# Confidentiality & the Duty to Warn: Ethical and Legal Implications for the Therapeutic Relationship

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What are the ethical and legal imperatives of client confidentiality, and what impact do they have on the therapeutic relationship? Perhaps the relationship that exists between the mental health system and the law could be best described as “an uneasy alliance” (Melton, Petrila, Poythress, & Slobogin, 1997, p. 3). Many mental health professionals would consider themselves fortunate to avoid contact with a system whose laws and procedures often seem foreign to the therapeutic aims of their profession. On the other hand, attorneys and other professionals surrounding the practice of law may view the mental health profession as a nebulous and somewhat unreliable science, particularly when it intersects with their system.{mosgoogle right}

However, their shared history leaves little doubt that their present and future relationship is here to stay; their intersection is unavoidable and can be one that is both mutually favorable and beneficial. Since Muller v. Oregon (1908, U.S. Supreme Court) and critical court decisions such as Brown v. Board of Education (1954, U.S. Supreme Court), evidence from the social sciences has been used in the judicial decision-making process (Levine & Wallach, 2002). For the clinician, a working knowledge of basic forensic social work would help in navigating the system of law in a way that is both helpful and contributes to the best interest of the client.

## Therapeutic Jurisprudence

Therapeutic jurisprudence is a term coined by David Wexler and Bruce Winick that describes the problem-solving process between two systems—a study of the impact of the system of law on mental health, as well as the impact of the social sciences on the law (Wexler, 1990; Wexler & Winick, 1991, 1996; Winick, 1997). With the increase in societal problems such as divorce, crime, substance abuse, and family violence, as well as the clear impact of mental illness on crime, scholars and professionals in the practice of law and the social sciences have been inextricably linked when looking at societal and systematic responses to these phenomena (Levine & Wallach, 2002). Those concerned with the practice of therapeutic jurisprudence focus on such problems as the manner in which the court system deals with the issues of domestic violence and substance abuse. The mental health system and our nation’s criminal justice systems (as well as civil court systems) depend on the expertise and knowledge base from each respective discipline, as well as the prudence of those specialists who have combined expertise (i.e., forensic social workers and psychologists), in attempts to address and solve problems. Both fields inform the practice of one another.

## The Conundrum of Confidentiality

One of the issues that is often in contention between these systems is the ethical responsibility to maintain a client’s confidentiality. Professionals in each field recognize its importance and have parallel processes in this regard—attorney/client privilege (in the realm of law), and client/clinician confidentiality (in the field of social work and related practice). It is one of the basic tenets of the therapeutic relationship and one that is an essential agent to the helping process for attorneys as well as clinicians. Indeed, it is a clinician’s ethical responsibility to maintain the privacy and confidentiality of clients and to practice within the confines of the law and in an ethical manner (American Psychological Association, 1994; American Psychological Association—Committee on Ethical Guidelines for Forensic Psychologists, 1991; Clinical Social Work Association (CSWA) Code of Ethics, 1997; National Association of Social Workers (NASW) Code of Ethics, 1996).

The NASW(1996) and CSWA (1997) codes of ethics outline the values and principles that govern social work practice and guide our profession in making ethical decisions. They compel licensed social workers to maintain the client’s privacy and confidentiality except under very specific circumstances. There is a particular portion that serves as a guide from which social work professionals may draw upon surrounding certain legal proceedings. It is as follows:

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client’s consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection. (NASW, 1996, Ethical Standards, 1.07)

Our code of ethics directs us to comply with the law (such as in the case of a court order for information on our client) but to clarify from the court order, for example, what specific information is needed and how that information will be guarded from public record.

## Summary of Tarasoff

Licensed social workers and other mental health professionals are compelled to reveal confidential information about their clients when they are a harm to themselves or others. As well, all professionals (mental health, educational, and health care) who work with minors are mandated to report incidents of alleged child abuse whether the child client agrees or not (Levine & Wallach, 2002, pp. 274-285). The California Supreme Court decision in Tarasoff v. Regents of the University of California (1974; 1976) set a standard for practitioners to reveal confidential information in their duty to warn others of the potential dangers from a client.

Briefly, the Tarasoff case involved a murder victim, Tatiana Tarasoff, who was killed by an alleged acquaintance, Prosenjit Poddar. Poddar was a client of Dr. Lawrence Moore, who was employed by the University of California, and had stated during a therapy session that he intended to kill Tarasoff because she had rejected him as a lover. He was assessed as a danger and was held briefly and released.

Shortly after his temporary confinement, he did indeed kill Tarasoff during an attack with a pellet gun and knife. The victim’s parents sued the therapist, campus police, and everyone who had contact with the case at the University of California (Board of Regents) for wrongful death. They asserted that if the therapist knew that Poddar was indeed a danger and there was intent related to his threat to his victim, that they had a duty to warn her. In the majority decision, the court found that the “protective privilege ends where the public peril begins” [17 Cal.3d 425, 441 (1976)]. The decision had a significant impact on the legal requirements for a clinician and certainly affected a client’s confidentiality. If, during the course of therapy, a clinician assesses a client as a danger to someone, he or she has a duty and is legally compelled to warn the intended victim (Levine & Wallach, 2002).

