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Confidentiality in Question: The Erosion of the Cornerstone of Counseling?

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Abstract

Confidentiality is a fundamental principle of the counseling profession. Recent events and initiatives, however, have led to a variety of efforts to infringe upon this principle by requiring mandated reporting of a number of issues, including domestic violence, infectious disease, animal abuse, professional impairment, and criminal activity, particularly sexual assault. This erosion of confidentiality needs to be examined by the helping professions, and further changes should not be implemented without thorough consideration of the unintended effects they could produce.

Keywords: confidentiality, mandated reporting, privileged communication, sexual assault, animal abuse, domestic violence, criminal activity

One of the most sacred principles of the mental health professions is that of confidentiality. Clients/patients are provided with assurances that their privacy as a person seeking services will be protected and that what they choose to disclose in a session will only be revealed in a very limited set of circumstances, such as cases of known or suspected child or elder (vulnerable adult) abuse/neglect or when an identifiable person is in immediate danger (the professional's duty to warn and protect a potential victim; *Tarasoff v. Regents of the University of California*, 1976). These exceptions are reviewed and agreed upon in the informed consent discussion with the client at the initiation of services and throughout the therapeutic process. Recently,

however, a trend has emerged in which additional exceptions to the fundamental provisions for client privacy have been proposed and, in some cases, enacted. Although these exceptions are no doubt well intentioned, they represent a serious threat to the profound importance of preserving client confidence in the sanctity of the clinical relationship and, thus, should be seriously challenged prior to any further consideration. Examples that have appeared in the recent professional discourse include mandated reporting of alleged animal abuse, infectious disease, professional impairment, domestic violence, and sexual assault, as well as efforts to encourage or mandate reporting of criminal activity in general. Each will be explicated herein in an attempt to initiate this discussion and review in the professional mental health community.

Overview of Confidentiality

Provisions to protect the identity of those seeking services (e.g., counseling, psychological services, and mental health care), as well as the content of those sessions, have historically been a fundamental principle of the helping professions (Welfel, 2015). Similar to the protections afforded to the attorney-client, doctor-patient, and clergy-penitent relationships, the counselor-client relationship has been based on the agreement/contract that what is revealed in a session will not be disclosed elsewhere, except in very narrow, clearly defined, and agreed-upon circumstances. As Remley and Herlihy (2014) noted, “clients need to know that that they can trust their counselors to respect their privacy, and the counselor’s privacy pledge is the cornerstone on which this trust is built” (p. 109). Specific federal confidentiality laws (and corresponding regulations) have even been promulgated to protect clients/patients receiving substance abuse services and to encourage individuals to seek care without fear that their disclosures of illegal substance use will be used against them in legal proceedings (Code of Federal Regulations [CFR 42], 2016). As the helping professions (particularly counseling, psychology, and social work) have matured, the protections of privileged communication have been extended to them, particularly for licensed providers (Herlihy & Corey, 2006; Remley & Herlihy, 2014). Few would argue that the likelihood of counseling being successful is dramatically dependent on the individual client trusting both the professional delivering the services and the process, including the privacy of the session content, underscoring the importance of the informed consent process. State laws addressing suspected child abuse/neglect and vulnerable-elder abuse/neglect, as well as the well-known Tarasoff decision (*Tarasoff v. Regents of the University of California*, 1976) serve as valuable and accepted guidelines for providers regarding situations in which confidentiality must be broken (Rothstein, 2014), but further infringement on the privacy protections should only be considered in the most extreme of circumstances. However, several such initiatives have been advanced recently and will be considered on their own merits in the paragraphs that follow.

Proposed Exceptions

Animal Abuse

A recent article in the member publication of the American Counseling Association (ACA), *Counseling Today* (Wollheim, 2014), as well as subsequent postings

on the member listserv ACA Connect, proposed that mental health professionals who learn of abuse to animals be mandated to report these occurrences to the appropriate authorities. Follow-up correspondence expressed support for this idea (Bleiber, 2015). Among the justifications cited for the proposal included the idea of correlation between animal abuse and other serious criminal behavior and the concept that animals have the same right to protection as humans.

