Respecting the confidentiality of information obtained from clients is a primary obligation of counselors. The maintenance of a confidential relationship—one that respects the privacy and integrity of the client—clearly enhances the psychotherapeutic process. In some states, such confidential communications have the statutory status of “privileged communication,” protecting the client’s right to refuse to disclose and to prevent anyone else from disclosing a confidential communication between the client and counselor. The principles of confidentiality, however, can conflict with the counselor’s duty to protect, which arises when clients pose a threat to others and when counselors become aware of this fact.

The duty to protect has recently begun to encompass the HIV-related threat sexual partners may pose to one another. While several studies have reported on the views of practitioners regarding the duty to protect, this article describes the first to poll the potential client population—a largely gay, lesbian, bisexual sample in Los Angeles—about the HIV-related duty to protect.

The Duty to Protect

Standards limiting privileged communication have grown from the 1976 California case Tarasoff v. Regents of the University of California. Adopted since by many other states, they can be articulated generally as: if a psychotherapist has reasonable cause to believe that a client is imminently dangerous to a specifically identified person and that disclosure of privileged communication is necessary to prevent the threatened danger, these states allow disclosure of that communication.

Is the risk of HIV infection a circumstance in which confidentiality can be broken because a seropositive client is placing a third party in clear danger of HIV transmission? Some states have broadened the Tarasoff standard by enacting legislation that allows physicians, under certain conditions, to disclose the seropositive status of a patient to the spouse of that patient. For counselors, however, there are no legal directives regarding confidentiality and the protection of third parties from HIV infection.

Using the concepts described by Tarasoff, counselors can derive the following standards regarding HIV-related disclosure.¹ A provider must assess the “dangerousness” of the client: Tarasoff requires that the client present a serious danger of violence, and danger may be mitigated by the fact that HIV is not transmitted equally as well through all routes of transmission and that transmission can be prevented in a variety of ways. Dangerousness is further mitigated by the fact that with the exception of rape and sexual molestation, sexual partners have control over the type of sexual activity in which they will engage and, in the age of AIDS, are expected to be aware of the dangers of unprotected sex. The issue is complicated if the client and his or her partner assume they are in an exclusive sexual relationship when, in fact, they are not. In such a case, the client’s partner may have already been exposed to HIV.

Literature Review

The professional literature identifies several ethical and legal issues related to HIV infection and confidentiality. Samuel Knapp cites medical diagnosis, participation in high-risk behavior, and adherence
Editorial: Honesty is the Best Policy
Robert Marks, Editor

It could be argued that two of the most intimate relationships—that is, ones that rely most on honesty and trust—are between sexual partners, and between psychotherapist and client. These relationships are at the center of the conflict posed by the legal duty to protect. And it is the quality of intimacy—again, honesty and trust—that underlies this conflict.

In the therapeutic relationship, honesty and trust enable clients to share their deepest feelings and, in doing so, change the way they view the world and interact with others. Clients are able to brave such vulnerability because law and custom protect the privacy of the therapeutic bond.

While the law also protects privacy in marriage, married and unmarried partners alike are often less committed to honesty and trust than the ideal of the romantic relationship would have us believe. If all sexual relationships were, in fact, based on honesty and trust, there would be no need to invoke the duty to protect and threaten the integrity of therapeutic relationships.

In response to this situation, Tarasoff and its progeny require the licensed therapist to mediate the therapeutic relationship by playing the role of a double agent—ostensibly loyal to the client’s needs, but secretly prepared to sacrifice this loyalty when the client crosses a poorly defined line.

When a client claims the intent to murder a “third party,” the duty to protect helps provide standards by which to balance the moral duty to protect life and the professional duty to protect the therapeutic relationship. But, the criteria used to define the duty to protect—inherent action, identifiability of a victim, and degree of dangerousness—are not easily applied in the hidden and unpredictable world of HIV transmission.

