no impact;" 46.8% felt that the decision has had a positive effect, 42.2% felt that there had been no impact, and 11.0% felt that the decision has had a negative effect.

CHAPTER V

DISCUSSION

Return Rate and Representativeness of Sample

Before discussing the relevance and meaning of the results, it seems prudent to examine the survey return rate. The overall return rate of 41.9% was quite close to the predicted (though conservative) estimate of a 40% return rate. The observed overall return rate is felt to underestimate the actual return rate. This underestimation probably occurred because the initial surveys were mailed bulk rate and as such were not forwarded to the psychologists whose addresses had changed, nor were they returned if they were not deliverable as addressed. This problem was discovered because the "thank you / reminder" post cards were mailed first class, and thus were forwarded to new addresses if forwarding addresses were available, or were returned if the addreses were unknown. When the post cards were returned as "address unknown," the return rate was adjusted accordingly. A problem in determining the final return rate arose because of those psychologists who had moved and had a forwarding address; they received the post cards but not the survey. Of those undeter-

mined number of psychologists, six wrote letters[1] expressing interest in participating in the survey. However, there is no way of knowing how many psychologists did not take the initiative to write such a letter; these psychologists never received the survey, yet were considered to be "non-responders." While the return rate reached its predicted level, it needs to be underscored that a sizeable proportion of the total sample surveyed did not return the survey. For this reason, inferences about the population of psychologists in the seven states must be made cautiously. There was a considerable range in return rate across states from a low of 28.3% in Vermont, to a high of 69.0% in West Virginia. Exactly why these two states had such low and high rates respectively is not clear.

The sample of responders was compared with the total population of Register members on some of the demographic variables. This check was made to see of there might be some detectable bias in terms of who responded to the survey and who did not. In general, the sample was close to the parent population on all but the number of years of experience . The sample registered approximately five more years of experience than the overall population. This was probably due to the fact that this survey was conducted between four and five years later than was the survey which gathered data on the population (Vandenbos, Stapp, & Kilburg, 1981). There did not seem to be any significant

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[1] two each from Illinois and West Virginia, and one each from Pennsylvania and South Carolina

demographic differences between the present sample and the population which would suggest a demographic bias in terms of who responded to the survey and who did not.

Knowledge of Confidentiality

The research revealed some interesting information regarding psychologists' knowledge about confidentiaity. The vast majority (93.5%) knew what the term "confidentiality" meant, which of course is a key definition to know as it greatly affects responses to the rest of the questionnaire. Because it is a concept frequently discussed in the area of psychotherapy, it was not suprising that so many psychologists could define the term.

Psychologists' definitions of "privileged communication" were much less accurate, with only 26.5% of them defining the term accurately. This term is much more limited in scope than "confidentiality," in that the term applies only to the specific situation of testimony in court. It is a legal term which is not as intrinsic to the domain of psychotherapy. Psychologists did have some understanding of what the term seemed to imply but they simply lacked the knowledge necessary to provide a technically accurate definition. It is noteworthy that those psychologists who had to break confidentiality in the past had significantly more accurate definitions of the term. Perhaps some of those psychologists were subpoenaed. Yet even those psychologists who breached confidentiality in the past had rather

innaccurate definitions of the term. Many of the psychologists had confused the terms "confidentiality" and "privileged communication." Typically they referred to the latter as the mere legal version of the former. This confusion is consistent with what Suarez and Balcanoff (1966) suspected when they polled psychiatrists about their privilege status.

The psychologists in this study were generally aware of their privilege status even if they were largely unaware of how to define the concept. Using the error score system, they were less than one error score off (or one point on a five point Likert scale) in their ratings of whether or not they had privilege in their state of practice. When these error scores are translated into percentages, 71.9% were accurately aware of their privilege status (using an error score of "1" or "0" as the criteria of awareness). Previous research which examined mental health professionals' knowledge of their privilege status (Suarez & Balcanoff, 1966; Swoboda et al 1978) found that roughly one fourth of their samples were unaware of their privilege status. These two studies were conducted in states where privilege had existed for a while. When the psychologists in the present study from the two states which were recently granted privilege were removed for the sake of comparison, the accuracy increased to 74.8%. Thus the psychologists' knowledge of their privilege status in this study is consistent with previous findings.

Psychologists in the present study were compared across states for the accuracy in their knowledge of their privilege status. It was not suprising that Iowa and Vermont were less accurate in their knowledge of their privilege status since "privilege" is quite recent in these states. Of particular interest, however, is the fact that the psychologists from West Virginia were just as inaccurate in their knowledge of their privilege status as those from the two states whose privilege status had just changed. One possible explanation for this is that the return rate from West Virginia (69.0%) was substantially higher than any other state.[2] Perhaps West Virginia reflects the overall population more accurately in terms of knowledge about privilege status. It may be that the majority of psychologists from the other states who were not knowledgeable about confidentiality were less likely to participate in the survey.

The last of the issues to be discussed regarding psychologists' knowledge about confidentiality is their general awareness of their state confidentiality laws. Only Illinois psychologists were studied, and as a group, they were quite aware of their state confidentiality laws. They were the most uncertain about the legality of breaking confidentiality in order to answer further questions from an insurance company. Perhaps this is because this situation occurs less frequently than that of client's a family member or employer contacting a

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[2] and higher than the return rates in either of the two previously mentioned studies

psychologist.

Management of Confidentiality

As a group the psychologists would require the client's complete consent and knowledge before sharing information with a family member or employer. This is not suprising since ethical and legal guidelines are rather clear on this issue. It might have been helpful, however, to have qualified the item in the survey which dealt with sharing information with a family member by specifying the age of the client in question (i.e., child or adult). Psychologists who work predominantly with children may be less inclined to require their (child) client's consent before sharing information with a family member (i.e., parent). A striking finding was that 14.6% of the psychologists indicated that they would never share information with a family member of the client under any circumstance, even with the client's consent and knowledge. A similar finding occurred when sharing information with an employer, in that 24.9% of the psychologists would never share information with the client's employer under any circumstance. The psychologists' refusal to share information was not present in the other four situations. Perhaps the psychologists who would not share the information did not consider that the client may have wanted them to share the information with a family member or employer.

