

Confidentiality and Family Therapy: Cultural Considerations

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Abstract: Maintaining confidentiality in family and couple's therapy can prove to be complicated due to the involvement of multiple parties; there are multiple avenues for problems to arise, and it is imperative for therapists to be able to decide when they should keep secrets and when they're justified in breaching confidentiality. To add to this dilemma, therapists must also take into account individual personalities, which includes but is not limited to cultural differences between therapists and clients. As such, the purpose of the current paper is to determine the extent that culture influences marriage and family therapists' understanding of their duties and responsibilities related to issues around confidentiality, as well as clients' perceptions and understanding of confidentiality. Upon research, it became apparent that there is a dearth of information exploring clients' perceptions and understanding of confidentiality. Furthermore, there is a lack of research taking into account how cultural components may influence a client's willingness to disclose, as well as how therapists' decisions may differ based on their own culture, or that of their clients. Thus, this literature review presents the need for additional refined research in (1) decision making in confidentiality as it relates to Western and non-Western therapists, (2) how non-Western clients view the confidentiality process, and (3) how ones' culture can influence their beliefs.

Keywords: confidentiality, family therapy, couples therapy, secrets.

Confidentiality in marital and family therapy can be complicated due to the various parties involved (Shaw, 2015; Younggren & Harris, 2008). As such, the American Psychological Association (APA) and American Association of Marriage and Family Therapy (AAMFT) recommend that policies concerning confidentiality be discussed at the beginning of therapy during the informed consent process. More specifically, the AAMFT code of ethics (2001), section 2.2, states "a therapist is not allowed to reveal any individual's confidence in the system-oriented therapy setting without the prior written permission of that individual" (Kuo, 2009; p. 352). Gottlieb (1996) described four conceptually distinct variations of confidentiality that could be used with couples or families: 1) treat information disclosed individually as confidential; 2) inform each client that no information is confidential; 3) allow certain information to remain confidential as a matter of personal privacy; or 4) agree to allow certain information to be temporarily kept confidential, with the stipulation that it must be disclosed at a later time. Deciding which of these approaches to use is not an exercise to be

taken lightly; it may have very serious implications depending on the client (or family/couple) scenario. For instance, a couple's therapist who is informed by one of the partners that he or she is having an affair may approach the problem differently depending on the type of confidentiality approach said therapist engages in. Thus, in cases of couple and family treatment, the therapist should outline the rules of treatment, defining who the patients are, as well as confidentiality and any limitations (Younggren & Harris, 2008).

The purpose of this review is to determine the extent to which culture influences marriage and family therapists' understanding of their duties and responsibilities related to issues around confidentiality, as well as clients' perceptions and understanding of confidentiality. This paper expands the current knowledge in this area by considering the role of culture on the therapist's decision to disclose as well as differences related to culture around clients' feelings and expectations for privacy in therapy. Presently, there are no legal or professional ethics that directly address the issue of cultural mismatch

between clients (or therapists) and the Western concept of confidentiality.

1. LITERATURE REVIEW

The following review of the literature focuses on ethical dilemmas related to confidentiality including how to handle family secrets and therapists' breach of confidentiality. Unfortunately, only one of the studies reviewed examined the manner in which clients' culture impacted the confidentiality process (Monshi & Zieglmayer, 2004); thus, the present study seeks to address this issue by considering the role of culture on the therapist's decision to disclose as well as differences related to culture around clients' feelings and expectations for privacy in therapy. The subsequent sections review the literature related to confidentiality dilemmas in counseling including how to handle family secrets and the therapists' decision to breach confidentiality agreement.