In this month’s FOCUS, Craig Georgianna and Michael Johnston present data from an original study that confirms the significant place of confidentiality in the minds of potential clients. Peter Daniolos outlines the attempts of professional associations to reconcile the duty to protect third parties and the duty to protect the therapeutic relationship.

Two points can be drawn from these articles. First, subjects in a study have the luxury of advocating for absolute confidentiality in the abstract; therapists who face this issue, however, must struggle with real people, frightening situations, and equally unsatisfying alternatives. Ultimately, they must make the decision to warn in the context of law, science, custom, and conscience.

Second, before threatening the therapeutic relationship, practitioners need to work with clients to develop honesty and trust in relationships. Practitioners might also work in their communities to help schools develop sex education that goes beyond the birds and the bees, to teach students to talk about sex, disease, fear, and ethical responsibility. In the age of sexually transmitted diseases, consenting adults have the responsibility to protect themselves, and fostering honesty may be the safest sex of all.

to safe sex techniques as useful factors for practitioners to consider when assessing the dangerousness of clients. He proposes guidelines for determining the level of risk of an incident of HIV transmission, and concludes that the best protection occurs when both partners know the risks and the more vulnerable partner makes a responsible decision to protect him or herself. Frederic Reamer states that the maintenance of confidentiality is central to HIV prevention because HIV-infected people will be deterred from entering counseling if they believe their privacy will be threatened, and he suggests that in most cases, disclosure without the permission of the client is not necessary.

About half the articles conclude that it is the ethical responsibility of counselors to warn others of foreseeable harm related to HIV transmission. The other half consider the client’s right to privacy to be paramount. Samuel Perry states that Tarasoff is not directly applicable to most HIV-infected clients because the majority do not have homicidal wishes nor do they have intended victims. Douglas Lamb and associates indicate that the obligation to protect can be accomplished in a variety of ways beyond warning the intended victim or notifying a law enforcement agency. For example, practitioners can take actions to isolate or hospitalize dangerous clients.

While counseling during HIV antibody testing is different from psychotherapy, studies comparing client response to confidential versus anonymous testing offer an indication about how clients might feel about the therapist’s duty to protect. These studies conclude that anonymity encourages screening participation and that a significant proportion of respondents would avoid HIV antibody testing if it were not anonymous. The
available research appears to be split between advising counselors to breach confidentiality and to hold it as paramount; the antibody test site studies imply that potential clients may consider confidentiality as essential.

Method
In 1992, researchers surveyed gay men and lesbians in Los Angeles to determine the opinion of the gay community about whether a psychotherapist should breach confidentiality in order to protect a third party from exposure to HIV. Participants were presented with written vignettes placing them in the roles of mental health counselor, physician, and minister. They were asked what action they would take if faced with each situation. In addition, they were asked what actions should be taken by professionals in similar situations. Survey workers distributed written questionnaires at meetings of two religious and two political organizations in the Los Angeles, and at the city’s annual gay pride festival. Participants completed the survey in approximately 15 minutes.

Placing participants in the role of mental health practitioner, the survey asked whether they would reveal to the sexual partner of a seropositive client the fact that the client was HIV-infected, if the client refused to inform the partner. The survey also asked how a “real” counselor should respond to this situation. Other questions asked participants their opinions about legislation that requires counselors to take specific actions when faced with seropositive clients who engage in risky sexual behaviors.

A total of 520 participants were surveyed; 498 surveys were completed fully and analyzed. Over one half of the respondents identified themselves as gay (58 percent) and 22 percent identified themselves as lesbian. Eight percent of the participants reported that they were bisexual (63 percent males and 37 percent females) and 11 percent heterosexual (23 percent males and 77 percent females). Eleven percent of all subjects were HIV-infected and 7 percent did not know whether or not they were infected.

Sixty-five percent of the participants were male. The mean age of respondents was 32 years. Respondents were highly educated, with 52 percent having a college degree and 19 percent having some kind of professional degree. Fifty-four percent of respondents had been in counseling at some time in their lives, while 18 percent were currently in counseling.