The issue of contacting a collection agency to recover money from an unpaid bill left the psychologists divided. Many (37.4%)

indicated that they would never contact a collection agency. Perhaps, as some psychologists wrote, they felt that it was a therapeutic error to have allowed a bill to amass, and thus did not pursue the collection of the bill. Many psychologists (35.6%) would first notify the client of the intention to contact a collection agency, but would not require the client's consent. Only a minority (6.9%) would require the client's knowledge and consent. That this is such a small percent makes sense because probably few ex-clients would give their consent for the psychologist to contact a collection agency, especially clients who are not paying their bills. There do seem to be many psychologists (20.1%) who would contact the collection agency without first attempting to notify the client that such an action might be taken. This would seem to be a less desirable method of handling the situation since it is not clear whether this is either ethical or legal. Surely the act of first informing the client would appear to be a more ethical way of managing the situation. This may even encourage the client to pay the bill, thus avoiding the process of of contacting the collection agency altogether. It may be that situations related to insurance or a collection agency generated the most uncertainty since they are situations which may occur less frequently. Moreover, the ethical and legal guidelines governing the disclosure to these sources are less clear.

Although the issue of whether or not to break confidentiality when a client was imminently dangerous also does not occur too fre-

quently, the ethical and legal guidelines governing this have been more widely publicized. The psychologists were willing to break confidentiality when a client was imminently dangerous; this was not suprising in the light of the Tarasoff case. In addition, most of the seven states contain specific clauses in their confidentiality laws which make it legal (although never mandatory) to break confidentiality whenever a client is imminently dangerous to self or others. Still, the psychologists preferred to inform the patient first before making a breach in this situation. This appears to be a more desirable method of handling such a situation. This is also consistent with what Roth and Meisel (1977) recommended when dealing with a dangerous patient. Sharing information with a colleague is also an instance where it is legal in most states to break confidentiality. Indeed, more psychologists in the present study were willing to break confidentiality without the client's knowledge in order to consult with a colleague than in any other of the six clinical situations. The majority of the psychologists (59.5%) felt it unnecessary to inform the client when they consulted with a colleague about them. Apparently they felt it to be in the client's best interest to not inform them of this. Might they fear that it would undermine the client's confidence in them? It will be interesting to see if the psychologists' position changes over time in this situation since the APA's most recent recommendation (1984) that all clients be informed if a psychologist consults with a colleague for the purpose of discussing that client.

The survey revealed a wide range of attitudes and behaviors regarding the psychologists' routine management of confidentiality. The trend among the ethical guidelines is for clients to be better informed about the limits of confidentiality. This was underscored both in the speciality guidelines and most recently (APA, 1984) in the recommendation that clients be informed when information is to be shared with a consultant or supervisor. The sample appears to be equally divided when examining their behaviors in light of this trend. Nearly half of the sample (49.5%) indicated that they routinely either alluded to, or mentioned explicit limits to confidentiality from the outset of therapy. This is in sharp contrast to previous research (Wise, 1978) in which a survey of primarily psychiatrists in California revealed that only 14.5% would discuss confidentiality from the outset. In the present study, of the 49.7% of the sample who reported that their position on confidentiality had changed over the years, 78% (or 39% of the total sample) have changed towards a position of informing their clients more about the limits of confidentiality.

In contrast to those psychologists who mentioned the limits of confidentiality from the outset, the other half of the sample (50.5%) appeared to take a different stand on the management of confidentiality; 38.8% of the total sample of psychologists say nothing about confidentiality from the outset, while an additional 11.7% tell their clients that everything is confidential. This divergence in direction between two equally large groups of psychologists is cause for con-

cern. The most widely recognized governing body of psychology, the APA, clearly is moving in the direction of more informed consent, and more explanation to clients about the limits of confidentiality. The fact that half of the psychologists do not seem to reflect such a position could create many ethical and legal complications in the years to come. In a general way, this survey verifies what is reflected in the clinical literature; that is, there is much variability among psychologists about the management of confidentiality.

Attempts to explain the differences among psychologists were made first by asking the psychologists why they may have changed their position on confidentiality. The reasons which the psychologists gave for a change in their position on confidentility were consistent with some of the factors or variables suggested in the literature, and this reinforced the importance of studying them in a systematic way in the present research. The Tarasoff decision was the most frequently mentioned reason for a change in position about confidentiality. Previous personal experiences with breaches of confidentiality (or failure to breach confidentiality when it was warranted) was the second most commonly cited reason. Fear of malpractice suits and privilege status were also given as reasons.

Not all of the factors had the predicted effect on the routine management of confidentiality. Privilege status did not have the effect which was predicted. This was somewhat suprising given that

47% of the psychologists reported that they had had a personal experience much like the one portrayed in the privileged communication vignette. There are a couple of explanations, however, for why privilege status may have had little effect on the routine management of confidentiality. First, perhaps privilege truly represents only a small aspect of confidentiality and thus really has little to do with the routine management of confidentiality. The fact that many psychologists could not accurately define the term really was not an issue since a re-analysis using only those psychologists who understood the term did not change the results. This is by no means to be construed that privilege has no effect and therefore might just as well be abolished. More will be said about the concept's importance when discussing the privilege vignette.

A previous breach of confidentiality did affect the management of confidentiality, but not in the broad, general way which was predicted. First, it was not significantly associated with a change in position on confidentialty. Indeed, based on the reasons which the psychologists provided, a change in position on confidentiality was less likely to occur as a result of personal clinical experience (N=22) than it was as a result of changes in laws, court decisions, or fears of malpractice (N=36). Personal experience with a breach in confidentiality did not affect when confidentiality was raised with new clients, regardless of what affect the previous breach had on the therapy (of a previous client). A previous breach of confidentiality

did have an effect on what was said about confidentiality when the issue was raised from the outset of therapy. As predicted, those who breached confidentiality and it affected therapy, were the most explicit about the limits of confidentiality. Perhaps this means that they may be no more likely than the other psychologists in the frequency with which they think to bring up the issue, but once they do, they are more explicit about the limits of confidentiality based on their past experience.

The fact that theoretical orientation had no significant differential effect on what and when confidentiality is routinely mentioned was somewhat suprising. It appears to run contrary to the clinical writings of the psychodynamic theorists who advocate absolute confidentiality. Perhaps the psychodynamic psychologists' report of their routine management of confidentiality is different from what they actually do in specific clinical situations. It was in the latter context that differences based on theoretical orientation occurred. Indeed many more of the psychodynamic writings have dealt with the management of specific clinical situations (Goldstein & Katz, 1962; Kubie, 1950; Langs, 1976; Mariner, 1967; Siegel, 1979; Uchill, 1978) than in the routine management of confidentiality (Kubie, 1950; Langs, 1976).