2. KEEPING SECRETS

As mentioned above, one of the issues faced by therapists relates to whether or not secrets should be kept. Butler, Rodriguez, Roper, and Feinauer (2010) examined therapists' perceptions of the impact of infidelity secrets in couple therapy. Therapists' ($N = 148$) attitudes were surveyed concerning the relational impact of infidelity secrets and their judgments concerning how they should be handled in therapy. The sample comprised of primarily marriage and family therapists, psychologists, or social workers, 57% of which were male. Participants were 46 years old on average ($SD = 13.35$; range = 22-75 years) with an average of 13 years of experience ($SD = 10.73$; range = 0-43 years). Of the sample, 77% were listed as Caucasian, while African American, Hispanic, Asian, American Indian, and Other comprised 23% without the specific breakdown of each ethnic group. Participants completed a survey that explored their attitudes regarding how infidelity secrets along with the therapists' judgement could impact the relationship, as well as how they should be handled if they do arise in therapy. The results indicated that overall, relational therapists' supported facilitated disclosure of infidelity, so long as it was in an informed and voluntary manner. Additionally, the therapists felt that healing and attachment security were optimally achieved through disclosure.

Jansen's (2007) study also examined couple therapists' perceptions of secrets in therapy. Accordingly, their exploratory study sought to

investigate how therapists handle secrets in couple's therapy; in particular, whether they maintain the secret or disclose it, how the issue of secrets is addressed in the informed consent process, and whether they obtain a release from the client to disclose the secret. The sample consisted of 160 randomly selected clinical members of the American Association for Marriage and Family Therapists (AAMFT), with an average age of 54 years old. In order to be eligible for the study, participants had to 1) practice in California, Florida, Illinois, New York, or Texas; 2) have had experience working with a minimum of 25 couples; and 3) be clinical members of AAMFT. Of the 160 participants, 61% were female; 91% were Caucasian, 3% African American, 2% Hispanic, 1% Asian, and 3% other; and 66% possessed Master's degrees and 34% had their doctorates. Participants were mailed a 38-item investigator-developed survey pertaining to how therapists handled secrets in therapy. Findings revealed that therapists spent a great deal of time deciding how to handle secrets, used a "professional judgment" approach, and informed clients verbally of their confidentiality policy. Results also revealed that 25% of the sample noted that a couple was unhappy or expressed concern over the manner in which a secret was handled and that the approach used to deal with the secret was not predictive of the number of complaints lodged. While the study is marked by a number of strengths (i.e., examines therapists' perspectives on the policies, procedures, and practices used to deal with secrets in couples therapy), an important limitation that must be noted involves the lack of representativeness of the sample.

Several years prior, McCurdy and Murray (2003) examined couple therapists' perceptions of secrets in therapy, but in terms of the dilemma faced by marriage and family therapists when a child discloses information that a counselor is mandated to report. A case example is provided to demonstrate the complexities of confidentiality with minors and the legal responsibilities towards parents in a situation in which the therapist is working with the family, plus seeing the adolescent son for individual sessions. When the adolescent admits to engaging in high-risk behaviors during an individual session, the therapist faces the difficult decision of whether or not it is appropriate to inform parents since the therapist had only provided a basic explanation of confidentiality and had not discussed (or

envisioned) this type of situation. The article concludes by providing recommendations for marriage and family therapists from the International Association of Marriage and Family Counselors and American Counseling Association codes of ethics. In particular, the authors suggest relying on sound professional judgment when deciding whether or not it is appropriate to breach confidentiality and suggest reviewing confidentiality and the limitations associated with it on an ongoing basis. As noted by McCurdy and Murray, ethical issues surrounding disclosures by minor children in marriage and family therapy is grossly understudied.

3. THE CONFIDENTIALITY DILEMMA

In some instances and for a variety of reasons, therapists are faced with the question of whether or not they should breach confidentiality. Watts (1999) was interested in this type of situation, and conducted a case study investigating the challenge for marriage and family therapists between maintaining a client's confidentiality and deciding to breach confidentiality due to the duty to warn or protect. The case involved a couple in which the female partner disclosed that her husband, a doctor, intentionally overmedicated her step-mother. He did so because she was the lone benefactor on the insurance policy, and the money would help pay off their debts. The article reviewed ethical and legal codes, state laws regarding privilege communication, and the constitutional right to privacy. It concluded by recommending that marriage and family therapists be aware of their state's laws prior to breaching confidentiality. Furthermore, the article recommended that in the event that a client is participating in illegal activity, the counselor should encourage the client to turn him or herself in to the proper authorities. Relatedly, should a counselor choose to report a client's illegal activity, the authors argue that he or she should refer the client to another therapist because the counselor has now become the accuser.