Results
The study revealed that 80 percent of respondents, when placed in the role of psychotherapist, would not inform third parties about the HIV infection of their clients. In addition, 76 percent stated that an actual counselor in a similar situation should not disclose the serostatus of the client. Participants who were male, age 35 and older, better educated, and knew more people who were HIV infected were significantly less likely to believe that disclosure was appropriate. Whether a respondent had ever received counseling was not a significant factor in deciding whether to disclose serostatus to a third party.

Sixty percent of participants would sue counselors who disclosed their HIV infection status to their sexual partners. Fifty-nine percent believed that it is not necessary to have laws that direct counselors when to disclose serostatus to sexual partners. Fifty-eight percent said that counselors should not have a choice as to whether or not to disclose a client’s HIV infection. Fifty-nine percent would not support a law that would require seropositive clients to inform their sexual partners.

Respondents who were age 35 and older were less likely to want a law directing counselors when to disclose or a law requiring counselors to disclose. This group was also significantly less likely to want a law requiring HIV-infected individuals to disclose serostatus to sexual partners. Male subjects were significantly less likely to want any of the three proposed laws. Participants who had received mental health counseling did not respond significantly differently from other participants regarding these legal implications. Seropositive respondents were significantly more likely to state that they would sue a therapist and significantly less likely to want a law requiring a seropositive client to disclose to sexual partners. Finally, gay male participants were less likely to want laws guiding counselors about when to disclose or requiring counselors to disclose.

These results clearly indicate the reluctance of those surveyed to support any laws directing or requiring counselors to disclosure.
disclose, requiring the seropositive individual to disclose, or giving the counselor a choice of disclosure. These findings differ significantly from the published opinions of many mental health professionals.

Limitations

The methodology of this study limits the generalization of the findings to people who do not attend public events, to people in nonurban areas, and to people in other geographic regions of the United States and in other countries. In addition, the study fails to identify the racial and ethnic background for participants and to analyze differences among these subgroups.

The survey did not ask participants to identify the HIV infection status of their current romantic-sexual partner, nor did it ask, “If your romantic-sexual partner were seropositive and engaging in risky sexual behavior with you, would you want to be notified by your partner’s counselor?” It also failed to define the term “partner,” so that some respondents may have interpreted the word to mean anything from anonymous sexual partner to life partner.

The mind-set of the participants may also have affected their responses. The surveys were completed in a public setting and, thus, may have been completed too quickly. However, the respondents indicated the strength of their beliefs for each decision on a numerical scale, and statistical analysis indicated a strong conviction for answers to each of the hypothetical decisions.

Finally, and most significantly, the vignettes provided limited information regarding the ethical and legal considerations faced by counselors. The survey did not include more detailed vignettes in order to avoid biasing responses although it might have been useful for researchers to provide more information about the range of issues counselors face.

Conclusion

Limitations aside, this study clearly suggests that the gay community—particularly men and people over 35 years old—resists counselor disclosure of client serostatus to third parties and supports maintaining the confidentiality of the therapeutic relationship. It may be that respondents are sensitive to the effects of HIV-related or homophobic discrimination, that they understand the anxiety related to facing HIV disease, that they believe that breaching confidentiality will interfere with the helping process, or that they believe that the counseling process can itself limit destructive HIV-related behaviors.

All three parties in the duty to protect scenario bring similar beliefs and struggles to the counseling process. The uninformed, uninfected person struggles with the responsibility for self and with trust in his or her partner. The sexually active, HIV-infected client struggles with maintaining personal integrity and congruence between personal values and actual behavior, and may face intrapsychic and interpersonal conflicts, fear and despair. The counselor struggles with the obligation to protect third parties and to protect the therapeutic process by respecting the autonomy, dignity, and privacy of clients. The struggles cannot be eliminated, but it may be useful for counselors to address these different perspectives by discussing the potential duty to protect early in the therapeutic relationship and, with a “dangerous client,” employing clinical options before legal ones: as long as a client actively participates in therapy, the counselor can maintain confidentiality.