The psychodynamic psychologists had a different response to the self versus other variable than did the other psychologists. Three

questions were asked using theoretical orientation, and "self versus others" as the independent variables. Three different dependent variables were used: (a)tendency to inform about limits to confidentiality; (b)tendency to say that everything was confidential; and (c)tendency to say nothing at all about confidentiality. Although these questions may appear somewhat redundant, only (b) and (c) were significantly correlated (r=.50, p<.001) while the other correlations were near zero.

The only analysis in which theoretical orientation played a significant role was in the second analysis (b), the one which could be construed as the absolute confidentiality question. The "absolute" stance written about in the clinical literature was found in the present research to a mild degree. The psychodynamic psychologists were not sure whether or not to maintain absolute confidentiality when a patient was potentially harmful toward others, whereas the other psychologists were not as ambivalent; they would not say that everything was confidential. This difference may be explained by the construct of transference. Many of the psychodynamic clinicians wrote that when the patient was potentially harmful towards others, it was a manifestation of transference. Perhaps these psychologists felt that potential harm towards others represented a transference issue which would be best handled by maintaining absolute confidentiality and interpreting the transference. When the patient was potentially harmful towards self, however, this may represent to the psychodynamic psy-

chologists more of a "real" threat and thus they were less likely to maintain absolute confidentiality than when the patient is harmful towards others.

The fact that these orientation effects were discovered is particularly noteworthy since there was the possibility that they could have been "washed out" in the way in which orientation was coded for the data analysis. More than half of the sample (56.5%) initially indicated that they were eclectic. These "electics" were then recoded into the four main orientation categories.

There were differences in the management of confidentiality when the client was potentially harmful towards self as opposed to potentially harmful towards others. The psychologists as a group were more likely to say something about confidentiality in the presence of the client who might be dangerous towards others as compared to towards self. This represents a quantitative difference only, because they were inclined to say something about confidentiality regardless of which type of patient they were working with.

The issue of whether there has been a shift in values on the part of psychologists in the wake of Tarasoff is difficult to determine. There are no pre-Tarasoff measures available to see if there were inherent "self versus others" descrepancies prior to Tarasoff. Thus effects can only be loosely inferred. In the present study, the Tarasoff decision was cited the most frequently as the reason why a

change in position on confidentiality had occurred. In terms of the management of confidentiality in specific clinical situations, the present study revealed what might be construed as a quantitative as opposed to a qualitative shift in values in the management of a Tarasoff-like situation. That is, as a group, the psychologists would not guarantee absolute confidentiality, but would say something about confidentiality regardless of whether the patient was potentially harmful to self or others. They just would be more sure to say something about confidentiality when the patient was harmful to others, perhaps out of fear of a lawsuit. There was no radical shift, with rampant, liberal warnings to third parties when the patient was harmful towards others as Roth (1983) had feared.

A more potent Tarasoff effect might have been discovered in the present study had a more true Tarasoff situation been presented in the questionnaire. It needs to be underscored that in the vignette, the client never actually said that he intended to hurt himself or someone else; it had only been hinted at. As a result, in contrast to the Tarasoff case, an imminent danger was never clearly established.

Although privilege status did not seem to be a factor in the routine management of confidentiality, it did affect the management of a specific clinical situation, that of possibly having to testify in court. The fact that the psychologists with privilege were more likely to assure the client in the privilege vignette that the law

protects from a subpoena, suggests that the psychologists may have a better understanding of the concept of privilege than was initially thought to be the case (based on their definitions of the term). It was interesting that regardless of privilege status, the psychologists tended to shy away from the idea of telling the client that the law protects from a subpoena. The influence of the law in clinical decision making was suggested in that 73.6% of the psychologists would consult with a lawyer in a situation like the one presented in the privileged communication vignette. They would do so regardless of privilege status or the client's level of functioning.

Although it was unclear that privilege status had any measurable effect on the management of confidentiality in the present research, the psychologists felt that having privilege had a positive impact on their clinical work, while those without privilege felt that absence of privilege affected their clinical work in a negative way. Perhaps they felt that it is better to have a privilege if given a choice, even if they are not able to define the concept or even if it appears to matter little in the course of their day-to-day clinical work.

Psychologists Opinions of Guidelines and Statutes

Psychologists' opinions of ethical guidelines and legal decisions in general suggest that they desire established guidelines to aid them in the conduct of their clinical work. Although only half of the sample either alluded to or made specific mention of the limits of

confidentiality from the outset of therapy, 70.8% of the sample approved or strongly approved of an ethical guideline which recommends that clients be informed in advance of the limits of confidentiality, which is of course already an ethical guideline (APA, 1981a). The fact that they strongly approved of a guideline which was discrepant with their own behaviors speaks to their desire to have some direction in dealing with the often confusing issues surrounding confidentiality. Similarly, although much had been written about the problems with the Tarasoff decision (which appear to be quite valid), half of those psychologists familiar with the decision felt that the decision has had a positive impact on their clinical work. Perhaps they felt comforted knowing that in the anxiety arousing situation of treating a dangerous patient, there is a clear precedent of how to act in a way that is legally sanctioned and that provides some protection for society.

Summary and Direction for Future Research

The purpose of the present study was to gather data regarding psychologists' knowledge about confidentiality as well as how they manage confidentiality in routine and specific clinical situations. This study revealed that psychologists understood what the term "confidentiality" meant, but were less accurate in their understanding of the concept "privileged communication." They were generally aware of their privilege status and state confidentiality laws.

The psychologists were equally divided about how to routinely manage confidentiality. Half of the psychologists either allude to or are explicit about the limits of confidentiality with their patients from the outset of therapy. At the same time, half of the psychologists either say nothing about confidentiality from the outset, or else say that everything is confidential.

This research demonstrated empirically that variables such as privilege status, previous breach of confidentiality, theoretical orientation, and the nature of a client's potential dangerousness all play a role in the management of confidentiality. Privilege status did not have the effect on the routine management of confidentiality which was predicted. However, a mild privilege effect was observed in how psychologists managed confidentiality in the privileged communication vignette. Not suprisingly, psychologists with privilege were more likely than those without it to tell the client that the law protects them from a subpoena. Even in this situation, however, few of the psychologists would tell the client that the law protects them from such a subpoena.

