Protecting Confidentiality Rights

The Need for an Ethical Practice Model

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All psychologists must uphold the same ethical standards about confidentiality even though each state imposes different legal limits on their ability to protect clients' confidences. The resulting ethical–legal confusion is exacerbated by legally based confidentiality training that treats legal exceptions as if they were the rule and fosters the impression that attorneys are now the only real experts about this aspect of practice. This article provides an ethics-based confidentiality practice model that clarifies the ethical rule and puts its legal exceptions into ethical perspective. Like the Confidentiality section of the American Psychological Association's (2002) Ethical Principles of Psychologists and Code of Conduct, *this outline would apply to all psychologists regardless of state laws, but the details of its implementation would vary according to role and setting. It can be used as a universal training outline, a consultation and supervision tool, a guide to professional practice, and a basis for clearer ongoing conversation about the ethics of "conditional confidentiality." Psychologists can use this practice model to regain their status as experts about the confidentiality ethics of their own profession.*

Keywords: ethics, confidentiality

Protecting confidentiality has always been a primary obligation of psychologists (American Psychological Association [APA], 1959, 1963, 1968, 1979, 1981, 1990, 1992, 2002). Ethics texts reflect this continuity: Koocher and Keith-Spiegel (1998) noted that confidentiality has long been regarded as "a cornerstone of the helping relationship" (p. 115); Haas and Malouf (2002) described it as a central factor underlying the public trust in mental health practitioners. The APA Ethics Office has punctuated its importance: "Confidentiality is a core value of our profession. It is, as they say, bred in our bones" (Behnke, 2005a, p. 76).

Psychologists themselves, across decades, have overwhelmingly endorsed the importance of protecting clients' confidences, sometimes describing this as their most important professional duty (Crowe, Grogan, Jacobs, Lindsay, & Mark, 1985; Jagim, Wittman, & Noll, 1978; Knapp & VandeCreek, 1987). Yet, somewhat paradoxically, psychologists have also reported that confidentiality creates their most serious ethical problems and is the source of more ethical dilemmas than any other aspect of practice (Haas, Malouf, & Mayerson, 1986; Pope & Vetter, 1992). Unfortunately, there seems to be much confusion and anxiety about confidentiality (Bollas & Sundelson, 1995).

The problems are not new. During the 1970s, psychologists toiled with the issues raised by new legal demands for disclosure (Everstine et al., 1980; Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979). By the 1980s, over half (61.9%) of psychologists reported sometimes violating confidentiality unintentionally (Pope, Tabachnick, & Keith-Spiegel, 1987); half named it the ethical mandate they were most likely to violate intentionally (Pope & Bajt, 1988); and it was noticeably represented among APA ethics cases (Hall & Hare-Mustin, 1983). In the years 1983 through 1987, it was the fourth most frequently adjudicated ethical violation, leading the APA Ethics Committee to note (perhaps in understatement) that "Confidentiality appears to present various difficulties for psychologists" (APA Ethics Committee, 1988, p. 570). During the 1990s, confidentiality continued to rank high on the list of ethical violations leading to disciplinary action, with psychologists in one state acknowledging it to be the second most frequent cause of complaints about them to their licensing board (Montgomey, Cupit, & Wimberley, 1999).

The problems are persistent. Confidentiality issues have continued to be reflected in ethics complaints, sometimes in a significant percentage of cases (APA Ethics Committee, 2001, 2002, 2003). In 2004, 15% of the cases opened by the APA Ethics Committee involved confidentiality, either as the primary factor or as one of multiple factors (APA Ethics Committee, 2005). In the combined years 2000–2004, confidentiality still ranked fourth among APA ethics cases, exceeded only by dual relationships, custody cases, and insurance/fee issues (Pope & Vasquez, 2007). It is troubling that the following sentence, which opened the confidentiality chapter of a 1991 ethics text for clinicians, could be repeated 10 years later with incidence rates that reflected no improvement: "Ethics complaints, malpractice suits, and licensing disciplinary actions make clear the difficulties most of us encounter in addressing issues of confidentiality" (Pope & Vasquez, 1991, p. 139; Pope & Vasquez, 2001, p. 223). In the third and most recent edition, that sentence was replaced by a similarly troubling statement: "The area of confidentiality has been

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full of pitfalls for therapists" (Pope & Vasquez, 2007, p. 241).

The problems did not arise in a vacuum. The confidentiality dilemmas experienced today by individual psychologists may mirror an earlier dilemma at the national level of the profession when APA, itself under legal pressure, spent years redefining the "primary obligation."

Historical Context: Resurrecting the "Old" Ethical Rule?

Initially, the ethical obligation was unambiguous. The first APA Ethics Code (APA, 1953) required psychologists to "guard professional confidences as a trust" (p. 55). The next three Ethics Codes (APA, 1959 [p. 280], 1963 [p. 57], 1968 [p. 358]) retained that concept of guarding confidences: "Safeguarding information about an individual . . . is a primary obligation of the psychologist." Clearly, the profession was not ambivalent about what constituted ethical behavior.

By the 1970s, however, there was significant disagreement within APA about how to respond to the new child abuse reporting statutes and duty-to-protect laws. Many within the profession were concerned that the legal demands for disclosure meant a lowering of the ethical standard (Siegel, 1976). That stance, albeit commendable, created an unfortunate stalemate. Unable to agree on a new ethical standard, the profession maintained the status quo: The 1979 APA Ethics Code, although significantly revised in other respects, had nothing new to say about confidentiality (Pope & Vetter, 1992). This left psychologists ethically responsible for upholding confidentiality standards enacted two decades earlier, during a very different legal era.

It is evidence of the profession's earlier consistency that, up to that point, the one and only exception to the confidentiality rule had never changed: "Information received in confidence is released only after most careful deliberation and when there is *clear and imminent danger* [italics added] to an individual or to society" (APA, 1959 [p. 280], 1963 [p. 57], 1968 [p. 358], 1979 [p. 4]). Unfortunately, this gave psychologists no guidance about how to respond to the legal demands they now faced. Child abuse reporting statutes not only protected children who were in imminent danger but often also required reports of past abuse (Kalichman, 1993). Therapist–patient privilege no longer applied in court cases involving child abuse (Knapp & VandeCreek, 1987). Psychologists, now visible as convenient repositories of information, were soon receiving subpoenas in other types of court cases, especially child custody cases (Knapp & VandeCreek, 1987; Weithorn, 1987).

This was a true ethical–legal conflict. In the absence of imminent danger, should psychologists maintain confidentiality (as their Ethics Code still seemed to require) or should they breach confidentiality (as their state laws now required)? The 1979 APA Ethics Code contained no answer. Psychologists were on their own, responsible for resolving in their individual cases an ethical–legal dilemma that the profession had not resolved within its Ethics Code. In addition to the breaches of confidentiality, there was a further unfortunate consequence: Psychologists were finding their Ethics Code no longer relevant to their real-world experiences about confidentiality.

The next revision (APA, 1981), far from clarifying matters, introduced an ambiguous new mandate. The words "safeguarding information" were replaced with the phrase, "respect the confidentiality of information" (p. 635). This was very confusing: How could psychologists "respect the confidentiality" of information they were unable to "safeguard"? This wording was repeated in the next revision (APA, 1990). Meanwhile, unable to resolve the ethical–legal conflict, what were psychologists doing? Many followed their own consciences, even if that meant violating ethical principles *and* laws in the name of "client welfare or deeper values" (Pope & Bajt, 1988, p. 828).

The 1992 APA Ethics Code received very mixed reviews. Many criticized its legal qualifiers, vagueness, ambiguity, and lack of specificity (Bersoff, 1994; Keith-Spiegel, 1994a, 1994b; Vasquez, 1994). Some considered it a step backward in certain respects (Sonne, 1994). One complaint seemed especially applicable to the Confidentiality section: "[A]t best [it] builds an ethical floor but hardly urges us to reach for the ceiling" (Bersoff, 1994, p. 385).