Clearinghouse: Duty to Warn

References


Since the 1973 *Tarasoff* decision, therapists have had to balance traditional obligations to protect client confidentiality and newer demands to protect third parties who may be harmed by clients. The sexual transmission of HIV complicates this already difficult situation by transforming common and pleasurable acts into potentially dangerous ones. Since laws covering HIV-related confidentiality vary from state to state and often overlook ethical considerations, practitioners have the additional task of reconciling law and conscience. This article presents a survey of professional association guidelines, which serve to guide association members in thinking about these issues, and describes some of the principles that guide policy makers.

**Policy Statements**

The AMA Council on Ethical and Judicial Affairs states that "Physicians have a responsibility to prevent the spread of contagious diseases, as well as an ethical obligation to recognize the rights to privacy and to confidentiality of the AIDS victim." It continues: "Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities...the physician should 1) attempt to persuade the infected patient to cease endangering the third party; 2) if persuasion fails, notify authorities; and 3) if the authorities take no action, notify the endangered third party."

The American Psychiatric Association AIDS Policy on Confidentiality and Disclosure also recognizes rights to privacy and confidentiality. However, "If the physician has reason to suspect the patient is infected with HIV...or is engaging in behavior that is known to transmit HIV disease, the physician should notify the patient of the specific limits of confidentiality." That is, if a client refuses to change his or her behavior or notify his or her partner, "It is ethically permissible for the physician to notify an identifiable person who the physician believes is in danger of contracting the virus."

**Recent studies suggest that safeguarding civil rights makes it more likely that clients will cooperate with partner notification efforts and seek health assistance.**

According to the American Psychological Association’s AIDS-Related Policy Statements: "1. A legal duty to protect third parties from HIV infection should not be imposed, 2...disclosure is permitted only when (a) the provider knows of an identifiable third party who the provider has compelling reason to believe is at significant risk for infection; (b) the provider has a reasonable belief that the third party has no reason to suspect that he or she is at risk; and (c) the client/patient..."
has been urged to inform the third party and has either refused or is considered unreliable in his/her willingness to notify the third party.3 These guidelines go a step further than the others by stating that “If...legislation is adopted, it should include immunity from civil and criminal liability for providers who, in good faith, make decisions to disclose or not to disclose information about HIV infection to third parties.”

The National Association of Social Workers echoes the other association guidelines. It adds that social workers have a responsibility to consult with other practitioners and to consider legal counsel if they feel they have a duty to warn.4 Each of these guidelines respects the importance of confidentiality, but, notably, as the survey of policies moves from medical to mental health professionals, there is a trend to grant more leeway to practitioners. The AMA guidelines, state that physicians “should” warn, while the other policies permit but do not require warning.

Civil Liberties versus Public Health

Association policies reflect the conflict inherent in HIV-related confidentiality—the tension between civil liberties and public health. Kevin Kelly identifies three principles that should guide policy makers in negotiating this conflict.5 First, the principle of “clear and preventable harm” dictates that individual rights take precedence over state interests except in situations where it is clear that harm will come to society. Second, the principle of the “least restrictive alternative” argues that if the state must intervene to protect public health, the intervention chosen should be the one that infringes least on individual rights. Third, in order to determine the least restrictive alternative, policies must be based on the unique biological features of a disease. For example, it may be effective to impose quarantine for diseases with short courses, but it would be mistaken to assume that individuals with a chronic, life-threatening illness, such as HIV disease, would respond to this tactic.

In the case of the third-party notification, association policies acknowledge the potential danger of HIV transmission to harm society, but they rank measures to prevent this harm from least restrictive to most restrictive. For example, they require that practitioners first attempt to get clients to change their behaviors or to warn their partners themselves. This latitude is justified in terms of the unique biological features of HIV disease. That is, HIV infection—unlike more easily transmitted infections—is spread through consensual and intimate acts, with partners able to take some responsibility for protecting themselves.