The issue of whether or not privileged communucation makes any difference in the psychotherapist- patient relationship has been raised before (Chafee, 1943; Yale Law Journal, 1962). The legal profession has historically taken the position that there is no evidence to suggest that privileged communication is beneficial in such a rela-

tionship. Ironically, it has also been the legal profession (Yale Law Journal, 1962) which has suggested that privileged communication probably has no discernable effect because patients probably do not know whether or not they have privilege. It would be of key importance to study the effects of privilege status from the patient's perspective before deciding that privileged communication has no effect on the therapist-patient relationship. In the only known study which examined the effects of levels of confidentiality on client self-disclosure, clients disclosed more when more confidentiality was assured (Woods & McNamara, 1980). It would be important to study the effects of a client's knowledge of privilege status on level of self disclosure. One other note of caution about interpreting these findings has to do with the nomothetic nature of this study. This study examined a large group of psychologists. It did not study privileged communication in depth. It would be very interesting to talk with psychologists for whom court testimony about a case and the need to maintain privilege was a real issue. The role of privilege could then be more thoroughly examined.

A previous breach of confidentiality affected the routine management of confidentiality. Although it did not affect when confidentiality was brought up with a client, psychologists who breached confidentiality in the past where it affected the therapy were more explicit about the limits of confidentiality once the issue was brought up. The "breach" variable was not studied very thoroughly in

this research. Future research could more closely examine the this variable more closely. There are numerous research questions which could be addressed. The type of breach could be more fully explored. Who was it that the psychologist contacted which created the breach? Was the breach made without the client's prior knowledge? Are there different breach effects when working with a child-client as compared to the adult client? More open-ended, exploratory questions could be asked about the psychologists' rationale for breaking confidentiality and what they feel the ultimate effect was on the therapy. Did the breach have a positive or negative impact? What was the effect from the client's perspoective? Did it foster a feeling of greater safety and security, or undermine a sense of trust in the therapist? These are but a few of the many un-answered questions which could be explored with this one variable alone.

Although theoretical orientation did not seem to affect how psychologists routinely managed confidentiality, it did affect how it was managed when a client was potentially dangerous. As predicted, the psychodynamic psychologists tended to take more of an absolute confidentiality position with the client who was potentially dangerous towards others than did the other psychologists. From a qualitative analysis of their responses, it was inferred that they viewed such potential danger as a manifestation of transference which required interpretation. It would be interesting in future research to compare psychologists of more "pure" orientations to see if the orientation

effects become more pronounced. Asking psychologists for a more detailed description of their orientation might help to further clarify (for research purposes) what their theoretical orientations are. It would also be interesting to include a group of "eclectics" for the sake of comparison since this latter group comprises such a large proportion of psychologists.

The theoretical orientation findings raised some questions about the management of the dangerous patient. The study in general showed that psychologists manage confidentiality a little differently based on the type of danger (i.e. dangerous to self or others). Although in either case the psychologists would tell the dangerous patient about the limits of confidentiality, they were more likely to do so when the patient was dangerous towards others. However, because the psychodynamic psychologists were not sure whether or not to maintain absolute confidentiality in such a situation, important questions need to be addressed in future research. At what point do psychologists determine that a danger exists? How does the assessment of danger affect what and when a client is told about confidentiality, or when a breach is likely to be made? What are the effects of maintaining absolute confidentiality when a patient is potentially dangerous (to either self or others)? Does this indeed change the risk of a dangerous act occurring? Might it be that the psychodynamic psychologists do not maintain absolute confidentiality once the presence of a danger is etsablished? If however, they do maintain an absolute stance in the

face of an actual danger, how do these psychologists manage the imminently dangerous patient?

This research was the first comprehensive, large scale study to examine the management of confidentiality by mental health professionals. It has demonstrated that there are specific factors which affect how confidentiality is managed. Each of these variables now must be explored in more detail in future research.

REFERENCES

American Psychiatric Association (1968). The prinicples of medical ethics with annotations especially applicable to psychiatry. Washington, D.C , APA.

American Psychological Association (1967). A model for state legislation affecting the practice of psychology 1967: Report of APA committee on legislation. American Psychologist, 22, 1095-1103.

American Psychological Association (1981). Specialty guidelines for the delivery of services by clinical psychologists. American Psychologist, 36,(6), 640-663. a

American Psychological Association (1981). Ethical principles of psychologists. American Psychologist, 36,(6), 633-638. b

American Psychological Association (1984). Monitor, May, 1984.

Appelbaum, S.A. (1978). How strictly confidential? In R. Langs (Ed.) International Journal of Psychoanalytic Psychotherapy, 7, 220-224.

Beck, J.C.(1982). When the patient threatens violence: An empirical study of clinical practice after Tarasoff, Bulletin of the American Academy of Psychiatry and Law, 10, 189-201.

Bersoff, D.N. (1976). Therapists as protectors and policeman: New roles a a result of Tarasoff? Professional Psychology, 7, 267-273.

Chafee, Z. (1943). Privileged communications: Is justice served or obstructed by closing the doctor's mouth on the witness stand? Annals of Internal Medicine, 18, 606-617. Yale Law Journal, 52, 607.

DeKraai, J., & Sales, B.D. (1982). Privileged communucations of psychologists. Professional Psychology, 13,(3), 372-388.

Diamond B.L. and Weihofen H. (1953). Privileged communication and the clinical psychologist. Journal of Clinical Psychology, 9, 388-390.

Dillman, D.A. (1978). Mail and Telephone Surveys: The Total Design Method. New York: John Wiley and Sons.

Donelly, J. (1978). Confidentiality: The myth and the reality. In W.E. Barton and C.J. Sanborn (Eds.), Law and the Mental Health Professions: Friction at the Interface. New York: International Universities Press, 1978.

Dubey J. (1974). Confidentiality as a requirement of the therapist: technical necessities for absolute privilege in psychotherapy. American Journal of Psychiatry, 131, 1093-1096.

Everstine, L. Everstine, D.S., Heyman, G.M., True, R.H., Frey, D.H., Johnson, H.G., & Seiden, R.H. (1980). Privacy and Confidentiality. American Psychologist, 35,(9), 828-840.

Fleming J.G. and Maximov B. (1974). The patient of his victim: The therapist's dilemma. California Law Review, 62, 1025-1068.

Fromm-Reichmann, F. (1950). Principles of Intensive Psychotherapy. Chicago: University of Chicago Press.

Garfield, S.L., & Kurz, R. (1976). Clinical psychologists in the 1970's. American Psychologist, 31, 1-9.

Garfield, S.L., & Kurz, R. (1977). A study of eclectic views. Journal of Consulting and Clinical Psychology, 45, 78-83.

