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Balancing Confidentiality: Protecting Privacy and Protecting the Public

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Confidentiality is a primary obligation for psychologists. Yet confidentiality has been subjected to legal and professional balancing tests, in which the need for a confidential relationship is balanced and then gives way to other societal or professional needs. The protection of children, prevention of violence, professional training, and treatment coordination have been given priority over maintaining confidentiality. In the process, psychologists seem increasingly inclined to disclose confidential information or seek opportunities to disclose confidential information even when there are other clinical or legal options. This article takes the position that any disclosure of confidential information should be a last resort and that psychologists must push back and limit the growing list of mandatory and permissible disclosures.

Keywords: confidentiality, ethics, privacy, decision making, psychotherapy

Unbalancing Confidentiality

Michael B. Donner

The American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (Ethics Code) (APA, 2002) requires that all information provided to a psychologist in the course of her or his professional work is to be kept private. Details that could result in the identification of a patient, client, research participant, student, or any other person whom the psychologist has met with in the course of professional activities is protected by the Ethics Code and, in some situations, by the laws

and regulations affecting the practice of psychology. Confidentiality is the only standard in the Ethics Code that is positioned hierarchically. Section 4.01 says in part, "Psychologists have a primary obligation to protect confidential information" (APA, 2002, p. 1006). The word *primary*, derived from the Latin, means "first" or "most important" (Oxford Compact English Dictionary, 2007). Although this point is infrequently discussed in the literature, it is clear that the APA has accorded confidentiality unique status and has made it an ethical imperative. Confidentiality has been described as "the cornerstone of professionalism" (Woody, 1999, p. 607).

Psychotherapy clients also have a keen sense of the importance of confidentiality. Breaches of confidentiality lead to the percep-

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tion of psychologists as less trustworthy (Merluzzi & Brischetto, 1983), and in Miller & Thelen's (1986) study of psychotherapy clients, the vast majority "view confidentiality as an all-encompassing, superordinate mandate for the profession of psychology" (p. 18). Those authors found that the participants wanted information about the limits of confidentiality; however, most would also limit their therapeutic disclosures in response. In its brief in support of the right to a privileged relationship, the APA (1996) wrote:

Maintaining the confidentiality of client communications is thus both an ethical duty and a practical necessity for this profession. Psychologists cannot effectively treat mental and emotional disorders if their clients fear that their innermost thoughts and feelings will not be kept confidential. (p. 2)

Although the terms *privacy*, *privilege*, and *confidentiality* may seem synonymous, there are important distinctions. Privacy has been defined as:

... the right to be left alone. It is a fundamental and compelling interest. It protects our homes, our families, our thoughts, our emotions, our expressions, our personalities, our freedom of communion and our freedom to associate with the people we choose [I]f there is a quintessential zone of human privacy, it is the mind. (*Long Beach City Employees Association v. City of Long Beach*, 1986, p. 3)

Confidentiality protects the privacy of information received in professional relationships. The duty of confidentiality requires that psychologists not disclose information received in the professional relationship, in which privilege is the right to refuse to allow private information to be disclosed to the legal system, a right not afforded in most circumstances.

The legal system has also given great importance to confidential relationships in psychotherapy. The right of psychotherapy patients to have a confidential relationship with a psychotherapist is enshrined in the laws of every state and in the federal courts (*Jaffee v. Redmond*, 1996). The psychotherapist–patient privilege offers legal protection to the confidential relationship by providing an exception to the truth-seeking task of the legal system. In the judicial system, the general rule is that all information is available for review. Corporations must turn over their business records, parents can be compelled to testify against their children, and even personal individual diaries may not be withheld. "For more than three centuries, it has now been recognized as a fundamental maxim that the public has a right to every man's evidence" (*Jaffee v. Redmond*, 1996, p. 9).

An amicus brief to the Supreme Court in *Jaffee v. Redmond*, jointly prepared by the American Psychoanalytic Association, the Division of Psychoanalysis of the American Psychological Association, the National Membership Committee on Psychoanalysis in Clinical Social Work, and the American Academy of Psychoanalysis, argued the following:

The possibility that a therapist might reveal in a court of law a patient's most troubling inner secrets would stand as a permanent obstacle to development of the necessary degree of patient trust in the therapist, and would pose a significant, and for many patients an insurmountable, barrier to effective treatment. (American Psychoanalytic Association, 1996, Background, Part 2, Paragraph 2).