Recent studies suggest that safeguarding civil rights makes it more likely that clients will cooperate with partner notification efforts and seek health assistance. Passing antidiscrimination initiatives decriminalizing homosexual acts, and implementing anonymous testing to maximize accessibility all make it more likely that people with HIV disease will seek HIV-related counseling, testing, and treatment.5,6 Marcia Angell suggests that by promoting political and social measures, government can free the public health sector to address the epidemic as they have other diseases, using systematic contact tracing and partner notification.7 In addition, Ronald Bayer notes that resistance to partner notification has lessened as therapeutic options have become available and as patient comfort has increased with the process of notification.8

Conclusion

To institutionalize these policy initiatives, Lawrence Gostin recommends the adoption of uniform federal guidelines using as a model the New York Testing and Confidentiality Act of 1988, which requires informed consent for testing, test counseling, and strong protection of confidentiality.9 Practitioners have a power, as opposed to a legal duty, to notify sexual or needle-sharing partners, and they are shielded from legal liability whether or not they issue a warning. Such a policy enhances public health efforts by strengthening the treatment bond, and leaves the ultimate decision regarding warning to providers.

Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

Editor, FOCUS
UCSF AIDS Health Project, Box 0884
San Francisco, CA 94143-0884
Applying of Tarasoff to AIDS Psychotherapy


Psychotherapists working with HIV-infected clients considered degree of dangerousness to be more important than identifiability of victims when making decisions to warn third parties, according to a survey of clinical psychologists. Tarasoff v. Regents of California and laws derived from it require that practitioners consider dangerousness of the act, identifiability of victims, and imminence of the danger in deciding to breach confidentiality.

Researchers surveyed 241 psychotherapists, of whom 67 percent were male, 56 percent were between 40 and 59 years of age, and 57 percent were in private practice. The most common degree held (93 percent) was the doctorate. Clinicians assessed on a seven-point scale the likelihood of their breaching confidentiality in hypothetical scenarios about gay men, bisexuals, prostitutes, and injection drug users.

In all cases, degree of dangerousness was directly associated with whether subjects would breach confidentiality, and this result was statistically significant; the breaching was more likely to occur if hypothetical clients were sex workers or gay men. Identifiability became an influential factor in determining that subjects would breach confidentiality only when there was also a high degree of dangerousness associated with the situation. Subjects identified ethical and legal concerns, sexual practices, injection drug use and needle sharing, psychological diagnosis, alternate methods of breaching confidentiality, and effects on the therapeutic relationship as other factors that affect decisions to breach confidentiality.

Therapists who had no experience working with HIV-affected clients were significantly more likely to breach confidentiality than those who had experience working with these clients. The researchers conclude that this finding may indicate that experienced clinicians have developed other ways to handle the potential risk to partners posed by HIV-infected people.

Contact Tracing and Duty To Warn


The duty to warn and contact tracing are two different approaches to partner notification, the process of informing third parties that they may be at risk for contracting HIV infection from a sexual partner. A description of the history, evolution, and political ramifications of these methods clarifies the contributions of each to the control of HIV infection.

Contact tracing evolved from public health efforts in the 1940s to control sexually transmitted diseases (STD) and was the cornerstone of programs to eradicate syphilis, gonorrhea, and chlamydia. Its characteristics were voluntary participation by the “index” patient (that is, the infected patient) who identified partners who would then be contacted by public health officials and informed of their potential STD infection. In return for voluntary participation, index patients were guaranteed absolute anonymity.

Duty to warn developed out of the ethical and professional principles of clinical practice. Following Tarasoff, the 1974 California decision, health professionals were required to breach the confidential practitioner-patient relationship when their patients threatened third parties with serious harm. Several professional organizations, including the American Medical Association, subsequently pronounced policies in support of duty to warn in certain circumstances.

AIDS activists among others maintain that both contact tracing and duty to warn compromise individual rights to privacy. They drive people with HIV infection away from medical care because they fear HIV- and gay-related discrimination that may follow from public disclosure of serostatus. Opponents also raised questions about the effectiveness and costs of informing at-risk third parties.