Goldstein, A.S. & Katz, J. (1962). Psychiatrist-patient privilege: the GAP proposal and the Connecticut statute. American Journal of Psychiatry, 118, 733-739.

Greenacre, P. (1954). The role of transference: practical considerations in relation to psychoanalytic theory. Journal of the American Psychoanalytic Association, 2, 671-684.

Grossman, M. (1978). Confidentiality: The right to privacy versus the right to know. In W.E. Barton and C.J. Sanborn (Eds.), Law and the Mental Health Professions: Friction at the Interface. New York: International Universities Press, 1978.

Group for the Advancement of Psychiatry (1960). Group for the advancement of psychiatry: Confidentiality and privileged communications in the practice of psychiatry, Report No. 45.

Gurevitz, H. (1977). Tarasoff: Protective privilege versus public peril. American Journal of Psychiatry, 134, 289-292.

Ivey, A.E. (1980). Counseling 2000. Time to take charge. The Counseling Psychologist, 8,(4), 12-16.

Jagim, R.D., Wittman, W.D., & Noll, J.O. (1978). Mental health professionals' attitudes toward confidentiality, privilege, and third party disclosure. Professional Psychology, 9,(3), 458-466.

Kahle, L.R., & Sales, B.D. (1978). Attitudes of clinical psychologists toward involuntary civil commitment law. Professional Psychology, 9, 428-439.

Karasu, T.B. (1980). The ethics of psychotherapy. American Journal of Psychiatry, 137,(12), 1502-1512.

Kernberg, O.F. (1975). Borderline States and Pathological Narcissism. New York: Jason Aronson.

Kubie, L. (1950). Practical and Theoretical Aspects of Psychoanalysis. New York: International Universities Press,

Lane, P. J., & Spruill, J. (1980). To tell or not to tell: The psychotherapist's dilemma. Psychotherapy: Theory, Research, and Practice, 17, 202-209.

Langs, R. (197t). The Bipersonal Field. New York: Jason Aronson.

Louisell D.W. (1956). Confidentiality, Conformity, and confusion: Privileges in federal court today, 31 Tulsa Law Review, 101.

Mariner, A. (1967). The problem of therapeutic privacy. Psychiatry, 30, 66-72.

Menninger, K. (1958). Theory of Psychoanalytic Technique. New York: Basic Books.

Mervis J. (1983). Max Siegel: a president looks at the past, present, and future of psychology. Monitor, 14(1), 24-25.

Michels, R. (1976). Professional ethics and social values. International Review of Psychoanalysis, 3, 377-384.

Naisbitt, J. (1982). Megatrends. New York: Warner Books.

National Register of Health Service Providers in Psychology (1981). Natonal Register of Health Service Providers in Psychology. Washington D.C.: Council for the National Register of Health Service Providers in Psychology.

National Register of Health Service Providers in Psychology (1981). Natonal Register of Health Service Providers in Psychology: Cumulative Supplement 1982-83. Washington D.C.: Council for the National Register of Health Service Providers in Psychology.

Noll, J.O. (1974). Needed: A bill of rights for clients. Professional Psychology, 5, 3-12.

Noll, J.O., & Hanlon, M.J. (1976). Patient privacy and confidentiality at Mental Health Centers. American Journal of Psychiatry, 133,(11), 1286-1289.

Nye, S. (1983). Confidentiality and privacy. Recent Developments in Mental Health Law, Chicago, June, 1983.

Oldham, J.T. (1978). Liability of therapists to non-patients. Journal of Clinical Child Psychology, 7, 187-188.

Paul, R.E. (1977). Tarasoff and the duty to warn: Toward a standard of conduct that balances the righhts of clients against the rights opf third parties. Professional Psychology, 8, 125-128.

Payson, H.E. (1978). Preface. In W.E. Barton and C.J. Sanborn (Eds.), Law and the Mental Health Professions: Friction at the Interface. New York: International Universities Press, 1978.

Rappaport, H. (1963). Psychiatrist-patient privilege. Maryland Law Review, 39

Roston, R.A. (1975). Ethical uncertainties and "technical validities." Professional Psychology, 6, 50-54.

Roth, L.H. (1983). Clinical management of the conflict between dangerousness and confidentiality. Recent Developments in Mental Health Law. Chicago, June, 1983.

Roth, L.H. & Meisel, A. (1977). Dangerousness, confidentiality, and the duty to warn. American Journal of Psychiatry, 134, 508-511.

Schuchman H. (1980). Confidentiality: Practice issues in new legislation. American Journal of Orthopsychiatry, 50, 641-648

Siegel, M. (1979). Privacy, ethics, and confidentiality. Professional Psychology, 10,(2), 249-258.

Simon, G.C. (1978). The psychologist as whislte blower: A case study. Professional Psychology, 9, 322-340.

Slawson, P.F. (1969). Patient-litigant exception - A Hazard to psychotherapy. Archives of General Psychiatry, 21, 347-352.

Slovenko, R. (1966). Psychotherapy, Confidentiality, and Privileged Communication. Springfield, Il: Charles C. Thomas

Spiegel, R. (1979). Editorial: On psychoanalysis, values, and ethics. Journal of the American Academy of Psychoanalysis, 6, 271-273.

Stapp, J., & Fulcher, R. (1982). The employment of 1979 and 1980 doctoral recepients in psychology. American Psychologist, 37,(11), 1159-1185.

Stone, A.A. (1983). New challenges for law and psychiatry. Recent Developments in Mental Health Law, Chicago, June 1983.

Stone, A.A. (1984). Law, Psychiatry, and Morality. Washington D.C.: American Psychiatric Association Press.

Suarez, J.M., & Balcanoff, E.J. (1966). Massachusetts psychiatry and privileged communication. Archives of General Psychiatry, 15, 619-623.

Swoboda, J.S., Elwork, A., Sales, B.D., & Levine, D. (1978). Knowledge of and compliance with privileged communication and child abuse reoprting laws. Professional Psychology, 9,(3), 448-457.

Szasz, T. (1962). The problem of privacy in training analysis. Psychiatry. 25, 195-207.

Tarasoff v. Regents of University of California, (1974). 529 P.2d 553, 118 Cal. Rptr. 129.

Uchill, A.B. (1978). Deviation from confidentiality and the therapeutic holding environment. In R. Langs (Ed.), International Journal of Psychoanalytic Psychotherapy, 7, 208-219.