Yet, despite the pervasive emphasis on confidentiality in the law, the literature, and in our Ethics Code, there are all too many

exceptions to confidentiality and privilege. Every state has regulations that mandate reporting child abuse, and most have exceptions to the psychotherapist–patient privilege and laws governing confidential medical records. These exceptions permit or require disclosures of confidential information in order to protect the public or the individual in psychotherapy. Although not unique, in California, in addition to child and elder abuse reporting, there are a total of 15 other exceptions to confidentiality. For example, psychotherapy records are not protected in litigation in which the mental condition of the patient has been raised by the patient, or in cases in which a patient has died without a will or in which the patient is a danger to self, others, and property (California Evidence Code, 2006).

It is not only the legal system that requires disclosures of confidential information, but confidentiality is affected by the fact that psychology interns, practicum students, and many licensed psychologists are in supervision and consultation. Cases are routinely discussed in individual and group supervision and in classroom settings, and professional colleagues frequently use each other for informal consultation in social settings and on Internet listservs. Although supervision and clinical consultation are critical components of training and essential for ongoing professional development, there is little discussion in the literature of the actual impact of all of these disclosures. Supervision and consultation routinely involve detailed disclosures of patient information, and it is unlikely under such circumstances that individually identifiable information will be adequately disguised. If it is true that disclosures of confidential information in psychotherapy would be a "permanent obstacle" to psychotherapy, then it is not sufficient to say that the benefits of training outweigh the impact upon the treatment. We must attempt to address and reconcile this discrepancy.

It seems that it has become the norm and expectation of both psychologists and those with whom we work that information routinely flows in and out of the professional relationship. Informed consent documents declare the confidential nature of the relationship followed by detailed descriptions of the circumstances that may lead to disclosures. While it may seem rare that the risk of disclosure dissuades signatories from participation, there is no way to actually know whether clients and participants are holding back or in some other way modifying their responses in an effort to protect their own privacy, as they are no longer assured that the psychologist can or will do so.

The Problem of Balanced Confidentiality

Psychologists have taken on the duty to perform balancing tests, weighing the needs of society against the individual being served; however, the relationship between societal goals and confidentiality appear to have become unbalanced. The Ethics Code, case law, and state regulations that make exceptions to confidentiality represent efforts to balance the privacy needs of those with whom psychologists work against the needs of others in society. In *Tarasoff v. Regents of the University of California* (1976), the court held that "the protective privilege ends where the public peril begins" (Buckner & Firestone, 2000, p. 195), finding that a threat of serious violence against another overrides the privacy rights of the patient. Like child abuse reporting before it, the Tarasoff model has spread across the country. At the present time, some 36 states permit or require warnings, 9 have no standard, and 1 does not

allow it (Herbert, 2002). It may be understandable that a psychologist might wish to protect children from abuse or avert serious violence; however, these exceptions have been received by many psychologists as unquestioned moral imperatives.

The courts and the legislatures have taken the position that societal needs trump the privacy rights of psychotherapy patients, and there are exceptions that have much less significant social value than protecting against violence and child abuse. For example, many states have an exception that allows family members access to psychotherapy records in cases in which the deceased has not left a will. This seems an unwarranted intrusion on the right of the deceased patient to speak to a psychologist about his or her estate or any other matter. Disclosing confidential information is no longer seen as an unusual activity made legally permissible under exceptional circumstances, but instead confidentiality is something that may be breached in many more routine ways.

As a consultant and educator teaching continuing education and graduate courses on law and ethics for psychologists, I have found it common for participants to seek clarification and ask questions about confidentiality requirements. Ominously, many of the questions are framed in a manner that makes it seem as if the inquirer is looking for a loophole in the confidentiality requirements that would permit disclosures, as opposed to asking questions to determine whether a disclosure must be made. Calls and questions are often framed by the inquirers' asking to whom must a report be made, rather than whether it is absolutely necessary to disclose the information. It is as if psychologists and graduate students no longer view the obligation to maintain confidentiality as their primary obligation but rather as one among many other obligations and desires they have in mind. A recent report from the California Board of Behavioral Sciences (2007), the board that licenses marriage and family therapists, licensed clinical social workers, and licensed educational psychologists, noted that the most common complaints received by the board involved breaches of confidentiality, perhaps underscoring the importance of confidentiality to patients and the erosion of confidentiality amongst clinicians.