First, Ethical Standard 1.02 (Relationship of Ethics and Law) required psychologists, when faced with an ethical–legal conflict, to "make known their commitment to the Ethics Code and take steps to resolve the conflict in a responsible manner" (APA, 1992, p. 1600). If the conflict was not resolvable, were psychologists now ethically free to simply obey all legal demands and disclose information without the client's consent? Perhaps the answer was im-

plied by the fact that the Confidentiality section now began not with a statement of the rule, but with a mandate to inform prospective clients about its *exceptions* (Standard 5.01, Discussing the Limits of Confidentiality).

Furthermore, Standard 5.02, Maintaining Confidentiality, did not even mention the protection of information, only the protection of rights: "Psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work or consult" (APA, 1992, p. 1606). This primary obligation was more confusing than the previous one. Exactly what confidentiality rights were respected if information was not always protected? The rule seemed to be receding into the background as legal exceptions took priority.

In 2002, the APA Ethics Code returned to the rule-first format and reclaimed some of the client-protective language of earlier Ethics Codes. The "primary obligation" is again the protection of *information*, not just the protection of rights (Ethical Standard 4.01, Maintaining Confidentiality); and the statement of the rule appropriately *precedes* the requirement to inform clients of its exceptions.

Do these changes clarify how psychologists should behave about confidentiality? To borrow Bersoff's (1994) metaphor: Does the current Ethics Code (APA, 2002) once again provide a solid ethical floor about confidentiality? Does it encourage psychologists to "reach for the ceiling" in protecting confidences? If so, what does this require in actual practice?

Understanding the Ethical Floor: Clarifying the Implications of Conditional Confidentiality

Proponents of absolute confidentiality have always emphasized the clinical consequences of placing conditions on the protection of confidences. (See, e.g., Bollas & Sundelson, 1995; Siegel, 1976). But conditional confidentiality also has important *ethical* consequences. Many of the "conditions" now placed on confidentiality allow psychologists to avoid risks to themselves. For example, when psychologists obey reporting laws, they thereby avoid the legal and financial risks of civil disobedience; but this simply transfers the risk to the clients whose confidences are betrayed. Similarly, when psychologists disclose information against a client's wishes in a court case, they avoid a contempt citation, a financial penalty, and incarceration; the risk is borne instead by the client whose confidential information becomes public information.

It is this potential risk to clients that creates the ethical necessity for informing them in advance that confidentiality might be breached. In other words, if confidentiality will be conditional, clients have a right to be informed about the "conditions" *before* they consent to confide, regardless of the clinical consequences of that conversation.

Early APA Ethics Codes did not use the words *informed consent,* but they were very clear about the ethical implications of conditional confidentiality. The first APA Ethics Code was published when exceptions were so rare that psychologists could promise, "Everything you say will remain in this room." It nevertheless set the standard: "When . . . some departure is required from the normal expectation that clinical or consulting relationships are confidential, it is expected that the psychologist will make clear to the client the nature of his role before the client enters the relationship" (APA, 1953, p. 56). In other words, it is ethically appropriate to begin without discussing exceptions to confidentiality only if confidentiality will have no exceptions. In subsequent Ethics Codes, the language changed but the meaning remained the same: Psychologists were required to inform prospective clients about "limits of the confidentiality" (APA, 1959 [p. 280], 1963 [p. 57], 1968 [p. 358], 1979 [p. 4]); "legal limits of confidentiality" (APA, 1981 [p. 636], 1990 [p. 393]); and then "the relevant limitations on confidentiality" and "the foreseeable uses of the information generated" (APA, 1992, p. 1606). For years, however, this requirement lay buried deep within the Confidentiality section, as if an afterthought; but by 1992 it was considered so important that it appeared first, even before the statement of the rule.

The current Ethics Code (APA, 2002) makes the relationship between "informed consent rights" and "confidentiality rights" very visible. First, Ethical Standard 3.10 (Informed Consent) requires psychologists to inform clients about limits of confidentiality before obtaining consent for court-ordered services. Then seven further standards protect the client's right to be informed about limits of confidentiality in specific contexts. (See Ethical Standards 3.07, Third-Party Requests for Services; 3.11, Psychological Services Delivered to or Through Organizations; 4.02, Discussing the Limits of Confidentiality; 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; 10.01, Informed Consent to Therapy; 10.02, Therapy Involving Couples or Families; and 10.03, Group Therapy.)

This new emphasis is well warranted. When confidentiality is conditional, failing to explain the conditions in advance will deprive prospective clients of two related rights: (a) the right to be *informed* about the risk that confidentiality might be breached and (b) the right of the informed client to then give (or to refuse) *consent* to accept that risk as a condition of receiving services. Without this informed consent conversation, clients lose the right to make autonomous decisions about whether to enter the relationship and accept the confidentiality risks.

Unfortunately, psychologists were slow to accept the ethical necessity for this initial conversation. Many who accepted it in theory remained reluctant to fully implement it in practice. In one national survey (Somberg, Stone, & Claiborn, 1993), 80.2% of psychologists considered it "very important" to inform prospective clients about limits of confidentiality, but only 59.5% always did so. Of those who sometimes neglected to tell prospective clients that confidentiality might be breached, 46.7% either considered the conversation "not relevant or necessary" or were deliberately avoiding the "negative impact" of explaining confidentiality's limits (p. 157). Such rationalizations reflect a blatant disregard for the client's informed consent rights. Clinically speaking, it may be preferable to begin a rela-

tionship by listening, not by explaining that what is about to be said may not remain confidential. Ethically speaking, however, psychologists who place conditions on confidentiality are not free to treat discussion of this risk as irrelevant or unnecessary, no matter how clinically inconvenient.

Of those who skipped the informed consent conversation about confidentiality, 13.3% did so because they believed the client "already has knowledge of the issue" and 7.5% because they believed clients were "unable to understand" (Somberg et al., 1993, p. 157). The problem with the first rationalization is that limits of confidentiality can now vary from clinician to clinician and from setting to setting. Each clinician is therefore the client's only possible source of accurate information, so no prospective client can "already know" what exceptions will be imposed. Regarding the second rationale, the fact that the subject matter is complex does not absolve psychologists of the ethical responsibility for helping clients understand it.

Whether or not such attitudes still prevail, there may be an even deeper problem: lack of preparation. Psychologists who enter this conversation unprepared may be more anxious about discussing legal requirements, unwilling to fully describe limits of confidentiality, or unable to answer clients' questions honestly. Pope and Vasquez (2007) noted the practical consequence of entering this ethically required conversation without preparation: "Nothing blocks a patient's access to help with such cruel efficiency as a bungled attempt at informed consent" (p. 135).

Although some breaches of confidentiality do involve unforeseeable circumstances, in most cases there is ample opportunity to (a) establish clear policies in advance and (b) explain their implications to clients in advance. For example, by now psychologists should know exactly when, whether, and how they intend to respond to reporting laws and subpoenas. Yet they still describe ethical dilemmas that arise from being unsure about the legal requirements in their states (e.g., Behnke & Kinscherff, 2002). This can lead to avoidable ethical and clinical dilemmas when they (and thus their unprotected clients) are "taken by surprise" by a legally imposed disclosure whose possibility was very predictable. Similarly, clinicians who work with minors often voluntarily breach confidentiality to report dangerous behavior to parents. Although such a disclosure can create clinical complications, it creates no *ethical* dilemma unless the psychologist failed to inform minor and parents about that policy at the onset of the relationship (Beeman & Scott, 1991; Behnke, 2005b, 2007a; Behnke & Warner, 2002; M. A. Fisher, 2002).