Berry-Harris (2007) also explored how therapists handled confidentiality with their clients, while taking into account the differences among therapists from a variety of backgrounds including professional organizations, work settings, and personal characteristics regarding their beliefs, experiences, and behaviors. Participants ($N = 114$) were randomly selected from the American Psychological Association, American School Counselor Association, and

the American Mental Health Counselor Association. In terms of participants' ethnicity, the breakdown is as follows: 98 European American (86%), 6 African Americans (5%), 4 Hispanic (4%), and 5 Other (5%). Regarding age, gender, and education levels, the following statistics were reported: a) 49 (43%) respondents were aged 50 or younger, 65 (57%) were age 51 and over; b) 85 (75%) of participants were female; and c) 58 clinicians (51%) possessed doctoral degrees and 56 had Master's degrees (49%), respectively. Each participant was mailed the Therapy with Clients Survey Measure survey, which assesses therapist views of the way they manage confidentiality issues in therapy, along with a return address envelope. Results revealed differences in therapist behavior in terms of how they handled confidentiality issues with clients of diverse ages. More specifically, findings revealed differences in the ways of obtaining informed consent, approach to discussing confidentiality, information shared with parents or guardians, and the influence of client-specific factors on the management of confidentiality (please refer to Berry-Harris (2007) for further breakdown of these results). Limitations of this study include the lack of diversity, use of an older sample (i.e., 57% of participants were aged 51 and over), and lack of information regarding religious affiliation.

Yet another study piloted by Sullivan, Ramirez, Razo, and George (2002) examined the decision-making process of pediatric psychologists regarding when it is appropriate to break confidentiality. All participants belonged to the American Psychological Association; of the 74 pediatric psychologists, 70 (95%) possessed a doctoral degree, and 69 (93%) were licensed psychologists. In addition, 38 participants were women (51%), the mean age of respondents was 49.3 years ($SD = 10.32$), and the majority of participants were Caucasian ($n = 72$; 97%). These pediatric psychologists were surveyed using the Survey of Ethical Dilemmas in Reporting Adolescent Risk-Taking Behavior. Interestingly, but perhaps not surprisingly, results indicated that two factors play a large role in the therapist's decision to breach confidentiality: 1) the negative nature of the client's behavior, and 2) the desire to maintain the therapeutic process. Each factor has important implications for therapists in terms of comprehensively assessing the degree of potential risk to clients as well as developing ways to maintain the therapeutic relationship

even when confidentiality must be broken. However, attention should be directed to the small sample size, which is an important limitation of this study.

Additionally, another study investigated the confidentiality challenges and ethical dilemmas among social workers (Millstein, 2000). The purpose of this investigation was to better understand the dilemma faced by counselors when deciding to break confidentiality using an exploratory-descriptive research design. The sample employed by Millstein (2000) consisted of 152 experienced masters level social workers. Respondents were mailed an investigator-generated questionnaire, which contained five parts: 1) background information about the respondent, 2) beliefs about confidentiality in clinical practice, 3) the ways in which confidentiality issues are handled with clients, 4) the confidentiality policies in their place of employment, and 5) areas in which the counselor has experienced ethical dilemmas and how they were handled. The author reports the following demographic characteristics of the sample: 91% were Caucasian, 84% female, average amount of experience ranged from 11-15 years, and average age was 42 years old. Millstein found that the greatest number of ethical dilemmas regarding confidentiality occurred when collaborating with other agencies or client families. Interestingly, results also revealed that a small percentage of respondents were not informing their clients about confidentiality (and its limits) until a problem arose. Along these lines, fewer than half of participants surveyed inform their clients about their confidentiality policy in writing. Based on these findings, the author recommends review and discussion of written confidentiality policies with each client, the need for comprehensive written policies about limits to confidentiality that go beyond legally determined requirements to include collaborative relationships, third-party payers, and supervision, and training on ethical dilemmas related to confidentiality focusing on the areas identified in the study as areas of need including collaborative relationships, legal knowledge, and managed care. However, as seen in other studies, a vital limitation involves the use of a small, homogeneous sample.