Psychologists appear to have absorbed the accumulated teachings in law and ethics courses and risk management programs by responding to the ethical obligation of confidentiality as if it were an impediment to other more important societal goals. Participants in courses that I have presented frequently invoke the specter of an HIV-positive man potentially infecting an unsuspecting sexual partner. Many of the psychologist participants wish to intervene by reporting the behavior to some outside agency rather than seeking a clinical solution to potentially risky behavior. Participants in courses taught in a state where it is typically not permissible to disclose HIV status are frequently disappointed and sometimes angry that they cannot report the behavior to the authorities or notify potential sexual partners. There is considerable resistance to the argument that the overriding consideration should be to maintain confidentiality and address the issue clinically. It seems clear that these audiences have begun to consider a wide range of behaviors worthy of disclosure. Protecting the public against a broad range of potential harms has apparently become a higher priority than the obligation to maintain confidentiality of the individual client.

Another example can be found in the increasing awareness by psychologists of the potential harm faced by children who witness domestic violence and the debate as to whether these effects constitute child abuse. Here again, rather than asking the question

of when and under what circumstances must a report be made, the emphasis seems to be more on seeking to expand the circumstances under which disclosures can be made. Audience members often insist that they "heard someone say that children witnessing domestic violence is child abuse" (Donner, 2007a, p. 31) and must be reported.

Confidentiality Must Be First

The example of the desire to report the HIV-positive patient without a clear sense of the legal right or consideration of the impact of such a disclosure serves to underscore that for many psychologists, confidentiality is no longer viewed as a "primary obligation," the first and most important consideration of ethical practice. Public and private interests, mandatory reporting laws and the fear of liability attached to the possibility of a complaint about failure to protect, and continuing education courses that emphasize risk management may have diluted the value and meaning of confidentiality in the minds of many psychologists. The critical infrastructure that is the ethical obligation to maintain confidentiality as the primary consideration has crumbled under the pressures of these other demands. There are few psychologists calling for it to be rebuilt and renewed in professional practice. Courses on how to maintain confidentiality in the face of social or legal demands and strategies to resist the demands for information are needed, not detailed courses on the rules for disclosure.

Instead of courses on reporting laws, psychologists should be educated on how to resist a subpoena and taught that doing so is an ethical imperative, not only a risk management strategy to prevent liability or licensing board complaints. Guidelines from professional associations are helpful but typically emphasize legal strategies rather than ethical considerations (APA, 2006). The pervasive threat of litigation hangs over psychologists, yet there is a relatively low risk. In a review of data from the California Board of Psychology, Donner (2007) found that of the more than 16,000 licensed psychologists in California, less than one tenth of 1% were actually disciplined in any given year, and the risk of a subsequent or concurrent successful malpractice claim in any given year is even less likely (Baerger, 2001; Dorken, 1990; Montgomery, Cupit, & Wimberly, 1999).

Nevertheless, the threat of litigation seems to have contributed to the dilution of the importance of confidentiality as an ethical imperative, so that a mandate to maintain confidentiality seems to have become more a consideration for managing risk rather than the primary obligation of professional practice. It is argued that in responding to a subpoena against the wishes of a patient or participant, a psychologist's emphasis must be on maintaining the maximum degree of confidentiality of the records. Psychologists can be encouraged and trained to do everything reasonable to limit the disclosure of confidential material. Our training on responding to subpoenas could focus more on the efforts of Joseph Lifschutz (*In re Lifschutz*, 1970) and Jennifer Bier (Moffeit, 2005), clinicians who risked contempt citations and jail in order to pursue every legal option to protect the confidentiality of their clients.

Although it is not necessary for psychologists to go to jail rather than turn over confidential records, psychologists must be encouraged to once again treat confidentiality as the most important ethical obligation and to advocate for all psychologists to assert the right to a confidential relationship whenever faced with an intrusive demand for information from third parties. Information re-

ceived by psychologists should not flow in and out but should ideally move in only one direction. Psychologists should be vigilant against efforts to dilute confidential relationships and, when disclosure of confidential information is unavoidable, should provide only the minimal amount of information necessary in order to preserve privacy to the fullest extent possible.