While well-meaning, this proposal would raise serious issues should it be enacted. Unlike human victims of abuse, animal victims could not be interviewed, and any evidence of abuse would need to be determined to have been perpetrated by the client in question and to have been intentional—a difficult task at best. Additionally, the question as to what animals the regulations would cover would need to be explored, as well as any applicable statute of limitations relating to the alleged abuse. State laws vary as to what constitutes a criminal offense relating to animal abuse. It would seem to be a challenging if not treacherous path down which to tread to mandate such reporting by counselors. Given the prioritization of client privacy, such reporting seems to be beyond the scope of what rises to the standard level of professional practice.

The simple abhorrence of client behavior should not in and of itself be the determinant of what should be reportable and risks conflicting with the ethical principles that urge counselors not to impose their values on others: “Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors.” (ACA, 2014, p. 5). Numerous states mandate animal abuse reporting by professionals with particular expertise in this field (American Veterinary Medical Association, 2015), such as animal control officers and veterinarians—leading one to surmise that perhaps sufficient regulations are already in place and handled by those with the knowledge needed to make appropriate reports. Putting counselors in this position seems both inappropriate and excessively intrusive.

Infectious Disease Reporting

Another area of service provision that has been characterized by efforts to increase reporting requirements is that of infectious disease. Beginning with the reporting of HIV/AIDS infection, reporting parameters have expanded to include other infectious diseases. In fact, the two most recent versions of the ACA Code of Ethics (2005, 2014) include provisions stating that counselors “may be justified” (ACA, 2014, p. 7) in reporting “contagious, life-threatening diseases . . . to identifiable third parties, if the parties are known to be at serious and foreseeable risk of contracting the disease.” (ACA 2014, p. 7).

The issues with this are abundant. First is the issue of reporting to sexual partners or potential sexual partners. It is unlikely that a mental health professional would have the opportunity to warn a partner *before* an initial exposure to an infectious disease. In other words, a client revealing that he or she is HIV-positive, for example, who discloses being in a potentially sexual relationship, and not having informed the partner of the infection, might lead a professional to consider warning the partner of potential infection. One might ask if this is really the counselor’s role, particularly given the progress made in the treatment of HIV/AIDS. As Remley and Herlihy (2014) stated, “[d]ue to medical advances, AIDS is no longer routinely fatal, which makes the applicability of this standard open to question” (p. 190), as HIV/AIDS may no longer meet the standard of a

“life-threatening disease.” If a disease is not life-threatening (and again, nearly all diseases are, of course, potentially fatal), it would seem at least arguable that the counselor not only *would not* have an obligation to warn a partner, but *should not* do so—and would be violating confidentiality provisions by doing so. Second, taking such a dramatic step (warning an identifiable third party) may not be warranted as numerous campaigns have been waged encouraging people to engage in safe sexual practices, consider being tested, and observe universal precautions, defined as the idea that any potential partner is considered to be infected (U.S. Department of Labor, 2016). The question then becomes one of balancing the client’s autonomy and privacy with the partner’s need/right to know—and then determining the professional’s responsibility. An argument can be made that it may be overly intrusive to require counselors to warn potential partners.

Finally, the issue of reporting to local authorities is sometimes raised as well. In the early days of HIV/AIDS, laws were enacted requiring mental health professionals to report cases to local public health authorities as fears relating to epidemics and outbreaks abounded. State and local laws varied as to how much personal information was to be disclosed, and it is unclear if these laws remain universally in place, observed, and enforced. As noted earlier, given the current environment, these requirements seem excessive and unnecessary. One can imagine similar efforts emerging relating to the recent Ebola infections as well as any number of other diseases that might develop in the future. A measured response to efforts to expand legally or ethically mandated reporting requirements is advised rather than a rush to inject reactionary obligations into the mental health treatment community.