Vandenbos, G.R., Stapp, J., & Kilburg, R.R. (1981). Health service providers in psychology: Results of the 1978 APA resoureces survey. American Psychologist, 36(11), 1395-1418. Wexler, D.B. (1981). Mental Health Law: Major Issues. New York: Plenum Press.

Wigmore J.H. (1940). Evidence, third edition. Boston: Little, Brown & Co.

Wildman, R.W., & Wildman, R.W. Jr. (1967). The practice of clinical psychology. Journal of Clinical Psychology, 23, 292-295.

Winnicott D.W. (1965). The Maturational Processes and the Facilitating Environment. New York: International Universities Press.

Wise, T.P. (1978). Where the public peril begins: A survey of psychotherapists to determine the effects of Tarasoff. Stanford Law Review, 31,(Pt 1), 169-190.

Woods, K.M., & McNamara, J.R. (1980). Confidentiality: Its effect on interviewee behavior. Professional Psychology, 11,(5), 714-721.

Yale Law Journal (1962). Confidential communications. Yale Law Journal, 71, 1226-1273.

Zenoff, E. (1962). Confidential and privileged communications. Journal of the American Medical Association, 182, 656.

APPENDIX A

CONFIDENTIALITY AND PRIVILEGED COMMUNICATION EXCERPTS

Of the seven states which will be included in this survey, three states (Illinois, Georgia, and Pennslyvania) contain liberal privileged communication statutes. Four other states (Iowa, South Carolina, West Virginia, and Vermont) do not have privileged communication statutes.

Section 10 of the Mental Health and Developmental Diabilities Confidentiality Act (State of Illinois, 1981) states that

> Except as provided herein, in any civil, criminal, administrative, or legislative proceeding, or in any proceeding preliminary thereto, a recipient, and a therapist on behalf and in the interest of the recipient, has the privilege to refuse to disclose and to prevent the disclosure of the recipient's record or communications.

The exceptions to this privilege are:

(1) where the client introduces his mental condition

as an element of his claim or defense, only where

the court decides that it is relevant and admissible.

The Act further states that ...

> Except in a criminal proceeding in which the recipient, who is accused in that proceeding, raises the defense of insanity, no record or communication between a therapist and a recipient shall be deemed relevant for purposes of this subsection, except the fact of treatment, the cost of services and the ultimate diagnosis unless the party seeking disclosure of the communication clearly establishes in the trial court a compelling need for its production.

(2) When a claim is being filed by a client for injury caused in the course of providing services. The therapist may disclose records and communications to his attorney.

(3) Records and communications made to or by a therapist during the course of a court-ordered examination. provided that the recipient ..."has been adequately and as effectively as possible informed before submitting to such (an) examination that..." what will be talked about will not be considered confidential or privileged.

(4) disclosure can be made of communications which determined a reipient's competency or need for guardianship.

(5) "Records and communications may be disclosed when such are made during treatment which the recipient is ordered to undergo to render him fit to stand trial on a criminal charge, provided that the disclosure is made only with respect to the issue of fitness to stand trial" (p.11).

(6) Records and communications may be disclosed when a therapist determines that disclosure is necessary to initiate or continue civil commitment proceedings, or to otherwise "...protect the recipient or other person against a clear, imminent risk of serious physical or mental injury or disease or death being inflicted upon the recipient, or by the reipient on himself or another...." (p.12). In the course of providing services, a therapist may disclose a record or communucations without consent to:

(1) the therapist's supervisor or consulting therapist....(p.8). (2) an attorney or advocate consulted by the therapist.

Within the state of Pennsylvania, the provisions and exceptions to privilege are not spelled out in such detail as that found in Illinois. Section 5944 of Title 42 Pa.C.S.A. reads:

> No person who has been licensed under the act of March 23, 1972 (P.L.136, No.52), to practice psychology shall be, without the written consent of the client, examined in any civil or criminal matter as to any information acquired in the course of his professional services in behalf of such client. The confidential relations and communications between a psychologist and his client shall be on the same basis as those provided or prescribed by law between attorney and client.

Section 5928 of this same title 42 specifies what the confidential relationship is between attorney and client. Essentially it says that an attorney shall not be required, and is not permitted to disclose anything said to him by his client unless the client waives this right.

The statute on privilege in Georgia is short and straightforward. It reads:

> confidential relations and communications between licensed applied psychologist and client are placed upon the same basis as those provided by law between attorney and client (84-3118).

A licensed applied psychologists is defined as a person of good moral character who is a U.S. citizen who holds a doctoral degree in psychology (or a closely related field) and who has atleast one year of post-doctoral experience.

Vermont was one of the states which did not have privilege communication at the time that this survey was constructed. In section 7103 of Title 18 Ch. 171, "Disclosure of Information," all clinical

information relating to a client is to be kept confidential and not disclosed to anyone except when:

(1) the client grants written consent to release information.

(2) "...as a court may direct upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make disclosure would be contrary to the public interest" (p.76).

Most recently, however (Vermont Statutes Annotated, 1983), psychologist-patient privilege was established. The only exception to this privilege which was specified was a clause which allowed the patient to waive privilege should he/she desire to do so.

The West Virginia Code (Volume 9, Chapter 27, 3-1) defines a confidential communication as including: the fact that a person has been or is presently a client, all diagnoses and opinions, mental or emotional condition, any advice, instructions, prescriptions etc. Confidential information may be disclosed when:

(1) conducting an examination for involuntary commitment,

(2) "pursuant to an order of any court based upon a finding that said information is sufficiently relevant to a proceeding before the court to outweigh the importance of maintaining the confidentiality established by this section."

(3) to protect against a clear and substantial danger of imminent injury by apatient or client to himself or another, and

(4) for treatment or internal review purposes to the staff of the mental health facility where the patient is being cared for or to other health professionals involved in the treatment of the patient.

Although privilege communication exists for some professionals in Iowa (attorney, counselor, physician, surgeon, minister or priest) privilege did not exist for clinical psychologists during the time that this survey was constructed. While the statute itself never made this explicit, this decision had been held up in case law (In re Marriage of Gaumer, 1981, 303 N.W.2d 136). More recently mental health professionals (which includes psychologists) were granted privilege on the same basis as attorney-client (Iowa Code Annotated, 1983-1984). The only exceptions to this privilege to be mentioned specifically are as follows: if the client wishes to waive privilege, or if the client is using his/her mental condition as an element of a claim or defense.