In order to achieve the objective of treating confidentiality as the primary ethical obligation, psychology must more actively assert the position that without confidentiality, psychologists cannot be effective. This means that wherever pressure is applied to disclose confidential information, whether for utilization review, public health concerns, or the many broad concerns for the well-being of the public in general, psychologists must push back and strive to protect the privacy of our clients. Pushing back can take many forms, including more careful analysis of what actually constitutes mandatory disclosures, more thoughtful disclosures to other professionals, or more detailed assessments of dangerousness. What began as an effort to protect children from abuse and the public from dangerous patients has resulted in an ever-larger set of exceptions to confidentiality. The effort to balance the privacy rights of clients against the broader needs of society has not just weakened privacy protections but threatens to undo a fundamental basis for our ability to serve the very public such disclosures were intended to protect. Psychologists must consider rejecting the idea of balancing the privacy rights of clients against the rights of society and return to a more unbalanced position where confidentiality is once again the primary ethical obligation of all psychologists.

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Commentaries

Considering Confidentiality Within Broader Theoretical Frameworks

Leon VandeCreek

Michael Donner has called for psychologists to refocus on the centrality of confidentiality in mental health practice by attending more to the essential role that confidentiality plays in psychological services than to avoidance of violating ethics codes and laws. A useful way to think about confidentiality of client information is to frame this principle within the broader frameworks of principle-based ethics and positive ethics. When psychologists understand confidentiality within these broader frameworks, they are more likely to aim to be exemplary practitioners rather than to just avoid breaking rules.

Principle-Based Ethics

According to principle-based ethics applied to health care, providers have some basic obligations to their clients unless a superior obligation overrides them. Beauchamp and Childress (2001) determined that several overarching ethical principles, such as beneficence (promote the welfare of others), nonmaleficence (avoid harming others), justice (refrain from unfair discrimination), and respect for client autonomy (encourage clients to make decisions about their health care), were especially important for providers of health care. The principle of autonomy refers to respecting the decision making of clients. "Personal autonomy is, at the minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choices" (p. 58). Following this principle, to the extent possible, psychologists should treat clients as autonomous individuals who typically have given up none of their human

rights by virtue of becoming clients, and they should participate as fully as possible in determining treatment goals and methods, including making decisions about sharing their health care information (Knapp & VandeCreek, 2004).

For example, when clients request that their providers share records with another provider or entity, clients have a right and a need to know the content of the records. This need and this right are included in the meaning of *informed* in the term *informed consent* and are based on respect for client autonomy and for people's rights and dignity (Principle E, American Psychological Association [APA] Ethics Code, 2002). Clients may assume that their providers will share only positive information and may not be aware of the contents of their records. Yet, principles of confidentiality and client autonomy suggest that providers need to fully inform their clients about the nature and content of the records that will be released. The most complete way to fully inform clients is to share the record (or the information to be shared) with the client before sending it on. Only then is the client fully informed.

The act of sharing the record also may impress on clients the extent to which they should be alert to challenges to confidentiality of their health care information. In my experience of sharing copies of psychological assessment reports with clients before sending the report to the recipient of the client's request, I have frequently been impressed by the impact on the clients of reading about themselves. In some instances, clients have spotted errors of fact; in other instances, they have reacted positively to my efforts to "make sense" of them. Yet, in other instances, clients have requested that the report not be sent, not because of factual errors but because the clients recognized that the information might not serve them in the ways they had hoped. In some of these instances, I have modified the report by deleting information that was not germane to the request, but in other instances clients have changed their minds about releasing the information altogether. In most instances, these clients gained an enhanced perspective on their rights to keep personal information confidential. Just because clients sign consent forms does not mean they understand the consequences of doing so. Our obligation is to teach clients about the broader principles that frame their requests for release of information.