Bollas and Sundelson (1995) found "profound confusion" (p. xii) among clinicians of all professions, many of whom seemed anxious about the increasing legal demands for disclosure and unclear about whether clients still had any confidentiality rights. As legally imposed limits on confidentiality have increased, so has the reliance on legal experts, a trend that has elevated the legal anxiety and compounded the ethical confusion.

In an attempt to explain why the ethical–legal confusion that began with *Tarasoff* (1976) has lingered for so long, Beck (1990) suggested that legally mandated breaches of confidentiality became so commonplace that mental health professionals simply began confusing the legal exceptions with the ethical rule. If this "figure–ground reversal" hypothesis is correct, and if legal exceptions continue to multiply, the ethical rule could eventually become invisible.

Reaching for the Ethical Ceiling: "De-Legalizing" Confidentiality Ethics and Clarifying the Ethical Rules

Currently, no single document describes confidentiality ethics in simple terms. The APA (2002) Ethics Code is exceedingly well organized; but it covers all areas of professional practice, so confidentiality mandates are scattered throughout. When establishing their policies about confidentiality, psychologists must consider 28 ethical standards that address it specifically, plus 9 other ethical standards that, without using the word *confidentiality*, are directly relevant (see Table 1).

Each new Ethics Code triggers the publication of casebooks. (See, e.g., C. B. Fisher, 2003; Knapp & VandeCreek, 2003; Nagy, 2005). APA, in cooperation with the APA Insurance Trust, has provided a risk-management handbook with focus lists about both confidentiality and informed consent (Bennett, Bryant, VandenBos, & Greenwood, 1990). Across the years, many other APA documents have included discussion of confidentiality in specific contexts. (See, e.g., APA Committee on Legal Issues, 1996; APA Committee on Professional Practice and Standards, 1993, 1994, 1998, 2007; APA Committee on Psychological Tests and Assessment, 1996; APA Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force, 2000; APA Ethics Committee, 1997; APA Working Group on the Older Adult, 1998.)

Clearly, psychologists' difficulties about confidentiality do not arise from lack of information. Instead, the problem seems to be the absence of a coherent ethical framework on which to hang all the information that is already available. Hansen and Goldberg (1999) noted that "the complexity of contemporary practice necessitates a comprehensive, systematic approach to identifying pertinent legal-ethical variables, issues, and guidelines. . . . Without a comprehensive organizing schema, professional psychologists cannot be expected to grasp intuitively the conflicting demands" (p. 496).

Their comment seems especially applicable to confidentiality. With no clear schema or ethical framework available, it is difficult to organize the wide-ranging obligations in a meaningful way. This has made it more complicated to teach this topic, whether in graduate school ethics classes or in continuing education workshops. Without a shared organizing framework, conversations about confidentiality become complicated, both in case consultations with peers and in formal consultations with professional advisers or ethics offices.

When psychologists reach outside the profession for guidance about confidentiality, they receive conflicting advice from attorneys, managed care managers, and indepen-

Table 1
APA Ethical Standards Relevant to Confidentiality

APA ethical standard	Step in ethical practice model (see Table 2)
A. Ethical standards directly addressing confidentiality and disclosure	
1. RESOLVING ETHICAL ISSUES	
1.04 Informal Resolution of Ethical Violations	IV, VI
1.05 Reporting Ethical Violations	IV, VI
1.06 Cooperating With Ethics Committees	IV, VI
2. COMPETENCE	
2.05 Delegation of Work to Others	V
3. HUMAN RELATIONS	
3.05 Multiple Relationships	II, V
3.07 Third-Party Requests for Services	II
3.09 Cooperation With Other Professionals	I, IV, VI
3.10 Informed Consent	II
3.11 Psychological Services to or Through Organizations	II
3.12 Interruption of Psychological Services	V
4. PRIVACY AND CONFIDENTIALITY	
4.01 Maintaining Confidentiality	III
4.02 Discussing the Limits of Confidentiality	II
4.04 Minimizing Intrusions on Privacy	V
4.05 Disclosures	III
4.06 Consultations	I, III, V, VI
4.07 Use of Confidential Information for Didactic or Other Purposes	III, V
6. RECORD KEEPING AND FEES	
6.01 Documentation of Work and Maintenance of Records	V
6.02 Maintenance, Dissemination, Disposal of Records	III, V
6.04 Fees and Financial Arrangements	II, V
6.06 Accuracy in Reports to Payors and Funding Sources	III, V
7. EDUCATION AND TRAINING	
7.04 Student Disclosure of Personal Information	II, V
8. RESEARCH AND PUBLICATION	
8.02 Informed Consent to Research	II
8.15 Reviewers	V
9. ASSESSMENT	
9.03 Informed Consent in Assessments	II, V
9.04 Release of Test Data	II, IV, V
10. THERAPY	
10.01 Informed Consent to Therapy	II
10.02 Therapy Involving Couples or Families	II
10.03 Group Therapy	II
B. Other ethical standards relevant to confidentiality	
1.02 Conflicts Between Ethics and Law	I, II, IV, V, VI
1.03 Conflicts Between Ethics and Organizational Demands	I, II, V, VI
2.01 Boundaries of Competence (re: undertaking consultation)	I, VI
3.04 Avoiding Harm	(entire model)
3.06 Conflict of Interest	II
4.03 Recording	II, III, V
8.03 Informed Consent for Recording in Research	II
8.05 Dispensing With Informed Consent for Research	II
10.9 Interruption of Therapy	V

Note. Ethical standards can be found in American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060–1073.

dent consultants. If they attend nationally sponsored confidentiality training, it is likely to be conducted by a law firm or malpractice insurer; and although the word *ethics* may appear in the advertising brochure, the focus is usually on laws and risk management. Enactment of the Health Insurance Portability and Accountability Act (HIPAA)

brought an upsurge in attorney-taught HIPAA-compliance training that threatens to further replace ethics-based training about confidentiality.

Such legally based training creates several ethical problems for psychologists. First, it fosters the impression that attorneys—not clinicians—have become the only "real" experts about this aspect of practice. Second, it creates a legal language about confidentiality that threatens to usurp psychologists' own clinical or ethical language about it: Laws take center stage, when what is needed is a language for placing them into ethical context. Third, it exacerbates the figure–ground confusion (by substituting legal rules for ethical rules) and often takes a risk-management perspective that raises anxiety: It encourages psychologists to focus on obeying laws in order to avoid risks to *themselves*, when what they need is a clearer focus on their ethical obligations and the potential risks to *clients*. Finally, the legal emphasis obscures an important fact about risk management: Understanding and following the relevant ethical principles is an essential ingredient in avoiding a malpractice suit (Bennett et al., 1990, 2006).

Psychologists can reclaim their status as confidentiality experts in their own right only by regaining an understanding of clients' rights about it, not as defined by law, but as defined by the ethics of their own profession. If psychologists are confused about their obligations, what they need is not more information, but an ethics-based model for organizing and using the information they already have. If psychologists are having difficulty seeing the ethical forest for the legal trees, what they need is not more legal training, but clearer ethics-based training.

Underneath all the legally imposed exceptions, the familiar old ethical rule is still there. The rule is simple enough. It is the exceptions that create the ethical complications. However, to clarify the rule and its ethically allowed exceptions, one must refer to three separate ethical standards in a sequence different from their order of appearance in the Ethics Code:

Confidentiality Rule. Protect confidential information (Ethical Standard 4.01); disclose it only with client consent (Ethical Standard 4.05a); and inform clients, in advance, about any foreseeable exceptions to this rule (Ethical Standard 4.02).

Ethically Allowed Exceptions to the Rule. Disclose without client consent only (a) as mandated by law or (b) where permitted by law for a valid purpose (Ethical Standard 4.05b).