Limits of Confidentiality and Privilege: A Legal Analysis

Often, the terms confidentiality and privilege are used interchangeably to describe the same general phenomenon—keeping information about a client private. However, the two terms can be distinguished from one another. The professional necessity of keeping a client’s information private (for both attorneys and social workers) is referred to as maintaining a client’s confidentiality and is “rooted in the ethical codes of each profession as well as in statutory law” (Stein, 2004, p. 11). On the other hand, privilege “refers to the right to withhold confidential information in a court of law . . . [and] is conferred by the legislature of the courts” (p. 105). In a general sense, the conduct of the professional practitioner must be “measured against the traditional negligence standard of the rendition of reasonable care under the circumstances” [17 Cal.3d 425, 439-440 (1976)].

Laws regarding mandated reporting and other limits of confidentiality differ. For instance, lawyers in New York are not mandated reporters (Stein, 2004). In some cases, social workers who are “employed by an attorney [are] covered by attorney-client privilege and may not be required to report abuse or neglect” (p. 11). Practitioners should familiarize themselves with the appropriate statutes in the states where they practice.

The history of confidentiality and how it has been guarded and breeched can be traced through pertinent case law. Familiarity with pertinent case law related to confidentiality can also be helpful in guiding practitioners negotiating work with a client, for example, who has threatened harm. As discussed earlier, the Tarasoff ruling in 1976 formed the foundation of case law that guided practice with regard to a clinician’s duty to warn others of a client’s intent to harm.

Three rulings that followed helped to support the Tarasoff duty to warn. In David v. Lhim (1983), the court ruled in favor of the plaintiff who administered the estate of the deceased, Ruby Davis, who was killed by her son (who had schizophrenia) after his release from the hospital. Counsel for the plaintiff argued successfully that the staff psychiatrist at the hospital did not sufficiently warn the mother, a “foreseeable” victim (Reamer, 2003, p. 30).

In Chrite v. United States (2003), a Veterans Administration (VA) patient (Henry O. Smith) had written a threatening note on the day he was released from the hospital. Although the note was recorded in his case notes, no warning was ever given to the intended victim, his mother-in-law. Smith did follow through on his threat and killed his mother-in-law. The court ruled in favor of the plaintiff (her husband) in finding that the hospital staff had a duty to warn the intended victim about the threat (2003).

In Jablonski v. United States (1983), Phillip Jablonski had been hospitalized and had a history of violence, including threatening to kill and rape his mother-in-law. Following his stay, he killed his mother-in-law. His estranged wife sued the VA Hospital where he had been treated. The court found in favor of the plaintiff, citing that the staff at the hospital “should have concluded, based on the information and prior records available, that Kimball [the victim] was a foreseeable victim” (p. 31).

However, subsequent rulings have helped to clarify (in most cases) what constitutes such things as imminent harm, the intended victim, and what actions constitute a warning. The ruling in the case of Mavroudis v. Superior Court (1980) clarified that threats must pose an “imminent threat of serious danger to a readily identifiable victim” (Reamer, 2003, p. 31). This was further clarified during a subsequent ruling in Thompson v. County of Almeda (1980), when the court ruled that the threat must be specific (Reamer, 2003).

Clearly, the best therapeutic choice for a therapist treating clients who pose an immediate danger to themselves or others is to seek hospitalization. However, the court’s ruling in the case of Currie v. United States (1986) “suggests that therapists may have a duty to hospitalize dangerous clients to protect potential victims” (Reamer, 2003, p. 34). Thus, clinicians should take heed to their ethical and potential legal obligations to protect others from a client posing an imminent danger.

Reamer (2003) offers four guidelines to help clinicians balance the professional obligation of confidentiality with the duties to warn (and protect):

First, the social worker should have evidence that the client poses a threat of violence to a third party.... Second, the social worker should have evidence that the violent act is foreseeable.... Third, the social worker should have evidence that the violent act is imminent.... Finally...a practitioner must be able to identify the probable victim. The disclosure of confidential information against a client’s wishes should not occur unless the social worker has specific information about the client’s apparent intent (pp. 38-39).

It is clear that work with a dangerous client poses many therapeutic and ethical challenges. Clinicians may be concerned

about the liability that a breach of confidentiality may pose. Dickson (1998) suggests that “When there is no statutory protection, consultation combined with careful documentation should minimize the chances of successful litigation” (p. 164). In many states, mental health practitioners are protected from litigation when they are following, for instance, mandated reporting guidelines. A careful assessment and consultation with a supervisor are often the first steps in making an appropriate plan of action. Reamer (2003) further outlines ten steps to be taken by clinicians if their clients pose a threat to another party:

- Consult an attorney who is familiar with state law concerning the duty to warn and/or protect third parties.
- Consider asking the client to warn the victim (unless the social worker believes this contact would only increase the risk).
- Seek the client’s consent for the social worker to warn the potential victim.
- Disclose only the minimum amount necessary to protect the potential victim and/or the public.
- Encourage the client to agree to a joint session with the potential victim in order to discuss the issues surrounding the threat (unless this might increase the risk).
- Encourage the client to surrender any weapons he or she may have.
- Increase the frequency of therapeutic sessions and other forms of monitoring.
- Be available or have a backup available, at least by telephone.
- Refer the client to a psychiatrist if medication might be appropriate and helpful or if a psychiatric evaluation appears to be warranted.
- Consider hospitalization, preferably voluntary, if appropriate (p. 41).