Positive Ethics

Many psychologists view ethics in terms of rules and standards and the adjudicatory procedures of disciplinary bodies. From this standpoint, the study of ethics is defined in terms of rule breaking and punishment and is understandably anxiety producing. Ethics codes then represent the ethical "floor" or minimal standards to which psychologists should adhere (Fisher, 2008; Knapp & VandeCreek, 2006). "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*" (Fisher, 2008, p. 6, italics in original). In contrast, from a positive ethics perspective, ethics is viewed as a way to help psychologists fulfill their highest potential. It means relying on an underlying philosophical system to help think through complex ethical dilemmas, rather than searching for solutions primarily to avoid sanctions (Knapp & VandeCreek, 2006). This view of positive ethics parallels the development of positive psychology. Positive psychology focuses, in part, on shifting the emphasis of professional psychologists away from an almost exclusive focus on wrongdoing,

pathology, and disciplinary actions toward a vision of high ethical standards. Positive ethics also encourages individual psychologists and institutions to actively promote exemplary behavior.

At first, it may appear difficult to strive for moral excellence with the principle of confidentiality. The APA ethics code and laws provide several basic rules to follow. But if we just follow the rules, we minimize the importance and the major point of confidentiality. Originally, confidentiality rules were constructed to ensure that clients feel safe enough to share private and sometimes embarrassing information. Cullari (2001) surveyed clients about what they wanted and expected from psychotherapy, and two of the highest rated goals were to have "a feeling of safety and security" and "the chance to talk to someone in a safe environment and without fear of repercussion" (p. 104). Positive ethics then asks psychologists, How can we facilitate that safe environment?

Psychologists can help to create that environment by being meticulous about maintaining the confidentiality of the client's revelations. They can earn that trust by taking special care to inform clients about the limits to confidentiality at the outset of treatment and along the way as client disclosures raise questions about confidentiality. For example, when clients request that their information be shared with an insurance company for reimbursement, psychologists can inform clients that information on insurance forms usually does not stop at the desk of the claims manager. In fact, the information likely is further shared with national data banks where the information can be accessed by other insurance companies when the client elects to purchase another insurance product or a large home mortgage. Psychologists can play a helpful role in teaching clients about the risks of sharing their health information, and this information should be shared at the beginning of service.

Fisher (2008) presented an ethical practice model for confidentiality that clarifies the importance of the ethical principle, places the rules and exceptions into perspective, and encourages psychologists to reach for the "ethical ceiling" (p. 4). The model provides a sequence of six steps for psychologists: (a) be well prepared for a discussion with clients about the importance of confidentiality, (b) tell clients the truth up front, (c) obtain truly informed consent, (d) respond ethically to legally imposed requests for disclosure, (e) avoid the "avoidable" breaches of confidentiality (e.g., closely monitor record-keeping practices, protect client identity in presentations), and (f) talk about confidentiality to peers, students, and attorneys. Fisher's goal is to assist psychologists to reclaim their status as experts about confidentiality.

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Informed Consent Can Solve Some Confidentiality Dilemmas, But Others Remain

John C. Gonsiorek

In “Unbalancing Confidentiality,” Michael Donner mirrors concerns comparable to those in Fisher’s (2008) discussion on confidentiality. This unease has been building for some time: Those who anticipated that the U.S. Supreme Court in *Jaffee v. Redmond* had placed therapist privilege on a firmer legal foundation will, on closer scrutiny of the decision, be disabused of this hope (Shuman & Foote, 1999). The expectation of confidentiality—that bedrock of psychological services—and its corresponding legal privilege are deeply eroded, perhaps moribund.

Donner’s critique of the situation is more hopeless than is warranted because he does not emphasize how effective a remedy informed consent can sometimes be. Creative, situation-specific, and proactive use of informed consent can manage some problems. Foote and Shuman (2006) describe how this remedy might be applied in forensic evaluations. Indeed, an argument can be made that without proactive informed consent as the core of confidentiality, effective management is not likely.

Yet, Donner’s call for a reconfigured balance regarding confidentiality is well taken: The situation is hardly hopeful. Informed consent more squarely addresses legal liability than the erosion of privacy, the foundation of psychotherapy. How can a psychologist obtain informed consent for possible challenges to privilege stemming from future events: divorces from marriages that have not yet taken place, motor vehicle accidents or criminal allegations that have yet to occur, and the like? These are not uncommon, and a vague admonition that anything might be possible does not convey the potential seriousness; at the same time, a dire admonition seems overly pessimistic. Foote and Shuman (2006) present data suggesting that clients may be less troubled by the tenuous nature of privilege than anticipated, but this is scant comfort. Those seeking psychological services are typically preoccupied with the issues that impelled them to seek relief. A future scenario of records being unexpectedly ordered into legal proceedings against their wishes with adverse results is simply not salient. But when it occurs, clients are usually very troubled by it.