Similarly, a chronological listing of ethical standards (as in Table 1) bears no resemblance to the sequence in which they must be applied in practice. No list, regardless of sequence, can reflect the interrelationships among these overlapping ethical mandates. In short, psychologists lack a coherent description of the ethics of conditional confidentiality.

Constructing an Ethical Practice Model

To qualify as "ethics based," a confidentiality model should meet certain criteria. In the absence of known published criteria, the following were used for this purpose: (a) The model must incorporate those ethical standards considered by the profession to be necessary for protecting clients' confidentiality rights; (b) it must include nothing inconsistent with those standards; (c) to the extent that it contains additional recommendations, these should be implied by or deduced from the APA Ethical Standards or other APA guidelines; (d) it should make a clear distinction between the confidentiality rule and its exceptions; (e) it should separate ethical mandates from legal mandates, placing laws within an ethical context; and (f) it should reflect the disparate ethical implications of voluntary disclosures (requiring client consent) versus legally compelled disclosures (ethically allowed without client consent). These criteria differentiate the proposed model from "legally based" outlines that organize confidentiality around laws, not ethics.

To qualify as a practice model, it must provide a sequence of steps that bear a direct relationship to actual practice. The proposed confidentiality practice model in Table 2 contains a sequence of six ethical steps that would apply for all psychologists. Within each step, however, the details will differ across roles and settings. This version of the practice model contains the ethical details that would apply in clinical settings. It can be further adapted for use in specialized clinical roles (e.g., assessment), or with specific populations (e.g., minors, couples, families) by incorporating details from ethical standards and professional guidelines specific to those needs.

For research psychologists, or those in teaching, supervision, or consultation roles, the six topic areas of the practice model would remain exactly the same; only the details would change. Researchers, for example, would need to incorporate the relevant ethical standards from Section 8 of the APA Ethics Code (Research and Publication); so Step 2 would necessarily include the informed consent mandates from Ethical Standards 8.02 (Informed Consent to Research), 8.03 (Informed Consent for Recording Voices and Images in Research), 8.05 (Dispensing With Informed Consent for Research), and 8.07 (Deception in Research).

One of the strengths of this six-step outline is that, like the Confidentiality section of the APA Ethics Code, it applies to all psychologists, regardless of role or setting. It thus provides a uniform description of the ethical steps involved in protecting clients' confidentiality rights. Like the Ethics Code, it leaves psychologists responsible for learning their state laws; and it gives them the freedom to devise voluntary disclosure policies specific to their settings or agencies. Unlike the Ethics Code, it provides a structure for organizing the relevant ethical standards from Table 1 into an integrated whole.

It is difficult to overstate the importance of Step 1, Preparation. The APA Ethics Code does not mention the need for this advance preparation, and it is often ignored, both in training and in practice. However, without careful planning, psychologists will be unable to carry out the subsequent steps of the model that *are* ethically required, such as informing prospective clients about limits of confidentiality and answering their questions honestly (Step 2)

Table 2
An Ethical Practice Model for Protecting Confidentiality Rights

I. Prepare
A. Understand clients' rights and your ethical responsibilities in behalf of those rights.
B. Learn the laws that can affect your ability to protect confidential information.
C. Clarify your personal ethical position about confidentiality and its legal limits.
D. Decide when/how you will limit confidentiality voluntarily.
E. Develop plan for ethical response to laws that require you to disclose "involuntarily."
F. Choose reliable ethics consultants and legal consultants and use as needed.
G. Devise informed consent forms that reflect your real intentions.
H. Prepare to discuss confidentiality and its limits in understandable language.
I. Conduct confidentiality training for employees, supervisees, interns, etc.
II. Tell Clients the Truth "Up Front" (Inform Their Consent)
A. Inform prospective clients about the limits you intend to impose on confidentiality.
B. Explain any roles or potential conflicts of interest that might affect confidentiality.
C. Obtain informed client's consent to accept limits as a condition of receiving services.
D. Reopen the conversation if/when patient's circumstances (or your intentions) change.
III. Obtain Truly Informed Consent to Disclose Voluntarily
A. Respect the rule: Disclose without client consent only if legally unavoidable.
B. Inform client adequately about content and implications of potential disclosures.
C. Obtain and document the client's consent before disclosing.
IV. Respond Ethically to Legally Imposed Disclosure Situations
A. Notify client of pending legal requirement for a disclosure without client's consent.
B. Respond to each type of law according to plan (from Step I–E above):
1. Laws requiring psychologists to initiate disclosures (e.g., reporting laws)
2. Laws giving others access to information without client consent
3. Exceptions to psychologist–client privilege in court cases
4. Laws allowing others to redisclose information that psychologists disclose
C. Limit disclosure of confidential information to the extent legally possible.
V. Avoid the "Avoidable" Breaches of Confidentiality
A. Avoid making unethical exceptions to the confidentiality rule.
B. Establish and maintain protective policies and procedures; train nonclinical staff.
C. Monitor note taking and record keeping practices.
D. Avoid dual roles that create conflicts of interest in courtroom and elsewhere.
E. Anticipate legal demands; empower clients to act protectively in their own behalf.
F. Protect client identity in presentations, research, and consultations.
G. Prepare a professional will to protect client confidentiality in event of illness or death.
VI. Talk About Confidentiality
A. Model ethical practices; confront others' unethical practices.
B. Provide peer consultation about confidentiality ethics.
C. Teach ethical practices to students, supervisees, employees, and agency.
D. Educate attorneys, judges, consumers, and the public.

and responding ethically when faced with legal demands for confidential information (Step 4). Step 1 is thus necessarily implied by the APA Ethics Code.

Steps 2 through 5 of this model define "The Ethics of Conditional Confidentiality," which requires an understanding of both the rule and its exceptions. According to the APA Ethics Code, psychologists have only three ethically available doors to disclosure: client consent, legal mandate, and legal permission (Behnke, 2004; Behnke, 2007b; Behnke & Kinscherff, 2002). The "client consent" door is addressed in Step 2 (obtaining prospective clients' consent to accept foreseeable limits

of confidentiality as a condition of receiving services), in Step 3 (obtaining consent for subsequent voluntary disclosures), and in Step 5 (avoiding voluntary disclosures for which no consent was obtained). The "legal mandate" door (which can involve "involuntary" disclosures without the client's consent) is the focus of Step 4. The "legal permission" door is discussed under Step 3, and cautions about it are described further in Step 5.

Step 6 incorporates ethical responsibilities about professional relationships, not client relationships. It includes ethical mandates about training, supervision, consultation, and peer monitoring. It also includes education of the public, no longer mandated by the Ethics Code.

The simplicity of this outline belies the difficulty of actually carrying out the ethically required tasks. This practice model represents psychologists' *ongoing* ethical obligations about confidentiality; but for resolving ethical dilemmas that might arise at any step along the way, psychologists are advised to employ a structured decision-making process (Barnett, Behnke, Rosenthal, & Koocher, 2007). Many ethical decision-making models are available (Cottone & Claus, 2000). Regardless of the model chosen, however, an early stage in the decision-making process involves clarifying the relevant ethical mandates. (See, e.g., Step 1 in the 5-step model in Knapp & VandeCreek, 2006; Steps 1 and 2 in the 9-step model by Koocher & Keith-Spiegel, 1998; and Step 5 in the 18-step model by Pope & Vasquez, 2007.) Clarifying one's ethical obligations about confidentiality is precisely the purpose of this practice model.

Using the Confidentiality Practice Model

Step 1: Preparation

It is impossible for psychologists to inform clients about confidentiality's limits without first informing themselves. This requires both information gathering and personal decision making. Clarifying one's ethical position about confidentiality involves more than knowing the words of one's Ethics Code. It requires a balancing of competing values (Behnke, 2001) and a willingness to grapple with the consequences of following one's personal moral principles (Knapp, Gottlieb, Berman, & Handelsman, 2007). It involves a weighing of demands arising from clinical considerations, agency policies, and federal, state, and local laws (Behnke, 2007a; Hansen & Goldberg, 1999).