4. RELATED ISSUES

Confidentiality and the decision to keep secrets are only a few of the dilemmas therapists are faced with. Lambert (2011) attempted to ascertain the procedures followed by marriage

and family therapists in determining whether and how to hold individual breakout sessions as well as who constitutes the client in these instances. The study employed a qualitative approach in which eight licensed psychologists were interviewed. The author reports the following demographic characteristics for the sample: 1) four males and four females, 2) a range of 1 to 32 years of practice, and 3) all Caucasian participants. The results of a grounded theory methodology revealed three main concepts: 1) defining who constitutes the therapy client, 2) maintaining privacy and confidentiality during the therapeutic process, and 3) handling private or secret disclosures made during individual breakout sessions. Based on these results, Lambert proposes a systems model for therapists to follow when conducting individual breakout sessions and offers guidelines for clinicians to follow to help avoid ethical dilemmas in their work with couples and families. However, the lack of diversity among participants is an important limitation of the study.

Disclosure practices of public and private sector rehabilitation counselors is another facet to consider, which is what Shaw, Chan, Lam, and McDougall (2004) examined. Participants were surveyed about the content, circumstances, timing, and format of their disclosures. The Commission on Rehabilitation Counselor Certification (CRCC) Professional Disclosure Survey (PDS) was mailed to a randomly selected sample of certified rehabilitation counselors ($N = 261$). The authors reported that 63% of participants were women, the average length of experience was 17 years, and that the mean age of participants was 46.33 ($SD = 10.26$) years. Interestingly, no data regarding ethnicity were presented. Findings indicated that while some information is disclosed, other information typically considered important to the counseling relationship is not disclosed at the outset of therapy (e.g., limits of confidentiality, treatment risks). In particular, results revealed many rehabilitation counselors do not fully inform their clients about the limits of confidentiality at the outset of counseling. However, an important note is that this study lacked of an ethnic breakdown of participants, which may directly impact the generalizability of results.

The last study to be discussed is that of Monshi and Zieglmayer (2004), which described the results of an ethnographic study of patient-healer relationships in Sri Lanka. The study took

place at the University of Human Sciences in the Principality of Liechtenstein. According to Monshi and Zieglmayer, the study was pluralistic and integrative; in particular, results from quantitative, qualitative, and introspective procedures were used to allow the investigators to assess a participant from different perspectives. The sample consisted of 47 Sri Lankans and 9 Germans. Data collection methods included semi-structured interviews, behavioral observation, qualitative experiments, diaries, and continuous conversations between the researchers and the interpreter. Results indicated that participants' view of privacy differed greatly from Western views and that the privacy protections used in the study created discomfort among participants. The authors concluded that any definition of privacy must take into account the cultural variations in defining and understanding this concept. The study has important implications for practitioners, revealing that confidentiality is not a one-size fits all approach, particularly for practitioners working with a very diverse caseload. Yet, as with several aforementioned studies, a primary limitation of this article is the lack of demographic information about the sample.

5. PUTTING IT TOGETHER

This review examined the literature related to confidentiality dilemmas in counseling including how to handle family secrets and the therapists' decision to breach confidentiality agreement. While the results of these studies provide valuable information, they are also characterized by a number of limitations including small sample sizes and the lack of representativeness or diversity among the participants.