The porousness of confidentiality seems to be increasing. Most discussions of mandated reporting focus on neglect and abuse of minors, elders, and the vulnerable. There is arguably more consensus on this type of reporting than on other mandates that the states have created, such as selective reporting of misconduct by health care professionals (required of other health care professionals) and of pregnant women ingesting certain substances. Child and elder welfare were compelling reasons for initial mandated reporting statutes, but the temptation for legislatures to expand them seems irresistible, even as the rationales are generally worthy. But as health care professionals become deputized as agents of the state—without consent, compensation, or training—for a broadening array of functions, the net effect may undermine the core of the health care relationship.

More troubling is the perception by some in the legal community that medical records are legitimately intended for future legal discovery. An attorney once asked me the mechanism for filing an ethics complaint against a plaintiff’s (distant) past treating psycho-

therapist who destroyed treatment records. After ascertaining the particulars, I informed the attorney that no violation had occurred because given the age of the records, the psychotherapist was within existing standards of record destruction. The attorney was incredulous, stating that psychology was negligent in allowing this practice and that the legal system needs mental health records retained in perpetuity, like dental X-rays, in case attorneys might find them useful in future discovery. Contrast this reasoning with the nuanced and balanced cost–benefit analysis regarding records retention in the American Psychological Association’s most recent *Record Keeping Guidelines* (2007). This attorney’s view is somewhat extreme but probably more consistent with judicial thinking than are most psychotherapists’ expectations. As Shuman and Foote (1999) noted, “[T]he confidentiality of the psychotherapist relationship is a fragile and perishable commodity” and “the barrier of privilege is relatively porous in the best of circumstances” (p. 483).

Several authors (e.g., Fisher, 2008; Foote & Shuman, 2006; Shuman & Foote, 1999) have offered thoughtful and useful models for managing such confidentiality challenges. Yet, problems remain. The fact that we need models to effectively implement the Ethics Code (APA, 2005) suggests that its implementation is obscure and fragile. The models are complex, even for experienced psychologists. Since confidentiality challenges often occur under duress, it can reasonably be anticipated that even experienced psychologists will sometimes fail in implementing them. Additionally, these models are complicated for clients’ informed consent and perhaps beyond the scope of understanding. Informed consent requires that the client actually understands the information such that reasonable choice can be exercised. Genuine informed consent may sometimes not be possible in these models, no matter how many forms are duly signed. Finally, the models rest on the assumption that risk can be reliably assessed in the present and that such assessment predicts future risk. The former seems imprecise; the latter, mere fantasy.

How did psychology reach a point where the confidentiality that animates the relationship is so besieged? The bases of this crisis are multidetermined but likely include the following:

1. *Weakness in ethics training.* The self-examination and critical thinking required to master confidentiality are daunting. Psychologists in training have little hope of adequate preparation if faculty and supervisors have minimal direct experience in these challenges (a vulnerability in research-oriented programs) or if the program finds it unprofitable to devote adequate resources (a vulnerability in for-profit training programs). A remedy: Require accredited programs to demonstrate sophisticated ethics training.
2. *Excessively legalistic language in professional codes and standards.* Section 4.01 of the current Ethics Code may be an example of legally accurate but clinically opaque wording. In Section 4.05, the meaning of the phrase *only as mandated by law or where permitted by law* may be precise legally but can suggest an inaccurate degree of option in disclosure. There are other examples. A remedy: Psychology can do a better job of wording future codes in ways that illuminate, not obfuscate. Vetting a code with counsel to assure legal viability is not the same as adopting terminology that is more transparent to lawyers than to psychologists.