Within the state of South Carolina (title 44, chapter 23, article 1090) all records are to be kept confidential and shall not be disclosed except inso far as: (1) the cient or patient grants consent, (2) "A court may direct, upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosures would be contrary to the public interest" (p.531), (3) in order to cooperate with state and federal agencies, (4) in order to cooperate with law enforcement agencies, and (5) when the public safety is involved. In this latter case, disclosure may be made to the commissioner of mental health.

Other portions of the law concerning confidentiality are found in other statutes. In statute 44-17-130, it is stated that information

received by the Department of Mental Health shall not be disclosed publicly unless ordered to do so by a court of "competent jurisdiction" (p.435). Statute 44-21-230 says that any person, hospital, or organization can file clinical information about clients or patients with the Department of Mental Health related to the "...condition and treatment of any person." All of these records will remain confidential except when the client waives confidentiality, or under a court subpoena. Privilege does exist in South Carolina according to statute 44-53-140 when treating a person for a drug problem. Treatment includes counseling or therapy. The only exceptions to privilege in this case are when the client waives privilege, or if the services are sought to enable the recepient to commit a crime or tort. Thus in South Carolina, privileged communication exists only when treating persons for drug problems.

APPENDIX B

THE SURVEY

Below is a description of a clinical situation. Please read the description and respond to the following questions.

An agency has referred a 25 year old man to you for individual psychotherapy. You were told in the referral that this man has had trouble in the past with impulses to harm others (himself). You agree to work this man. In his first session with you, he tries to tell you what is troubling him but stops himself and expresses a fear that if he is more explicit about what these impulses are, then you as the therapist might take some action against him such as hospitalizing him or calling the police.

1. How might you respond to such a situation?

_____

_____

_____

_____

_____

_____.

2. Speculate as to what the impact that a breach of confidentiality might have on the therapy at his time.

_____

_____

_____.

Please use the following rating scale to answer questions about the vignette just described. Please circle your choice.

1 2 3 4 5

definitely would not — definitely would

3.I would inform this man of the limits of confidentiality in this first session. 1 2 3 4 5

4.I would try to reassure him that everything that is said in therapy remains confidential. 1 2 3 4 5

5.I would not mention confidentiality at first in the hopes that the client would be able to mention more specifically what it is that is troubling him. 1 2 3 4 5

6.Has a clinical situation like the one just described ever happened to you during the course of your clinical work? ____yes ____no

if yes, briefly explain how you dealt with the limits of confidentiality.

_____

_____

_____.

7. In your work as a psychologist, have you ever shared personal, identifying information about a client with anyone else without your client's consent (other than in routine situations such as filling out insurance forms, staffings, etc)?

____ yes

____ no (if not, go on to item 8).

(a)If you did have to share such identifying information in the past, did it affect the outcome of therapy? ____ yes ____ no.

explain briefly _____

_____

_____

_____.

The following group of items ask about what you typically say to an average client or patient when you see him(her) for a first therapy session. Please answer the folowing questions using the five point rating scale below. Please circle your choice.

1	2	3	4	5
Never	Almost never	some-times	almost always	always

8. From my first contact with a client, I inform them that everything that is said in 1 2 3 4 5

therapy remains confidential.

I inform my clients from my first contact with them that :

9. everything is confidential except when subpoenaed by a court of law. 1 2 3 4 5

10. everything is confidential except when the client wishes to waive confidentiality. 1 2 3 4 5

11. except when you the therapist feel that the client may be harmful to self or others. 1 2 3 4 5

12. I routinely mention something about confidentiality from my first contact with a patient. 1 2 3 4 5

Please respond to item 13 or item 14 but not both.

13. If you usually inform clients about confidentiality from the outset of therapy, what do you usually tell them?

_____

_____

_____

_____.

14. If you do not usually inform clients from the outset, how do you handle confidentiality?

_____

_____

_____

_____.

15.Has your position on confidentiality changed over the years?

____yes ____no (if not, please go to item 16)

(a)If yes, how has it changed?

_____

_____

_____

(b)Do you have any ideas about why it has changed?

_____

_____

_____.

Here is a description of a different clinical situation. Please read the description and answer the questions that follow.

"High functioning vignette"

For three months now you have been treating a 35 year old woman who entered therapy following a recent divorce. It is your impression that she has functioned quite well psychologically throughout much of her life and is presently trying to adjust to her new roles as single

woman and single parent since the divorce. She has attended her sessions regularly and seems to be making progress. Her ex-husband has just expressed his intention to take her to court in order to obtain custody of the children on the grounds that your client is an unfit parent. Your client fears that her ex-husband may use the fact that she is in therapy as evidence against her. She is concerned about continuing in therapy out of fear that it will leave the impression in court that she is emotionally unstable. During the course of the session she also mentions that her husband intends to file for a subpoena in order to have you testify about your client's emotional stability.

"Low functioning vignette"

For three months now you have been treating a 35 year old woman who entered therapy following a recent divorce. It is your impression that she has <u>not</u> functioned very well psychologically throughout most of her life. She has a history of depression for which she has been hospitalized three times, the most recent of which followed a nearly fatal suicide attempt. Her present attempt to adjust to her new role of single woman and single woman since the divorce is but one of many "crises" which this woman has experienced. She has attended her sessions regularly and seems to be making a little progress. Her ex-husband has just expressed his intention to take her to court in order to obtain custody of the children on the grounds that your client is an

unfit parent. Your client fears that her ex-husband may use the fact that she is in therapy as evidence against her. Your client is concerned about continuing in therapy out of fear that it will leave the impression in court that she is emotionally unstable. During the course of the session she also mentions that her husband intends to file for a subpoena in order to have you testify about your client's emotional stability.

16. How might you handle this clinical situation?

_____

_____

_____

_____

_____

_____.

17. Has a situation like the above ever happened to you during the course of your clinical work? ____yes ____no

Please use the following rating scale to answer questions about the clinical situation just described.

1	2	3	4	5
definitely would not				definitely would

With respect to this vignette, would you:

18. assure her that the law protects you from such a subpoena 1 2 3 4 5

19. terminate with your client 1 2 3 4 5

20. be in favor of testifying if requested to do so? 1 2 3 4 5

21. Refuse to testify if she did not want you to 1 2 3 4 5

22. consult with your lawyer about the best action to take. 1 2 3 4 5

23. consult with a colleague about the best action to take. 1 2 3 4 5

24. Place an "x" next to the phrase which best completes the following sentence:

If a psychologist from your state were to be subpoeneaed in the clinical situation just described, he/she would:

____ definitely have to testify

____ probably have to testify

____ probably not have to testify

____ definitely not have to testify

____ not sure

25. Please read the following statement and place an "x" next to one of the five choices which best describes whether or not you agree with the statement.