6. CULTURAL AWARENESS

More research is needed to directly assess cultural influences on the confidentiality process. However, in the meantime, therapists can take steps to ensure that they become more culturally competent. For example, Sommers-Flanagan and Sommers-Flanagan (2015) detail some of the issues that may arise when interviewing individuals who are Native American, Asian American, and/or Hispanic / Latin American. They note that many Native Americans consider silence to be a sign of respect, and that they value careful listening. Some may even perceive too many questions as being rude or disrespectful, along with taking notes during an interview since it defers from

vigilant listening. Asian American clients may also have some characteristics that need to be considered. For example, Asian American individuals may be less confrontational and yearn for harmonious relationships. They may also view direct eye contact as invasive, and may desire a level of formal respect. In some instances, as with Hispanic/Latin American individuals, religion may take prominence over therapy; the Catholic Church is very influential within this group, and often plays a vital role in helping individuals with mental health problems. Probing further, some Hispanic/Latin American individuals may believe that their mental health is out of their control, which may create issues in situations where a therapist needs to aid the individual in establishing a locus of control.

It is important to note that the aforementioned details are merely a guideline; individuals within cultures are very diverse, and it is unfair to assume that these guidelines will apply to every single person. However, it is still imperative for therapists to have knowledge of the possible cultural influences, as this can undeniably affect the client-therapist relationship including, but not limited to, the confidentiality process.

7. RECOMMENDATIONS

While a number of studies have examined the confidentiality process, there is a dearth of information exploring clients' perceptions and understanding of confidentiality and even less that takes into account how cultural components may influence a client's willingness to disclose during sessions. The present review addressed this issue by considering the role of culture on the therapist's decision to disclose as well as differences related to culture around clients' feelings and expectations for privacy in therapy. Unfortunately, the majority of studies focused on these issues without directly considering cultural influences. Still, therapists should be weary of clients' and their own cultural influences; careful care should be taken to ensure that the client understands the therapists' confidentiality terms and conditions when confidentiality terms or a secret may not be maintained. More specifically, it is recommended that family therapists take into account the context of culture prior therapeutic decisions (Sori & Hecker, 2015). Thus, the proposed study has important implications for marriage and family therapists that may be assuming a certain degree of understanding

among clients of diverse backgrounds that may not be present.

8. DISCUSSION

It is our belief that culture significantly influences the manner in which a therapist employs a confidentiality policy in his or her practice. More specifically, we argue that culture plays a large role in an individual's decision-making process in terms of when it is appropriate to breach confidentiality as well as how the breach is perceived. As noted by Zygmund and Boorheim (1989), values may not always be considered ethical, which may create the possibility that a clinician's personal values do not protect the welfare of his or her clients. In addition, I also thought a lack of understanding around the limits of confidentiality would limit the amount of information disclosed in sessions. This anticipated finding is based on work by Pabian, Welfel, and Beebe (2009), who examined psychologists' knowledge of legal and ethical guidelines and found almost 75% of participants were misinformed about their state laws, despite reporting a belief they were well aware of state statutes and ethical guidelines. Moreover, I felt that therapists' understanding of the confidentiality concept as well as the implications this may have for couples and families, has been grossly understudied (Sullivan et al., 2002; Whetten-Goldstein, Nguyen, & Sugarmen, 2001). Finally, I strongly believe the influence of culture on the therapy process is an important area of inquiry which has implications for the therapeutic alliance, the type of information disclosed, and treatment effectiveness and outcome (McGuire, Total, & Blau, 1985). It is my hope that the results of this study (and others) will be used to provide recommendations or guidelines in terms of discussing confidentiality with diverse clients that is both respectful and effective in furthering their understanding of the concept.

9. CONCLUSION

The purpose of the present study was to determine the extent that culture influences marriage and family therapists' understanding of their duties and responsibilities related to issues around confidentiality as well as clients' perceptions and understanding of confidentiality in a diverse sample of participants. Findings revealed: 1) therapists from different cultures viewed confidentiality policies differently, and 2) clients from different cultural backgrounds reported significant differences in their

understanding and comfort level with their rights to confidentiality and its limits. As noted in the American Association for Marriage and Family Therapy (AAMFT) code of ethics (1.1), "Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation." However, the results of this study may support the notion that there is passive discrimination occurring in that individuals from non-Western cultures have different perceptions and understanding of the confidentiality process, which may influence their willingness to disclose, and thus, impact the outcome of treatment. Along these lines, the findings of the present study may also conflict with AAMFT ethic 1.2, which states:

Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship, and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible.