In other words, to be prepared for honest conversations with prospective clients, psychologists must take ethical responsibility for doing some legal homework and engaging in some personal soul searching: "Am I willing to risk the legal and financial consequences of disobeying this law in order to protect confidences?" and if not, "Exactly when might this law require me to disclose something against the client's wishes, and to whom?" Psychologists must not only decide what they *should* do in a variety of such foreseeable situations—a difficult-enough task—but they must also be prepared to give prospective clients an honest description of what they actually *will* do, which may be different (Smith, McGuire, Abbott, & Blau, 1991).

Step 1 is difficult to implement alone. The legal information can be hard to obtain and harder to decipher. State associations could facilitate this preparation by placing legal updates into ethical context, using the categories from Step 4 of the practice model. Ethics texts are a valuable resource because they address both confidentiality and ethical decision making. (See, e.g., Haas & Malouf, 2002; Kitchener, 2000; Knapp & VandeCreek, 2006; Koocher & Keith-Spiegel, 1998; O'Donohue & Ferguson, 2003; Pope & Vasquez, 2001.)

Consultation is important at any stage, but it was included at Step 1 because it is far better to ask questions in advance, not in the midst of a confidentiality crisis. Psychologists are now responsible for developing individualized policies that both protect clients' rights and protect themselves from liability, and that is a difficult task alone. Bennett et al. (1990) considered peer consultation "one of the important resources for maintaining and enlarging competence" (p. 26). About a topic as anxiety-provoking as confidentiality, psychologists need to develop, in advance, safe places to obtain advice and support in a future crisis. Ethics consultation can be obtained from the APA Ethics Office, from state professional associations, and from respected colleagues. At this planning stage, legal consultation should be obtained only after the ethical issues are clarified. Attorneys are experts about laws; but psychologists must be experts about the ethics of their own profession and should be prepared to ask their legal questions from that perspective.

Finally, all that has been learned and decided must be reduced to a simple statement about confidentiality and its limits, including both the voluntary limits imposed in one's setting and the limits that can be imposed by law. It should be written in language that clients can understand. No "canned" form will suffice, because it must be personalized to reflect each psychologist's actual intentions. The Ethics Code does not require this to be in writing, but that is strongly recommended (see Step 3); and HIPAA legally requires a written "Notice of Privacy Practices."

Step 2: Telling Clients the Truth "Up Front"

The initial informed-consent interview is the first—and sometimes the only—opportunity to protect the confidentiality rights of clients whose confidences may later be unprotectable. In the therapy setting, the psychologist must (a) inform each prospective client about the potential limits of confidentiality and the foreseeable uses of the information that might be gathered, and then (b) obtain the informed client's consent to accept those limits, as a condition of receiving psychological services. The APA (2002) Ethics Code requires that the conversation cover "limits of confidentiality" (Ethical Standard 10.01, Informed Consent to Therapy, p. 1072) in language "reasonably understandable to that person" (Ethical Standard 3.10, Informed Consent, p. 1065), and with "sufficient opportunity for the client to ask questions and receive answers" (Ethical Standard 10.01, Informed Consent to Therapy, p. 1072).

For minors, and for adults who are legally incapable of giving informed consent, it is ethically important to obtain their "informed assent." According to Ethical Standard 3.10b (Informed Consent), this involves providing an appropriate explanation, seeking their assent, and considering their preferences and best interests while also obtaining "appropriate permission from a legally authorized person" (p. 1065) when permitted or required by law. Since state laws differ about minors' rights to independently consent to mental health treatment, and since HIPAA has further complicated minors' legal rights about confidentiality, obtaining legal consultation may be necessary (APA Legal and Regulatory Affairs Staff, 2005).

As indicated in Table 1, other ethical standards also have implications for informed consent. With multiclient interventions, third-party referrals, or agency services, it is especially important to clarify client status and verify confidentiality rules for each participant (see Ethical Standards 3.07, Third Party Requests for Services; 3.11, Psychological Services Delivered to or Through Organizations; 10.02, Therapy Involving Couples or Families; and 10.03, Group Therapy).

The content of this initial conversation will vary, because the potential limits of confidentiality vary from state to state and from setting to setting within each state. At the process level, however, certain considerations will apply everywhere:

Timing. A conversation about confidentiality's limits must take place "at the outset of the relationship" (Ethical Standard 4.02, Discussing the Limits of Confidentiality, p. 1066) and "as early as is feasible" (Ethical Standard 10.01, Informed Consent, p. 1072)—in other words, before prospective clients present sensitive personal material that might later be disclosed without their consent.

Honesty. This conversation offers clients their best (and possibly only) opportunity to protect their own rights, so it is ethically essential that psychologists not make (or by silence imply) confidentiality promises that will not be kept. Informing clients protects their autonomy, allowing them to exercise their right to decide whether to consent and confide, or whether instead to exercise their right to "informed refusal" of services. It can be tempting to avoid discussion of the implications of some potential disclosures. However, as noted by a former APA Ethics Committee chair in the early days of managed care, "If a treating therapist fails to provide important information which might affect a potential client's decision to enter therapy . . . then he is not helping that individual to make a well-informed choice" (Nagy, 1993, p. 5).

Clarity. Using simple language, the psychologist should begin the conversation with a statement of the rule; otherwise it will be obscured by its exceptions. Psychologists are ethically free to recite the old mantra "Everything you tell me will remain in this room" only if they are prepared to accept the personal, legal, and financial consequences of civil disobedience. But all psychologists can still honestly say, "As a rule, I will disclose no information without your consent," as long as they follow this statement by describing the exceptions to that rule—the "limits of confidentiality" in their setting. For clarity, these can be listed in two separate categories as (a) disclosures required by law and (b) setting-specific voluntary disclosures (e.g., to answering services, billing services, on-call colleagues, parents of minor clients). The rule and its exceptions can fit on a single page. The long forms provided in legal workshops (including HIPAA forms) can be simplified to include only the exceptions that will actually apply in the particular setting. For the protection of both client and clinician, it is recommended that this take the form of a written contract on which clients' signatures indicate both that they were informed (i.e., they received a "Notice of Privacy Practices") and that they consent to accept the stated confidentiality limits as a condition of receiving services (Harris & Bennett, 1998; Pope & Vasquez, 2007).

Repetition. This conversation must be reopened whenever "new circumstances may warrant" (Ethical Standard 4.02, Discussing the Limits of Confidentiality, p. 1066). This could include changes in the client's own circumstances (as when entering a custody battle), legal changes (new state laws), changes in the psychologist's policies, or any other circumstance that risks disclosure or reduces the level of confidentiality promised during the initial conversation.

Step 3: Obtaining Truly Informed Consent Before Disclosing Anything Voluntarily

Here, the model directly reflects the ethical requirement to obtain the client's consent (Ethical Standard 4.05, Disclosures). Ethically speaking, it is important to distinguish the voluntary disclosures of this step from the "involuntary" disclosures of Step 4. Step 3 of the model deals only with disclosures the psychologist is legally free not to make, and for which the client is free to withhold consent, and therefore for which obtaining client consent is ethically required. In contrast, Step 4 covers legally compelled disclosures, which may be made whether or not the psychologist wants to disclose and even if the client objects.