Domestic Violence

One could argue that domestic violence is one of the most pressing public health issues of our time. Laws regarding the mandatory reporting of incidents of domestic violence vary state by state, but are generally captured in one of four categories: (a) injuries caused by weapons, (b) injuries caused by a criminal act, (c) domestic violence cases, and (4) no mandatory reporting laws. Such reporting laws exist to serve and protect the public as well as to enhance responses from law enforcement and health-care providers, to take appropriate legal action on the alleged batterer, and to collect accurate statistics on domestic violence.

Most states limit mandated reporters to medical professionals (i.e., physicians, medical examiners, surgeons, nurses, health care practitioners, pharmacists, and dentists), however the law in Kentucky includes social workers and mental health professionals. In Kentucky, counselors are to report any adult who is the suspected victim of an abusive or neglectful spouse (Durborow, Lizdas, O’Flaherty, & Marjavi, 2010). Although this reporting supports the stated goals (protect the public, collect data), it also may serve to delay or even prevent a victim from seeking professional counseling services. It is not uncommon for an abused partner to remain in the toxic relationship for an extended time, with many unsuccessful attempts to permanently leave the abuse. If an abused spouse seeks counseling and that counselor is mandated to report the abuse, the therapeutic relationship is potentially jeopardized, and the client may be placed in increased danger for escalated abuse. A mandated reporting standard also removes the client’s autonomy and right to choose for him/herself a course of action. Although mental health caregivers

are included as mandated reporters in at least one state at this point, other states may soon follow.

Sexual Assault

The infamous *Rolling Stone* article of 2014 (Erdely, 2014) cast much-needed light on campus sexual assault, although it was later found to be inaccurate at best and fabricated at worst. The allegations, however, combined with a growing national awareness about sexual assault, have led to numerous efforts at the state level to mandate the reporting of such incidents by college personnel. Although some legal exemptions exist for college counseling center personnel specifically, the implications of the effort to mandate reporting are, nonetheless, significant (U.S. Department of Education, 2014). Consider the effect on a victim, who would need to have overcome a variety of obstacles (e.g., shame, stigma, and guilt) simply to come forward. Mandatory reporting by counselors could serve as a strong deterrent to victims receiving the support they might need, making its imposition something that should be considered with extreme caution due to the potential for inhibiting victims from disclosing at all. Likewise, alleged perpetrators might also have a disincentive for seeking counseling for the same reason. Certainly, having an individual who has engaged in inappropriate, and even exploitative, sexual behavior, and who has the desire to change such behavior, is a positive step. Requirements that a counselor must report something of this nature when it is disclosed in a confidential counseling session would have a chilling effect on the likelihood that such individuals would indeed come forward to seek help.

Additionally, Federal Title IX reporting originally posed a potential threat to privacy and confidentiality; however, in April 2014, the Office for Civil Rights (OCR) relaxed the requirements of “responsible employees” in order to maintain reporting exemption for professionals serving in counseling and health capacities. Campus psychologists, mental health counselors, social workers, pastoral counselors, health center employees, and other licensed professionals or supervised trainees with professional confidentiality standards are exempt from Title IX reporting. “OCR recognizes the importance of protecting the counselor-client relationship, which often requires confidentiality to ensure that students will seek the help they need” (U.S. Department of Education, 2014, p. 22). In doing so, OCR appropriately honored the mental health standard of care and the fact that maintaining confidentiality would promote help-seeking behavior for students who have been victimized. Consistent with OCR, the NotAlone guidelines, formed in connection with the White House Task Force to Protect Students from Sexual Assault (formed on January 22, 2014), state that professionals with confidentiality standards (i.e., counselors, psychologists, clergy, and health providers) are not required to report incidents related to Title IX (The White House Task Force to Protect Students from Sexual Assault, 2016; U.S. Department of Education, 2016).