I consider the therapy relationship to be the most critical ingredient in the process of treatment.

____ strongly agree

____ agree

____ neither agree nor disagree

____ disagree

____ strongly disagree

26. Define the following terms in the alloted space provided.

Confidentiality: _____

_____

_____.

Privileged communication:_____

_____

_____.

Please indicate the conditions under which you would share confidential, identifying information about a client in each of the following situations. Pick the one condition in each siutation which best describes your choice and record the condition number next to the corresponding situation.

No.	Condition:
1.	I would not share such information under any circumstance.
2.	I would share such information only with

a client's complete consent and knowledge.

3. I would share such information with a client's knowledge, but not necessarily with a client's consent.

4. Neither a client's consent nor knowledge is necessary.

Situations:	No.
27. You believe your client to be imminently dangerous to self or others.	____
28. A concerned family member contacts you for an explanation of why your adult client is having so many difficulties.	____
29. Your client's employer contacts you for an explanation of why your client has missed so much work lately.	____
30. You would like to consult with a colleague about certain troubling aspects of the therapy with your client.	____
31. An insurance carrier contacts you and asks for a more detailed	____

explanation of your client's
therapy in order to warrant
further payment.

32. You would like to contact ____
a collection agency in an
attempt to recover the money
from an unpaid bill of a client
who has recently left therapy.

33.On the average, how many patients/clients do you treat each year (on an outpatient basis?) whom you consider to be dangerous?

_____.

34. Is there privileged communication for professional psychologists in your state of practice?

____ definitely is

____ probably is

____ not sure

____ probably is not

____ definitely is not

Based on your understanding of your state law, please rate how legal it would be for you to share confidential, identifying information about your client in each of the following situations without your client's consent. Use the rating scale below and circle your choice for each item.

1 2 3 4 5

definitely illegal	probably illegal	not sure	probably legal	definitely legal	
35.You believe that your client is imminently dangerous to self or others.					1 2 3 4 5
36.A concerned family member contacts you for an explanation of why your client is having so many difficulties.					1 2 3 4 5
37. Your client's employer contacts you for an explanation of why your client has missed so much work lately.					1 2 3 4 5
38.You would like to consult with a colleague about certain troubling aspects of the therapy with your client.					1 2 3 4 5
39.An insurance carrier contacts you and asks for a more detailed explanation of your client's therapy in order to warrant further payment.					1 2 3 4 5
40. You would like to contact a collection agency in an attempt to recover the money					1 2 3 4 5

from an unpaid bill of a client
who has recently left therapy.

41. What kind of impact does the privileged communication law for psychologists in your state have on your clinical work? Please circle your choice.

1	2	3	4	5
very negative impact		no impact		very positive impact

Comments: _____

_____

_____

_____.

42. What would be your opinion about the presence of an ethical guideline which recommends that clients be informed in advance of the limits of confidentiality? Please circle your choice.

1	2	3	4	5
strongly disapprove		neither approve nor disapprove		strongly approve

Comments:

_____

_____

_____

_____.

43. Briefly, what is the policy of your institution concerning confidentiality?

_____

_____

_____

_____.

44.State in which you currently work. _____

45.Sex _____

46.Are you a member of APA? ____ yes ____ no

47.Below is a list of possible settings in which you may be working. Please indicate the percentage of your time which you currently spend in each setting. Please be sure that the percentages total to 100.

____ University / school

____ inpatient psychiatric unit of a hospital or community mental health center

____ outpatient clinic

____ medical unit of a hospital

____ private practice

____ consultation

____ counseling center

____ other, specify _____.

48.Of the patients or clients that you see, indicate what percentages of these are adult, adolescent, or children.

____Adult

____Adolescent

____Child

____I am not seeing any clients or patients at the present time.

49.Please indicate the approximate percentage of your clients or patients for whom substance abuse has been a major focus of treatment _____%.

50.Highest degree earned in psychology: ____Ph.D. ____Psy.D. ____Ed.D. ____M.A./M.S. ____B.A./B.S. ____other, specify _____

51.Number of years of post-graduate experience _____.

52.Major field of graduate study

____ Clinical psychology

____ Counseling psychology

____ School psychology

____ Community psychology

____ Educational Psychology

____ other, specify _____.

53.Check which one of the following best describes your predominant theoretical orientation.

____Adlerian ____ Gestalt

____Behavioral ____ Person-centered

____Cognitive-behavioral ____ Psychodynamic

____Existential ____ Rational Emotive

____Family systems ____ Reality Therapy

____Eclectic(If you check eclectic, please rank order those orientations which contribute to your eclecticism in their order of importance).

____other, please specify _____.

54. How familiar are you with the Tarasoff decision?

1	2	3	4	5
not at all		not sure		very much

If you are familiar with this decision, does it have an impact on your clinical work?

1	2	3	4	5
very negative impact		no impact		very positive impact

55.Below is a list of possible activities in which you may be engaged in each week. Please indicate the average number of hours that you spend in each activity per week.

____ Individual psychotherapy

____ Group psychotherapy

____ Family therapy

____ Psychodiagnostic/neuropsychological testing

APPENDIX C

THANK YOU / REMINDER POST CARDS

First post card

By now you should have received a copy of the questionnaire: Clinical Management of Confidentiality: A Survey of Professional Psychologists. If you have already mailed in your completed questionnaire, I would like to thank you again for your participation. If you have not yet completed it, I would like to encourage you to do so. As I am sure you are aware, the quality of survey research increases for every additional questionnaire that is returned. Thank you for your help.

Second post card

This is a second reminder for those of you who have still not sent in your questionnaire entitled: Clinical Management of Confidentiality: A Survey of Professional Psychologists. I would greatly appreciate it if you could fill out and return the questionnaire as soon as possible. Thank you.

APPROVAL SHEET

The dissertation submitted by Keith Baird has been read and approved by the following Committee:

Dr. Patricia A. Rupert, Director
Associate Professor, Psychology, Loyola University

Dr. Eugene Kennedy
Professor, Loyola University

Dr. Roderick Pugh
Professor, Loyola University

The final copies have been examined by the Director of this dissertation and the signature which appears below verifies the fact that the disssertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

October 3, 1984
Date

Patricia A. Rupert
Director's Signature