In 1988, public health officials issued the Guide to Public Health Practice: HIV Partner Notification Strategies. It was a compromise that endorsed the privilege, not the requirement of practitioners to disclose, and supported anonymity for index patients. Many state legislatures

Before warning, social workers must build upon the client-worker relationship to get HIV-infected clients to voluntarily reveal serostatus to partners.
subsequently rejected mandatory notification laws. Current public policy reflects elements of the two approaches by recognizing the right of unsuspecting third parties to protection, the clinician's duty to inform, and the patient's right to privacy.

Social Work and Duty to Warn
Reamer FG. AIDS, social work, and the “duty to protect.” Social Work. 1991; 36(1): 57-60. (Rhode Island College.)

Whether or not the Tarasoff duty to warn is applicable to HIV disease, social workers can infer that they have a requirement to breach confidentiality when danger is imminent, according to a discussion of social work and the duty to protect. This requirement can be deduced from mandatory reporting laws for child and elder abuse and from the National Association of Social Workers’ Code of Ethics.

To make the decision to breach confidentiality less arduous and to keep such breaches at a minimum, social workers must build upon the client-worker relationship to get HIV-infected clients to voluntarily reveal serostatus to partners. Social workers can also take other steps including: becoming familiar with local laws and statutes pertaining to AIDS, informing clients orally and in writing about the limits of confidentiality; becoming knowledgeable about guidelines concerning informed consent; maintaining carefully prepared case notes and knowing whether local laws distinguish between public notes and private notes in terms of whether they may be subject to subpoena; and becoming aware of the liability risks involved in HIV-related cases. In addition, they should publicly advocate to counter some of the potential developments associated with an across-the-board application of Tarasoff to HIV disease.

Clinical Practice and Liability Protection
Knapp S, VandeCreek L. Application of the duty to protect to HIV-positive patients. Professional Psychology: Research and Practice. 1990; 21(3): 161-166. (Pennsylvania Psychological Association and Indiana University of Pennsylvania.)

A discussion of the duty to warn, AIDS, and psychotherapy concludes that to best protect third parties from HIV infection, counselors should seek to maintain a therapeutic relationship based on trust and open communication, and should be knowledgeable about legal and ethical codes.

When working with clients who engage in high-risk behaviors and refuse to voluntarily disclose their serostatus to partners, therapists must assess the level of risk clients pose to others, since warning third parties is required only if harm is imminent and of sufficient dangerousness. Determining level of dangerousness is often a subjective judgment about the patient’s credibility, their social concern for sexual partners, and other factors.

When talking to clients, therapists should openly express their concerns for those who might be harmed by client actions. If a therapist decides to invoke the duty to protect, he or she should obtain the client’s permission or encourage the client to be present. The therapist and client can consider using public health department partner notification systems, if they decide not to notify the third party directly. After partners are warned, they must receive additional HIV-related information and counseling.

Several states have enacted statutes that provide liability protection for physicians and surgeons who make good-faith warnings, pursuant to the duty to protect. For example, in California, physicians may but are not required to disclose. In doing so, they must first discuss infection status with their clients and encourage them to voluntarily disclose. When invoking the duty to protect, doctors may not reveal the identity of their clients. Psychotherapists would benefit from such laws.

Next Month
As of January 1, 1993, the Centers for Disease Control (CDC) added three conditions to the list of AIDS-defining diseases: pulmonary tuberculosis, invasive cervical cancer, and recurrent bacterial pneumonia. In the May issue of FOCUS, Allen Gifford, MD, a physician at the University of California AIDS Clinic, describes the diagnosis and symptoms, course, and treatment of these conditions. In addition, he defines differences between their HIV- and non-HIV-related manifestations.

The CDC also added to the case definition T-helper cell counts of less than 200, for the first time identifying people who may be asymptomatic while being AIDS. Also in the May issue, Mary Alice O'Dowd, MD, Director of the Psychiatry AIDS-Connected Ambulatory Program at Montefiore Medical Center in New York, discusses how HIV-related counseling changes over the course of the disease as symptoms become more severe.
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