Reporting of Criminal Activity

An additional area for discussion is that of reporting criminal activity in general. At first glance, revelations of illegal activity might not seem to be a commonplace occurrence in a counseling session; however, a deeper consideration reveals this not to be the case. In certain professional arenas, such as counseling individuals with substance use

disorders, illegal/criminal activity may be more the norm rather than the exception. As noted earlier, specific federal laws and regulations protect clients from non-authorized disclosure of their illegal actions, such as illicit drug use (The Health Insurance Portability and Accountability Act of 1996, 1996). Given current priorities relating to public safety, however, it is not difficult to imagine scenarios in which professionals would be pressured or encouraged to report crimes or alleged crimes by clients to law enforcement. In one example of this, a letter was sent to licensed professionals in Virginia during the summer of 2014 from law enforcement officials asking for information to help solve a crime in which the alleged offender had previously been in therapy (personal communication, 2014). Recipients were asked to report identities of any potential suspects to the authorities, raising a myriad of questions about confidentiality and privileged communication, not the least of which would be the effect on the clinical relationship if the professional were to have made such a report. Similarly, efforts have been made to encourage reporting of allegations of domestic violence, as noted earlier. While well-intentioned, requiring professionals to make such reports would likely serve to discourage individuals (perpetrators) of such violence from seeking services or from disclosing such, making it less likely that mental health interventions would be delivered and remediation received. Additionally, as compared to mandated report of child or vulnerable adult abuse in which the victims are considered to be unable to make reports for themselves, adult victims are presumed to possess the autonomy to do so. Intruding upon this highly personal right may be ill-advised. Mental health professionals would be better served to assist their clients in taking steps to protect their safety (such as seeking shelter or moving from the situation), advocating for themselves by self-reporting, or initiating services with both parties in the relationship, rather than by unilaterally reporting to law enforcement or social services. Many other crimes, such as tax evasion, not paying child support, driving without a license, or stealing from an employer, for example, are not far-fetched to be disclosed during a therapy session. Mandating mental health professionals to report crimes inherently changes the relationship between client and counselor and creates a damaging dynamic that is harmful to the safety required for the honest and deep disclosure needed for effective mental health services to occur.

Reporting of Impairment

Another related area of intrusion is that which mandates counselors (and other helping professionals) to report impairment by other health care providers. A specific example of such a mandated reporting requirement would be one that attempts to protect the public by requiring certain professionals to report health care practitioners who have sought treatment for substance use or mental health disorders. The Commonwealth of Virginia, for example, under the 2006 Code of Virginia, Title 54.1, states that CEOs of hospitals, hospice organizations, assisted living facilities, and home health care are now required to report to the Department of Health Professions knowledge of any licensed, certified, or registered professional who warrants treatment or who has received inpatient treatment for substance issues or another psychiatric illness that may jeopardize the safety of the professional him/herself, the public at large, or patients under the care of the professional (2006 Code of Virginia, § 54.1-2400.6). This law, although undoubtedly designed to protect the public, increases the potential to discourage help-seeking behavior

of those professionals who certainly deserve professional treatment. If a counselor is struggling with depression and voluntarily seeks intensive care in an inpatient facility to gain a comprehensive evaluation and a treatment plan, should he/she need to fear being reported? The ACA Code of Ethics (2014) states that counselors self-monitor and address professional effectiveness (C.2.d) and impairment resulting from physical, mental, or emotional concerns (C.2.g). Counselors are not to serve clients when personal issues impede their ability to provide quality care. Furthermore, the Code states that if impairment is present, the counselor is to seek assistance. However, there is tension between taking the ethical action of engaging in self-care and the reality that seeking treatment will be reported.

Discussion

Clearly, the concept of confidentiality is, and should be, an evolving one as circumstances dictate and as the mental health professions evolve and mature. Efforts to mandate reporting, even when well-intentioned, however, should be scrutinized with the utmost seriousness and professional oversight. The risk of unintended consequences, such as discouraging people in need of services from seeking help, is great, and proposed exceptions to confidentiality should be evaluated with these potential ramifications in mind. Likewise, the effectiveness of the counseling session itself may be jeopardized if clients believe that there are things they cannot disclose within the session due to the risk of being reported. Mental health practitioners must exert the highest level of professional caution when considering any efforts to tamper with the time-honored principle of confidentiality.

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