Consistent with this ethic, it may be that therapists should be more proactive in assessing clients' understanding of the confidentiality process. If a client either does not understand the concept of confidentiality or feels that it is inconsistent with his or her culture or worldview, it is incumbent upon the therapist to process with the client the best way to proceed, prior to the onset of treatment. In addition, while article 33 of the New York State Mental Hygiene Law pertains to confidentiality and indicates it cannot be breached without client consent, no mention is made of the potential impact of culture on this process. Thus, in the

event a therapist violated confidentiality, but had explained the policy prior to the onset of treatment and the client(s) expressed agreement, but did not quite understand or maybe did not agree based on their value system or worldview, he or she would be acting in a legal manner, despite a client's lack of comprehension of the policy to begin with. Unfortunately, as argued by Millstein (2000), this lack of clear guidance has resulted in more and more providers deciding to not consult professionals in ethics or the law to resolve their ethical dilemmas; rather they are consulting supervisors and colleagues.

Furthermore, neither the AAMFT code of ethics or New York State Mental Hygiene Law offers guidance regarding how non-Western therapists should proceed if their cultural values or worldview is inconsistent with our Western confidentiality policy. In particular, results of the present study revealed reluctance among non-Western clinicians to breach confidentiality under any circumstance. This finding is consistent with Sullivan et al. (2002), who wrote, "in practice, the decision to break confidentiality is multi-factored and complex, likely influenced by a combination of the psychologist's own values, the items and factors discussed in the present study, and additional considerations that have yet to be discovered" (p. 400). This dilemma has cultural, legal, and ethical implications for the field and much more study is needed to determine how to address this issue.

These findings have important implications for treatment providers. More specifically, similar to the therapy process, confidentiality may not be a one-size-fits-all concept. Results indicate that clients from non-Western cultures did not completely understand the concept of privileged communication or the limits to confidentiality. Thus, our current manner of explaining the confidentiality process may merely be an academic exercise for some clients since they do not comprehend the concept. This idea is consistent with Oyen (1982), who felt confidentiality policies were limited and argued for their reexamination as they relate to therapy.

In addition, findings also revealed that for some clients, the concept of confidentiality was inconsistent with their beliefs, thus creating a disconnect between one of the benchmarks of therapy (i.e., confidentiality) and an individual or family's culture of origin. Findings also indicated that non-Western therapists expressed reluctance to breach confidentiality under any

circumstance. Consequently, as argued by Millstein (2000), confidentiality guidelines should be tailored to the particular context and individuals involved in treatment.

The results of this investigation underscore the need for further study. In particular, future research may wish to examine the decision-making process as it relates to confidentiality of non-Western therapists more closely with more diverse and larger samples. Snyder and Doss (2005) believe that it is not the intent of clinicians to conduct ineffective treatment or behave unethically; however, there does seem to be a failure to recognize the role of personal values and culture. In addition, more specific information is needed directly from non-Western clients regarding how to modify the confidentiality process in a way that is respectful, yet still provides the safeguards intended. Given that confidentiality is considered the cornerstone of the therapeutic process, it is imperative that clinicians find a culturally-respectful way to make clients feel safe to reveal what may be embarrassing or personally sensitive information in treatment (Younggren & Harris, 2008). Finally, more precise comparative study is needed among cultures to better understand the influence of different beliefs. "Ethical therapist behavior clearly requires more than good intentions, and the values permeating therapeutic efforts must...be more than a matter of personal bias and subjectivity" (O'Shea & Jessee, 1982; p. 18). Ultimately, it is my hope that the results of the present study, coupled with further work in this area, will inform a decision-making manual which can be easily disseminated to educators and treatment providers.

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