3. *The corporatization of psychology.* Many psychologists are trained by or work in for-profit corporations controlled or managed by nonpsychologists. The primary duty of corporations is to its owners or stockholders. This duty mixes poorly with psychologists' duties to clients and professional standards. Managerial cognitive styles are typically at odds with critical and scientific thinking. Adoption of language and thought derived from marketing and management can undermine socialization into psychology as a behavioral science and acceptance of its fiduciary duties. Watson (2005) noted, "Not only is managerial language an inadequate tool with which to explore these fundamental questions about the nature of truth, it has no respect for them. It is not a language for serious inquiry or explanation, or even for thinking" (p. 27). A remedy: Require maintenance of psychological intellectual and linguistic traditions in whatever systems psychologists are trained or operate.
4. *Encroachment by the legal/judicial system.* The legal/judicial system is expansionist and operates on the assumption that what is best for it is best for society. This however, is an empirical question, not a fact. Little data document the costs and benefits of mandated reporting, especially in its more exotic and idiosyncratic forms. Even less data document the benefit to society of aggressive legal discovery. But costs include depleting resources in health care, compromising informed consent, demoralizing professionals, and weakening that core patient-professional relationship. A remedy: Psychology could form alliances with other health care disciplines to seek tort and other legal reforms to create greater checks and balances and to require that legislative initiatives be subject to cost-benefit and effectiveness tests.

There are few roles in society in which the role bearer is ethically required to place the welfare of vulnerable and often lesser status individuals above the needs of one's employers, the convenience of the powerful, and one's own comfort. But such is the role of health care professionals. This is the fundamental difference between professional and employee. This role is inherently subversive, because it does not view typical power structures as primary. Our clients, often mentally troubled and not societally valued, and the integrity of our science, with its often uncomfortable findings and difficult methodologies, must come first. Otherwise, we are unworthy of public trust. The unchecked erosion of confidentiality is nothing less than an erosion of psychology, and of all health care, as professions and as independent entities.

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The APA Ethics Code and the Need for Balanced Confidentiality and Disclosure Decisions in Psychotherapy

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"Unbalancing Confidentiality" insightfully calls for renewed attention to the need to reflect on the place of confidentiality in moral considerations and obligations of practicing psychologists to individual clients, affected others, and society. Michael Donner's goal is to reposition confidentiality on top of what he sees as a pyramid model of ethical obligations. The goal of this commentary is threefold: (a) to correct the impression that the current American Psychological Association's (APA's) Ethical Principles and Code of Conduct (2002) was crafted to dictate a hierarchy of ethical obligations, (b) to dispute the notion that the Ethics Code accords confidentiality a "most important" status, and (c) to demonstrate the value of the Ethics Code's flexibility in recognizing that ethical practice decisions require sensitivity to the goodness of fit among the therapeutic goals, professional responsibilities, relevant laws, and stakeholder needs unique to each client-therapist relationship (Fisher, 2002).

The Nonhierarchical Nature of the Ethics Code's Principles and Standards

The 2002 APA Ethics Code begins with a set of five general principles intended to inspire psychologists toward the highest ethical ideals of the profession. The remainder of the code is composed of 151 enforceable standards that describe required, prohibited, and permitted behaviors across a broad range of roles and activities performed by psychologists. Unlike the Ethical Standards, the principles do not represent specific or enforceable rules of conduct. Rather in reflecting the moral values of the profession's community of purpose, they help guide psychologists' decision making by providing an analytic framework from which to identify those standards that are appropriate to the situation at hand (Fisher, 2002). The introduction and preamble to the code make clear that the priority given and the manner in which each principle or standard is applied are context specific. For example, as articulated in the introduction to the code, "the application of an Ethical Standard may vary depending on the context" (APA, 2002, p. 1061). With respect to the aspirational principles, the Ethics Code Task Force (ECTF) charged with presenting a revision of the 1992 Ethics Code to APA's Council of Representatives explicitly rejected a hierarchical organization of moral ideals and listed the principles in alphabetical order. Thus, an underlying assumption of the Ethics Code is that the moral priority of any principle or standard will be determined by the ethical requirements of the situation in which it is embedded.

Balancing Confidentiality and Aspirational Principles

Several of the Ethics Code's aspirational principles provide a moral framework for supporting contextually sensitive decisions to maintain or to disclose confidential information. The principles call for psychologists to strive to do good and avoid harm, to keep promises and recognize their fiduciary responsibilities, and to respect the dignity and worth of all people and the rights of individuals to privacy, confidentiality, and self-determination. (Principles A, Beneficence and Nonmaleficence; B, Fidelity and Responsibility; and C, Respect for People's Rights and Dignity).