But not all clinical situations involving confidentiality are quite so clear. Let’s look at a case vignette to examine some of the clinical issues surrounding client confidentiality and the practitioner’s role in working with a blended family where custodial parties believe a third party to have the potential for violence.

Case Vignette

Jill sought play therapy treatment for her son Bobby, age 6, because of his reported difficulty revolving around his parents’ divorce. Jill and William (Bobby’s father) share custody. Bobby was allegedly exposed to a great deal of his parents’ marital strife by his mother’s report. She stated that prior to the divorce, there was constant tension and turmoil in the home. Jill attributed much of this to his father’s alleged untreated mood disturbance and substance use. In a separate meeting with William, information concerning Bobby’s exposure to marital conflict was not confirmed. His father was suspicious of why I was asking about this and stated that his relationship with his former wife did not have “anything to do with Bobby” and his treatment. It was one of my main hopes for his treatment that the contentious nature of the parental separation and divorce would not contaminate Bobby’s ability to use the therapeutic relationship most effectively.

Although my individual work with Bobby was critical in terms of his own development and understanding about his experience, the work with his family was perhaps equally important in the effort to tend to his psychological health. It was in my work with his family that the issue of confidentiality and the possibility of an intersection with the courts became a treatment issue.

Bobby’s paternal grandfather related to me that he was pursuing legal action against William in regard to Bobby’s custody arrangement, pursuing what he deemed his legal “grandparent rights.” His grandfather also related that Bobby had been increasingly withdrawn in their home and had been indirectly asked to “take sides” and placed in a precarious situation of choosing between his father (on one side) and his mother and paternal grandparents (on the other). Following this meeting, I met with William once again. He was quite resistant and seemed mistrustful of my intentions to gain helpful information from him in the interest of his son. Although his willingness to come to our meeting was a good start, I was able to gather only limited information from William, as he was thoroughly guarded and defended against attempts to build a meaningful alliance.

The week following this contact, I met with Jill and the paternal grandparents. As I began to provide them an update on Bobby’s progress and work during his therapeutic play, my meeting with them was quickly pervaded by a much more serious and somewhat adversarial tone. His paternal grandfather pressed for specific information that Bobby may have revealed regarding his feelings and thoughts about his father and his treatment of him or other family members. Specifically, Bobby’s paternal grandparents were concerned that their own son’s behavior was becoming increasingly combative and were concerned about his potential for violence. I informed him that the themes present in Bobby’s play indicated conflictual feelings of loyalty and marked differences between households, although he had not revealed any specific information regarding his father. I further explained that it would not be appropriate for me to reveal any specific information in this regard, as it may affect the therapeutic relationship and trust that had developed, not to mention the issue of confidentiality. I explained that therapy was a special place for Bobby in that it may have been the only place where he didn’t have to choose sides. Lastly and most importantly, I suggested to all parties that a family evaluation be completed by an independent clinician, so that any potential risks (for violence, for instance) could be assessed, and that this would not interfere with my work with Bobby.

The grandfather pressed me further and insisted that I would be compelled to reveal any specific information if asked by a judge. Clearly, the grandparents were interested in pursuing revised custody and/or contact arrangements between Bobby and his father through involvement with the legal system and were hoping I would collude with them in this effort. What are the issues legally relevant to my work with this client?

Legally and Ethically Relevant Issues, Discussion, and Concluding Remarks

I am ethically (and legally) bound not to reveal any information about Bobby and my work with him to anyone but his parents without a court order. However, there are indications that his grandparents are directly attempting to have me collude with their efforts to alter Bobby’s custody and/or visitation arrangements with them. Certainly, the legally relevant issue at hand is Bobby and the current custody arrangement. The grandparents (and Jill) inferred that William might be prone to violence and were concerned about the impact that possible exposure may have had on Bobby. It was not clear to me that he posed an imminent danger, and I referred the family to a forensic practitioner who performs independent family evaluations for the local courts. This evaluation would include a battery of psychological assessments, including measures of any potential dangerousness. Ethically, I had to distinguish and clarify my role with Bobby. I was not in the role of custody evaluator and made my therapeutic role very clear to all parties. In this case, I was a clinical social worker and not a forensic evaluator.

In addition to issues surrounding the parental separation and divorce, particularly as it related to and was experienced by Bobby, it was important to guard his confidence within the therapeutic relationship. Work with children is specialized in that a clinician must balance the confidentiality of the client while maintaining an appropriate alliance with the caregivers and/or legal guardian(s). The contentious nature of the divorce and the interference by the grandparents certainly made this case much more complex than some. I needed to balance and protect Bobby’s needs and our therapeutic alliance and confidence with the sometimes competing interests of his estranged adult caregivers.

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