Included here are disclosures that, although not legally required, are legally permitted. State laws and HIPAA regulations allow many disclosures without client consent, including disclosures for obtaining reimbursement for services. The APA (2002) Ethics Code treats such legally allowed disclosures as ethically allowed exceptions to the confidentiality rule (Ethical Standard 4.05, Disclosures). However, this raises hard ethical questions about consent (Behnke & Kinscherff, 2002). Since they are not legally required, these legally allowed disclosures are considered "voluntary" within this model. Obtaining client consent is recommended at intake (Step 2) and/or at the time of disclosure (Step 3) in order to avoid disclosures without consent whenever possible. (See further discussion in Step 5.)

The term *truly informed* is a reminder that this involves more than obtaining a signature on a consent form. It includes a conversation about the nature and extent of the information to be disclosed as well as any foreseeable negative implications of disclosing it. Obtaining "informed assent" from minors is as important at this stage as it was in Step 2.

Pope and Vasquez (2001) suggested that the most frequent error in obtaining consent for voluntary disclosure is the failure to obtain it in writing. Although not explicitly required by the Ethics Code, written consent is recommended in the APA Guidelines for Providers of Psychological Services (APA Board of Professional Affairs, 1987) and by the APA Insurance Trust (Bennett et al., 1990) and is required by some state laws.

Step 4: Responding Ethically to Legal Demands

This practice model protects several client rights about legally imposed disclosures. Step 1 requires psychologists to learn and understand laws that affect clients' confidentiality rights. Step 2 protects (a) the client's right to be informed in advance about legally mandated disclosures and (b) the right, once so informed, to give or withhold consent to receive services on these terms. Step 4 protects an implied right: (c) the right to expect the psychologist to respond ethically to legal demands, by protecting confidentiality to the extent legally possible.

Since legal demands can be contested, it is ethically important to avoid premature disclosures. Ethical Standard 1.02 (Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority) requires psychologists in all roles and settings to "make known their commitment to the Ethics Code and take steps to resolve the conflict" (APA, 2002, p. 1063). In conflicts that pit their legal requirements against their personal ethical values, psychologists can use a structured process for deciding whether to "follow the law despite their ethical concerns" or whether "a conscientious objection is warranted" (Knapp et al., 2007, p. 54). (Few psychologists choose to incur the risks of civil disobedience in order to protect a client's confidentiality, but it should be noted that refusal to disclose can sometimes lead to more protective confidentiality laws, as in *Jaffee v. Redmond,* 1996.)

At this step of the model, psychologists must insert the legal specifics that apply in their own settings, including state laws that limit their ability to maintain confidentiality. These legally imposed exceptions to the confidentiality rule can be organized into four categories, each requiring different preparation in Step 1, because each requires a different response in Step 4:

Laws requiring psychologists to initiate a breach of confidentiality. State laws can require psychologists to initiate reports of such things as suspected abuse of a child or of an aged/incapacitated adult and unprofessional conduct by a licensed peer professional. (Some "duty to protect" statutes also fall into this category; but unlike reporting laws, they may allow psychologists to avoid a breach of confidentiality if they can ensure safety through other means.) Some states also require reports if one is treating a licensed mental health professional whose condition might place clients at risk. One way to limit the scope of such disclosures is to start with a "hypothetical" report, protecting the client's identity while determining whether a report is actually legally required in the situation. If made, the report should contain only the information necessary for that purpose.

Laws allowing others to obtain access to client information. In certain circumstances, others can legally obtain access to records without the client's consent. For example, depending on the state's laws, records of a minor child may be legally available to parents or accessible without parental consent if the minor is being evaluated for involuntary commitment. In many states, court-appointed special advocate (CASA) volunteers are given legal access to the records of minors in abuse or neglect cases. In most such circumstances, the psychologist can attempt to limit the disclosure (e.g., by agreeing to provide an oral or written summary appropriate to the circumstance, rather than providing the records).

Legal exceptions to therapist–patient privilege. In every state, the therapist–patient relationship is given some level of protection in court cases; but all such privilege laws contain exceptions that allow a psychologist's records or testimony to be admitted as evidence in certain circumstances. Exceptions to privilege have always varied widely from state to state (Knapp & VandeCreek, 1987). However, regardless of state or setting, it is ethically and legally important for psychologists not to treat an attorney's discovery subpoena as if it had the legal authority of a court order. Failure to make this distinction places clients' confidences at risk unnecessarily; and this in turn can raise ethical (and in some states, legal) risks for the psychologist (Bennett et al., 2006). As described by the APA Committee on Legal Issues (1996), in the absence of client consent, the appropriate response to a discovery subpoena is to file a motion to quash it, thereby requiring a judge to determine whether the information can be legally protected.

It is also important to distinguish the professional roles in which privilege applies and must be protected (e.g., client–therapist relationships) from those roles in which the client must waive privilege in the initial informed consent interview (e.g., custody evaluations and other forensic assessments). Confidentiality complications will foreseeably arise if psychologists are confused about roles or engage in multiple roles in forensic situations (e.g., see APA Committee on Professional Practice and Standards, 1994; Weithorn, 1987). (Also see discussion in Step 5.)

Laws allowing others to redisclose the information psychologists disclose. All disclosures of identifiable client information should bear a notice: "Confidential. Not to Be Re-Released." In states where redisclosure is illegal, quoting the relevant statute gives legal weight to the warning. However, once information is released, both client and psychologist lose control over redisclosure. That is why the initial discussion of confidentiality (Step 2) should include the implications of this limitation on confidentiality, including the risk that a third-party payer may be legally allowed to disclose to employers or transfer information into national databases.

Step 5: Avoiding the Avoidable Breaches of Confidentiality

This step serves as a reminder that most behavior about confidentiality still remains entirely within the psychologist's control. As used here, the term *avoidable* refers to voluntary disclosures without client consent in the absence of any legal requirement to disclose.

This includes informal disclosures and gossip (to family or friends; in social settings); appropriate conversations in inappropriate places (e.g., peer consultations in hallways or public restaurants); potentially appropriate disclosures without appropriate consent (e.g., disclosing sensitive personal information to a prescribing physician without client consent); overdisclosures (e.g., disclosing beyond what the client authorized, or beyond what is needed in the circumstance); disclosures triggered by "technology glitches"; and so forth. Such breaches are avoidable. They place clients at risk and thereby place psychologists at risk.

This step is also a reminder that role confusion can lead to unnecessary disclosures and confidentiality conflicts that are both clinically destructive and ethically impossible to resolve. Confidentiality issues arise when psychologists multiply roles, become confused about their role(s) in a given case, or fail to answer the question "Who is the client?" In multiclient therapies, child custody situations, and third-party referrals, a better question might be, "What are my ethical obligations to *each* of the parties involved, especially as they affect confidentiality?"

Staff training is an important component of Step 5. Ethical Standard 2.05 (Delegation of Work to Others) requires psychologists to "take reasonable steps to . . . see that such persons perform these services competently" (p. 1064). The practice model can be useful for providing ethics-based training about psychologists' confidentiality obligations; using that structure, the HIPAA-required workforce training can be placed into ethical context within Step 5. Confidentiality training should be available to both clinical and nonclinical personnel, and especially those new to the setting. (State laws vary, as do voluntary policies across settings; disclosures acceptable in a previous setting may not be appropriate in the current setting.) Knapp and VandeCreek (2006) suggested that "the most effective way to prevent breaches of confidentiality is to ensure a 'culture of safety' in which confidentiality is viewed as everyone's responsibility" (p. 115).