As Donner rightly notes, protecting confidentiality can promote client autonomy and welfare by helping to establish and preserve a trusting therapeutic alliance and protect clients against social, legal, and economic harms that can result from the disclosure of such information. At the same time in appropriate circumstances, disclosure of confidential information can (a) protect clients from their own or others' actions that would lead to substantial social, physical, legal, or economic harm; (b) enhance therapeutic goals through helping the client recognize that some behaviors and situations are serious obstacles to autonomous decision making and mental health; and (c) demonstrate that psychologists' fiduciary obligations to clients (by means of their specialty training and license to practice) require them to act on their expert knowledge and legal obligations in both maintaining and disclosing confidential information.

Balancing Confidentiality and Enforceable Standards

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.—APA Ethics Code Standard 4.01, Maintaining Confidentiality)

Donner presents a number of important arguments regarding the need to reconsider ethical priorities related to confidentiality and disclosure in professional practice. For example, he rightly calls for psychologists to question whether they are abdicating their professional decision-making role by resorting to risk-averse confidentiality and disclosure policies that prioritize minimizing the potential for conflict between ethics and law or institutional policies rather than maximizing clients' rights and welfare. However, as illustrated in the quote from Standard 4.01, he errs in arguing that the Ethics Code language and intent privilege confidentiality over other ethical standards and procedures.

First, without resorting to dictionary definitions of the term *primary*, I would note that Standard 4.01 does not state that maintaining confidentiality is *the* primary obligation of psychologists but rather that it is *a* primary obligation among other competing obligations explicitly described in the same standard as related to law, institutional rules, or the professional or scientific relationship. Thus, Standard 4.01 neither prioritizes confidentiality over other obligations nor does it prioritize professional over law or institutional obligations.

Second, the need for a balanced ethical decision-making approach to confidentiality is communicated throughout the remaining standards within Section 4 (Confidentiality) and other sections of the Ethics Code. For example, the need to discuss the limits of

confidentiality is highlighted in Standard 4.02 and is repeated in all standards relevant to informed consent (Standards 3.10, Informed Consent; 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; 10.01, Informed Consent to Therapy). Finally, the conditions under which confidential information can be ethically disclosed without a client's consent are clearly delineated in Standard 4.05b, Disclosures.

The point of this brief exercise in the language of specific principles and standards is to underscore that the Ethics Code's balanced position reflects the discipline's recognition that an absolutist approach to either confidentiality or disclosure decisions can be damaging to client autonomy and welfare.

Confidentiality and Ethical Decision-Making

Donner provides excellent examples of instances in which risk management procedures may override rightly practiced confidentiality procedures in psychotherapy. His argument that liability concerns regarding child abuse and Tarasoff-type laws should not trump ethical decision making is well grounded and is consistent with the Ethics Code's approach to conflicts between ethics and law (Standard 1.02, Conflicts Between Ethics and Law, Regulations, and Other Governing Authority). However, there is no ethical menu from which the right ethical actions can simply be selected. Many ethical challenges are unique in time, place, and persons involved (Fisher, 2002). Assigning confidentiality privileged status in ethical decision making does not do justice to the complex relationship between ethics and law that often emerges in therapeutic contexts nor to a conception of psychologists as active moral agents in constructing solutions to ethical quandaries (Fisher, 2002).

Confidentiality and disclosure decisions should not be isolated or isolating. Practitioners need to apply practical wisdom to confidentiality challenges leading to right solutions that can be realized given the nature of the problem and the individuals involved. The goals of psychotherapy are not well served when confidentiality decisions are isolated from equally important professional, moral, and legal considerations. Nor are clients well served if maintaining confidentiality isolates them from understanding the practical and legal consequences of their own or others' harmful behaviors, the protective and welfare-promoting aspects of law, or the fiduciary obligation of psychologists to understand and appropriately respond to clients' mental health needs within the opportunities and restraints imposed by these needs and the legal and social contexts in which they are expressed. Envisioning confidentiality decisions as a process that draws on psychologists' human responsiveness to those with whom they work and their awareness of their obligations to society will sustain a profession that is both effective and ethical.

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