Finally, Step 5 is a reminder that managed care creates no new ethically allowed exceptions to the rule of confidentiality. The unfortunate figure–ground reversal (Beck, 1990) is very visible in this area of practice, where disclosures without informed consent have become the rule rather than the exception. With advances in technology, clinicians have become dangerously accustomed to routine electronic transmission of private and sensitive client information, often without adequately informing clients of the content or obtaining their informed consent to disclose it. Psychologists may experience their extensive disclosures via treatment plans as "involuntary" (i.e., "financially coerced") disclosures. Ethically speaking, however, disclosures for reimbursement are voluntary; so unlike the legally coerced disclosures of Step 4, they require the client's truly informed consent. As described in Step 3, HIPAA and some state laws allow (but never require) disclosures for this purpose without specific consent from the client. Ethically, however, client consent is required. The initial informed consent conversation (Ethical Standard 6.04, Fees and Financial Arrangements) should include discussion of disclosures required for reimbursement purposes (Acuff et al., 1999; Nagy, 1993). However, since it is impossible at intake to predict the content of future disclosures, the "usual rule of thumb" should be to discuss the treatment plans at the time of transmission (Acuff et al., 1999, p. 570).

Step 6. Talking About Confidentiality

With this practice model as a shared ethical language, practicing psychologists can obtain clearer continuing education and engage in more effective peer consultation about this difficult aspect of practice. This structure can also be helpful when confronting colleagues who do not adequately protect their clients' confidentiality rights. (See Ethical Standards 1.04, Informal Resolution of Ethical Violations; and 1.05, Reporting Ethical Violations.)

For training purposes, the six steps of the practice model can be taught separately; but the model as a whole clarifies how the apparently unconnected ethical mandates fit together to form an integrated whole. For example, consider how the model might be used in a graduate clinical training program for teaching confidentiality ethics as it applies to managed care: Step 1 requires careful reading of provider contracts, to clarify disclosure provisions; Step 2 covers the initial discussion with clients about disclosures that are required for obtaining reimbursement; Step 3 is a reminder that treatment plans are voluntary disclosures that require client consent; and Step 5 requires security in the storage and transmission of reimbursement-related information.

HIPAA training becomes less confusing within this practice model, because it is easy to clarify how those legal regulations overlap with the profession's ethical obligations. For example, the "Notice of Privacy Practices" required by the HIPAA Privacy Rule fits neatly into Step 2; and the HIPAA Security Rule simply adds more details to the ethical mandates in Step 5.

Confidentiality is a topic that raises no turf issues, so psychologists can use the practice model to lead the way with multidisciplinary ethics-based confidentiality training. It can also facilitate conversations with attorneys and judges, who are confused by why psychologists change confidentiality rules when they change roles. Finally, it can be useful in educating consumers and the public about the need for legislative reform to protect confidentiality rights.

Implications

The profession's ethicists had difficulty deciding what to say about confidentiality in the 1970s, and 30 years later, psychologists still have difficulty understanding their ethi-

cal obligations about it. Psychologists will "reach for the ethical ceiling" about confidentiality only if they have a sturdy ethical floor on which to stand. This ethics-based organizing schema can serve that purpose.

Conversations about confidentiality can be enhanced by the existence of an ethical outline that applies to all psychologists regardless of state laws, practice settings, or professional roles. Psychologists can use this practice model to place legal mandates into ethical perspective, to frame ethical questions more clearly, to seek consultation more confidently, and to protect clients' confidentiality rights more effectively. In short, psychologists can use this practice model to reclaim their status as experts about the confidentiality ethics of their profession.

REFERENCES

Acuff, C., Bennett, B. E., Bricklin, P. M., Canter, M. B., Knapp, S. J., Moldawsky, S., & Phelps, R. (1999). Considerations for ethical practice in managed care. *Professional Psychology: Research and Practice, 30,* 563–575.

American Psychological Association. (1953). *Ethical standards of psychologists.* Washington DC: Author.

American Psychological Association. (1959). Ethical standards of psychologists. *American Psychologist, 14,* 279–282.

American Psychological Association. (1963). Ethical standards of psychologists. *American Psychologist, 18,* 56–60.

American Psychological Association. (1968). Ethical standards of psychologists. *American Psychologist, 23,* 357–361.

American Psychological Association. (1979). *Ethical standards of psychologists.* Washington, DC: Author.

American Psychological Association. (1981). Ethical principles of psychologists. *American Psychologist, 36,* 633–638.

American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). *American Psychologist, 45,* 390–395.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060–1073.

American Psychological Association Board of Professional Affairs, Committee on Professional Standards. (1987). Guidelines for providers of psychological services. *American Psychologist, 42,* 712–723.

American Psychological Association Committee on Legal Issues. (1996). Strategies for private practitioners coping with subpoenas or compelled testimony for client records or test data. *Professional Psychology: Research and Practice, 29,* 245–251.

American Psychological Association Committee on Professional Practice and Standards. (1993). Record keeping guidelines. *American Psychologist, 48,* 984–986.

American Psychological Association Committee on Professional Practice and Standards. (1994). Guidelines for child custody evaluations in divorce proceedings. *American Psychologist, 49,* 677–680.

American Psychological Association Committee on Professional Practice and Standards. (1998). *Guidelines for psychological evaluations in child protection matters.* Washington, DC: Author. (Available at http://www.apa.org/practice/childprotection.html)

American Psychological Association Committee on Professional Practice and Standards. (2007). Record keeping guidelines. *American Psychologist, 62,* 993–1004.

American Psychological Association Committee on Psychological Tests and Assessment. (1996). Statement on the disclosure of test data. *American Psychologist, 51,* 644–648.

American Psychological Association Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force. (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist, 55,* 1440–1451.

American Psychological Association Ethics Committee. (1988). Trends in ethics cases, common pitfalls, and published resources. *American Psychologist, 43,* 564–572.

American Psychological Association Ethics Committee. (1997). *APA statement on services by telephone, teleconferencing, and internet.* Retrieved July 23, 2007, from http://www.apa.org/ethics/stmnt01.html

American Psychological Association Ethics Committee. (2001). Report of the Ethics Committee, 2000. *American Psychologist, 56,* 680–688.

American Psychological Association Ethics Committee. (2002). Report of the Ethics Committee, 2001. *American Psychologist, 57,* 646–653.

American Psychological Association Ethics Committee. (2003). Report of the Ethics Committee, 2002. *American Psychologist, 58,* 650–657.

American Psychological Association Ethics Committee. (2005). Report of the Ethics Committee, 2004. *American Psychologist, 60,* 523–528.

American Psychological Association Legal and Regulatory Affairs Staff. (2005). *A matter of law: Privacy rights of minor patients.* Retrieved July 23, 2007, from http://www.apapractice.org/apo/insider/practice/pracmanage/legal/minor.html#

American Psychological Association Working Group on the Older Adult. (1998). What practitioners should know about working with older adults. *Professional Psychology: Research and Practice, 29,* 413–427.

Barnett, J. E., Behnke, S. H., Rosenthal, S. L., & Koocher, G. P. (2007). In case of ethical dilemma, break glass: Commentary on ethical decision making in practice. *Professional Psychology: Research and Practice, 38,* 7–12.

Beck, J. C. (1990). The basic issues. In J. C. Beck (Ed.), *Confidentiality versus the duty to protect: Foreseeable harm in the practice of psychiatry* (pp. 1–8). Washington, DC: American Psychiatric Press.

Beeman, D. G., & Scott, N. A. (1991). Therapists' attitudes toward psychotherapy informed consent with adolescents. *Professional Psychology: Research and Practice, 22,* 230–234.

Behnke, S. (2001, October). Ethics matters: A question of values. *Monitor on Psychology, 32,* 86.

Behnke, S. (2004, September). Ethics rounds: Disclosures of confidential information under the new APA Ethics Code: A process for deciding when and how. *Monitor on Psychology, 35,* 78–79.

Behnke, S. (2005a, April). Ethics rounds: Disclosing confidential information in consultations and for didactic purposes. *Monitor on Psychology, 36,* 76–77.

Behnke, S. (2005b, December). Ethics rounds: Letter from a reader regarding a minor client and confidentiality. *Monitor on Psychology, 36,* 78–79.

Behnke, S. (2007a, February). Ethics rounds: Adolescents and confidentiality: Letter from a reader. *Monitor on Psychology, 38,* 46–47.

Behnke, S. (2007b, April). Disclosures of information: Thoughts on a process. *Monitor on Psychology, 38,* 62–63.

Behnke, S. H., & Kinscherff, R. (2002, May). Must a psychologist report past child abuse? *Monitor on Psychology, 33,* 90–91.

Behnke, S. H., & Warner, E. (2002, March). Confidentiality in the treatment of adolescents. *Monitor on Psychology, 33,* 44–45.

Bennett, B. E., Bricklin, P. M., Harris, E., Knapp, S., VandeCreek, L., & Younggren, J. N. (2006). *Assessing and managing risk in psychological practice: An individualized approach.* Rockville, MD: American Psychological Association Insurance Trust.

Bennett, B. E., Bryant, B. K., VandenBos, G. R., & Greenwood, A. (1990). *Professional liability and risk management.* Washington, DC: American Psychological Association.

Bersoff, D. N. (1994). Explicit ambiguity: The 1992 ethics code as an oxymoron. *Professional Psychology: Research and Practice, 25,* 382–387.

Bollas, C., & Sundelson, D. (1995). *The new informants: The betrayal of confidentiality in psychoanalysis and psychotherapy.* Northvale, NJ: Jason Aronson.

Cottone, R. R., & Claus, R. E. (2000). Ethical decision-making models: A review of the literature. *Journal of Counseling & Development, 78,* 275–283.

Crowe, M. B., Grogan, J. M., Jacobs, R. R., Lindsay, C. A., & Mark, M. M. (1985). Delineation of the roles of clinical psychology: A survey of practice in Pennsylvania. *Professional Psychology: Research and Practice, 16,* 124–137.

Everstine, L., Everstine, D. S., Heymann, G. M., True, R. H., Frey, D. H., Johnson, H. G., & Seiden, R. H. (1980). Privacy and confidentiality in psychotherapy. *American Psychologist, 35,* 828–840.

Fisher, C. B. (2003). *Decoding the ethics code.* Thousand Oaks, CA: Sage.

Fisher, M. A. (2002, October). Ethical issues [Letter to the editor]. *Monitor on Psychology, 33,* 8.

Haas, L. J., & Malouf, J. L. (2002). *Keeping up the good work: A practitioner's guide to mental health ethics* (2nd ed.). Sarasota, FL: Professional Resource Press.

Haas, L. J., Malouf, J. L., & Mayerson, N. H. (1986). Ethical dilemmas in psychological practice: Results of a national survey. *Professional Psychology: Research and Practice, 7,* 316–321.

Hall, J. E., & Hare-Mustin, R. T. (1983). Sanctions and the diversity of ethical complaints against psychologists. *American Psychologist, 37,* 714–729.

Hansen, N. D., & Goldberg, S. G. (1999). Navigating the nuances: A matrix of considerations for ethical–legal dilemmas. *Professional Psychology: Research and Practice, 30,* 495–503.

Hare-Mustin, R. T., Marecek, J., Kaplan, A. G., & Liss-Levinson, N. (1979). Rights of clients, responsibilities of therapists. *American Psychologist, 34,* 3–16.

Harris, E., & Bennett, B. (1998). Sample psychotherapist–patient contract. In J. Koocher, J. Norcross, & S. Hill (Eds.), *Psychologists' desk reference* (2nd ed., pp. 635–640). New York: Oxford University Press.

Jaffee v. Redmond, 518 U.S. 1 (1996).

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

Kalichman, S. C. (1993). *Mandated reporting of suspected child abuse.* Washington, DC: American Psychological Association.

Keith-Spiegel, P. (1994a). The 1992 ethics code: Boon or bane? *Professional Psychology: Research and Practice, 25,* 315–316.

Keith-Spiegel, P. (1994b). Teaching psychologists and the new APA ethics code: Do we fit in? *Professional Psychology: Research and Practice, 25,* 362–368.

Kitchener, K. S. (2000). *Foundations of ethical practice, research, and teaching in psychology.* Mahwah, NJ: Erlbaum.

Knapp, S., Gottlieb, M., Berman, J., & Handelsman, M. M. (2007). When laws and ethics collide: What should psychologists do? *Professional Psychology: Research and Practice, 38,* 54–59.

Knapp, S., & VandeCreek, L. (1987). *Privileged communications in the mental health professions.* New York: Van Nostrand Reinhold.

Knapp, S., & VandeCreek, L. (2003). *A guide to the 2002 revision of the American Psychological Association's ethics code.* Sarasota, FL: Professional Resource Press.

Knapp, S. J., & VandeCreek, L. (2006). *Practical ethics for psychologists: A positive approach.* Washington, DC: American Psychological Association.

Koocher, G. P., & Keith-Spiegel, P. (1998). *Ethics in psychology: Professional standards and cases* (2nd ed.). New York: Oxford University Press.

Montgomery, L. M., Cupit, B. E., & Wimberley, T. K. (1999). Complaints, malpractice, and risk management: Professional issues and personal experiences. *Professional Psychology: Research and Practice, 30,* 402–410.

Nagy, T. F. (1993, September/October). Applying the new ethics code to practice. *The National Psychologist,* 5–6.

Nagy, T. F. (2005). *Ethics in plain English: An illustrative casebook for psychologists* (2nd ed.). Washington DC: American Psychological Association.

O'Donohue, W., & Ferguson, K. (Eds.). (2003). *Handbook of professional ethics for psychologists: Issues, questions, and controversies.* Thousand Oaks, CA: Sage.

Pope, K. S., & Bajt, T. R. (1988). When laws and values conflict: A dilemma for psychologists. *American Psychologist, 43,* 828–829.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42,* 993–1006.

Pope, K. S., & Vasquez, M. J. T. (1991). *Ethics in psychotherapy and counseling: A practical guide for psychologists.* San Francisco: Jossey Bass.

Pope, K. S., & Vasquez, M. J. T. (2001). *Ethics in psychotherapy and counseling: A practical guide for psychologists* (2nd ed.). San Francisco: Jossey Bass.

Pope, K. S., & Vasquez, M. J. T. (2007). *Ethics in psychotherapy and counseling: A practical guide for psychologists* (3rd ed.). San Francisco: Jossey Bass.

Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association: A national survey. *American Psychologist, 47,* 397–411.

Siegel, M. (1976, Fall). Confidentiality. *The Clinical Psychologist* [Newsletter of Division 12 of the American Psychological Association], *30,* 1; 23.

Smith, T. S., McGuire, J. M., Abbott, D. W., & Blau, B. I. (1991). Clinical ethical decision making: An investigation of the rationales used to justify doing less than one believes one should. *Professional Psychology: Research and Practice, 22,* 235–239.

Somberg, D. R., Stone, G. L., & Claiborn, C. D. (1993). Informed consent: Therapists' beliefs and practices. *Professional Psychology: Research and Practice, 24,* 153–159.

Sonne, J. L. (1994). Multiple relationships: Does the new ethics code answer the right questions? *Professional Psychology: Research and Practice, 25,* 336–343.

Tarasoff v. Regents of the University of California, 13 Cal. 3d 177, 529 P. 2d 553 (1974, *vacated*), 17 Cal. 3d 425, 551 P. 2d 334, 131 Cal. Rptr. 14 (Cal. 1976).

Vasquez, M. J. T. (1994). Implications of the 1992 ethics code for the practice of individual psychotherapy. *Professional Psychology: Research and Practice, 25,* 321–328.

Weithorn, L. S. (1987). Psychological consultation in divorce custody litigation: Ethical considerations. In L. A. Weithorn (Ed.), *Psychology and child custody determinations: Knowledge, roles, and expertise* (pp. 183–209). Lincoln: University of Nebraska Press.